The Royal Children's Hospital Melbourne

Immigrant health service Annual report 2024

Immigrant health, Department of General Medicine

Key achievements 2024

Clinical care

We provided 2004 direct clinical care episodes and more than 2450 additional consultations. We delivered **1525** care episodes at our main RCH clinic, attendance was **89%.** We saw children from **49** countries of birth, speaking **51** languages. Interpreters assisted with **70%** consultations.

- Our medical team saw **1117** attendances for **743** patients, including **265** new patients. **5%** of new and **14%** of review appointments were by telehealth/phone. The medical team, particularly the fellows, also provided **2375** consultations.
- Our mental health team saw **236** attendances for **44** patients, including **18** new patients. No new appointments were telehealth/phone, **28%** of review appointments were by telehealth/phone. Mental health provided **71** consultations and continued school-based outreach work.
- Our dental therapist saw **138** children for assessment/care linkage and social work saw **34** consultations.
- We developed a joint clinic model with the Victorian Paediatric Rehabilitation Service (VPRS) for new arrival children with complex disability to commence in 2025.
- We shared care for ~**40** children with Foundation House, and continued referrals to Refugee Legal.

Capacity building, service improvement, education

In 2024, we transitioned to a full NWAU funding model, which allowed access for other non-resident children, and saved time and workarounds with RCH finance. Our team also:

- **Developed shared information systems and strong clinical governance for offshore health alerts** together with AMES team leaders/staff and Refugee Health Program (RHP). We provided advice for **372** cases, from **136** families over Jan 2024 - May 2025. **54** of these children required admission after arrival.
- **Delivered 11 education sessions** to more than **1300** participants, including **2** conference presentations.
- **Developed and updated web resources** – **1** new guideline – Palestinian refugees, **3-monthly** updates of the Covid-19 guideline, **12** updated clinical guidelines, and **3** other resources updated.

Policy

Immunisation - community based immunisation reduced after PRIME ended in late 2023, since this time we have seen a higher proportion of children requiring catch-up, with financial impact for families through reduced Centrelink, and challenges with early childhood education access.

Sunsmart guidelines Balancing the risks and benefits of sun exposure - published in early 2024.

Ongoing implementation of Immigration Medical Examination (IME) changes arising from work completed with Department of Home Affairs (DHA) in 2022, with updates to the Departure Health Check guidelines, health alerts system and high-quality vaccination records now included in offshore records.

Research

Publications – **5** peer reviewed publications. Our team congratulates A/Prof Hamish Graham on the Lancet Global Health Commission on Medical Oxygen Security, published in 2024.

Working groups, advisory roles, networks

We attended more than **200** meetings in 2024, including:

Hospital – team meetings, secondary consult meetings, Stepped care, Better Access to Mental Health

State – Victorian Refugee Health Network, CALD advisory group, Fellows meetings, RHP-Fellows meetings.

National – RHEANA, Department of Health and Ageing CALD Health advisory group, HAIMAP, Health in a new home Translation Panel.

Background

Global forced displacement continued to increase, with UNHCR reporting 123.2 million displaced people by the end of 2024. Global events continue to affect migration flows, with direct impacts and stress for the communities we see in clinic. In 2024, these included: continuation of wars in Ukraine and Gaza, Pakistan and Iran progressing the repatriation of millions of undocumented Afghan refugees, ongoing conflict in Sudan displacing more than 12.4 million people, and ongoing displacement of Rohingyan populations with more than 1 million people in Bangladesh.

Australia's Humanitarian intake increased to 20,000 people annually in August 2023, also with additional Afghan intakes and additional community sponsored refugee pathways – this increase in humanitarian arrivals has been evident with increasing referrals.

Key clinical issues in 2024 included a 10-fold increase in offshore health alerts for new arrivals requiring coordination across hospital and community services for a range of complex conditions.

Victorian government funding for PRIME ended in December 2023. PRIME (Program for Refugee Immunisation Monitoring and Education) had supported catch-up vaccination for more than 16,500 people of refugee and asylum seeker background in Victoria over 7 years. With the loss of PRIME, we have seen immunisation coverage drop in 2024, and clinical risk with increasing measles cases in early 2025.

Our focus through 2025 continued to be clinical care for children and families of refugee and asylum seeker background, responding to increased offshore alerts and increasing clinical complexity.

Clinical care

Service model

The RCH immigrant health service now includes 2 weekly outpatient clinics (increased from late 2021), inpatient and outpatient consultations, and telephone/email advice. On Mondays we run the main immigrant health clinic, on Tuesdays, both fellows now see new arrival families with complex health needs. We provide post-arrival health screening, dental screening, and immunisation catch-up where required, and a tertiary consultation service for health, developmental and mental health issues. The team have weekly clinical meetings (medical case discussions alternating with mental health secondary consultations). We are in regular contact with case workers, settlement services, schools, primary care practitioners, refugee health nurses (RHN) and allied health services to support patient care.

- **We have seen markedly increased medical complexity in new arrivals** - there have been a high number of children with complex neurodevelopmental, neurological, genetic, metabolic, and haematological presentations. We have facilitated a much larger number of post-arrival admissions, working with a range of units across the hospital.
- **Our service has continued to deliver a large component of post-arrival screening and vaccination** with the influx of new arrivals and gaps in post-arrival care and immunisation in Victoria.
- **We maintained a dual physical and mental health model.** Mental health has been embedded in our service since 2018, with psychiatry and mental health social work. Tasha Holt (mental health social work) has offered limited outreach school-based work since 2023.

Collaboration with other services

RCH services

- **Immunisation** – after a pilot of integrated immunisation nursing in late 2023, we returned to using the immunisation drop service. Narelle Jenkins (immunisation nursing) evaluated these different models and the return to baseline care, demonstrating the benefits of integrated immunisation nursing.
- **Pathology collection** – with increased patient numbers and necessary focus on post arrival screening, there was an increased load on RCH pathology collection, with significant impact on workflow. We

worked with the pathology team to develop processes to help ensure timely pathology collection, allocated service providers and increased awareness of this patient group.

- **Tuberculosis (TB) service** – Dr Elliot Lyon worked in the TB clinic in 2024. Both A/Prof Hamish Graham and A/Prof Shidan Tosif also work in the TB service.
- **Stepped Care** – Dr Amy Williamson (2024 fellow) continued fortnightly meetings with RCH Stepped care to triage refugee-background and asylum seeker children referred to RCH for developmental care.
- **Victorian Paediatric Rehabilitation Service (VPRS)** – with increased referrals from our team to the VPRS in 2024, we have developed a plan for a combined (bimonthly) clinic to commence in 2025. This service will provide post arrival assessment (from immigrant health) and assessment, advice on tone management and equipment prescriptions (from VPRS) for new arrival children with complex disability. Our team are grateful for the assistance of the VPRS in 2024 and look forward to collaborating in 2025.
- **Finance** – in 2024, our clinic transitioned to NWAUs funding, enabling access for complex asylum seeker cases and other non-resident groups, allowing non-medical referral pathways and avoiding billing mishaps, also streamlining care for these patients at RCH. We continued work with the RCH Finance Department to avoid inappropriate billing of asylum seeker patients and new refugee arrivals without Medicare in other parts of the hospital, with liaison approximately monthly.

External services

- **coHealth** – in 2024 Dr Amy Williamson continued with at coHealth in West Footscray with Drs Jade Woon and Jane Standish providing care close to home for an increasing number of patients.
- **AMES (settlement provider) and Refugee health program (RHP)** – from December 2023, we saw a marked increase in queries about offshore alerts and new arrivals. We developed a shared information system and governance between and met fortnightly with AMES and RHN to plan for the arrival of complex cases.
- **Shaping the paediatric workforce** – the RCH fellow position has been funded by the Department of Health since 2009. We have now trained **34** fellows; all 34 are now consultant paediatricians, with Dr Amy Williamson completing her training at the end of the 2024 year, and Dr Elliot Lyon transitioning to consultant work at Western Health – congratulations Amy and Elliot! We regard this as a significant achievement of our training model – building child refugee health capacity in Victoria through appointing new fellows each year and providing clinical training in refugee health.

Affiliated services

There are multiple affiliated services across metropolitan Melbourne (as below) and in regional Victoria, including Ballarat, Bendigo, and Goulburn Valley Base Hospitals and Barwon Health. Most of these services are led by previous fellows (now consultants), and the RCH team facilitated development of services at coHealth (2007), EACH (2014) and Craigieburn Health Service (2017). All teams work collaboratively, and we aim for care close to home wherever possible, also co-managing patients where required.

- **Craigieburn Health Service** - Northern Health: Dr Czarina Calderon, rotating community fellow.
- **EACH Social and Community Health,** Ringwood East: restarted 2024 Drs Jade Woon and Eva Sudbury.
- **Monash Health** – Refugee health and wellbeing: Dr Saniya Kazi, rotating community paediatrics fellow.
- **Your Community Health Service,** Preston: Drs Sophie Oldfield, Ingrid Laemmle Ruff.
- **Utopia Clinic** - Hoppers Crossing – Dr Dan Mason, Werribee Mercy Health rotating registrars.
- **Western Hospital Sunshine** - based at IPC Deer Park – Dr Yoko Asakawa.
- **Orygen Youth Health (OYH) Refugee Access Service (RAS)** – Dr Tiba Maloof works as a psychiatrist in both the RCH Immigrant health service, and the OYH-RAS.

Staff

In total, the team includes **14** people, reaching **3.74** full time equivalent (FTE). In 2024, the immigrant health

team included: 3 medical consultant roles, a shared full time fellow position, consultant psychiatrist, mental health social work, social work, dental therapist, research nurse, and clinic coordinator.

Dr Hamish Graham took a 12-month leave of absence in 2024 as he commenced ward service and led the Lancet Oxygen Commission (covered by Dr Ingrid Laemmle Ruff) and Dr Shidan Tosif was away for 6 months on Sabbatical leave (covered by Dr Davina Buntsma). Dr Elliot Lyon had a period of parent leave and also reduced hours as he took on consultant work at Sunshine Hospital in November 2024. Our lovely volunteers continued in 2024, with Paula Uren and Anne Howell helping our patients navigate RCH.

Table 1: Immigrant health staff 2024

Position	Staff member	EFT	Totals
Medical lead	Georgie Paxton GP	0.5	Medical **1.74**
Consultants	Andrea Smith AS	0.12	
	Hamish Graham HG cover Ingrid Laemmle Ruff ILR	0.06	
	Shidan Tosif ST cover Davina Buntsma DB	0.06	
Fellows	Elliot Lyon (EL) – change fraction Nov 2024	0.8 (+0.1 TB)→ 0.6	
	Amy Williamson (AW) – change fraction Oct 2023	0.2 (+0.2 coHealth)→ 0.4	
Psychiatrist	Tiba Maloof TM	0.1	Mental health **0.7**
Mental health SW	Tasha Holt TH	0.6	
Coordinator	Natale Massa	0.8	Other **1.3**
Social work	Sarah Martin SM	0.2	
Dental therapist	Tatiana Polizzi TP	0.1	
Research nurse	Katrina Sangster KS	0.2	

Attendances

In 2024, we provided **2004** direct clinical care episodes for **743** patients, including **1525** at RCH Immigrant health clinic.

- **RCH Immigrant health medical** – **1117** attendances for **743** patients, including **265** new patients. **5%** of new attendances and **14%** of review appointments were by telehealth/phone.
- RCH Immigrant health mental health - **236** attendances for **44** patients, including **18** new patients. No new attendances and **28%** of review appointments were by telehealth/phone.
- RCH dental therapy **138** consultations, and social work **34** consultations.

Table 2: Patient attendances 2024

Clinic	**Attendances**				
	Fellows	**Consultants**	**Other staff**	**Mental health**	**All**
RCH Immigrant health	272 AW 279 EL	249 GP, 129 AS 46 ST, 54 ILR, 88 DB	138 TP dental 34 SM social work	141 TH 95 TM	1525
Sub-total	*551*	*566*	*172*	*236*	*1525*
RCH TB Clinic	40 EL	60 HG, 20 ST	-	-	120
CoHealth	359 AW	-	-	-	359
Totals	950	646	172	236	**2004**

Patient numbers medical - AW 163, EL 163, GP 167, AS 83, ST 43, ILR 41, DB 83.

Patient numbers mental health - TM 23, TH 21

Patient numbers other – TP 138, SM 34

Demographics – RCH clinic

- **Clinic attendance was 90%** for medical (1117/1248 bookings), **86%** for mental health (236/276 bookings) and **89%** overall, (1353/1524 bookings).
- **We saw children and young people from 49 different countries of birth**, most commonly Australian-born children from refugee and asylum seeker families, and children from Iran, Afghanistan, Syria, Myanmar, Ethiopia, Iraq and Gaza. This is a further increase compared to 2023 (43) and higher than the decade prior (around 30-34).
- **We saw families speaking 51 languages, and language diversity continues to increase** compared to previous years (42 languages 2024, around 30-33 languages decade prior). The most frequent languages were English, Arabic, Persian, Dari, Oromo and Swahili.
- **Interpreters assisted with 70% of consultations** again due to strong English proficiency in many new arrival Afghans and long-term asylum seeker families.

Other clinical activities

We provided more than **2450** additional clinical consultations during 2024, including the following :

- **Offshore alerts** – **372** cases, from **136** families, between Jan 2024 - May 2025, **16%** (54/337) children who had arrived required an admission, **31** elective and **23** emergency admissions.
- **Hospital inpatient consultations** for around **40** patients, predominantly the offshore alert cohort and billing queries for ~**10** patients.
- **Mental health consultations** – **66** secondary consultations in mental health meetings, and around **5** secondary consults for Foundation House.
- **Hospital internal** – around **800** secure chat and direct staff queries (**50** included as consults).
- **External phone/email consultations/advice** – General Practitioners (GPs), RHN, allied health or case managers – **1800 (150/month)** emails about clinical care.
- **IHMS or Healthcare Australia** requests for medical files on **15** patients.
- **Secondary consultations for Stepped care** - for around **54** patients referred in 2024.
- **Child protection (CP) and unaccompanied minor care team meetings** – at least **38** care team meetings for **58** patients in **25** families with CP involvement, coordinating paediatric review /supports.

Key clinical issues in 2024

Offshore alerts

Offshore health alerts were a key piece of work in 2024 (see above and capacity/service improvement section). In previous years we received around 30 offshore health alerts/complex cases each year, so this represents a **10-fold increase** per year.

Post-arrival screening

Models of post arrival paediatric refugee screening are failing in Victoria. More than 90% of children do not get recommended screening after arrival in current primary care models.

- **Our audits of paediatric refugee health screening in the Victorian primary care model** have found that only **2%** Syrian/Iraqi (2018), **1%** asylum seeker (2023) and **9%** Afghan cohorts (2025) receive recommended screening.
- **Around 30% of new patients had partial screening in primary care**, which results in hours spent chasing results, and increased cost to children/families and the health system through additional health system attendances, pathology collection and repeated blood draws.

Post arrival screening remains essential, with high prevalence of positive screening results for conditions that are easily treatable, and where treatment improves health outcomes. We continue to advocate for good quality, efficient, single timepoint health screening for refugee and asylum background children in Victoria.

Complex disability, genetic, and other medical conditions

In 2024, offshore alerts and general referrals were predominantly for children with complex disability, and/or complex/rare neurological, genetic, metabolic and haematological conditions. Approximate numbers: children with severe cerebral palsy (15+), epilepsy (12+), congenital deafness, (12+), transfusion dependent haemoglobinopathies (6), metabolic conditions (3), cleft palate/complex surgical conditons (5), congenital cardiac disease (5), immunodeficiencies (2), other syndromes (10+), intellectual disability (20+), autism spectrum disorders (20+), other complex medical conditions (10+).

For the first time families are reporting they were prioritised for travel to Australia because their child has a disability, and this complexity is mirrored in an increase in tier 3 (complex) cases reported by AMES (from less than 10% → greater than 30%). Many of these cases required intensive supports after arrival, and many children required admission. A number of children were seen by VPRS leading us to propose a shared clinic model in 2025.

Most new arrival children with complex disability are unwell, malnourished, have significant orthopaedic complication, and frequently have uncontrolled epilepsy. They usually do not have equipment (including wheelchairs), and families rely on public transport after arrival, which is genuinely complex for settlement and attending RCH. The process to get cognitive assessments and wheelchair prescriptions takes months, and we have seen many unsafe interim situations, including injuries sustained from adult size wheelchairs without appropriate seatbelts. Without assessments, children cannot access NDIS, which becomes a catch-22 in terms of equipment and support needs, with flow on effects for housing and school entry.

New Disability Inclusion pathways in Victorian government schools have resulted in long delays in school enrolment and **children with disability typically miss 6-12 months school after arrival.** We have seen many children excluded from school while waiting for cognitive assessments or equipment, perpetuating their educational disadvantage in Australia. There is further complexity in waitlists for specialist education in western Melbourne, which is an area of high settlement. **This is a significant inequity for refugee background children in Victoria, which needs urgent policy consideration.**

Developmental and behavioural paediatrics

Developmental assessments and support for managing learning and behavioural concerns continue to comprise a large part of our work (estimated 70% of clinical workload, also including the complex cohort above). Our cohorts include a high proportion of children with neurodevelopmental concerns, including learning difficulties, behavioural challenges, intellectual disability and autism. Navigating the NDIS entry and support process remains challenging for new arrival children and families. We see substantial and ongoing inequities in NDIS for children from culturally and linguistically diverse (CALD) backgrounds.

We see significant social complexity, and impact on children's wellbeing from poverty, housing stress, cost of living pressures, family violence, and child protection matters. Within our team we work across medical, social work and mental health disciplines to provide holistic child and family centred care.

Mental health

We have seen ongoing and significant stress and mental health concerns in our patient cohorts, and in 2024, this was overt for children and families coming from Gaza. Many of our patients/families have been affected by new or escalating conflict in their countries of origin, and the impact of natural disasters and global politics. Afghan Australians have been deeply distressed about the situation for their families in Afghanistan, and the threat of deportation from Iran and Pakistan, and situations in Sudan and Myanmar continue to deteriorate.

Most mental healthcare is provided within our service, and families express strong preferences for joined up medical and mental health care. Co-located medical and mental health care enables streamlined access, avoids delays through intake processes, and allows comprehensive assessment and therapeutic care. Tasha Holt continues in clinic and school based outreach therapeutic care, providing mental health care close to home and working with care teams within schools. Dr Tiba Maloof provides assessments and direct care and also works with the Refugee Access team within OYH.

In 2024, we had **4** patients seen by Orygen Youth Health (OYH), **<5** patients where the Refugee Access Service (OYH0 were involved, and around **40** patients where care was shared with Foundation House.

Asylum seekers

By 2024, almost all our asylum seeker children and families who arrived by boat have finally received permanent residency. For families who experienced offshore detention in Nauru and Manus, most have now resettled, with some of the remaining children engaging in the New Zealand resettlement process. We see a small number of seriously unwell children and families not engaged in resettlement, with extremely complex circumstances and ongoing impact from their migration experience. An increasing number of asylum seeker background children born in Australia have reached 10 years of age and now hold citizenship. We are seeing increasing numbers of children born in Australia to asylum seeker parents who arrived by plane, whose families' have experienced protracted migration uncertainty.

Advocacy

Advocacy continues to be a large part of our day-to-day clinical work, with many letters, (NDIS, kindergartens, schools, housing), coordination of care and liaison around medications, taxi vouchers/transport, legal support, finance/billing, EMR issues, and interpreter systems.

Capacity, service improvement, education

Offshore alerts and shared information systems

Offshore health alerts or 'potential medical issues (PMI)' are generated if health issues are identified in the immigration medical examination (IME), requiring coordination of care in the early post-arrival period. Individuals/parents sign consent for this follow-up after arrival before travel to Australia. There was a sudden influx of offshore alerts at the 2023 Christmas break, which continued in 2024, requiring a focus on clinical governance and development of new shared information systems.

Offshore information is sent to AMES and then shared with the RHP, who may send paediatric clinical queries to our team. There is significant complexity in keeping track of a large cohort of patients not yet in Australia, with variable (or unknown) arrival times, and no Medicare, address or contact details in Australia.

We were seeing increasing clinical risk and multiple errors in long/mixed email chains from community providers. We completed significant work on our internal governance, including:

- Ensuring all offshore patients are registered correctly on EMR – registering based on information from offshore IME (correct name/date of birth), and AMES paperwork (language, interpreter, family details), providing a descriptive address (e.g. coming from Iraq') and updating details after arrival.
- Documenting sibling groups - in many incoming cohorts, each child in the family has a different surname (e.g. Congolese, Burundian, Rwandan and Rohingyan cohorts).
- Scanning all offshore paperwork in the EMR (IME, departure health check, any other documents, AMES-RHP forms requesting clinical advice) so this is available if children present to RCH.
- Using a proforma for RCH advice and including this in all siblings' EMR files so all advice is documented/available should they present to RCH. Advice is sent to the requesting provider through the EMR.
- Using this system as a form of triage, to direct care close to home (with GP or alternative paediatric care) wherever possible.

We developed a shared information system between RCH-AMES-RHP using a secure RCH sharepoint system, after seeking approval from the RCH Health Information Services (HIS) Committee (approved November 2024). We completed retrospective entry for children/families who had not yet arrived. Evaluation was submitted 8 May 2025, and the system has been approved for ongoing use. Overall, between January 2024 and 8 May 2025, we:

- Included **294** children from **93** families in the SharePoint, with retrospective inclusion of most of the cohort (children yet to arrive).
- Tracked arrival dates and post-arrival case-management details through use of a shared spreadsheet,

reducing email traffic.

- Stored pdf copies of RCH advice in the shared system so this was available for AMES case workers and RHP when children arrived. AMES case managers passed this information onto GPs after arrival, strengthening post arrival care coordination.
- Met with AMES team leaders and RHP staff fortnightly to track cases and plan for any imminent arrivals.

This system ended up saving hours of time each fortnight, and provided a framework for improved patient safety, clinical handover, reduced email queries, and effective triaging systems. One RHP team (DPV) declined to use the shared system. and continue to use standard email to send patient information.

Education

In 2024, increased clinical load reduced our capacity to deliver education. We delivered **11** sessions to more than **1300** participants, including presentations (or contributions to presentations) at **2** conferences.

Table 3: Education sessions, presentations and conferences 2024

Date	Session
7 May 2024	RHP teaching - Malnutrition (EL, 20) - online
8 May 2024	RCH CCCH teaching – Refugee health, English as an Additional Language (AW, GP, 40)
3 Sep 2024	RHP teaching – Deaf and hard of hearing (GP, 20) - online
8 Sep 2024	RCH ED nurses teaching – Refugee health (GP, 10)
2 Oct 2024	ED nurse practitioner education seminar (AW, 10)
17 Oct 2024	RCH JRMOs – Working with interpreters (GP, 40)
24 Oct 2024	**SPANZA-ENT conference** Psychosocial aspects of caring for children plenary (GP, 150)
25 Oct 2024	Victorian **MCH conference** (GP, 1000)
13 Dec 2024	RCH Board and Executive – Immigrant health service (GP, 25)
17 Dec 2024	RHP teaching – Case discussion Epilepsy (EL, 20) - online
15 Jan 2025	Western Health JMS – Refugee Health in Victoria (EL, 10)

Website updates

The Immigrant health website is widely used both inside and outside RCH and is an important part of paediatric refugee health resources in Australia, used by paediatricians, GPs and others working in refugee health.

- **New guideline:** Palestinian refugees
- **3-monthly updates** of Covid-19 guideline
- **Updates to 12 existing guidelines**: Initial assessment, Birthdate Issues, Developmental assessment, Growth and nutrition, Immunisation, Intestinal parasites, Afghan refugees, Caseworker resources, HAPlite – summary for clinicians, Refugee policy and timeline, Syrian refugees, Ukraine refugees.
- **Other updates**: Clinical resources, Other resources, Talks

RACP accreditation

The Immigrant health service is accredited for **Social Paediatrics** (2023) and **Public Health** training (2023) by the Royal Australasian College of Physicians (RACP). This is in addition to RACP accreditation for **Developmental core training** and **Community Child Health** (non-core) with re-accreditation for Community Child Health due in early 2025.

Staff professional development

Team members participated in regular immigrant health meetings, and RCH teaching, and in addition attended the following professional development:

Tasha Holt

- Latest Research on Effective Interventions and Models for Torture and Refugee Trauma, Oct 2024
- When Trauma Intrudes into Sleep: Current Treatment for Traumatic Nightmares in People who have Experienced Torture and Refugee Trauma, Nov 2024

Elliot Lyon

- TB symposium Mar 2024
- Waterpump public health teaching, 8 sessions over the course of the year
- APLS course Apr 2024 (3 days)
- APLS Instructor course Jul 2024 (3 days)
- Neonatal resuscitation course Jul 2024

Amy Williamson

- Australasian Society for Developmental Paediatrics (ASDP) Annual Conference: 22 - 24 Aug 2024
- Practical Skills in Developmental/Behavioural Paediatrics: Friday 25th Oct 2024

Policy, research, health systems

We remain involved in policy work at local, State and Commonwealth levels, including through the committees and working groups listed below.

Policy areas

Immunisation

Narelle Jenkins (Immunisation nursing) completed her analysis of the integrated nurse immunisation model, including baseline data (Jul-Sep 2023), pilot data (Oct-Dec 2024) and follow-up data 12 months later (Oct-Dec 2024). Broader details are included in the 2023 annual report. The proportion of patients due catch-up was **30%**, **17%** and **48%** for the 3 time periods. The increased proportion of patients who are un or under immunised reflects the loss of PRIME, and new gaps in Victorian immunisation for these cohorts.

Vitamin D Sunsmart guidelines

Georgie Paxton had contributed to the Australian Skin and Skin Cancer Research Centre Position statement: Balancing the harms and benefits of sun exposure, published in late 2023, and the academic paper was published in Feb 2024.

Implementation of offshore IME work

The final recommendations arising from work reviewing the offshore immigration medical examination (IME) for humanitarian entrants - submitted in 2022 (Georgie Paxton and Dr Gill Singleton) were implemented in late 2024, with changes to the post arrival alert system to include timelines for review of 1 day (medical escort cases), 1 week (conditions with potential to deteriorate after arrival) and 1 month (general follow up).

Committees, advisory roles, meetings

Over 2024, team members attended around **208** meetings, at hospital, sector/network, State and Commonwealth level. Key advisory roles included: Department of Home Affairs (DHA) Home Affairs Independent Medical Advisor Panel, Department of Health and Aging (DoHA) CALD-Health advisory group, and Department of Health (DH) CALD Advisory Group (all Georgie Paxton).

Table 4: Meetings, committees, advisory roles 2023

Setting	Meetings	No
Regular immigrant health meetings	Weekly - supervision meetings/fellow education (GP, fellows) Weekly - team meetings alternating medical and mental health (all) Weekly - clinic coordinator - referral triage, coordination (NM, GP, fellows) Fortnightly – Stepped care (developmental intake triage at RCH) (fellows)	182

		Fortnightly – AMES-RCH-RHP meetings Monthly – Better access to mental health (OYH) (6 meetings) (GP)	
Committees, working groups, reference groups	State	DH CALD Advisory Group 9/5/24, 19/6/24, 5/8/24, 23/9/24, 18/11/24 Victorian Refugee Health Network 14/3/24, 25/7/24, 14/11/24 RHP meetings – 2-monthly 8/2/24, 3/9/24, + teaching sessions (fellows, GP) Fellow/RHP/DH meetings 19/9/24 Immunisation bimonthly 6/2/24, 16/4/24, 4/6/24, 8/10/24, 3/12/24 (GP, ST)	16
	National	DoHA CALD-Health advisory group 12/3/24, 19/6/24, 3/12/24 RHEANA 21/3/24, 11/4/24, 6/6/24, 29/8/24, 10/9/24, 5/12/24 (GP) Translation panel – Health in a new home 25/9/24, 1/12/24	11

Research

We would like to acknowledge and celebrate research by A/Prof Hamish Graham and A/Prof Shidan Tosif, especially acknowledging Hamish' leadership on the The Lancet Global Health Commission on Medical Oxygen Security. Hamish had **18** publications in 2024, predominantly in high impact journals, which is a phenomenal achievement. This work was completed alongside multiple plenaries, panels and overseas collaborations. Shidan has continued research into Covid,-19 influenza, pandemic preparedness and implementation of essential newborn care programs in low and middle income countries. We have only included Shidan and Hamish' immigrant health relevant publications in the list below.

Georgie Paxton continued in the working group for the Sunsmart guidelines, with the academic paper published in early 2024, and supervised work on the Afghan patient audit and oral health data.

Amy Williamson continued work auditing post-arrival screening and services for a cohort of 218 Afghan refugee entrants.

Anysha Walia is auditing oral health screening data, with a cohort of **668** patients over 2010-22, building on earlier work (2006-2010). Tatiana Polizzi, Georgie Paxton and Ingrid Laemmle-Ruff are also contributing, with HREC approvals in place.

Katrina Sangster has continued work on the nursing experience working with interpreters.

Publications - peer reviewed

1. Evans N, Ahmadi N, Morgan A, Zalmai S, Milner K, Faiz Atif M, **Graham HR**. Supporting caregivers of children living with disability in a humanitarian context: realist-informed evaluation of the Mighty Children program in Afghanistan. *BMJ global health*. Accepted August 2024.
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Strengths and challenges

Strengths include building partnerships with AMES, coordination of healthcare access by AMES working in the complex post-arrival space and developing the clinical governance around shared information systems. We have developed strong collaborations with RCH pathology and Immunisation. Our transition to NWAU funding has reduced billing issues for asylum seeker patients, opened referral pathways for vulnerable children, and fostered collaborations with the Language Schools who can use direct referrals for complex patient situations. The 2024 fellows worked with the Victorian Paediatric Rehabilitation Service to develop a shared clinic model that will commence in February 2025.

Our challenges and areas of concern from 2024 mirror those from 2023 and are summarised as follows:

1. **Increasing intake and increasing need for paediatric refugee health services in Victoria** (demand outstripping capacity)**.** The humanitarian intake has increased, and we have seen greater complexity, a dramatic increase in offshore health alerts, probable triaging of refugee children with disability for Australian settlement, and increased referrals to our service. The high prevalence of disability and complex (often unmanaged) medical conditions mean paediatric refugee health services are an important safety net, especially given long waiting times (often 1-2 years+) for hospital and community paediatrics services in Victoria. Many of the children arriving in 2024 have needed tertiary hospital services and more than 50 children needed admission from the offshore alert cohort. Care for children with intellectual disability, autism, and developmental/behavioural concerns is a major part of our workload, and barriers to cognitive/autism assessments, school entry and NDIS access, and prolonged delays in school enrolment, mean paediatric review is often time critical and an important part of advocacy for these children.

   There is an urgent need for i) more clinic time, ii) to formalise and fund the network of paediatric refugee health providers, and ii) to strengthen statewide child refugee health planning, ensuring refugee background cohorts are included in child health policy and service planning in Victoria.

2. **Failure of post-arrival health screening models in Victoria**. While all new arrival children are linked with a GP by AMES, more than 90% of children do not complete recommended health screening. Around 30% children receive partial screening in primary care, resulting in additional time and costs for children, families and health systems. Even if partial screening has been completed, it is usually difficult to obtain results, and for reasons that are not clear, the My Health Record interface does not seem to be reliable for refugee children. TB screening remains problematic, Mantoux tests are not available in the community, and IGRA is not MBS rebated for screening, presenting costs for families, and a barrier to screening. Immunisation catch-up has notably reduced with the loss of PRIME, resulting in susceptibility to vaccine preventable diseases, lower Centrelink payments, and increased financial stress for new arrival families.

   The role of the RHP varies, around 30% of our patients report seeing a RHN, however complex cases (who most need coordination) are typically placed in short term accommodation for weeks to months after arrival and are not seen by the RHP in this setting. We receive few RHP assessments (<10 in 2024), and there is no process in Victoria to ensure screening is completed in primary care.

   Current systems and policy settings are not meeting post arrival healthcare and screening needs**.** This is in no way intended as a criticism of general practice, and we work with a large cohort of excellent GPs and work to link *all* our patients with a GP for long term care. Rather, this reflects the underlying tension around whether post arrival screening is feasible in primary care, current strains on general practice, and the specialised nature of this work. These challenges are compounded by the increasing medical complexity. With 40% of the humanitarian intake aged under 18 years, **there is a strong case to reappraise models of post-arrival care in Victoria to ensure the health needs of refugee children are addressed.**

3. **Disability care** – there has been a marked increase in new arrival children with complex disability, requiring functional assessments, diagnostic clarification, equipment, NDIS entry and school-based support or specialist education, and sometimes immediate medical stabilisation and admission. There have typically been 6–12-month delays in accessing school and NDIS, perpetuating disadvantage and

inequities, and we have observed a range of unsafe interim situations.

Current infrastructure to support the caseload with disability is inadequate. Components of a response need to include additional intensive casework, paediatric service capacity, early functional assessment and equipment pathways, and streamlining of NDIS and schooling entry. This requires a coordinated policy response across DHA, Department of Health and Ageing (noting NDIS has since come into this portfolio) and State Departments of Health, Families, Fairness and Housing, and Education.

4. **Sector (clinical) coordination** – we remain concerned about siloes in refugee healthcare, the load placed on case workers (who do a remarkable job, especially AMES), and the need for supports beyond the initial 6 months for many families. Challenges include mobile populations, gaps in information sharing, long delays in mental health and counselling intake processes, and further delays in mental health service delivery risking disengagement, NDIS access, school enrolment processes, primary care screening (as above), immunisation, and gaps in coordination across the health system.

   There is a need for additional (direct) capacity in child refugee health, rather than capacity building or indirect coordination roles, which are not currently meeting the needs of new arrival children and families.

Special acknowledgement

This report marks 25 years of Immigrant health at RCH. Our service started in late 1999, developed by Professors Sue Skull and Jonathan Carapetis, with Tatiana starting in 2001, Georgie in 2004, Andy in 2005, the fellow role and Katrina in 2009, Shidan and Hamish in 2014, mental health services in 2018 (Tiba and later Tasha in 2022), and dedicated social work in 2020. Natale started in 2023, preceded by Lily and Helen, coordinating clinic. The service initially provided care to predominantly Somali Australian children living close to RCH. Since this time, we have seen children from all over the world; Sudan, South Sudan, Burundi, Liberia, Ethiopia, Eritrea, Somalia, Democratic Republic of the Congo, Myanmar (Karen, Chin, other groups), Iran, Iraq, Kurdish cohorts, Syria, Afghanistan, Ukraine, Gaza, Rohingyan cohorts, and now Venezuela. Our team have led work on guidelines in refugee health, have worked with the TB service since 2009, and were involved in developing services at Footscray (2007), Preston (2012), Ringwood (2014) and Craigieburn (2017). We still work with all these teams, many now led by our previous fellows (now consultants).

We have seen more than 35,000 attendances over this time, working with thousands of refugee background and asylum seeker children, including those who experienced Australian mainland and offshore detention. We have provided post-arrival and long-term care for children from protracted displacement and from direct conflict situations. We have witnessed the direct and indirect impacts of war on children and families. Medical complexity has increased dramatically, in part reflecting 2012 legislative changes and Australia's inclusive approach to disability and migration. We see the early and long-term trajectories of settlement, and the extraordinary resilience and strength in these communities.

On behalf of RCH Immigrant health - thank-you to our patients and their families for their trust and engagement with our service. The best parts of our job are getting to know children, adolescents, and their families, seeing their health improve, achieving change, and supporting them to settle well in Victoria.

Our thanks to the wonderful volunteers who help our patient group navigate the hospital – Paula Uren and Anne Howell, and to Natale Massa who provides to coordination and practical support that keeps the show on the road.

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Georgie Paxton, Amy Williamson, and Elliot Lyon,

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