TRANSCRIPT

LEGISLATIVE ASSEMBLY LEGAL AND SOCIAL ISSUES COMMITTEE

Inquiry into Early Childhood Engagement of CALD Communities

Melbourne—Monday, 28 October 2019

MEMBERS

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WITNESSES

Professor Stephanie Brown, and

Dr Elisha Riggs, Intergenerational Health Research Group, Murdoch Children's Research Institute.

The CHAIR: Good morning. I declare open the public hearings for the Legal and Social Issues Committee's Inquiry into Early Childhood Engagement of Culturally and Linguistically Diverse Communities. All mobile phones should be turned to silent at this point. I welcome Dr Elisha Riggs of the Intergenerational Health Research Group from Murdoch Children's Research Institute and also Professor Stephanie Brown. All evidence taken by this Committee is protected by parliamentary privilege. Therefore you are protected against any action for what you say here today, but if you go outside and repeat the same things, including on social media, those comments may not be protected by this privilege. All evidence given today is being recorded by Hansard to my right. You will be provided with a proof version of the transcript for you to check as soon as available. Verified transcripts, PowerPoint presentations and handouts will be placed on the Committee's website as soon as possible. I now invite you to proceed with a brief 5 or 10-minute opening statement to the Committee, which will then be followed by questions from the Committee. Welcome.

Dr RIGGS: Good morning. I would like to thank the Committee for inviting us to speak today, and I would also like to acknowledge the traditional custodians of the land on which we are meeting and pay my respect to elders past, present and future.

As we just said, I am Elisha Riggs, from the Intergenerational Health Research Group at the Murdoch Children's Research Institute and I am here with Professor Stephanie Brown, who heads up our research group. Our submission focuses on the health and wellbeing of refugee and migrant children, families and communities and their engagement in particular with health services related to pregnancy and early childhood in Victoria. Our work is with refugee communities as a culturally and linguistically diverse population that experiences particular hardships, meaning that they are vulnerable to poor outcomes. I will be drawing from the research of our Intergenerational Health Research Group at MCRI where our vision is health, wellbeing and equity for mothers, fathers, children and families. Our research with refugee and migrant communities is all conducted in partnership with the Victorian Foundation for Survivors of Torture —Foundation House.

Today I will provide an overview of some aspects from our submission, including why our research focuses on pregnancy and early childhood, the challenges for identifying refugee background people in our health datasets, some of the gaps where families may not be engaging with services and evidence about why this may be occurring, a best practice example of what is working for families and why community engagement is necessary for ways forward.

Our focus is at the very start of life, during pregnancy, and this is important because over a third of all women giving birth in Victoria were born overseas, the majority from countries where English is not the main language. Approximately 10 per cent of all births at major Melbourne metropolitan maternity hospitals are to women of refugee background. Our submission cites several recent studies demonstrating that women of refugee background are more likely to experience pregnancy complications and poorer birth outcomes, including stillbirth, neonatal death and low birthweight.

Accurate ascertainment of refugee background in Victorian routinely collected hospital data is essential to understanding what lies behind these poorer outcomes and disparities, and how Victorian health services need to respond. However, identifying people of refugee background is not straightforward. There is no single 'refugee' visa in Australia. In addition, people may choose not to identify as a refugee once issued with protection visas, and there are sensitivities in asking people questions about migration background for administrative purposes. People may be reluctant to disclose their migration history for fear of how this information may be used. Hence, it is problematic for services to determine 'visa status' and use of this information to identify families of refugee background is likely to result in under-ascertainment. The inability to identify mothers and children of refugee background in hospital, maternal and child health and other health service datasets limits the capacity of services to plan, implement and evaluate programs designed to improve outcomes for children of refugee background.

I will return to the importance of pregnancy. Antenatal care is universally accepted as a key preventive health strategy for optimal health for pregnant women and newborn babies. Maternal physical and psychological health, social wellbeing and exposure to stressful events and social health issues, such as housing insecurity and intimate partner violence, can influence health outcomes of both mothers and babies. Maternal medical conditions and complications during pregnancy pose risks to women and their unborn baby. Timely access to antenatal care during the first trimester of pregnancy and ongoing engagement with antenatal care throughout pregnancy are essential to safeguard the health of mothers and their babies.

The trauma of the refugee experience and challenges of settlement in a new country put families of refugee background at increased risk of poor outcomes. The psychological and social impacts of torture and other traumatic events have wideranging impacts over the short and long term and can be experienced intergenerationally. Mental and physical health issues can persist for many years post-settlement and are influenced by stress and socio-economic factors. For example, the loss of family members through death, detention or separation is common and has significant negative impacts on mental health and family functioning.

In Victoria it is mandatory for all births to be notified to the universal maternal and child health service closest to where the mother resides. However, there are no publicly available data on the participation of refugee and migrant children in the Victorian maternal and child health service. A Victorian study explored the engagement of refugee-background families with Victorian maternal and child health services. The study spoke to 87 women who had had a total between them of 249 children. There were a range of backgrounds: Karen, who are from Burma; Iraqi; Assyrian-Chaldean, which is an ethnic group from Iraq and Syria; Lebanese; South Sudanese; and Bhutanese women. The study found that most mothers reported good initial engagement with the maternal and child health service through the hospital birth notification system and being automatically connected to a maternal and child health nurse by receiving a first home visit when they went home with their baby from the hospital. However, several mothers reported that it was difficult for them to engage with the service when they gave birth overseas and arrived in Australia with young infants and children. Mothers reported that they were not told about the service on arrival and did not understand what the service offered, particularly given it is a preventative and early detection service rather than a service for unwell children. This presented a missed opportunity by settlement services to automatically introduce newly arrived families with young children to the maternal and child health service and all it has to offer.

In this study some mothers were not confident using telephones due to their limited English. In turn this made booking or changing appointments challenging because women were concerned that they would not be understood, especially if they were required to leave voicemail messages. Our research indicates that poor access to information is a key factor in families' engagement with services and understanding of professional advice. Low health literacy explains why families from some refugee and migrant backgrounds face difficulties accessing and understanding information about pregnancy care and early childhood services, including early intervention services and preschool. In this study that I was referring to some mothers reported a desire to learn English but were often unable to due to child-rearing roles, and in one example of positive engagement, group-based visits whereby a maternal and child health nurse visited existing supported playgroups facilitated by a bicultural worker were found to be an effective way of engaging families and building trust between communities and maternal and child health services and therefore referral to other services if required.

Difficulties associated with communication are thought to be a major contribution to adverse outcomes experienced by refugee-background families. Our research has demonstrated in the maternity and early childhood health context that very few families of refugee background reported access to onsite interpreters. Men commonly interpreted for their wives. There was minimal professional interpreting support for imaging and pathology screening appointments or during labour and childbirth. Health professionals noted challenges in negotiating interpreting services when men were insistent on providing language support for their wives and difficulties in managing interpreter-mediated visits with standard appointment times. Failure to engage interpreters was apparent even when accredited interpreters were available and at no cost to the client or provider.

We are currently supporting local partnerships to implement a program called Group Pregnancy Care, which is an innovative model of multidisciplinary trauma-informed antenatal care for families of refugee background. It

involves collaboration between public maternity hospitals, maternal and child health services and a refugee settlement service. The program was initially implemented in Werribee with the Karen community, who are from Burma, and is now operating at a second site with the Assyrian-Chaldean community—they are from Iraq and Syria—living in Melbourne's northern suburbs. We have recently secured funding to expand this to the South Sudanese and Iraqi Muslim communities. In our model of Group Pregnancy Care women are invited to participate in a community-based group program designed to overcome isolation and provide opportunities for learning about pregnancy and pregnancy care as well as other settlement issues of concern to them. In addition they are also able to access pregnancy check-ups with a midwife and interpreter in the same venue. In an evaluation we did the findings demonstrated that the program is enabling women of refugee background to feel culturally safe, empowered and confident to learn about pregnancy and childbirth in a group setting, and we found that the program was supporting women to develop trusting relationships with a team of health professionals. Women valued being able to communicate with health professionals in their preferred language, they learned about where and how to seek help should they need it, and they particularly valued the role played by the bicultural worker in the team.

A rigorous four-year evaluation is currently underway and due for completion at the end of 2020. The outcomes that we are looking for are access and engagement with care, improvement in health literacy and the strengthening of social connections to improve social inclusion. The evaluation will also explore what it takes for our universal health systems to support staff to provide trauma-informed approaches to care. Trauma-informed approaches are based on recognising when traumatic events in people's lives are the cause of ongoing difficulties—what is known as complex trauma, which affects individuals, families and communities. Such approaches are based on principles of promoting safety, justice, dignity and focusing on strengths. Trauma-informed services provide a safe environment for survivors of traumatic experiences, integrate knowledge about trauma into their policies, procedures and practices, and actively resist retraumatisation. Trauma-informed interventions emphasise empowerment and are generally aimed at developing skills such as problem solving, communication and social skills, creating and facilitating social connections, and participation in service planning.

Group Pregnancy Care is an example of an integrated model of care situated in Victoria's universal health system using a trauma-informed approach that has demonstrated that a multidisciplinary team, including a bicultural staff member, enables culturally safe care whereby women attend early in pregnancy and remain engaged with care postnatally.

Another critical component of children's engagement with services is a lack of a focus on fathers. Fathers of migrant and refugee backgrounds are particularly vulnerable to poor mental health in the early years of parenting, yet fathers are rarely asked about their own health needs by maternity or early childhood services, and health professionals involved in the care of migrant and refugee families during pregnancy and the early years of parenting are unsure about what they can do to support fathers. A major barrier to improving health system capacity to address the needs of fathers is the lack of research evidence to inform service redesign.

I would like to finish by commenting on the importance of community engagement. In our program of refugee and migrant research, community advisory groups have played a critical role in the engagement of both women and men throughout all stages of the research process. The advisory groups, established by community and language-matched bicultural staff, demonstrated that inclusive research strategies that address diversity of and within communities are necessary to obtain the evidence required to address health inequalities in vulnerable populations.

Understanding how to engage refugee and migrant families in discussions about service delivery requires prioritisation, additional resources and time. Our submission has outlined several recommendations pertaining to three key areas: partnership and community engagement, the health workforce and data and research. In particular we highlight the need for recurrent funding to train, employ and build the capacity of people from refugee and migrant backgrounds—our bicultural workforce—to develop, deliver and evaluate programs within their communities. Alongside this, we call for the development of a standard for services to provide trauma-informed care and guidelines for implementation, including professional development to support the capacity of health professionals to work effectively with bicultural workers to engage and support families from refugee and migrant backgrounds. Thank you. We will take questions together.

The CHAIR: Thank you very much for your presentation. You have just spoken about the importance of a bicultural and culturally responsive workforce, and we heard during last week's public hearing as well of the importance of having a much more culturally diverse workforce reflecting the community, and that it is something that needs to happen. But what might the Victorian Government and local government do to promote this and promote and increase it in their workforce?

Dr RIGGS: What might the Victorian Government do? I think, as I said, it needs to be something that is prioritised, so the health service system needs to want to be able to do this and the services themselves need to be supported to attract, retain and provide training for the staff but also existing staff on how to work together. What we have found from Group Pregnancy Care, which involves midwives and maternal and child health nurses and a bicultural worker as well as an interpreter, is that they make a fantastic team working together, and it is really the bicultural worker who is enabling women to find out about the program, access the program and remain engaged with the program. Her role has been to introduce the services, introduce the professional clinical staff and explain what they do, what they can offer and what they can provide. Their role has really been about developing trust with health professionals and services and an understanding of what the services can offer.

Prof. BROWN: Maybe if I could add to that, just in terms of the question about what the Victorian Government could do, I think the parallel is actually with what has happened in Aboriginal health where there has been a State commitment and a Federal commitment to building the Aboriginal workforce. That is across all areas of health and social care, so a big push to train Aboriginal doctors, but before that a big push to train and support Aboriginal health workers with a very different role. I think we are at that stage in terms of the bicultural workforce. I mean, obviously people are going to come through the system and get into medical training and nursing training over time, but at the moment, especially with the newer groups such as the Karen, there are really skilled bicultural workers that have got a lot to offer but we are not systematically funding and training and supporting them and supporting services to work with them.

What is really clear in the research program is the stand-out examples where those partnerships are working. The Healthy Happy Beginnings project, which was the start of Group Pregnancy Care, is one such stand-out example. What needs to happen is that needs to become a systems approach, not an isolated result of particular services nutting out that this is what needs to happen. I think that would be my answer.

The CHAIR: Thank you. Just in relation to data collection, you spoke about the importance of data collection, and we heard that from the previous presenter as well. Just in relation to data collection, what is the importance of monitoring and analysing this collection? Would you be able to just elaborate a little bit more the importance of the data collection?

Prof. BROWN: Around how we go about identifying people?

The CHAIR: Yes.

Prof. BROWN: We have done as a research group some work in this area. Because the health datasets that we look at did not collect information around refugee status we have found it incredibly valuable to work with four data items that can operate as a proxy for identifying someone's refugee background. Those items are country of birth, year of arrival, whether or not someone needs an interpreter and their preferred language. So when we use those four data items together in consultation with migration settlement reports, we can look at the waves of migration and see who is likely to have been of refugee background at that time of migration. That is the way we have approached it from a research evaluation and monitoring sense.

The CHAIR: And I suppose, just the next question, what is required from the Victorian Government to address these issues? What are some of the suggestions that you may be able to provide Government?

Dr RIGGS: We know when we look at some of the health datasets that year of arrival was never collected. We did a lot of advocacy around that to actually get that put into datasets, so that has been one thing that could be rolled out, actually asking people, 'If you were born overseas, what year did you arrive?'—collect that data.

Prof. BROWN: And to adopt that as a standard in all the administrative datasets because it is the best that we can do. There is really not a better way because, as Elisha was elaborating, the visa status will not clarify

that and people make their own choices about whether or not they want to see themselves as of refugee background.

The CHAIR: Just in relation to your submission, it recommends a review of NDIS provision for CALD families. What does the research indicate is most important to support these children and their families?

Dr RIGGS: We would have to advise the Committee to speak to someone else from the Murdoch Children's Research Institute.

The CHAIR: Thank you. We will take that on note then. I just have one more question. Do you feel that there are adequate resources in this area, and if not, what are some of the recommendations to all levels of government? Or if yes, that is fine, but do you believe there are enough resources?

Prof. BROWN: I think just stepping through the three questions you have asked us, the first one was about the investment in bicultural workforce—obviously that needs greater investment. That is both in training and support for services to change their ways of working to actually integrate the role of a bicultural worker. Am I answering the question?

The CHAIR: Yes, you are.

Prof. BROWN: So that is one step. Changing the administrative datasets is also an urgent issue for any careful planning, so it is imperative that that occurs as well. When we look at the fact that a third of births are to women born overseas, the majority of them from countries where English is not the main language, and 10 per cent of the births in metropolitan hospitals in Melbourne are to women of refugee background who are dealing with the legacy of the trauma that they have experienced and that their families have experienced, as well as language and communication barriers, all of those things demand greater investment. I think it is understandable that the issue has crept up on government because it has been gradual, but it is certainly only likely to increase in future years. That needs to be addressed.

Mr TAK: I have come across a few migrants and refugees who are very skilled, very highly educated in their home country before reaching Australia. Have you seen through your work that our employment or our education systems have been able to recognise their education and their experience? Because sometimes gaining Australian experience before you can secure a professional job is difficult, I would say.

Prof. BROWN: We have seen that in our own staff, our own bicultural research staff. They are really highly qualified in their own country but working way below their skill level—nonetheless making really valuable contributions and doing important work, but definitely not recognising the skills that they bring to the Victorian and Australian community.

Mr TAK: Is that due to the assessment of their academics or their experience in their country, or because language is the barrier?

Prof. BROWN: I think it is recognition of the skills and qualifications, or lack of recognition, and the hurdles that people need to step through to have qualifications. It is seen that upgrading of qualifications to be relevant to the Australian community is just not possible for people who have recently arrived—all of the issues that have been referenced probably in the submission from Foundation House and ourselves in terms of the things that people are dealing with in their lives getting in the way of being able to undertake the sort of training that would enable them to—I am putting inverted commas around—'upgrade' their qualifications.

Dr RIGGS: People do want to arrive and start working, so there is that reliance on them to be getting an income, whether that is to support family here or to support family overseas. We hear a lot of the need to just be employed.

Ms SETTLE: It was really good to hear about the success of the group program, and that makes me interested: do you think that the way forward then is the targeted services? So obviously that group service works very well because of a sense of safety and community within it. So is the way forward to target services, or is it to bring the whole of the mainstream service up to scratch?

Dr RIGGS: I think we need a bit of both actually. Absolutely the mainstream service needs to come up to scratch as you say, but to enable newly arrived women—they do not have to be newly arrived, but when there are language barriers and issues around cultural safety and issues around trust with government services and other health services, creating that safety, creating those connections, is highly valuable. We found it works particularly well in pregnancy because you are coming together because you are pregnant. It is not like you are coming together because you have got some other background or some other issue.

There are a whole range of reasons why this program has been successful, and we are looking at the economics of it as well. So by bringing a group of women together with one interpreter at one time, is that a more cost-effective way of providing a service for a very strained public hospital? I guess my answer would be both, and it would be both for different reasons.

The CHAIR: Thank you very much for taking the time to present to us today. Your submission will be part of the final deliberations of the Committee before we hand the final report to Parliament next year with some strong recommendations. On behalf of the Committee, I would like to thank the Murdoch Children's Research Institute for all the work that you do. We truly appreciate it. Thank you.

Prof. BROWN: It is a pleasure.

Dr RIGGS: Thank you for your time.

Witnesses withdrew.