



Department of Education and  
Early Childhood Development

Victorian Child and  
Adolescent Monitoring System

# Refugee Status Report

A report on how refugee children and  
young people in Victoria are faring



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# Abbreviations

ABS	Australian Bureau of Statistics
ACIR	Australian Childhood Immunisation Register
AEDI	Australian Early Development Index
AMEP	Adult Migrant Education Program
AMES	Adult Multicultural Education Services
BSL	Brotherhood of St Laurence
CALD	Culturally and Linguistically Diverse
CAMHS	Child and Adolescent Mental Health Service
CBR	Crude Birth Rate
CMY	Centre for Multicultural Youth
COB	Country of Birth
DEECD	Department of Education and Early Childhood Development
DH	Department of Health
DHS	Department of Human Services
DIAC	Department of Immigration and Citizenship
EACACOV	East and Central African Communities of Victoria
EHA1	Early Health Assessment and Intervention
ELS/C	English language school/centre
EPI	Expanded Program of Immunisation
ESL	English as a Second Language
EYC	Ethnic Youth Council
FARREP	Family and Reproductive Rights Education Program
FGM	Female Genital Mutilation
FKA	Free Kindergarten Association
GP	General Practitioner
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HEMS	Humanitarian Entrant Management System
Hib	Haemophilus influenzae type B
HIV	Human Immunodeficiency Virus
HREOC	Human Rights and Equal Opportunity Commission
HPV	Human Papilloma Virus
HSS	Humanitarian Settlement Services
HU	Health Undertaking
IHSS	Integrated Humanitarian Settlement Strategy
IPV	Injectable Polio Vaccine
LTBI	Latent Tuberculosis Infection
MBS	Medical Benefits Scheme
MCH	Maternal and Child Health



MCEEDYA	The Ministerial Council for Education, Early Childhood Development and Youth Affairs
MEA	Multicultural Education Aid
MLO	Multicultural Liaison Officer (Victoria Police)
MHW	Mercy Hospital for Women
MLU	Multicultural Liaison Unit
MMR	Mumps Measles Rubella
MRC	Migrant Resource Centre
NECLO	New and Emerging Community Liaison Officer (Victoria Police)
NIPS	National Immunisation Program Schedule
OECD	Organisation for Economic Cooperation and Development
PDMS	Pre-Departure Medical Screening
PMR	Perinatal Mortality Rate
PSD	Program for Students with a Disability
PTSD	Post Traumatic Stress Disorder
RCH	Royal Children's Hospital
RHN	Refugee Health Nurse
RMP	Refugee Minor Program
RWH	Royal Women's Hospital
SAC	Special Assistance Category (visa)
SCAAB	Springvale Community Aid and Advice Bureau
SEHQ	School Entry Health Questionnaire
SGP	Settlement Grants Program
SHP	Special Humanitarian Program
SMR	Standardised Mortality Ratio
SRP	Student Resource Package (funding)
STI	Sexually Transmitted Infection
TB	Tuberculosis
TST	Tuberculin Skin Test
UHM	Unaccompanied Humanitarian Minor
USA	United States of America
VCAA	Victorian Curriculum and Assessment Authority
VCAL	Victorian Certificate of Applied Learning
VCAMS	Victorian Child and Adolescent Monitoring System
VFST	Victorian Foundation for Survivors of Torture
VPD	Vaccine Preventable Disease
VPDC	Victorian Perinatal Data Collection
VZV	Varicella Zoster Virus
WELS	Western English Language School



# Definitions

The United Nations High Commissioner for Refugees (UNHCR) definition of a refugee is a person who:

owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country...

*Article 1, The 1951 Convention Relating to the Status of Refugees*

An *asylum* seeker is a person who has left their country of origin, has applied for recognition as a refugee in another country, and is awaiting a decision on their application.

For the purposes of this report, the term ‘refugee’ is used to describe all people of a refugee or refugee-like background and includes all those entering Australia under the Humanitarian Program.





# Additional information

A document including background information to accompany this report is accessible on-line at [www.education.vic.gov.au/statewideoutcomes](http://www.education.vic.gov.au/statewideoutcomes)

This covers:

## **1. Migration: Historical overview**

An historical overview of humanitarian settlement in Victoria since the 1970s.

## **2. Humanitarian entry visas to Australia**

Information about visas sourced from the Commonwealth Department of Immigration and Citizenship website, including details of visa numbers, names, programs and types.

## **3. Methodology and data sources**

Further information about project methodology and data sources (including the service providers' questionnaire).

## **4. Detailed source country profiles**

Demographic information from the 2006 Census of Population and Housing on the 10 most frequent source countries for humanitarian program entrants to Victoria for the period 1996–2007

## **5. Detailed tables of metropolitan and rural resettlement location**

Information from the Commonwealth Department of Immigration and Citizenship Settlement Reporting Facility about the resettlement location of humanitarian program entrants to Victoria.

## **6. Health screening**

Further information on pre- and post-arrival health screening, including examples of post-arrival screening protocols.



# Executive summary

## Introduction

This report examines the health, wellbeing, development, learning and safety of children and young people of a refugee background in Victoria. The report focuses on children and young people who have entered Australia under the Humanitarian Program.

These children and young people have a different background, experiences and health profile to people born in Australia and will often have specific health and wellbeing needs. They also face many challenges on arrival, negotiating a future in an unfamiliar language and environment while also seeking to establish their individuality and identity as part of growing up.

Drawing on published and unpublished data and on consultations with service providers and stakeholders, the report paints a picture of how refugee children and young people in Victoria are faring, and highlights important gaps in our knowledge about their wellbeing. The report provides a foundation for further research and policy development, and informs the development of new data collections to enable ongoing monitoring of outcomes for refugee children and young people in Victoria.

## Context and approach

The report has been produced as part of the Victorian Department of Human Services *Refugee health and wellbeing action plan 2005–2008*,<sup>1</sup> which identifies the Department's commitment to developing a greater understanding of, and capacity to respond to, the needs of refugee communities into the future.

Research and consultations were carried out over 2008 to inform a significant overview of the status of refugee children and young people for the Victorian Government, leading to the development of this final report over 2009–2010. The data provided in the original overview have been updated where information has been made available.

The report draws on multiple data sources. Where available, data recording refugee status are used; however, it is notable that few datasets were found to include this information. In most of the data presented, country of birth is used as a proxy for refugee status, including the 10 most frequent countries of origin for Humanitarian Program entrants to Victoria over the period 1996–2007.

In documenting how refugee children and young people are faring, the report uses the established Victorian Child and Adolescent Outcomes Framework of 35 outcomes of children's health, wellbeing, development, learning and safety. Through development of this framework, four priority population groups were identified for particular attention: Aboriginal children; children with a disability; children from a refugee background; and children affected by chronic disadvantage, including children in out-of-home care.



# Victoria's refugee population

## Demographic information

Currently, 3500 to 4000 people enter Victoria each year under the Humanitarian Program for refugees and others in refugee-like situations.<sup>1</sup> The majority of Humanitarian Program entrants arrive via the offshore program, which gives rise to two categories of permanent visas: Refugee visas and Special Humanitarian Program (SHP) visas.

The 10 most frequent countries of origin for Humanitarian program entrants to Victoria over the decade to 2007 were Sudan, Iraq, Afghanistan, the former Yugoslavia, Bosnia Herzegovina, Croatia, Ethiopia, Somalia, Burma (Myanmar) and Iran.

Children and young people aged up to 19 years make up half the Humanitarian Program entrants. This represents a much higher proportion of children and young people than in the Victorian population as a whole (25%).

Almost 10,000 'family units' entered Victoria under the Humanitarian Program between mid-1996 and the end of 2007. Although one-third of these units comprised one person, over 40% were families with four or more members.

Children and young people of a refugee background are more likely to live in metropolitan Melbourne than in rural or regional areas of Victoria. Although fewer than 10% of Humanitarian entrants have settled in rural Victoria, rural settlement is currently increasing with strong policy and program support.

## Family circumstances

Data from the 2006 Census of Population and Housing have been used to examine family circumstances for a refugee-like group compared with the Victorian population overall.

Children and young people in the refugee-like group are more likely to live in poverty than Victorian children and young people overall. Using half of the median income as a measure of relative poverty, 50.1% of children and young people in the refugee-like group are living in poverty compared to 14.3% of all Victorian children and young people.

In the refugee-like group, 54.8% of adults have Year 12 or higher education compared to 56.8% of adults in Victoria. At the same time, 7.8% of adults in the refugee-like group have no previous education compared to 1.1% of adults in Victoria. A higher proportion of adults in the refugee-like group are not currently employed, but analysis was not undertaken to adjust for age, parenting status and current education.

Children and young people in the refugee-like group are more likely to live in a household with no car (17.0%) than Victorian children and young people overall (2.9%) and are less likely to live in a household connected to the internet (48%) than Victorian children and young people overall (77%).

Children and young people in the refugee-like group are more likely to live in a flat or an apartment (17.5%) than Victorian children and young people overall (3.9%), and they are more likely to live in private rental accommodation. Foundation House data indicate that at least one-quarter of refugee families experience housing stress after arrival in Victoria. Accurate data are lacking on the prevalence of homelessness in refugee young people/families.

Australian and international literature suggest high rates of food insecurity in resettled refugee families, although the only study from Victoria did not find food insecurity in African–Australian families.

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<sup>1</sup> Victoria also accepts a proportion of asylum seeker arrivals in Australia, although precise numbers are unavailable.



# Health and wellbeing

## Health screening and health on arrival

All permanent entrants to Australia, including Humanitarian Program entrants, undergo a visa health assessment prior to departure. Humanitarian Program entrants may also have pre-departure medical screens. Post-arrival health checks are recommended, but not mandated. Children who have post-arrival health checks are better placed to receive appropriate information and treatment, including lifestyle advice, specific nutrient supplementation, ongoing screening, preventive medications and targeted treatments. Available post-arrival health screening data indicate that children and young people have a different profile of health issues to Victorian children overall.

### Nutrition

Refugee children and young people in Victoria have much lower rates of overweight/obesity on post-arrival screening than Australian children. Around 5% are overweight compared to around 20% of Australian children.

Up to 40% of refugee children and young people have low levels of Vitamin A, which is essential for vision, growth and immunity. Refugee children and young people have a higher prevalence of anaemia and iron deficiency than Australian-born children.

Up to 90% of African refugee children and young people have low Vitamin D. Vitamin D is essential for bone and muscle health and there is increasing evidence that it is also important in other aspects of health. Refugee children and young people may have multiple and persisting risk factors for low Vitamin D and be at risk for long-term health issues.

### Other medical conditions

Refugee children and young people appear to have very low rates of allergic disease compared with Australian children, although data are limited. There is a lack of data on the prevalence of other long-term health issues and no data on disability have been identified.

### Exposure to toxins

There is a lack of information on rates of exposure to environmental toxins in refugee children and young people. In the international literature, small studies suggest high blood lead levels affect a significant proportion of young refugee children resettled in Western countries.

### 'Healthy immigrant effect'

The 'healthy immigrant effect' refers to the observation that migrant populations often have better health than native-born people in the new country of settlement. A systematic review from Canada found refugee groups had lower age-standardised death rates, lower cancer death rates and lower rates of chronic health problems than people born in Canada.

### Conditions with an infectious origin

Refugee children and young people in Australia have a high prevalence of latent Tuberculosis (TB) infection (37–55%). Latent TB infection means someone has been exposed to the TB organism and has a risk of becoming unwell with active TB disease. Refugee children and young people are likely to have higher rates of TB disease than Australian-born children, although the actual number of cases of active TB disease is very low. The rate of TB disease in Victoria has been stable since 1985.

Refugee children and young people screened after arrival in Australia also have a higher prevalence of:

- hepatitis B infection (found in up to 8%)
- malaria (rates of 5–10% were seen among refugee children from Africa before the introduction of additional pre-departure medical screening in 2005)

- parasites: faecal pathogens (found in 16–39% on post-arrival screening in Australian cohorts) and other pathogenic parasites including Schistosomiasis, a fluke infection, (in up to 30%) and *Strongyloides*, a nematode infection (in up to 9%). These parasites are long-lived and may cause chronic disease. They do not pose a risk for the Australian-born population, as conditions for transmission do not occur in Victoria.

### Oral health

International literature suggests that dental issues are common in refugee children, with reports indicating that more than half have dental disease. Evidence from consultations for this report suggests that there may be problems with access to public dental care for refugee children and their families. No local data on the prevalence of dental issues have been identified.

### Health service use

Around 10% of people entering Australia under the Humanitarian program have a health undertaking (generated by offshore medical screening), which is similar to the proportion of people entering under other permanent visas. There are no data on how many refugee children and young people have their recommended post-arrival health check. Interstate and New Zealand data suggest 50–80% of people having a refugee health screen require further specialist medical assessment.

People of a refugee background in Victoria have lower rates of admission to hospital and fewer days in hospital than Victorians overall, although there are no data on the rates for children and young people.

## Immunisation

Refugee children and young people have inadequate protection against vaccine preventable diseases, based on reported completion of immunisation and on evidence of immunity as determined by blood tests. Research indicates that shortfalls exist in the delivery of immunisation catch-up to refugee children post-arrival, and in most cases there are missed opportunities for vaccination.

No child arrives vaccinated in accordance with the Australian National Immunisation Program Schedule and all refugee children will need catch-up immunisation. Consultations indicated that issues with immunisation catch-up include vaccine funding, coordination of services, incomplete catch-up programs, secondary migration, difficulty tracing vaccination for older children and lack of a patient-held record.

## Mental health

International data indicate that a proportion of refugees experience mental health problems, including Post Traumatic Stress Disorder (PTSD), depression and anxiety as a result of their refugee and post-migration experience. No Australian data on the prevalence of mental health problems in refugee children and young people have been identified.

There are difficulties with diagnosis and measurement of mental health issues across cultures. Studies of refugee children and young people report widely varying prevalence figures for mental health problems in different groups and different rating scales are used. Figures range from 3% to 94% for PTSD, from 4% to 47% for depression and from 3% to 96% for anxiety problems. The largest pooled analysis of mental health problems in people of a refugee background found the prevalence of PTSD was 11% in children. Unaccompanied minors and people with uncertain visa status are at higher risk of mental health problems.

### Behaviour problems

Studies of refugee children and young people have found variable rates of behaviour problems. There are few studies that provide a direct comparison with other groups, and the reported prevalence varies with age and with who completes the rating scales. In a South Australian study, the prevalence of behaviour problems in refugee young people was lower on teacher report than similar age groups in a national Australian survey.



### Exposure to trauma

Many refugee children and young people have experienced physical and psychological violence. Information from Victoria shows that most refugee children and young people have experienced a threat of harm to their family and half have undergone a dangerous flight leaving their home country. Around 40% have been separated from their family at some point, more than a third have witnessed violence, around one-quarter have been under combat fire and one-quarter have experienced the disappearance of family members.

### Resilience

Alongside the literature on the effect of trauma on mental health, there are also studies on the resilience and positive social adjustment of refugee children and young people. Trauma experience does not always predict worse mental health outcomes, and mental health symptoms may not cause problems with how children function. The majority of refugee children grow up to be well-adjusted adults.

### Mental health service use

Data from Victorian Child and Adolescent Mental Health Services indicate only a small number of 0–17 year-old clients are from Humanitarian Program source countries and they are less likely to use mental health services than Victorians in the same age group. This warrants further investigation, given the international prevalence data on torture/trauma experience and mental health issues in this group.

## Antenatal and perinatal health

The perinatal mortality rate is higher for the refugee-like group than the perinatal mortality rate for Victoria overall and the crude birth rate is higher for refugee communities than for Victorians overall.

Women of a refugee-like background giving birth in Victoria:

- have a higher fertility rate
- are less likely than Victorian women overall to give birth at a younger age
- have a higher proportion of deliveries in tertiary (teaching) hospitals than Victorian women overall
- are less likely than Victorian women overall to have pre-term babies, or low birth weight babies.

Victorian data on antenatal care indicators are limited. No data are available on smoking or alcohol use during pregnancy for women of a refugee background, although consultations indicated that this was extremely uncommon.

A study of dark-skinned or veiled women from East Africa attending the Royal Women's Hospital (RWH) for antenatal care found the vast majority (98%) have low levels of Vitamin D (with implications for maternal and child health).

Female Genital Mutilation (FGM) is practised in some source countries for recent Humanitarian Program entrants and has implications for obstetric care. There is no published information on the prevalence of FGM in females of a refugee background in Victoria. Consultations indicated a shift in community attitudes and acceptance of laws prohibiting all forms of FGM in Australia.

Population data suggest fewer births to women born in Humanitarian Program source countries aged under 20 years than women in Victoria overall. Nonetheless, sexual health education is an identified area of need for many refugee young people.

There are no data on the prevalence of breastfeeding in women of a refugee background giving birth in Victoria, although health workers report very high rates. There are also no data on Maternal and Child Health service usage, infant mortality or Sudden Infant Death Syndrome for children of a refugee background.



### Healthy lifestyles

Families of a refugee background may experience difficulties in locating affordable supplies of traditional and fresh foods, and in adjusting to the timing of meals and school lunches. Data are limited in other areas relating to healthy lifestyle. No information is available on the uptake of smoking and alcohol by refugee young people in Victoria. There are no data on participation in sport for this group, although sport has been identified as important in the resettlement process.

## Development and learning

### Child and adolescent development

Firm conclusions on early childhood development in refugee children compared to other groups are limited by inadequate data. Clinical experience suggests that developmental concerns may not be raised initially in health consultations and that service providers frequently attribute developmental concerns to problems of English language acquisition.

#### Kindergarten participation

Data from the 2006 Census of Population and Housing indicate a different pattern of numbers of children attending preschool for children in a refugee-like group than for Victorian children overall, but more research is needed on kindergarten participation in Victoria to draw any conclusions.

#### Second language acquisition

Immigrants are usually able to have a fluent conversation 2–3 years after starting a new language, but it takes much longer to achieve academic success in a new language. Children who are 8–12 years old when they arrive and who have some schooling in their first language achieve second language for academic purposes more quickly than other age groups, but they take 5–7 years to reach the standard of native-born speakers.

Large international studies emphasise the importance of English as a Second Language (ESL) support for the educational outcomes of ESL students. These studies suggest that ESL support needs to be prolonged, with English taught through academic content. The best outcomes are seen with bilingual education programs. Immersion in mainstream schooling without ESL support is associated with poorer outcomes.

#### ESL in Victorian schools

In 2007 there were 5549 new arrival ESL students and 39,341 students in the ESL program in Victoria. Refugee students make up approximately one-third of new arrival ESL students; this proportion has been relatively consistent since 2002.

The preferred point of entry for all new arrival ESL students to schools is via participation in a full-time intensive language program in an English Language School/Centre (ELS/C). Of all new arrivals, approximately one-third enter education in Victoria via an ELS/C. A higher proportion of refugee new arrival students attend ELS/C, around 40% of primary level and 70% of secondary level students. There are multiple program initiatives to support refugee ESL students in Victorian government schools.

Around 400–500 refugee new arrival students enter the Catholic education system directly each year.

The amount of federal funding for ESL new arrivals entering Australia through the Humanitarian Program doubled in 2008 to fund 12 months of intensive English language support either through an intensive ELS/C or intensive ESL support of at least 10 hours a week in a mainstream school.



## School and post-school pathways

There are just over 7000 refugee students in Victorian government schools, with greatest numbers in the Southern Metropolitan Region.<sup>2</sup>

### Engagement and attendance

Refugee parents may experience many barriers to participating in their children's schooling, including the impact of resettlement, understanding, expectations and language barriers. School attendance for refugee children is identified as a problem, although there is a lack of reliable data. Out of school hours support programs may present opportunities to support students of a refugee background.

### Literacy and numeracy

In 2008 the proportion of refugee students who met education benchmarks for reading, writing and mathematics (in years 3, 5 and 7) was lower than that for Victorian students overall. The pattern was similar in 2009. However, there are concerns with the validity of benchmark testing early in the settlement period during language acquisition. Alternative forms of measuring progress may be required.

### Students with additional needs

Refugee students are not overrepresented in the Program for Students with Disabilities (PSD) in Victorian government schools, although some variation exists by country of birth. There are proportionally fewer refugee students in special education. There are challenges in assessing refugee students, and professionals are provided with supplementary guidance for this population.

### Year 12 completion and post-school pathways

No data have been identified on Year 12 completion for refugee students, or on the progression of this group to tertiary study. Data from the 2006 Census of Population and Housing suggest high rates of ongoing education in the refugee-like group.

## Safety

There is a lack of data on safety indicators for children and young people of a refugee background in Victoria.

A 2007 report on racism experienced by migrant and refugee communities in Victoria found nearly 40% of adults born in non-English-speaking countries experienced discrimination in the workplace and 30% experienced discrimination in education. There are no data on the experience of racism by refugee children and young people in Victoria.

There are no data on the rates of young people of a refugee background in the youth justice system. Victoria Police have introduced a number of initiatives to engage with recently arrived communities, but despite this, many refugee young people report unwarranted police and media attention.

There are also no data to allow any appraisal of the rates of notification or substantiation of child abuse in refugee children, even using country of birth as a proxy.

Data suggest that refugee children and young people are overrepresented in Family Services programs. These are programs that help families improve their ability to care for children and strengthen family relationships. For children born in Humanitarian source countries the rate was 12.4 (per 1000 per year), compared with 1.0 for Victorian children overall. However, these data should be interpreted with caution.

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<sup>2</sup> Data extracted from Department of Education and Early Childhood Development datasets using country of birth as a proxy for refugee status.





## Service provision and usage

An overview of community support services for Humanitarian Program entrants, combined with a detailed analysis of service provider views of these services, is attached in Appendix A. This analysis identified the following key points:

- More intensive services are provided in the initial 6 months after arrival. The umbrella term for these services is the Integrated Humanitarian Settlement Strategy (IHSS).<sup>3</sup> In Victoria, the lead IHSS agency since 2005 has been the Adult Multicultural Education Services (AMES). Multiple agencies are involved in providing settlement support.
- Victoria uses a primary care health-screening model, underpinned by the innovative Refugee Health Nurse Program. Mental health assessment occurs through the Victorian Foundation for Survivors of Torture. Currently refugee health and mental health screening are generally separate processes in Victoria.
- There are increased supports through IHSS for people entering on Refugee visas compared to those entering on SHP visas, including a case coordinator for the first 6 months.
- SHP entrants make up just over half the Humanitarian Program intake. These people are sponsored by someone living in Australia who is responsible for helping SHP entrants to access health assessment, education and housing. This group are likely to have unmet settlement needs and their access to services is not known.
- There are no data available on what proportion of Humanitarian entrants attend a primary care provider and whether they receive a refugee health focused assessment. Other issues include variable access to tuberculosis screening for children, access to some medications in primary care and a lack of data on long-term service use.
- There is extensive duplication of the information collected from new arrivals by different agencies. This is an area to target for service development and efficiency.
- In rural areas there is often less distinction made between refugee and SHP entrants, with similar pathways to services for both groups.
- There is a gap in adolescent-specific health services.
- There are significant difficulties with accessing dental services.
- Refugee status is not usually documented, and many organisations do not collect demographic data that enable identification of refugee clients.
- Compared to many other countries that accept significant numbers of refugees and asylum seekers, Australia's approach to health screening post-arrival is comprehensive, but it is variably applied between and within States, including Victoria.

<sup>3</sup> In March 2010, the Parliamentary Secretary for Multicultural Affairs and Settlement Services released a request for tender for a new Humanitarian Settlement Services (HSS) program. This new program will replace the IHSS.



## Key facilitators and barriers – service provider views

The analysis of services identified common factors that facilitate or constrain the provision of high-quality care for Humanitarian Program entrants.

The key facilitators are:

- accessible, flexible and responsive services
- partnerships between agencies
- staff professional development on refugee issues
- community guide support and assistance
- language services, including use of interpreters
- bilingual workers and language resources
- settlement location and service coordination so appointments and duplication in the assessment process are minimised.

The key barriers are:

- differential settlement support for Refugee visa entrants and SHP visa entrants
- inadequate language support/use of interpreters
- difficulty for clients in understanding Australian health systems
- tension in prioritising settlement needs
- poor communication between services
- the problem of services catering for a single area of need only
- duplications in assessment.

Housing instability, transport issues and financial stress also constitute significant factors affecting people's ability to engage with services, education and their communities.

## Conclusion

Refugee children and young people are an expanding group in Victoria with diverse and complex backgrounds and unique individual, family and community factors affecting their health and wellbeing. They are faring well on some measures of health and wellbeing and less well on others.

Having a different profile of health conditions and educational needs to Victorian children on the whole, they are a group that warrants specific consideration in the development of social policy and service delivery models.



# Section 1

Background to this report



# 1. Background to this report

## Immigration in Australia and the Humanitarian Program

Australia is a nation built on migration, accepting more than 6.5 million migrants and 700,000 refugees since 1945.<sup>2</sup> Australia's Immigration Program has two components:

- the Migration Program for skilled and family migrants
- the Humanitarian Program for refugees and others in refugee-like situations.

The Humanitarian Program includes:

- an offshore program for the resettlement of people in humanitarian need who apply for Australia's protection from overseas
- an onshore program for people already in Australia who seek Australia's protection.

The majority of Humanitarian Program entrants to Australia arrive via the offshore program, which gives rise to two categories of permanent visas:

- Refugee visas: Refugee (200); In-Country Special Humanitarian (201); Emergency Rescue (203); Women at Risk (204)
- Special Humanitarian Program (SHP) visa (202) for people outside their home country because of substantial discrimination there, with violation of their human rights.


Under its Humanitarian Program, Australia currently accepts approximately 13,500 entrants each year, with the intake equally divided between refugees and SHP entrants.

A further group – people requesting international protection whose claims for refugee status have not been determined – are generally described as asylum seekers.

## Report focus

This report examines the health, wellbeing, safety, learning and development of children and young people of a refugee background living in Victoria. It provides a considered and clear evaluation of the available evidence on how these children and young people are faring, and reports on areas in which data are lacking.

For the purposes of the report, the term 'refugee' is used to describe all people of a refugee or refugee-like background and includes all those entering under the Humanitarian Program. These children and young people share experiences of conflict and upheaval and have fled their country of origin. Their backgrounds and experiences differ from those of people born in Australia and their health and wellbeing are affected by migration and resettlement.



The report has been produced as part of the Victorian Department of Human Services *Refugee health and wellbeing action plan 2005–2008* which identifies the Department’s commitment to develop a greater understanding of, and capacity to respond to, the needs of refugee communities into the future.

Research and consultations were carried out over 2008 to inform a significant overview of the status of refugee children and young people for the Victorian Government, leading to the development of this final report over 2009–10.

The report:

- describes how refugee children and young people are faring in the broad domains of health, wellbeing, development, learning and safety
- examines factors that have influenced the wellbeing of refugee children and young people following settlement in Victoria
- details the service provider and community views on facilitators and barriers in the delivery of community support services
- details gaps in our knowledge and understanding of the needs of these children and young people and their families, including gaps in available data
- provides a foundation for further research and policy development
- informs the development of new data collection to enable ongoing monitoring of outcomes for refugee children and young people in Victoria.

Data provided in the original overview document (2008) have been updated where information has been made available. The report does not include data from the Victorian Admitted Episode Dataset (VAED) or School Entrant Health Questionnaire (SEHQ). These datasets may be analysed in the future.

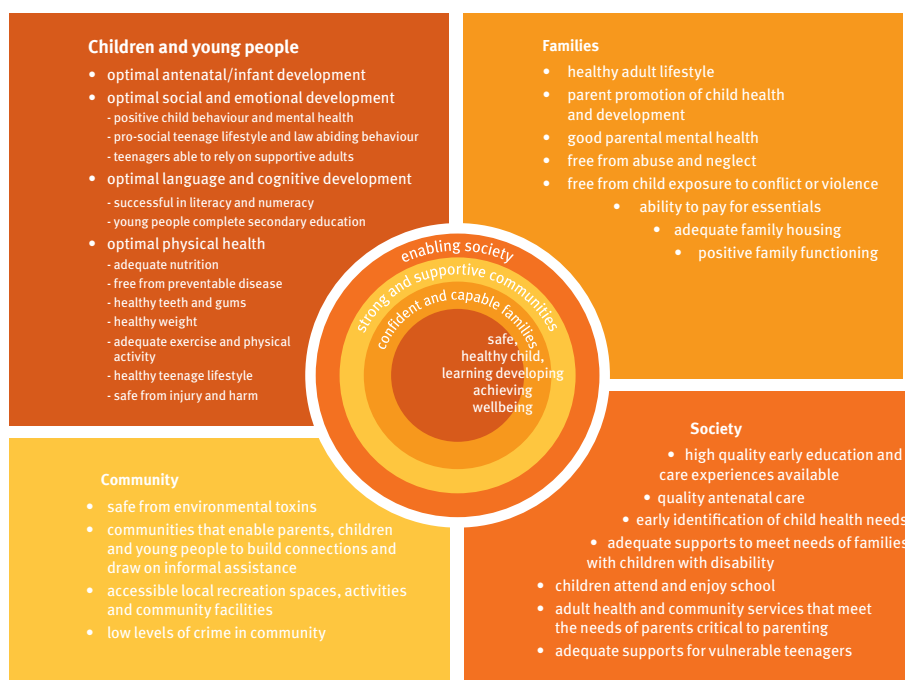
## An outcomes framework

In documenting how refugee children and young people are faring, the report uses the established Victorian Child and Adolescent Outcomes Framework of 35 outcomes of children’s health, wellbeing, development, learning and safety (Figure 1.1). Through development of this framework, four priority population groups were identified for particular attention: Aboriginal children, children with a disability; children from a refugee background; and children affected by chronic disadvantage, including children in out-of-home care. Evidence suggests that these groups of children are not faring as well as others and that they may face more complex problems or are likely to require different approaches to improving their wellbeing.

The Victorian Child and Adolescent Framework provides a common basis for setting objectives and planning for children across the whole of Government and forms the basis for annual reports on the status of Victoria’s children<sup>3, 4</sup> as part of the Victorian Child and Adolescent Monitoring System (VCAMS).

Some of the outcomes relate to the child directly and others relate to key factors that influence child wellbeing: the family, the community and services and supports.

**Figure 1.1: The Victorian Child and Adolescent Outcomes Framework**



## Data sources and methodology

In the course of preparing this report, the authors:

- consulted directly with 37 key refugee stakeholders/groups to elicit key themes, identify unpublished datasets, and map services in Victoria.
- developed a questionnaire and received responses from over 90 service providers representing 77 organisations in metropolitan, rural and regional areas of Victoria.
- evaluated both the published literature and unpublished primary source materials. Much of the material sourced has not been published previously and some was extracted specifically for this report.
- assessed international data to benchmark where Victoria stands.

The report draws on datasets that capture information about refugee status where available; however, very few datasets were found to include this information. In much of the new data presented, country of birth is used as a proxy or substitute for refugee status, including the 10 most frequent countries of origin for Humanitarian Program entrants to Victoria over the period 1996–2007.

Data were collected and collated from a wide variety of sources, including medical literature; government information and policy documents; the Department of Immigration and Citizenship (DIAC), the Department of Human Services (DHS); the Department of Health (DH), the Department of Education and Early Childhood Development (DEECD); the Department of Justice; and the Australian Bureau of Statistics 2006 Census of Population and Housing.<sup>4</sup>

<sup>4</sup> The report relies on data from the 2006 Census of Population and Housing, as the next Census of Population and Housing will not take place until 2011.



# Section 2

## Victoria's refugee population

## 2. Victoria's refugee population

### Demographic information

Australia accepted 121,740 entrants under its Humanitarian Program between July 1996 and December 2007.<sup>5</sup> Of these, 35,931 settled in Victoria, with approximately 3000 to 4000 arrivals in most years.

During this same period, Victoria had 16,849 entrants aged 0–19 years at the time of arrival, representing 46.6% of the total number of Humanitarian Program entrants. By comparison, at June 2007, children and young people 0–19 years represented 25.6% of Victoria's population.<sup>6 6</sup>

### Country of origin

Table 2.1 lists the source countries for Victoria's Humanitarian entrants for the period July 1996<sup>7</sup> to December 2007.

Time trends for the four main regions from which Victoria receives Humanitarian entrants show:

- a sharp increase in the number of Sudanese arrivals over 2002–05 then a decrease
- a continued rise in the number of people from Afghanistan
- a decrease in arrivals from Eastern Europe after 2000–01
- a significant increase in the number of Burmese arrivals starting 2005–06.

<sup>5</sup> This section uses data from the beginning of July 1996, which is the earliest data available on the electronic 'Settlement Reporting Facility' of the Department of Immigration and Citizenship (DIAC).

<sup>6</sup> At this time, Victoria's total population was estimated to be 1,334,251 people.

<sup>7</sup> The electronic 'Settlement Reporting Facility' of the Department of Immigration and Citizenship contains immigration data from this date onwards.



**Table 2.1: Source countries for Humanitarian entrants to Victoria, 1 July 1996 – 1 January 2008**

Country of origin	Humanitarian entrants to Victoria <sup>5</sup>	
	Number	Percentage of total
Sudan	7,695	21.4
Iraq	5,109	14.2
Afghanistan	4,175	11.6
Former Yugoslavia not further defined	3,360	9.4
Bosnia–Herzegovina	1,902	5.3
Burma	1,833	5.1
Ethiopia	1,460	4.1
Somalia	1,272	3.5
Croatia	1,163	3.2
Iran	1,095	3.0
Others	6,867	19.1

Source: Humanitarian Entrants Management System. 2008. Accessed 5 August 2008.

## Language

The languages spoken by Humanitarian entrants correspond to the countries of origin. The most frequent languages are Arabic (29.2%), Bosnian (7.4%), Dari (7.3%), Serbian (7.1%), Persian (4.3%) and other African languages (4.1%).<sup>5</sup> Consultations identified that refugee children and young people are often multilingual;<sup>8</sup> no published information on this area has been identified.

## Family size and type

Victoria's Humanitarian entrants comprised just fewer than 10,000 discrete family groupings or units between July 1996 and December 2007. The most common configuration was one person (29%), while 43% had four or more members (Table 2.2).

Based on data from the 2006 Census of Population and Housing,<sup>9</sup> 7 children and young people in a refugee-like group are slightly more likely (21% compared to 17.8%) to live in one-parent families than children and young people in the whole of Victoria. Living in a one-parent family is more likely where the person completing the Census form is from Sudan, Somalia or Ethiopia, although this may be partly explained by DIAC priorities for the Humanitarian Program intake in recent years.<sup>10</sup>

<sup>8</sup> Consultation with immigrant health paediatricians, May 2008 and refugee health nurses, April 2008.

<sup>9</sup> For methodology: see additional information document at [www.education.vic.gov.au/statewideoutcomes](http://www.education.vic.gov.au/statewideoutcomes)

<sup>10</sup> A partial explanation for this finding may be that the majority of Humanitarian entrants in recent years have come from African countries, and the 'Women At Risk' refugee visa category (visa 204) for single women and female-headed households has made up at least 10.5% of the offshore refugee intake.

**Table 2.2: Size of families, Humanitarian Program entrants, July 1996 to December 2007, Victoria**

Number in family <sup>5</sup>	Number of families	Percentage
1	2,876	29.4
2	1,294	13.2
3	1,408	14.4
4	1,736	17.8
5 to 7	2,111	21.6
8 to 10	328	3.4
More than 11	27	0.3
<b>Total</b>	<b>9,780</b>	<b>100.0</b>

Source: Humanitarian Entrants Management System 2008. Accessed 5 August 2008.

## Settlement location

The majority of Humanitarian Program entrants settle in metropolitan regions, primarily in Melbourne's outer suburbs (Table 2.3). In 2008, increasing priority was given to rural/regional resettlement of humanitarian entrants, with rural settlement planned for 7%.<sup>8</sup>

**Table 2.3: Humanitarian Program entrants, July 1996 to December 2007, by Government region**

Government Region	Number	Percentage of Humanitarian Program entrants
Hume	998	2.9
Loddon Mallee	460	1.3
Grampians	133	0.4
Gippsland	200	0.6
Barwon – South Western	789	2.3
North and West Metropolitan	18,351	53.0
Southern Metropolitan	10,970	31.7
Eastern Metropolitan	2,710	7.8
Metropolitan Victoria total	32,031	92.5
Victoria total	2,580	7.5
<b>Total Victoria</b>	<b>34,611*</b>	<b>100.0</b>

Source: DIAC Settlement Reporting Facility. Data accessed 27 June 2008, searching for all Humanitarian visa categories by statistical division and subdivision for Victoria.

\*The total number of people identified is lower than the total number of Humanitarian entrants to Victoria over the same period, but within 10% of the total figure.

## Unaccompanied Humanitarian Minors

Young people who arrive unaccompanied on Humanitarian Program visas are called Unaccompanied Humanitarian Minors (UHM). They are classed either as UHM wards<sup>11</sup> or UHM non-wards.<sup>12</sup>

Records have been kept of UHM numbers since 2002. Since 2005 there have been 250–350 UHMs in Victoria in any given year. Prior to 2005, the number of UHMs in Victoria in any given year was significantly lower. The proportion of UHM entrants in rural areas has increased since 2006.

In Victoria, the Refugee Minor Program (RMP) supports UHMs. Table 2.4, compiled from various data sources, presents available figures on UHM in Victoria from 1979 to 2009. There are currently (mid 2010) around 360 children/young people in the RMP.

**Table 2.4: Number of Unaccompanied Humanitarian Minors by year (Victoria)**

Year	Total UHM	UHM wards	Percentage in rural areas
1979	80–90	Most	
1980	240	115	
1982	84	Few	
1985	69	Few	
1986	194	73	
1987	194		
1988–89	171		
1990 (May)	173	23	
1991 (June)	229		
1994 (Dec)	84		
1996 (Sept)	59		
1997–99	65–75/year		
2000 (Mar)	52		
2001 (Oct)	109	Most	
2002 (Dec)	102	~ Half	
2003	138*		
2004	169*		
2005	232*		
2006	280	51	4.3
2007	310	67	8.1
2008	284	52	14.8
2009 (Mar)	273	51	15.4

Source: Figures 1979–2002 supplied by the RMP, Victoria, January 2009, from an internal report. Figures 2003–09 supplied by the RMP, May 2009. Numbers comprise the total number in the program in a given year.

\* These numbers are estimates. Complete data are available from 2006.

<sup>11</sup> A UHM ward is a minor who does not have a parent or relative aged over 21 to care for them in Australia. The Minister for Immigration and Citizenship is the legal guardian of UHM wards. Guardianship functions are delegated to officers of the Department of Immigration and Citizenship (DIAC) and to officers of the relevant child welfare authority in each state/territory. Guardianship continues until the ward turns 18 years, leaves Australia permanently, becomes an Australian citizen or when directed by the Minister. Young people in this group were previously referred to as 'Unattached Minors'.

<sup>12</sup> A UHM non-ward is a minor who does not have a parent but has a relative aged over 21 years to care for them in Australia. This person becomes their legal guardian.

## Asylum seekers

No data are available on the number of asylum seekers living in Victoria. In 2005 it was estimated there were 2000–2500 community-based asylum seekers.<sup>9</sup> The current numbers are likely to be lower as the temporary protection visa system was abolished in August 2008 with the introduction of a Resolution of Status visa.<sup>10</sup>

## Settlement support services

### Settlement support: early period

After arrival in Victoria, Humanitarian Program entrants receive settlement support through the Integrated Humanitarian Settlement Strategy (IHSS).<sup>13</sup> The designated IHSS lead agency in Victoria is the Adult Multicultural Education Services (AMES).<sup>14</sup>

In Melbourne, AMES works in a consortium with the Victorian Foundation for Survivors of Torture (VFST, also known as Foundation House), Redback Security Services, the Brotherhood of St Laurence, and the Springvale Community Aid and Advice Bureau.<sup>15 11</sup> In rural areas AMES works through different sub-contractors and settlement planning committees in the 10 DIAC statistical subdivisions.

IHSS providers assess refugee and SHP entrants to identify settlement needs and coordinate the delivery of services to meet these needs. IHSS services include case coordination, information and referrals, on-arrival reception and assistance, accommodation and short-term torture/trauma counselling. Services are provided for the first 6 months post-arrival, and may be extended for up to a year for complex cases.<sup>12</sup> Refugee entrants receive more support than Special Humanitarian Program (SHP) entrants in the initial 6-month period. In rural areas there is often less distinction made between refugee and SHP entrants, with similar pathways to services for both groups.

Victoria uses a primary care health-screening model, underpinned by the innovative Refugee Health Nurse (RHN) program. The RHNs provide an initial health screen, health education, help with referral for primary care medical assessment and health service coordination. Follow-up of health undertakings (generated by offshore screening) occurs through a separate process at the Royal Children’s Hospital (age 15 years or younger) and the Western Hospital (for those over 15 years).

Best practice settlement involves families being linked with AMES case management, English language school, VFST, a refugee health nurse and a general practitioner. Demographic information is typically collected 6 to 7 times and is not shared between service providers.

### Refugee visa holders

Refugee entrants are allocated a case coordinator from AMES for the initial 6-month period after arrival. AMES organises referral to a refugee health nurse and health and dental assessments; housing and furniture packages; enrolment in schooling/English classes; and orientation to household safety, the local area and public transport, as well as other essentials (Medicare numbers, bank accounts, enrolment with Centrelink).

### SHP visa holders

SHP visa entrants are sponsored by a proposer<sup>16</sup> who agrees to cover most of the costs associated with resettlement, including airfares and accommodation. In most cases the proposers are only recently arrived and are former refugees or SHP entrants themselves.<sup>13</sup> The onus is on the proposer to provide orientation to Australia and help SHP entrants to access services. Support for proposers is available through AMES.

<sup>13</sup> A request for tender for a new Humanitarian Settlement Services (HSS) program was released in 2010. This new program will replace the IHSS.

<sup>14</sup> AMES has been the designated lead agency since 2005.

<sup>15</sup> Springvale Community Aid and Advice Bureau sees clients in the eastern metropolitan area only.

<sup>16</sup> A proposer is usually a relative or friend; the proposer must be an Australian citizen, permanent resident or eligible New Zealand citizen, or an organisation based in Australia.

### *Unaccompanied Humanitarian Minors*

The Department of Human Services (DHS) Refugee Minor Program (RMP) is informed by DIAC of the arrival of Unaccompanied Humanitarian Minors (UHMs).<sup>17</sup> The RMP assists UHMs with settlement<sup>18</sup> using a casework-based approach in conjunction with AMES and carers, to ensure settlement needs are met.<sup>19</sup>

## Settlement support: 6–12 months onwards

Support for Humanitarian Program entrants after the initial 6-month period occurs through different sources. These include agencies funded by DIAC under the Settlement Grants Program (SGP), as well as community-led organisations and faith-based organisations. The SGP provides funding to settlement services for people who are 6 months – 5 years after arrival.<sup>20</sup> The aim of the SGP is to assist clients to become self-reliant and participate in Australian society. Services receiving SGP funding provide supports such as orientation to Australia, practical help to promote self-reliance, community development assistance, and programs facilitating integration, inclusion and participation.<sup>14</sup>

Some of the key agencies in Melbourne that receive SGP resources to facilitate refugee settlement include Migrant Resource Centres, the Ecumenical Migration Centre and the New Hope Migrant and Refugee Centre.

In rural areas where refugee and SHP entrants have been supported during initial settlement through a contracted IHSS provider, there is usually funding available for a settlement grants program.

A detailed analysis of services for Humanitarian Program entrants is attached in Appendix A.

## Family circumstances

### Household type

Around half the people arriving on refugee visas stay with a friend or contact when they first arrive.<sup>21</sup> SHP entrants frequently stay with their sponsor, although exact figures are not available. Although a high proportion of refugee children and young people share accommodation with other families initially, data from the 2006 Census of Population and Housing<sup>22</sup> suggest over 90% of the refugee-like group live in single family accommodation in the longer term. This figure is the same for Victorian children and young people overall.

### Housing

At the time of writing there is a shortage of private rental accommodation and increasing rental prices, creating a competitive rental market in Victoria. Families of a refugee background are especially vulnerable to housing stress because of poverty, lower employment and, in the early stages of resettlement, lack of English proficiency and difficulties negotiating the private rental market.

<sup>17</sup> There are occasions when a UHM may arrive in Victoria without DIAC's knowledge, such as secondary migration of a UHM from another state. In these instances, DHS notifies DIAC of the UHMs arrival.

<sup>18</sup> Questionnaire response, Family Care, Shepparton, February 2008.

<sup>19</sup> Consultation with caseworker, Refugee Minor Program, Footscray, February 2008.

<sup>20</sup> Organisations funded under the SGP provide services for Humanitarian Program and Family visa holders, as well as dependants of skilled migrants.

<sup>21</sup> Consultation with East and West team leaders, AMES, Melbourne, May 2008.

<sup>22</sup> For methodology: see additional information document at [www.education.vic.gov.au/statewideoutcomes](http://www.education.vic.gov.au/statewideoutcomes)

The location of affordable housing also affects settlement. Larger families need larger places of accommodation, and families may need to move to outer metropolitan areas where housing is cheaper and/or more readily available. However, these areas may have less developed infrastructure and public transport.<sup>15</sup>

The Refugee Council of Australia consulted with refugee families across Australia and identified a lack of affordable housing and housing stress<sup>23</sup> as significant issues.<sup>15</sup> Refugee families also reported poor quality older housing, fear of losing housing and difficulties negotiating tenancy rights.

Housing problems are identified as a common issue early in settlement for refugee families in Victoria, affecting 23–29% of 0–17 year-olds over 2004–07.<sup>16–18</sup> Consultations with multiple organisations and settlement support providers identified housing and the private rental market as a pre-eminent issue in settlement and one of the main sources of stress for families.

Data from the 2006 Census of Population and Housing<sup>24 7</sup> show that the proportion of 0–17 year-olds in the refugee-like group that live in flats or apartments (17.5%) is greater than the proportion for Victoria overall (3.9%). The refugee-like group is also overrepresented in private and other rental arrangements (47.0%) compared to Victoria overall (18.7%). The refugee-like group are more likely to live in accommodation rented from the State Housing Authority than 0–17 year-olds in Victoria overall.

No published data have been identified on homelessness in refugees in Victoria.<sup>15</sup>

## Food security

The 2005–06 Victorian Child Health and Wellbeing Survey<sup>19</sup> found that 5.8% of children lived in households where in the preceding 12 months parents had run out of food and could not afford to buy more.

There are no comprehensive Australian data on food insecurity after settlement for people of a refugee background. A 2001 Victorian survey of Sub-Saharan African migrants in Melbourne did not identify any food insecurity post-arrival,<sup>20</sup> but food insecurity was common in refugee groups in recent studies from Perth (71%)<sup>21</sup> and Sydney (68%).<sup>22</sup> International studies also document very high rates of food insecurity in recently arrived refugees in London<sup>23</sup> and the USA.<sup>24–26</sup>

## Transport

Having a car increases mobility, independence and the ability to work further from home or work shift hours. Families without cars rely on public transport, which varies in different areas. Lack of a car can also affect ability to seek employment<sup>15</sup> and attend support services, including language classes/schools.

Consultations confirmed transport access and transport infrastructure in more recent areas of settlement as a significant issue, with effects on attendance and punctuality for appointments.<sup>25</sup>

Data from the 2006 Census of Population and Housing<sup>7</sup> show 17.0% of 0–17 year-olds in the refugee-like group live in dwellings with no cars, compared to 2.9% of all 0–17 year-olds in Victoria.

<sup>23</sup> Housing stress is defined as a condition experienced by individuals whose incomes are in the bottom 40%, spending more than 30% of their income on housing.

<sup>24</sup> For methodology: see additional information document at [www.education.vic.gov.au/statewideoutcomes](http://www.education.vic.gov.au/statewideoutcomes)

<sup>25</sup> Questionnaire responses from English Language Schools, Family Day Care, March–May 2008.



## Internet connection status

Data from the 2006 Census of Population and Housing<sup>7</sup> show 48.3% of 0–17 year-olds in the refugee-like group live in dwellings with some form of internet connection, compared to 76.9% of all 0–17 year-olds in Victoria. Within the refugee-like group, internet connection is least likely where the person completing the Census form is from Sudan, Ethiopia or Burma.

## Parent education

Data on highest educational achievement for those aged 18 and older were extracted from the 2006 Census of Population and Housing.<sup>7</sup> The proportion of adults in the refugee-like group with Year 12 education or higher is similar to that for Victoria as a whole, at 54.8% compared to 56.8%.<sup>26</sup> The proportion of people with no educational achievement is higher for the refugee-like group, at 7.8% compared to 1.1% for Victorians overall.

Parent education is also reported in some studies on refugee child health. Recent studies from Melbourne on cohorts of African refugee children and young people suggest around 40% of their parents have completed secondary school education<sup>27–29</sup> and 20% or more have tertiary qualifications.<sup>20, 27, 28</sup> The international literature suggests similar figures.<sup>30–34</sup>

Adults of a refugee background in Victoria have reported that they have significant problems with their overseas qualifications not being recognised<sup>16–18, 35, 36</sup> and that this affects mental health and entry into the workforce.<sup>36</sup> Similar findings have been reported in Western Australia,<sup>37</sup> with refugees reporting employment below their skill level. The consequences of ‘occupational mismatch’ and of failing to capitalise on people’s skills and education are significant at an individual and economic level.<sup>15</sup>

The difference in education levels across refugee groups warrants further investigation, as there are implications for settlement services, vocational training/pathways to employment and program delivery in English language teaching. Facilitating parents’ employment and workforce participation is essential to family health and functioning and to optimal settlement in Australia.

## Parent employment

Parent employment affects family stability, income, resources, mental health and wellbeing; and obtaining stable, paid and fulfilling employment is a contributor to, and a measure of, successful resettlement.<sup>15</sup>

Data are lacking on the employment of Humanitarian Program entrants in Australia post-resettlement. The 2007 *Labour force status and other characteristics of recent migrants* survey<sup>38</sup> found lower workforce participation by Humanitarian Program entrants (arriving after 1997) than other groups (50.4% compared to 68% for recent migrants overall and 66% for people born in Australia). This workforce participation rate seems relatively high considering the low rates of workforce participation reported in the first 6–18 months after settlement and potential barriers to gaining employment.<sup>15</sup> These data give no measure of underemployment (people in unstable jobs with casual or fluctuating hours) or people employed below their skill level.<sup>15</sup>

Barriers to employment may include limited English proficiency, lack of recognition of overseas skills/qualifications, lack of a driver’s licence (and reliance on public transport), not having citizenship,<sup>27</sup> access and affordability of child care and mental and physical health. Unfortunately, discrimination in the workplace is frequently reported by Australians of a refugee background,<sup>15</sup> both when applying for jobs and in the workplace. In a 2008 study of refugees in Western Australia, 62% reported experiencing difficulties in finding work, with people from the Middle East most likely to report difficulty (78%), followed by those from

<sup>26</sup> Examining this indicator within the refugee-like group shows a greater proportion of Year 12 or higher education where the person completing the Census form is from Iran, former Yugoslavia and Bosnia–Herzegovina, and a lower proportion where the household reference person is from Burma, Iraq or Afghanistan.

<sup>27</sup> There is a requirement for length of residency for citizenship, and certain occupations require Australian citizenship.

Yugoslavia (58%) and Africa (52%). These difficulties included requirements for local work experience (62%) or local referees (41%) and problems with local recognition of qualifications (31%).<sup>39</sup> Finally, lack of an established community also affects the ability to find employment, as community connections can facilitate entry into the workforce.

National data from the 2006 Census of Population and Housing by country of birth<sup>40–48</sup> without restriction by entry date show the labour force participation of those aged 15 or older from the source countries of interest is 40–60% compared with 65% for the Australian population overall.

### Income

Many Humanitarian Program entrants experience significant financial stress as they attempt to repay travel costs and pay rent, bills, living costs and education expenses, and many are also sending funds back to relatives in their country of origin.<sup>13</sup> Financial demands, combined with the pressure and complications in seeking employment, may affect the mental health of Humanitarian Program entrants.<sup>15</sup>

Relative poverty may be measured using half the median equivalised household income as a cut-off.<sup>28 49</sup> Data from the 2006 Census of Population and Housing<sup>29 7</sup> show a much higher percentage of the refugee-like group living in relative poverty than other groups. Overall, 50.1% of 0–17 year-olds in the refugee-like group live in relative poverty, compared to 14.3% of all 0–17 year-olds in Victoria.<sup>30</sup>

### Issues affecting children and young people in refugee families

Some information is available from Foundation House client services data on identified needs and problems in the post-arrival period.<sup>16–18</sup> These figures should be interpreted with caution.<sup>31</sup>

Table 2.5 shows details for the 0–17 year age group.<sup>32</sup> The figures suggest that issues with housing and financial need affect a significant number of children and young people in refugee families. Social isolation and concern for family overseas affect a similar proportion.

<sup>28</sup>

This measure of relative poverty is used by the Organisation for Economic Co-operation and Development (OECD).

<sup>29</sup>

For methodology: see additional information document at [www.education.vic.gov.au/statewideoutcomes](http://www.education.vic.gov.au/statewideoutcomes)

<sup>30</sup>

Within the refugee group, the percentage of children living below this income cut-off point was higher for any given country group than the percentage for Victorian children overall; but the percentage was lower when the household reference person was from one of the European source countries.

<sup>31</sup>

In interpreting this data it is important to note that the 2004–07 data relate to screening assessments on all refugee arrivals, and assessments of Special Humanitarian Program entrants referred on the basis of need. Of note, a large number of children and young people were assessed compared to the total Humanitarian Program intake for the same time period. The VFST and DIAC figures are not directly comparable; there are differences in the age groups and there may be a lag between arrival and assessment.

<sup>32</sup>

Numbers of clients are given by age 0–20, data prevalence is reported for 0–17, exact numbers for 0–17 year-olds assessed were not available.



**Table 2.5: Tabulated client services data, Foundation House, 2004–08**

	2004–05	2005–06	2006–07	2007–08
Assessment stream	EHA1	IHSS	IHSS	IHSS
0–10 years	663	724	858	551
11–20 years	473	618	760	527
Total 0–20 years	1,136	1,342	1,618	1,078
Humanitarian intake 0–19 years (DIAC) <sup>50</sup>	2,208	1,884	2,040	1,474
Needs and problems of VFST clients, age 0–17 years (% affected)				
Family violence		2	1	2
Family breakdown				7
Family support	30	15		
Financial: income support		21	24	
Housing	23	29	24	*
Immigration (sponsorship)	16	22	21	
Major illness in family	12	11	8	8
Marital/family discord		7	4	6
Significant concern for family overseas	28	38	36	37
Social isolation	32	33	28	25

*Source: Victorian Foundation for Survivors of Torture Annual Reports – 2004–05 to current. Direct Client Services data have been used for the Integrated Humanitarian Settlement Support group; where assessment is provided for new arrivals. EHA1 refers to Early Health Assessment and Intervention. This was also a program for new arrivals.*

*There is variation in the indicators reported from year to year. In 2007–08 there is no information on the number of 0–17 year-olds affected by employment/housing issues; but for those 18 years or older, 25% had difficulty with employment, 33% had issues with financial: income support and 34% had issues with housing.*

## Key findings

### Victoria's refugee population

Each year approximately 3500–4000 people of a refugee background settle in Victoria.

The proportion of Humanitarian arrivals who are children and young people is greater than the proportion of children and young people in Victoria overall (around 50% compared to around 25%).

The 10 most frequent countries of origin for Humanitarian entrants to Victoria over the period 1996–2007 were Sudan, Iraq, Afghanistan, Bosnia Herzegovina, Croatia and other countries of the former Yugoslavia, Burma (Myanmar), Ethiopia, Somalia and Iran.

Over 90% of humanitarian entrants settle in metropolitan Melbourne, although settlement in regional Victoria is increasing.

There are approximately 300 unaccompanied Humanitarian minors in Victoria in any given year.

No figures are available on the number of asylum seekers in Victoria.

Compared with Victorian children and young people overall, children and young people of a refugee-like background:

- are just as likely to live in a single family household
- are more likely to live in a flat or apartment
- are less likely to live in a household with a car or an internet connection
- are just as likely to have parents with Year 12 or higher education although a proportion of parents have no previous access to education
- are more likely to live in poverty.



# Section 3

## Health and wellbeing

## 3. Health and wellbeing

### Health screening and health on arrival

#### Health screening pre-arrival

All permanent entrants to Australia, including those entering under the Humanitarian Program, must meet health requirements described in the *Migration Act 1958* and have a visa health assessment.<sup>51, 52</sup> This assessment is usually 3–12 months before departure.<sup>53</sup> The visa health assessment is particularly focussed on excluding active Tuberculosis (TB) disease and can generate a ‘health undertaking’ where people have to follow up with specific health services after they arrive in Australia.<sup>33 54</sup> Screening is limited for children aged less than 11 years.

Refugee families may also have Pre-Departure Medical Screening (PDMS).<sup>34</sup> These screening programs were introduced in 2005 to reduce the number of medical issues refugee and SHP entrants presented with post-arrival and to ensure better onshore follow-up of medical issues. In 2007 approximately half the Humanitarian Program entrants to Victoria had some form of PDMS,<sup>35</sup> although coverage has been higher in subsequent years.

#### Health screening post-arrival

A health assessment is recommended for all Humanitarian Program entrants after arrival.<sup>55</sup> However, since the closure of the Fairfield Hospital Refugee Screening Clinic in early 1992, there has been no process for universal health screening in Humanitarian Program entrants to Victoria. There is also no way of measuring the total number of people who have had an assessment, or what assessments have been performed.

No single protocol exists in Victoria, or Australia, for post-arrival health screening. There is, however, increasing consensus around screening tests that should be performed, and Australasian guidelines for the diagnosis, management and prevention of infections in recently arrived refugees have been published.<sup>55</sup> In general, post-arrival health checks involve an assessment of health and specialised tests for nutritional deficiencies, parasites and infectious diseases; including screening for TB.

<sup>33</sup> Approximately 90% of all health undertakings are for follow-up of TB screening results.

<sup>34</sup> PDMS was introduced for humanitarian entrants from East and West Africa in August 2005. Similar programs have subsequently been commenced in Northern Africa and Thailand (April–May 2006) Southern Africa (September 2007), Pakistan and in the Middle East, India and Nepal in late 2007.

<sup>35</sup> Information from a questionnaire to health providers from the Department of Immigration and Citizenship, 2008.

## Non-communicable health conditions

### Weight

Being above or below a healthy weight for age has adverse effects on health. Children who are undernourished are more susceptible to infectious diseases and developmental problems; childhood overweight/obesity is also associated with poorer health outcomes and with adult overweight/obesity.<sup>56</sup>

A number of research studies have reported measures of growth in refugee children and young people on initial health screening after settlement, including two studies from Melbourne.<sup>27, 57</sup> In this group, few children were overweight/obese<sup>36</sup> (5%), in comparison to the number of children in the overweight/obese range in the 1995 Australian National Nutrition survey (19.5% of males and 21.1% of females aged 2–18 years).<sup>37 58</sup>

The international literature also suggests children of a refugee background have low rates of overweight/obesity found on post-arrival health screening with a normal distribution of weight in groups.<sup>59, 60</sup> A recent study of Karen<sup>38</sup> children in Canada found no children were in the overweight range and around one-third had low weight and/or low height for age.<sup>61</sup>

Although these studies suggest a low rate of overweight/obesity after arrival, there is some evidence that these health issues can emerge after settlement. A study of Somali 3–12 year-olds living in Victoria longer than 5 years found the rate of overweight/obesity was similar to the rate reported in Australian children.<sup>39 62</sup> A body of literature from the USA has reported on improved growth, higher birthweight and increasing prevalence of overweight/obese in immigrants after settlement and in subsequent generations.<sup>63, 64</sup>

### Vitamin A deficiency

Vitamin A is required for vision, immune function, growth and maintenance of epithelial (skin) cells.<sup>65</sup> Vitamin A is found in orange and green vegetables and fruit as well as meat, eggs and milk. The prevalence of low vitamin A was found to be 19% and 38% in two separate groups of refugee children of African background in Victoria.<sup>27, 57, 66</sup> Vitamin A levels would not normally be measured in well children eating a broad diet.

### Vitamin D deficiency

Vitamin D is essential for bone and muscle health in all age groups. Low vitamin D causes poor bone mineralisation (softer bones), causing rickets in children and osteomalacia in adults.<sup>67</sup> There is also evidence that low vitamin D is associated with other health problems including: an increased risk of colon cancer,<sup>68</sup> heart disease,<sup>69</sup> high blood pressure,<sup>70</sup> stroke,<sup>71</sup> problems with immunity and autoimmune diseases including diabetes.<sup>72, 73</sup>

Vitamin D is made predominantly in the skin from the action of sunlight. People with naturally very dark skin need more sun exposure than people with light skin to make enough vitamin D.<sup>40</sup> They probably need 3–6 times as long in the sun,<sup>74, 75</sup> which may be up to 5 hours a day in winter.<sup>41</sup> The amount of sun exposure required for adequate vitamin D in children is unclear.<sup>76</sup> Only a few foods naturally contain vitamin D (e.g. fish, eggs) and most Australians only get 10–25% of their vitamin D from food sources.<sup>77</sup>

<sup>36</sup> Defined by BMI z-score > + 2.

<sup>37</sup> Defined by International Obesity Task Force definitions: percentile curves of BMI passing through cut-off points of adult overweight (25 kg/m<sup>2</sup>) and obesity (30 kg/m<sup>2</sup>) at age 18 years.

<sup>38</sup> From Karen State in Burma (Myanmar).

<sup>39</sup> Defined by BMI for age.

<sup>40</sup> The pigment in skin (melanin) acts as a natural sunscreen and increases the time needed to make Vitamin D.

<sup>41</sup> Estimation is based on exposure of 15% of body surface area (face and arms) to enough sunlight to produce 1/3 of the Minimal Erythematous Dose; this will produce approximately 1000 IU of vitamin D3.

People at risk for low vitamin D include those who spend most of their time inside or who do not expose their skin to sunlight, people with naturally dark skin, people with health conditions or medications that affect vitamin D metabolism and breast-fed babies with other risk factors. Refugees (and others) with naturally dark skin, or who wear covering clothing for religious or cultural reasons, are at risk for low vitamin D.

Low vitamin D is a significant problem for African communities in Melbourne. A study of East African children in Melbourne found 87% had low levels (< 50 nmol/L)<sup>27</sup> and studies of African adults in Melbourne have found 92–98% to have low levels.<sup>78, 79</sup> Very low levels (< 25 nmol/L) were found in 44% of East African children;<sup>27</sup> and 53–80% of African adults in Melbourne.<sup>78–81</sup> A follow-up study of women at the Royal Women’s Hospital with low vitamin D during pregnancy found 100% still had low levels 12 months later and 12 of 16 of their breast-fed infants also had low vitamin D.<sup>82</sup>

Most people with naturally very dark skin in Victoria will not be able to get enough sun exposure during the winter months to maintain their vitamin D levels and will need supplements to treat and prevent low vitamin D.

**Iron deficiency and anaemia**

Iron deficiency is the commonest cause of anaemia (low blood counts) in children. Iron deficiency is associated with tiredness, irritability, behaviour change and adverse effects on cognitive development.<sup>83–85</sup> Prevention and treatment of iron deficiency in children is recommended.<sup>86</sup>

Australian data suggest the prevalence of anaemia is 10–30% in African refugee children post-settlement.<sup>27, 87–89</sup> In the largest study of 238 children from the Horn of Africa in Melbourne, 39% of children under 5 years had anaemia.<sup>27</sup> The prevalence of iron deficiency is also 10–30% in groups of African refugee children on post-arrival health screening in Australia.<sup>27, 57, 89</sup> International prevalence figures for anaemia are generally comparable with those for Australia.

Interstate refugee health services have recently reported low Vitamin B12 and low folate in people of a refugee background. Vitamin B12 and folate are important for neurological function, and low levels cause anaemia. No Victorian data have been identified on low B12 or folate in refugee children.

**Other health conditions**

There is a lack of data on other chronic diseases in refugee children and young people after settlement. At the time of writing, there are no Australian studies tracking the health of refugee children over time; a large longitudinal study in Canada is currently under way.<sup>90</sup>

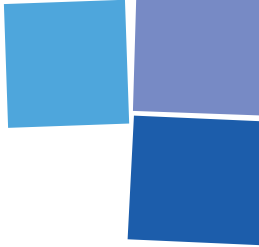
The reported prevalence of allergic disease in resettled refugee children is surprisingly low in the international literature (asthma 0.7–1.9%).<sup>91–94</sup> No local data have been identified, although Melbourne paediatricians working with refugee children and young people report asthma and eczema are rarely noted in recent arrivals.<sup>42</sup> These figures compare to a 2002 study of Melbourne school children where 20% had wheeze and 17.2% had eczema on parent report.<sup>95</sup> Migrant children have previously been shown to have lower rates of allergic disease than local born children;<sup>96, 97</sup> although the prevalence of allergic disease for migrant children trends towards the prevalence in children in the country of settlement.<sup>98</sup>

No data have been identified on disability in groups of resettled refugee children and young people.

**Exposure to toxins**

High blood lead levels are reported in groups of South Asian and African refugee children settled in the USA.<sup>59, 99–101</sup> The largest study of 693 refugee children aged less than 7 years in Massachusetts<sup>101</sup> found elevated blood lead levels in 11% of the total sample, which was a prevalence nearly three times higher than that of US-born children. Repeat measurements after 6 months on 213 children found blood lead levels declined in 73%, suggesting that lead exposure occurred pre-migration for the majority. However, newly elevated levels were found in 12 children, suggesting they had been exposed to lead after arrival.

<sup>42</sup> Consultation with immigrant health paediatricians, May 2008.



The authors suggested that the causes of pre-migration lead exposure might be the use of leaded petrol in countries of origin, industrial emissions, lead in cookware or traditional medicines, and increased lead absorption by children with diets low in calcium and iron. They suggested exposure after resettlement might relate to social disadvantage, with refugee families living in older, substandard housing with lead-based paint.<sup>102</sup> They recommended that refugee status alone should be considered a risk factor for elevated blood lead levels.

No Australian data on blood lead levels in refugees have been identified.

## ‘Healthy immigrant effect’

The ‘healthy immigrant effect’ refers to the observation that migrant populations often have better health than native-born populations in the new country of settlement. A 2007 systematic review on the healthy immigrant effect in Canada<sup>103</sup> found:

- lower direct age standardised mortality (death) rates than the general population for all refugee subgroups. Although the relative risk of mortality increased with length of stay for immigrants, it did not for refugees
- a significantly lower prevalence of chronic conditions<sup>43</sup> in immigrants than in Canadian-born; rates in immigrants approximated the rates in Canadian-born after 30 years
- lower cancer mortality for all immigrant groups compared to their home countries and Canadian-born rates, except for stomach cancer. Standardised mortality ratios (SMR) for cancer (at any site) were lower for refugees, except for the SMR for liver cancer in refugee males.

The healthy immigrant effect is thought to be due to lower rates of chronic health conditions in new arrivals, rather than different patterns of health service usage.<sup>104</sup> The healthy immigrant effect is also described in Australia.<sup>105</sup>

## Diseases with an infectious cause

Some infectious diseases are prevalent in resettled refugee children and young people. As these conditions have implications for long-term health, close attention to screening and treatment is essential. Detection and treatment of these conditions is a priority for the individual, rather than a public health concern. There is little (if any) evidence of transmission of Tuberculosis (TB) between the overseas-born and Australian-born populations,<sup>106</sup> and the rate of TB has been stable in Victoria at below six per 100,000 people per year since 1985.<sup>107</sup> It is not possible for malaria, *Schistosoma* or *Strongyloides* infection to be transmitted in Victoria.

Victorian data over an 8-year period indicate that the refugee group is overrepresented in notifications for Hepatitis B, Tuberculosis and malaria, although the total number of cases per year is low (Table 3.1). It is likely that the actual numbers of cases of parasite infections and Hepatitis B are higher than the notifications would suggest, given prevalence figures in the Australian and international literature. It is also of concern, as children with Hepatitis B require further assessment and monitoring.

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<sup>43</sup> Heart disease, diabetes, cancers.

Table 3.1: Notifiable communicable diseases, age 0–17 years, Victoria, pooled data 1999–2007

Condition	Victoria – total	Humanitarian source countries	
		Number of cases	Percentage of total
Salmonellosis	4,555	7	0.2
Giardiasis	3,182	99	3.1
Shigellosis	156	7	4.5
Cryptosporidiosis	2,171	<5	0.1
Hepatitis A	209	<5	1.9
Hepatitis B	609	46	7.6
Hepatitis C	710	<5	0.6
Tuberculosis	196	43	21.9
Malaria	151	62	41.1

Source: Data from Epidemiology and Surveillance Section, Communicable Diseases Prevention and Control Unit, Department of Human Services, July 2008. Information is not collected specifically on refugee status; these numbers are a composite of source country and cases where ‘refugee’ was noted in the optional comments section. Notifiable conditions should be notified by both the treating clinician and the laboratory performing diagnostic testing.

Tuberculosis

Tuberculosis (TB) disease is caused by bacteria of the *Mycobacterium Tuberculosis* complex. Latent TB Infection (LTBI) is the presence of TB infection without evidence of active TB disease. LTBI is not infectious. Approximately one-third of the world’s population have LTBI; only 5–10% of people with LTBI develop TB disease.<sup>106</sup> The risk of progression from TB infection to TB disease is highest in young children;<sup>106, 108</sup> relatively high in adolescents;<sup>108</sup> and increased in the first years after migration.<sup>109, 110</sup> Up to 50% of infants and 15% of older children with LTBI will develop TB disease within 2 years of being infected, which is why screening for LTBI is important in children and young people.<sup>111</sup>

The risk of LTBI progressing to TB disease can be reduced by 50–90% with 6–9 months of prevention therapy with isoniazid. Prevention treatment for LTBI is generally recommended in people less than 35 years<sup>55, 106</sup> and is well tolerated in children and young people. It is not used routinely in older age groups because of an increased risk of drug side-effects.


LTBI in children<sup>44</sup> is diagnosed by a positive Tuberculin Skin Test (TST or Mantoux test) without findings of active disease. The TST is available in hospitals and has been accessible in the community health setting since late 2008. Consultations and research<sup>859</sup> suggest many refugee children and young people were not screened for LTBI prior to this time.

Recent Australian studies have found the prevalence of positive TST varies from 3–63% in African refugee children,<sup>66, 87, 112–114</sup> although the larger studies show a prevalence of 37–55%.<sup>87 114</sup> By comparison, the prevalence of a positive TST in Australian-born school students in years 9 and 10 in Melbourne in 1995 was 0.7%.<sup>115</sup>

The international literature suggests the prevalence of a positive TST is 34–36% on universal screening of refugees / asylum seekers in New Zealand<sup>91, 116</sup> and 43–51% in very large cohorts of refugee arrivals to the US.<sup>117, 118</sup> The prevalence is 35–52% in groups of predominantly African refugees<sup>59, 119, 120</sup> and 20–60% in groups of predominantly South Asian refugees.<sup>61, 92, 109, 118, 121, 122</sup>

<sup>44</sup> The TST is the appropriate first line screening tests in children aged less than 13 years. An alternative test (the Quantiferon gold blood test) may be used in those aged over 13 years, although the TST can be used at any age.





The prevalence of TB disease in newly arrived groups of refugee adults may be as high as 1–5%,<sup>91, 116, 117, 123–126</sup> although diagnostic criteria vary between studies. Only one paper in the international literature gives figures for refugee children; fewer than 1% of 6643 children arriving in Minnesota in the years 1997–2001 had active TB disease.<sup>117</sup>

Pooled data (1999–2007) from the Communicable Diseases Section of DHS indicate that children from the Humanitarian Program source countries of interest are overrepresented in TB disease notifications; however the annual number of cases is low (as detailed earlier in table 3.1).

### Hepatitis B

Hepatitis B (HBV) is a viral infection affecting the liver that can be prevented by vaccination. Infants and children who get HBV are less likely to develop symptoms of acute illness but are more likely to develop chronic infection.<sup>127</sup> Chronic HBV infection may cause cirrhosis, liver failure<sup>128</sup> and liver cancer.<sup>129</sup> HBV can be transmitted from mother to child (vertically), between children (horizontally) and by exposure to infected body fluids (blood-borne or sexual transmission). Horizontal transmission is important in children younger than 5 years and household contacts of people with HBV infection.<sup>130, 131</sup>

The prevalence of chronic HBV infection in Australia is low, at 0.5–0.8%.<sup>132</sup> Australian studies have found the prevalence of chronic HBV infection in recently arrived refugees is 3–8% in groups from Africa,<sup>89, 114, 133–136</sup> (although it was 16% in a study from Adelaide<sup>133</sup>), 3.5% in a group from South Asia,<sup>114</sup> and 2.5% in a group from Iraq and Afghanistan.<sup>137</sup>

Pooled data (1999–2007) from the Communicable Diseases Section of the DHS indicate HBV infection is underdiagnosed or underreported in children born in the Humanitarian Program source countries of interest (Table 3.1).

The international literature shows similar prevalence figures for chronic HBV infection, ranging from 4.7–7.1% in universally screened cohorts,<sup>91, 118, 138</sup> 4–14% in predominantly African refugee cohorts;<sup>59, 119, 123</sup> 5.3–13.2% in predominantly South Asian cohorts,<sup>61, 92, 118, 139</sup> and 0.5–13.6% in cohorts from Europe and the Middle East.<sup>116, 140–142</sup>

The available literature suggests that the prevalence of HBV infection in refugee groups falls into what is known as the medium endemic range. This level of infection is typically associated with immunity, through past infection, in 20–60% of the population. This means a significant number of people within a community remain susceptible to HBV infection and are likely to have regular close contact with HBV carriers. The prevalence of immunity to HBV in paediatric refugees in Melbourne is in keeping with this, at 26–33%.<sup>66, 89, 112</sup>

A vaccine is available to prevent HBV infection. This vaccine is part of the Australian National Immunisation Program Schedule.

### Hepatitis C

Hepatitis C Virus (HCV) is usually transmitted through exposure to blood products. Mothers with HCV can pass the infection on to their babies during pregnancy or at the time of delivery, 4–7% of infants born to women with HCV will have HCV infection.<sup>143</sup> The infection is usually asymptomatic and chronic infection occurs in 50–60% of infected children, although fewer than 10% develop chronic Hepatitis and fewer than 5% develop cirrhosis of the liver.<sup>144</sup>

The prevalence of HCV in groups of refugees in the Australian literature is 1–3%.<sup>89, 133, 134, 137</sup> The only specific paediatric data (from Tasmania) found that HCV prevalence was less than 1%.<sup>135</sup> There is no routine screening for Hepatitis C in refugee children in Victoria.

### HIV

The prevalence of HIV infection in groups of refugee children in Australia has been so low that some services do not perform routine post-arrival refugee screening for HIV in children.

### *Helicobacter pylori*

*Helicobacter pylori* is a bacteria that causes gastritis (stomach inflammation) and gastric ulcers, and is associated with an increased risk of stomach cancer. A study from Perth found that the prevalence of *Helicobacter pylori* infection was 81.9% in African refugee children.<sup>145</sup> Most of these children were asymptomatic and the significance of this finding is unclear.

Parasites

Parasites are organisms that live on or in a host organism. In the process they may cause disease in their host (pathogenic parasites). Pathogenic parasites may not cause symptoms early in infection. Refugee health assessments involve screening for malaria and gastrointestinal parasites.

In Australian studies of refugee groups the rates of pathogenic parasites found in fecal specimens range from 16–39%.<sup>66, 88, 89, 114, 133, 135, 136</sup> *Giardia intestinalis*, the parasite that causes Giardiasis, is the most common pathogen identified, with a prevalence of 11–19% in refugee cohorts from Africa<sup>66, 114, 133</sup> and 17% in a group from South Asia.<sup>114</sup>

In the international literature the prevalence of pathogenic fecal parasites in refugees is reported at 17–72%,<sup>60, 61, 91, 92, 118-120, 123, 146-149</sup> with larger studies tending to show higher prevalence, and children typically having higher prevalence than adults.<sup>119, 135, 148</sup> Pathogenic fecal parasites are found in refugee cohorts from all areas, including Europe and the Middle East, as well as Africa and South Asia.

Pooled data (1999–2007) from the Communicable Diseases Section of DHS indicate there is significant underdiagnosis or underreporting of pathogenic fecal parasites in children born in the Humanitarian Program source countries of interest (see table 3.1).

Schistosomiasis<sup>45</sup> is a treatable parasitic infection affecting 200 million people worldwide, with 85% of the burden of disease in Africa.<sup>150</sup> It is a chronic disease which is often asymptomatic until late stage infection, when damage to organs becomes apparent.<sup>55</sup>

The prevalence of *Schistosoma* infection in refugees in recent Australian studies ranges from 2% to 30% in children<sup>66, 87, 88, 135</sup> and 12% to 38% in groups including both children and adults.<sup>89, 133, 134, 136</sup> The international literature shows similar figures.

Strongyloidiasis<sup>46</sup> is endemic in tropical areas and is common in recently arrived refugees. The prevalence of *Strongyloides* infection in refugees in recent Australian studies is 1–9%.<sup>66, 87-89, 134</sup> Earlier studies of refugee cohorts in Victoria found a prevalence of 24–42% in people from Laos and Cambodia.<sup>151, 152</sup> In the international literature the prevalence of *Strongyloides* infection is 23–49% in African refugees<sup>153, 154 155</sup> and 7.5% in a group of Karen refugees.<sup>61</sup>

Malaria<sup>47</sup> is a severe disease that can escalate rapidly, especially in young children. Pooled data (1999-2007) from the Communicable Diseases Section of DHS indicate a significant proportion of notified cases of malaria occurred in children born in the Humanitarian Program source countries of interest (Table 3.1).

Recent Australian studies report that the prevalence of malaria in African refugees is 5–10%.<sup>87, 114, 133, 134, 136, 156, 157</sup> These studies indicate that the prevalence of malaria is generally higher in children (9.5–28%),<sup>114, 134, 156</sup> although some of these studies were prior to the introduction of PDMS (which includes screening and treatment for malaria).<sup>48</sup>

Oral health

International literature on dental status in recently arrived child refugees suggests very high rates of dental disease, with approximately 50% or more having dental caries or problems.<sup>49 60, 93, 94, 158</sup> Only one of these studies described oral health behaviours in refugee children and young people in their area of origin.<sup>158</sup> This study found toothbrush use was uncommon outside Europe and fewer than 20% of the non-European children had ever seen a dentist. Specific cultural practices relating to the teeth and mouth are noted in the refugee health literature.<sup>50 159, 160</sup>

<sup>45</sup> Schistosomiasis is caused by infection with one of five species of trematodes (flukes) through contact with infected water. The life cycle of the parasite is complicated and involves an intermediate snail host. Chronic infection is associated with damage to the liver/spleen or bladder/kidneys, depending on the species causing infection.

<sup>46</sup> Strongyloidiasis is caused by infection with a type of nematode (worm) through contact with infected soil. Humans are the host for this parasite and the infection can last for decades. Most people with Strongyloides infection are asymptomatic; however Strongyloides can (rarely) cause a hyperinfection syndrome, which is often fatal if it does occur.

<sup>47</sup> Malaria is caused by infection with parasites transmitted by mosquitoes.

<sup>48</sup> A study of refugee children and young people in Perth found a prevalence of malaria of 9.5% after the introduction of PDMS.

<sup>49</sup> It should be noted that five of these studies involved groups arriving in 1998 or earlier.

<sup>50</sup> Removal of the uvula is practised in some parts of Somalia, and Dinka groups may remove the lower front incisors for cultural reasons.

In the absence of data on the dental status of child refugees in Australia, we have drawn on the views of clinical care providers in Melbourne. These providers identified dental caries as a major health issue in refugee children and families.<sup>51</sup>

A University of Melbourne PhD dissertation explores child/family oral health behaviours, beliefs and attitudes of refugee and migrant communities in Victoria (Iraqi, Lebanese and Pakistani).<sup>161</sup> Focus group discussions identified significant issues in child oral health including limited toothbrush and toothpaste use, a lack of awareness of the importance of primary dentition, and barriers to accessing dental services.

## Health service use

In May 2006, the Federal Government sought to encourage General Practitioners (GPs) to provide refugee health assessments by introducing a Medicare Benefits Schedule item for Health Assessments for Refugees and other Humanitarian Program Entrants (Item 714).<sup>52</sup> This Medicare item provides GPs (not specialists) with a rebate for assessing the health of Humanitarian Program entrants within a year of arrival in Australia.<sup>162</sup>

Table 3.2 provides figures for Item 714 uptake for children and young people (aged 0–14 years), and estimated numbers of Humanitarian Program entrants in this age range in 2006–07 and 2007–08. The figures suggest that an increasing proportion of children are receiving initial health assessments by GPs, although there is no easy way of verifying whether recommended screening tests are completed.

**Table 3.2: Uptake of Medicare Item 714, Victoria, 2006–07 and 2007–08**

	2006–07	2007–08
Item 714 age 0–14 <sup>163</sup>	790	795
Estimated Humanitarian entrants 0–14 <sup>53</sup>	1,492	1,085
Estimated coverage (percentage)	53	73

Source: Medicare Australia. Item reports. Item 714 by financial year and state, also reporting on age. Accessed 16 August 2008.

## Health undertakings

In 2007 over 10% of Humanitarian Program entrants (342 of 3247)<sup>164</sup> had a health undertaking.<sup>54</sup>

## Specialist referral

No Victorian data are available on how many refugee children and young people required specialist referral after initial refugee health screening. However, interstate and New Zealand figures suggest high rates of referral to specialists. In Perth, over 80% of children required specialist assessment after their initial refugee health screen at the Migrant Health Unit.<sup>55</sup> In New Zealand, 47.6% of all refugees screened between 1995–1999 required specialist review (in total 2189 specialist referrals for 2992 people).<sup>91</sup> These figures suggest the majority of refugee entrants will see both a general practitioner and a specialist. This increases the complexity of families' interactions with the health care system, particularly where multiple family members may be referred to

<sup>51</sup> Consultation immigrant health paediatricians, Royal Children's Hospital, May 2008.

<sup>52</sup> The Medicare item 714 ceased in May 2010, as part of the general review of primary care item numbers announced by the Federal Government in December 2009. It was replaced by time-based item numbers, supporting assessment of complex patients in primary care. The new time-based item numbers are not specific for Humanitarian entrants.

<sup>53</sup> Estimated Humanitarian entrants 0–14 calculated by assuming even distribution across age 10–19 years and adding half this number to 0–9 intake.

<sup>54</sup> Health undertakings are generated when someone is found to have a health issue on their visa medical assessment that requires follow-up after arrival in Australia, and they agree to follow up with Australian health services after arrival. The majority of health undertakings (approximately 90%) are to follow up on TB screening test results. People with active TB disease are treated fully before they are allowed to enter Australia.

<sup>55</sup> Communication Paediatric Refugee Clinic staff, Princess Margaret Hospital, May 2008.

different specialists. In comparison, the overall rate of referrals from GPs to specialists in Australia was 8% in 2006–07.<sup>165</sup>

**Hospital use**

A comprehensive Victorian study has examined hospital use in Victoria by people born in refugee source countries<sup>56</sup> over the period 1998–2004.<sup>166, 167</sup> There is no information specific for children. Compared to people born in Australia, the refugee group had:

- lower rates of total hospital admission
- lower rates of surgical admissions
- fewer days in hospital
- lower rates of admission for mental and behavioural disorders
- similar rates of admission for infectious/parasitic diseases.

**Access to dental services**

A 2007 review of dental services available to refugee clients in Australia identified problems with fragmented and limited dental services, long waiting times (13–58 months) and limited interpreter services.<sup>168</sup> Other research<sup>169</sup> and consultations<sup>57</sup> have also identified access to dental services as a significant issue for refugee children and families in Victoria.

<sup>56</sup> Afghanistan, Bosnia–Herzegovina, Burma, Eritrea, Ethiopia, Iraq, Somalia, Sudan. Croatia, Iran, Former Yugoslavia also available in the full report.

<sup>57</sup> Consultations with immigrant health paediatricians, Royal Children’s Hospital, May 2008; questionnaire responses from refugee health nurses.

# Health screening and health on arrival

Refugee children and young people:

- have low rates of overweight/obesity post-arrival
- have a high prevalence of Vitamin A deficiency
- may have multiple and persisting risk factors for low Vitamin D, are at risk for long-term ill-health as a result, and are likely to need long-term supplementation. Up to 90% of children and young people from Africa have low Vitamin D levels
- have a high prevalence of anaemia and iron deficiency
- have very low rates of allergic disease on arrival
- are reported to be at risk for high blood lead levels in the international literature
- have a high prevalence of latent TB infection, regardless of area of origin
- are not always being screened for TB infection, even though prevention therapy for latent TB infection is recommended
- are likely to have higher rates of TB disease than Australian-born children
- have a higher prevalence of Hepatitis B infection than the Australian population overall
- have a high prevalence of parasite infection, regardless of area of origin
- have a high prevalence of *Schistosoma* infection, which can cause severe chronic disease
- account for 41.1% of all malaria cases notified in Victoria.

## Other points

Not all children see a GP after arrival.

The rate of post-arrival health assessment or whether assessments follow recommended screening is unclear, although data from Medicare indicate increasing uptake of Item 714.

Children who have a health assessment frequently require specialist referral.

Communicable diseases are underreported in Victoria based on prevalence information in the published literature.

People of a refugee background in Victoria do not have higher rates of hospital use than people born in Australia.

Research and consultations highlight significant concerns about oral health and access to dental services in refugee children, young people and their families.

# Immunisation

Immunisation against communicable diseases reduces morbidity and mortality. While offering protection for individual children, it also reduces the rate of disease circulation within the community. In general, vaccination coverage of over 90% is required to stop disease transmission.

The Australian National Immunisation Program Schedule (NIPS) provides vaccination for all children against Hepatitis B, diphtheria, tetanus, whooping cough (*Bordetella pertussis*), poliomyelitis (polio), *Haemophilus influenzae* type b (Hib), pneumococcal disease, rotavirus disease, meningococcal disease, mumps, measles, rubella and chicken pox (*Varicella Zoster Virus* (VZV)).<sup>170</sup> Human Papilloma Virus (HPV) vaccine is provided for girls. Available data show over 90% of Victorian children are fully immunised at 12–15 months and at 24–27 months.<sup>4</sup>

The Australian Childhood Immunisation Register (ACIR) is a national database that records vaccinations for all children up to their seventh birthday.<sup>170</sup> ACIR provides a way for health providers to monitor childhood immunisation status, but it is not possible to extract figures on immunisation in refugee children.<sup>58</sup>

Refugee children and young people (and adults) are at high risk of inadequate immunisation coverage for many reasons including:

- country of origin schedules that do not include the same vaccines as the Australian NIPS
- inadequate vaccinations in country of origin<sup>59</sup>
- missed opportunities for catch-up vaccination in Australia
- service delivery issues.

Additionally, most refugees do not have written documentation of immunisations, and Australia does not require completed Expanded Program of Immunisation (EPI) records prior to departure for Australia.

## Immunisation prevalence data

Adequate immunity against Vaccine Preventable Diseases (VPD) can be checked on blood tests (‘serological immunity’). For most diseases, serological immunity reflects either vaccination or exposure to natural infection.

Data are available from Melbourne on serological immunity in African refugee children and young people. For measles, protection ranges from 80% to 90%,<sup>66, 112, 113</sup> although it was much lower (56%) in children in a community based sample.<sup>89</sup> This may have improved since the introduction of Measles Mumps Rubella (MMR) vaccination in the PDMS in 2005, although PDMS coverage is incomplete.<sup>170</sup>

Coverage for mumps is low in African refugee children and young people (60%)<sup>89</sup> and coverage against rubella is also inadequate (74–82%).<sup>66, 89, 112, 113</sup> Coverage against rubella appears to be better in refugee adults in Australia (87–96%),<sup>89, 114</sup> but it is still lower than rates seen in the general population in Melbourne. In a Melbourne survey in 2000, 97.5% of women of childbearing age were protected against rubella.<sup>170</sup> All pregnant women in Victoria are screened for rubella immunity.

Protection against diphtheria, tetanus and Hepatitis B is also inadequate. Tetanus coverage ranges from 52% to 61% in three groups with a refugee background,<sup>89, 112, 113</sup> although it was 88% in a fourth group.<sup>66</sup> Diphtheria coverage ranges from 45% to 69%.<sup>66, 112, 113</sup> Hepatitis B immunity ranges from 26% to 33%,<sup>66, 89, 112, 113</sup> which is important given the prevalence of chronic Hepatitis B infection in this group (3–8%),<sup>89, 114, 133–136</sup> and the risk of Hepatitis B transmission between household contacts.

Limited international data also suggest inadequate protection against vaccine preventable diseases.

<sup>58</sup> ACIR is, however, linked to Medicare, and this linkage offers a potential means to explore immunisation coverage.

<sup>59</sup> Immunisation coverage is affected when health services are disrupted in settings of conflict. Many vaccine preventable diseases (VPDs) are endemic and/or epidemic in the countries of origin and in countries through which refugees transit. Furthermore, childhood immunisation programs in resource poor or conflict situations may not be able to maintain the system required to keep and distribute vaccines in good condition (known as the ‘cold chain’).

## Catch-up immunisation

The *Australian Immunisation Handbook* recommends catch-up vaccination as a priority, with special reference to people entering Australia as refugees or immigrants.<sup>170</sup>

Only a small number of refugees have written immunisation records<sup>55</sup>, as documents are often lost in flight.<sup>60</sup> Full catch-up immunisation is recommended if there is no written record.<sup>55</sup>

Among African refugees attending general practice clinics in Melbourne, more than 80% of those aged under 15 years and around 50% of those aged over 15 years needed catch-up vaccination. In groups of East African children attending the Royal Children's Hospital in 2000–2003; 98–100% had incomplete or unknown immunisation status and needed catch-up immunisation.<sup>112, 113</sup>

Health authorities in Victoria provide free catch-up vaccination for tetanus, diphtheria, polio (all ages), mumps, measles, rubella (for those born in 1966 or later), Hib (under 5 years) and pneumococcus (under 2 years). Because rotavirus vaccine is only given in early infancy, it is rarely needed as 'catch-up'. Pertussis (whooping cough) immunisation (given with diphtheria and tetanus) is free and available for those aged under 8 years, however there is no separate pertussis vaccine and there is a lack of evidence on using the booster formulation to provide a primary immunisation course for those over 8 years. Hepatitis B vaccine funding is detailed below.

There are several vaccines that are routine for Victorian-born children that are more difficult for refugee children in Victoria to access.

- Meningococcal vaccination is part of the NIPS and prior to 2007 was funded for catch-up to 19 years of age. It is now funded for children born after 1 January 2002. This means 0–18 year-olds in Victoria are vaccinated, but 9–18 year-olds of a refugee background who missed the catch-up program in Victoria have to pay for this immunisation.
- Hepatitis B vaccination has been included for infants in the NIPS since 2000. Hepatitis B vaccine is funded as catch-up for children born after 1 May 2000 and for all secondary school students; Year 7 catch-up is available until 2012 and vaccination is also available free of charge for household contacts. Secondary school vaccination is targeted at Year 7 level. This means there is a group of late primary school children who may have delayed Hepatitis B vaccination, and older adolescents (and adults) are at risk of missing Hepatitis B vaccination. There is no universal screening of refugee children in Victoria (to detect household contacts) and they have a real risk of transmission from contact with HBV carriers living in close proximity.
- HPV vaccination is part of the NIPS and prior to mid 2009 was funded for catch-up for females aged 13–26 years. It is now funded as part of Year 7 vaccinations in Victoria. This means 13–18 year-old girls in Victoria are vaccinated, but 14–18 year-old girls of a refugee background who missed the catch-up program in Victoria have to pay for this immunisation.

### Missed immunisation opportunities and service delivery issues

Evidence suggests that Victorian health services miss opportunities for immunisation. In 150 East African children attending the Royal Children's Hospital (RCH) (2000–02), where 98% had incomplete or unknown immunisation status, children had been resident in Australia for up to 4 years.<sup>112</sup> In the next group of children studied, where no child was reported as being up to date for schedule vaccines,<sup>113</sup> two-thirds reported having no vaccinations and two-thirds had seen a Maternal and Child Health (MCH) nurse or GP at least once.

A more recent community-based survey of 70 recently arrived refugee children in Melbourne indicates the situation has not changed.<sup>29</sup> This study found that while 75% of children had had a post-arrival health check and 91% had a family doctor, only 28.6% had immunisation at a GP and 4.8% had immunisation at a Community Health Centre. Of children who had been in Australia less than 6 months, none had had immunisations in primary care, although 89.5% had had a post-arrival health check at a general practice.

<sup>60</sup> Consultation with immigrant health paediatricians, Royal Children's Hospital, December 2007.

Catch-up immunisation has been introduced in English Language Schools and Centres (ELS/C) in recent years, but not all newly arrived refugee children attend these services. Consultation with the ELS/C sector<sup>61</sup> identified many difficulties with catch-up immunisation programs, including:

- immunisation was provided only once a term in three of four schools consulted<sup>62</sup>
- there were difficulties communicating with parents about the need and process for catch-up immunisation
- there was doubling up with catch-up immunisation programs coordinated by local community services
- there were difficulties maintaining accurate records and accessing council records
- three of the four schools consulted reported parents being concerned about HPV vaccination because it relates to sexual health.

Interstate data support the finding that there are missed opportunities for immunisation.<sup>171, 172</sup> Additional issues affecting catch-up immunisation include:

- the need for multiple vaccinations from different stages of the NIPS, especially when dealing with several children in a family simultaneously
- movement of families after resettlement and resulting changes in health care providers, making records difficult to track
- lack of a centralised register for children over 7 years of age (ACIR is available up to the seventh birthday)
- lack of a patient-held record for older children, equivalent to the ‘blue book’ given to parents on the birth of a child.

## Immunisation

### Key findings

Based on reported completion of immunisation and on serological evidence of immunity, refugee children and young people are inadequately protected against vaccine-preventable diseases.

Current data indicate there are shortfalls in the delivery of immunisation catch-up to refugee children post-arrival and the majority have missed immunisation opportunities.

<sup>61</sup> Consultation with Western English Language School, Blackburn English Language School, Noble Park English Language School and Brunswick English Language Centre, May 2008.

<sup>62</sup> One school provided this twice a year.





# Mental health

## Risk factors for mental health problems

Trauma experience and stress after resettlement can affect the mental health of refugees,<sup>173, 174</sup> and parent mental health is a significant influence on the mental health of children.<sup>175–178</sup> A 2002 meta-analysis of 56 studies published between 1969 and 2002 provides information on factors affecting mental health outcomes in refugee groups, including comparative data for refugee and non-refugee groups.<sup>179</sup>

Some of the identified risk factors for less favourable mental health outcomes in refugees include:

- institutional or temporary housing after settlement
- restricted economic opportunity after settlement
- ongoing conflict in the country of origin
- higher education level and higher socioeconomic status pre-arrival
- coming from a rural area.

Child and adolescent refugees had relatively better mental health outcomes than adults in this analysis.

Unaccompanied refugee and asylum seeker children may be particularly vulnerable to mental health problems because family and community support systems are lacking,<sup>180</sup> and they are at increased risk of neglect, sexual assault and other abuses.<sup>181, 182</sup>

Australia's Human Rights and Equal Opportunity Commission (HREOC) 2004 national inquiry into children in detention concluded that uncertain visa status was a significant factor in mental health problems of children and their families.<sup>183</sup> In addition, HREOC concluded that a large number of detained asylum seekers had mental health problems,<sup>184</sup> highlighting associations between length of detention and adverse effects on mental health for children and families, and the negative effects of detention on parenting and family function.<sup>183</sup> Small Australian studies of detained asylum seeker children and young people have found that an extremely high proportion have significant mental health problems.<sup>183, 185, 186</sup>

## Measuring mental health

There are particular issues that need to be taken into account when considering prevalence data in refugee mental health. Research in any refugee group relates to their country of origin, their country of settlement and the period of time; it is not possible to generalise the research findings. There are also concerns with how mental health is measured in refugee populations. A 2002 systematic review examined 183 studies using 125 different instruments to measure mental health in refugee populations.<sup>187</sup> The authors found that fewer than 10% of the instruments had been validated in refugee groups.

## Mental health problems

There are no published systematic studies of mental health problems of refugee children and young people in Australia. A large study from South Australia conducted over 2005–08 will provide information on the prevalence of mental health problems in this group and their patterns of service use. In the international literature, more information is available on Post Traumatic Stress Disorder (PTSD) and symptoms of depression, than on the prevalence of anxiety, grief or social impairment. There is limited information on how mental health problems affect settlement, education and how children function.

### Post traumatic stress disorder

PTSD is an anxiety disorder where exposure to a traumatic event is followed by persistent re-experiencing of the event, hyper-arousal and avoiding stimuli associated with the trauma.<sup>188</sup> The only pooled analysis of PTSD in refugee children suggests a prevalence of 11%; adult refugees settled in western countries are 10 times more likely to have PTSD than age-matched general populations.<sup>189</sup> Published studies on the rates of PTSD in refugee children are shown in Table 3.3. The only population-wide study found the lowest prevalence (2.9%).

### Depression, anxiety and other mental health diagnoses

The reported prevalence of depression/depressive symptoms and anxiety problems in refugee children and young people varies widely. Published studies on the rates of these problems in refugee children are shown in Table 3.3.

In comparison to the figures in Table 3.3, in a randomly selected sample of 1300 adolescents in Melbourne in the year 2000, the prevalence of depression was 14.2% and the prevalence of anxiety was 13.2%.<sup>190</sup>

Other mental health diagnoses such as psychosis and eating disorders are reported in young people of a refugee background at specialist services;<sup>191</sup> however, there is limited information on how often they occur. Available studies do not suggest such conditions are more common.<sup>192, 193</sup>

### Behaviour problems

Studies of refugee children and young people have found varied prevalence of behaviour problems.<sup>63</sup> The reported prevalence varies with age and whether it is a self or teacher report. A South Australian study has assessed behaviour problems in refugee students.<sup>213</sup> Behaviour problems were found in 30% of children and were most commonly anxiety symptoms. The number of children in the clinical range for behaviour problems<sup>64</sup> was approximately double the rate found in the same age group in a 1998 Australian National Survey of Mental Health and Wellbeing (14.1%). However, the number of adolescents in the clinical range for behaviour problems<sup>65</sup> was less than half the rate for this age group found in the same national survey (14.1%). Local consultations identified behaviour problems in the school setting, with particular concerns for students with interrupted schooling.<sup>66</sup>

High self-esteem may protect refugee and immigrant youth against maladjustment and behavioural problems after resettlement. There is also some evidence that the quality of peer relationships provides a positive predictor of children's social adjustment and feelings of self-worth.<sup>177</sup>

No Australian data have been found on sleep in refugee children. In the international literature, a review of eight studies on sleep in refugee children and young people found the prevalence of sleep problems was 12–55%; although five of the eight studies found over 50% of refugee children had sleep problems.<sup>214</sup>

### Bullying

Refugee children may be at risk of experiencing bullying and its detrimental effects.<sup>215</sup> The Good Starts study examined the resettlement experiences of 88 refugee young people in Melbourne (85% born in Africa), starting while the students were at English Language School (ELS). The study found that by the end of the second year of settlement one-third of the 48 boys in the study reported bullying, with similar levels of bullying in ELS and mainstream school.<sup>216, 217</sup> One-third of the 40 girls also reported bullying at ELS, although girls reported less bullying at mainstream school.<sup>218</sup>

## Experience of torture and trauma

Some information on psychological and physical violence experienced by refugee children and young people aged 0–17 years is available from VFST client services data.<sup>16-18, 35</sup>

<sup>63</sup> There is a need for more Australian and population data and there are issues with the cultural validity of behaviour rating scales.

<sup>64</sup> On teacher report using the Achenbach Child Behaviour Checklist.

<sup>65</sup> On teacher report using the Achenbach Child Behaviour Checklist.

<sup>66</sup> Consultation with African Think Tank members, May 2008; youth health nurses, Western Region, May 2008.

**Table 3.3: Summary of published information on mental health diagnoses in refugee children and young people.**

PTSD	<p>28% of 95 Bosnian children in temporary foster care in Greece (published 2000).<sup>194</sup></p> <p>2.9% of 1224 Kosovar 0–18 year-olds in Denmark (1999)<sup>195</sup></p> <p>56.7% of 120 repatriated Bosnian refugee adolescents and 68.1% of 119 internally displaced adolescents (1999)<sup>196</sup></p> <p>94% of 364 internally displaced Bosnian children (1997)<sup>197</sup></p> <p>25% of 12 Bosnian adolescents in the USA (1995)<sup>198</sup></p> <p>61.5% of 265 Bosnian 14 and 15 year-olds in Slovenia (1994)<sup>199</sup></p> <p>13% of 38 refugee young people from Afghanistan in the USA (published 1995)<sup>200</sup></p> <p>75% (moderate or severe symptoms) of 168 unaccompanied Sudanese refugee children in a Kenyan refugee camp (2000)<sup>201</sup></p> <p>20% of 304 Sudanese refugee minors in foster care in the USA (2002)<sup>202</sup></p> <p>20% of 56 Sudanese children in refugee camps in Uganda (1994–96)<sup>203</sup></p> <p>23% of 104 young Burmese adults in Thailand (1992–93)<sup>204</sup></p> <p>40% of 186 children who had experienced war in Cambodia (1997)<sup>173, 205</sup></p> <p>18% of 209 randomly sampled Cambodian adolescent refugees in the USA aged 0–12 years at the time of the Pol Pot regime (1994)<sup>192</sup></p> <p>24% of 16–25 year-old Cambodians in the USA in 1995, 15 years after exposure to trauma<sup>206</sup></p>
Depression	<p>33% of 40 refugee children aged 8–16 years living in the UK (2004)<sup>207</sup></p> <p>4.1% of 1224 Kosovar 0–18 year-olds in Denmark (1999)<sup>195</sup></p> <p>47% of 95 Bosnian refugee children in temporary foster care in Greece (2000)<sup>194</sup></p> <p>17% of 12 Bosnian adolescents in the USA (1995)<sup>198</sup></p> <p>12.5% of 265 Bosnian 14 and 15 year-olds in Slovenia (1994),<sup>199</sup> compared to 22% of 195 age- and grade-matched local students</p> <p>29% of 38 refugee young people from Afghanistan in the USA (1995)<sup>200</sup></p> <p>20% of 56 Sudanese children 6–14 years in Uganda (1999)<sup>208</sup></p> <p>38% of 104 Burmese young adult political dissidents in Thailand (1992–93)<sup>204</sup></p> <p>12.9% of 170 Cambodian youth resettled in the USA (1996);<sup>209</sup> this was four times higher than the reported prevalence rate in a large sample of school children living in the same area<sup>209</sup></p> <p>11% of 209 Cambodian youth in the USA (1995)<sup>192, 210</sup></p>
Anxiety	<p>10.2% of 1224 Kosovar 0–18 year-olds in Denmark (1999)<sup>195</sup></p> <p>23% of 95 Bosnian refugee children in temporary foster care in Greece (2000)<sup>194</sup></p> <p>3.3% of 120 Bosnian repatriated adolescents (after 7 years) and 24.4% of 119 internally displaced Bosnian adolescents (1999)<sup>196</sup></p> <p>95.5% of 364 internally displaced Bosnian 6–12 year-olds (1994)<sup>197</sup></p> <p>55.3% of 150 Albanian refugee children in Turkey (1999) compared to 15.2% of 66 controls in the same study<sup>211</sup></p> <p>67% of 311 Middle Eastern children in Denmark (1992–93)<sup>212</sup></p>

**Table 3.4: Physical or psychological violence, tabulated client services data, Victorian Foundation for Survivors of Torture (VFST), 2004–08**

	2004–05	2005–06	2006–07	2007–08
Assessment stream	EHA1	IHSS	IHSS	IHSS
0–10 years	663	724	858	551
11–20 years	473	618	760	527
Total 0–20 years	1,136	1,342	1,618	1,078
Humanitarian intake 0–19 years (DIAC) <sup>50</sup>	2,208	1,884	2,040	1,474
Psychological violence experienced by VFST clients, age 0–17 years (percentage affected)				
Dangerous flight	54	47	45	36
Detention of family or friends	21	13	16	8
Disappearance of family members	21	25	23	11
Forced separation from family	42	43	40	24
House raided	16	26	10	9
Solitary confinement	1	1	0	0
Subject to mock executions	0	0	1	2
Threat of harm to family	62	68	56	37
Witnessing violence	51	45	39	30
Witnessing others killed	12	13	14	8
Physical violence experienced by VFST clients, age 0–17 years (percentage affected)				
Severe beating	2	1	1	1
Combatant	1	2	1	0
Rape or other sexual assault	0	4	0	0
Under combat fire	29	29	24	14
Hardship experienced by VFST clients, age 0–17 years (percentage affected)				
In hiding or internal displacement	33	30	29	8
Lack of food, water or shelter	28	56	44	16
Refugee camp	39	45	38	41
Detention experienced by VFST clients, age 0–17 years (percentage affected)				
Detention including concentration camp or home detention or detention centre or prison term or illegal detention	4	2	1	–

Source: Victorian Foundation for Survivors of Torture Annual Reports – 2004/05 to current. Direct Client Services data have been used for the Integrated Humanitarian Settlement Support group; where assessment is provided for new arrivals. EHA1 refers to Early Health Assessment and Intervention. This was also a program for new arrivals



Table 3.4 shows details for the 0–17 year age group.<sup>67</sup> These data should be interpreted with caution.<sup>68</sup> Nevertheless, the figures suggest the majority of refugee children and young people have experienced a threat of harm to their family, around half have experienced a dangerous flight to safety, around 40% have undergone forced separation or witnessed violence; around one-third have been under combat fire; and over 20% have experienced disappearance of family members.

In the international literature there is more information on the trauma experience of young people from Bosnia and countries of the former Yugoslavia than other refugee source countries; however, there are high rates of extreme stressors in all the groups studied. Groups of unaccompanied minors have an extraordinarily high prevalence of trauma experiences,<sup>202, 219–221</sup> but the experience of being separated from parents/family is common to many refugee children and young people. There are limited data on sexual violence against refugee children and young people; the available information suggests that it is common in some groups.<sup>208, 220, 222, 223</sup>

## Positive psychosocial adjustment and resilience

Alongside the literature on the negative effect of trauma on mental health, there is a body of literature on the resilience and positive social adjustment of refugee children and young people. Some studies have found that following arrival in a new country, refugee children have fewer mental health symptoms than other groups<sup>33, 224</sup> and trauma experience does not always predict worse mental health outcomes.<sup>202, 205, 225, 226</sup> Other studies have found that psychological symptoms do not necessarily correlate with impaired function.<sup>199, 210</sup> The evidence suggests that peer relationships are important in social adjustment,<sup>177</sup> as are connections to communities of a similar background in the country of resettlement.<sup>227</sup> The majority of traumatised refugee children grow up to become well-adjusted adults.<sup>202, 228, 229</sup>

## Mental health service usage

No paediatric data have been identified on rates of referral to mental health services in Victoria, but consultations indicated that referral for mental health issues in children of a refugee background was uncommon. The low rate of referral was felt to relate more to under-ascertainment than to lack of need.<sup>69</sup>

Foundation House provide mental health assessment for recently arrived refugees and short-term intervention; some long-term support is available and there is also a specialist mental health clinic. Overall, 18% of clients required prolonged support<sup>70</sup> in 2006–07; however, no figures are available for children and young people. Only 4–6% of people attending the specialist mental health clinic were aged under 20.<sup>16, 35</sup> Given that children and young people make up around half the Humanitarian Program intake, they are underrepresented in specialist mental health referrals, but whether this signifies lower need or lower ascertainment is uncertain.

Data from the Child and Adolescent Mental Health Service (CAMHS) show that over an 8-year period, young people of a refugee background made up only 0.5% of children and young people first registered as CAMHS clients in any year (Table 3.5).

Table 3.6 shows the rate of CAMHS usage for 0–17 year-olds in 2001 and 2006. Young people of a refugee background have lower usage of CAMHS than children and young people first registered with CAMHS in Victoria for both time periods. It is also possible that the true rates of usage may be even lower in the refugee group.<sup>71</sup> This is concerning given the available prevalence data on torture/trauma experience and mental health issues, however the figures do not include assessment and treatment provided through other services such as Foundation House.

<sup>67</sup> Numbers of clients are given by age 0–20, data prevalence is reported for 0–17, exact numbers for 0–17 year-olds assessed were not available.

<sup>68</sup> For 2004–07, figures relate to screening assessments of all refugee entrants and referred SHP entrants. This is not research data; however, a large proportion of the Humanitarian intake to Victoria are seen in any given year.

<sup>69</sup> Consultation with immigrant health paediatricians, Royal Children's Hospital, May 2008.

<sup>70</sup> Defined as the number of people requiring more than 20 sessions or longer than 12 months of intervention with intensive counselling.

<sup>71</sup> The number of 0–17 year-olds born in the source countries of interest according to the 2006 Census of Population and Housing (n=8897) seems low considering the government school Census data for 2006 identified 7247 school age children born in the same countries (i.e., this number does not include 0–4 year-olds and not all students attend government schools).

Table 3.5: CAMHS clients age 0–17 years, Victoria, 2000–01 to 2007–08

Year	Humanitarian Program source countries	Total first CAMHS registrations Victoria
2000-01	33	5,922
2001-02	31	5,376
2002-03	27	5,251
2003-04	33	4,922
2004-05	17	4,921
2005-06	31	4,314
2006-07	18	4,085
2007-08	21	3,769
Total (percentage)	211 (0.5%)	38,560 (100.0%)

Source: Child and Adolescent Mental Health Service (CAMHS) dataset, accessed from the Department of Human Services, September 2008. Country of birth using the 10 most frequent countries for Humanitarian entrants to Victoria (1996–2007) has been used as a proxy for refugee status.

Table 3.6: Rate of CAMHS service usage, age 0–17 years, Victoria, 2001 and 2006

	2001			2006		
	Clients	Population	Rate per 1,000	Clients	Population	Rate per 1,000
Humanitarian Program source countries	31	7,361	4.2	18	8,897	2.0
Total Victoria	5,376	1,155,413	4.7	4,085	1,181,483	3.5

Source: Child and Adolescent Mental Health Service (CAMHS) dataset, accessed from the Department of Human Services in September 2008. Country of birth using the 10 most frequent countries for Humanitarian entrants to Victoria, (1996–2007) has been used as a proxy for refugee status.

Rates have been calculated using the following denominators:

Humanitarian source countries of interest: unpublished ABS 2001 and 2006 Census of Population and Housing data, country of birth by age, usual residence Victoria

Total Victoria: ABS 2008 Estimated Resident Population by age for June 2001 and June 2006<sup>230</sup>

## Mental health

### Key findings

Refugee children and young people are known to experience Post Traumatic Stress Disorder (PTSD), depression and anxiety disorders as a result of their refugee and post-migration experience.

Unaccompanied minors and people held in immigration detention are identified as particular risk groups in the mental health literature.

The most detailed pooled analysis of PTSD in refugee children suggests a prevalence of 11%. The reported prevalence of depressive symptoms ranges from 4% to 47% and the prevalence of anxiety symptoms ranges from 3% to 96%.

Refugee children may be at risk of experiencing bullying and its detrimental effects.

Many refugee children and young people have experienced physical and psychological violence and separation from their parents/family.

Refugee children and young people function better than might be assumed from their psychological profiles and mental health problems do not always correlate with functional impairment.

No local data exist on the rate of referral of children and young people to mental health services.

CAMHS data indicate a lower rate of service use by refugee children and young people in Victoria than by the broader population. This is concerning given the prevalence data on torture/trauma experience and mental health issues in refugee children and young people. Because mental health matters: *The Victorian mental health reform strategy 2009–2019*<sup>72</sup> recognises the need to explore issues and strategies to address service access to improve mental health outcomes for people from refugee backgrounds and their families.

## Antenatal and perinatal health

### Perinatal data

Data for this section are from the Victorian Perinatal Data Collection (VPDC), which collects and analyses information on all births in Victoria of 20 or more weeks' gestation or 400 g or more birthweight. Maternal country of birth has been used as a proxy for refugee status.<sup>72</sup> The data relate to children born in Victoria to mothers from these countries, so figures should be interpreted with this in mind. The crude birth rate and fertility rates may be underestimates. Other points worth noting are that some indicators report on births, and others use confinements (pregnancies); and that these differ as one pregnancy can give rise to more than one birth.

<sup>72</sup> Country of birth using the 10 most frequent countries of origin for Humanitarian Program entrants over 1996 – 2007. For methodology: see additional information document at [www.education.vic.gov.au/statewideoutcomes](http://www.education.vic.gov.au/statewideoutcomes)

Perinatal mortality

The adjusted Perinatal Mortality Rate (PMR) published by the VPDC is the number of stillbirths and neonatal deaths<sup>73</sup> per 1000 adjusted births,<sup>74</sup> excluding late terminations of pregnancy for psychosocial reasons.<sup>232</sup> In the following, the PMR has been adjusted to exclude all terminations of pregnancy for any indication.<sup>75</sup>

Table 3.7 shows the adjusted PMR<sup>76</sup> for women from the refugee-like group, compared to all Victorian women. The adjusted PMR in the refugee-like group is higher than the adjusted PMR for all Victorian women.

Table 3.7: Adjusted Perinatal Mortality Rates per 1000 adjusted births, Victoria, 1999–2006

Population	1999	2000	2001	2002	2003	2004	2005	2006
Refugee-like	18.3	10.1	9.6	10.5	14.8	10.6	11.7	11.0
Victoria	9.9	8.1	8.5	8.0	8.8	7.9	8.2	7.9

Source: Victorian Perinatal Data Collection, September 2008.

Definitions:

**Perinatal deaths** is the number of still births (death more than 20 weeks gestation or 400 g) and neonatal deaths excluding late Termination of Pregnancy (TOP) for all causes (maternal medical indications, maternal psychosocial indication, congenital abnormalities).

**Adjusted births** is the number of live births and stillbirths (death more than 20 weeks gestation or 400g) not including late terminations of pregnancy for all causes (maternal psychosocial reasons, maternal medical conditions and congenital abnormalities).

**Perinatal Mortality Rate (PMR)** is the number of perinatal deaths per 1000 adjusted births.

These figures are different from the PMR published in the Births in Victoria reports due to the different inclusion/exclusion criteria.

Infant mortality

No data were available to calculate the infant mortality rate in children born to women of a refugee background.

Crude Birth Rate

The Crude Birth Rate (CBR) is the adjusted births per 1000 total population. The number of adjusted births for the refugee-like group is expected to increase each year as the population number increases, with a corresponding increase of women in their childbearing years.

Table 3.8 shows that the CBR increased more between 2001 and 2006 for the refugee-like group compared with the general Victorian population.

As described earlier, it is important to note that the refugee population has a younger age structure than the total population. This difference in age structure is likely to be a contributory factor to the higher CBR in the refugee-like group when compared with the total population.

<sup>73</sup> Stillbirths and neonatal deaths counted if gestation ≥ 20 weeks or ≥ 400g. Neonatal deaths are deaths occurring in the first 28 days of life.

<sup>74</sup> In the Consultative Council on Obstetric and Paediatric Mortality and Morbidity Annual Reports, adjusted births is the number of live births and stillbirths (fetal death more than 20 weeks gestation or 400g). It does not include late terminations of pregnancy for psychosocial reasons.

<sup>75</sup> Maternal psychosocial indications, maternal medical conditions and congenital abnormalities.

<sup>76</sup> The number of births to women from Humanitarian Program source countries increases each year as extra population members are added with each year’s intake.



**Table 3.8: Crude birth rate, Victoria, 2001 and 2006**

Population	2001			2006		
	Adjusted births	Total population	Crude birth rate	Adjusted births	Total population	Crude birth rate
Refugee-like	1,150	68,975	16.7	2,092	79,889	26.2
Total Victoria	62,009	4,804,726	12.9	69,553	5,126,540	13.6

Source: Victorian Perinatal Data Collection, September 2008. Definitions as above.

Rates have been calculated using the following denominators: Humanitarian source countries of interest: unpublished ABS 2001 and 2006 Census of Population and Housing data, country of birth by age, usual residence Victoria;<sup>7</sup> total Victoria: ABS 2008 Estimated Resident Population by age for June 2001 and June 2006.<sup>230</sup>

#### **Fertility rate**

The fertility rate is the number of live births per 1000 women aged 15–44 years. Table 3.9 shows the fertility rate is higher for women in the refugee-like group. Although the fertility rate increased between 2001 and 2006, the increase was much greater for the refugee-like group. Fertility rates are higher for women born in Somalia, Sudan, Ethiopia, Iraq and Afghanistan.

**Table 3.9: Fertility rates, Victoria, 2001 and 2006**

Population	2001			2006		
	Live births	Women aged 15–44	Fertility rate	Live births	Women aged 15–44	Fertility rate
Refugee-like	1,142	14,391	79.4	2,078	17,685	117.5
Total Victoria	61,688	1,063,056	58.0	69,230	1,106,117	63.0

Source: Victorian Perinatal Data Collection, September 2008. Rates have been calculated using the following denominators: Humanitarian source countries of interest: unpublished ABS 2001 and 2006 Census of Population and Housing data, country of birth by age, sex, usual residence Victoria;<sup>7</sup> total Victoria: ABS 2008 Estimated Resident Population by age for June 2001 and June 2006.<sup>230</sup>

### Maternal age

Table 3.10 shows pooled data for 1999–2006 on the proportion of births by maternal age. Overall the pattern is similar for women in the refugee-like group and women in Victoria overall.<sup>77</sup>

**Table 3.10: Total births by maternal age group, Victoria, pooled data 1999–2006**

Maternal age (years)	Refugee-like		Total Victoria	
	Number	Percentage	Number	Percentage
< 20	293	2.5	15,501	3.0
20–34	9,116	78.7	389,289	75.7
35 +	2,152	18.6	109,460	21.3
Total	11,561	100.0	514,298	100.0

Source: Victorian Perinatal Data Collection, September 2008. Total births includes births where maternal age is unknown.

### Location of births

Women in the refugee-like group are more likely to deliver in a level 3 hospital (that is a hospital with obstetric and neonatal intensive care, and a broad range of other specialist services) than other hospital types (Table 3.11).

**Table 3.11: Total confinements by hospital category, Victoria, pooled data 1999–2006**

Hospital category	Refugee-like		Total Victoria	
	Number	Percentage	Number	Percentage
Level 3	5,455	47.9	103,311	20.5
Metro Public	4,825	42.3	132,998	26.3
All Private	538	4.7	148,201	29.3
Country Base	457	4.0	60,111	11.9
Other country	117	1.0	59,333	11.7
Homebirth	<5	0.0	1,260	0.3
Total	11,396	100.0	505,214	100.0

Source: Data from Victorian Perinatal Data Collection, September 2008. Note total confinements, not total births, so numbers differ.

### Low birth weight

Low birth weight is defined as less than 2500g and very low birth weight as less than 1500g. Women in the refugee-like group giving birth in Victoria are slightly less likely than Victorian women overall to have a low birth weight baby. The proportion of babies with low birth weight (pooled data 1999–2006) is:

- 5.7% of babies born to mothers in the refugee-like group
- 6.4% of all babies born in Victoria.

<sup>77</sup> Data from the 2006 Census of Population and Housing suggests women in the refugee-like group are more likely to have high parity compared to women in Victoria overall. For methodology see additional information document at [www.education.vic.gov.au/statewideoutcomes](http://www.education.vic.gov.au/statewideoutcomes)

### Estimated gestation

Pre-term or premature birth (less than 37 weeks gestation) is one of the main factors associated with perinatal death in Australia. Overall, women born in the refugee-like group are less likely to have a pre-term birth than women in Victoria overall, and are more likely to have a baby after 41 weeks gestation (Table 3.12).

**Table 3.12: Total births by estimated gestation, Victoria, pooled data 1999–2006**

Gestation					Total Victoria	
	Number	Percentage	Number	Percentage	Number	Percentage
< 37 weeks	774	6.7	483	13.5	40,628	7.9
37-41 weeks	10,516	91.0	3,057	85.0	466,925	90.8
> 41 weeks	271	2.3	55	1.5	6,691	1.3
Total	11,561	100.0	3,597	100.0	514,298	100.0

Source: Data from Victorian Perinatal Data Collection Unit, September 2008. Total includes births where gestational age was unknown.

## Antenatal care

Antenatal care may be provided through hospital-based services (either medical or midwifery led), or in primary care in a ‘shared care’ model where the woman is cared for by both hospital staff and community-based antenatal care providers (general practitioner or community-based midwife). Over 50% of women attending the Royal Women’s Hospital (RWH), the Mercy Hospital for Women (MHW) and Sunshine Hospital participate in such shared care arrangements.<sup>233</sup> Consultations indicated these sorts of arrangements were common in women of a refugee background.<sup>78</sup> In addition, the Family and Reproductive Rights Education Program<sup>79</sup> (FARREP) is a resource for antenatal care and women’s health.

A recent qualitative study on the views of African women attending antenatal care in Melbourne found there was a process of adjustment for women as they shifted from viewing pregnancy as ‘not special’ to placing value on regular antenatal care. Resettlement was viewed as the overwhelming priority for participants.<sup>234</sup>

### Smoking and alcohol in pregnancy

No specific Australian data were identified regarding smoking and alcohol use in pregnancy among women of a refugee background. Consultation with FARREP workers and refugee health nurses highlighted that both smoking and alcohol use were extremely uncommon in women of a refugee background.<sup>80</sup> Alcohol use is prohibited under Islamic teaching, which may be a factor in low reported usage for some communities.

### Vitamin D and folate in pregnancy

Low Vitamin D is a significant issue in antenatal health in African–Australian women in Melbourne. In a study of 222 dark skinned and/or veiled women delivering at the RWH (RWH) in winter 2003, 98% had low Vitamin D levels (< 50 nmol/L) and 69% had very low levels (< 25 nmol/L).<sup>79</sup> An earlier study of dark-skinned and/or veiled women attending RWH found 80% had very low levels.<sup>80</sup> Consultations<sup>81</sup> indicated that screening and supplementation of low Vitamin D during pregnancy is now widespread at the RWH and MHW.

<sup>78</sup> Questionnaire responses from FARREP and Women’s Health West, April 2008.

<sup>79</sup> FARREP is a national program that commenced in 1995 providing sexual and reproductive health services for women affected by female genital mutilation (FGM) and women from countries where FGM is practised. In Victoria it is used predominantly by women of African background.

<sup>80</sup> Consultation with FARREP workers as above, 13 May 2008; consultation with refugee health nurses, 6 May 2008.

<sup>81</sup> Consultation with FARREP workers, Southern Region, Women’s Health West, RWH and MHW, April and May 2008.

In recent years, research has demonstrated folate supplements are important before pregnancy and during early pregnancy to protect against birth abnormalities such as spina bifida. No research has been identified examining the dietary intake of folate in refugee women in Victoria.

## Breastfeeding

Australia's National Health and Medical Research Council recommends that infants are exclusively breastfed for the first 6 months of life, with continued breastfeeding and complementary foods to twelve months and beyond.<sup>235</sup> Only one study was found that reported on breastfeeding rates in children of a refugee background in Victoria. It followed a sample of 232 East African children, predominantly from Somalia and Sudan, during 2000–02.<sup>27</sup> In this group 96% had been breastfed, with a median duration of 12 months, but only 44% had received any infant formula, suggesting rates of exclusive breastfeeding were high.

## Maternal and Child Health Service usage

Across Victoria, Maternal and Child Health (MCH) service providers use a range of data collection systems. Although maternal country of birth is recorded and could be used as a proxy for refugee status, it is not possible to extract information at present.

An evaluation of the MCH service in 2005<sup>236</sup> found that CALD clients were proportionally represented at the key ages and stages visits, up to and including the 2-year visit,<sup>82</sup> but there is no information by country of birth. An evaluation survey within the same audit concluded that CALD clients found the service less useful and more difficult to access than other groups.

One study at the immigrant health clinic at the Royal Children's Hospital in 2001 found that only 7% of 199 refugee children had seen an MCH nurse; however, the mean age of the sample was 8.8 years and this may have reflected area specific issues.<sup>28</sup> Consultation with MCH nurses indicated that attendance at mothers' groups may be particularly difficult for newly arrived women due to other settlement concerns or care of other children.<sup>83</sup>

## Female Genital Mutilation

Female Genital Mutilation (FGM) includes all procedures involving partial or total removal of the external female genitalia, or other injury to the female genitals for non-medical reasons. An estimated 100 million to 140 million girls and women worldwide have undergone FGM, and it is usually performed between infancy and age 15 years.<sup>237</sup>

A study of 28,393 women in Africa found FGM was associated with worse obstetric outcomes with higher rates of caesarean sections, postpartum haemorrhage, extended maternity stay, and higher rates of infant resuscitation and stillbirth/neonatal death.<sup>238</sup> There is no published analysis on the prevalence of FGM in refugee women in Victoria or the effects of FGM on obstetric indicators in Victoria.

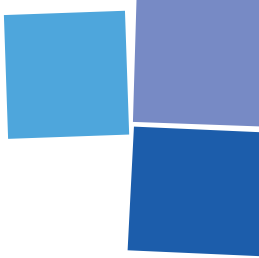
FARREP workers reported that most women from countries where FGM is practised identified it as a 'bad practice' that should not continue and there was good community understanding and acceptance that FGM is not legal in Australia. They identified specific issues for women after childbirth who had undergone FGM. The reported women were more willing to discuss FGM with doctors and midwives than previously, and increasing numbers of women are opting for reversal of FGM procedures where possible, which was felt to represent a significant shift in community attitudes.

## Teenage pregnancies

No data have been identified on the rate of teenage pregnancies in Victoria for young women of a refugee background. A longitudinal study of refugee young people aged 12–19 years in Melbourne (85% African) found that 14% (8/58) reported a pregnancy during their first 2 years in Australia.<sup>239</sup> FARREP workers also identified teenage pregnancy as a significant issue. However, unpublished perinatal data do not suggest an increased number of teenage pregnancies in young women of a refugee background.

<sup>82</sup> Routine Maternal and Child Health visits occur at a home visit (after discharge from hospital) and at 2, 4 and 8 weeks; 4, 8, 12 and 18 months; and at 2 years and 3½ years.

<sup>83</sup> Questionnaire response and consultation with Maternal and Child Health nurses, June 2008.



Published literature<sup>239</sup> and consultations<sup>84</sup> identified a need for improved sexual health literacy in recently arrived refugee young people. In addition to a lack of reproductive and sexual health knowledge, including a lack of knowledge around Sexually Transmitted Infections (STIs), they identified that young people were not communicating with their parents on sexual health issues. Other agencies identified issues with sexual health education, specifically that young Muslim women may require female groups and a female teacher, and for young men, education programs delivered by male teachers met with greater acceptance and respect.<sup>85</sup>

A 2008 qualitative study of sexual health literacy in 143 resettled refugee youth living in Victoria for 1–5 years<sup>240, 241</sup> found that young people generally had a poor understanding of sexual health issues including STIs, other than HIV/AIDS. Young people were aware of contraception (particularly condoms), but they recognised barriers to use.

Participants reported limited opportunities to learn more about sexual health both before and after arrival in Australia, although they were interested in doing so. Barriers to obtaining sexual health information included shame, embarrassment, cultural issues, language skills and access to relevant material.

Young people who do not attend school presented as a group with limited opportunity to learn about sexual health.<sup>86</sup> Health professionals, including GPs, and school-based sexuality programs were viewed as useful and appropriate sources of information. Parents, friends, partners and the mass media were generally not used for sexual health information. There was little awareness of specialised youth sexual health services and few participants had accessed health services to address sexual health problems.

Young people expressed preferences for:

- verbal group-based education
- same-sex groups with gender matched educators
- clear factual information from health providers or schools before the onset of sexual relationships.

## Antenatal and perinatal health

### Key findings

The perinatal mortality rate is higher for children born to women in the refugee-like group than for those born in Victoria overall. Also, the crude birth rate is higher in the refugee-like group than for Victorians overall.

Compared to Victorian women overall, women of a refugee-like background:

- have a higher fertility rate
- have a higher proportion of deliveries in tertiary hospitals
- are less likely to have pre-term babies and more likely to deliver after 41 weeks gestation
- are less likely to have low birthweight babies.

Low Vitamin D is a health issue for pregnant women with risk factors including dark skin or covering clothing and there has been increased awareness and screening in recent years.

There are no data on the prevalence of breastfeeding in women of a refugee background giving birth in Victoria, but high rates are reported by health workers.

Appropriate education on sexual and reproductive health is important for refugee young people.

<sup>84</sup> Consultation with FARREP program workers, Royal Women's Hospital, Mercy Hospital for Women, Southern Region, April–May 2008; youth health nurses, Western region, May 2008; African Think Tank leaders, May 2008.

<sup>85</sup> Questionnaire responses from English Language Schools, primary school nurses, secondary school nurses, February–June 2008.

<sup>86</sup> Sexual health education is provided in six of the nine English language schools/centres in Melbourne.

# Healthy lifestyle

## Food and diet

Data on the dietary habits of children and young people of a refugee background after settlement are lacking, although it has been identified as an issue of significant concern in program delivery for refugees in Victoria, New South Wales<sup>87</sup> and Western Australia.<sup>242</sup> Consultations identified concerns with healthy eating and the provision of adequate school lunches in the early post-arrival period in some families, and that lack of familiarity with Australian foods and difficulty assessing the health value of processed food may be an issue.<sup>88</sup>

## Tobacco and alcohol

The Australian secondary school students survey (2008) found 8% of male and 9% of female Victorian secondary school students were current smokers (that is, they had smoked in the past week). The percentage of students who had smoked on at least one day of the past week (current smokers) increased with age, and by 17 years, 15% of both male and female students had smoked cigarettes in the past week.<sup>243</sup> World Health Organization data suggest similar prevalence of youth smoking in the source countries for recent Humanitarian Program entrants.<sup>244</sup>

No prevalence data for tobacco use in refugee youth in Victoria have been identified. Consultations with a lead community organisation identified that drug and alcohol use were felt to be associated with social isolation, experience of discrimination, lack of employment opportunities, and mental health issues. Youth workers who drank alcohol and smoked cigarettes were identified as powerful negative role models, with adverse effects on smoking uptake for refugee young people.<sup>89</sup>

## Participation in sport

The Centre for Multicultural Youth (CMY) notes that sport is a high priority for newly arrived young people; it is important in settlement and can promote health and wellbeing.<sup>245</sup> CMY also details a range of strategies and programs that aim to increase participation of CALD young people in sport.<sup>246, 247, 248</sup>

Lack of parental support for sporting activities, cost, reliance on public transport, lack of awareness of sporting clubs, options for young women and discrimination have all been identified as barriers to participation in sport for CALD young people in community consultations.<sup>247</sup>

No prevalence data have been identified on the participation of refugee children and young people in sport.

### Healthy lifestyle

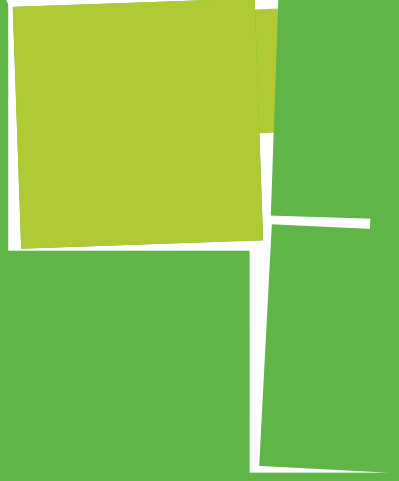
Victorian data are lacking on issues related to healthy lifestyles for refugee children and young people

### Key findings

<sup>87</sup> Consultation with Dr Shanti Raman, South West Sydney Refugee Screening Clinic, May 2008.

<sup>88</sup> Consultation with Western English Language School, Blackburn English Language School, Noble Park English Language School and Brunswick English Language Centre, May 2008. Questionnaire responses from refugee health nurses, MRCs, Edmund Rice Centre, EACACOV, February–June 2008.

<sup>89</sup> Consultation with African Think Tank leaders, May 2008.



# Section 4

## Development and learning

## 4. Development and learning

### Child and adolescent development

#### Early childhood

Early childhood development sets the trajectory for long-term outcomes in adult life and experiences during the early years affect brain development.<sup>249</sup>

Children of a refugee background and their families:

- have been exposed to significant disruption to their family and community
- have migrated and experienced language, social and cultural transitions
- may have had significant trauma experiences
- may have had limited or interrupted access to education
- may have complicated physical health and nutrition issues
- may have mental health issues.

All these factors affect child development. In addition, refugee children may have other risk factors for adverse development outcomes that are not usually seen in Australia, such as severe malnutrition or cerebral malaria.<sup>250, 251</sup>

No systematic data have been identified on developmental delay/disability in cohorts of refugee children after resettlement.<sup>90</sup>

Consultations with paediatricians<sup>91</sup> indicate that the primary focus for newly arrived families is general health. Families do not usually raise concerns regarding development, emotional wellbeing and behaviour in early consultations; and health care providers must make time to enquire. Similarly, discussions with a lead community group highlighted that parents are occupied with settlement issues and with managing on a day-to-day basis, and they need support to focus on child development.<sup>92</sup> Paediatricians also identified multiple instances of systems not catering to non-English-speaking families, noting that detection of significant developmental problems may be delayed when the developmental concerns are attributed to acquiring a new language.

#### Specialist Children's Services and Early Intervention Services

Specialist Children's Services and Early Intervention Services provide multidisciplinary intervention for children aged 0–6 years who have developmental issues in more than one area. No information is currently available on the number of refugee children using these services,<sup>93</sup> and measuring use is problematic with current data collection.

<sup>90</sup> A study is currently being completed in Perth which will provide cross-sectional screening data.

<sup>91</sup> Consultation with immigrant health paediatricians, Royal Children's Hospital, Melbourne, May 2008

<sup>92</sup> Consultation with African Think Tank leaders, May 2008.

<sup>93</sup> Questionnaire response from Specialist Children's Services, Eastern Region, March 2008; contact with Northern and Western Specialist Children's Services.



### Kindergarten participation

Preschool participation has intellectual, social and behavioural benefits, especially for disadvantaged children. For young children with limited English proficiency, not participating in formal preschool services can widen the academic gap over the next years in school.<sup>252</sup> Since June 2008, all children in refugee/asylum seeker families (including those with bridging visas) have been eligible for free 4 year-old kindergarten for 10 hours a week, through the Kindergarten Fee Subsidy.<sup>253</sup> From 2013 there will be a universal entitlement for 15 hours of 4 year-old kindergarten.

Kindergarten participation in Victoria overall was estimated at 92.4% in 2008.<sup>4</sup> No data have been identified on kindergarten participation for refugee children.

Data from the 2006 Australian Census of Population and Housing<sup>94</sup> provide a cross-sectional estimate of the number of 4 year-old children and the number of children reported to be attending preschool at the time of the Census; however, the term preschool could be interpreted in different ways and children may be 4 years old or younger or older when they attend preschool.

Figures for Victoria (Table 4.1) show the number of children attending preschool is greater than the resident 4 year-old population, whereas the number is lower in the refugee-like group.

**Table 4.1: Number of 4 year-old-children and number of all children reported to be attending preschool**

Group	Number of 4 year-old children	Number of all children reported to be attending preschool
Refugee-like <sup>95</sup>	655	536
Victoria	60,618	76,489

*Source: Unpublished data, 2006 Census of Population and Housing, Australian Bureau of Statistics, obtained June 2008. Note these data do not represent kindergarten attendance and they are different to published DEECD data on kindergarten participation, which draw on actual enrolment data.*

A qualitative study by the Centre for Culture, Ethnicity and Health examined the attitudes of CALD communities to, and perceptions of, kindergarten.<sup>254</sup> It included a Somali focus group who identified kindergarten participation as extremely important, particularly in preparation for school. Although group members were aware of enrolment requirements, they were unaware of fee subsidies. Identified barriers to kindergarten participation were short hours, lack of places and distance. These perceived barriers were also common to other groups (Lebanese, Vietnamese).

Consultations indicated that other potential barriers to kindergarten participation for children of a refugee background include the complexity of the enrolment process and funding guidelines that prevent clients from contacting the Free Kinder Association (FKA)<sup>96</sup> directly unless they are in the Adult Migrant Education Program (AMEP). All other children are referred once they are enrolled in kindergarten.<sup>97</sup>

<sup>94</sup> For methodology: see additional information document at [www.education.vic.gov.au/statewideoutcomes](http://www.education.vic.gov.au/statewideoutcomes)

<sup>95</sup> Figures reflect families from the top 10 Humanitarian source countries for Victoria, over the period 1996 – 2007.

<sup>96</sup> The role of the FKA is to advocate for children of a CALD background in kindergarten through promoting cultural and linguistic rights, quality services and meaningful participation in children's services.

<sup>97</sup> Consultation with FKA staff, August 2008.

**Social and emotional development at school entry**

The Australian Early Development Index (AEDI)<sup>255</sup> provides data about children’s development at school entry. No specific AEDI data on children of a refugee background are available. No other published information has been identified on parent concerns about child development in refugee groups at school entry.

Staff at English language schools reported that social and emotional problems are common in new arrivals of a refugee background, with many students suffering grief and feelings of loss in the early period of resettlement.<sup>98</sup> However, they also noted that students were generally excited to start school, and identified learning ability as a risk for behavioural problems.

The School Entry Health Questionnaire (SEHQ) could be used to collect population-level data on developmental and health concerns in children of a refugee background in the future.<sup>99</sup>

**Adolescence**

Adolescence is a period of transitions, including physical, cognitive, educational, vocational and financial transitions. Adolescent developmental issues include autonomy and independence, personal identity and body image, peer relationships and recreational goals, educational and vocational goals, and sexuality.<sup>256</sup> Young people of a refugee background have all these issues in addition to the challenges of settlement and the need to integrate past experiences and trauma. Adolescents are faced with balancing the values and expectations of their parents and culture with those of their new peers<sup>257</sup> while developing their own values and identity, learning a new language and adapting to a new education system.

For each of the areas covered by this report – health and wellbeing, development and learning, and safety – there are specific factors to consider in the context of adolescent development.

**Key findings**

**Child and adolescent development**

- There are inadequate data on kindergarten participation in children of a refugee background.
- There are inadequate data to make firm conclusions on early childhood development in children of a refugee background compared to other groups.
- Clinical experience suggests that developmental concerns may not be raised initially in health consultations.
- Service providers may attribute developmental concerns to English language acquisition.

<sup>98</sup> Consultation with Western ELS, May 2008.

<sup>99</sup> Consultation Blackburn ELS, May 2008.

# Acquiring a second language

## English language proficiency

Data from the 2006 Census of Population and Housing<sup>100</sup> 7 show that 58.4% of 0–17 year-olds in the refugee-like group report speaking English ‘very well’ or ‘well’, while 27.7% report speaking English ‘not well’ or ‘not at all’ (compared to 2.9% for Victoria overall).<sup>101</sup> While data are limited, it should also be noted that refugee children are highly likely to be multilingual.<sup>102</sup>

## Language acquisition

Language development begins at birth and continues until at least age 12 years, with ongoing refinement through life. From birth to around 5 years, children acquire enormous amounts of knowledge in the *domains*<sup>103</sup> of their first language. From 6 to 12 years they develop more complex *language skills*<sup>104</sup> such as reading and writing, while they continue to acquire knowledge in the language domains.

The language needed for school is unique and far more complex than basic conversation skills. Students need to develop proficiency in language domains and language skills and then apply this learning to the content areas of education: language subjects, mathematics, science and social studies.<sup>258</sup>

Immigrants learning English take approximately 2 to 3 years to achieve proficiency in conversation,<sup>259</sup> but much longer to achieve proficiency in academic language. Conversational fluency can be misleading for teachers.<sup>260</sup>

Cognitive development and proficiency in the first language are the key variables in acquiring a second language; therefore, age and previous education strongly influence second language acquisition.<sup>261</sup> The amount of first language schooling is the strongest predictor of academic achievement in a second language.<sup>262</sup>

Nurturing the first language is essential for academic development and cultural integrity. Consistent cognitive development and support for the first language is more important than the number of hours of second language tuition for academic success in the second language.<sup>261</sup> Lack of ongoing cognitive development in the first language (during second language acquisition) may lead to lower proficiency in the second language and lower academic performance. However, children who achieve full cognitive development in two languages do better academically than children who only speak one language.<sup>261</sup>

Large longitudinal studies in the USA, involving as many as 210,000 language minority students in the late 1990s and early 2000s, have shown that direct immersion in mainstream schooling for ESL students without ESL support is associated with worse outcomes.<sup>105</sup> 262 These studies also suggest bilingual education models produce the best outcomes for ESL students.

### Young children

Simultaneous bilingual children (children exposed to two languages from birth) typically mix the languages initially, then separate the languages between the ages of 3 and 5 years.<sup>261</sup> Children who acquire languages successively need to continue cognitive development in their first language as they acquire the second language in order to progress to age-appropriate cognitive language skills in either language.

<sup>100</sup> For methodology: see additional information document at [www.education.vic.gov.au/statewideoutcomes](http://www.education.vic.gov.au/statewideoutcomes)

<sup>101</sup> The highest proportion of those speaking English ‘not well’ or ‘not at all’ is found where the person completing the Census form is from Burma (Myanmar) or Sudan, which are the more recent source countries for Humanitarian Program entrants.

<sup>102</sup> While information is collected at enrolment at ELS/Cs on languages spoken, this is unpublished. The Settlement Reporting Facility does not provide information on number of languages spoken and English proficiency is reported at country level only.

<sup>103</sup> Language domains include phonetics, phonology, inflectional morphology, syntax, vocabulary, discourse, pragmatics and paralinguistics.

<sup>104</sup> Language skills include listening, speaking, reading, writing and meta linguistic knowledge.

<sup>105</sup> These studies included immigrant children to the USA without English language exposure before migration who were grade level in their first language on arrival and who were from a middle or upper class background in their country of origin.

Very young children may appear to pick up a second language quickly as they use simpler language to communicate,<sup>260</sup> but they are not more efficient at learning a second language.<sup>252</sup> Children aged 4–7 years on arrival with little or no schooling in their first language do less well than those aged 8–12 years; and may take 7–10 years to reach the average performance level of native speakers.<sup>261</sup>

### Primary school aged children

Children starting a second language before puberty achieve higher proficiency (in the second language) after 2–3 years compared to those starting a second language as adolescents or adults.<sup>261</sup>

Children who have received at least 2 to 3 years of schooling in their first language before migration do better in second language schooling than those who receive all their schooling in the second language.<sup>263</sup>

The number of years of primary language schooling (if four or more) has more influence than socioeconomic status on second language achievement.<sup>262</sup>

Children aged 8–12 years on arrival with at least 2 years of schooling in their country of origin have the fastest attainment of second language for academic purposes when schooling occurs in the second language in the new country. However, they take 5–7 years to reach the performance of native speakers on standardised testing in the second language, although they reach national standards in as little as 2 years for mathematics and language arts (spelling, punctuation, simple grammar).<sup>261</sup>

### Adolescents and adults

Adolescents and adults usually achieve conversational proficiency more quickly than young children.<sup>258</sup>

Adolescents take longer to achieve academic proficiency in a new language than primary school age children and are at risk of educational disadvantage as they do so. Those aged over 12 years on arrival may take 6–8 years to reach the national average performance of native speakers. They remain below national standards at 4 years after arrival for all subjects except mathematics.<sup>258</sup>

Adolescents with good cognitive development in their first language and solid schooling can develop second language proficiency relatively quickly, that is, in 2–3 years. Even so, they lose a period of academic instruction during this time (while they master the second language). If academic work in the first language is not continued at home or at school they may not be able to catch up during high school.<sup>261</sup>

Older adolescents with low first language literacy or severely interrupted schooling are a group at particular disadvantage.<sup>262</sup>

## Key findings

### Acquiring a second language

Immigrants are usually able to converse fluently after 2–3 years of learning a new language, but it takes much longer to achieve academic success in a new language.

Children who are 8–12 years old on arrival and who have some schooling in their first language achieve second language for academic purposes more quickly than other age groups, but they take 5–7 years to reach the standard of native-born speakers.

Large international studies emphasise the importance of ESL support for the educational outcomes of ESL students.

## ESL in Victorian schools

English as a Second Language (ESL) teaching is provided through both the New Arrivals Program and through broad program support in Victorian government schools.

Schools are one of the first and most influential service systems that refugee children and young people encounter after resettlement.<sup>264</sup> In Victoria schooling is compulsory between the ages of 6 to 17 years (Prep to Year 10).

The Victorian government school system aims to ensure a high quality education to build the capabilities of all Victorian children and young people. Refugee students have been identified as requiring specific attention.

### New arrival ESL students

New arrival ESL students to Australia who meet eligibility criteria are funded under the Federal Government's English as a Second Language New Arrivals Program.<sup>265</sup> New arrival students who are Humanitarian Program entrants receive double the amount of federal funding<sup>106</sup> to assist with intensive English language support (\$11,572) and are expected to receive a minimum of 12 months of intensive English language tuition in intensive language centres/units or in schools.<sup>107 108 266</sup> New arrivals funding is available to government, Catholic and independent schools.<sup>109</sup>

In Victoria there are four English Language Schools (ELSS) – at Blackburn, Collingwood, Noble Park and Braybrook – that are stand-alone facilities; and there are five English Language Centres (ELCs) – at Springvale, Broadmeadows, Brunswick, Glen Eira and Westall – attached to mainstream primary or secondary schools.<sup>110</sup> The ELSS also coordinate outreach, intensive, outpost and visiting programs in primary schools.<sup>111 267</sup> Outreach service coordinators provide services to schools within their region to support new arrivals.

ESL teaching for new arrival students in rural and regional areas is provided through the Geelong English Language Program, the Shepparton New Arrivals Program, programs at Ballarat and Mildura, and the Isolated ESL Student Program.<sup>267</sup> The Isolated ESL Student Program provides either direct or mentoring support to schools for students needing ESL support in outer or non-metropolitan areas.<sup>267</sup>

Additional supports available through ELS/Cs include an introduction to the education system in Australia and to Australian culture, settlement assistance, parent groups, linking students and families with other agencies, grief and trauma focused wellbeing programs, welfare advice and casework. Health education units are also provided for students.<sup>112</sup>

Despite these initiatives, consultations with ELS/Cs identified difficulty meeting students' needs in the context of catering for a wide range of language groups and variable pre-arrival schooling and literacy.<sup>113</sup> They also identified increased access to school nursing services as an unmet need.

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<sup>106</sup> Compared to other eligible new arrivals.

<sup>107</sup> Where new arrival ESL support is provided in schools, it is expected that students will have a minimum of 10 hours ESL each week.

<sup>108</sup> This information was correct at the time of writing. For current (2010) information, see: <http://www.deewr.gov.au/Schooling/Programs/EnglishasSecondLanguageNewArrivalsProgram/Pages/Visa.aspx>

<sup>109</sup> Additional programs are available for students enrolled in Australian schools for longer than 12 months. Bridging programs / transition initiatives provide support for students at early stages of literacy development who are not ready to enter mainstream classes but have completed their studies in an ELS/C.

<sup>110</sup> This information was correct at the time of writing. For current (2010) information about the number of English language schools (ELSS) and centres (ELCs) in Victoria, see: [www.education.vic.gov.au/studentlearning/programs/esl/newelscontact.htm](http://www.education.vic.gov.au/studentlearning/programs/esl/newelscontact.htm)

<sup>111</sup> In intensive programs a primary teacher from an ELS/C provides an intensive English language learning program in a mainstream school / cluster of schools for newly arrived students. In visiting programs primary teachers from an ELS/C visit a number of schools, dividing their time between schools.

<sup>112</sup> Consultation and questionnaire responses from ELS/C, May 2008.

<sup>113</sup> Consultation with WELS, Brunswick ELC, May 2008.

Consultation with a lead community organisation<sup>114</sup> highlighted the following issues:

- the need for longer duration ELS/C support<sup>115</sup>
- difficulties faced by students with interrupted schooling including effects on morale, social and school connectedness, with the net effect of some young people leaving school early
- a mismatch between high parent expectations and educational support for new ESL students.

**New arrival ESL students: Government schools**

Over the period 2002–07, the number of new arrival students enrolling in ESL programs in Victoria has increased. In 2007 there were 5549 new arrival ESL students in Victorian Government schools; 30.1% enrolled in English language schools or centres (ELS/Cs); 18.4% of all new arrival ESL primary students and 53.2% of all new arrival ESL secondary students.<sup>268</sup>

A higher proportion of refugee new arrival ESL students enter education in Victoria via ELS/Cs. Around 40% of primary age and over 70% of secondary age refugee new arrival ESL students enter education through an ELS/C program. A further 20% of primary age students are supported through intensive outpost programs. The proportion of students attending regional language programs has also increased with time (Tables 4.2 and 4.3).

It is encouraging that there has been a decrease in the number of refugee new arrival ESL students starting education in mainstream government schools (without intensive language support). On a less positive note, a significant number are still not accessing the intensive ESL support provided through the new arrivals program.

The majority of students at ELS/Cs in Victoria are not children of a refugee background. In recent years, refugee students have made up 37–46% of ELS/C students.

**Table 4.2: Primary new arrival ESL refugee students**

	2004		2005		2006		2007		2008	
	number	percentage	number	percentage	number	percentage	number	percentage	number	percentage
English language schools/centres	326	(45.9)	317	(41.2)	275	(31.8)	240	(34.3)	219	(36.7)
Regional language programs	19	(2.7)	11	(1.4)	0	(0.0)	45	(6.4)	60	(10.1)
Outpost intensive	154	(21.7)	172	(22.4)	183	(21.2)	159	(22.7)	113	(18.9)
Outpost visiting	40	(5.6)	47	(6.1)	26	(3.0)	35	(5.0)	61	(10.2)
Isolated support	7	(1.0)	10	(1.3)	24	(2.8)	13	(1.69)	9	(1.5)
Mainstream	164	(23.1)	212	(27.6)	357	(41.3)	207	(29.6)	135	(22.6)
Primary total	711		769		865		699		597	

Source: New arrivals dataset, ESL Unit, Department of Education and Early Childhood Development, June 2009. Country of birth has been used as a proxy for refugee status using the 10 Humanitarian source countries of interest. Figures represent all new arrivals over a calendar year, so numbers for 2008 may be an underrepresentation due to variation in source countries. Only the ‘refugee-like’ group have been shown, not total new arrival ESL students.

<sup>114</sup> Consultation with African Think Tank members, May 2008.

<sup>115</sup> At the time of consultation most children and young people were receiving 6 months ELS/C support.

**Table 4.3: Secondary new arrival ESL refugee students**

	2004		2005		2006		2007		2008	
	number	percentage	number	percentage	number	percentage	number	percentage	number	percentage
English language schools/centres	348	(62.8)	321	(57.6)	378	(59.2)	371	(69.9)	401	(75.8)
Regional language programs	2	(0.4)	9	(1.6)	11	(1.7)	26	(4.9)	46	(8.7)
Isolated support	3	(0.5)	5	(0.9)	10	(1.6)	6	(1.1)	6	(1.1)
Mainstream	201	(36.3)	222	(39.9)	239	(37.5)	128	(24.1)	76	(14.4)
Secondary total	554		557		638		531		529	

Source: *New arrivals dataset, ESL Unit, Department of Education and Early Childhood Development, June 2009, as previous.*

#### New arrival ESL students: Catholic schools

New arrival ESL students entering the Catholic education system directly are also eligible for federal new arrival ESL funding. Currently the new arrival program provides four consultants for primary school level students and variable classroom support. Until the mid 1990s the Catholic education system had a stand-alone ESL program.<sup>116</sup>

No specific funding is available for ESL support in schools after the first year; however, two further years of classroom support are generally provided, with an extended learning program and access to individual programming. Numbers of refugee new arrival ESL students in Catholic education are shown in Table 4.4.

**Table 4.4: New arrival ESL refugee students in Victorian Catholic schools**

Year	Primary	Secondary	Total
2007 and 2008	526	284	810
2009 (predicted)	303	232	535

Source: *Catholic Education Office, Melbourne. Accessed December 2008. New arrival students have visa status recorded.*

#### Interrupted schooling

All ELS/Cs collect information on previous schooling, although this is not currently published. Data extracted from the 2006 Census of Population and Housing<sup>117</sup> show 7.8% of the refugee-like group aged 18 or older in Australia report no educational achievement. A report on refugee youth in the Adult Migrant Education Program (January 2009)<sup>269</sup> examined internal DIAC data on previous schooling. Among 5305 Humanitarian Program entrants aged 16–24 years on arrival between 2004–06, 38% reported schooling for seven years or less.

#### Barriers to enrolment at ELS/C

Although the preferred point of entry for all new arrival ESL students to education is via participation in a full-time intensive language program in an ELS/C, around one in five primary age students and one in six secondary students in government schools do not access new arrival support.

A qualitative study undertaken in 2005 of Victorian ESL teachers working with African refugee students reported students may resist programs that are perceived as ‘special’ or non mainstream.<sup>260</sup> Consultations<sup>118</sup> also identified that some families think their

<sup>116</sup> Consultation with Executive team staff, Catholic Education Office.

<sup>117</sup> For methodology: see additional information document at [www.education.vic.gov.au/statewideoutcomes](http://www.education.vic.gov.au/statewideoutcomes)

<sup>118</sup> Consultation with Noble Park ELS, May 2008.

children will learn English more quickly if they are immersed in English by attending a school without ESL support. A further barrier is that families may settle long distances from ELS/Cs, meaning that young children have to negotiate complex public transport trips to schools, and parents spend the greater part of their day transiting to and from school if they accompany them.<sup>119 15</sup>

Similar issues for refugee youth are noted in the January 2009 DIAC report *Opening the door: Provision for refugee youth with minimal/no schooling in the Adult Migrant English Program*.<sup>269</sup> This report found it is common for refugee youth with severely interrupted schooling to enrol directly in schools rather than ELS/Cs. The reasons given were identical to those identified in consultations for this report: young people may not appreciate the extent that academic success depends on ESL support, they may not be aware of education options, and ELS/Cs may be geographically inaccessible.

**Issues for older new arrival refugee students**

Older new arrival refugee students are a group facing particular challenges entering education in Australia, especially if they have low literacy or interrupted schooling. It may be difficult to place them in an appropriate year level, balancing academic and social needs<sup>15, 268, 269</sup> and they have multiple risk factors for disengaging with the education system.

Humanitarian entrants aged over 16 years without functional English, are eligible for 510 hours of English tuition through the Adult Migrant Education Program (AMEP).<sup>120</sup> This tuition is provided through a range of options including in classes, with a tutor or via distance learning. Humanitarian entrants aged 16–24 years with seven or fewer years of formal schooling are eligible for up to 400 hours of additional tuition<sup>15</sup> under the provisions of the Special Preparatory Program (SPP400). Increased funding in the 2007–08 Federal Budget allows an additional 100 hours of tuition for Humanitarian entrants, targeted at those aged less than 25 years.<sup>15</sup>

There are three pathways into education/English language tuition in Victoria for newly arrived Humanitarian entrants aged 16–18 years. They can access the school system or the AMEP/SPP400 stream (but not both), or enrol in non-AMEP-funded special refugee/migrant youth programs.<sup>269</sup> Specific program development targeted at this group includes the Victorian Certificate of Applied Learning (VCAL) programs, piloted in 2003, then established at four secondary schools. Other programs include the Young Adult Migrant English Course and Youth Access English classes at Victoria University, which assist young people aged 16–19 years with English tuition to help them get into years 11 or 12, or a TAFE course.<sup>121</sup>

In addition, transitional VCAL programs are being established incorporating literacy, numeracy, work skills and industry specific skills in a way that is relevant to the interests and learning of young refugees.<sup>270</sup>

**Transition to mainstream schooling**

All students aged up to 15 years exit ELS/Cs to mainstream schooling.<sup>122</sup> Transition from an ELS/C to mainstream schooling is a critical point in the education of refugee students.<sup>271</sup>

*Transition coordinators*

At ELS/Cs transition coordinators assist with explaining schooling and vocational pathways, negotiate with students and families to choose a suitable school, help school enrolment, work with ESL and classroom teachers at the new school, and create an awareness of support structures in the wider community.<sup>123</sup>

*Bridging programs/transition initiatives*

These offer transition support to refugee students and assist with further literacy and numeracy development while students integrate into their mainstream school. The programs run as parallel programs within schools and a number of schools in a region may use a bridging program provided at one school in the area.

<sup>119</sup> Consultation Eastern Region forum, March 2008.

<sup>120</sup> Those eligible must register within 3 months of arrival and commence classes within 1 year to maintain entitlement.

<sup>121</sup> Consultation with Youth Access English staff, July 2008.

<sup>122</sup> Consultation with WELS, May 2008.

<sup>123</sup> Consultation with WELS, Brunswick ELC, Noble Park ELS May 2008.



## Other ESL students

All Victorian government schools are eligible for ESL index funding for students if students meet three criteria: English is not the main language spoken at home; the student has been enrolled in an Australian school less than five years; and the student is eligible for Student Resource Package equity funding. A weighted formula is used to calculate funding, and around 25% of funding is directed to employing Multicultural Education Aides (MEA).<sup>267</sup>

In 2007, 20.5% of students in government schools were from a language background other than English (110,383 students) and 39,341 of these students met ESL index funding criteria.<sup>268</sup> Currently 460 schools in Victoria are funded to provide ESL programs to their eligible enrolled students.

### ESL support in mainstream schools

Program delivery may occur through direct intensive instruction, team teaching or other means. In direct intensive instruction the ESL teacher uses content from the mainstream program. This includes transition classes for students recently finished at an ELS/C. Team teaching is where ESL and mainstream teachers plan and teach together.<sup>267</sup>

### Multicultural Education Aides (MEAs)

MEAs are an essential part of program delivery. MEAs help students in the classroom and facilitate interaction between schools and families of a non-English-speaking background. They have been identified as essential in supporting the education and wellbeing of students of a refugee background.<sup>271</sup>

### Access to interpreting and translation services.

Interpreters are available to schools to assist with student enrolments, parent–teacher interviews, information dissemination about school programs, and individual student issues relating to discipline, welfare or student assessments.<sup>267</sup>

### Professional development.

Professional developer is provided for teachers and schools,<sup>267</sup> with a series of resources for use in schools developed by VFST and Regional Project Officers.

### ESL program officers

ESL program officers are available to discuss issues relating to students in intensive or mainstream classes.

## ESL in Victorian schools

### Key findings

In 2007 there were 5549 new arrival ESL students to Victorian government schools, and approximately 1230 of these were of a refugee background.

In recent years, approximately one-quarter to one-third of new arrival ESL students to Victoria are refugee background.

The Catholic education system has approximately 400–500 new arrival ESL refugee students each year.

Of all new arrival ESL students, approximately one-third enter education in Victoria via ELS/Cs. The proportion is higher for new arrival ESL students of a refugee background (around 40% of primary students and 75% of secondary students).

The amount of Commonwealth funding for ESL new arrivals of a Humanitarian background doubled in 2008, to fund 12 months of intensive English language support.

There are different programs for new arrivals and additional supports are available for refugee students and older refugee students with limited literacy.

In 2007 there were 39,341 students in Victorian government schools who met ESL funding criteria and 460 schools funded to provide ESL programs.

# School and post-school pathways

## Refugee students in Government schools

DEECD data were used to examine the number and distribution of refugee children and young people in government schools. Data were available for the period 2006–08.

Table 4.5 shows the number of government school students who were born in the Humanitarian Program source countries.<sup>124</sup> The changes in numbers reflect changes in the Humanitarian Program intake, with an increase in students from Sudan, Afghanistan and Burma and a decrease in students from Bosnia–Herzegovina, Croatia, and former Yugoslavia.

Table 4.5: Refugee students enrolled in Victorian government schools, 2006-2008

Country of birth	Year		
	2006	2007	2008
Afghanistan	870	1,096	1,443
Bosnia and Herzegovina	991	808	682
Burma (Myanmar)	105	165	355
Croatia	404	318	263
Ethiopia	300	302	368
Iran	356	373	411
Iraq	1,007	1,012	964
Somalia	555	468	447
Sudan	1,702	1,968	2,091
Yugoslavia (FRY)	886	737	N/A
Total	7,176	7,247	(7,024)

Source: Data from the Department of Education and Early Childhood Development (DEECD), August 2008.

In the absence of data on visa type,<sup>125</sup> information was extracted on students born in the 10 most frequent Humanitarian Program source countries for Victoria over the period 1996–2007. As birth country was used as a proxy for refugee status, the group identified does not include children born in Australia to families of a refugee background.

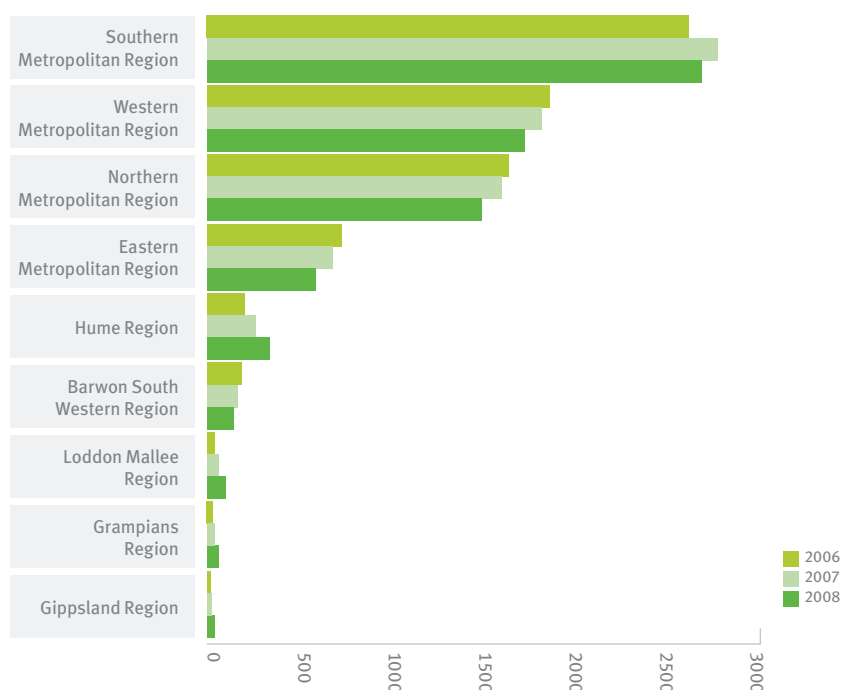
No data are available on students born in former Yugoslavia for 2008, therefore the actual total is expected to be higher for this year. Numbers for a given year are based on student numbers in the August of the year prior at the time of the government school census, consistent with other DEECD reporting.

The distribution of refugee students in government schools across government regions is shown in Figure 4.1. The greatest numbers of students are found in the Southern Metropolitan Region.

<sup>124</sup> Additional data were extracted on other likely refugee source countries (Burundi, Republic of Congo, Congo, Democratic Republic of Congo, Cote d'Ivoire, Eritrea, Ghana, Guinea, Kenya, Liberia, Malawi, Rwanda, Sierra Leone, Tanzania, and Uganda); however this increased the total number by 10% only and has not been included for consistency across the report.

<sup>125</sup> Although information on visa status has been collected since 2007, this was not available at the time of preparing this report.

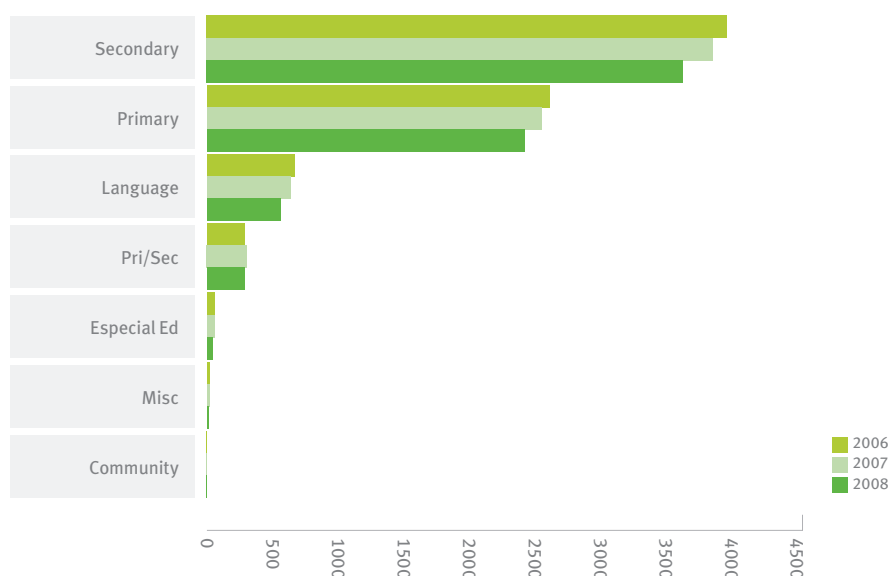
**Figure 4.1: Distribution of refugee students by government region**



Source: Data from the Department of Education and Early Childhood Development, August 2008, as above

Figure 4.2 shows that a relatively low proportion of the total group are in language school in a given year (7.5–8.9% over 2006–08), although refugee students have made up 37–46% of the students in ELS/Cs in recent years.

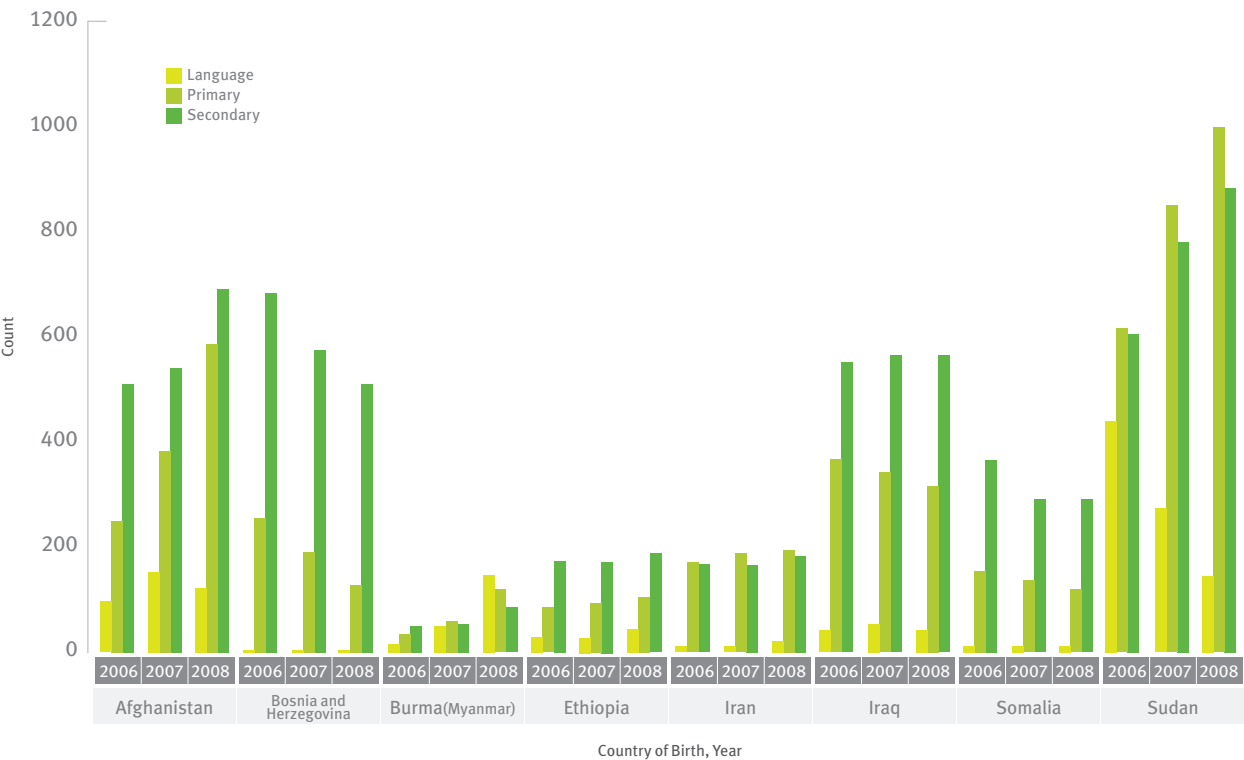
**Figure 4.2: Distribution of refugee students by school type**



Source: Data from the Department of Education and Early Childhood Development, August 2008. Numbers for a given year are based on student numbers in the August of the year prior at the time of the government school census, consistent with other DEECD reporting.

The school type varies with country of birth; trend data for selected countries are presented in Figure 4.3. This shows that the numbers of students born in Burma (Myanmar) in language school is increasing, while the numbers of students born in Sudan is decreasing.<sup>126</sup>

Figure 4.3: School type by country of birth



Source: Data from the Department of Education and Early Childhood Development, August 2008. As previous.

### Refugee students in Catholic schools

Numbers of refugee new arrival students are given earlier in this section. No data are available on the total number of students of a refugee background in the Catholic education system.

### Parent participation in schools

Active involvement of parents in their children’s education has a significant positive effect on student attitudes, behaviours and learning.<sup>271</sup>

Refugee parents face multiple barriers to participating in their children’s schooling.<sup>15, 271</sup> These include language barriers, the impact of migration, fears about the effect of school on culture, experience of schooling in their country of origin/transit, understanding of the Australian education system, and expectations for children.<sup>273</sup>

<sup>126</sup> Data for Croatia and former Yugoslavia are not shown; the pattern is similar to Bosnia, with no students in language school and a higher proportion of students in secondary school.



Consultations identified parent understanding of school systems in Australia as an issue.<sup>127</sup> Strengthening parent and community partnerships with schools and developing schools as hubs for children and communities has been a key focus of Victorian education and early childhood policy.

## School attendance

No population-level data are available on school attendance in refugee students or Victorian students overall.

Client service data from Foundation House indicate school attendance was identified as a problem on initial assessment in 12–15% of 0–17 year-olds assessed in 2006–08.<sup>128 16, 35</sup> It is important to note that this assessment occurs in the first 6 months of settlement when multiple family appointments may affect school attendance.

Absenteeism has been identified as a problem for refugee students at the point of transition between ELS/Cs and mainstream schooling<sup>271</sup> and during instruction at ELCs.<sup>129</sup> Consultation with a lead African community organisation identified school absenteeism as a particular issue for refugee young people, including younger adolescents aged 12–14 years, with limitations in detecting truancy and in program support for this age group.<sup>130</sup>

## Connectedness to school and motivation to learn

Connectedness to school has been shown to have a positive effect on education, behaviour and psychological outcomes. Adjusting to schooling and achieving a connection to school is an important part of the overall adjustment of refugee children and young people after resettlement.<sup>264</sup> A study of 76 Somali adolescent refugees in the USA found a greater sense of school belonging was associated with lower depression and higher self-efficacy, regardless of the level of past adversity.<sup>264</sup> There is growing interest in school-based refugee mental health programs internationally.<sup>274</sup>

Refugee students face challenges in education related to their background and the resettlement process. The Refugee Council of Australia consulted with young people of a refugee background and highlighted the following issues:<sup>15</sup>

- profound difficulty in transitioning between life in a protracted refugee situation and an Australian school environment
- difficulty adjusting to formal education if students have no past experience of such education
- pressure to enter employment to provide financial support for their families
- difficulty in providing effectively for refugee students in underresourced schools
- difficult home environments and resettlement stress where parents are not able to support children in school
- pressure to assist family members with resettlement needs
- discrimination and racism.

Local Melbourne research<sup>271</sup> and consultations<sup>131</sup> have confirmed that Out of School Hours Learning Support programs are an important source of support for refugee students. Data collected from 51 programs in 2005 indicated that at least 1420 refugee students regularly attended such programs, although 75% of the programs were in the Northern and Western metropolitan regions. Issues with limited resources and consistency in program delivery were noted.<sup>271</sup>

<sup>127</sup> Consultation Brunswick ELC, May 2008; Catholic Education Office Executive staff, December 2008

<sup>128</sup> These percentages are for children and young people aged 0–17 years, so the percentage will be higher if only school age children and young people are included.

<sup>129</sup> Consultation with Brunswick ELC, May 2008.

<sup>130</sup> Consultation with African Think Tank members, May 2008.

<sup>131</sup> Consultation with a religious community leader, January 2008.

The Good Starts study has examined the settlement experiences of 88 refugee young people over 5 years.<sup>132</sup> In the year after arrival, boys reported high levels of optimism and satisfaction and a strong sense of connectedness with school and at least one adult at school. In the second year after resettlement 41 of the 48 boys were attending mainstream school; however, they enjoyed school less, were less satisfied with their academic achievement, felt less accepted by their teachers and were less connected with their schools, although they remained positive overall about schooling.<sup>216</sup> Girls showed a similar pattern. In the first year they expressed high levels of satisfaction with school and had a strong sense of connection to school, teachers and adult support figures; in the second year they reported feeling less accepted by teachers and less satisfied with their academic achievement, and although most reported feeling connected with school, there was a decrease in the number of girls planning to complete secondary school.<sup>218</sup>

This suggests that strengthening support structures for transition and mainstream schooling is essential and students may be more vulnerable after the early resettlement period.<sup>216</sup>

### Literacy and numeracy

The National Assessment Program: Literacy and Numeracy (NAPLAN) was implemented in 2008. Students in years 3, 5, 7 and 9 across all Australian schools are tested on the same items in reading, writing, spelling, grammar and punctuation, and numeracy.

For each year level and for each learning area, a national minimum standard band has been established. Students with results in the national minimum standard band have typically demonstrated the basic elements of literacy and numeracy needed to participate in school for their year level. Students whose results are below the national minimum standard for the year level are at risk of being unable to progress satisfactorily at school without targeted intervention.

Students may be exempt from NAPLAN testing if they have a language background other than English and have been in Australia less than one year. Exempt students are deemed not to have met the national minimum standard, and are included in the percentage of students below the national minimum standard for the year level.

The proportion of students at or above the national minimum standards for reading, writing and numeracy at years 3, 5, 7 and 9 are shown for 2008 (Figure 4.4) and 2009 (Figure 4.5).

The proportion of students born in the Humanitarian Program source countries whose results were at or above the national minimum standards in 2008 was lower for every year level and for every learning area than for Victorian students overall. This was also true of the 2009 NAPLAN data.

It is crucial to note that:

- these data are not adjusted for time of arrival
- at group level, English language learners may take 5 years or more to reach the level of native-born speakers on standardised tests.

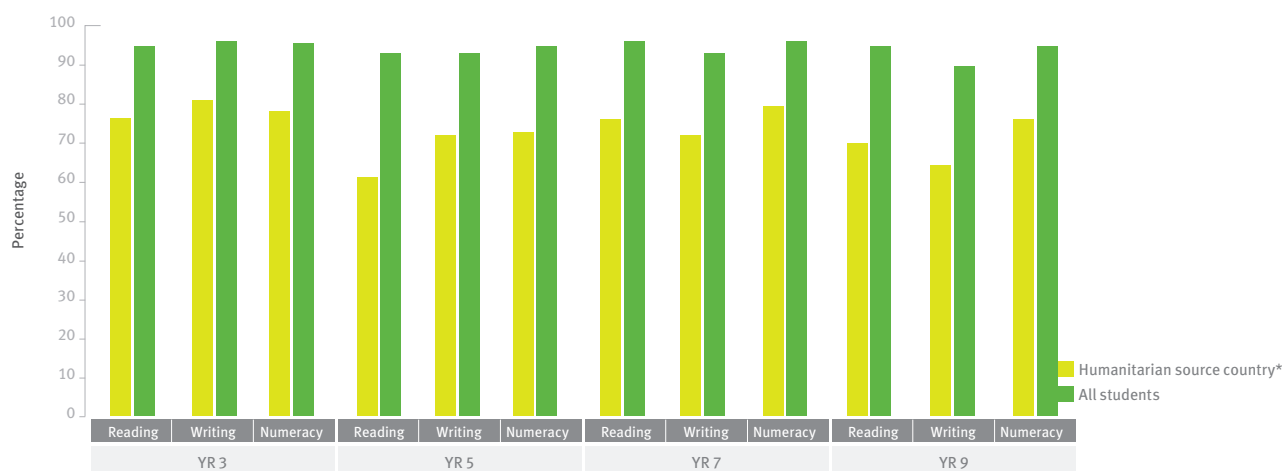
While it is important to monitor outcomes for refugee students, the national minimum standards used for English speakers may not be an appropriate measure. Differentiating the issues and outcomes for refugee students compared to other students receiving ESL support is essential for successful program responses.<sup>271</sup> Longitudinal data collection and further analysis of education outcomes may be beneficial. Ideally outcomes for refugee students should be compared across all forms of entry into education in Victoria: ELS/C, ESL support in mainstream schools and direct entry to mainstream schools. This may require the development and validation of an assessment tool for second language learners in order to examine best practice, develop an evidence base and inform policy in the local setting.

The Victorian Catholic education system has used the same benchmark testing as government schools since 2008. Specific data for refugee students are not available.<sup>133</sup> Newly arrived refugee students in the Catholic education system are exempt from benchmark testing for one year.

<sup>132</sup> Students were recruited in their first year in Australia, from ELSSs.

<sup>133</sup> Consultation with Executive team staff, Catholic Education Office.

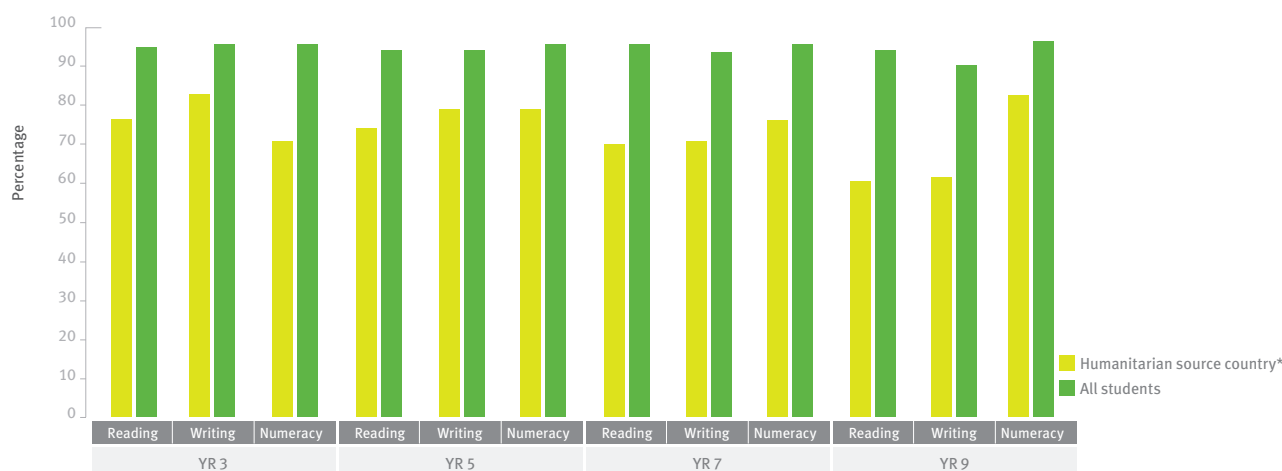
**Figure 4.4: Percentage of years 3, 5, 7 and 9 students at or above the national minimum standard, Victoria, NAPLAN 2008**



Source: NAPLAN National Report 2008, The Ministerial Council for Education, Early Childhood Development and Youth Affairs (MCEECDYA)

\*Humanitarian source countries data: Victorian Curriculum and Assessment Authority (VCAA) Assessment Processing System (APS) database – NAPLAN 2008 data as at October 2008

**Figure 4.5: Percentage of years 3, 5, 7 and 9 students at or above the national minimum standard, Victoria, NAPLAN 2009**



Source: NAPLAN National Report 2008, The Ministerial Council for Education, Early Childhood Development and Youth Affairs (MCEECDYA)

\*Humanitarian source countries data: Victorian Curriculum and Assessment Authority (VCAA) Assessment Processing System (APS) database – NAPLAN 2008 data as at October 2008

## Students with additional needs

### Program for Students with Disabilities

Students with disabilities may be educated in a special education setting or receive assistance within mainstream schooling. The Program for Students with Disabilities (PSD) supports students with moderate to severe disabilities in Victorian government schools. PSD provides resources to schools to support students if they meet eligibility criteria in one of seven categories: intellectual disability, Autism Spectrum Disorder, severe language disorder with critical educational needs, physical disability, visual impairment, hearing impairment or severe behavioural disorder.<sup>275</sup> In addition to the PSD Guidelines, supporting guidelines exist for each of the seven categories, which detail the program assessment and reporting procedures for professionals. While the existing eligibility criteria for these categories need to be addressed in PSD applications, it is acknowledged that use of the standard assessments is not always the most appropriate form of assessment, and other methods for addressing the criteria may be used by assessing and reporting professionals.<sup>275</sup>

Assessing for learning and language disabilities in refugee students presents enormous challenges. As with any other group, a proportion of refugee children will have disabilities and additional learning needs over and above other children from the same background. On the other hand, all refugee children have at least some risk factors for educational disadvantage (language transitions, displacement) and many have additional, cumulative risk factors (trauma, lack of prior schooling, mental health issues). This may lead to significant educational impairment in cognitively normal children.

Intelligence tests are not validated for use across languages for children from different cultures and contain many culturally bound testing items. A 2008 systematic review of cognitive testing in 40 cohorts (where comparative data were available for racial groups) highlights startling and consistent disparity of test scores at group level.<sup>276</sup>

Research<sup>277</sup> and consultations with a range of health care providers<sup>134</sup> have identified a range of concerns about the use of cognitive assessment tools with recently arrived refugee students. These include:

- Cognitive tests are not culturally validated or validated for use with interpreters. Assessing and reporting professionals may be required to use a range of quantitative and qualitative methods to form a diagnosis for the student.
- There are challenges around the timing of assessments for diagnosis. Professionals need to consider individual circumstances and information available in deciding when to assess a student. Providers described tension between harm from not providing early support to students with severe learning problems and the detrimental effects of an inaccurate diagnosis of intellectual disability.
- Developmental problems may be attributed to ESL issues, and ESL/schooling issues may be attributed to intellectual disability. Careful professional judgments are required where there are ESL considerations. Professionals may provide 'provisional' diagnoses and review the student's presentation over time.
- Parent understanding of cognitive test results is often less than adequate.
- Paediatricians felt that developmental assessment was underutilised in assessing refugee students for learning problems. Providers also noted there is limited research into the relationship between trauma and learning difficulties.

The PSD has defined timelines for submission of applications for existing students and new students transferring into the Victorian government school system. Applications for the PSD may be submitted outside of these timelines and are considered according to the guidelines for 'Post Annual Round Applications' within the PSD Guidelines.

The PSD Guidelines contain procedures regarding the 'assessment of refugees and recent arrivals from non-English speaking backgrounds'. These guidelines were developed during 2008 in consultation with a range of stakeholders and experts, and released in 2009. Areas addressed include factors to consider in assessment, working with interpreters and families, assessment processes and use of alternative tools when existing recommended tests are not considered appropriate.<sup>278</sup>

Examination of the rates of students supported by the PSD in 2008 indicates students of a refugee background are not

<sup>134</sup> These included general practitioners, paediatricians, ELC staff, psychologists and Foundation House staff.



overrepresented in the PSD overall (Table 4.6). Variation by country of birth is evident, with higher rates for students born in Somalia, Sudan, Former Yugoslavia, Iraq and Croatia than the rate for all students in Victoria.

#### Special education

**Table 4.6: Number and rate of students supported by the Program for Students with Disabilities, Victoria, August 2008**

Country of birth	Total students	Rate per 1,000 students
Somalia	23	63.0
Sudan	104	51.9
Former Yugoslavia	21	47.2
Iraq	39	39.4
Croatia	< 10	37.8
Ethiopia	12	33.0
Iran	10	20.8
Afghanistan	30	17.6
Bosnia and Herzegovina	< 10	13.4
Burma (Myanmar)	< 10	3.6
Total Humanitarian countries	258	33.3
Total Victoria	18,133	33.7

Source: Student Wellbeing Division, Department of Education and Early Childhood Development, September 2008. Rates calculated using unpublished Victorian school census data from 1 August, 2008, also from Department of Education and Early Childhood Development. This is cross-sectional data of the number of students with current PSD funding. No retrospective data are available.

Table 4.7 shows that there is a lower proportion of refugee students in special education<sup>135</sup> than Victorian students overall. This is consistent over the time period 2006–08.

**Table 4.7: Proportion of refugee-background students in special education**

Year	Students born in Humanitarian source countries		Students in Victoria	
	Total number	Percentage in special education	Total number	Percentage in special education
2006	7,176	0.6	539,343	1.4
2007	7,247	0.5	538,858	1.5
2008	7,024	0.5	538,116	1.6

Source: Country of birth used as a proxy for refugee status: 10 most frequent Humanitarian source countries for entrants to Victoria 1996–2007. Data on number of students born in countries of interest and education placement obtained from the Department of Education and Early Childhood Development, May 2008. Information on total numbers from published Summary Statistics for Victorian Schools, March 2008.<sup>279</sup>

<sup>135</sup> Special education includes special developmental, special schools or schooling for deaf children.

Catholic education – Additional Learning Needs Program

In the Victorian Catholic education system, the Additional Learning Needs Program is equivalent to the PSD. Currently funding is criteria-based, although there is some flexibility in how funding is administered at a school level. Like the PSD program, the Catholic Education Office is examining alternative forms of assessing refugee students, particularly assessment that will guide program development for students. Cognitive testing is usually deferred for 2 years after arrival. There is increasing representation of refugee students in this program, but specific figures are not available.<sup>136</sup>

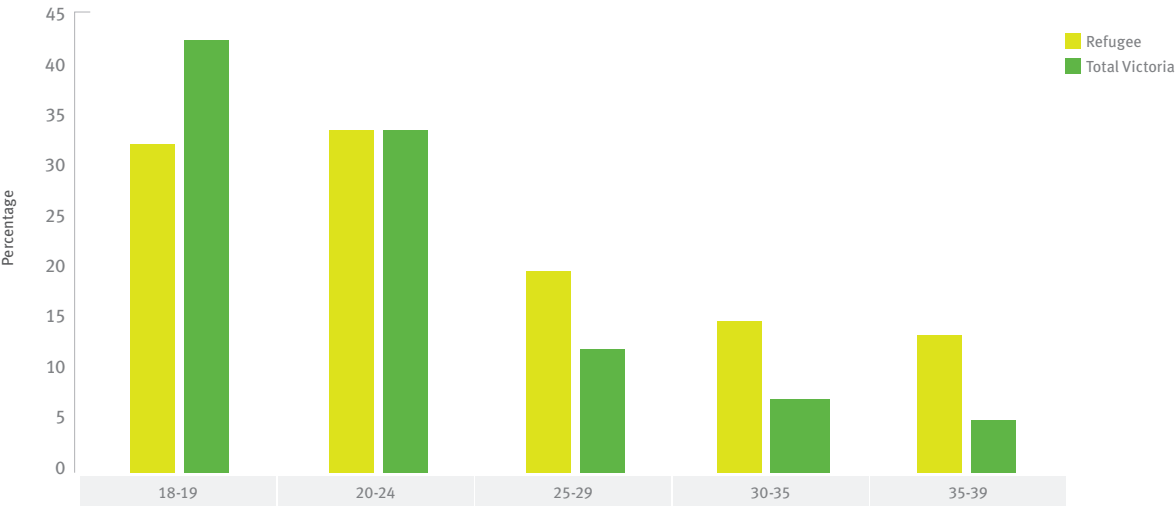
Completion of Year 12 and progression to further education

No data have been identified on Year 12 completion for refugee students, or on the progression of this group to tertiary study.

Data extracted from the 2006 Census of Population and Housing<sup>137</sup> show that 17.4% of those aged 18 years and older in the refugee-like group report current technical, TAFE, university or other tertiary study, compared to 7.8% for the whole of Victoria. This suggests high rates of ongoing education in the refugee group.

Analysing these data by age (Figure 4.6) shows a higher proportion of adults in the refugee-like group report current technical, TAFE, university or other tertiary study in the older age groups. Some of the refugee-like group will be attending TAFE bridging English language courses,<sup>138</sup> and adult English language classes may be reported as current study. Further research is necessary to verify this trend and to analyse enrolments at tertiary institutions.

Figure 4.6: Current reported tertiary study by age



Source: Unpublished data, 2006 Census of Population and Housing, Australian Bureau of Statistics, obtained June 2008. Tertiary study refers to educational institution attendance at technical, TAFE, university or other educational institution.

<sup>136</sup> Consultation with Executive team staff, Catholic Education Office.

<sup>137</sup> For methodology: see additional information document at [www.education.vic.gov.au/statewideoutcomes](http://www.education.vic.gov.au/statewideoutcomes)

<sup>138</sup> Approximately 60–80 students/year in Youth Access English classes at Victoria University and 100 students/year at the Young Adult Migrant Education Course annually; these numbers cannot account for the high prevalence of current tertiary education seen in the Census data relating to the refugee group (consultation with staff at both programs, July 2008).

### School and post-school pathways

Using country of birth as a proxy for refugee status and information extracted from the DEECD datasets it was found that:

There are just over 7000 refugee students in government schools in a given year, with the greatest numbers in the Southern Region.

There are proportionally fewer refugee students in special education.

Refugee students are not overrepresented in the PSD funding system, although variation is noted by country of birth.

### Other points

There are multiple barriers to refugee parents participating in their children's schooling.

School attendance is identified as a problem although there is a lack of reliable data.

Out of School Hours Learning Support programs are likely to be an important support for refugee students.

The proportion of students who meet education benchmarks across all levels is lower for refugee students than for Victorian children overall, although there are considerations in using this form of testing for refugee background students.

There are inherent challenges in assessing ESL students for intellectual/language problems in English. Professionals should use a range of methods to address the PSD eligibility criteria and refer to 'Assessment of refugees and recent arrivals from non-English speaking backgrounds'.





# Section 5

## Safety

# 5. Safety

In general, there is a lack of data on safety indicators for children and young people from a refugee background. There is a lack of youth justice and child protection service data and there is no information available on rates of hospital presentation and admission for injury in refugee children and young people.

## Racism and discrimination

Research suggests that ethnic groups in Australia experience racism and discrimination,<sup>39</sup> with high levels of discrimination reported towards Australians of Muslim, Middle Eastern, African and Asian backgrounds.<sup>280, 281</sup> There is increasing concern about racism and discrimination and about the serious health, social and economic consequences for affected individuals and their families.<sup>282</sup>

A systematic review of 138 studies on the association between self-reported racism and health found there was strong evidence for the negative effects of racism on mental health and health-related behaviours, with weaker effects for positive mental health outcomes, self-assessed health status and physical health.<sup>283</sup> Protective factors against the effects of racism included having a strong sense of racial/ethnic identity, participation in traditional activities, spirituality, and some personality traits. Risk factors for worse effects of racism included poor self-esteem, stressful events and substance misuse.

In 2007, VicHealth reviewed racism and discrimination in Victoria, resulting in the publication of *More than tolerance: Embracing diversity for health: Discrimination affecting migrant and refugee communities in Victoria, its health consequences, community attitudes and solutions – A summary report*.<sup>282</sup>

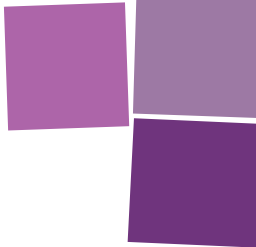
The report reviewed the Australian literature and found that discrimination affected people in multiple contexts including housing, health, education and employment. These are all crucial aspects of successful settlement. The report included a telephone survey of just over 4000 Victorian adults.

In people born in non-English-speaking countries:

- nearly two in five had experienced discrimination in the workplace
- 30% had experienced discrimination in education
- 18% had experienced discrimination in housing
- 19% had experienced discrimination in policing.

While these figures do not represent the experience of refugee children and young people, they suggest that a substantial proportion of families of a refugee background in Victoria may be experiencing discrimination. The survey also found that most Victorians support cultural diversity, although 84% agreed there was racial prejudice in Australia.

Some information on young people’s experiences of discrimination is available from the Good Starts study, a longitudinal study on the resettlement experience of 88 refugee young people at school in Melbourne (85% born in Africa). The study found



that 42% had experienced discrimination, with 9% reporting discrimination in the first year of school in Australia, and 20% by the end of the second year.<sup>284</sup> Discrimination occurred in different locations, with 12% experiencing it on the streets and 21% in shops or on public transport.

Consultation with a lead community organisation identified racism and discrimination as significant issues for communities and for refugee young people in particular, and identified media reporting as a factor in inflaming racial tensions and fuelling further discrimination.<sup>139</sup>

## Refugee young people and youth justice

It is not possible to assess the representation of refugee young people in the Victorian youth justice system.<sup>140</sup>

Victoria Police has 4 Multicultural Liaison Units (MLUs) based in a range of Melbourne metropolitan areas and in Swan Hill. These units are staffed by police members appointed as full-time Multicultural Liaison Officers (MLOs). The Multicultural Liaison Officer works within a multicultural framework that increases the capacity of police to deal with culturally and faith diverse youth issues and which addresses some of the needs of modern policing, operational police and the local culturally and faith diverse community.

MLO's are also responsible for

- Assisting police with information and advice on policing culturally and faith diverse communities
- Enabling culturally and faith diverse communities access to Victoria Police services
- Providing new and emerging communities with information on Victorian legislation and on the role of police in Victoria
- Building trust with culturally and faith diverse youth via meaningful initiatives which include: forums, camps, sporting activities and informal mentoring and role modelling.

The role of the New and Emerging Community Liaison Officer (NECLO) is to provide a positive link between Victoria Police and Victoria's new and emerging communities. This is being achieved through ongoing dialogue and involvement in appropriate proactive intervention and leadership programs, as well as workshops and community development activities. One of these positions is specifically engaged in working on family relationships to increase understanding of the role of police in family issues and the reporting mechanisms and supports available to new and emerging community members. The benefit to Victoria Police is that it gives operational police a more direct link to families and youth, and builds trust between community members and police.

Anecdotal information from African youth networks indicates young people report frequently being stopped and questioned by police. Other community-based organisations report similar findings, with refugee young people describing unwarranted community and police attention, resulting in secondary effects on self-confidence, self-esteem, mental health and community participation.<sup>141</sup>

These findings are supported by the findings from the Good Starts study of the resettlement experiences of 88 refugee young people in Melbourne (85% born in Africa). This study found that by the end of the second year of settlement 37% of young people reported being stopped and questioned by the police (49% of males, 22% of females). While refugee youth reported that they trusted the police, 13% reported experiencing discrimination by the police since arrival.<sup>285</sup>

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<sup>139</sup> Consultation with African Think Tank members, May 2008.

<sup>140</sup> The 'country of birth' field was not completed in the majority of cases in youth justice data systems and information on refugee status is not recorded.

<sup>141</sup> Questionnaire responses from MRCs, Edmund Rice Centre, City of Melbourne Family Services.

## Child protection and family support

No data are available for child protection notifications in Victoria in children of a refugee background.<sup>142</sup>

Data are available on clients involved with intensive family support services. These services aim to improve the ability of families to care for children and strengthen family relationships.<sup>286</sup>

Tables 5.1 and 5.2 show the usage of family support services among 0-17 year-olds. The number of 0–17 year-olds includes both people aged less than 17 years as lead clients, as well as all children aged 0–17 years associated with a lead client aged 18 and older (typically a parent).

These data suggest that refugee children are overrepresented among users of intensive family services. However, it is important to note that higher numbers of children per client (i.e. larger family size) leads to a higher number of children identified within the system. This may be a factor in the apparent overrepresentation of refugee children among users of intensive family services. Issues with denominator calculations in the refugee group may also elevate the rates for this group.<sup>143</sup>

Table 5.1: Total number of 0–17 year-olds in family support services from 2002–03 to 2006–07

Year	Commencing service		With case during the year		With case at 30 June	
	Refugee	Total Victoria	Refugee	Total Victoria	Refugee	Total Victoria
2002–03	< 5	93	< 5	123	< 5	102
2003–04	17	415	20	517	14	322
2004–05	55	742	69	1,064	35	493
2005–06	56	789	91	1,282	47	612
2006–07	61	875	110	1,487	56	740

Source: Data from the Client Relationship Information System database (previously Family Services database) from the Children, Youths and Families Division of the Department of Human Services, obtained June 2008. Country of birth has been used as a proxy for refugee status using Humanitarian source countries.

<sup>142</sup> Country of birth is included as a field code; however, this was completed in less than 10% of cases. Refugee status is not recorded.

<sup>143</sup> The number of 0–17 year-olds born in the source countries of interest by 2006 Census of Population and Housing (n=8897) seems low considering the government school Census data for 2006 identified 7247 school age children born in the same countries (i.e., this number does not include 0–4 year-olds and not all students attend government schools). A low denominator will elevate the rates in the refugee group. In the absence of other demographic data, Census data have been used for rate calculations.



**Table 5.2: Rate per 1000 of 0–17 year-olds in family support services, Victoria, 2006**

Population	Number	Commencing service during year		With case during the year		With case at 30 June	
		Number	Rate		Rate	Number	
Refugee	8,897	61	6.9	110	12.4	56	6.3
Total Victoria	1,181,483	714	0.6	1,221	1.0	740	0.6

*Rates have been calculated from previously unpublished data from the Children, Youth and Families Division of the Department of Human Services obtained June 2008. Denominators are as follows: Refugee: using the 10 most frequent Humanitarian source countries, unpublished ABS 2001 and 2006 Census of Population and Housing data, country of birth by age, usual residence Victoria;<sup>7</sup> total Victoria: ABS 2008 Estimated Resident Population by age for June 2001 and June 2006.<sup>230</sup>*

## Family violence

There are no accurate estimates for the number of children or refugee children affected by domestic violence in Victoria.<sup>3</sup>

A qualitative study examining family violence in Somali and Eritrean communities in the Western Metropolitan Region (2005)<sup>287</sup> found women in the focus groups had a thorough understanding of family violence, including violence against children. Interviews with ethno-specific workers in the same study found widely varying reports as to how prevalent family violence was within the community.

Victoria Police recognise family violence as an issue that is present in all communities, including new and emerging communities; however it is not felt to be more prominent in new communities. Police often seek the assistance and support of community structures such as churches and mosques, women's welfare groups and, importantly, elders, to communicate the supports and interventions available to families experiencing violence.

Client services data from Foundation House found domestic violence was an issue affecting 1–2% of young people assessed (see Table 2.5 in Section 2).

## Environmental safety

Environmental safety means both freedom to enjoy the environment and freedom from environmental threats. There is a lack of data on environmental safety for refugee children and young people in Victoria.

A lead community organisation identified cultural issues with supervising children, noting the problem of leaving young people unsupervised and vulnerable to unwanted influences.<sup>144</sup> Similar issues were raised in recent focus group work in Melbourne, where parents stated that while it was safe to let children play outside in their country of origin because someone 'was always looking out for them', this changed on settling in Australia.<sup>36</sup>

Other service providers highlighted the effect of living environments on health, with fear of violence and racism in high-density public housing contributing to poor health and to families staying inside.<sup>145</sup> In a forum run by CMY in 2006 attended by 50 CALD young people, safety was the most prevalent theme when young people discussed what was most important for them. Many young people reported feeling unsafe on public transport, in the streets, at parties and in the school environment.<sup>288</sup>

<sup>144</sup> Consultation with African Think Tank members, May 2008.

<sup>145</sup> Questionnaire responses from MRCs, Edmund Rice Centre, City of Melbourne Family Services.

# Safety

## Key findings

Many children and young people of a refugee background report experiencing discrimination post-arrival.

There are no data to allow appraisal of refugee young people in the youth justice system, even using country of birth as a proxy.

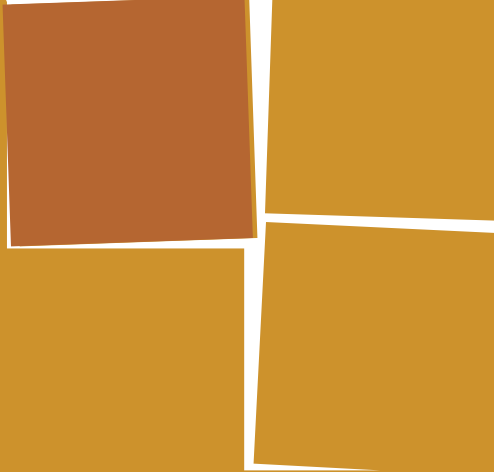
There are multiple initiatives by Victoria Police to engage with recently arrived communities.

Refugee young people report unwarranted police and media attention.

There are no readily available data to allow any appraisal of the rates of notification or substantiation of abuse in children of a refugee background, even using country of birth as a proxy.

Data suggest that children and young people of a refugee background are overrepresented in family services programs.

The rate of presentation and admission for injury in refugee children and young people was beyond the scope of this report.



# Appendices and references

# Appendix A: Analysis of community support services

## Introduction

This analysis focuses on services provided to people from refugee or refugee-like backgrounds by government and non-government organisations. These organisations include settlement providers, asylum seeker support agencies, hospitals, community health services, child care centres, kindergartens and schools, councils, charities, multicultural support agencies, financial and legal services, religious groups, local community groups and nationality-specific clubs and organisations.

The organisations can be broadly divided by the location in which they operate (Melbourne metropolitan and rural Victoria), their service speciality (e.g. health, education, housing) and their client group (e.g. refugee, SHP entrant or asylum seeker). With the number of support organisations continuing to grow, it is not possible to include all agencies in the analysis.<sup>146</sup>

The analysis is based on data derived from a range of methods used in this study – literature review, a survey of service providers and consultations<sup>147</sup> –and is presented in two parts.

Part 1 provides an overview of community support services, focusing on settlement support, health, mental health and education services, by region and visa type. This section includes flowcharts of settlement and health pathways for refugee and SHP entrants, and available data on service use.

Part 2 lists factors that serve to facilitate or constrain the provision of high-quality services for people of a refugee background in Victoria, as identified by service providers.

## Part 1: Overview of community support services

### Settlement support: the first six months

Official settlement support agencies are known as **Integrated Humanitarian Settlement Strategy** (IHSS) providers.<sup>148</sup> IHSS providers assess the settlement needs of Humanitarian Program entrants and coordinate the delivery of services to meet these needs. IHSS services include case coordination, information and referrals, on-arrival reception and assistance, accommodation and short-term counselling for

<sup>146</sup> The analysis of community service providers was completed in mid 2008. Although it is not exhaustive, the analysis highlights the breadth of services available.

<sup>147</sup> It is important to note that the information presented is based on the perceptions of service providers. Although consultations included community organisations representing some service user groups, the scope of the report did not include community consultation.

<sup>148</sup> In March 2010 the Parliamentary Secretary for Multicultural Affairs and Settlement Services released a request for tender for a new Humanitarian Settlement Services (HSS) program. This new program will replace the IHSS.

torture and trauma. Services are provided for the first 6 months after arrival, and may be extended for up to a year for complex cases.<sup>12</sup> Since October 2005 the designated IHSS lead agency in Victoria has been the **Adult Multicultural Education Services (AMES)**.

The Department of Immigration and Citizenship (DIAC) holds an online database on Humanitarian Program entrants called the **Humanitarian Entrant Management System (HEMS)**. HEMS is used to assist contracted IHSS service providers settle Humanitarian Program entrants in Australia.<sup>5</sup> In Victoria, HEMS is used to inform the settlement consortium of expected new arrivals. New arrivals are allocated a case coordinator through AMES. The entrant's visa type determines the nature and extent of service support, as shown below.

HEMS is also used to inform the **Department of Human Services (DHS)** Refugee Minor Program (RMP) of the arrival of Unaccompanied Humanitarian Minors (UHMs).<sup>149</sup> The RMP is a statewide program that supports UHMs in the settlement process and ensures that provision of care arrangements up until the age of 18 years. RMP provides support in metropolitan and regional Victoria as well as case management until a UHM reaches 18 years. The RMP assists UHMs with settlement using a casework-based approach in conjunction with AMES and carers to ensure their settlement needs are met.<sup>150</sup>

### **Melbourne metropolitan area**

In Melbourne, AMES works in a consortium with the **Victorian Foundation for Survivors of Torture (VFST)**, also known as **Foundation House**), **Redback Security Services**, the **Brotherhood of St Laurence (BSL)**, and the **Springvale Community Aid and Advice Bureau (SCAAB)**.<sup>151, 11</sup>

#### *Refugee Visa Holders (Visa 200, 201, 203 and 204)*

The settlement consortium provides refugee entrants with airport reception, accommodation, a furniture package, orientation to life in Australia, referral for health assessment, support to access education and referral for trauma counselling if needed.

Redback Security Services organise temporary housing for the entrants, pick-up from the airport, and an initial orientation to household safety.

There are three options for accommodation:

- **Long-term (6 plus months) rental accommodation** – this is arranged through local real estate agents who have a close relationship with Redback. The first month of rent is provided free. Approximately 45% of refugee entrants are placed in long-term accommodation at the outset.
- **Accommodation with a link** – a 'link' is a friend or contact (not a relative) of the refugee who is willing to host the family in the initial settlement stage. The duration of stay with a link varies from days to months. Around 45% of refugee entrants stay with a link initially, until long-term rental accommodation is available.
- **Temporary/emergency accommodation** arranged by AMES for a few weeks or months until long-term rental accommodation can be found. This option is used for approximately 10% of refugee entrants when long-term rental accommodation is not available.<sup>152</sup>

The BSL provides a basic household furniture and goods package for all new refugee arrivals. This is placed in the long-term rental accommodation either prior to the entrant's arrival or within a week of the entrant moving from the 'link' or temporary housing to another abode.

The **AMES case coordinator** visits new refugee entrants within 12 hours of their arrival at their accommodation and addresses any essential health alerts. The case coordinator helps clients with bank account applications, Centrelink appointments, Medicare and tax file number applications, enrolment in school or English language classes, and orientation to the local area and public transport system.

<sup>149</sup> There are occasions when a UHM may arrive in Victoria without DIAC's knowledge, such as secondary migration of a UHM from another state. In these instances, DHS notifies DIAC of the UHM's arrival.

<sup>150</sup> Consultation with caseworker, Refugee Minor Program, Footscray, February 2008.

<sup>151</sup> Springvale Community Aid and Advice Bureau sees clients in the eastern metropolitan area only.

<sup>152</sup> Consultation with East and West team leaders, AMES, Melbourne, May 2008.

AMES provides a **community guide** to assist newly arrived refugee entrants with their orientation to essential aspects of daily life in Australia. In the first 2–3 days, the community guide takes the refugee entrant, usually by public transport, to register with banks and **Centrelink**.<sup>153</sup> In the following weeks, the community guide also assists with **orientation to a number of other services and facilities** (such as public transport, supermarkets, local parks and community centres).

The community-based organisation SCAAB assists entrants to deal with migration and resettlement issues, or crises such as retrenchment, family separation or illness, that require people to search out new information, services or support. It provides information about accessing services, refers individuals to health or crisis services, and advocates for clients in financial difficulty.<sup>289</sup>

#### *Special Humanitarian Entrant Visa Holders (Visa 202)*

SHP visa entrants are sponsored by a **proposer**,<sup>154</sup> who helps the SHP entrant to access services in Australia and covers the costs associated with their resettlement. These costs include the SHP entrant's airfare to Australia, airport pick-up and their accommodation. In most cases the proposers are only recently arrived and are former refugees or SHP entrants themselves.<sup>13</sup> Proposers can request assistance from AMES.<sup>290</sup>

The International Organization for Migration (IOM) has a travel loan scheme to assist proposers with the cost of travel for their sponsored entrant. Other loan schemes are available through community or religious organisations.<sup>15</sup>

Once DIAC informs AMES of SHP visa allocations and their proposers' contact details, AMES case coordinators contact the proposers in about 90% of cases.<sup>155</sup> The AMES case coordinators then meet with the proposer before the SHP entrant arrives, and provide a checklist and advice for the proposer to help the SHP entrant. The proposer informs AMES of the flight details of new arrivals.

After the SHP entrant arrives, their proposer helps orientate them to life in Australia, under the guidance of the AMES case coordinator. The case coordinator makes two further appointments with the proposer in the first weeks. Additional appointments may be made if further assistance is required.<sup>290</sup> **AMES volunteers** may help with the orientation process if the case coordinator is unavailable.

SHP entrants usually stay with their proposer initially (for weeks or months) before moving into their own accommodation.<sup>156</sup> The onus is on the proposer to help the SHP entrant find rental accommodation and financial assistance. Approximately 50% of SHP entrants receive additional support from AMES to find accommodation.

SHP entrants can access an interest-free **bond loan through the Office for Housing** once their rental application is approved. The loan covers the cost of the bond and is repaid at the end of the tenancy.<sup>290</sup> Financial assistance is also available for the first month's rent-in-advance through the **Transitional Housing Management (THM)** service,<sup>290</sup> with ongoing rental assistance available through Centrelink. Once long-term rental accommodation has been secured, the proposer arranges for the **Brotherhood of St Laurence furniture package** delivery, utilities, gas and other necessities.

The **Settlement Grants Program (SGP) providers** also assist SHP entrants, if they are referred by AMES or their proposer. Some African community groups – especially the **East and Central African Communities of Victoria (EACACOV)** – offer settlement type services in the form of case management, referral and information. They assist people with low English proficiency and will liaise with service providers, accompany people to appointments, make appointments, help complete forms (e.g. for Centrelink), and assist with general information such as advice on healthy eating and reading a street directory.<sup>157</sup>

<sup>153</sup> Centrelink also provides a month of free MET tickets.

<sup>154</sup> A proposer is usually a relative or friend; a proposer must be an Australian citizen, permanent resident or eligible New Zealand citizen, or an organisation based in Australia.

<sup>155</sup> Approximately 10% of proposers are not found when contact details are traced.

<sup>156</sup> Consultation with East and West Team Leaders, AMES, Melbourne, May 2008.

<sup>157</sup> Questionnaire response, EACACOV.

### Asylum Seekers

The majority of asylum seekers arrive by air, with tourist, student or work visas, and then claim asylum after arrival.<sup>291</sup> They are allowed to live in Australia while their applications are being processed, but may not have the right to work, healthcare or welfare-based support.<sup>292</sup> IHSS providers do not provide support services for asylum seekers, but there are a number of specialist agencies that do, including:

- **Red Cross Asylum Seeker Assistance Scheme (ASAS)**
- **Asylum Seeker Resource Centre (ASRC), Melbourne**
- **Hotham Mission Asylum Seeker Project**
- **Asylum Seeker Welcome Centre**
- **Dandenong Hospital Refugee Health Clinic**
- **Asylum Seeker Centre, Dandenong**
- **North Yarra Specialist Clinic.**

These organisations provide a variety of supports while asylum seekers seek refugee status in Australia,<sup>158</sup> and link with many other organisations, including VFST, Migrant Resource Centres and Legal Aid.<sup>159</sup>

### Rural Victoria

AMES works through different sub-contractors and settlement planning committees in the 10 rural DIAC statistical subdivisions. These sub-contractors and settlement planning committees do not provide the same range of services that are available in the Melbourne metropolitan area. **Case coordination, information and referral, on-arrival reception and assistance, accommodation and furniture packages are provided** either by members of the settlement consortium or a sub-contracted rural settlement partner. **Short-term torture and trauma counselling services are available in all rural areas where there is a settlement planning committee.**

In rural Victoria, there is often less delineation between refugee and SHP entrants. With lower numbers of settlers, there is usually more opportunity to provide orientation to the local services. Community Guides are used less commonly, but **volunteers** carry out the same role. Colac settlement services provide new arrivals with DVDs in community languages on health, education and the local services.<sup>160</sup>

Three of the 10 DIAC areas, **Wimmera/Horsham, Ovens–Murray/Wodonga and East Gippsland/Bairnsdale have no significant refugee or SHP settlement to date**, so there is no allocated sub-contractor or settlement committee. Some areas provide services for predominantly SHP entrants (Western District/Warrnambool, Mallee/Mildura and Loddon/Bendigo); others provide for both refugee and SHP entrants (Barwon/Geelong, Central Highlands/Ballarat, Goulburn/Shepparton and Gippsland/Latrobe Valley).

## Settlement support: after six months

After the first 6–12 months, support for Humanitarian entrants is available through the **Settlement Grants Program (SGP)**. DIAC provides funding to organisations supplying settlement services to people up to five years after arrival in Australia.<sup>161</sup> The overall aim of the SGP is to assist clients to become self-reliant and participate in Australian society. Services receiving SGP funding provide supports such as orientation to Australia, practical help to promote self-reliance, community development assistance, and programs facilitating integration, inclusion and participation.<sup>14</sup>

<sup>158</sup> Supports include housing, financial assistance, health care and medical costs, case management, volunteer support, information, computer access, counselling, education, social support groups and excursions, material goods and clothes, electrical goods (including computers), furniture, food, telephone and transport cards, referral to other agencies (e.g. legal), recreation and fitness programs, migration advice and advocacy.

<sup>159</sup> Consultation with ASRC, Dandenong, May 2008.

<sup>160</sup> Questionnaire response, Colac Adult Community Education, February 2008.

<sup>161</sup> Including Humanitarian Program entrants, family stream migrants and dependents of skilled migrants.

### Melbourne metropolitan area

Some of the key agencies in Melbourne that receive SGP resources to facilitate refugee settlement in the longer-term include:

- Migrant Resource Centres
- Ecumenical Migration Centre
- New Hope Migrant and Refugee Centre.

**Migrant Resource Centres (MRCs)** provide advice and information in many community languages about housing, education, immigration, intergenerational relationships, income support, and other settlement needs. The centres assist community groups applying for funding and grants, support recently arrived groups, facilitate individual and community connections, help new entrants with employment and visa applications, and provide additional support to people with high needs (for instance, the aged or people with disabilities). **MRC Youth Programs** often involve an **Ethnic Youth Council (EYC)**, which is a committee of young people aged 15–25 years from migrant and refugee backgrounds. EYCs promote leadership and represent young people of migrant and refugee backgrounds. Other youth activities include sport and recreation activities, camps, driving programs, social activities and employment and media training.<sup>162</sup>

The **Ecumenical Migration Centre (EMC)** is part of the BSL and provides resources and advocacy for refugee individuals and communities, including family support (which is funded by DHS). Other projects focus on education, employment, capacity building, family relationships<sup>163</sup> and refugee youth.

The **New Hope Migrant and Refugee Centre** and the **Migrant Information Centre** provide settlement services, aged services, employment and training services, education programs, English classes, and volunteer and community visiting schemes. Both assist a variety of groups and projects, including a Sudanese women's group on family violence and a healthy lifestyle project for CALD communities. The **Southern Ethnic Advisory and Advocacy Council**, based at New Hope, provides services including casework, community capacity building, recreation programs, homework support groups and settlement support services to CALD young people. New Hope's related agency, the **New Hope Foundation**, coordinates **Refugee Resource Centres in Footscray and Wyndham**, as well as a personal support program, settlement and employment services, and material aid.<sup>164</sup>

### Rural Victoria

In regional and rural areas where refugee and SHP entrants have been supported during initial settlement through a contracted IHSS provider, there is usually funding available for a settlement grants program. In some areas (Ballarat, Mildura, Bendigo, Castlemaine, Latrobe Valley and Wonthaggi) the contracted IHSS provider is also the SGP provider. In all other areas of Victoria (Geelong/Colac, Warrnambool, Swan Hill/Robinvale and Shepparton) different organisations, agencies and city councils implement SGP funding.

## Health services

Health Undertakings (HU), red alerts and general alerts generated by pre-departure health screening all require post-arrival health checks. People with HU need to attend a specific service and health alerts must be followed up within a specified time period.<sup>165</sup> A health assessment is recommended for all people of a refugee background after arrival in Australia.<sup>55</sup> The pathways to refugee health assessment and health care vary according to area and visa type.

<sup>162</sup> Questionnaire responses from Migrant Resource Centres, February 2008.

<sup>163</sup> Stronger Family Program – a family relationship program for Humanitarian entrants in the north and west (funded by Departments of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA))

<sup>164</sup> Additional services include financial relief, assistance with school enrolment/expenses, transport tickets, access to social/recreational opportunities, access to health care and referral for drug and/or alcohol issues.

<sup>165</sup> Red alerts require post-arrival health assessment within 24 hours and arrive with a medical escort; general alert cases require assessment within 72 hours.



## Melbourne metropolitan area

### *Refugee Visa Holders (Visa 200, 201, 203 and 204)*

**Health alerts** are addressed with the support of the AMES Case Coordinator and Community Guide, who ensure the entrant sees a medical doctor or visits a hospital emergency department.

People who have a **health undertaking for tuberculosis screening results**<sup>166</sup> are notified by letter (in English) of an appointment for post-arrival follow-up to provide further screening and/or treatment as required.<sup>167</sup> Adults (aged 16 years or older) are seen at the Western Hospital, while those aged under 16 are seen at the Royal Children's Hospital. Health undertaking paperwork is transferred from DIAC directly to the service at the Western Hospital (which also triages children and young people to RCH). This process occurs independently of other health assessments, hence other providers are frequently unaware of the presence of an HU. There is no single service that reviews clients with HUs for other indications.

The **Refugee Health Nurse Program** is a Victorian State Government initiative that commenced in August 2005, to coordinate refugee health service provision and promote accessible and culturally appropriate health care services.<sup>293</sup>

Where a **Refugee Health Nurse (RHN)** is available, the AMES Case Coordinator or other agencies refer newly arrived refugee entrants for additional health assistance and support. As of 2010, sixteen health services have received funding to employ refugee health nurses. These nurses are located in Brimbank, Greater Dandenong, Hume, Maribyrnong, Moonee Valley, Melbourne, Darebin, Maroondah, Wyndham, and Casey in metropolitan Melbourne. In rural areas, positions have been funded at Greater Geelong, Shepparton, Warrnambool, Ballarat, Castlemaine, Colac, Morwell, Bass Coast, and Bendigo.

The RHN conducts an initial health screen and arranges a health assessment with a local private or community health centre general practitioner (GP). The RHN also provides case management, health service coordination, information and education, links to welfare and social work, and advocacy for other services, such as housing and employment services. Where a RHN is not available, the AMES Case Coordinator arranges a GP appointment for a health assessment<sup>168</sup> and may also refer the entrant to a community health nurse.

The GP provides ongoing follow-up if needed, and may refer the entrant to a specialist refugee service. They may also refer the entrant to allied health services, Maternal and Child Health (MCH) nurses, other health specialists, mental health services or other supports.

In metropolitan Melbourne there are a number of **specialist refugee clinics** based at tertiary hospitals or health centres. The Royal Melbourne Hospital and Dandenong Hospital provide clinics for refugee adults with complex health needs, typically communicable diseases. The Royal Children's Hospital, the Dandenong Hospital Refugee Clinic and Deer Park Health Centre also provide **specialist paediatric refugee clinics** to complement initial GP assessments.<sup>169</sup> These clinics perform a variety of roles, such as full initial health screening, providing consultation and management for issues arising in primary care screening, and completing screening if investigations have been missed in primary care. They may manage complex patients and coordinate other sub-speciality care within their clinic arrangements. Most of the issues arising in primary care screening in children (TB screening, Hepatitis B infection, rickets, complicated iron deficiency or parasites) are not usually managed in primary care settings.

In areas with greater numbers of refugees, **allied health services may also provide health promotion programs**, addressing issues such as food security, diet and nutrition, and the need for regular exercise.

The AMES Case Coordinator refers refugee entrants to a **dental service** for initial assessment. Since December 2005 refugee clients have had priority access to public dental care and are exempt from paying fees.

Apart from RHN, there are a number of other specialty nurses who may provide services to the refugee community. These include community health nurses, women's and youth health nurses, MCH nurses, primary school nurses and secondary school nurses.

<sup>166</sup> Over 90% of all HU are to follow up TB screening results.

<sup>167</sup> Consultation with East and West Team Leaders, AMES, Melbourne, May 2008.

<sup>168</sup> Questionnaire responses from refugee health nurses, March 2008.

<sup>169</sup> Questionnaire responses from specialist refugee clinics, March 2008.

**Community health nurses** often work with refugee clients when RHN are not available, providing health checks and immunisations.<sup>170</sup> **Women’s and youth health nurses** provide services, including community midwifery (antenatal and post-natal care), Pap smears, family planning, sexually transmitted infection screening, women’s health education and sexual health education for young people.<sup>171</sup>

*Special Humanitarian Entrant Visa Holders (Visa 202)*

The health assessment process is the same for SHP entrants, except the **proposer is responsible for facilitating the necessary health assessments**. This is done with support and advice from the AMES Case Coordinator who assists with a checklist, ensuring health alerts and undertakings are addressed and arranging appointments as required. AMES volunteers may be used to assist with the health assessment process. If the entrant (and/or family) is assessed as having complex needs, they may also be referred to a RHN for additional support. While RHNs primarily see refugees, they can offer assistance to SHP entrants when they are referred.

Most health services do not differentiate between refugee and SHP entrants, however refugees tend to be seen more frequently because of the extra range of supports available for them and the additional support they receive to access services. Referral pathways to health care for SHP entrants appear to be less efficient (than IHSS referral pathways), primarily because proposers are often unfamiliar with health systems.

**Rural Victoria**

Health pathways exist for refugee and SHP entrants in some regional and rural areas, primarily where there are larger numbers of Humanitarian Program entrants settling. These areas (in order of settlement numbers at the time of writing) include Goulburn (Shepparton), Barwon (Geelong/Colac), Mallee (Mildura/Swan Hill), Gippsland (Latrobe Valley/Bass Coast), Central Highlands (Ballarat), Ovens–Murray (Wodonga/Wangaratta), Western District (Warrnambool) and Loddon (Bendigo/Castlemaine). Refugee health nurse positions have been located in nearly all of these areas.

In all rural areas, GPs conduct refugee health assessments. They may or may not use the refugee health assessment tool recommended by Medicare or the relevant MBS item numbers, and they have variable experience in refugee health assessments. **Specialist refugee clinics have been established in Geelong Hospital and a paediatric refugee clinic has opened in Shepparton.** Follow-up medical support is limited to that provided by community midwives, MCH nurses, allied health professionals, VFST contracted counsellors and SGP providers.

A map of settlement, including health pathways, for refugee entrants is shown in Figure A1.

A map of settlement, including health pathways, for SHP entrants is shown in Figure A2.

A more detailed map of refugee and SHP entrant health pathways in the four regions of Melbourne is shown in Figure A3.

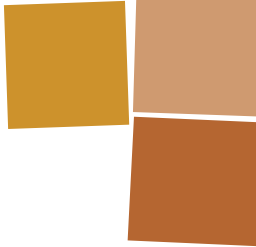
A more detailed map of refugee and SHP entrant health pathways in the four largest rural settlement areas is shown in Figure A4.

**Other supports for health**

Most of the following health providers are available for all Victorians. These providers can play a key role in supporting health care for refugee children and families.

**Maternal and child health nurses** initiate contact with mothers after childbirth. They provide 10 key age and stage visits between 0–5 years of age and assist with birth registration forms, breastfeeding, immunisation, family support and counselling. They also assess child development, and advise on child safety. The MCH nurse can organise an invitation to take part in first-time

<sup>170</sup> Questionnaire responses from community health nurses, March 2008.  
<sup>171</sup> Questionnaire response from women’s and youth health nurse, March 2008.



mother's groups, which continue for six support sessions. They also provide **enhanced programs of home visits for mothers with high needs**. MCH nurses use contacts in other program areas to provide opportunities and support for new mothers from refugee backgrounds to integrate into their communities.<sup>172</sup>

**Healthy Mothers, Healthy Babies Program** is a new program that aims to reduce the burden of chronic disease and social inequity by addressing maternal risk behaviours and providing support during pregnancy. The program operates in the outer growth suburbs of Melbourne that have high numbers of births, higher rates of relative socioeconomic disadvantage, and lower service accessibility.

The program targets women who are not able to access antenatal care services or require additional support because of their socioeconomic status, culturally and linguistically diverse backgrounds, Aboriginal and Torres Strait Islander descent, age or residential distance to services.

An evaluation of the program is currently under way; early reports indicate that a number of women from refugee backgrounds are being seen by this program.

**Specialist children's services and early intervention services** provide multidisciplinary early intervention for children (aged less than 6 years or prior to school entry) with developmental issues in more than one area. No information is available on the number of refugee children using these services.<sup>173</sup>

**Primary school nurses** use the School Entry Health Questionnaire and a teacher reported screening tool to identify new students who may require a health assessment. Standard checks include assessments of vision, hearing, speech, general development, allergies, asthma, bed-wetting and parental concerns. If problems are identified, they refer the student to an appropriate service. Primary school nurses also provide health education about nutrition, hygiene and oral health/dental care, and run health education sessions for 11–13 year-olds on puberty. They can conduct home visits to discuss health issues with parents and they can provide counselling, advocacy and support for refugee families.<sup>174</sup>

**Secondary school nurses** provide health education (including nutrition, dental health, body image and sexual health), health promotion, counselling, advocacy, and family and welfare support. They can also initiate referrals for students with health problems to appropriate services.

The **Family and Reproductive Rights Education Program** (FARREP) provides sexual and reproductive health services for women affected by female genital mutilation (FGM) and women from countries where FGM is practised.<sup>175</sup> In Victoria, FARREP is active across the state, with centres in the Western, Northern and Southern regions as well as a state-wide service based at the Royal Women's Hospital. At the time of writing, there are 14 FARREP workers and one coordinator in Victoria. Program delivery includes antenatal care and maternity services support, as well as maternal and child health care, health promotion activities and education for health professionals.

## Mental health services

The **Victorian Foundation for Survivors of Torture** is the primary initial mental health provider for refugees and SHP entrants in Victoria. VFST is part of the settlement consortium, and is informed of all new refugee and SHP arrivals by DIAC.

Clients are referred for short-term trauma counselling by their AMES case coordinator if they meet specified indicators or criteria. Prior to mid 2008, all refugee entrants received mental health screening and short-term counselling, and SHP entrants were seen if they were referred.<sup>176</sup>

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<sup>172</sup> Questionnaire response and consultation with Brimbank Maternal and Child Health nurses, April and June 2008.

<sup>173</sup> Questionnaire response from specialist children's services, Eastern Region, March 2008.

<sup>174</sup> Questionnaire responses from primary school nurses, March 2008.

<sup>175</sup> Consultation with FARREP program workers, April and May 2008, Mercy Hospital, Royal Women's Hospital, Southern health.

<sup>176</sup> SHP entrants were referred when concerns were raised during the AMES initial health screening process.

All referred clients receive an average of eight 2-hour counselling sessions.<sup>177</sup> In metropolitan Melbourne, counsellor advocates based at branches of VFST usually see clients at their homes. In rural areas, VFST<sup>178</sup> contract counsellors, usually through a local community health centre. All areas of rural settlement have VFST counsellors, apart from the statistical divisions of Wimmera/Horsham, Ovens–Murray/Wodonga and East Gippsland/Bairnsdale.

This short-term intervention is part of IHSS service provision; humanitarian entrants are eligible for this service within the first 12 months of their arrival. Referrals for IHSS counselling may also be initiated by other agencies or by clients directly.

If a client is found to have more serious psychological issues or an ongoing need for support after their short-term counselling, they can receive additional counselling through the ‘generalist stream’ for specialised mental health care at VFST. Approximately 18% of clients are referred for additional services.<sup>179</sup> Clients can be referred to services within the generalist stream at any time after settlement.

**Child and Adolescent Mental Health Services (CAMHS)** provide tertiary public mental health services for children and young people (aged up to either 15 or 17 years depending on area), their families and carers. Clients are usually referred to CAMHS if they have severe mental health symptoms or they need crisis containment, assessment and treatment. In all Victorian regions, CAMHS provide intensive mobile youth outreach services, continuing clinical care and acute inpatient services. In some regions, CAMHS provide day programs and services for young people with conduct disorder. No data are collected on refugee status. In most regions, CAMHS staff report seeing very few people of refugee-like backgrounds (on average only two to three families per year). CAMHS staff reported that cultural issues, concepts around mental health and a client’s knowledge of CAMHS influenced service provision.<sup>180</sup>

Other mental health services

Other mental health services for children and young people include:

- **Headspace**, a community-based youth health service that includes psychologists and counsellors. There are seven Headspace sites in metropolitan and rural Victoria
- **counsellors based at community health centres**
- **private psychologists.** Private psychologists have become more accessible with the Federal Government’s ‘Better access to mental health care’ initiative that provides a Medicare rebate for some psychology services. However, there is usually an out of pocket expense, and access to interpreters is problematic
- **hospital- or university-based psychology clinics.** At the time of writing, no university psychology clinics (seeing children or families) are able to access interpreter services to see non-English-speaking clients
- **Frontyard Youth Services**, a multidisciplinary service for young people aged up to 25 years who are at risk of homelessness. Frontyard has counselling services available.

General practitioners and the school welfare system may also be sources of mental health care for children and young people.

Education and early childhood services

All Humanitarian Program entrants aged over 18 years with low English proficiency are eligible for 510 hours of free English language tuition, provided by the **Adult Migrant Education Program (AMEP)**, either directly or through a sub-contractor.<sup>290</sup> Humanitarian entrants aged over 16 years are also eligible for the 510 hours of English classes if they have elected not to attend school.<sup>181</sup> Entrants must be registered for English classes within 3 months of arrival and start tuition within a year.<sup>290</sup> Children under age 6 years are eligible for **free childcare associated with AMEP** while their parents are in English language classes.

<sup>177</sup> Consultation with VFST, June 2008. Referrals are usually based on the initial health screening process with AMES, but are sometimes made based on demographics alone (e.g., a single mother with multiple children).

<sup>178</sup> Branches of VFST are located in Brunswick and Noble Park.

<sup>179</sup> Information from VFST, August 2008.

<sup>180</sup> Questionnaire responses from Alfred CAMHS and Monash Adolescent Inpatient Psychiatric Unit, March 2008.

<sup>181</sup> In Victoria, school is compulsory between the ages of 6 and 17 years. Entrants aged 16-18 years can access either the school system or the AMEP program (but not both), or specialised programs for refugee and migrant youth.

Humanitarian entrants aged 16–24 years with seven years or less of formal education who attend the AMEP program are eligible for up to 400 hours of additional English tuition, under the provisions of the **Special Preparatory Program (SPP400)**.<sup>15</sup>

The **kindergarten fee subsidy** is available to children in refugee and/or asylum seeker families who are attending 4-year-old kindergarten. The subsidy provides 10 hours of kindergarten weekly.<sup>253</sup> The Refugee Council of Australia has identified that in the past many Humanitarian entrant families did not access kindergarten services because of cost.<sup>15</sup>

The **Free Kindergarten Association (FKA) Children's Services** provide consultation on request to kindergartens, Commonwealth-funded child care centres and family day care providers for any child from a CALD background who requires extra support. FKA aims to facilitate culturally responsive child care services for refugees. This includes the provision of translated materials, culturally responsive play materials, and bilingual support for families, as well as access to a mobile resource library. FKA is also contracted by AMEP to support kindergarten and child care placements for children aged 0–5 years whose parents are Humanitarian entrants enrolled in English language classes. FKA supports approximately 800 children a year in this arrangement.<sup>182</sup>

**Family Day Care (FDC)** is a home-based child care service that can provide emergency and general care for children aged up to 12 years. The flexible hours and small home-like settings of FDC providers may be less intimidating for refugee families. Carers from the same cultural background may be available. FDC is often used for children while parents attend AMEP English classes as it provides more flexible hours and is less expensive (payment is only required for hours of care used).<sup>183</sup>

The **Preschool Field Officer (PSFO) Service** promotes the inclusion of children with disabilities into state-funded preschool programs. The PSFOs have little direct contact with refugee or asylum seeker children and usually only receive single referrals through paediatricians or social workers. These requests are mainly for enrolment support.<sup>184</sup>

For new arrival students who do not speak English, the preferred point of entry into education in Victoria is via an **English Language School or Centre (ELS/C)**. Students of a refugee background make up around one-quarter to one-third of new arrival English as a Second Language (ESL) students in Victoria. Primary school students are placed into classes according to their age, while secondary school students are enrolled according to English ability.

A number of organisations provide **after school homework support and tutoring options** for students of refugee-like backgrounds. These include the Smith Family, Good Shepherd Youth and Family Services, Jesuit Social Services, Edmund Rice Refugee Services and Sudanese Australian Integrated Learning (SAIL).

The **Smith Family provides scholarships** for the children of disadvantaged families. The Smith Family has several structured programs for people who do not have 'functional' English language skills. The **Each One Teach One** program focuses on daily life activities such as answering phone calls, shopping, communicating with teachers/schools, visiting the doctor and using public transport. Volunteers (trained by AMEP to be English tutors) provide additional support for students in their homes as part of this program. The **Student to Student Program** is a peer-mentoring program conducted over the telephone. It is designed to improve literacy and build the confidence of students who are behind in their reading. The **Learning for Life Program** builds general life skills and abilities and **Microsoft Unlimited Potential** is a global support program focused on improving lifelong learning for young people and adults by providing technology skills.<sup>185</sup>

**Good Shepherd Youth and Family Services** provide support groups for Sudanese women (that include child care). These groups promote English language learning for mothers; informal and directed play for their children; education about food, parenting, and life in Australia; counselling; family support; and family recreation programs. **Jesuit Social Services** run an African youth program which, in addition to homework and educational help, provides sports programs, assistance with police and housing issues, support for community development, and health education. **Edmund Rice Refugee Services** provide tuition by volunteers

<sup>182</sup> FKA services the state of Victoria, apart from the Northern Metropolitan Region, where support for childcare during English classes is contracted to Northern Metropolitan Institute of Technology (NMIT).

<sup>183</sup> Questionnaire responses from FDC and FKA providers, March 2008.

<sup>184</sup> Questionnaire response from Brimbank PSFO, May 2008.

<sup>185</sup> Questionnaire response, The Smith Family, April 2008.

to students from refugee-like backgrounds, access to programs such as camps and activity days, a mentoring program, computer and internet access, advice on educational pathways, recreational activities and opportunities to socialise.<sup>186</sup> SAIL provides English language tutoring and community services for the Sudanese Australian community.

Melbourne Metropolitan

Refugee Visa Holders (Visa 200, 201, 203 and 204)

Refugee entrants are initially supported by AMES to access English language learning if required. AMES assists adult entrants to enrol in English language classes or other education, and helps parents to enrol children in school. The AMES case coordinator makes an appointment with the school, and the family attend with the help of an AMES community guide.<sup>187</sup> Alternatively, parents may enrol children in a primary school providing ESL support, or a mainstream government or Catholic school. Pathways vary between regions: in the South East Region all students are encouraged to attend ELS/C; in the North West Region secondary age students are usually referred to an ELS/C, and primary age students are usually enrolled in schools with outpost intensive (ESL) programs. Families receive the names of local kindergartens, but may not be supported further in the (complex) enrolment process.

Special Humanitarian Entrant Visa Holders (Visa 202)

For SHP entrants, their proposer is responsible for facilitating access to education, under the guidance of an AMES Case Coordinator if needed. SHP visa holders can be enrolled in ELS/C and receive the same support as refugee entrants within the school system. SHP families often contact schools independently with the help of more established relatives or friends, or settlement service workers may assist them. SHP visa holders are eligible for the same new arrival, bridging and assisted language courses as refugee entrants. Many SHP entrants make use of external homework and tutoring support options and libraries, in a similar manner to refugee entrants.

Rural Victoria

ESL teaching for students in regional and rural Victoria is available through the **Geelong English Language Program**, the **Shepparton New Arrivals Program**, and **programs in Ballarat and Mildura**. There is also an **Isolated ESL Student Program** that provides either direct or mentoring support to schools for students needing ESL support in outer or non-metropolitan areas. In Swan Hill, a primary school and the secondary school have the support of ESL-trained teachers for their growing number of Afghani students. **AMEP providers exist in most rural areas**, and some areas have a strong network of **local volunteers** who help humanitarian entrants learn English.

A map of settlement, including education pathways, for refugee entrants is shown in Figure A1.

A map of settlement, including education pathways, for SHP entrants is shown in Figure A2.

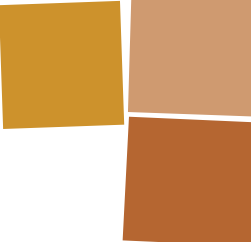
Youth, family and other community services

Child and Family Support Services through Local Government Areas provide families with an introduction to local community services and agencies. They provide information about child care, English classes, kindergarten enrolments, library services, and cultural playgroups and parenting groups. Services include maternal and child health, playgroups, occasional counselling, parenting services and family camps coordinated through city council programs.<sup>188</sup>

**City Council Youth Services** operate from most municipal councils, including in areas of high refugee settlement. These services are for young people aged 11–25 years. Young people can self refer or are referred by other providers, schools, parents/guardians or the justice system. Some councils have a **Multi-Cultural Youth Project Officer** who can build links between programs, develop services and provide advocacy.

<sup>186</sup> Questionnaire responses from agencies listed, May 2008.  
<sup>187</sup> Consultation with East and West Team Leaders, AMES, Melbourne, May 2008.  
<sup>188</sup> Questionnaire response from City of Melbourne Family Services, February 2008.





**Greater Dandenong Council Youth Services** provide youth programs,<sup>189</sup> support services,<sup>190</sup> individual and family counselling, and community development, giving young people the opportunity to organise events. Youth ConneXions, a refugee and migrant youth support program for 12–25 year-olds, aims to create links and provide opportunities for involvement in community activities. This agency provides information and referral, life skills programs, and assistance with relationship problems, family conflict, sexual health, study, employment and internet access.<sup>191</sup>

The **Centre for Multicultural Youth (CMY)** is one of the lead agencies providing youth oriented programs and advocacy for young people of migrant and refugee backgrounds. CMY provides direct services to young people and their families, and professional development, as well as developing policy and education resources. It provides personal support and counselling, case work and a range of programs for young people, including leadership training, arts and environment programs and sport and recreation programs. It also provides advice to services working with refugee young people, enhancing their capacity to work more effectively with this group.

The **CMY Reconnect – NAYS (Newly Arrived Youth Specialist) Program** supports newly arrived young people aged 12–21 years who are homeless or at risk of homelessness. The program provides counselling, group work, family mediation and practical support.

The **CMY Youth Referral and Independent Person Project (YRIPP)** provides support for young people in the justice system who do not have a parent or guardian who can be present during police questioning. An external, unconnected adult acts as the ‘independent person’ required to attend during the police interview. YRIPP trains people to take this role, ensuring they can refer to relevant services. This offers an opportunity to address the needs of refugee young people in the justice system.<sup>192</sup> YRIPP also provides resources for police and parents, and access to a 24-hour advice line for young people in custody.

The CMY also administers DEECD funded **Learning Beyond the Bell** programs, providing Out of School Hours Learning Support for refugee and migrant students.

**Victoria Police** have a number of dedicated MLO and NECLO positions across the organisation. These roles provide a link between communities and operational police. The NECLO's provide cultural competency information sessions to police members, and in partnership with other proactive police roles such as Youth Resource Officers and Crime Prevention Officers, promote preventative programs and community educations and activities. The liaison officers bring with them expertise and knowledge about communities and the unique settlement process, that enhances relationships between police and communities.<sup>193</sup>

Women of a refugee background in Victoria can access **Women's Health Victoria**, which provides health information, referrals, health promotion programs and professional development for service providers. Other agencies, such as the **Immigrant Women's Domestic Violence Service**, assist women with a culturally adapted case management model, using a telephone support service and face-to-face assessment. Women can access help for child protection and housing issues, family violence, sexual assault, safety plans, pregnancy support, psychological services, counselling and liaison with schools.<sup>194</sup>

**Disability Services** provide support for people with intellectual, physical, sensory or neurological disability, their carers and families by providing case management, referral, respite and recreation options. Disability Services also provide community education and information to groups, including schools, community centres and migration centres.

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<sup>189</sup> Youth programs include Muso network, FreeZa events, basketball, volleyball, soccer, dance classes and hospitality training.

<sup>190</sup> Support services include the Visy Care intake service, Y-Space Castle Drop In, casework support, the Gain Respect, Increase Personal Power (GRIPP) Program.

<sup>191</sup> Questionnaire responses from Dandenong and Casey City Council Youth Services, February and March 2008.

<sup>192</sup> Questionnaire response from CMY, February 2008.

<sup>193</sup> Consultations with Multicultural Liaison Unit Police Officers from all 5 regions of Victoria, March 2008.

<sup>194</sup> Questionnaire responses from various Women's Agencies, March 2008.

**Local churches** are key centres for the Burmese and Sudanese communities, providing social support and network development. Some churches have congregations of over 150 people from refugee backgrounds. Churches may develop congregations of a particular group, such as asylum seekers, refugees or SHP entrants, and some churches have even acted as proposers.<sup>195</sup>

**Libraries** provide opportunities for learning support. They may offer a virtual library, with online databases, multilingual websites, including Arabic and Dinka pages, literacy and ESL collections, audio-visual materials, orientation sessions, free internet access, computer classes, story times, school holiday activities, conversation/games clubs, homework help, inclusive community spaces and a home library service for people who are unable to get to the library.<sup>196</sup>

## Financial support and financial planning services

Many Humanitarian Program entrants experience significant financial stress as they attempt to repay travel costs and pay rent, bills, living costs and education expenses. Many are also sending funds back to relatives in their country of origin.<sup>15</sup> Financial demands, combined with the pressure and complications in seeking employment, may affect the mental health of Humanitarian Program entrants.<sup>15</sup>

There are few agencies providing financial support for humanitarian program entrants. Many of the SGP providers give financial advice as a component of other programs. **East and Central African Communities of Victoria** (EACACOV) provides financial courses for its clients and **Good Shepherd Youth and Family Services** provide education on the legal aspects of loans and financing. The **Inner West Financial Counselling Service** provides a financial counsellor, information and assistance for Humanitarian entrants experiencing financial difficulties at a community legal centre in Footscray.<sup>197</sup>

## Legal services

IHSS providers offer information on the Australian legal system and the requirements for permanent residence and Australian citizenship.

The **Victoria Police** provide education on:

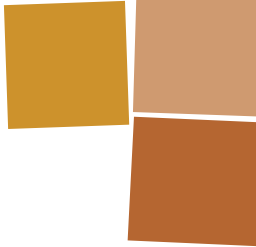
- emergency services and legal services (including tours of police stations and court houses)
- road safety and driving programs
- safe street behaviour and using automatic teller machines
- intergenerational issues
- the legal implications of family violence, leaving children unsupervised, and unlicensed driving
- drug and alcohol issues.<sup>198</sup>

A number of legal centres specialise in refugee and migration law, including **Victorian Legal Aid**, which provides immigration legal services for asylum seekers living in Victoria under the **Immigration Advice and Application Scheme** administered by DIAC. Victorian Legal Aid can represent clients appealing decisions of the **Refugee Review Tribunal** in the Federal Court.

The **Refugee and Immigration Legal Centre** (RILC) specialises in all aspects of refugee and migration law, policy and practice. RILC assists asylum seekers and disadvantaged migrants with sponsorship of family members from overseas, applications for permanent residence, advice for people seeking to be proposers, advocacy to immigration agencies and appeals and representation before the migration tribunals. It also provides help for people held in immigration detention.

<sup>195</sup> Consultation at Eastern Regional Refugee Forum, March 2008.  
<sup>196</sup> Questionnaire response, Brimbank Libraries.  
<sup>197</sup> Questionnaire responses and consultation with these agencies, February 2008.  
<sup>198</sup> Consultations with Multicultural Liaison Unit Police Officers from all five regions of Victoria, March 2008





The Victorian Government's **Justice for Refugees Program** aims to improve access to legal protection and to information about rights and responsibilities for refugee communities.

Local community legal centres such as the **Footscray Community Legal Centre** provide free legal assistance. Footscray Community Legal Centre also runs a weekly **African Legal Service**.<sup>199</sup>

## Language services

The **Translating and Interpreting Service (TIS) National**, provided by DIAC, has over 1300 contracted interpreters speaking over 120 languages and is continuously accessible (24 hours, 7 days a week) for people or organisations in Australia requiring interpreting services.<sup>294</sup> Its services are **free of charge** for:

- private medical practitioners providing Medicare rebatable services, and their reception staff to arrange appointments and provide results of medical tests (Doctors Priority Line)
- non-profit, non-government, community-based organisations for casework and emergency services where the organisation does not receive funding to provide these services
- Members of Parliament
- local government authorities, for communication on issues such as rates, garbage collection and local services
- trade unions, to respond to members' enquiries
- Emergency Management Australia
- pharmacies, for dispensing Pharmaceutical Benefits Scheme Medications.<sup>295</sup>

Interpreting and translating standards are set by the **National Accreditation Authority for Translators and Interpreters (NAATI)**, which was established in 1977.

## Service usage data

It is difficult to quantify service usage by refugee children and young people. There are no systematic surveys of service use by Humanitarian Program entrants, and most services do not collect adequate demographic information to identify refugee clients.

In summary, the areas of the service system where there are high levels of contact with refugee communities are:

- **Integrated Humanitarian Settlement Strategy providers**, which see all refugee entrants and have contact with SHP entrants/proposers in 90% of cases
- **Migrant Resource Centres**, which have a huge number of contacts annually. The North West Region office had over 6000 client contacts in 2006–07, and the vast majority of them were of a refugee background
- **Victorian Foundation for Survivors of Torture**, which sees a total of 3100–4600 people annually, including 1100–1600 new arrivals aged 0–17 years

The other **key health service providers with 800–1000 (or more) contacts annually** include:

- **Refugee Health Nurses** – around the state, RHNs have seen more than 2500 clients since the program started in 2005
- the **FARREP program**
- **Asylum Seekers Resource Centres at Dandenong and Melbourne**, with 600–1000 asylum seekers seen annually
- **Royal Children's Hospital Immigrant Health Clinic**, which has 1100 attendances each year
- **Western Region Health Centre's Vitamin D Clinic**, which had just fewer than 900 patients in 2007.

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<sup>199</sup> Consultation with and website information on these agencies, February 2008.

Other key service providers are:

- **Settlement Grants Program providers** (such as New Hope and Ecumenical Migration Centre), which assist between 500–750 clients a year
- **Community Health Centres in Werribee and Footscray**, with more than 400 clients annually
- **Non-Government Organisations and Charities** (Jesuit Social Services and the Edmund Rice Centre and SAIL), with over 300 clients a year and over 1000 people attending information and education sessions
- **EACACOV**, which assists up to 500 clients a year.

English language schools and centres have approximately 600 refugee new arrival ESL students each year in total across the five ELSs and four ELCs.

Some individual GPs have a high caseload of refugee clients. Individual primary and secondary school nurses, and other mental health and disability support services generally have low numbers of clients.

**Data collection by agencies**

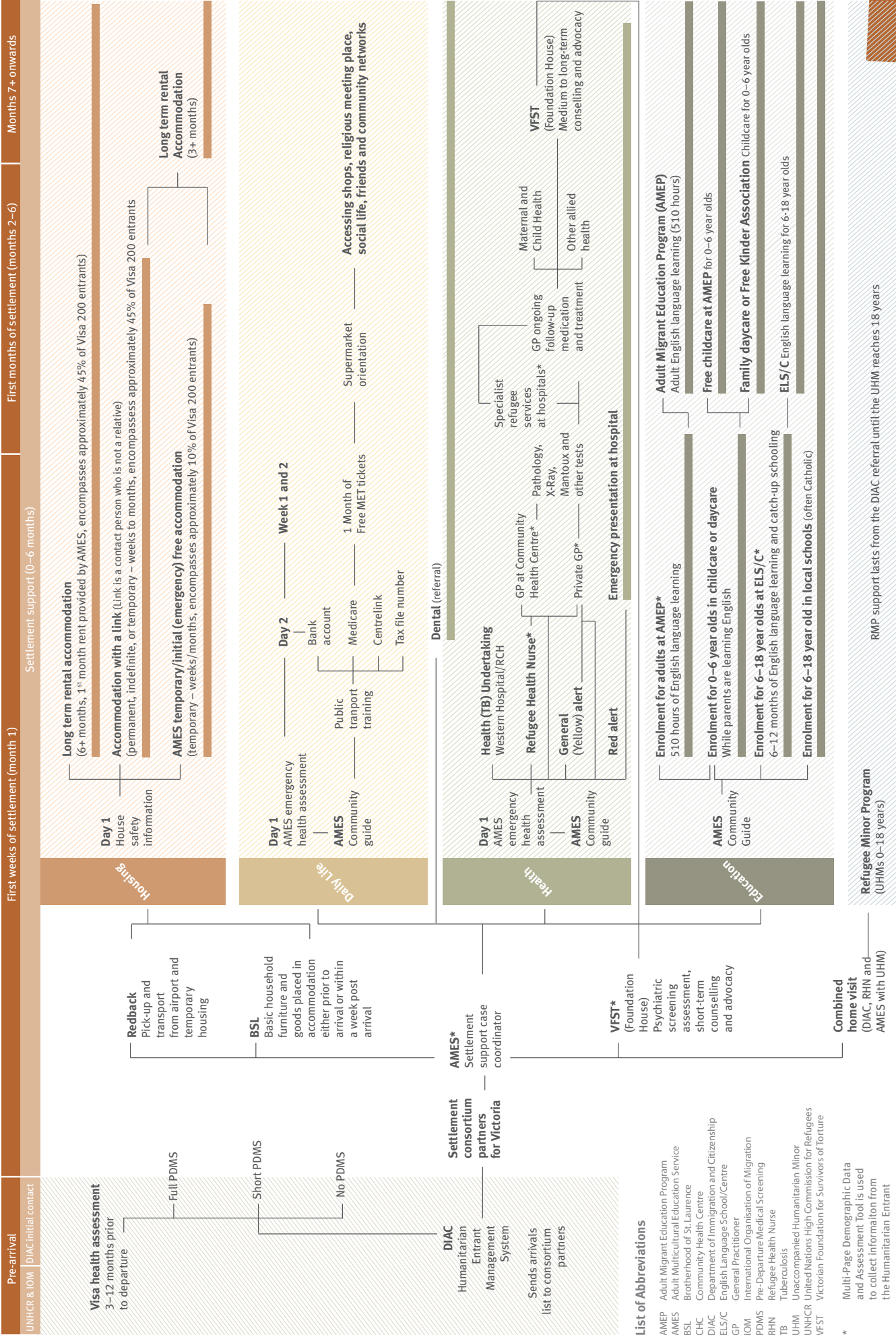
Only AMES, the English language schools/centres, the VFST, the ASRC and the Ecumenical Migration Centre collect refugee status as a mandatory field on their data entry systems.

For the majority of agencies, refugee status is included in case notes but is not easily accessible without individual case note audit. This presents enormous challenges in documenting health status and service use over time, and when comparing service use between refugee and SHP entrants. Improving data collection by agencies is fundamental to documenting the health and service use of people of a refugee background in Victoria.

A summary of the number of clients of a refugee background seen by different agencies, grouped by type of service, is included in Table A1.

A summary of demographic information collected by agencies is included in Table A2.

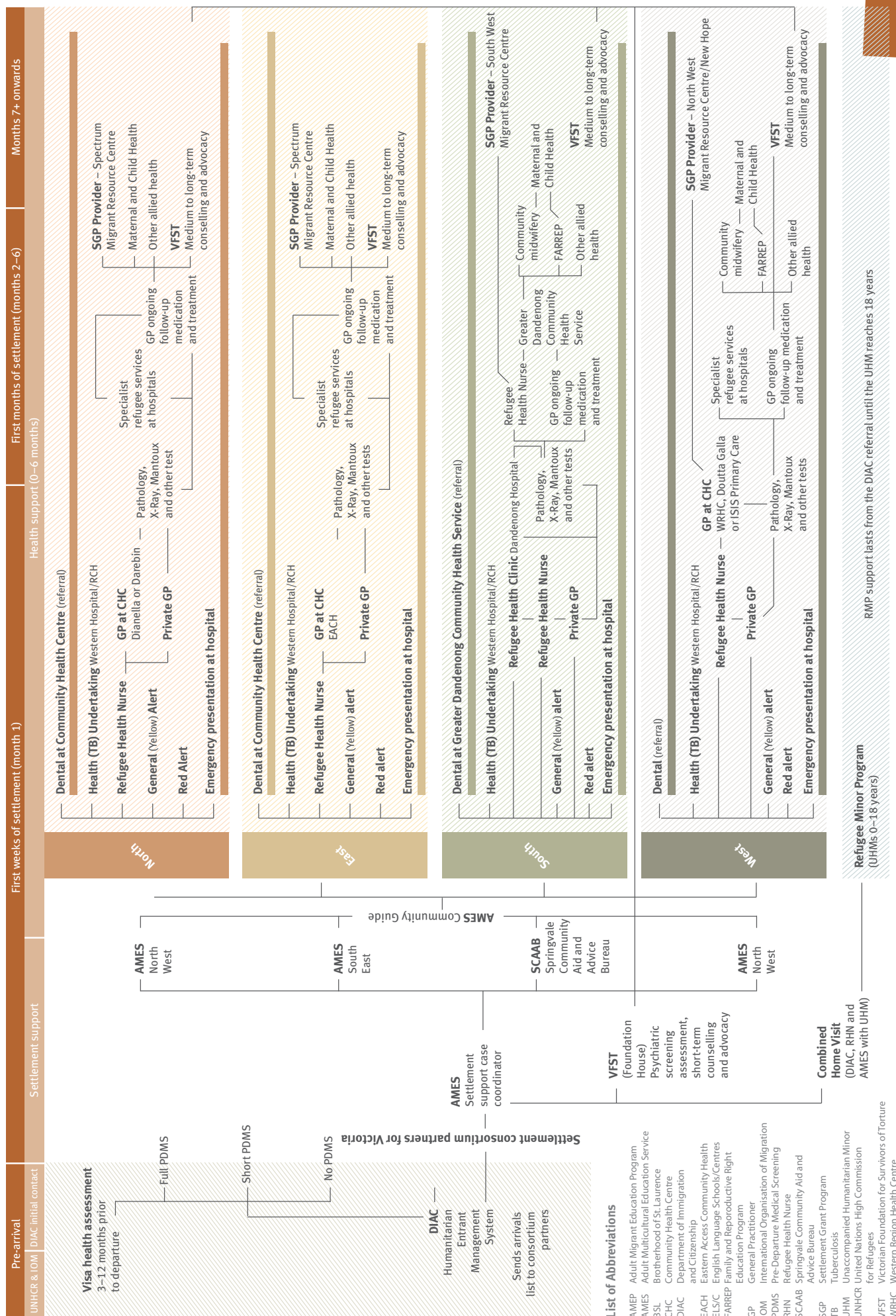
Figure A1: Settlement pathways in Victoria for refugee entrants: Visa 200, 201, 203 and 204







**Figure A3: Settlement pathways: health assessment, metropolitan regions of Melbourne, Victoria**





The data presented in this table are from published agency reports, or were provided by the listed agencies. They include both adult and child refugees unless specified. 'Refugee' refers to both refugee and SHP entrants. 'COB' refers to country of birth. Information was collected in early 2008. Services in bold font are identified as key points of contact for Humanitarian Program entrants to Victoria, with large numbers of clients.

**Table A1: Service use by refugee clients**

Service area	Type of service	Organisation	Children	Refugee status recorded	Refugee client number			
Education	English language schools	Blackburn English Language School	All	Y	2005	2006	2007	2008
		Collingwood English Language School	All	Y	88	35	53	
		Noble Park English Language School	All	Y	35	38	28	
		Western English Language School	All	Y	298	316	229	
	English language centres	Broadmeadows Secondary College	All	Y	178	121	125	
		Brunswick English Language Centre	All	Y	34	43	40	
		Glen Eira College	All	Y	25	16	32	
		Springvale Primary School	All	Y	5	2	2	
		Westall Secondary College	All	Y	44	49	30	
		Ballarat English Language Centre	All	Y	18	24	50	
	Regional English language centres	Geelong English Language Centre	All	Y	Numbers not available			
		Mildura English Language Centre	All	Y	36	19	23	65
		Shepparton English Language Centre	All	Y	73 students since May 2008			
	Kindergartens	Free Kindergarten Association Children's Services	All	N (COB)	~190 since 2002			
	Primary school nurses	Primary School Nursing Program	All	N	2006–07: ~ 6,000 contacts to support CALD children in kindergartens, child care and family day care around the state except for northern metropolitan region (NMIT)			
Settlement	Secondary school nurses	Secondary School Nursing Program	All	N	Refugee numbers mostly unknown or inaccessible.			
	Settlement	Adult Multicultural Education Service	50%	Y	Refugee numbers mostly unknown or inaccessible.			
					6,560 since October 2005			

Service area	Type of service	Organisation	Children	Refugee status recorded	Refugee client number
Health	Refugee health nurses – metropolitan	Darebin Community Health	64%	Y*	January 2007 – August 2008: 302 (193 children)
		Dianella Community Health	60%	Y*	Unknown
		Doutta Galla Community Health	50% < 24 years	Y*	144 since 2005–06
		Greater Dandenong Community Health	42%	Y*	2006–07 = 133
	Refugee health nurses – regional	ISIS Primary Care, Sunshine	70%	Y*	257 since 2005
		ISIS Primary Care, Hoppers Crossing	50%	Y*	436 in 2007
		Western Region Health Centre	70%	Y*	1999–2002: ~300/year 2004 = 842, 2005 = 725, 2006 = 337, 2007 = 458
		Ballarat Community Health	60%	Y*	22 adults, 34 children, 23 casual family contacts since May 2007
	GPs and community health centres	Goulburn Valley Community Health	> 50%	Y*	170 primary settlers since 2002
		Warrnambool Community Health	~ 50%	Y*	Unknown
		The Clinic, Footscray	50%	N	Approximately 100 new patients/year
		Inner South Community Health Service	Low	N (COB)	Unknown
	Specialist refugee clinics	North Yarra Community Health Centre	Immunisation only	N	2007: 24 ongoing clients for midwifery care
		Central Gippsland Health Service	Unknown	N	Unknown
		WRHC Vitamin D Clinic	> 70%	N (COB)	878 registered patients in 2007
		Pediatrician at ISIS Deer Park	All	Y*	104 new clients, 56 reviews since 2007
	Women's health services	Royal Children's Hospital Immigrant Health	All	Y*	1,100 attendances/year, ~ 350 new patients/year Other RCH services unknown
		VIDS Royal Melbourne Hospital	See 16 years +	Y	~ 300 adults since 2006–07
		Dandenong Hospital Refugee Health Clinic,		Y	2–3 children/week since 2006
		Family and Reproductive Rights Education Program (FARREP)	90% of women seen have children	N (COB)	Total program client numbers not available Client contacts at the Mercy Hospital for Women: 2003 = 543, 2004 = 762, 2005 = 624, 2006 = 802
	Mental health services	Immigrant Women's Domestic Violence Service	Unknown	N	600 clients/year (refugee and non-refugee)
		Foundation House (VFST)	50%	Y	2004/5 = 3,102, 2005/6 = 3,611, 2006/7 = 4,213, 2007/08 = 3,973
		Alfred Child and Adolescent Mental Health Services	All	N	Anecdotal – 2–3 families/year
		Maternal & Child Health, Brimbank	All	N	~ 10% of around 480 births/year
Other health services		DHS, Disability Services Intake & Response	Unknown	N (COB)	Unknown
		Eastern Specialist Children's Services (DEECD)	All	N	Aware of 5 refugee clients
		Southern Specialist Children's Services (DEECD)	All	N	Unknown
		Northern Specialist Children's Services (DEECD)	All	N	Unknown
		Western Specialist Children's Services (DEECD)	All	N	Unknown



Service area	Type of service	Organisation	Children	Refugee status recorded	Refugee client number
Settlement grants programs	Settlement	Adult Multicultural Education Service	50%	Y	6,560 since October 2005
		Migrant Resource Centre North West Region	45-50%	Y*	For 2006–2007: 98% of clients are refugee or Humanitarian entrants 14,463 reception contacts (8,000 Hume office) 6,448 client contacts 1,500 youth client contacts 333 clients received 46,534 hours of care 103 client received assistance with disability
		New Hope Migrant and Refugee Centre	15%	Y*	Each worker sees approximately 150 clients/year, 5 workers, ~750 clients/year
		Ecumenical Migration Centre	90% of clients have children	Y	~ 500 refugee clients/year 525 refugee clients assisted by programs in 2007
		Edmund Rice Refugee Services	95%	N	2005 = 250, 2006 = 340, 2007 = 330
Non-Government organisations		Jesuit Social Services	90%	N	Per year: community building information sessions – 106, casework – 85, cultural events – 800, education – 1,390
		The Smith Family	60–70%	N	~320 since 2006–07
		Good Shepherd Youth and Family Service	25–35%	N	Unknown
		Centre for Multicultural Youth	All 12–25 yrs	N (COB)	220–240 per year
	Youth services	Youth Connexions (including Whitehorse Refugee & Migrant Youth Support Program)	All 12–25 yrs	N	Clients are refugees, immigrants or overseas students 2002–03 = 880, 2003–04 = 1,102, 2004–05 = 2,739, 2005–06 = 2,255, 2006–07 = 1,258
Other services		Asylum Seeker Resource Centre, Melbourne	Unknown	Y	2004–05 = 259, 2005–06 = 380, 2006–07 = 599
		The Asylum Seeker Centre, Dandenong	5–10%	Y	2000–2500 / year until 2007–08 = 1139
		Brimbank Libraries	60%	N	769 borrowers who speak one of Syrian, Persian, Swahili, Somali, Iranian, Dinka, Amharic, 1753 Arabic speaking borrowers
		Eastern and Central African Communities of Victoria	Unknown	N	200–500 people/year

\* Refugee status recorded in individual case notes but not on computer systems

Table A2: Demographic information collected by agencies

Service area	Organisation	Collected, can be collated from data systems				Collected, cannot be collated from data systems			
		Refugee status	Visa type	Country of birth	Arrival date	Refugee status	Visa type	Country of birth	Arrival date
Health	Refugee Health Nurses			Y		Y	Y		Y
	GPs using Medical Director	Y	Y	Y	Y				
	GPs not using computerised programs					Y	Y	Y	Y
	Community Health Centres			Y		Depends on the clinician at CHC			
	Public Hospital Specialists			Y		Y	Y	Y	Y
	Specialist Refugee Health Clinics			Y		Y	Y	Y	Y
	FARREP					Y	Y	Y	Y
	VFST	Y	Y	Y	Y				
	Communicable Disease notifications			Y					
	Child and Adolescent Mental Health Services			Y					
	Victorian Perinatal Data Collection Unit			Y					
	Maternal & Child Health Nurses			Y					
	Immigrant Women's Domestic Violence Service			Y					
	Disability Services Intake & Response (DH)			Y					
	Specialist Children's Services (DEECD)			Y					
	English Language Schools / Centres	Y	Y	Y	Y				
Education	DEECD	Y (2007)		Y					
	DEECD – new arrivals dataset	Y	Y	Y	Y				
	SEHQ			Y					
	Student Wellbeing Unit (PSD)			Y					
	Free Kindergarten Association			Y					
	Primary School Nursing Program			Y					
	Secondary School Nursing Program			Y					

Service area	Organisation	Collected, can be collated from data systems				Collected, cannot be collated from data systems			
		Refugee status	Visa type	Country of birth	Arrival date	Refugee status	Visa type	Country of birth	Arrival date
Settlement	Adult Multicultural Education Services	Y	Y	Y	Y				
Settlement Grants Programs	Migrant Resource Centres					Y	Y	Y	Y
	New Hope Migrant and Refugee Centre					Y	Y	Y	Y
	Ecumenical Migration Centre					Y	Y	Y	Y
	Edmund Rice Refugee Services							Y	
Non-Government Organisations (Charities)	Jesuit Social Services							Y	
	The Smith Family					Y		Y	
	Good Shepherd Youth and Family Service							Y	
	Centre for Multicultural Youth Issues	Y	Y	Y	Y				
Youth Services	Asylum Seeker Resource Centre, Melbourne	Y	Y	Y	Y				
Asylum Seeker	Asylum Seeker Centre, Dandenong					Y	Y	Y	Y
	CRIS database, Department of Justice			Y					
	Family Services database			Y					
	Victoria Police			Y					
	EACACOV					Y	Y	Y	Y

## Part 2: Facilitators and barriers to service delivery – service provider views

This section provides an overview of factors facilitating service delivery and barriers to optimal service delivery identified by service providers. Factors identified by a number of organisations are acknowledged with a footnote at the beginning of each section. There is a lack of information on refugee communities’ views on service delivery. A summary of published information is included at the end of this section.

### Key facilitators of service delivery

The following were found to be key facilitating factors for service delivery: <sup>200</sup>

- accessible, flexible and responsive services
- partnerships and networking between agencies
- professional staff development about refugee issues, health and culture
- community guide support and assistance
- use of interpreters, bilingual workers and language resources
- settlement location: close to support services, health providers, transport, education and community
- coordination of services: minimising appointments and reducing duplications in the assessment process
- refugee health nurse support.

#### Facilitators of service delivery by service speciality

##### Language and education services <sup>201</sup>

Service providers identified the following facilitating factors:

- access to and use of interpreters, bilingual workers and language resources, with interpreters trained in specific fields, such as health or legal work
- provision of educational materials in first languages (especially in audio-visual and DVD formats)
- availability of flexible education sessions on evenings and weekends to fit in with family commitments and to enable women’s access to education, especially for single female parents.

ELS/Cs were recognised as positive learning experiences, and service providers noted most refugee young people show enormous appreciation of school. Services reported that refugee clients prioritised English classes above other appointments.

##### Housing and transport services <sup>202</sup>

In addition to accessible, affordable housing, service providers identified the following facilitating factors:

- provision of settlement housing that enables access to other services, i.e., housing situated close to public transport networks, health care, schools, and settlement services
- housing situated close to communities of similar background, facilitating development of social networks and supports

<sup>200</sup> Consultation with and questionnaire responses from AMES, African Think Tank, refugee health nurses, The Clinic Footscray, Deer Park Paediatric Clinic, primary school nurses, secondary school nurses, Migrant Resource Centres, Colac Adult Community Education, Albanvale Community Kindergarten, Dorothy Carlton Preschool.

<sup>201</sup> Consultation with and questionnaire responses from refugee health nurses, African Think Tank, Central Gippsland Health Service, Colac Otway Shire Family Day Care, Dorothy Carlton Preschool.

<sup>202</sup> Consultation and questionnaire responses from AMES, Western Region Health Centre, City of Melbourne Family Services, Swan Hill District Hospital, Dandenong Refugee Health Clinic, MRCs, CMY.

- availability of education on using public transport and the provision of public transport tickets in the early stages of settlement
- help with transportation to appointments in the early resettlement phase
- access to community guides to explain public transport and to accompany families on initial trips.

#### Health services <sup>203</sup>

Service providers identified the following facilitating factors:

- client's education and previous experience of health services. Refugees coming from countries with organised health systems were reported to have a better understanding of the Victorian health system. In general, providers felt most refugee families were aware of the importance of health appointments
- provision of one-stop services to provide assessment, diagnostic testing, immunisations and treatment, reducing appointment numbers, travel time and appointment duplication, especially in relation to health screening in children
- accessible catch-up immunisation programs (e.g. during GP or MCH nurse consultations)
- patient-held records
- provision of antenatal classes focused on birthing in Australia and the provision of support for isolated pregnant women
- maintenance of efficient health service networks with optimal referral and communication systems.

#### Justice <sup>204</sup>

Service providers identified the following facilitating factors:<sup>205</sup>

- provision of police multicultural unit programs to develop links with communities
- professional development for police staff on cultural needs and refugee circumstances.

## Key barriers to service delivery

The following were found to be key barriers to optimal service delivery:

- differential settlement support for shp visa entrants compared to refugee visa entrants
- language
- understanding of Australian health systems by clients, despite the information provided during early settlement
- tension in prioritising settlement needs, exacerbated by the need to attend multiple services, poor communication between services, and multiple appointments
- duplications in assessments
- housing stress, financial stress and difficulty accessing transport
- the lack of services for clients who have been in Australia longer than five years.

<sup>203</sup> Consultation with and questionnaire responses from refugee health nurses, Western Region Health Centre, Dandenong Refugee Health Clinic, Brimbank Maternal and Child Health Nurses, Gippsland Women's Health. Service, Greater Shepparton Family Day Care.

<sup>204</sup> Consultations with Multicultural Liaison Unit Police Officers from all five regions of Victoria, March 2008.

<sup>205</sup> Consultations with and questionnaire responses from refugee health nurses, Western Region Health Centre, Goulburn Valley CHS, CMY, Noble Park ELS, The Clinic Footscray, Royal Melbourne Hospital, Brimbank Maternal and Child Health Nurses, Dandenong Refugee Health Clinic, East and Central African Communities of Victoria, MRCs.

Barriers to service delivery: detailed analysis of service provider views

Differential settlement support<sup>206</sup>

Differential settlement support for entrants with 202 visas was identified as a major gap in service delivery and a barrier to optimal health and settlement for SHP entrants.

SHP entrants rely on proposers to initiate service access. There is potential for relationship breakdown between the proposer and the new SHP entrants, and there are deficiencies in access to settlement services if the proposer does not effectively access services on their behalf. In some instances the proposer may be a recent entrant themselves and may not be able to:

- find a GP with an interest in refugee health
- understand whether the new entrant has had an adequate health assessment
- help with appointments or orientation due to their own work or family commitments
- help access housing or negotiate tenancy issues. Many agencies participating in our consultations identified overwhelming housing stress for SHP entrants
- identify the pathways into ELS/Cs
- understand the process for accessing kindergarten
- help the family they are sponsoring if that family moves to a different suburb
- afford to provide long term loans to the new entrants
- repay loans to fund the airfares to Australia of the new entrants.

Although proposers can access help from AMES, it is unclear how often this occurs, or whether AMES has the capacity to ensure that SHP entrants’ needs are addressed. No systematic evaluation of service use by SHP entrants has been identified.

Asylum seekers<sup>207</sup> have high needs and a lack of access to support in recent years. Historically this has related to their residency status, issues with work rights, Medicare access and reliance on limited funded services or pro bono services.

Language<sup>208</sup>

Language was identified as a major barrier to service delivery, with the following issues emphasised:

Clients

- not being able to read maps/directions
- inability to complete forms accurately and loss of confidentiality when relying on community guides to assist in this regard
- not understanding reminder calls or appointment letters/other letters sent to them (in English)
- relying on English-speaking friends to book appointments
- concern around confidentiality and use of known interpreters in small communities
- low levels of literacy and numeracy in their first language
- inability to participate in their children’s schooling
- assumptions that children will learn English more quickly by direct immersion in mainstream schooling.

<sup>206</sup> Consultation with and questionnaire responses from Goulburn Valley CHS, Noble Park ELS, The Smith Family.

<sup>207</sup> Consultation with and questionnaire responses from Noble Park ELS, Mercy Hospital for Women.

<sup>208</sup> Consultation with and questionnaire responses from refugee health nurses, Royal Melbourne Hospital, Inner South CHS, North Yarra CHS, Brimbank Maternal and Child Health nurses, MRCs, Monash Adolescent Inpatient Psychiatric Unit, primary school nurses, City of Melbourne Family Services, Women’s Health West, Werribee Family Day Care, Banyule City Council Family Day Care, Albanvale Community Kindergarten, Brimbank Library, Carlton Primary School, Ballarat Police, The Smith Family, Good Shepherd Youth and Family Services, Edmund Rice Refugee Services, City of Casey Youth Services, African Think Tank.

## Services

- not using translating and interpreting services, or not accessing the correct (language) interpreter
- not explaining interpreter confidentiality adequately
- providing letters, scripts and medication instructions in English, with this information being of limited use for people with low English print literacy
- lack of consideration for low literacy and/or numeracy in the first language
- failure to use bicultural workers
- lack of recognition that internet-based information is inappropriate for families without computers. Small group and outreach work was recognised as an effective way of delivering health education.

### *Understanding of Australian health and settlement systems by client*<sup>209</sup>

All agencies identified issues with new arrivals' understanding of Australian health and settlement systems as an important barrier to service delivery.

Specific problems reported for clients' understanding of services were:<sup>210</sup>

- difficulty finding a framework to understand life in Australia
- lack of awareness and understanding of services and their roles, and limited understanding of resources and how to access supports
- not knowing how to, or being confident to make appointments and not knowing to notify reception on arrival
- problems with attending services at specified times, with reliance on public transport identified as a significant contributor
- problems with competing circumstances causing missed appointments, e.g. Centrelink appointments may take priority over health visits
- difficulties making follow-up appointments.

### *Understanding of client issues by services*

Problems reported in services' understanding of refugee clients were:

- delayed appointments, which can be discouraging for clients and difficult for parents trying to manage many children in a waiting room
- lack of systems to ensure client follow-up, for example sending appointment letters in English, or expectations that clients will phone for appointments
- lack of appreciation of the logistics involved in attending appointments; such as negotiating public transport with multiple children, or children missing school due to appointments
- lack of recognition that reliance on public transport to access services further adds to the time required to attend these appointments;
- lack of awareness of cultural events that may affect service uptake (e.g. fasting during Ramadan)

<sup>209</sup> Questionnaire responses from refugee health nurses, Western Region Health Centre, Royal Melbourne Hospital, Dandenong Refugee Health Clinic, The Clinic Footscray, Deer Park GP Clinic, Eastern Specialist Children's Services, Colac Adult Community Education, Brimbank Maternal and Child Health, Warrnambool Police, Monash Adolescent Inpatient Psychiatric Unit, East and Central African Communities of Victoria, MRCs, EMC, CMY, Youth Connexions, City of Casey Youth Services, City of Dandenong Youth Services, Gippsland Women's Health Service, Women's Health West, Shepparton Family Care, Colac Otway Shire Family Day Care, Banyule City Council Family Day Care, Albanvale Community Kindergarten, Dorothy Carlton Preschool, Brimbank Library, Carlton Primary School, primary school nurses, secondary school nurses, The Smith Family, Good Shepherd Youth and Family Services, Edmund Rice Refugee Services, Jesuit Social Services.

<sup>210</sup> Questionnaire responses from Inner South CHS, North Yarra CHS, Swan Hill District Hospital, Alfred CAMHS, East and Central African Communities of Victoria, EMC, Edmund Rice Refugee Services, secondary school nurses.

- Underestimation of how difficult it is for clients to attend multiple appointments, for multiple services, for multiple family members during early settlement
- Poor awareness of referral pathways (to other services), appointment duplications or health undertakings.

#### *Duplication in assessments*

If a refugee family has ‘best practice settlement’ they will be linked with AMES case management, English Language School, VFST, the Refugee Health Nurse system and primary care screening. Someone in the family will almost certainly be referred on for specialist care. At each one of these points (illustrated in Figure A1), large amounts of demographic and/or health information will be collected. This information will not be shared between care providers and a copy is not usually given to the family, except by specialists, who are likely to be a late point of contact. This is a potential source of stress for families and is an inefficient use of families’ time, interpreter services and service delivery.

#### *Housing*<sup>211</sup>

During consultations the following issues were raised:

- accommodation instability and related financial stress affect the ability of clients to engage with services, education and the community
- newly arrived families are sometimes split between other families/households and across suburbs
- housing may be larger, cheaper and more accessible in outer areas, but this may be a long way from services. In the Eastern Region of metropolitan Melbourne refugees are settled over a large geographic area, presenting special challenges for service delivery.

#### *Transport*<sup>212</sup>

Issues relating to transport were identified as a major barrier to service delivery, specifically:

- client understanding and confidence in using public transport
- the cost of transport tickets for large families
- difficulty in using public transport with several young children
- effects on punctuality
- young children having to use public transport to access English language schools during crowded peak hour periods.

#### *English language classes for parents*<sup>213</sup>

The following issues were highlighted during consultations:

- Centrelink free child care support is only available to mothers during the IHSS 510 hours of English language learning. Some child care centres charge fees after this period and families may face unexpected bills
- the waiting lists for limited free child care positions connected to AMEP schools represent a significant barrier to English language proficiency for parents, especially mothers. This has previously been noted as a significant barrier to young women participating in the 510 hours of English tuition in a 2009 review of the AMEP program<sup>269</sup>
- poor client understanding of the extent and breadth of the 510 hours English teaching and other program supports available.

<sup>211</sup> Questionnaire responses from refugee health nurses, Royal Melbourne Hospital, EMC, Gippsland Women’s Health Service.

<sup>212</sup> Questionnaire responses from refugee health nurses, Western Region Health Centre, Dandenong Refugee Health Clinic, Deer Park Paediatric Clinic, Deer Park GP Clinic, The Clinic Footscray, Swan Hill District Hospital, Colac Otway Shire Family Day Care, Colac Adult Community Education, East and Central African Communities of Victoria, MRCs, EMC, The Smith Family, Good Shepherd Youth and Family Services, CMY, City of Casey Youth Services, primary school nurses, Women’s Health West, Brimbank Library.

<sup>213</sup> Consultation with AMEP, Footscray, March 2008.



### *Maternal and Child Health* <sup>214</sup>

One of the issues specified during consultations was that families are usually not linked with Maternal and Child Health nurses until after a child is born in Australia. This is a lost opportunity for developmental screening, parenting support and linkage to local communities, although attendance at MCH services may be difficult for newly arrived families with multiple children.

### *Child Care/Play Groups* <sup>215</sup>

Key issues raised in consultations included:

- difficulties understanding how these services function
- cultural differences and legalities around child care and child rearing.

### *Kindergartens* <sup>216</sup>

Consultations raised the following issues:

- kindergarten may not be a familiar concept, and there may be confusion about the differences between play groups, kindergarten and child care
- the enrolment process is complex; families need to pick up a form from kindergarten, complete it and take it to the local council. They are then sent a position-offer letter (in English) months before their child is to attend, and they are required to respond with an acceptance letter (in English)
- kindergarten hours (or days) may not be long enough to coincide with parent English language classes
- the lack of links between kindergartens and ELS/Cs represents a missed opportunity to improve ESL support for new arrivals.

### *Education* <sup>217</sup>

Consultations raised the following issues:

- limited years of education for both parents and children prior to arrival is a constraint on families' understanding and ability to participate in schooling in Victoria
- the distance families live from ELS/Cs is a particular issue for the Eastern region of metropolitan Melbourne
- there is a lack of parental understanding of the difference between mainstream and English language schools
- there is a relative lack of ESL support for students in the Catholic Education system
- the cost and access to school activities/education needs such as excursions, computers and books may be prohibitive
- developmental problems may be attributed to ESL issues and learning issues may be attributed to second (or subsequent) language acquisition
- there are issues relating to the use of cognitive assessment tools with recently arrived refugee students, including challenges around the timing of assessment for diagnosis of intellectual disability.

### *Out of School Hours Learning Support programs* <sup>218</sup>

Consultations raised the following issues:

- peer pressure from other refugee youth to attend/not attend Out of School Hours Learning Support programs
- parents' reluctance to support their teenagers' attendance at programs.

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<sup>214</sup> Consultation with Brimbank Maternal and Child Health nurses, June 2008.

<sup>215</sup> Questionnaire responses from City of Melbourne Family Services, primary school nurses, Swinburne Children's Centre.

<sup>216</sup> Questionnaire responses from Eastern Refugee Forum, Albanvale Community Kindergarten, Dorothy Carlton Preschool.

<sup>217</sup> Questionnaire responses from Collingwood ELS, Brunswick ELS, Western ELS, Werribee Family Day Care, Colac Adult Community Education, Albanvale Community Kindergarten, refugee health nurses, secondary school nurses.

<sup>218</sup> Questionnaire responses from CMY, Youth Connexions, Edmund Rice Refugee Services, City of Casey Youth Services.

Libraries<sup>219</sup>

Consultations raised the following issues:

- there is a perception that libraries are intimidating places
- under 18 year-olds initially require a parent or guardian as guarantor and are required to provide identification.

Health<sup>220</sup>

Consultations identified general barriers to health service delivery, including:

- different presentations of illness and ways of discussing illness
- cultural issues around mental health and mental health service use
- reluctance to disclose history, sometimes because of stigma (e.g. Tuberculosis contact history), suspicion of health care providers or treatments, concern at using an interpreter or concern about implications for visa status
- past experience of health service usage in country of origin (e.g., seeking help only when sick, having to pay for all treatments)
- difficulties with adhering to medical treatment if not acutely unwell
- difficulties in understanding culturally specific health assessment tools (e.g. pain rating scales)
- GP availability and waiting times for appointments
- insufficient communication and referral between medical and other health services
- a lack of specific services for young people, particularly outreach services for early intervention rather than crisis response strategies
- inflexible and inappropriate service system expectations. Service age limits (e.g. only seeing young people aged under 18 years) were identified as a particular issue; providers felt increased flexibility would improve continuity of care for this group.

Barriers to refugee health assessments

Consultations identified specific barriers to refugee health assessments, including:<sup>221</sup>

- confusion over catch-up immunisations
- unfunded vaccines
- lack of a central immunisation register for those aged over 7 years
- lack of a client held medical and immunisation record to facilitate information transfer between services
- lack of access to tuberculosis (TB) screening for children in primary care, and issues with provider understanding of TB screening in children (and interpretation of results)
- issues for specialists with accessing tests done in primary care<sup>222</sup>
- parallel systems for Health Undertakings and other health screening
- separation of mental and physical health screening
- Medicare billing issues: only the first three tests ordered in primary care are Medicare billed, meaning either the pathology service bears the cost or bills are sent to families

<sup>219</sup> Questionnaire response from Brimbank Libraries.

<sup>220</sup> AMES, Western Region Health Centre, Royal Melbourne Hospital, Dandenong Refugee Health Clinic, Deer Park Paediatric Clinic, The Clinic Footscray, Monash Adolescent Inpatient Psychiatric Unit, Alfred CAMHS, East and Central African Communities of Victoria, refugee health nurses, MRCs, EMC, New Hope Foundation, City of Melbourne Family Services, Noble Park ELS, Immigrant Women’s Domestic Violence Services, Swinburne Children’s Centre, Edmund Rice Refugee Services, secondary school nurses, primary school nurses.

<sup>221</sup> Questionnaire responses from refugee health nurses, Goulburn Valley CHS, North Yarra CHS, Moreland CHS; consultation with Youth health nurses, immigrant health paediatricians, refugee health nurses.

- lack of access or the prohibitive expense of some medications in primary care<sup>222</sup>
- lack of access to public child and youth mental health services
- the need for combined primary and specialist level care. Despite primary care screening, many children require specialist input for management of conditions identified at the time of the initial screening. Unlike other screening systems where only a small proportion of people are referred, a very large proportion and sometimes the majority need referral.

Post-arrival health screening practice has evolved based on an adult service model using one-to-one care. As children make up half the Humanitarian intake and all family members have health, education and other settlement needs, family-based service delivery models may be more appropriate. Consideration should be given to family based models of post-arrival health screening that include both primary care and specialist health providers, based in community settings.

### **Barriers to service usage: community views**

There is limited published information on the views of refugee communities about health services in Victoria.

An excellent 2008 study of cultural competence in community health services in Victoria<sup>296</sup> included nine community focus groups of adults of different (targeted) ethnic origins<sup>223</sup> as well as interviews with 50 service providers. Four themes emerged from the focus groups and interviews, namely:

- service provision is not needs-based and the responsibility to fill gaps is unclear and confronting
- available services are underutilised
- there are issues with interpreter services
- service delivery is duplicated and has gaps.

The study found that services adopted a generalist approach and only one in 10 services developed programs based on findings from consultations with CALD communities. The most pressing areas of need identified by focus group participants included maternal and child health services, parenting support, dental services, violence and domestic violence, and the safety of children in public housing. Other issues of concern included discrimination, drug and alcohol use, and access to and understanding of the legal system.

Focus group participants identified the following reasons for poor interpreter service usage: client confusion about cost, poorly coordinated bookings, provider indifference, differential access to information for clients (depending on visa status), and interpersonal issues with interpreters (related to communication between the interpreter and client).<sup>296</sup> Participants preferred to rely on family members for most consultations and children were identified as the most frequently used interpreters. Face-to-face interpreting was preferred to phone interpreting where a professional interpreter was required, and specific gender interpreters were considered essential. Other general factors in service underutilisation identified by focus group participants were a lack of translated information about health services, schools and housing, and a lack of information about rights and entitlements.

A 2007 study of 126 adults in Melbourne from the Horn of Africa found that difficulties with language and the availability of interpreters were the biggest barriers to accessing health services.<sup>297</sup> An earlier study of 199 East African children at the Royal Children's Hospital in 2001 asked parents to identify factors that would facilitate their access to health services.<sup>28</sup> Their responses included: availability of interpreters (26%), information on health services (23%), health services being closer to home (19%), health providers having better understanding of cultural needs (18%), health providers speaking the same language (14%), and more translated health information (12%).

The issues identified in these studies have all been emphasised in consultations for this report.

<sup>222</sup> This situation has changed since the time of writing, with PBS approval of several anti-parasite medications.

<sup>223</sup> The study included Afghani, Cambodian, Sudanese, Croatian, Chile, Vietnamese, Iraqi, Bosnians, and East Timorese focus groups.

# Appendix B: Questionnaire respondents

Role/Organisation	Location
Adolescent Inpatient Psychiatric Unit, Monash Medical Centre	Clayton
Adult Community Education, Otway Community College	Colac
Adult Multicultural Education Service	South East Region Team
Adult Multicultural Education Service	West Region Team
Albanvale Community Kindergarten	Albanvale
Asylum Seekers Centre	Dandenong
Brimbank Libraries	Sunshine
Carlton Primary School	Carlton
Centre for Multicultural Youth Issues	Carlton
Child and Adolescent Mental Health Services, Alfred Hospital	Moorabbin
Community Health Service, Inner South	South Melbourne
Community Health Service, Central Gippsland	Sale
Community Health Service, Goulburn Valley	Shepparton
Community Health Service, Moreland	Coburg
Community Health Service, North Yarra	Fitzroy
Department of Human Services, Disability Services	Geelong
Dorothy Carlton Preschool	North Sunshine
East and Central African Communities of Victoria	Dandenong
East and Central African Communities of Victoria	Prahran
Ecumenical Migration Centre (2 respondents)	Fitzroy
Edmund Rice Refugee Services	St Albans
English Language Centre	Shepparton
English Language Centre	Brunswick
English Language School	Collingwood
English Language School	Noble Park
English Language School	Braybrook
Family Day Care	Shepparton

## Role/Organisation

## Location

Family Day Care	Banyule City Council
Family Day Care (2 respondents)	Shepparton
Family Day Care	Colac
Family Day Care	Werribee
Family Services, City of Melbourne	Carlton
Free Kinder Association	Richmond
General Practitioner	Deer Park
General Practitioner	Footscray
General Practitioner, Western Region Health Centre	Footscray
Good Shepherd Youth and Family Services (2 respondents)	St Albans
Health Promotion Department, Swan Hill District Hospital	Swan Hill
Immigrant Women's Domestic Violence Service	Melbourne
Jesuit Social Services	Richmond
Maternal and Child Health (2 respondents)	Sunshine
Mercy Hospital for Women	Heidelberg
Migrant Resource Centre, North West (4 respondents)	St Albans
Multicultural Youth Worker, City of Casey Youth Services	City of Casey
New Hope Migrant and Refugee Centre	Oakleigh
Paediatrician, Refugee Health Clinic, Dandenong Hospital	Dandenong
Paediatrician, Western Hospital, ISIS Primary Care	Deer Park
Police Multicultural Liaison Officer	Ballarat
Police Multicultural Liaison Officer	Warrnambool
Preschool Field Officer	Sunshine
Primary School Nursing (3 respondents)	Box Hill
Primary School Nursing	Footscray
Primary School Nursing	Mildura
Primary School Nursing (5 respondents)	Preston
Primary School Nursing	Shepparton
Refugee Health Nurse, Dianella Community Health Service	Broadmeadows
Refugee Health Nurse, Doutta Galla Community Health Service	Kensington
Refugee Health Nurse, ISIS Primary Care	Hoppers Crossing
Refugee Health Nurse, ISIS Primary Care	Sunshine
Refugee Health Nurse, Western Region Health Centre	Footscray

Role/Organisation	Location
Secondary School Nursing	Bendigo
Secondary School Nursing	Melbourne
Secondary School Nursing	Box Hill
Secondary School Nursing	Sunbury Downs
Secondary School Nursing	Sale
Secondary School Nursing	Korumburra, Mirboo North
Secondary School Nursing	Warragul
Specialist Children’s Services	Box Hill
Spectrum Migrant Resource Centre	Preston
Swinburne Children’s Centre	Croydon
The Smith Family (2 respondents)	Dandenong
The Smith Family	Footscray
Victorian Infectious Disease Service, Royal Melbourne Hospital	Melbourne
Women’s Health Nurse, Western Region Health Centre	Footscray
Women’s Health Service, Gippsland	Sale
Women’s Health West (2 respondents)	Footscray
Youth Connexions, Whitehorse Refugee and Migrant Youth Program	Box Hill
Youth Services	Greater Dandenong



# Appendix C: Direct consultations

## **Adult Migrant Education Program management**

Footscray, February 2008

## **Adult Multicultural Education Service team leaders**

North West Region and Eastern Region, Footscray, Noble Park, May 2008

## **African Think Tank members**

Parkville, May and October 2008

## **Asylum Seekers Resource Centre staff**

Dandenong, May 2008

## **Barwon Refugee Health Clinic staff**

Geelong, September 2008

## **Catholic Education Office staff**

Flemington, October 2008

## **Community Health Nurse**

Corio Community Health Service, Corio, June 2008

## **Community Health Service staff**

Logan and Beaudesert, October 2008

## **Dandenong Hospital Refugee Clinic staff**

Dandenong, August 2008

## **Deer Park Refugee Clinic staff, ISIS Primary Care**

Deer Park, July 2008

## **Eastern and Central African Communities of Victoria staff**

Prahran, February 2008

## **Eastern Region Refugee Health forum**

Representatives from Primary Health Care, Regional Manager AMES Settlement, Inclusion Support Facilitators, Preschool Field Officers, School Development Officer – ESL, Department of Education and Early Childhood Development (DEECD) - Policy, Early Years Service Branch, Alcohol and Drug Regional Coordinator. Box Hill, April 2008

## **English Language Centre staff**

Geelong, Ballarat, Shepparton, Mildura. August and October 2008.

## **English Language School staff**

Western, Noble Park, Blackburn, Collingwood. April and May 2008.

## **Eritrean Church staff**

Collingwood, February 2008

## **Family and Reproductive Rights Program workers**

Royal Women's Hospital, Mercy Hospital for Women, Women's Health West, Western Region Health Centre, Southern Health. Parkville, Footscray, Dandenong. April and May 2008

**Free Kinder Association Manager**

Richmond, September 2008

**Hobart Hospital staff**

Hobart, September 2008

**Immigrant Health Service staff, Royal Children's Hospital**

Parkville, May 2008

**Maternal and Child Health Nurses**

Sunshine, June 2008

**Migrant Health Service staff**

Adelaide, September 2008

**Migrant Resource Centre Staff**

St Albans, May 2008

**Migrant Screening Clinic staff**

Western Hospital, Footscray, June 2008

**Northern Territory Communicable Diseases Unit staff**

Darwin, September 2008

**NSW Refugee Health Service staff**

Sydney, July 2008

**Queensland Integrated Refugee Community Health Clinic (QIRCH) staff**

Brisbane, August 2008

**Refugee Clinic staff, Princess Margaret Hospital**

Perth, June 2008

**Refugee Health Clinic staff**

Newcastle, September 2008

**Refugee Health Clinic staff, Westmead Children's Hospital**

Sydney, July 2008

**Refugee Health Nurses**

Doutta Galla Community Health Service, Western Region Health Centre, Darebin Community Health Centre, Dandenong Community Health Centre, Goulburn Valley Community Health Service, Ballarat Community Health Centre, South West Health. Kensington, Footscray, Preston, Dandenong, Shepparton, Ballarat, Warrnambool. April and May 2008

**Refugee Health Service staff**

Coffs Harbour, August 2008

**Refugee Minor Program staff**

Western Region, Footscray, May 2008

**Sydney Children's Hospital staff**

Sydney, July 2008



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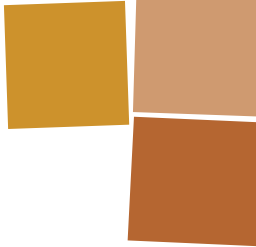


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