HUMANITARIAN ARRIVALS IN MELBOURNE
A SPATIAL ANALYSIS OF POPULATION DISTRIBUTION & HEALTH SERVICE NEEDS

SUMMARY REPORT

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This research was developed in partnership between the Department of Health and Human Services, University of Melbourne and representatives of government, health and settlement services to build evidence about recent humanitarian arrivals across northern and western metropolitan Melbourne.

In many health planning and related forums conversations focused on the increasing numbers of humanitarian arrivals across numerous suburbs of Melbourne and the difficulties that health service providers had in meeting the needs of the rapidly changing and increasingly diverse population. Strangely, little quantitative data was available on the topic and a research project naturally evolved.

The main aim of the research project was to scope and map available data sets to build quantitative evidence about the spatial location of recent humanitarian arrivals and combine this with qualitative information from key informants working with these people in health service provision. Another key objective was to identify data sets to provide a spatial analysis of bilingual General Practitioners and possibly the use of interpreters in health services.

Several quantitative data sets were identified as useful to achieving the objectives of the research: the Australian Bureau of Statistics Australian Census and Migrants Integrated Dataset (2011); Department of Immigration and Border Protection Settlement Database (2010-2015); the AMES Australia Humanitarian Entrants Management System (2013-2015); and the National Health Services Directory for General Practitioner listings.

This Summary Report provides examples of spatial analyses of these datasets with detailed information on visa categories within locations, countries of birth, languages spoken and changes to settlement patterns over time available in the companion Extended Report. These quantitative analyses were also informed by in-depth interviews with key informants providing health services to humanitarian arrivals including members of the project’s Research Advisory Group.

Key findings and recommendations from the Extended Report are summarised on the following pages and extracted from the extensive spatial and qualitative research findings.

For more information on detailed findings access the Extended Report online at www.communityindicators.net.au/humanitarian_arrivals_in_melbourne.
KEY FINDINGS

SETTLEMENT PATTERNS

Migration based on humanitarian reasons formed 12% of arrivals to Victoria in 2011.

Humanitarian entrants were predominantly from Sudan, Iraq, Afghanistan and Burma/Myanmar between 2001-2011 while more recently from 2010-2015 most entrants came from Afghanistan, Iraq, Burma/Myanmar and Iran.

Large populations of humanitarian arrivals live within the Local Government Areas of Greater Dandenong, Hume, Casey, Brimbank and Wyndham and each area has people from a diverse range of countries and associated language needs.

In 2011, approximately two-thirds of humanitarian arrivals living in Victoria lived in the 20% most socio-disadvantaged areas of Victoria.

In 2014, over one-quarter of people on Bridging Visa E lived in Dandenong or Doveton.

Numbers of Special Humanitarian Program visas have decreased dramatically between 2003 and 2011 similar to Refugee visas which peaked in 2008-2009 and steadily decreased leading up to 2011.

Constant changes in the policy environment particularly in terms of visa bands and associated entitlements create confusion for both humanitarian arrivals and health service providers.

DATA SOURCES AND AVAILABILITY

Data on the spatial distribution of humanitarian arrivals are rare, difficult to capture, not easy to access and infrequently reported for planning purposes.

Language spoken, country of birth and year of arrival in Australia should be consistently collected for humanitarian arrivals to gather data and build further evidence needed for health and social services planning.

The Australian Bureau of Statistics Australian Census and Migrants Integrated Dataset (2011) provides a very useful data set that can be analysed in detail but needs to be reconstructed at each Census year to capture rapid changes that occur over time.

Longitudinal data are needed to measure and monitor long term changes in location of humanitarian arrivals and to understand more about secondary migration.

The Department of Immigration and Border Protection Settlement Database was difficult to use and plagued by system faults during 2015 when data were extracted.

Population and service planning provision requires access to annual, recent and detailed data on the demographics and spatial location of humanitarian arrivals.

The most recent data held within the AMES Australia Humanitarian Entrants Management System is an extremely useful data set providing more recent information on language and ethnicity of humanitarian arrivals across Victoria.
LANGUAGES

Language difficulties including native language literacy, English literacy, health literacy, health service system literacy are some of the greatest barriers to health service provision and health outcomes for humanitarian arrivals.

In Victoria there is no central resource that provides information on how to access General Practitioners, specialist medical practitioners or allied health practitioners that speak a language other than English.

A considerable number of General Practitioners speak a wide range of languages other than English in Melbourne but there is no resource available to link humanitarian arrivals or service providers to these medical professionals.

More evidence and resources for language assistance need to be directed towards specialist medical practitioners, mental health professionals and allied health professionals including reception staff making first contact with humanitarian arrivals.

Arabic has consistently been the most common language spoken by humanitarian entrants in Victoria over the past 15 years and Arabic speakers are also commonly proficient in spoken English.

Karen speakers are the least likely humanitarian arrivals to report proficiency in spoken English skills.

The most common languages spoken by humanitarian arrivals to Victoria over the past 15 years are Arabic, Dari, Karen, Hazaragi and Farsi (Persian).

The use of the languages of Farsi (Persian) and Chin Haka increased notably in Victoria between the years of 2010-2015.

Arabic speaking humanitarian arrivals are common in the northern and north-western suburbs of Melbourne while Dari, Hazaragi, Pashto and Arabic are most common in the south-east.

In 2011, approximately two-thirds of humanitarian arrivals living in Victoria lived in the 20% most socio-disadvantaged areas of Victoria.

In 2014, over one-quarter of people on Bridging Visa E were living in Dandenong or Doveton.

Arabic, Dari, Hazaragi, Karen, Farsi (Persian) and Tamil are the most common languages spoken in a select number of towns across regional Victoria.
**FIGURE 1**  AMES HUMANITARIAN ARRIVALS AND LANGUAGE, BY SA2 MELBOURNE 2013-2015

![Map showing humanitarain arrivals by language and local government area in Melbourne, 2013-2015.](image)

Language:
- Albanian
- Arabic
- Arabic & French
- Dari
- Dari & Hazaragi
- Dari & Pashto
- Hazaragi
- Persian & Farsi
- Burmese
- Chin
- Karen
- Mandarin
- Nepali
- Vietnamese
- Punjabi
- Tamil
- Amharic, Tigrinya & Oromo
- Arabic, Dinka & Nuer
- Dinka
- French
- Kiswahili
- Krio
- Lingala
- Tigrinya & Arabic
- Somali
- PNG

Data Source: AMES Humanitarian Settlement Services, April 2013 - April 2015.

**FIGURE 2**  MAIN LOCAL GOVERNMENT AREAS FOR HUMANITARIAN ENTRANTS, VICTORIA, 2010-MARCH 2015 (SETTLEMENT DATABASE)

![Pie chart showing distribution of humanitarian entrants across local government areas in Victoria, 2010-March 2015.](image)

- Hume (C) 3,586 (16%)
- Greater Dandenong (C) 3,914 (18%)
- Casey (C) 2,100 (9%)
- Wyndham (C) 1,386 (6%)
- Brimbank (C) 1,836 (8%)
- Greater Geelong (C) 945 (4%)
- Whittlesea (C) 929 (4%)
- Maroondah (C) 1,314 (6%)
- Greater Shepparton (C) 582 (3%)
- Maribyrnong (C) 823 (4%)
- Other 4,876 (22%)
Findings from this research project are the basis for a number of recommendations for future policy and practice that are provided below. These recommendations are summarised and based on extensive research documented in the Extended Report that accompanies this summary.

1. Greatest support for humanitarian arrivals is needed in the Melbourne LGAs of Brimbank, Casey, Greater Dandenong, Hume and Wyndham which are home to the majority of humanitarian arrivals within Victoria. The LGAs of Maroondah, Maribyrnong, Moreland, Greater Geelong and Greater Shepparton also have growing populations of humanitarian arrivals.

2. Data needs to be collected to measure and monitor secondary migration of humanitarian arrivals in Victoria. Future research should also address the issues associated secondary migration of humanitarian arrivals through additional longitudinal research.

3. Year of arrival in Australia, country of birth and preferred language spoken are the three essential pieces of information that should be routinely collected for all humanitarian arrivals.

4. The mapped data of bilingual GPs included in this report should be made available to the general community and also expanded to include other bilingual medical practitioners and allied health workers.

5. Additional training needs to be provided to GPs, medical practitioners, allied health professional and front line administrative staff to build their knowledge and skills in working with humanitarian arrivals and interpreters. This includes training and practical guidelines and toolkits on how to work with interpreters and how to complete Refugee Health Assessments. These should be delivered through the combined support of Primary Health Networks, the Royal Australian College of General Practitioners, undergraduate teaching and community health centres.

6. Advocate for the inclusion of an additional Medicare “Interpreter Item Number” similar to a Long Consultation Item to incentivise the use of interpreters. An additional fee of $5 could decrease the barriers of time and money that prevent GPs in working with interpreters.

7. Interpreters need additional training on the importance of informed consent and additional support for debriefing. This is particularly important when interpreting languages from a small community where confidentiality is difficult to maintain.

8. Further research is needed on the experience and needs of mental health professionals working with humanitarian arrivals.

9. The Australian Health Practitioner Regulation Agency and associated professional boards should collect language skills of all health practitioners during annual registration processes.

10. More general literacy and health literacy support is needed for humanitarian arrivals. This includes literacy in English, literacy in their native language, health literacy and literacy of the local health and hospital systems. Being unable to speak in a language they understand or access and interpreter they feel comfortable with further complicates these issues.

11. More support is needed for case management and Refugee Health Nurses. Inconsistent, short-term, overworked and under-resourced case management and Refugee Health Nurses are factors limiting the health and wellbeing outcomes of humanitarian arrivals.

12. More housing support is needed for humanitarian arrivals in Victoria. Two-thirds of humanitarian visa holders were living in the 20% most socio-economically disadvantaged areas of Victoria with housing affordability a large barrier to health, social and economic outcomes. Future research should investigate the impact of broader social determinants of health on long term health outcomes in humanitarian arrivals and health service provision needs.