MR WAKERMAN: Thank you very much, Sundram. There will be an opportunity to have more of discussion at towards the end of the afternoon when we will have all of the speakers here. The next speaker is Daniel Boyer, who is an officer of the Department of Immigration and Citizenship, with responsibility for programmes for those who settle in regional areas. Thank you, Daniel.

(Applause)

Settling refugees in regional areas and the government's services to them

Daniel Boyer
Department of Immigration and Citizenship

MR BOYER: Thanks John, and thanks Gordon for giving me the opportunity to speak today. I just wanted to touch on a couple of things that Sundram raised and in fact agree with him wholeheartedly on a couple of issues. The first is about the cooperation between not just various tiers of government, Sundram, but various government agencies who operate on the same tier. One of the great challenges we face in immigration is convincing other Commonwealth agencies, mainstream Commonwealth agencies, of their responsibilities in terms of providing specialist services for this particularly vulnerable client group.

I did also want to mention the fact that there has been a couple of really big wins here recently, and I will touch on those during my talk, and in particular a recent inter-departmental committee on humanitarian settlement and a raft of Commonwealth funding, that came from that.

The other thing that Sundram reminded me of, when he was speaking about the issues associated with interpreters - and yes, we know it is a significant set of issues - and also about culturally appropriate healthcare, it reminded me of a story that my boss, a fellow by the name of Peter Vardos, who is a Greek immigrant, told me about he and his mum and his dad when they first came to the country. I think I tell it now to illustrate the fact that these are not new issues that we are dealing with. These same issues were confronted by people 50 years ago. Peter tells this story - and I hope he doesn't mind me quoting him about it - he has told it in public before, but there is certainly a sensitivity there.

He had to, as a six year old boy, go to the doctor and interpret for his mother who was going through menopause and facing the issues associated with menopause. Now can you imagine that for a second and think about that these same issues are being dealt with now. I think we're probably doing it better now than we were 50 years ago, but what sort of an impact that would have on the mother/son relationship at that stage of Peter's and his mother's life, it is a very harrowing experience to go through.

Before I start, I want to tell you a little bit about myself and my role, in part, because

it will help give you a picture of the broad policy area and program area in which I work, but also to lower your expectations about my capacity to provide any detailed health specific information. I am responsible for a program funded by the Department of Immigration and Citizenship called the Integrated Humanitarian Settlement Strategy. The IHSS is the principle service of support for refugees arriving in Australia, initial assistance in particular. The IHSS fits within a broader range of programs and policy areas aimed at improving the integration of migrants into Australian society and the social cohesion of the broader Australian community. It is an interesting and challenging policy area and one where you don't always feel in control of the outcomes for your clients, but, most of all, it is particularly rewarding.

Today I'd like to outline how our settlement services help refugees start to build a life in Australia, including how we help them access appropriate medical care and general health services. I also want to highlight our Regional Settlement Programme and how we work with other government agencies as much as we can and - I take the point of the lady who spoke from Tamworth before, which is not, I would garner - I would suggest - one of our greatest success stories - how we work with other government agencies to improve the delivery services to refugees, including in the health area.

Throughout my talk today, I'll try and speak about our health specific measures, but of course, it is important to consider these in the context of our overall programs. Health, of course, is not DIAC's principal responsibility. I want to start by giving you a bit of background on Australia's humanitarian program. Since the end of World War II, nearly 700,000 refugees have come to Australia under our Humanitarian Programme. It is a massive number when you think about that in the context of Australia's overall population. In fact, the last figures I saw, and I think that this will be shown up in the 2006 Census as well, but from the 2001 Census suggests that 43% of Australians either had a parent born overseas or were born overseas themselves. Now that is a remarkable figure, and I don't think that there is very many countries around the world who come even close to that. The Minister has just announced the programme will remain at current levels and Australia will again welcome 13,000 refugees this year.

Australia's Humanitarian Programme is designed to respond flexibly to changing international circumstances. Over the past decade, the programme's focus has changed from Balkan countries to African countries and the Middle East. In recent years, there has been an increase in South-West Asian arrivals and we expect that that will shift towards South-East Asia in the coming years. As many of you will know from your work, many of these refugees have lived for long periods in refugee camps where overall conditions are poor, where they are likely to have a history of nutritional depravation, inadequate medical and dental care and exposure to areas of widespread disease.

Some of the wider challenges our refugees face in setting in Australia include large

families, low income levels, low level of literacy in English and in their own language, and high rates of torture and trauma. This range and complexity of needs presents considerable challenges to policy makers and to our service providers in the community sector. From the DIAC perspective, preparing for successful settlement, meeting these challenges begins well before refugees arrive in the country. All refugees attend a five day interactive cultural orientation programme before departing for Australia.

The course provides an initial introduction to aspects of Australian life, aiming to enhance refugees' settlement prospects and create realistic expectations for their life in Australia. The course provides practical information on support services, getting a job, political and legal frameworks, and a range of other topics. From a health perspective it introduces refugees to key concepts and terms in the Australian medical system like Medicare and bulk-billing. The information is reiterated I'm sure by our service providers.

Health is a significant focus of help. All permanent visa applicants in Australia including refugees undergo a full medical examination in order to assess their health. The health requirement is designed to minimise public health and safety risks to the Australian community. Active TB is the only disease prescribed as excluding a grant of a visa on public health grounds. If an applicant is found to have TB or in the past or evidence of exposure to tuberculosis they may still be granted a visa and placed on a health undertaking. This means the applicant agrees to contact the DIAC Health Undertaking Service upon arrival in the country. For refugees with health undertakings ..... service providers help them fulfil their obligations.

Additionally, pre-departure medical screening is a voluntary fit to fly health screening conducted 72 hours prior to departure to ensure refugees are healthy enough to travel to Australia. Medical results arising from pre-departure medical screening also contribute to linking refugees with particular health needs to appropriate State and Territory health services on arrival in Australia. If clients are not found fit to fly, the health condition is treated offshore at the Department's expense and the client's travel rescheduled. This pre-departure medical screening is currently conducted through most of Africa and in Thailand and we are looking to expand it to several other locations around the world.

In 2006 the Department introduced a two-tier medical alert system which ensures refugees with serious medical conditions received appropriate medical care once in Australia. Red alert cases are accompanied on route to Australia by a medical escort who can provide any required medical care while they are travelling, and are seen by an on shore doctor within 24 hours of arrival in the country.

Before talking about support - our settlement programmes provided on shore, I'd just like to give you an overview of the Department's regional humanitarian settlement practices. It is important to remember that for 70 per cent of refugees, DIAC does not choose their

settlement location. They already have social connections in Australia such as friends and family members, close friends and family members. We try to settle these entrants near these links because they provide important support during the initial settlement period.

I think there is as bit of a misconception that we have, you know, 30,000 people and we arbitrarily decide exactly where they go around the country. It just does not work like that. If we were to treat the Humanitarian Programme a little like that the amount of secondary movement we'd get from say Alice Springs to Sydney or from Launceston to Melbourne or from Tamworth to Sydney would be quite massive. So we only a very small pool of refugees for whom we have no links in Australia and consequently we can control their settlement location as much as we can.

Refugees settle in all capital cities and also in larger regional areas such as Toowoomba, Geelong, Coffs Harbour, Launceston and Wagga Wagga. Some also voluntarily move to regional and rural areas and we have been seeing a whole heap of this in recent years because of particular employment opportunities. There are a couple of cases in Victoria that are worth noting here. Warrnambool and Swan Hill and Mildura have also seen large amounts of secondary migration because there has been employment opportunities in those locations. In the last five years, just under 10 per cent of refugees have settled in a regional and rural area, although this varies dramatically from State to State. So in a State like New South Wales that's not a particularly high number, whereas in a State like, I think, Tasmania, 38 per cent of all refugees settling there are settled in what is designated as a rural or regional area.

In recent years, the Department has sought to identify new regional towns that have the right mix of services, opportunities and community support, and are interested in settling refugees. I can't emphasise that last point enough. In partnership with the relevant State or Territory government - and this is an important factor to consider as well - Local Government and other Commonwealth agencies, we assess whether areas are able to cope with the needs of refugees. Basically we will not settle anyone in a small town without consulting with the local community and without consulting the State or Territory Government. Unless the premier writes us a letter which says the State Government will support the settlement of refugees in a particular location, we will not go ahead with that level of settlement.

Availability and accessibility of adequate health services of course both general and specialist, and again I take Sundram's point on this, are significant considerations. We commenced the Direct Regional Settlement Pilot in Shepparton in November 2005 and settled around 10 Congolese families since then. Recently a number of Togolese families have settled in Ballarat and Mount Gambier has also welcomed some Burmese families last month.

As I said, the IHSS, which is my programme, provides intense settlement support for

newly arrived humanitarian entrants for six months after arrival. IHSS services are designed to provide refugees with the help they need to start building a life in Australia. The ultimate aim of all of our settlement programmes is self sufficiency. In fact, that is one of - our major challenge, I think, is about promoting self sufficiency and the capacity for someone to stand on their own two feet as quickly as possible after they arrive.

Services provided through the IHSS include initial information and assistant to adjust to a life in Australia, assistance in finding accommodation, which is particularly challenging at the moment with the housing prices we are all facing, a package of goods to help humanitarian entrants to establish a household, and short term torture and trauma counselling. As many of the needs of recently arrived refugees are shared with the broader Australian community, they will always need to be connected to mainstream State or Commonwealth Government agencies.

Settlement is a long and on occasions arduous process. One of the great challenges we in immigration face, as I've said, is convincing these other government agencies to work collaboratively in focussing on the particular needs of refugees, to put aside the bureaucratic barriers and think about the individual needs of these clients and the collective needs of them as a group. Nowhere is this more challenging than in the health area, I have to say. I'm sure you would appreciate the complexity of the responsibilities here. That said, in most cases, we and our service providers have built pretty strong relationships with State health authorities and I hope that Mitchell won't get up and contradict me on that. Work in this area is ongoing. A bit more on that later.

One of the critical roles of the IHSS is to connect refugees to the State and the Territory health authorities. In particular, our service providers provide an on-arrival emergency assistance and organised access to Medicare within a few days of arrival. Refugees are also given the opportunity to have a complete medical assessment and to honour any pre-arrival health undertakings and importantly our help to do so.

Mental health is also a significant concern. Refugees who have experienced or witnessed conflict or abuse are particularly vulnerable to developing mental illness, although I do think sometimes we tend to pigeon-hole mental illness or mental health issues amongst refugees as being just torture and trauma. It's much broader than that. The sense of isolation that comes with moving from a, you know, a non-urbanised environment to a large city must be absolutely traumatic in itself.

In that sense, I think that, as I say, we often tend to pigeon-hole mental health issues for refugees as just being in the torture and trauma basket. Longer term torture and trauma services are provided through a DOHAR programme, a Health and Aging programme called the Programme of Assistance for Survivors of Torture and Trauma.

Some of you may be aware of our Translating and Interpreting Services and the issues therein. It is also known as TIS. TIS provides a 24 hours a day, seven days a week, telephone interpreting service. In particular, the doctor's priority line is available to private medical practitioners undertaking Medicare rebate-able services. The service access is a national panel of 1,500 professional interpreters covering more than 120 languages and dialects. The Department has recently initiated a pilot project with the Pharmacy Guild of Australia to extend access to free interpreting services to pharmacists from June to December this year. Following the pilot we'll examine the merits of extending access on an ongoing basis.

We understand some of the problems with using interpreters, including a lack of interpreters in new and emerging languages and limited on-site interpreting available, particularly in rural and regional areas due to the resource intensive nature of this particular type of interpreting. We've got ongoing strategies to try and recruit interpreters in new and emerging languages, but this is always going to be challenge due to the changing focus of the Humanitarian Programme. It is one of the unsolvable problems and we need to do whatever we can, of course, to find appropriate interpreters, but it is a big challenge for us.

Sometimes our clients' concept of punctuality exacerbates these issues, something which is discussed in the AUSCO course I mentioned before and which our IHSS service providers try to reiterate on arrival. It must be very difficult as a rural GP to have a client turn up half an hour late when you've booked an interpreter and that interpreter is not available when the client finally shows up through the door. It's a challenge.

Learning English is integral to participating in the labour force and successful settlement generally. The Adult Migrant English Programme, or AMEP, sits alongside the IHSS and helps newly arrived adult migrants and refugees develop basic English language skills. Up to 910 hours of tuition is provided for some of our most needful clients.

The Settlement Grants Programme, or SGP, picks up settlement services where refugees exit the IHSS. It's a discretionary application based grants programme with an annual budget of around $32 million and it's based on a planning process which assesses individual and community needs in locations including rural areas across the country.

As I have suggested thought, it's obviously critical to say something of the whole of government approach to refugee services. I think that the success of our lobbying capacity and a lot of this is luck I would wager to say, is evidenced by the 2007/8 budget outcomes. It probably provided us with more than we were capable of getting.

The budget included a significant funding announcement to strengthen support for recently arrived refugees. The announcement came as the result of an inter-departmental committee of 16 government agency heads chaired by Peter Shergold, focussed solely on the

needs of recently arrived refugees. Even if we hadn't got any money out of this process, just the idea of 16 Commonwealth agency heads sitting around for 3 hours talking about the particular needs of refugees, you can't imagine what sort of an invaluable experience that is, regardless of the merits of the individuals concerned.

The budget allocated 209 million over four years to six government agencies. Specific programmes funded that may be of interest to you guys are 35 million over four years to establish complex case support services to deliver specialised and intensive case management to humanitarian entrants with exceptional needs, including serious health needs. 130 million over four years provided to government and non-government education authorities to increase the provision of intensive English language tuition for refugees in primary and secondary school education. 400,000 over four years to DIAC to encourage new interpreters in community languages where there are continuing shortages of interpreters. 1.5 million to support the long term sustainable settlement of refugees in regional areas.

12.2 million over four years to increase the capacity of the Programme of Assistance for Survivors of Torture and Trauma, or PASTT, to deliver torture and trauma counselling for humanitarian entrants. Tis funding will facilitate up to 10,000 additional occasions of service, which I believe is the common vernacular, each year, delivering support to a further 1800 people per annum. If anyone knows about the PASTT services and know the stress and pressure that they've been under, it is welcome funding indeed.

As I mentioned previously, we've made some recent inroads in working across government in the health area. As well as the additional funding for torture and trauma services, the multi-jurisdictional working group on refugee health which consists of representatives from DOHAR, DEAC and State and Territory health departments provides a good example of jurisdictions working collaboratively to improve health outcomes for refugees. The working group was established at the end of 2005, acknowledging the need for a more coordinated approach to meeting the health needs and care of refugees across all jurisdictions. The recent introduction of two Medicare benefit scheme items has been one of the key outcomes of the working group. Item 714 and 716 were developed to support GPs conduct a one-off health assessment of new humanitarian entrants.

In concluding, we should all be aware that there are significant challenges in servicing this vulnerable client group and that working collaboratively across traditional government and community networks requires considerable patience and resilience in some cases. I think we have made some significant progress in this as the recent budget has demonstrated. The role of health agencies and professionals is pivotal to the success of refugee settlement and, as the state of refugee health related media articles might suggest, even to the overall health of the Humanitarian Programme.

Whether it be health, welfare or ensuring a higher level of social cohesion, integration

can look like a very costly business. But the costs of this service provision is far outweighed by the substantial societal and economic benefits. Australia has a proud history of refugee resettlement and we in government and the community sector have worked hard to make this resettlement possible. The reward has been and is the vibrant culturally diverse nation that Australia has become. Thanks very much.

(Applause)

MR WAKERMAN: Thanks, Daniel. Just, I know you're busting with questions and comments. Just hold on to them please for later on because I think we'll just move on to the next speaker.

MR BOYER: Sure. The only problem is - I will say one quick thing. My apologies but I'm actually running my own service providers conference today and I had to duck out to come here, so if you have issues and concerns I'm happy to circulate the speech together with my contact details. Even if I can't answer your specific queries or concerns I'm happy to find the right person within Immigration to answer those concerns for you. So if I can't stay for that then that might be the best way to do it, if that's okay, John.

MR WAKERMAN: Thanks very much, Daniel.

MR BOYER: Thanks.

(Applause)