Submission No 44

IMPROVING ACCESS TO EARLY CHILDHOOD HEALTH AND DEVELOPMENT CHECKS

Organisation: Jesuit Refugee Service

Date Received: 4 March 2024

JRS AUSTRALIA
JESUIT REFUGEE SERVICE

Jesuit Refugee Service (JRS) Australia
24 Roslyn St, Rushcutters Bay NSW 2011
PO Box 522 Kings Cross NSW 1340
T: +61 2 9356 3888 E: [redacted]
W: aus.jrs.net

Committee on Community Services
Legislative Assembly, New South Wales Parliament

Email: communityservices@parliament.nsw.gov.au

4 March 2024

JRS Australia's Submission to the Inquiry into improving access to early childhood health and development checks

Dear Committee,

Jesuit Refugee Service (JRS) Australia welcomes the establishment of an Inquiry into improving access to early childhood health and development checks, and the opportunity to make a submission.

About JRS Australia

JRS is an international organisation with a mission to accompany, serve and advocate for and with refugees, other displaced people and migrants in situations of vulnerability. JRS works in situations of greatest need, where others may not be present, and where there is potential for partnerships to be formed.

JRS operates in close to 60 countries, serving over 1.5m people, many of whom are denied permission to work, to study and to access essential services. Consequently, many are highly exposed to trafficking, food insecurity, COVID-19, gender-based violence (GBV) and the impacts of the climate emergency amongst other scourges.

JRS Australia serves approximately 3,000 people annually in the state of New South Wales, concentrated in Western and South-Western Sydney. Our frontline services include specialist casework for individuals and families to address acute needs relating to physical and mental health, domestic and family violence (DFV), and housing , food and financial insecurity. We also support people to access safe and dignified employment, training, education, childcare, legal advice and other critical services. Further, we run a refugee leadership program and other activities to strengthen social and community connections and development.

The state of healthcare for the people we serve

Most of the people we serve are seeking asylum; others are recognised refugees who have not been granted permanent protection, and migrants in challenging circumstances whose visa status remains unresolved. Many have been living in Australia on temporary visas or with unresolved visa status for extended periods, including some for over ten years.

Due to their visa status, they are often ineligible for government-funded support that is available to Australian citizens and permanent residents, and for other private and community sector-run services. Some of the people we serve do not have permission to

work; those that do face considerable barriers to accessing safe, dignified and stable employment. Rising cost of living pressures have left charities providing emergency relief increasingly challenged in meeting demand.

A consequence of these mounting pressures is that families seeking asylum and with unresolved visa status face significant barriers to accessing early childhood health and development checks. Children in these demographics are falling through gaps in services and are not afforded the psychosocial conditions that support healthy development.

These gaps in healthcare outcomes run contrary to the key priorities set out in the NSW Multicultural Policies and Services Program (MPSP) Framework and to our shared vision of "an inclusive, connected and socially cohesive multicultural NSW," specifically:

- *NSW Language Services*: a lack of availability of interpreters and linguistically-diverse health education materials limits accessibility of early childhood health services.
- *Sector Capability*: a lack of coordination between departments and community organisations within the NSW healthcare sector means vulnerable children are not provided with adequate safeguarding and wraparound psychosocial care.
- *Community Resilience*: while children seeking asylum are not enabled with equal access to public health resources, they are also left out of opportunities to be welcomed in and contribute to the community, through childcare, parents groups, school and employment.
- *A Shared Sense of Value*: without access to healthcare, families seeking asylum or with unresolved visa status are made to feel that they are not valued in the New South Wales community, leading to a lack of trust in and disenfranchisement from the healthcare system and other support services; and
- *Settlement*: when children seeking asylum or with unresolved visa status are not enabled with equal and consistent access to healthcare, they are not provided with the psychosocial conditions to "thrive in place" over the long term.

Furthermore, according to the NSW Health Policy Directive, *Medicare Ineligible Asylum Seekers - Provision of Specified Public Health (PD2020_039)* (Directive), people seeking asylum should have access to essential health services. Despite this Directive, and despite the advocacy support provided by NSW Refugee Health Service, in practice it is still very difficult for refugees and people seeking asylum to access these entitlements.

Ultimately, regardless of barriers to access, the services they are entitled to remain insufficient to afford true health and wellbeing.

The following Submission speaks to the ways in which these healthcare gaps present themselves in the communities we serve, and provides recommendations as to how these can be addressed to bring NSW Health services in line with the Directive, as well as the MPSP Framework and its mandates.

Terms of Reference

We make this Submission based on our extensive experience of serving and consulting directly with affected families, and of working with diaspora communities and key partners in the health and social services sectors. We would be pleased to provide further written or oral submissions if required.

Our Submission will address points 1 and 2 of the Inquiry's Terms of Reference:

1. Changes needed to address gaps in outcomes for vulnerable children, including those in rural and remote communities, Aboriginal communities, and culturally and linguistically diverse communities.

2. Barriers that affect parents' access to routine health and development checks that track their child's progress against developmental milestones.

1. Barriers to early childhood healthcare generally

Many children who are seeking asylum or have an unresolved visa status are not eligible to access Medicare. When they are, this is often only intermittently and for short periods of time, interrupting the delivery of healthcare support to children and preventing timely identification and treatment of their health concerns.

As a result, vulnerable children seeking asylum and with unresolved visa status are exposed to increased health risks, whilst also receiving more limited access to essential care. Left unaddressed, this can escalate into long-term developmental disadvantage, and/or critical health conditions that impact their future wellbeing and increase the strain on health and social services in New South Wales.

Inconsistent access to Medicare

Many children who are on temporary visas or have unresolved visa status are not eligible to access Medicare. When they are, this is often only intermittently and for short periods of time, interrupting the delivery of healthcare support to children and preventing timely identification and treatment of their health concerns.

Furthermore, access to free health and development checks for families without Medicare may depend upon where they live. Policies and practices regarding the charging or waiving of fees for families without Medicare appear to vary between Local Health Districts (**LHDs**).

For example, in our experience, despite the Directive, Early Childhood Health Services in the Western and South Western Sydney LHDs charge families without Medicare for services, while the Sydney and South East Sydney LHDs do not. This is highly relevant to the people we serve as the majority of them reside in Western and South Western Sydney.

Families without Medicare are also often unable to access free checks through a General Practitioner, as this is not provided for under the Directive.

The financial burden of accessing healthcare deters families from engaging with the healthcare system for preventative care, and in dire situations obstructs children's access to emergency care when required.

Please see **Case Study 2** in the Appendix to this Submission.

Lack of clear and coordinated safeguarding and support

It can be very difficult to find clear and consistent information from healthcare services, or coordinated advice across departments as to the healthcare options available to our clients and their children.

As policies and practices on charging families for health and development checks vary between LHDs, securing healthcare solutions for children who have no or only intermittent access to Medicare often requires navigating a complex maze of "exceptions". There are rarely clear and sufficient pathways for families to follow to ensure their children receive sufficient care.

The people we serve have reported feeling immobilised by a lack of understanding of their rights or supports that are available, indicating that messaging around rights awareness is not being received, or sufficiently understood.

For example, despite the Directive, our clients have been unaware that they can access fee-waivers for ambulances, and therefore do not call for them as needed because they fear the cost of doing so. Similarly, clients often do not access dentists or GPs due to a lack of understanding of the associated costs and ways they can access these services for free.

For the families we serve, this complexity can be impossible to navigate without support from organisations like ours, and across the sector we are stretched beyond our capacity to meet the demand for support.

Without direct advocacy and casework, children can easily slip through the cracks because the public system does not offer coordinated care and there is insufficient communication between departments like NSW Health and the Department of Communities and Justice (DCJ) to ensure safeguarding of children's healthcare and developmental needs.

Please see Case Studies 2 and 3, attached in the Appendix to this Submission, as examples.

Unique health risks faced by children seeking asylum/with unresolved visa status

Families without permanent visa statuses experience systemic disadvantage in Australia.

In addition to a lack of access to Medicare, parents on temporary visas often do not have the right to work, are not eligible for Centrelink support, and do not qualify for many public or community housing programs. (You can find more information about this here in our submission on the impacts of the rental crisis on the families we serve.)

As a result, children in these circumstances are at a much higher risk of experiencing food and housing insecurity, physical and mental health impacts, as well as domestic and

family violence. Children from asylum-seeking backgrounds are also at a higher risk of interruptions in their schooling, and the associated community and social health benefits that schooling can afford.

Similarly, the prohibitively high cost of childcare and parents' lack of eligibility for the Childcare Subsidy through Centrelink means that many children seeking asylum miss out on the developmental and psychosocial benefits childcare affords. With the significant challenges the people we serve face regarding navigating visa pathways, dealing with ongoing trauma, and surviving without access to many basic supports, preventative healthcare is often considered comparatively less important and deprioritised.

Consequently, key health concerns for children in these circumstances that can often remain unaddressed include:

- Trauma and/or vicarious trauma from events pre- or post- journey to Australia.
- Trauma, mental health, and other challenges for parents that impact parenting capacity and availability, damage the attachment relationship and delay emotional regulation, cognitive and social development in children.
- Physical health issues for parents and children who may not have had historic access to adequate health care, particularly including dental care.
- Incomplete or no immunisations received.
- Childhood stress and mental health concerns due to social, financial, food, and housing insecurity.
- Poor nutritional status as a result of food insecurity or cultural barriers to knowledge.
- Isolation and loneliness.

2. Barriers that affect parents' access to routine health and development checks

In addition to the lack of access to Medicare and healthcare services broadly, there are additional barriers faced by children on temporary visas that affect access to routine health and development checks in Early Childhood Health Services.

Early Childhood Health Services provide health and developmental checks, but also address psychosocial determinants of health including social and financial issues, maternal mental health, family planning, domestic and family violence, social isolation and education – for example through referrals to play groups, parenting groups, mothers' social groups and multicultural organisations.

Barriers to these services ultimately result in lost opportunities for early intervention and fail to provide children with the psychosocial conditions required for healthy development.

Language Barriers and lack of access to interpreters

Like many children from linguistically diverse families, the children we serve face gaps in their health outcomes because information, resources and services are not provided to their parents in their home language – and interpreters are not adequately available.

Although it is NSW Health policy that interpreters are used for patients who need them, in practice this does not always happen and we have witnessed limited access and use of interpreters and lack of information in home languages to be a problem across all services including health. In particular, we have experienced the limited availability of interpreters, especially in certain languages. Using female interpreters to address women's health issues is crucial, so limited availability can create a barrier for women trying to access health services for themselves and their children.

Effective care and communication can therefore be compromised because families do not receive an interpreter at all, or they rely on family members or friends to interpret.

Service providers attempt to address the limited availability of interpreters by block-booking interpreters, or creating language-specific clinics that are held infrequently (monthly or bimonthly, for example). The resulting long waits for appointments and reviews are a core barrier to parents accessing health and development checks.

Furthermore, once appointments are scheduled, service providers do not adequately lengthen appointment times to accommodate the use of interpreters. This results in insufficient time to thoroughly assess the child and address the needs of the family.

Finally, language barriers are also faced in school and other community arenas. This limits access to health and development checks because families miss out on passive exposure to community health information and cannot take advantage of associated early intervention opportunities.

Please see Case Study 1 in the Appendix to this Submission, as an example.

Cultural Barriers, Health Literacy and Understanding of Healthcare System

Many families from culturally and linguistically diverse backgrounds come from countries with very different healthcare systems to Australia's. They may need help to navigate our system, and to understand the role of Early Childhood Health services and the importance of health and development checks for their children. Health literacy can be limited.

The education, information and support needed for parents to prioritise checks for their children, to understand the importance of possible interventions and to access other parts of the healthcare system may take considerably more time than is allowed for in a routine appointment for a health and development check. This creates a barrier to effective care and to families returning for further checks and review.

Families dislocated from cultures where parents have access to extended family and community can also find it difficult to adjust to a healthcare system which requires individual advocacy.

Please see Case Studies 1 and 2 in the Appendix to this Submission, as examples.

Lack of knowledge amongst healthcare workers

Healthcare workers who are not experienced with refugees and people on temporary visas are often insufficiently equipped to provide the correct information and care to families.

Healthcare workers may not be aware that children on temporary visas or with an unresolved visa status may not have access to Medicare and may not be able to access certain community healthcare services. They also may not know where else to refer families to for the required support in the absence of Medicare.

As a result, families may be given incorrect information, and billed for or directed to services they cannot afford. Ultimately this deters families from accessing healthcare because they see it as prohibitively expensive, even when there may be affordable alternatives available.

Similarly, healthcare workers may not be trained to screen for the abovementioned health risks that are particular to children who are seeking asylum or are on temporary visas. Incomplete immunisations, unaddressed nutritional deficiencies and neglected mental health concerns, lead to missed opportunities for early intervention and impact long-term development.

Recommendations:

In accordance with the United Nations Convention of the Rights of the Child (UNCRC), children have the right to healthcare that will help them to thrive (Article 24), as well as support specifically for refugees and people seeking asylum (Article 22).

In the New South Wales context, this means that children seeking asylum have the right to access appropriate and adequate health care and to be able to thrive in their development, regardless of their visa conditions or residency status, as mandated by the MPSP Framework and the NSW Health Policy Directive

In light of our experience serving, advocating for and accompanying families seeking asylum and with unresolved visa status as they navigate barriers to accessing healthcare in New South Wales, we make the following recommendations.

1. Health services and developmental checks be made accessible to all children in New South Wales, regardless of visa status.

2. Enhanced coordination and collaboration pathways must be created between NSW Health, the DCJ, and the community sector to enable higher quality, and more accountable wraparound support for vulnerable children and families.

3. Tailored healthcare orientation sessions be made available to people on temporary visas to ensure information outlining the Australian healthcare system and their rights in relation thereto are clearly communicated, including to furnish parents with information about the supports available to their children and themselves (for example, fee waivers and subsidised or free services).

4. Frontline health workers must be supported with tailored training to ensure understanding and practice of:

a. trauma-informed care (with a focus on the specific traumas experienced by refugees and people seeking asylum);

b. the use of interpreters;

c. managing cultural parenting dynamics;

d. identifying and assessing the specific healthcare concerns faced by children seeking asylum and/or with refugee backgrounds;

e. issues faced by women and children who have experienced domestic violence and gender based violence;

f. the application of the Directive; and

g. referring to services that are available to children seeking asylum and/or with refugee backgrounds.

5. The availability of interpreters, particularly female interpreters, must be increased to support the provision of timely and effective healthcare services, and to reduce barriers that deter families from linguistically-diverse backgrounds from seeking care .

6. Long appointments should become the best-practice standard when dealing with families seeking asylum and/or with refugee backgrounds, to account for the extra time required to accommodate interpreter-use and to address the wider range of vulnerabilities faced by children in this demographic.

Appendix to JRS Australia's Submission to the Inquiry into improving access to early childhood health and development checks

*Please note all names used in these case studies have been changed to protect the privacy of our clients.

*Case Study 1: Rowan**

Rowan arrived in Australia on a partner visa accompanied by her two daughters, aged 7 and 4. Rowan experienced domestic violence, which led to her separation from her partner, and ultimately put her visa status at risk, as well as her children's financial, food and housing security.

Neither Rowan nor her daughters could speak English, so in interactions with all support services, Rowan was relying entirely on interpreters which were not always available. Lack of native-language resources deterred Rowan from interacting with support.

Amidst these challenges, Rowan's youngest daughter suffered from severe dental decay. This condition went unnoticed and unaddressed throughout their stay in Australia, despite visits to medical practices for routine appointments and immunizations.

Like many parents from Rowan's cultural background, Rowan believed that because her daughter's milk teeth would naturally fall out, there was no urgent need for intervention. No concern was raised with Rowan until her caseworker at JRS Australia inquired about it.

With the caseworker's assistance, Rowan was able to schedule an appointment with a dentist. However, by this time, the situation had escalated to the point where her daughter required surgery at the hospital to remove all her teeth: a very serious consequence of medical neglect which has also had far-reaching impacts on her daughter's diet and mental wellbeing.

Rowan's ordeal highlights the critical need for a robust healthcare support system for children on temporary visas to ensure their wellbeing is protected and opportunities for early intervention are not missed.

A more robust healthcare support system would involve better coordination between support services, adequate provision of medical interpreters and accessible healthcare services.

*Case Study 2: Jaya**

Jaya came to Sydney as a child seeking asylum with her parents and older sister over a decade ago. Jaya is still awaiting a final determination on her asylum application and has been through a lengthy and financially and emotionally debilitating appeals process.

During this time, and due to delays in processing her applications, Jaya has spent time on and off temporary bridging visas, leaving Jaya with only intermittent access to Medicare.

Jaya graduated from high school in Sydney and has since been denied the right to attend university or to find employment because of her visa status. This has left her financially insecure and disenfranchised, with impacts on her physical and mental health.

Jaya now has two young children, who also have unresolved visa status. After their birth, Jaya had to undergo a lengthy application process to register her children and attach them to her visa application.

Jaya and her children had to wait many months before they were given a bridging visa and enabled with access to Medicare, risking missing developmental check-ups, immunisations and hospital visits because of the out-of-pocket cost.

*Case Study 3: Dipti**

Dipti is a client of JRS Australia's Finding Safety Project, which provides casework and other psychosocial supports to women and children seeking asylum or on temporary visas, who have experienced or are at risk of experiencing sexual and gender-based violence.

Upon arriving in Australia to pursue her studies, Dipti applied for a partner visa and eventually gave birth to their son. After experiencing physical and mental abuse inflicted upon her by her partner, Dipti left her husband and now lives in separate accommodation with her son and her mother.

Due to the trauma of her son's early life as a refugee and the discrimination and violence he has faced in Australia, Dipti's son has unaddressed psychological needs. He struggles to regulate anger, he avoids attending school and he has shown aggression and violent behaviour towards his mother and grandmother.

Despite referrals to a counsellor for support, Dipti's ex-husband had reservations about his son receiving therapy and refused to allow him to attend sessions with a counsellor.

The New South Wales Department of Communities and Justice has failed to respond to calls for assistance and has not mandated that Dipti's son receive the psychosocial care he requires.

This case study is an example of how a lack of coordination between the Department of Communities and Justice, New South Wales Health, and the community sector lead to children slipping through the cracks of services.

Dipti's son was not protected from early risks to his health and wellbeing, which has led to long-term developmental disadvantage - as well as increased risks to Dipti's wellbeing.

A system of inadequate safeguarding of mothers and children - particularly those made more vulnerable by their visa status - enables cyclical and intergenerational violence to continue. In Dipti's case, the lack of institutional support available to her means she has to choose between her own wellbeing, or her son's. Meanwhile, her perpetrator takes advantage of the lack of safeguarding and is able to continue inflicting this second-hand violence upon his family.