VICTORIAN PARLIAMENTARY INQUIRY INTO EARLY CHILDHOOD ENGAGEMENT OF CALD COMMUNITIES

Submission from the Melbourne Children’s Campus
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Table of Contents

1. Executive Summary and Recommendations ......................................................... 4
2. Refugee and Migrant Children and Families ....................................................... 7
3. Definitions ............................................................................................................. 8
4. Introduction .......................................................................................................... 9
   4.1 Refugee and migrant children and families ....................................................... 9
   4.2 The context of children’s health and development ........................................... 9
   4.3 Maternal and birth outcomes .......................................................................... 10
   4.4 Refugee and migrant children ......................................................................... 11
   4.5 Communication and access to information .................................................... 13
   4.6 Organisational change – an example of best practice ..................................... 14
   4.7 Children with disabilities ................................................................................ 15
6. What are the Knowledge and Practice Gaps? ...................................................... 19
   6.1 Ascertainment of refugee background ............................................................. 19
   6.2 Understanding the health and wellbeing of children of refugee background with a longitudinal follow-up of children/families ......................................................... 19
   6.3 Supporting the mental health of refugee and migrant fathers ......................... 20
   6.4 Trauma informed approaches to mainstream health care .............................. 20
   6.5 Community engagement ............................................................................... 21
7. Recommendations ................................................................................................. 22
   7.1 Engagement and partnership .......................................................................... 22
   7.2 Health workforce ............................................................................................ 22
   7.3 Research and data priorities ............................................................................ 23
8. References ............................................................................................................ 25
1. EXECUTIVE SUMMARY AND RECOMMENDATIONS

Australia is one of the most multicultural countries in the world, and Victoria home to an increasing number of families from low to middle income countries including families fleeing war, persecution and human rights abuses. Over a third of all women giving birth in Victoria are born overseas, the majority from countries where English is not the main language. Approximately 10% of all births at major Melbourne metropolitan maternity hospitals are to women of refugee background.

This submission focuses on refugee and migrant children, families and communities and their engagement with health services related to pregnancy and early childhood.

In particular, we have focused on:

- what is known about the health and wellbeing of refugee children and families
- what is working for children and families (based on current evidence)
- identified gaps where some families may not be engaging with services and evidence about reasons why this may be occurring
- implications for health services and ways forward

There is mounting evidence of disparities in maternal and child health outcomes for families of refugee background and some migrant communities. Despite this, there are major gaps in the research evidence regarding what works to engage refugee and migrant families in universal maternity and early childhood services that provide the foundation for a ‘healthy start to life’.

In this submission we summarise some of the available evidence on health disparities, identify evidence gaps, and highlight innovative Victorian programs that are seeking to build stronger evidence to guide policy and practice.

Drawing on our experiences of working collaboratively with Victorian refugee and migrant communities, public hospitals, Maternal and Child Health (MCH) Services and other community agencies, we have made a number of recommendations for consideration by the Parliamentary Inquiry. These are included below and at the end of the submission.
Recommendations

We recommend:

1. **Engagement and partnership**
   - The Victoria government make funding available to enable community and stakeholder engagement to co-design all planning, implementation and evaluation of programs, services and research.
   - Investments are made to support innovation in integrated models of care involving local partnerships and multidisciplinary teams.
   - Recurrent funding to support strengths-based approaches for community capacity building, supporting health literacy and social inclusion to enable the engagement of refugee and migrant families in services and programs.
   - Linkages between settlement services and other ethnic agencies to streamline engagement of newly arrived families into early childhood services including the MCH service and playgroups. Flexible programs to support mothers of young children to learn English are also required.

2. **Health workforce**
   - Recurrent funding to train, employ and build the capacity of people from refugee and migrant communities (bicultural workforce) to develop, deliver and evaluate programs within their communities.
   - The Victorian Government adopt funding models that ensure that all state-funded services are able to engage professional interpreters and translators when required.
   - Ongoing professional development for health professionals to facilitate effective implementation of trauma informed approaches, including support to facilitate effective use and integration of interpreters and bicultural workers into multidisciplinary health and social care teams.
   - The Victorian Government commission the development of a standard for services to provide trauma-informed care and practice and guidelines for implementation, including professional development to support the capacity of health professionals to work effectively with bicultural workers.
   - Organisational change to shift service systems to be culturally sensitive and responsive, to enable the service system to respond flexibly to community needs. This requires funding and staffing strategies that enable services to be reconfigured. Further, the workforce requires time, resources and support for community engagement activities.
3. Research and data priorities

- Active implementation of strategies to improve ascertainment of migrant and refugee background in Victorian health and other administrative data sets, specifically to collect and publish data that indicates the accessibility and responsiveness of services to people of refugee backgrounds.

- The Victorian Government require state funded services (including public maternity hospitals, maternal and child health services, early parenting centres, and other early childhood services) to collect, analyse and publicly report data for every child and family of refugee and migrant background on:
  
  o maternal and paternal country of birth, preferred language and requirement for an interpreter
  
  o provision of interpreters to clients whose preferred language is other than English (including in antenatal care, childbirth, early childhood settings)
  
  o timeliness and nature of engagement in universal service platforms (including participation in antenatal care and maternal and child health services)
  
  o maternal, paternal and child health outcomes (e.g. birth outcomes, key developmental outcomes).

- A major review of NDIS provision for CALD families focusing on the early identification of children with developmental disabilities, the provision of information about Early Childhood Intervention and NDIS services in community languages, and the provision of advocacy and interpreter support to assist CALD families to access and navigate the NDIS. While some of these changes need to be made by the NDIS itself, state governments continue to play a significant role and share responsibility with the federal government.

- Investments in longitudinal research to investigate the health, wellbeing and developmental outcomes of migrant and refugee children and young people in Victoria.

- Investments in health services research that evaluates innovative strategies to improve outcomes for migrant and refugee children, young people and families, focusing on strategies to promote access, improve communication, health literacy and social inclusion.

- Investment in working with refugee and migrant communities (and agencies working with these communities) to support co-development of measures of engagement and health and wellbeing outcomes that are meaningful and appropriate for children and young people of refugee and migrant backgrounds.
2. REFUGEE AND MIGRANT CHILDREN AND FAMILIES

Our submission focuses on refugee and migrant children, families and communities and their engagement with health services related to pregnancy and early childhood.

Research on the Melbourne Children’s campus has a particular focus on the health and wellbeing of refugee children and families and their experiences of engaging with health care in Victoria.

The trauma of the refugee experience and challenges of settlement in a new country puts families of refugee background at increased risk of poor outcomes. We acknowledge the diversity within and between refugee and migrant communities, and the wisdom and resilience of these families.¹

Our submission focuses on:

- what is known about the health and wellbeing of refugee children and families
- what is working for children and families (based on current evidence)
- identified gaps where some families may not be engaging with services and evidence about reasons why this may be occurring
- implications for health services and ways forward

¹ We have only used the term CALD when cited in the literature
Defining the term ‘refugee’ is complex because of the mixture of its complex legal basis.

Broadly, a refugee is someone who is outside their country and cannot return to it owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion [1]. An asylum seeker is someone who is seeking to be recognised as a refugee and is awaiting the outcome of their protection claims. In this submission we use the term “people from refugee backgrounds” to refer to those who: have arrived in Australia with, or who have subsequently been granted, permanent or temporary ‘humanitarian’ visas mainly because they are recognised as being refugees; people seeking asylum; and those who come from refugee backgrounds who may have another visa type. Where the immigration status a person currently has or had on entry to Australia is significant to service eligibility this is noted.
4. INTRODUCTION

4.1 Refugee and migrant children and families

Australia is one of the most multicultural countries in the world, and Victoria home to an increasing number of families from low to middle income countries including families fleeing war, persecution and human rights abuses. Over a third of all women giving birth in Victoria are born overseas, the majority from countries where English is not the main language. Using maternal country of birth data, approximately 10% of all births at major Melbourne metropolitan maternity hospitals are to women of refugee background [2, 3].

4.2 The context of children’s health and development

Children’s health and development is driven by the context in which they live – their family, community, and neighbourhood. These settings are inter-related and interdependent and set within a wider social, economic, cultural and political context. The socio-ecological model (See Figure 1, Bronfenbrenner, 1986) is a useful framework for conceptualising the multiple levels of influence in the lives of children of migrant and refugee background and their parents. Few studies examine child and parent experiences over time, or incorporate the multiple socio-ecological domains known to influence outcomes. For example, children’s health, developmental and behavioural outcomes will be influenced by pregnancy and birth factors, the parent–child relationship, family cohesion, financial hardship, neighbourhood safety, social discrimination, and educational opportunities.

Figure 1 Socio-ecological model of child health
4.3 Maternal and birth outcomes

The greatest potential to reduce health inequalities across the life course lies in giving children a healthy start to life [4]. A growing body of evidence shows that brain development is highly sensitive to external influences in utero and in early childhood, with potential for lifelong effects [5]. 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, such as gestational diabetes and hypertension, pose risks to women and to 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 babies, and to give children the best start to life.

There are major gaps in evidence regarding the timeliness and adequacy of antenatal care received by women of migrant and refugee backgrounds in Victoria. Two recent studies suggest that South Asian women and women arriving in Australia as humanitarian entrants are 2-3 times more likely to have a stillbirth [6, 7]. An earlier analysis of Victorian perinatal data identified that women of refugee background had consistently higher perinatal mortality rates per 1000 births compared to all Victorian women over the period 1999-2006. In 2006, the perinatal mortality (adjusted to exclude late terminations) for women likely to be of refugee background was 11.0, compared with 7.9 for all Victorian women [8].

The Victorian Refugee Status report - which aggregated data for women from a range of humanitarian entrant countries - found no evidence that women of refugee background were more likely to have a baby born preterm or with a low birthweight [8]. Other Victorian research focusing on East African immigrants has shown that as a group, East African women have elevated odds of preterm birth, low birthweight and small for gestational age infants. Individual country of birth analyses revealed significant variations, with Eritrean, Ethiopian and South Sudanese women all having elevated odds of preterm birth and low birthweight. Somali women were the only group not to have a higher risk of preterm birth or low birthweight [9].
Other research investigating pregnancy outcomes for Somali women confirmed this finding, but identified that Somali women have an excess risk of stillbirth and caesarean section [10].

**The challenge is to understand what lies behind these disparities, and how Victorian health services need to respond.**

Important gaps in knowledge include:

- the extent to which women requiring an interpreter are able to access appropriate language services during antenatal consultations, labour and birth and the postnatal hospital stay [11]
- the prevalence of intimate partner violence among refugee and migrant communities and the role that this may be playing in adverse birth outcomes and early childhood development [12, 13]
- what health services can do to overcome barriers to communication, increase women and families’ understanding of Australian maternity and early childhood health care, and respond to the issues affecting women’s health and wellbeing, including family violence and ongoing trauma associated with the refugee experience.

Accurate ascertainment of migrant and refugee background in Victorian hospital level and routinely collected perinatal data is essential to this effort. The Intergenerational Health research group at MCRI is currently undertaking a project drawing on 12 years of Victorian perinatal data to provide more current evidence regarding disparities in birth outcomes comparing the perinatal outcomes of women of refugee background with those of Australian born women.

### 4.4 Refugee and migrant children

The social context of children’s lives is critical to understanding their health and wellbeing and engagement with services [14]. Our research indicates that **children and families of refugee and migrant background:**

- are more likely to live in poverty than other children and families in Victoria [8]
- experience significant stress associated with housing insecurity, unemployment, low English proficiency, poor literacy in community language, and being in Australia without extended family [15].
- use fewer services, including paediatric, dental, mental health and emergency room services [16].
Furthermore more, a study by Riggs et al explored the engagement of refugee background families with Victorian MCH services [17]. The study included 87 participants who had a total of 249 children and were from Karen, Iraqi, Assyrian Chaldean, Lebanese, South Sudanese and Bhutanese backgrounds. The study found that:

- most mothers reported good initial engagement with the MCH service through the hospital birth notification system and being automatically connected to an MCH nurse with a home first after child birth. 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 MCH service.
- 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 required to leave voicemail messages.
- Some mothers reported a desire to learn English but were often unable to due to child rearing roles [18].
- In one example of positive engagement, group-based visits whereby the MCH nurses visited an existing Supported Playgroup facilitated by a bicultural worker, was found to be an effective way of engaging families and building trust between communities and MCH services and therefore referral to other services as required.

The psychological and social impacts of torture and other traumatic events have wide ranging impacts over the short- and long-term and can be experienced intergenerationally [19, 20]. Highly variable rates of health issues are reported in refugee adults and children. A recent systematic review of refugee mental health found prevalence estimates ranging from 2-80% for depression, 20-88% for anxiety and 4-86% for post-traumatic stress disorder [21], with rates varying by source and settlement country and study quality.

Mental and physical health issues can persist for many years post-settlement, and are influenced by stress and socio-economic factors [20]. 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 [20].
Parents of CALD children are more likely:

- to rate their children’s health as poor;
- to be assessed as vulnerable to developmental and behavioural problems, particularly for children with low English proficiency; and
- to have poor oral health [8, 22].

There are no publicly available data on the participation of refugee and migrant children in the Victorian MCH Service.

4.5 Communication and access to information

Campus research indicates that poor access to information is a key factor in families’ engagement with services and understanding of professional advice [23]. Low health literacy explains why families from some refugee and migrant communities face difficulties accessing and understanding information about pregnancy care and early childhood services, including early intervention services and preschool [24]. Low health literacy is a major barrier for families in understanding what these services have to offer and why these services are important for early childhood health and development [25].

Difficulties associated with communication are thought to be a major contributor to adverse outcomes experienced by refugee background families living in developed countries. Our research has demonstrated in the maternity and early childhood health context that very few families of refugee background reported access to on-site interpreters. Men commonly interpreted for their wives. There was minimal professional interpreting support for imaging and pathology screening appointments or during labour and birth. 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 within standard appointment times. Failure to engage interpreters was apparent even when accredited interpreters were available and at no cost to the client or provider [11]. The Watch Me Grow study in NSW also identified language as a key factor influencing their choice of healthcare provider such as their GP [26].
4.6 Organisational change – an example of best practice

The non-engagement of professional interpreters and use of a family member to interpret leads to errors in communication and adverse clinical outcomes. During pregnancy and childbirth, low English proficiency severely limits a woman’s capacity to ask questions, provide information to health professionals, understand what is happening, and make informed decisions.

The Bridging the Gap study conducted in collaboration with Victorian metropolitan public hospitals and early childhood services demonstrated that system change is achievable to enable increased, and sustained use of interpreters during labour [27]. The project applied principles of co-design to work with partner agencies to implement and evaluate iterative practice change.

See Figure 2 below.

**THE PRACTICE CHANGE**

In the birth suite at the hospital, midwives tried out a new way of enabling women to have language support in labour.

This included:

> Offering women a professional interpreter in early labour
> Trying out different ways of offering an interpreter
> Engaging an interpreter again if required
> Encouraging staff to practice using the telephone interpreter service on speaker phones

**What was achieved?**

<table>
<thead>
<tr>
<th>TIME</th>
<th>PROPORTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>AUGUST 2014 Baseline</td>
<td>28%</td>
</tr>
<tr>
<td>AUGUST 2015</td>
<td>62%</td>
</tr>
</tbody>
</table>

Women requiring an interpreter who had one in labour

The proportion of women identified as requiring an interpreter who went on to have one more than doubled from 28% at baseline to 62% following nine months of practice change.

**Figure 2: Practice change at a Victorian public hospital**

Success of this project was contingent upon local, multidisciplinary co-design. Specifically,

- The preparedness of hospital staff to collaborate across internal hospital silos
- Collaboration between service management and frontline staff in the design of a quality improvement initiative fostered relationships and enabled conversations about possibilities for change and ‘doing things differently’
- Opportunities for the participating clinicians to meet together and share ideas for improvement and refinement built shared ownership of the project
- Leadership at multiple levels facilitated collaboration and played a vital role in encouraging and supporting colleagues to try new approaches to quality improvement[25].
4.7 Children with disabilities

Children from migrant and refugee families who have developmental disabilities and/or delayed development are especially disadvantaged in accessing early childhood services and early childhood intervention services. This is due to a number of overlapping factors, including parents not being familiar with the early childhood system, not having access to interpreters, and cultural attitudes and stigma associated with disability. These problems have been compounded by the transfer of early childhood intervention services to the National Disability Insurance Scheme (NDIS) [28]. CALD families are less likely to be aware of the NDIS and are significantly less likely to access the NDIS, despite being eligible. Navigating the NDIS Portal is challenging for many families, either because they have limited internet access, do not read or write English, or are computer illiterate. As a result they are more likely to experience longer waiting times to receive service, get lower levels of funding, or not access the scheme at all.

It is important to identify developmentally vulnerable children as early as possible in the preschool years so that they can be referred for early intervention and/or further diagnostic assessment. The National Health and Medical Research Council Child health screening and surveillance review recommends “developmental surveillance” which consists of: ongoing contact with families and children within a universal system; regular contact with health professionals trained in child development and health promotion; and monitoring and responding to developmental concerns over time from infancy to the preschool period [29]. Woolfenden and colleagues in their NSW study found that there were variable practices of early detection through developmental surveillance and early intervention for children from CALD families [30, 31]. Family and service knowledge, community attitudes, social isolation and English language proficiency were dominant themes that reduced the likelihood of families accessing services in the first place.
Researchers on the Melbourne Children’s campus are involved in a range of studies seeking to build a better understanding of what works to engage refugee and migrant families in health and early childhood services.

The Intergenerational Health research group’s Refugee and Migrant Health Research Program works in partnership with the Victorian Foundation for Survivors of Torture (Foundation House), public hospitals, early childhood services and refugee and migrant communities to co-design, implement and evaluate a range of initiatives with a primary focus on improving engagement and outcomes for refugee and migrant families. Our work includes the Group Pregnancy Care study and Bridging the Gap Partnership.

The Group Pregnancy Care Study is currently evaluating an innovative model of multidisciplinary, trauma-informed antenatal care for families of refugee background involving collaboration between public maternity hospitals, maternal and child health services and refugee settlement services. The program was initially implemented in Werribee with the Karen (Burmese) community, and is now operating at a second site with the Assyrian Chaldean community in Melbourne’s northern suburbs. Women are invited to participate in a community based group program designed to overcome isolation and provide opportunities to for learning about pregnancy and pregnancy care. In addition, they are also able to access pregnancy check-ups with a midwife and interpreter in the same venue [32].

Qualitative findings demonstrate that the program is:

- Enabling women of refugee background to feel culturally safe, empowered and confident learning about pregnancy and childbirth in a group setting; and
- 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; learn about where and how to seek help, should they need it; and particularly valued the role played by the bicultural worker in the team.

“If we don’t understand anything, we can ask questions and then they explain it to us again.”
- Program participant –

“Being able to speak the same language and share stories in the same language was good for me.”
- Program participant –
Program evaluation is ongoing, with consultations underway regarding expansion to another two community groups.

The Bridging the Gap partnership aimed to change the way that maternity and maternal child health services support families of refugee background. MCRI and Foundation House as primary partners were joined by partners from Monash Health and Western Health and their local government MCH Services (City of Greater Dandenong, City of Wyndham), primary care and state government departments. The aims of the program were to improve access to universal health care for refugee families and build organisational and system capacity to address modifiable risk factors for poor maternal and child health outcomes [33]. Engagement of refugee communities and co-design with stakeholders was central to the achievements of Bridging the Gap initiatives. Multiple improvement projects and tailored professional development enabled organisational change in the participating health services within existing resourcing and workforce constraints [27, 32, 34].

Researchers on campus are also involved in several unique early childhood health and development programs. With support from the Centre for Community Child Health, the Victorian Cooperative on Children’s Services for Ethnic Groups (VICSEG) has been trialling the peer-led Empowering Parents Empowering Communities program with refugee and migrant communities [35]. This program is delivered by trained bicultural family mentors and parent peer educators and is offered in community languages to overcome barriers to participation.

Another team within the Centre for Community Child Health is utilising the Confident and Understanding Parents approach as the framework informing a child nutrition intervention implemented in the setting of supported playgroups. Supported Playgroups meet weekly for social and play opportunities for children, social connections for parents and bridging opportunities into early childhood services [23, 36]. Within this setting and underpinned by the trusting relationships between playgroup leaders and parents, the research team co-designed a child nutrition intervention with playgroup leaders (including bicultural workers) and service providers. Supported Playgroup leaders were also representatives from the migrant and refugee communities themselves.
These leaders provided insights into ‘translating’ evidence-based practices (healthy eating and active play guidelines) into practical strategies [37]. This ‘translation’ goes beyond the literal wording, to include context, meaning, and cultural considerations. Leaders gained confidence and embedded child nutrition messages into the playgroup setting. Families responded favourably and reported changes to their nutrition practices at home. A global non-government organisation has invested in the Confident and Understanding Parents approach and is currently scaling up nationally within their Supported Playgroup program.

Researchers and clinicians on campus are also looking at approaches implemented in other states with potential for replication in Victoria. The Healthy Happy Ready model, is an outreach model of early childhood developmental surveillance designed in NSW [38]. The model involves increasing access to early childhood developmental assessment for children from CALD backgrounds through outreach health services and non-government early childhood services such as supported multicultural playgroups, family workers or early childhood education centres.

The NDIS review, conducted by the Centre for Community Child Health for the Victorian Department of Education, has examined the impact that the transfer to the NDIS is having on early childhood intervention services. A literature review of the evidence regarding best practice in early childhood health services [39] confirmed the key features of effective early childhood intervention services, including culturally sensitive practice. Culturally sensitive and responsive practice is when people/organisations can reflect on their own cultural identities, beliefs and values; demonstrate a complex understanding of culture; recognise the impact of migration and exile on individuals; utilise communication skills for effective cultural understanding and incorporate strategies that build rapport and engagement.
6. WHAT ARE THE KNOWLEDGE AND PRACTICE GAPS?

6.1 Ascertainment of refugee background

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. [40, 41] The inability to identify mothers and children of refugee background in hospital, MCH and other health service data sets limits the capacity of services to plan, implement and evaluate programs designed to improve outcomes for children of refugee background.

Better ascertainment of refugee background families was a priority of the Bridging the Gap partnership. Four routinely collected data items - (1) maternal country of birth, (2) year of arrival in Australia; (3) preferred language; and (4) interpreter required - provide an indication of refugee background to better understand health disparities, guide service planning and delivery of health care. The data items, together with a set of questions for practitioners to use in the clinical encounter, are essentials to the provision of culturally competent health care [40].

6.2 Understanding the health and wellbeing of children of refugee background with a longitudinal follow-up of children/families

Evidence and an understanding of the needs of refugee populations is critical to ensure recovery from trauma [42], to promote positive integration [43], and to reduce pronounced disparities in health outcomes [8]. There are no longitudinal studies that focus on children born to refugee background parents after settlement. Refugee populations are under-represented in all mainstream birth cohorts in Australia (e.g. Longitudinal Study of Australian Children) and internationally, and refugee specific cohorts have tended to focus on adults [44]. The ‘Building a New Life in Australia’ cohort recruited adults in the early period after settlement and includes limited information on maternal, paternal and infant/child health, and none on parenting or experiences of maternity or early childhood services [45]. There are currently no birth cohorts (from pregnancy) available in which to examine early child development in refugee families, the social or familial factors that support positive child outcomes or what factors promote engagement with services.
6.3 Supporting the mental health of refugee and migrant fathers

Australian fathers experience clinically significant distress in the first year after having a baby, and these symptoms persist up to 7 years postpartum for nearly 10% of fathers [46]. Fathers of migrant and refugee backgrounds are particularly vulnerable to poor mental health in the early years of parenting [47]. Yet, fathers are rarely asked about their own health needs by maternity or early childhood services, and health professionals involved in care of migrant and refugee families during pregnancy and the early years of parenting are unsure about what they can do to support fathers [48]. A major barrier to improving health system capacity to address the needs of fathers is the dearth of research evidence to inform health system reform.

6.4 Trauma informed approaches to mainstream health care

Trauma-informed approaches are based on recognising when traumatic events in people’s lives are the cause of difficulties affecting 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’ [49]. 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.

Where the effects of traumatic events are severely disruptive of functioning, tailored trauma-focused interventions are required to address those effects. At the individual level, this means focusing on symptoms characteristic of disorders such as depression and post-traumatic stress disorder (PTSD), as well as behaviours characteristic of complex trauma, such as emotional dysregulation, interpersonal difficulties and problems of self and identity [42]. At the family level, trauma-focused interventions address communication breakdown, conflict and poor cohesion in the family system. At the community level, fragmentation, distrust, weakened identity and inability to act collectively that result from traumatic events will be targeted by trauma-focused interventions.

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.
6.5 Community engagement

Community engagement can be conceptualised as a process whereby a service, program or system:

- proactively seeks out community values, concerns and aspirations;
- incorporates those values, concerns and aspirations into a decision-making process or processes; and
- establishes an ongoing partnership with the community to ensure that the community's priorities and values continue to shape services and the service system [50].

In our Victorian partnership research, Community Advisory Groups have played a critical role in the engagement of both women and men throughout all stages of the research process [51]. The Advisory Groups, established by community and language matched bicultural staff, demonstrated that inclusive research strategies that address power imbalances in research, and diversity of and within communities, are necessary to obtain the evidence required to address health inequalities in vulnerable populations.

Understanding ‘how’ to engage CALD families in research, and discussions about service delivery requires prioritisation, additional resources and time. In our research we have demonstrated that working with bicultural staff, listening to families’ concerns, applying a strengths-based approach, reflective practice, mutual respect and culturally-competent approaches enhanced our ability to engage with CALD families, to design, implement and evaluate a relevant child nutrition program [37].
7. RECOMMENDATIONS

We recommend:

7.1 Engagement and partnership

- The Victoria government make funding available to enable community and stakeholder engagement to co-design all planning, implementation and evaluation of programs, services and research.

- Investments are made to support innovation in integrated models of care involving local partnerships and multidisciplinary teams.

- Recurrent funding to support strengths-based approaches for community capacity building, supporting health literacy and social inclusion to enable the engagement of refugee and migrant families in services and programs.

- Linkages between settlement services and other ethnic agencies to streamline engagement of newly arrived families into early childhood services including the MCH service and playgroups. Flexible programs to support mothers of young children to learn English are also required.

7.2 Health workforce

- Recurrent funding to train, employ and build the capacity of people from refugee and migrant communities (bicultural workforce) to develop, deliver and evaluate programs within their communities.

- The Victorian Government adopt funding models that ensure that all state-funded services are able to engage professional interpreters and translators when required.

- Ongoing professional development for health professionals to facilitate effective implementation of trauma informed approaches, including support to facilitate effective use and integration of interpreters and bicultural workers into multidisciplinary health and social care teams.

- The Victorian Government commission the development of a standard for services to provide trauma-informed care and practice and guidelines for implementation, including professional development to support the capacity of health professionals to work effectively with bicultural workers.
• Organisational change to shift service systems to be culturally sensitive and responsive, to enable the service system to respond flexibly to community needs. This requires funding and staffing strategies that enable services to be reconfigured. Further, the workforce requires time, resources and support for community engagement activities.

7.3 Research and data priorities

• Active implementation of strategies to improve ascertainment of migrant and refugee background in Victorian health and other administrative data sets, specifically to collect and publish data that indicates the accessibility and responsiveness of services to people of refugee backgrounds.

• The Victorian Government require state funded services (including public maternity hospitals, maternal and child health services, early parenting centres, and other early childhood services) to collect, analyse and publicly report data for every child and family of refugee and migrant background on:
  o maternal and paternal country of birth, preferred language and requirement for an interpreter
  o provision of interpreters to clients whose preferred language is other than English (including in antenatal care, childbirth, early childhood settings)
  o timeliness and nature of engagement in universal service platforms (including participation in antenatal care and maternal and child health services)
  o maternal, paternal and child health outcomes (e.g. birth outcomes, key developmental outcomes).

• A major review of NDIS provision for CALD families focusing on the early identification of children with developmental disabilities, the provision of information about Early Childhood Intervention and NDIS services in community languages, and the provision of advocacy and interpreter support to assist CALD families to access and navigate the NDIS. While some of these changes need to be made by the NDIS itself, state governments continue to play a significant role and share responsibility with the federal government.

• Investments in longitudinal research to investigate the health, wellbeing and developmental outcomes of migrant and refugee children and young people in Victoria.
• Investments in health services research that evaluates innovative strategies to improve outcomes for migrant and refugee children, young people and families, focusing on strategies to promote access, improve communication, health literacy and social inclusion.

• Investment in working with refugee and migrant communities (and agencies working with these communities) to support co-development of measures of engagement and health and wellbeing outcomes that are meaningful and appropriate for children and young people of refugee and migrant backgrounds.
8. REFERENCES


49. Substance Abuse and Mental Health Services Administration, *SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach*. 2014, Substance Abuse and Mental Health Services Administration: Rockville, MD.
