

Evaluation of the Integrated Humanitarian Settlement Strategy (IHSS)



Final Report

Prepared for
Department of Immigration and Multicultural and Indigenous Affairs
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Study Team

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Glossary

AMEP	Adult Migrant English Program
AMES	Adult Multicultural Education Services
AS	Accommodation Support
ASETTS	Association for Services to Torture and Trauma Survivors, WA
CALFRIC	Committee for the Allocation of Loan Funds to Refugees in Centres
CRSS	Community Refugee Settlement Scheme
CRU	Central Referral Unit
CSR	Community Support for Refugees
CSSS	Community Settlement Services Scheme
DHA	Commonwealth Department of Health and Ageing
DIMIA	Commonwealth Department of Immigration and Multicultural and Indigenous Affairs
EHA1	Early Health Assessment and Intervention
EIP	Early Intervention Program
FASSTT	Forum of Australian Services for Survivors of Torture and Trauma
GBLs	Guaranteed Business Levels
HFS	Household Formation Support
HUSCI	Humanitarian Settlement Client Information
IHSS	Integrated Humanitarian Settlement Strategy
IOM	International Organisation for Migration
IIOA	Initial Information and Orientation Assistance
MRCs	Migrant Resource Centres
MSAs	Migrant Service Agencies

NFSSTT	National Forum of Services for the Survivors of Torture and Trauma
OAA	On Arrival Accommodation
PASTT	Program of Assistance to the Survivors of Torture and Trauma
PS	Proposer Support
PV	Protection Visa
QIRCH	Queensland Integrated Refugee Community Health Clinic
QPASTT	Queensland Program of Assistance to Survivors of Torture and Trauma
RCOA	Refugee Council of Australia
SHP	Special Humanitarian Program
SSP	Service Support for Providers
STTARS	Survivors of Torture and Trauma Assistance and Rehabilitation Service, SA
STARTTS	Service for the Treatment and Rehabilitation of Torture and Trauma Survivors, NSW
TIS	Translating and Interpreting Service
TPV	Temporary Protection Visa
TTSSNT	Torture and Trauma Survivors Service of the NT (now Melaleuca Refugee Centre)
VFST	Victorian Foundation for Survivors of Torture

Executive summary

Introduction

The Commonwealth Department of Immigration and Multicultural and Indigenous Affairs (DIMIA) and the Commonwealth Department of Health and Ageing (DHA) commissioned Urbis Keys Young to carry out a combined evaluation of the Integrated Humanitarian Settlement Strategy (IHSS) and of Commonwealth funded services for survivors of torture and trauma.

The purpose of the evaluation was to review the services to provide better information for future development including funding. Specifically the evaluation was to:

- assess whether services are meeting their objectives and whether there are any gaps, omissions or duplications.
- identify any modifications necessary to deliver services to clients in a more efficient, effective and equitable manner.
- assess the extent to which services to survivors of torture and trauma funded by the Commonwealth Government are meeting client needs in accordance with the principles and standards stated in the relevant contracts and funding agreements between DIMIA, DHA and the Forum of Australian Services for the Survivors of Torture and Trauma.
- provide practical and implementable recommendations to improve service delivery for all aspects of the services.

The evaluation involved an extensive consultation process with the two Departments; clients of the services; service providers and a range of other stakeholders as well as a review of background data and documentation and an evaluation website with the capacity to receive submissions.

Details of the methodology for the evaluation are at Appendix A.

The evaluation has identified a number of positive outcomes achieved by IHSS services over their initial years of operation. These are as follows:

- There is increased equity in service provision – most eligible entrants are consistently receiving at least a core set of services.
- Timely provision of service – eligible entrants begin to receive these services from the moment they arrive in Australia and throughout their initial settlement phase.
- Basic support needs are being met and few major gaps have been identified.
- There is a very high level of satisfaction among clients.
- There is evidence of increased professionalism in the way services are delivered.
- The delivery of services is consistent with stated IHSS principles.
- Reliance on a sole provider and the potential for client dependency has been reduced.

The evaluation has also identified a number of general areas requiring attention in future development of the IHSS.

- While overall client needs have been met, there is a lack of common understanding of what constitutes initial settlement needs, how much service is appropriate and when and how clients should be referred to other IHSS and non IHSS agencies. There are also some gaps in the model, for example relating to how urgent physical health needs are addressed in the first two weeks after an entrant's arrival. Finally, there is some evidence that recent arrivals may have higher support needs than previous groups.
- Integration of the IHSS services has, in many instances, been inadequate and the divisions between agencies have created silos that affect smooth and efficient

service delivery. A lack of coordination between service providers results in clients not always receiving appropriate referrals, increased workloads for individual service providers and duplication of services.

- There is evidence of a degree of duplication of services and, occasionally, gaps in services arising from the way in which IHSS is structured and contracted out.
- There is evidence of a lack of continuity between *initial* (ie IHSS) services and longer term settlement services (eg CSSS). At issue is the nature of exit procedures from IHSS.
- Problems are experienced as a result of inadequate or incorrect information received from overseas posts. This, combined with short notice of arrivals, often prevents providers making appropriate arrangements prior to entrants' arrival and can result in unsatisfactory arrangements being made. However much of this is outside the control of DIMIA and may be difficult to address.
- Uneven flow of entrants continues to be a problem for service providers, who experience considerable difficulties that ripple through the whole service. Service providers acknowledge that part of the problem arises from their own lack of managerial experience in managing the flows. The situation has improved, but has not been completely resolved, by the introduction of Guaranteed Business Levels (GBLs).
- The HUSCI data management system was identified by service providers and departmental staff alike as being problematic.
- One issue raised by many service providers was that they considered that the structure and level of pricing under IHSS do not always reflect service delivery requirements. It was not possible, in the

course of the evaluation, to conduct an in-depth analysis of IHSS pricing arrangements to determine the validity of service providers' claims and such an analysis is clearly needed.

In relation to the individual IHSS service types, the evaluation found that:

- AS service providers in particular face difficulties resulting from the ebbs and flows of new arrivals, limited housing stock in many areas, higher rental prices and the fact that some families are particularly difficult to house. Where the same service provider handles both initial and long-term accommodation these difficulties seem to be dealt with more effectively.
- HFS pricing assumes that service providers will be able to 'top-up' goods with free goods provided on a charitable basis. In practice this has often not occurred, for a variety of reasons including short supply of appropriate goods, high demand for second-hand goods, unwillingness of other charitable organisations to assist the HFS provider and/or unwillingness of providers to 'top up' without being paid.
- Many humanitarian entrants have immediate physical health needs upon their arrival in Australia. There needs to be a mechanism to ensure that health problems identified before arrival in Australia are appropriately followed up.
- There is a gap in the services delivered under IIOA and EHAI; in practice no-one has explicit contractual responsibility for addressing the health needs of entrants in the period between the first 24 hours and the notional two weeks (after referral) within which the EHAI information process must commence.
- The evaluation identified that the training and advice/consultancy given by EHAI providers was of a very high standard but only a minority of the hours were delivered to medical health services. Training covered a very broad range of agencies including legal services and schools. While

the importance of this training is recognised, an issue for DIMIA to address is to what extent it should be provided by the IHSS or whether it is the responsibility of other agencies.

- There is a significant number of problems associated with PS including the inability of many proposers to provide support, difficulties in tracking down proposers and barriers to information actually being passed on to sponsored entrants. The result is that, often, PS simply does not deliver the expected outcomes.
- The transition to the IHSS has left a number of volunteers 'out in the cold' for a range of reasons eg concerns about levels of professionalism, quality control, capacity to resource volunteer management and contractual limitations. Volunteer involvement appears to be crucial to the success of IHSS. While CSR was developed in response, the reality is that many of volunteers operate outside CSR.

Recommendations

In addressing these issues, the evaluation recommends that:

Recommendation 1

Client Needs

DIMIA should work in conjunction with IHSS service providers to review and specify the range of activities/outcomes for IHSS, who is responsible for each group of activities/outcomes and how to identify and manage a reasonable level of need.

Recommendation 2

Integration

Consideration should be given to extending the contracting of multiple service types within one agency (within any one location) and to greater use of subcontracting where specialist services are sought.

Recommendation 3

Case Coordination

DIMIA, in conjunction with IHSS service providers, needs to review the way in which case and service coordination currently take place and to establish practices to ensure more effective integration of services to clients.

Recommendation 4

Exit Procedures

There is a need to develop standardised exit protocols and documentation and/or to disseminate good practice examples of IHSS exit procedures as part of a case planning process.

Recommendation 5

Duplication

There is a need to better align IHSS service providers with the CSSS, including clarification of roles in relation to longer term settlement, in order to avoid duplication.

Recommendation 6

Streamlining/Mainstreaming

DIMIA at a national level, needs to work more effectively with representatives from other key (national) Commonwealth departments and agencies (eg Centrelink, Health Insurance Commission, DEWR) and with other sections within DIMIA (eg AMEP) to develop mechanisms for streamlining service provision. This 'top-down' effort would be directed at enhancing access to mainstream services by humanitarian entrants and facilitating action by service providers at a local level.

Recommendation 7

Information

DIMIA should identify whether there are any ways of improving the accuracy of information provided by Overseas Posts.

Recommendation 8

Managing Uneven Flow

DIMIA needs to examine whether there are any means by which the peaks and troughs of entrants flows might be evened out. If peaks and troughs are unavoidable but predictable there needs to be improved communication regarding these patterns to service providers. As well, more flexible managerial systems need to be put in place by service providers to assist them to manage the variations more effectively.

Recommendation 9

Reporting and Accountability Requirements

More effective ways of ensuring appropriate reporting and of meeting accountability requirements by service providers need to be implemented. These reporting mechanisms should meet the needs of both DIMIA and service providers.

Recommendation 10

IHSS Pricing

A separate analysis needs to be undertaken of the structure and level of IHSS pricing to determine their appropriateness for service delivery requirements.

Recommendation 11

Accommodation Support Services

Where appropriate, short term and longer term accommodation support services should be combined to provide a continuous accommodation support service for entrants and to assist in dealing with some of the challenges in delivering this service

Recommendation 12

Household Formation Support

DIMIA should consider increasing the amount of money made available under HFS.

The HFS unit price should be tied to the size and composition of the household.

Recommendation 13

Basic Household Items

DIMIA should work with service providers to identify basic household items which must be available to all clients. Further they should also identify a list of optional items, from which entrants can select a specified number to a certain value that most effectively meet the needs of their particular household.

Recommendation 14

Medical Information Requirements

DIMIA needs to ensure that information on medical examinations conducted overseas (and any undertakings made) is provided to the most appropriate IHSS service before or upon the entrant's arrival in Australia and that the IHSS facilitates any follow up action.

Recommendation 15

Improving Physical Health Support

There is a need to review IHSS contractual arrangements to ensure that entrants are offered linkages to ongoing physical health support on arrival in Australia.

This would include determining whether it may be more appropriate to offer separately the physical and psychological support components of the IHSS.

Recommendation 16

Training Component of EHA

DIMIA should review the training component of EHA and determine whether the training efforts of EHA service providers should more strongly target workers in the health sectors rather than the non-health sectors.

Recommendation 17

Improving Proposer Support

The PS service as it currently stands should be abolished. In future both Refugee and SHP entrants should be assisted by IIOA providers. Greater flexibility should be provided in the delivery of this service. IIOA providers would be responsible for assessing the settlement support available to Refugees and SHP entrants from family or friends, and for providing guidance to maximise that support. For entrants (both Refugee and SHP) who require additional support, the provider would be responsible for making sure that entrants have the appropriate information and are linked with other services for which they are eligible. Entrants with comparatively lower needs could be linked with volunteer groups for the provision of these services.

Recommendation 18

Community Support for Refugees

DIMIA should continue to monitor the development of the CSR network and this should be undertaken with an awareness that a large proportion of volunteers currently operate independently of CSR. Ways to strengthen relationships with providers should be explored.

1 Introduction

The Commonwealth Department of Immigration and Multicultural and Indigenous Affairs (DIMIA) and the Commonwealth Department of Health and Ageing (DHA) commissioned Urbis Keys Young to carry out a combined evaluation of the Integrated Humanitarian Settlement Strategy (IHSS) and of Commonwealth funded services for survivors of torture and trauma. The Early Health Assessment and Intervention (EHAI) service (funded by DIMIA and part of the IHSS) and the Program of Assistance to Survivors of Torture and Trauma (PASTT) funded by DHA, constitute Commonwealth funded services for survivors of torture and trauma. The IHSS is delivered through 38 contracts with a range of non-government and some commercial organisations. Commonwealth funded services for survivors of torture and trauma are currently delivered by the Forum of Australian Services for Survivors of Torture and Trauma (FASSTT) through IHSS contracts with DIMIA (EHAI) and service agreements with DHA (PASTT).

The purpose of the Evaluation is to review the services to provide better information for future development including funding. Specifically the evaluation was to:

- assess whether they are meeting their objectives and whether there are any gaps, omissions or duplications
- identify any modifications necessary to deliver services to clients in a more efficient, effective and equitable manner
- assess the extent to which services to survivors of torture and trauma funded by the Commonwealth Government are meeting client needs in accordance with the principles and standards stated in the relevant contracts and funding agreements between DIMIA, DHA and the FASSTT
- provide practical and implementable recommendations to improve service delivery for all aspects of the services.

As there are two parts to the evaluation, separate terms of reference were developed.

1.1 Terms of reference

The Refugee Council of Australia (RCOA) was contracted to provide guidance to DIMIA in the development of the Terms of Reference for the IHSS evaluation. As part of this process, the RCOA held extensive consultations to prepare a report, which considered the terms of reference for this evaluation. The terms of reference for the IHSS evaluation were to:

- 1) assess the extent to which the IHSS is able to identify and meet the initial settlement needs of humanitarian entrants in an equitable, effective, efficient and timely manner
- 2) assess the extent to which each of the service types under the IHSS is able to achieve its specified objectives and outcomes for all clients and provide a service consistent with the IHSS service principles
- 3) assess the extent to which volunteers are able to contribute effectively to meeting the support needs of entrants as envisaged in the Community Support for Refugees (CSR) and IHSS models
- 4) assess the integration of services from the perspective of all relevant stakeholders

- 5) assess the transition arrangements (exit procedures) from the perspective of all relevant stakeholders.

The terms of reference for the evaluation of Commonwealth funded services for survivors of torture and trauma were developed jointly by DIMIA and DHA in consultation with the FASSTT. The terms of reference were:

- 1) identify the extent to which client and non-client services currently offered by the organisations and funded by DIMIA and DHA are meeting client needs and service requirements (eg newly arrived humanitarian program entrants including TPV holders; long term residents who have refugee or refugee-like backgrounds, clients residing outside major metropolitan areas and mainstream providers)
- 2) based on the information generated above, provide options for how the service parameters may be modified to ensure they reflect client needs
- 3) analyse the sources and level of Commonwealth funding, determining adequacy, the extent to which they are complimentary and the appropriateness of the funding arrangements
- 4) identify the extent to which torture and trauma services integrate/link with other relevant services including what issues impact on this
- 5) provide advice on possible mechanisms and processes that can assist with future monitoring, quality assurance and evaluation of services, such as national standards.

This report addresses the Terms of Reference for the IHSS Evaluation. A companion report, which has yet to be finalised, addresses the Terms of Reference for the Evaluation of the Commonwealth funded services for the survivors of torture and trauma. Both parts of the evaluation were undertaken concurrently.

1.2 Structure of this report

This report is structured as follows:

- Section 2 outlines the background to the IHSS.
- Section 3 presents the key achievements in relation to the IHSS
- Section 4 addresses the Terms of Reference 1, 3, 4 and 5 and some other issues raised during the course of the evaluation
- Section 5 addresses Term of Reference 2 which refers to the individual service types under the IHSS
- The methodology for the evaluation is at Attachment A.

2 Background

2.1 Introduction

This report presents the findings of the evaluation of the IHSS and a companion report, yet to be finalised, addresses the findings for the evaluation of the Commonwealth funded services for the survivors of torture and trauma. Before embarking on the discussion which forms the main body of the report, it is important to provide a historical and general overview of the services and particularly the relationship between the service and the funding bodies. This is presented diagrammatically below.

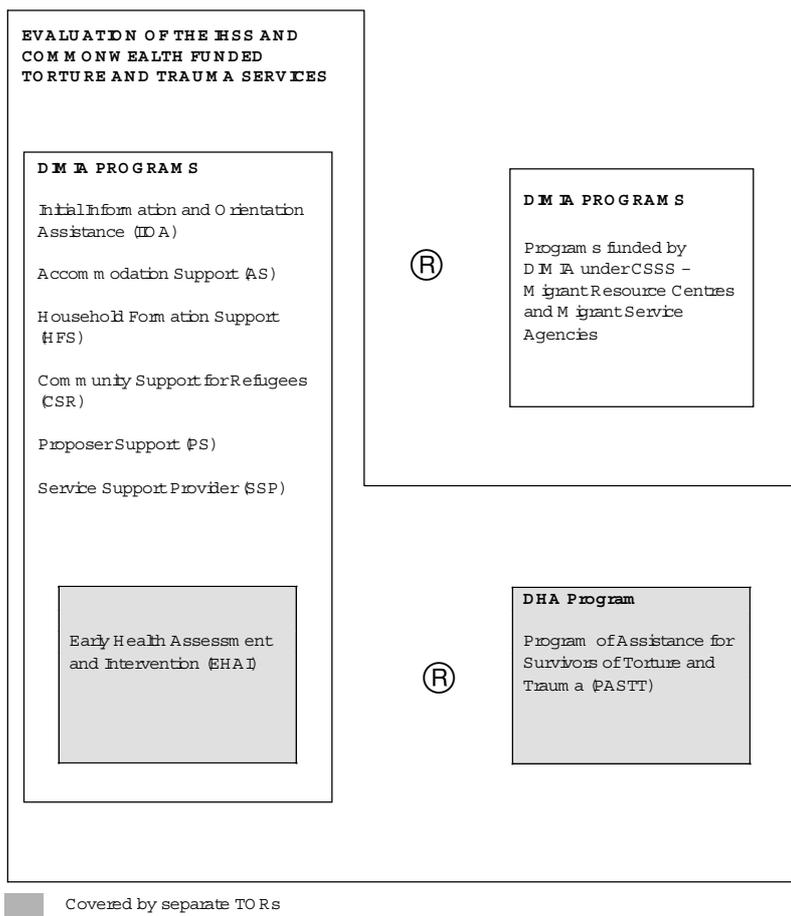


Figure 2.1: Structure of IHSS and PASTT services

2.2 IHSS¹

2.2.1 Historical overview

Until the 1970s, humanitarian entrants were eligible for accommodation at migrant hostels, along with other migrants who arrived by assisted passage. However it became clear that more specialised assistance was needed for humanitarian entrants who did not wish to live in migrant hostels. At the same time, the community sector was seeking a greater role in meeting the settlement needs of humanitarian entrants.

As a result, the Community Refugee Settlement Scheme (CRSS), a network of volunteer groups, was established in 1979 to provide assistance to humanitarian entrants with finding accommodation and employment, general orientation and social support. At the same time the Committee for the Allocation of Loan Funds to Refugees in Centres (CALFRIC) was established to provide support for humanitarian entrants who wished to move from hostels into private housing by offering interest-free loans to cover associated costs.

The CRSS and CALFRIC initiatives reflected formal recognition of the specific needs of humanitarian entrants as a distinct category and initiated a partnership between government and the wider community in the provision of settlement assistance. They also diversified settlement services by providing an alternative to migrant centres.

A review of migrant hostels in 1984 led to the closure of several hostels and a general shift towards self-contained accommodation. In 1986, the Review of Migrant and Multicultural Programs and Services recommended that accommodation should be provided only for those with limited financial resources, and especially for humanitarian entrants. It also recommended a shift to self-contained, self-catering units with co-located support services. DIMIA established the On Arrival Accommodation (OAA) Scheme in order to provide this kind of accommodation for humanitarian entrants. The former migrant centres were closed and replaced with government-leased flats.

From the mid-1980s there were three categories of assistance:

- OAA was provided for the highest needs entrants, refugee visa holders without proposers and permanent visa holders released from detention without family or community support. They were eligible for thirteen weeks of accommodation in government-leased flats, with extensions for cases of special need. After the first week of accommodation, entrants in the OAA service generally paid approximately 30% of their welfare benefits as rent and a small weekly contribution towards utilities. Their eventual move to private accommodation was assisted by CALFRIC loans. As CALFRIC was phased out from the mid-1990s, DIMIA developed a Rent Rebate Scheme by which entrants whose rent and utility contributions had been paid in full were eligible for a rebate of four weeks rental contribution. The OAA accommodation served as a useful base for access to other settlement support services.
- CRSS volunteers supported other high needs entrants - those without links in Australia, who had experienced torture or trauma and refugee women entering under the 'Women at Risk' category. Entrants were met at the airport and assisted with general orientation, practical assistance and social support, generally for six months after arrival. DIMIA provided a contribution of around \$1,100 for single entrants and a further \$300 per family member to enable volunteer groups to recover some of the costs involved. CRSS volunteers also proposed families.

¹ This information was provided by DIMIA and replicates the information in the Settlement Services Review (SSR).

- The third group were those who received support from their *proposers* (sponsors).

From 1989, entrants who had survived torture and trauma were able to access specialised support, including counselling, through a network of nationwide agencies. From the early 1990s, they were also eligible for assistance from the Clothing Reimbursement Scheme for emergency clothing on arrival. In 1995, DIMIA entered into a national contract for the provision of property management and ancillary services for OAA.

Under these arrangements, entrants were streamed into the CRSS or OAA services based on their visa category with no focus on relative need. Proposed humanitarian entrants were assumed to be receiving assistance from their proposers.

From 1997, DIMIA began to develop a national framework to make more effective use of settlement services for humanitarian entrants through partnerships with community organisations and improved links between settlement planning activities and service delivery. The 1997-98 Budget included an increase in the level of material assistance provided through CRSS groups and rolled the Clothing Reimbursement Scheme into a general grant for establishing a household.

Following a 1998 report on DIMIA's settlement services by the Auditor General and a 1998 DIMIA review of material assistance to humanitarian entrants, the Department began to explore options for a more developmental approach to humanitarian settlement. The new service for supporting humanitarian entrants needed to be explicit in its aim of respecting their autonomy and not encouraging dependency. It sought to affirm the capacity and dignity of entrants and provide them with skills and tools to reach self-sufficiency and make their own way along the settlement path as soon as possible.

Thus the IHSS evolved into a group of specialised services designed to provide intensive *initial settlement support* to newly arrived humanitarian entrants. The major innovation of the IHSS was that services were competitively tendered and contracted. The IHSS marked the first implementation of the purchaser/provider model of service delivery in humanitarian settlement services.

The new model also maintained the valuable role played by volunteers in assisting refugees to settle in Australia. The CSR service within the IHSS framework is delivered by registered volunteer groups whose role is to provide practical social support to newly arrived refugees and humanitarian entrants.

2.2.2 IHSS services

The suite of services provided to entrants under the IHSS is:

- *Initial Information and Orientation Assistance* (IIOA), which links entrants to the services they need in the initial stages of settlement. This service type includes meeting entrants at the airport, taking them to register for Centrelink benefits and health support such as Medicare and arranging and coordinating other IHSS services.
- *Accommodation Support (AS) Services*, which ensures that entrants have accommodation on arrival and assistance to secure long-term accommodation as soon as possible.
- *Household Formation Support* (HFS), which provides entrants with some material goods to start establishing a household in Australia.

- *Early Health Assessment and Intervention (EHAI)*, which offers entrants information on health services available to them, a physical and psychological/psychosocial assessment and referral to other health services including torture and trauma counselling where required.
- *Community Support for Refugees (CSR)*, through which volunteer community groups provide social and friendship support and may also choose to assist with the provision of other IHSS services.

The IHSS also provides support to proposers and to all providers of IHSS services, including volunteers, through the following services:

- *Proposer Support (PS)*, which provides information and a post-arrival 'help' service to assist proposers in meeting their responsibilities to entrants.
- *Service Support for Providers (SSP)* provides support and training to IHSS service providers to meet the service needs of entrants and their obligations as service providers and is responsible for the recruitment, coordination and registration of CSR groups and for providing them with support and training under CSR coordination and support services.

IHSS support is normally provided for around six months, although this period may be extended for particularly vulnerable clients with special needs. The IHSS focuses strongly on equipping entrants to gain access to mainstream services. However, a proportion of these entrants may require further assistance from other DIMIA-funded settlement services, such as Migrant Resource Centres/Migrant Service Agencies (MRCs/MSAs) and the Community Settlement Services Scheme (CSSS).

2.2.3 Eligibility for IHSS assistance

All humanitarian entrants are eligible for at least some IHSS services. Assistance within the IHSS is targeted according to the individual needs of the entrants.

Entrants under the Refugee category have been found to have been *subject to persecution in their home country*. The Commonwealth Government pays the airfares and medical screening costs of all Refugee category entrants and they receive the highest level of support within the IHSS. Entrants under this category may have been granted any one of the following visa sub-categories:

- *Subclass 200 – Refugee*: assists people who are outside their home country who are subject to persecution in their home country and have a strong need for resettlement.
- *Subclass 201 – In-Country Special Humanitarian*: assists people still in their home country who are identified as in need of resettlement by a major human rights organisation because they are being persecuted.
- *Subclass 203 – Emergency Rescue*: these visas may be granted to people in or outside their home country who are in urgent and compelling need to travel and for whom resettlement in Australia is the appropriate solution. Refugees in need of emergency resettlement are usually referred to Australia by UNHCR.
- *Subclass 204 – Woman at Risk*: assists women who are in particularly vulnerable situations and recognises that such women may be exposed to the risk of serious abuse, sexual assault, victimisation or harassment where traditional support and protection have unavoidably broken down.

Special Humanitarian Program (SHP) entrants (*Subclass 202*) – may not meet the persecution test described above, but have nevertheless suffered substantial discrimination amounting to a gross

violation of their human rights in their home country and who also have links with Australia. This is demonstrated by a proposal accompanying their application from an Australian citizen or permanent resident or a body operating in Australia. The proposer provides an undertaking to assist the new entrants with the cost for medical checks and air travel to Australia and to assist them with the equivalent of AS and IIOA upon their arrival in Australia.

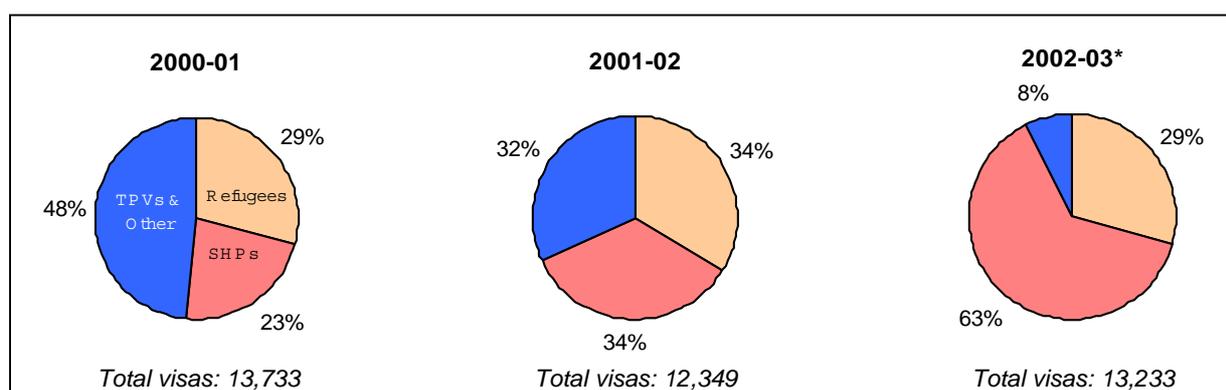
SHP entrants are eligible for HFS and EHAI under IHSS. They are also eligible for assistance under the PASTT. Their proposers are eligible for assistance through the Proposer Support service.²

Temporary Protection Visa (TPV) holders are unauthorised arrivals who have been found to be refugees and to warrant Australian protection. They are ineligible for most settlement services, however, under the IHSS they are eligible for EHAI, including torture and trauma counselling, if required.

A significant trend that has occurred over the past few years has been the steep rise in the overall number and proportion of total entrants represented by SHP entrants (Subclass 202). The graphs below illustrate this growth over the past three years.

One consequence of this growth has been significantly increased demand on the services for which these entrants are eligible (HFS and EHAI as well as torture and trauma counselling under PASTT). This trend has also highlighted the often considerable needs of these entrants which remain unaddressed because they are not eligible for the full range of IHSS services, although they may have very similar backgrounds and experiences as those receiving IHSS services. Thus, while they have similar needs, the SHP entrants have restricted access to IHSS services.

Figure 2.2: Visas granted 2000-01 to 2002-03



*2002-03 Allocated places (DIMIA figures)

2.2.4 IHSS Service Principles

Service principles for the IHSS focus on affirming the capacity of entrants. The IHSS principles are:

² SHP entrants may also become eligible for other IHSS services (eg IIOA) by agreement with DIMIA if support from their proposer breaks down. This is determined on a 'case by case' basis.

- a. Humanitarian Program entrants are individuals who have the inherent right to respect for their human worth and dignity.
- b. Humanitarian Program entrants are able to exercise choice.
- c. Humanitarian Program entrants are informed and involved in decision making.
- d. Services are designed and administered so as to promote Humanitarian Program entrants' competence and to discourage dependency.
- e. The health and well-being of Humanitarian Program entrants are protected.
- f. The best interests of children are taken into account.
- g. The least intrusive and the least disruptive option which offers the highest degree of stability and certainty is selected.
- h. Traditional, cultural and religious values are respected.
- i. Services and decisions are ethical and Humanitarian Program entrants are not exploited.
- j. Services promote participation of Humanitarian Program entrants in the wider community and their understanding of legal obligations.
- k. Organisations providing services are accountable to those who use their services and to the Commonwealth.
- l. Humanitarian Program entrants are enabled to access services in a coordinated way which minimises gaps and duplication between services received.

2.2.5 Contracting IHSS

All service providers, both community-based and some commercial, deliver IHSS services on a contractual basis. Volunteers generally support these providers in delivering IHSS services.

Through the Request for Tenders process, DIMIA identifies the services to be delivered, the associated standards and the geographical locations in which the services are to be provided. Organisations are invited to tender and tenders are selected on the basis of the best overall value for money. DIMIA negotiates the price and/or pricing formula it will pay for the provision of services and awards a contract for a fixed period of time.

The only service not competitively tendered to date has been the EHAI service. The Early Intervention Program, on which EHAI was based, was half way through a four year development period when the IHSS was introduced.

Thirty-eight IHSS contracts are currently in place, providing services in all States and Territories of Australia. IHSS services are available in all capital cities and in several regional areas.

Payments to service providers vary according to prices negotiated in individual contracts and are based on the number of entrants provided with the service. Individual contracts provide for yearly

adjustments to the unit price based on the national average Consumer Price Index (CPI) increase. Invoicing and payment procedures vary slightly from contract to contract and between States and Territories.

Contracts provide for an establishment price for the purpose of purchasing items or services for the delivery of contract services. This payment is usually made on commencement of the contract services.

Generally, contract fees are paid in advance in equal quarterly instalments based on the anticipated business level. Acquittal at the end of the period is based on actual business and service providers must provide information on the actual level of business performed during the period covered by the advance payment. Dates for the provision of invoices covering the advance payments are set in the individual contracts. Adjustments are made to each subsequent invoice for any over or under performance. If the service provider does not submit a correctly rendered invoice by the due date, or if performance reports are not forthcoming by their due dates, DIMIA can delay payment.

In order to address the issue of uneven flow of arrivals (which was causing considerable problems for service providers) in July 2002, DIMIA offered all IHSS service providers a minimum guaranteed business level in order to reduce the level of business risk. Under this guarantee, DIMIA will prepay 60% of the guaranteed business at the beginning of the financial year, the balance being paid the following January. The level of minimum guaranteed business is based on a conservative projection of offshore refugee cases settling in Australia during a service year.

Several IHSS service providers have opted to continue with previous arrangements, and DIMIA has issued these providers with estimated business levels.

2.2.6 The Central Referral Unit and referral processes

The Central Referral Unit (CRU) in DIMIA Central Office coordinates the arrival of entrants in Australia by liaising between overseas posts and State and Territory Offices. The CRU receives information from overseas posts regarding visa grants and any connections that the entrant may have in Australia. Decisions on where to send entrants take into account planned business levels for IHSS service providers in each State and Territory and the availability of community and other potential sources of support. State and Territory DIMIA Offices agree to referrals and advise relevant IHSS service providers. The CRU attempts to regulate to the degree possible the flow of entrants so that no one State or Territory is under used or overburdened at any one time. However, in the case of SHP entrants, settlement patterns are governed by the location of proposers. IHSS services are currently available in some regional locations such as the Coffs Harbour, Wagga Wagga and Newcastle areas of New South Wales; Geelong in Victoria; Townsville, Cairns, Toowoomba and the Logan, Beenleigh and Gold Coast region in Queensland; and in the Northern Region of Tasmania. While there may be IHSS providers in regional areas, access to services linking to the IHSS and the availability of employment and community support are key considerations in determining the most appropriate destination for an unlinked refugee. Refugee entrants generally require ongoing specialist health and counselling services as a result of their experiences before coming to Australia.

2.2.7 Pre-embarkation information

In order to address the problems caused by unrealistic expectations among entrants about their likely standard of living in Australia generally and about IHSS services in particular, new pre-embarkation information is currently being developed. DIMIA has engaged a specialist consultant for this purpose

and the information is expected to be available to Posts and on the DIMIA website by mid 2003. Information will cover general issues as well as State, Territory and regionally specific material. It will be translated into various languages and distributed via fact sheets as well as on-line.

2.3 Commonwealth funded services for survivors of torture and trauma

2.3.1 Historical overview

Commonwealth funded services for survivors of torture and trauma include both EHAI under the IHSS (funded by DIMIA) and PASTT (funded by DHA). Both are currently delivered by the FASSTT (formerly the National Forum of Services for Survivors of Torture and Trauma). The Forum is a network of organisations which offers specialist support for people who have come to Australia from countries where they have experienced torture and other forms of trauma. There is one member of the Forum in each State and Territory.

Since 1997 DIMIA has contracted the Forum to provide specialised torture and trauma support to newly arrived refugees and other Humanitarian Program entrants.

The history of the EHAI component of the IHSS was built around pilot services initiated by members of the Forum in the early to mid nineties. These initiatives were generated principally to meet new challenges created by the closure of migrant hostels in Victoria and NSW for the reception, care and initial accommodation of newly arrived refugees. They were also a response to the need to provide 'on arrival accommodation' facilities to Bosnian refugees recently released from concentration camps. These challenges emerged from a desire to decentralise this component of the settlement service and move new arrivals more directly into living in the community. However, this goal was seen as being compromised by several factors including:

- limited expertise and services to meet the particular needs of newly arrived refugees by governments, health, community, educational and to a lesser extent settlement service providers
- a lack of adequate resources to facilitate timely access to general and specialist services
- the absence of a coordinated and systematic model for providing initial settlement services
- a marginal role in the provision of targeted services to this client group by State and Territory government services.

In October 1997 DIMIA funded a proposal from the Forum to establish a National Early Intervention Service (EIP) for Refugee and Humanitarian Program entrants. This funding was in the form of annual grants. DIMIA funded members of the Forum approximately \$2.5 million to deliver the EIP across Australia in 1999-2000. The EIP essentially expanded the pilot project models developed by the Forum agencies.

The EIP was developed in each State and Territory by the relevant Forum member to:

- collaborate with key health and settlement services to establish systems for offering routine assessment to Humanitarian entrants shortly after their arrival in Australia
- offer assistance to entrants to address physical and psychological health problems which may become barriers to successful settlement
- facilitate entrants' access to mainstream services and resources required for successful settlement

- work in partnership with mainstream health and settlement providers to develop initiatives to enable Humanitarian entrants to access these services
- work with health and settlement providers to enhance their skills in identifying and providing appropriate support to Humanitarian entrants.

As the EIP was still being developed when DIMIA commenced implementation of the IHSS in late 1999, the Forum was invited to respond to a sole source tender for the delivery of the EHAI service under the IHSS. The EHAI service is largely based on the service elements of the EIP. In June/July 2000, DIMIA entered into three-year contracts with each individual State/Territory member of the Forum for delivery of the EHAI service.

The Forum agencies are also funded through DHA for longer-term support of torture and trauma survivors through PASTT. PASTT has been funded by DHA since 1994. The objective is to promote the physical health and psychological recovery of people who have experienced torture and trauma in their countries of origin or while fleeing these countries, prior to their arrival in Australia. PASTT aims to improve clients' access to health, mental health and related mainstream services after they have received the specialist assistance they need. Approximately \$5.84 million has been allocated to the PASTT service for the four year funding cycle 1999-2003.

While there are obvious synergies and the implication of a continuum of service between EHAI and PASTT, they were developed and implemented separately by the respective Departments. This combined evaluation recognises the potential relationship between the two services and will be addressed in more detail in the companion report.

2.3.2 Services provided under EHAI

EHAI offers the following support to entrants:

(a) Information about:

- the health services available to them including physical, psychological, psychosocial, optical, dental, hearing, rehabilitation, baby and women's health services
- health services for children and adolescents that also target the information needs of parents
- the effects of torture and trauma on everyday functioning
- how they can access the health assessment and intervention process available to them.

(b) A comprehensive physical health screening and referral process that:

- ensures that physical health issues are detected early and appropriately addressed;
- ensures that entrants have access to appropriate preventive health strategies
- incorporates the following physical health components:
 - an assessment and identification of the entrant's need for physical health attention
 - an assessment and identification of issues that may indicate potential barriers to the entrant's attainment of such services as a result of the entrant's prior experiences or local factors
 - an assessment and identification of any current treatment regimes or health interventions that may influence the course of the entrant's treatment offered by health services

- facilitation of appropriate referrals to general practitioners and other health services as indicated through the assessment and requested by the entrant
- with the permission of the entrant, ensuring that critical information is provided to health service practitioners necessary to the effective treatment of the entrant, including any issues that may influence the entrant's acceptance of assessment and treatment procedures, and any pre-existing treatment regimes.

(c) A comprehensive and appropriately structured assessment of psychological symptomatology and social functioning that takes into account the effect of past experiences of trauma and torture and their potential to inhibit the entrant's ability to settle in Australia. The psychosocial and psychological assessments include:

- an assessment of post-traumatic symptoms including depression, anxiety, and associated symptoms as well as the effects of grief, loss and anger as components of the trauma response
- an assessment of the quality of daily functioning and the extent to which, if at all, psychosocial issues may be contributing to a diminished level of participation in the community or other settlement support services
- the formulation of case plans arising from the assessment that details the range of interventions required and agreed to by the entrant
- where assessments indicate the need, the facilitation of referrals to a range of health and community service providers
- development of measures to commence to address the entrant's needs in various areas as they are identified in the assessment process.

(d) A range of short-term psychosocial and psychological interventions that will:

- assist the entrant to manage their recovery from serious traumatic and psychological difficulties
- assist the entrant to benefit from the health, community support and resettlement services available to them
- prevent deterioration of entrants who need long term counselling by providing interim counselling
- as appropriately indicated through assessments, interventions consisting of a range of possible strategies including:
 - psycho-educative strategies designed to strengthen the entrant's understanding of issues affecting them and their families and how these can be managed
 - provision of symptom management strategies that alleviate symptoms of psychological distress and reinforce the entrant's capacity to cope independently
 - working through the case plans arising from the assessment with the interventions required and agreed to by the entrant
 - the provision of short term counselling that assists entrants in addressing those emotional and psychological difficulties which are significantly affecting their ability to cope in the early stages of the resettlement process
 - facilitating referrals for longer-term counselling and casework services in situations where the psychological difficulties have been compounded by new information or experiences, or where the traumatic effects of past experiences require long term interventions.

In addition to direct services to entrants, EHAI service providers are required to provide training to a range of service providers including mainstream health services, general and specialised medical practitioners, settlement services providers, IHSS funded services, and other relevant services, in

order to increase their awareness and understanding of refugee health needs, and their ability to provide effective and appropriate services to this group.

Furthermore, EHAI service providers are required to improve the responsiveness of mainstream health and related services to humanitarian entrants' health needs and access to health services through the provision of advice, information products, consultancy and activities/initiatives.

This involves the following range of activities:

(a) Identification of gaps in the provision of mainstream services, or barriers to access, for Humanitarian Program entrants. Gaps are identified through the following activities:

- identifying and analysing client needs, and whether there are services/resources available to meet them
- liaison with other agencies in the service delivery network
- research projects
- initiation of activities and projects to address identified gaps/barriers.

(b) Participation in meetings with other service providers to improve the responsiveness of mainstream services to the health needs of Humanitarian Program entrants.

(c) Advocacy on the needs of individual clients and Humanitarian Program entrants in general with service providers to ensure appropriate service provision.

(d) Distribution of information products to service providers to increase their awareness and understanding of refugee health needs, and their ability to provide effective and appropriate services to this group. Methods used to distribute this information include:

- articles, materials and information products distributed on request, through meetings and other fora
- use of EHAI service providers' library by other service providers
- information products, articles, and materials available on Forum members' websites
- articles written for inclusion in journals, newsletters and other information material
- papers/presentations at conferences.

Clients receiving EHAI services, particularly short-term psychological and psychosocial interventions, may also be referred to PASTT services for longer-term support.

2.3.3 Contracting arrangements

EHAI service providers are contracted by DIMIA under the IHSS (see Section 3.2.5).

DIMIA spent approximately \$3.4 million to have EHAI delivered across Australia in 2001-2002. This is an increase of close to \$1 million on the funding EHAI providers received in 1999-2000 under the EIP.

A feature of the EHAI contracts the Department has with the EHAI providers is a sliding scale arrangement of payment. This operates as follows: each EHAI service provider has a set price for

each of the four outputs under the EHA service (ie output 1: information provision; output 2: assessment/referral/short term counselling; output 3: training of other service providers; output 4: advice/consultancy to other service providers). For outputs 1 and 2, a unit is an entrant serviced and for outputs 3 and 4, a unit is an hour of service.

At the beginning of the financial year, an estimated business level for each of the outputs is agreed between the EHA providers and the Department. If actual business during each quarter falls within the sliding scale (ie within 25% above or below the agreed estimated business level for the quarter), payment is guaranteed at the agreed estimated business level for the quarter multiplied by the set unit price. DIMIA agreed to the sliding scale arrangement in recognition of the fluctuations in arrival patterns of new entrants and the impact of this on service delivery arrangements. The sliding scale offers a considerable degree of certainty around funding levels for EHA providers.

3 . Key achievements in relation to IHSS

The evaluators found, it was not possible to draw general conclusions across the broad range of service providers and across differing localities. Moreover as with all evaluations – especially where advice on changes or enhancements to the current system is being sought – there is a tendency by the evaluators to disproportionately focus on the areas that are functioning least well. The result is that where services are succeeding and where improvements have been made to service delivery these may not be effectively recognised in an evaluation. To redress this, the evaluators have prefaced the identification of the major unresolved issues arising from the evaluation with a discussion of the positive outcomes, as they see them.

3 . 1 Equitable access to settlement services

If one finding above all emerges, it is that there is far greater certainty than has ever been the case in the past that most eligible entrants are now likely to receive at least a core set of services. Evidence to support this is drawn from appraisal of the procedures undertaken by service providers, from observations made by external stakeholders, and from the consultations with clients themselves. In fact this was brought home in the course of the evaluation through contact with humanitarian entrants whose arrival in Australia pre-dated the current service and who reported not consistently receiving the basic services now offered under IHSS.

3 . 2 Timely provision of services

Almost without exception, eligible entrants begin to receive services from the moment they arrive in Australia – most particularly orientation, information and housing. Thus, as might have happened in the past, they are not ‘lost’ to the system from the outset. Beyond this statement, however, the issue of ‘timeliness’ does become more complex. Certain specific services are struggling to achieve ‘timely delivery’ as discussed later in this report.

As well, differing client needs and circumstances make it difficult to determine what is appropriate ‘timing’ in any fine-grained sense. For example, it is extremely difficult to assess when various kinds of information will be salient to any one entrant and when he or she is ready to take in certain information. Nonetheless, it can confidently be said that services ensure that eligible entrants have a roof over their head, a bed to sleep in, food to eat and at least a first point of call or service contact from the time they arrive.

3 . 3 Basic support needs are met

A further general finding is that the range and mix of services provided to entrants appears to be appropriate and few major gaps were identified. Despite the diversity within the entrant group in terms of culture, demography, history and circumstances, they tend, with few exceptions, to have common needs that are reflected in the range of settlement services available to them. (Some exceptions are noted – for example, those Kosovo entrants who have previously resided in Australia under a special, interim arrangement whose orientation and information needs are likely to be reduced as a consequence.)

Again much can, and will, be discussed about how well specific or individual needs are met (eg need for a four bedroom house in a specific location) but the basic support needs (eg some form of affordable housing) are generally met.

3.4 Client satisfaction with services

The primary consideration in the development and delivery of the initial settlement services under review is that they be client-focused. It follows then, that a key measure of the effectiveness of these services is the level of satisfaction expressed by those receiving the services.

In this regard the evaluators found that the clients consulted in the evaluation consistently reported being generally satisfied with the help and support they received under both IHSS and PASTT services. Some, indeed, could not fault anything that they experienced. The evaluators were certainly sensitive to the possibility of entrants being reluctant to criticise or appearing ungrateful. Bearing this in mind the evaluators nonetheless concluded that the clients were, on the whole, genuinely satisfied with the services received, the range of services provided and with the people providing these services.

The fact that many were able to criticise aspects of service delivery (eg quality or nature of household goods, the multiplicity of workers on their doorstep) and sometimes came with extremely unrealistic expectations of what they might receive, only underlines the value of their general view that, on balance, they were well serviced.

3.5 Increased professionalism and transparency of service delivery

Many of the service providers have been delivering settlement services for a number of years and have been doing it well. While the introduction of a new service model has not proceeded without considerable difficulties, it is possible to say that there is evidence of an increased professionalism in the way services are delivered. As well, there is a growing culture of accountability in which service providers are, not without some difficulty, coming to terms with inroads on their previous levels of autonomy under the grants arrangements.

This process of determining appropriate standards of accountability is far from resolved yet and underlies many of the issues raised in the course of this evaluation (as discussed later in this report).

3.6 Provision of services consistent with IHSS principles

Again speaking at a very general level, the way in which the initial settlement services are provided is largely in accord with the stated IHSS principles (see section 2.2.4). Basically, most service providers do have their clients' best interests at heart, and at the same time endeavour to deliver their services in a professional manner which acknowledges the rights of the clients.

In some instances, the application of some IHSS principles can potentially conflict with others – for example, instances where exercising *choice* might conflict with protecting the *health or well-being* of an entrant. For example, what is the obligation of a service-provider who feels an entrant is intent on purchasing a vehicle which he can ill afford? Which principle should prevail – choice or well-being?

Also, as is always the case with any set of principles, it is in the operationalising of the principles where difficulties arise. For example, while there might be total agreement that services should

discourage dependency it can be difficult in practice to determine what constitutes over-servicing in a particular case.

3.7 Reduced dependency on sole service providers

A clear benefit of the current IHSS model is that it makes available to the humanitarian entrants, from the outset, a range of service providers that in itself lessens dependency on any one provider. With multiple lines of communication and contact available to the broader Australian community, the entrants are empowered as consumers to be able, more readily, to pick and choose who they want to deal with.

This situation contrasts sharply with early services eg the CRSS, where refugee families and individuals were totally dependent on a single provider – generally a volunteer organisation. In many instances these charitable organisations came to ‘own’ ‘their’ clients, sometimes creating problems for these refugees. The risk of this kind of extreme dependency is significantly reduced under the current settlement services model.

4 Issues for the IHSS

This section addresses Terms of Reference numbers 1, 3, 4 and 5. It also examines additional perceived impediments to effective and efficient service delivery commonly raised by stakeholders, primarily service providers.

The points made in this section are of a global kind, ie relating to all or many of the parts of the IHSS service. Reference is made by way of examples to individual services. However more detailed consideration of issues relating to individual services is reserved for a separate section of this report (section 5).

4.1 Meeting the initial settlement needs of clients

As noted in section 3, on the whole the IHSS is able to identify and meet the initial settlement needs of humanitarian entrants in an equitable, effective, efficient and timely manner. However there is a number of areas highlighted by the evaluation which require further consideration for the IHSS to operate more effectively. The first of these is the very fundamental question of what constitutes initial settlement needs to be delivered by IHSS and the extent to which there is common agreement among all stakeholders on what these include and most importantly what they do not include (and by implication therefore what is not included in the pricing structure). Inextricably linked with this is the extent to which the nature of client need can be identified and agreed, given that client need is not necessarily static and inevitably changes as the client group itself also changes. From this flow both perceived and real gaps in meeting the initial settlement needs of clients under the IHSS. In summary, the issue is how much service under IHSS is appropriate and required, where are the gaps within this amount of service and how well is this understood by all stakeholders.

How much service is required?

Very clearly there is a lack of common understanding of what constitutes initial settlement needs although technically these should be identified in the service providers' contracts. For example, many service providers reported that they were routinely filling 'gaps' in service delivery, which were not covered by their contracts and were therefore undertaken in their own time, at their own expense. Often service providers find themselves being 'on call' for more needy clients, responding to any and all problems that arise at any time of the day or night. Some providers had a perception that undertaking such 'extra' work had become an expectation of DIMIA.

A consequence of the perceived almost unlimited need for support and help on the part of entrants matched by the deeply-felt commitment by workers (and volunteers) to assisting refugees results in a situation where many workers feel an obligation to go to any lengths to help. Service providers consistently argue that the most needy clients have very real, significant and immediate needs and they cannot with conscience walk away from them without continuing support. It is the judgement of many service providers that withdrawing services will result in their clients sinking, not swimming. Many do not see their work as having boundaries and experience stress and burn-out as a result.

On the other hand, it may be that, counter to IHSS principle (d) of discouraging dependency, in some instances service providers are over-servicing clients and not encouraging them to 'sink or swim'. In

some localities, it was possible for the evaluators to observe both the 'rationed' and the 'gold-plated' models of service delivering. For example, in one regional area the IIOA services were delivered to entrants by either a salaried worker or through volunteers. Constraints on the worker's time meant that she was unable to be as available to her clients as the volunteers were to theirs. The worker was very conscious that her clients were getting less support than the others and had to address the question of what the consequences were. She has, guardedly, concluded that many of the clients she works with have had to become more resourceful, sooner than they would have if she had been able to devote more time to them.

To some extent, it may also be difficult for service providers who used to be a 'one stop shop' (under the previous system) to break with their 'all things to all people' role. In some instances, where agencies knew of no suitable agency to refer clients to, or doubted the ability of other agencies in the community to adequately deal with client's needs, they also preferred to try to meet their clients' needs. Problems relating to service coordination (analysed later in this section) also impact the ability and willingness of service providers to limit support. Rather than sharing the load of needy clients across agencies, according to each agency's skills and responsibilities, it appears that some or even many agencies are endeavouring to do everything.

As alluded to in the discussion above, at least part of the problem may be attributed to changing and perhaps also increasingly complex client needs. DIMIA and the field as a whole acknowledge that clients of the IHSS and services for the survivors of torture and trauma are – almost by definition – people with high level needs. This may be so for a number of reasons. Serious and multiple health problems, large families with a number of children, recent experience of torture or trauma and illiteracy are examples of factors that may create high level needs. Some refugees have spent a long time in overseas camps prior to arrival in Australia – indeed some children and young people may have grown up in refugee camps – and the consequent institutionalisation may have left them with few practical living skills. Others may lack functional living skills because they come from countries where there is no concept of social services. Some have come from non-industrialised societies and have never seen, let alone learned how to use, items such as washing machines and light switches.

On the other hand, some refugees are highly educated and astute regarding systems and institutions and are very demanding because they have strong expectations about their rights and entitlements. Often they talk among themselves and with entrants from other visa categories, and compare service entitlements. Some are very demanding because they came with unrealistic expectations of their new life in Australia, while others *become* demanding because of the high quality of the service they receive. In addition, as the nature of the client group changes for example from primarily European entrants to predominantly African entrants, so does the need of the group, requiring considerable flexibility on the part of the service providers.

Within IHSS services it appears that a principle of 'swings and roundabouts' exists that evens out resource allocation between more and less needy clients. However, many service providers argue that the nature of the clientele makes this an unrealistic expectation:

The Department figures that what you lose on the roundabouts you gain on the swings, but unfortunately it's all roundabouts and very few swings. Very few people with low needs, very few people with English. In fact we have to take money from other areas of the service to provide the [IHSS] service.

(IHSS Service provider)

The question arises, then, as to what is a reasonable level of need at which to set a benchmark? How, in practice, can services be rationed in the face of entrants' calls for support? It is clear that many service providers do not know how to or do not find it easy to decide where their role in providing initial settlement services reasonably ends. Further, they sometimes find it very difficult to draw the line with very needy clients and in fairness, sometimes this is not possible because of the very real level of need. Additionally, the whole issue of initial settlement needs is clouded by some real gaps in the IHSS model.

Gaps

Several gaps were identified by the evaluation, where significant client needs were not addressed by IHSS contracts, although there may be some debate about how many of these are initial settlement needs and fall under the auspices of the IHSS service providers. Where the gap relates to a specific service type, the issue is explored in more depth in section 5 of this report. The gaps identified were as follows:

- IIOA providers are responsible for identifying and addressing client health issues in the first 24 hours after arrival. In accordance with their contract requirements, EHAI service providers have up to two weeks to contact entrants to explain health services available to them, including a physical health assessment. No one is clearly responsible for ensuring clients receive ongoing attention to health needs during the intervening period – a significant gap as many arrivals have health problems some of which may have public health implications. Service providers and stakeholders generally agreed that where appropriate, the physical health needs of entrants should be addressed *on arrival* by referral to a health provider. This would be consistent with IHSS principle (e): 'the health and well-being of Humanitarian Program entrants are protected'.
- Goods supplied under HFS in some instances fell short of what clients are said to need. In the evaluation, some clients reported problems in regard to the household goods provided to them, but it was largely the service providers who were making the case that more or better quality goods were needed. It was felt that the basic HFS 'kit' needed to be enhanced and include additional items such as a heater in cold areas, a large refrigerator for large families, bed bases, a washing machine (particularly for large families) and where there are small children, a cot and stroller. Whether identified by clients or service providers, it is felt that limits in the kind and/or quality of household goods provided can result in problems for many entrants.
- Clients have reported experiencing difficulties in obtaining assistance to install household goods (eg washing machines, refrigerators). Some DIMIA State office staff reported that there had been significant problems caused by a lack of clarity within contracts regarding who is responsible for installing and assisting clients to operate appliances, and that there had been a number of instances where goods have been delivered on a family's doorstep without further assistance being provided.
- An increasing number of IHSS clients are from developing countries where there has been no opportunity to develop skills for living in an urban society. There is currently a gap in the model in terms of providing the 'life skills' information and education opportunities that such clients need to manage their lives in Australia. For example, some refugees have never experienced the sort of equipment available in Australian homes such as heating and kitchen appliances. In addition to the explanation on arrival that entrants are given, there is a need for ongoing support to help some entrants adjust to life in Australia.
- The absence of provision of a telephone, particularly in short-term accommodation, results in situations where communication is made difficult for both entrants and service providers. In some

instances, there is the potential for entrants to be at risk as a result of their inability to make timely contact with service providers.

- Many new arrivals are very concerned to begin looking for work as soon as they arrive. While the IIOA provider is responsible for providing information on which agencies will assist in finding employment, they are not employment specialists. Furthermore, the statistics indicate that finding employment is an ongoing concern for refugees, often for many years and is unlikely to be addressed in the initial settlement period. Some agencies indicated that under the previous settlement service arrangements, a special focus on the needs of children and young people existed through special activities and services. They felt that children's special needs tend to be backgrounded under IHSS.
- Another reported gap that has emerged relates to the services of a migration agent. A pervasive need identified by clients is assistance and advice on how to facilitate attempts to bring relatives and other loved ones to Australia. In many instances this is such a dominating concern that clients feel they cannot begin to settle until they have addressed this issue. As one client stated:

I woke up every morning thinking about my sister, and mother – wanting just to bring my family here. I can't sleep.

While general information regarding migration and sponsoring is available in capital cities through DIMIA information days, the information is too generic and too infrequently available, to satisfy clients' needs. And, while the IIOA service provider is responsible for providing information on how to link to sources of information advice, this also clearly does not meet client needs. Current IHSS contracts do not include resources for the services of a migration agent.

Some of these gaps are clearly gaps in the design of the model, including for example, early health needs and goods required for setting up a household. These are addressed in more detail in section 5 of this report. Living skills is an emerging need and there is general agreement that this will need to be recognised in future contracts. However others, such as employment and migration assistance may be more contentious, in terms of whether they constitute early settlement needs, what amount of service is appropriate under IHSS and what should be referred to other providers such as Centrelink.

Conclusion

There may be multiple causes for not fully meeting initial settlement needs of IHSS clients including gaps in the model, an increasing level of need within the client group, lack of clarity about what is required of service providers, how much service they should be providing and how and when they should be passing clients to other IHSS and non IHSS service providers. To address these issues, the Department will need to work with service providers to develop a common understanding of what activities and outcomes are included in initial settlement needs under IHSS (and what is not), who is responsible for each group of activities/outcomes and how to identify and manage a reasonable level of need.

Recommendation 1

Client Needs

DIMIA should work in conjunction with IHSS service providers to review and specify the range of activities/outcomes for IHSS, who is responsible for each group of activities/outcomes and how to identify and manage a reasonable level of need.

4.2 Role and use of volunteers

A key intention of the IHSS service model was to ensure that volunteers were able to contribute effectively to the settlement of new entrants while offering them greater flexibility, both in how they assisted entrants and in the level of their involvement. Under the IHSS, volunteers contribute by registering as a member of a CSR group and/or by working directly with IHSS service providers.

In practice, this has meant that many volunteers who were previously involved in CRSS groups have registered with CSR groups, although there is also a significant number of new groups. Others work directly with IHSS providers. In some cases they have joined an already well established pool of volunteers attached to the provider. Although both CSR and non CSR groups may work with IHSS clients, they are managed differently and are responsible to different organisations. CSR groups are registered by DIMIA and are coordinated by a CSR coordinator in each State as part of the SSP. In effect there are two parallel systems, with the CSR groups attached to DIMIA and supported by an external organisation and other volunteers who may or may not be CSR volunteers directly recruited and managed by IHSS service providers.

At the time the fieldwork was conducted for this evaluation, the CSR service was not fully implemented. State/Territory coordinators, recruited by the national SSP, had only just taken up their jobs in some States and recruitment was still underway for the remainder.

The involvement and use of volunteers varies between States/Territories and between service providers. Most commonly, service providers enlist the help of volunteers for tasks that are time and labour intensive, such as airport 'meet and greet' on arrival, accompanying clients to medical appointments and ongoing support and friendship. A few service providers seek the assistance of other recent entrants to welcome newer entrants as they are able to interpret and explain different cultural expectations, ensure culturally appropriate food preparation and help with grocery shopping and welcoming activities. However volunteers are also involved to some degree in the delivery of all contracted services. Tasks undertaken by both CSR and other volunteers included assistance with opening bank accounts, registering with Centrelink and Medicare, obtaining health assessments through the EHA service provider and helping children and adults start English language classes. At least two providers deliver much of their services using volunteers.

A number of service providers reported that they would be unable to fulfil their obligations without volunteer assistance. As one CSR volunteer said, *'We're there 24 hours a day, whereas the workers are only there at set times.'*

In some cases volunteers provide intensive support when families simply cannot cope.

Some families need a lot more support than others. We had one totally dysfunctional family that required constant assistance for months and months and months, and just as we'd thought we'd sorted out one problem, another would crop up, and that's extremely demanding and we had to seek a lot of professional help.

(CSR Volunteer group)

Some providers said they tend to use a small number of 'tried and tested' volunteers, because they know their capacities and ability to provide support.

In most cases the relationship between service providers and volunteer groups and individuals is informal. In some locations there is an established arrangement with one or more volunteer groups (either CSR or non-CSR or both), whereas in other locations volunteer assistance is sought in a more ad hoc manner.

Despite a generally wide use of volunteers, a small number of service providers have reduced or minimised their use of volunteers for the following reasons:

- Some said they do not wish volunteers to meet entrants on arrival because they feel that the service providers should interview entrants first to determine their needs.
- Some prefer volunteers to keep away from entrants completely, a few expressing concern regarding the accuracy of information provided by volunteers during this initial phase.
- It was also argued that professionalisation of the sector had left little room for volunteers and that clients should expect to receive a professional standard of service.
- Some service providers reported that their contracts did not allow them to use volunteers for activities that are part of the IHSS service provider's role.
- Some service providers felt that the restricted hours of availability of some volunteers limited the degree to which they could be relied on to respond to client needs (notwithstanding the comment above).
- Others said that they did not involve volunteers because they could not allocate resources to coordinate and monitor a volunteer service.

In some instances the perceived 'sidelining' of CSR volunteers under some service provider's administration of the IHSS has left feelings of resentment on the part of volunteer organisations that had previously played a more prominent role in providing support to refugees. Some CSR volunteers are baffled and hurt by the change and a number of volunteers have withdrawn altogether from participating in the service.

Service providers and volunteers report the greatest satisfaction where volunteers work closely with service providers, with clearly defined meaningful roles. It is clear that in many cases the use of volunteers effectively tops up or provides the extra level of support for many providers. Problems arise where volunteer roles are ill defined and they feel either sidelined and/or inappropriately used as unpaid labour. In a very small number of cases, some volunteer groups would still like to be providing the full range of settlement support and have not made the transition to the new scheme. There are still some ambiguities surrounding the CSR groups and this will be addressed in the next section.

It is clear that there is a need for greater coordination within the CSR service and support from the SSP, particularly in areas relating to quality assurance, levels of support, training and supervision of volunteers. In addition, some service providers are calling for clarification of referral processes. There is a strong preference amongst some service providers for volunteers to be coordinated in-house, with funding being provided specifically for this task.

The issue of CSR volunteer involvement with the IHSS is clearly complex and difficult. The nature of the service provider-volunteer relationship, including identification of appropriate roles and means of monitoring and support, is either not clearly enunciated or not well understood. Service providers do not always consider the management and training of volunteers as a legitimate area of expenditure although its importance is underlined by Volunteering Australia. In some cases, the transition for volunteers to the contract model has been managed effectively and they continue to play an active

and important role in the IHSS. However, in other cases, the new 'regime' has failed to embrace volunteers, many of whom have previously had a long-standing involvement in the settlement of humanitarian entrants. Finally there are risks in DIMIA's apparent responsibility for CSR groups when there is no corresponding accountability to the Department. Greater clarity is required about the appropriate role of volunteers within the IHSS service and how this should be implemented nationally.

4.3 Integration of services

The splitting of IHSS into different service types was intended to allow speciality services (eg accommodation) to be provided by agencies with experience and skills that best matched the requirements of the service. However in many instances the split between multiple agencies has created silos that do not always facilitate smooth service delivery. While there are advantages to this (eg discouragement of dependency on one provider), there are a number of disadvantages and service is not, in most cases, seamless.

In practice there are actually two models operating in regard to the delivery of IHSS – one is a totally integrated model and one is a disaggregated model. Generally the operation of one or the other model appears to be a function of the scale of the locality in which the service operates. In smaller localities (eg Hobart), where the services are all provided by one agency and where the number of entrants is smaller, the services appear to be better coordinated. In Hobart, the IHSS service provider is co-located with the EHAI/PASTT providers – resulting in even greater integration across major services. The mix of actual workers that a client comes in contact with appears to safeguard the provision of *choice*, even though the workers are operating under one agency. The disadvantage of such a model however is that where there is only one service, there is no ready alternative in the event of a breakdown of service provision.

Inefficiencies

Under the IHSS the administrative load of managing the service is often duplicated by multiple agencies, where the different services are separately contracted. Organisations have had to develop appropriate systems for management and administration of individual services and this means replication of these efforts from one service provider to another.

Resources are also taken up by the task of coordination between agencies delivering different arms of the services, including interagency meetings and service planning meetings.

A consequence of the disaggregation of services under IHSS, and one that has a direct impact on clients, was the not uncommon convergence of multiple agencies on a client shortly after arrival in order to carry out post-arrival interviews, health screening, needs assessments and other settlement support functions. As one client said:

There was too much help – everybody helping all these people coming to your home – wanting to take you out. You don't have time to yourself.

Often this has left the client feeling bombarded by information and questions. It is an issue whether this is consistent with IHSS principle (g): 'the least intrusive and the least disruptive option which offers the highest degree of stability and certainty is selected'.

Duplication

Dividing up the service between multiple providers has in some instances created a level of duplication between contracts that goes beyond multiple workers assessing client needs. In most instances, the duplication is of a minor nature. For example, there were reported overlaps between AS and HFS contracts around items such as bed linen and kitchen utensils, creating confusion as to which items can be kept by the client when they move from temporary accommodation and which are to remain. There was also duplication in some areas where a State government provides migrant health services to this client group and IHSS has set up a new structure for physical health care under EHA1. Due to the case management approach of EHA1 providers, there is also some duplication of their work with that of other IHSS service providers. Avenues to eliminate duplication should be considered.

Service coordination

Service providers, stakeholders and DIMIA staff consistently identified that integration of service and continuity of service delivery are hampered by a lack of adequate coordination. Although IIOA providers are identified within IHSS as having a 'case management' role, in practice their assumption of this role is patchy and it is not clearly articulated in IIOA contracts. This problem is most apparent where the various service types are contracted out to different agencies.

Some IIOA providers say they are the perfect agency to be case managers because of their close involvement with the client over the initial settlement period on a wide range of issues. However their concern is that their involvement is limited to a maximum of six months (again the issue of initial settlement needs) and often their involvement ends much sooner. Some providers indicate that they generally have little contact with the client beyond the first fortnight, and it therefore makes no sense their being case managers.

However an issue emerging here relates to the degree of authority that any one service provider can exert as a case manager. The notion of case management carries with it the assumption that the lead agency can *manage* and facilitate action by other agencies as necessary. The position of the IHSS service providers working in parallel (and in a number of instances as competitors in the tendering process) raises the question as to what kind of authority one IHSS service provider could have vis-à-vis another.

The problem appears to be one of confused terminology. Use of the term 'case management' in the context of IHSS may be misleading as it really refers to a different model of service. Case management is characterised by being holistic and integrative – where clients' needs are seen as the focus and services coordinated and delivered in accord with a case plan. Rather than the structured approach found in some other fields, 'case management' tends, at best, to see providers having an overview of a client's situation and stepping in to fill needs regardless of whether it is their contractually defined jurisdiction or not. A more relevant term to apply here is 'service coordination'.

Another barrier to achieving effective coordination seems to be a lack of understanding by some service providers of the boundaries of each service type, both in terms of roles and responsibilities and physical boundaries, particularly in the States/Territories where multiple agencies deliver the services. According to DIMIA, all agencies have been provided with clear information regarding service responsibilities and are required under their contracts to attend State integration meetings.

However factors such as agencies taking on tasks not included in their contracts and the existence of gaps in service provision are likely to continue to create confusion about exactly what the other agencies do.

While it is correct that explicit guidelines do exist as to what services service providers are expected to deliver, in practice this clarity is often lost. Clients, and their needs and problems, tend not to stay in neat boxes. For example, a woman's need for child care services that would allow her to attend English classes might be further caught up in issues relating to the state of her children's health which can best be addressed through a General Practitioner (GP), the choice of which is contingent upon her having long-term accommodation. Moreover, clients certainly cannot be expected to know and understand the lines of responsibility of the various agencies and so are likely to present with a complex problem to any one (or all) service providers. For better or worse, service providers are reluctant to tell a client that the client's presenting problem is another agency's responsibility. As a consequence, service delivery is often demand-driven by the clients, in which lines of responsibility and rationing of service become meaningless.

Some service providers feel – correctly or not – the unit costing/payment system exacerbates this problem. Many, while still attempting to respond to clients' needs, sometimes do so with a grudging reluctance – feeling that they are having to pick up the pieces which are other service providers' responsibilities without adequate recompense. In part, some of these issues may be addressed by the measures outlined in section 4.1. However to some extent this is a feature of shared responsibility in the provision of human services and may not be substantially different from problems which existed under grants funding.

A further factor identified as a barrier to coordination was the competitiveness of the tendering process, and this has resulted in some service providers being less than willing to work together. For example, a few service providers expressed reluctance to make certain intellectual property that they have developed (eg service protocols, evaluation processes and outcomes etc) available to other agencies – anticipating that they may very well be tendering competitively with these same agencies at some time in the future.

Some of the consultations revealed that the experience of competitive tendering had, in a small number of instances, exacerbated existing tensions between particular agencies, especially where one agency disagreed with the awarding of a contract to another agency. However, this was not a widespread finding. Some disgruntlement with the tendering process was heard during the consultations, but this appeared to be general dissatisfaction with the change from a grants model to a competitive tendering model, and in most cases did not appear to have a significant bearing on the way agencies worked together.

A lack of coordination between service providers results in clients not always receiving appropriate referrals, increased workloads for individual service providers and duplication of services. Too often, no one service provider has the 'bigger picture' of what is happening with their clients. Not surprisingly, integration was best where all or most service contracts were held by one agency, particularly where the agency also had responsibility for longer term settlement services. This was the case in some of the smaller States/Territories and in some regional areas, where the entrant receives a 'one stop' service. Attempts have been made, in certain localities, to offer an integrated service while still drawing on the specialised expertise or resources offered by selected service providers. This has been done by the lead agency sub-contracting a specialist (eg offering accommodation

support) to an agency with the most appropriate skills and experience. Greater use of mechanisms such as these needs to be explored in the tendering process.

In summary, integration of the services under the IHSS model has, in many instances, been inadequate and the divisions between agencies has created silos that impede smooth and efficient service delivery. Lack of coordination causes confusion and frustration among both clients and service providers.

Recommendation 2

Integration

Consideration should be given to extending the contracting of multiple service types within one agency (within any one location) and to greater use of subcontracting where specialist services are sought.

There is evidence, as already indicated, of a degree of duplication of services and, occasionally, gaps in services arising from the way in which IHSS is structured and contracted out. While IIOA providers are intended to provide a 'case management' role, this is often difficult to put in place. In part this difficulty arises as a consequence of separate services being contracted out to different agencies – none of whom has any authority to act as a lead agency.

Recommendation 3

Case Coordination

DIMIA, in conjunction with IHSS service providers, needs to review the way in which case and service coordination currently take place and to establish practices to ensure more effective integration of services to clients. .

4.4 Transition arrangement (exit procedures)

A significant issue that has arisen relates to exiting clients from IHSS services and the degree to which longer term settlement services 'pick up' where IHSS leaves off. Many IHSS service providers reported that they find it hard to exit needy clients, because of the gaps within settlement services as well as the client's fear about having to establish new relationships with an ongoing support provider.

One of the tensions around this issue relates to the claim by some stakeholders that perceptions of client readiness to exit have more to do with service providers 'holding clients' hands' too long than their actual degree of readiness. It is argued that by holding on to a client, some service providers promote dependency, which makes it even more difficult to move them on.

In response to this it needs to be noted that service providers and workers face a financial and/or personal disincentive in 'over-servicing' clients in that they do so in paid or unpaid time. Having noted this, the question of whether clients are exited at an appropriate time still needs addressing.

One answer lies in the nature and perceptions of longer term settlement services and concerns over continuity of service. Service providers who are confident that clients' needs will be accommodated by longer term settlement and mainstream services were generally better able to move their clients on. Where the IHSS contracts sat with a MRC or similar larger organisation with longer term settlement responsibilities, the transition from initial to long term settlement tended to be relatively seamless. In particular, co-location of the IIOA and AS contracts was seen to be important.

Another factor that contributed towards service providers' concern around exiting clients was the degree to which mainstream agencies such as Centrelink, Medicare and community health services had demonstrated that they can accommodate the special needs of newly arrived refugees. In one location, for instance, an arrangement had been made with Centrelink where an officer came to the MRC on specified days to help new arrivals arrange social security issues. The Centrelink officer, in turn, worked within his own organisation to ensure that other officers were trained to respond to this particular client group. Clearly it is an advantage to establish such relationships. There are numerous examples where service providers have been able to establish effective working relationships with mainstream agencies which have resulted in better, streamlined outcomes for clients. However in order to develop these links more readily, effort is required at both ends – from the mainstream agencies as well as the IHSS and PASTT service providers. There is also a need for both bottom-up (service level) and top-down (departmental level) effort on this issue.

There is a lack of clarity about who has responsibility for developmental work *within* mainstream agencies. IHSS providers have a potential role, as do other services addressing longer-term settlement needs (eg MRCs, CSSS). There is a need to consider how to optimise the activities of existing services and to identify where improvements may be made.

The exit interview

A primary mechanism through which appropriate handover of case responsibility occurs is the exit interview which is a requirement in the IIOA contract. The exit interview is a means of operationalising readiness to move beyond the initial settlement stage and services into longer term settlement services. In some instances formal exit interview protocols have been developed which assess the client's status (or residual need) in relation to a range of discrete services (eg income support, education and training, child care etc). What was not evident was clear agreement as to what constituted readiness to move on, nor how to measure or assess this. This reinforces the importance of establishing benchmarks for client outcomes under IHSS. In carrying out an exit interview and in assessing readiness an enormous amount of value judgement is involved. In regard to certain specific services (eg income support, health assessment) it is at least possible to determine whether a person has registered with Centrelink and is receiving the appropriate benefits, and whether the person has gone through a comprehensive physical examination by qualified personnel.

However, what is the expectation in regard to other services eg employment or education and training? Aside from English classes, these services, by definition, operate in a much longer time framework. Some IIOA service providers attempt to assess, as is appropriate, whether a client has actually received the necessary service, while other services assess the client's understanding of what general resources will be available to them and, most importantly, where to go to access

services when needed. Some service providers ‘test’ their clients’ understanding by posing ‘what if’ questions. For example, a client might be asked what he/she would do if a Centrelink benefit suddenly ceased or if a landlord undertook eviction proceedings. Readiness to move beyond the initial settlement service would be judged by the entrant’s understanding of the appropriate steps to take and the appropriate network of other service and information providers. This seems a useful measure of readiness to exit, and conceptualises ‘settlement’ as a continuing process in which ‘initial settlement’ by no means assumes that the entrant is totally self-sufficient.

The problem of referral after the initial settlement period is further exacerbated in non-metropolitan areas where dedicated longer-term settlement services may simply not exist. Referrals, if they happen at all, are likely to be to mainstream organisations or volunteer networks. It was said by some stakeholders that in smaller regional areas, linking clients in with broader community organisations is even more critical in their settlement period because a ‘ready made’ migrant community centred in a MRC does not exist.

A repeatedly stated principle was that settlement is to be conceived as a long, even lifetime process. It was therefore suggested a number of times that the distinction between the IHSS and CSSS services is somewhat artificial; however coordination between the two components is far from seamless. It appeared to the evaluators that many service providers under IHSS found it difficult to limit their services to *initial* settlement needs but instead were drawn into an attempt to meet what, perhaps artificially, was defined as ‘longer-term’ settlement needs. The problem is more marked where core elements of the two services are not managed by a single organisation.

Some CSR volunteers argued that if their participation within IHSS were appropriately recognised and managed, they could undertake to provide continuity over the transition between short and longer-term settlement.

Recommendation 4

Exit Procedures

There is a need to develop standardised exit protocols and documentation and/or to disseminate good practice examples of exit procedures as part of a case planning process.

Recommendation 5

Duplication

There is a need to better align IHSS service providers with the CSSS, including clarification of roles in relation to longer term settlement, in order to avoid duplication.

Recommendation 6

Streamlining/Mainstreaming

DIMIA at a national level, needs to work more effectively with representatives from other key (national) Commonwealth departments and agencies (eg Centrelink, Health Insurance Commission, DEWR) and with other sections within DIMIA (eg AMEP) to develop mechanisms for streamlining service provision. This 'top-down' effort would be directed at enhancing access to mainstream services by humanitarian entrants and facilitating action by service providers at a local level.

4.5 Other issues raised

4.5.1 Administration/management

Quality of information from Overseas Posts

There was considerable criticism from service providers (and some clients) regarding the quality and accuracy of the information provided from Overseas Posts.

Service providers complained that information about clients provided by Overseas Posts is often inadequate or inaccurate and that this tends to impede their preparation for the entrant's arrival. In particular the special needs of clients, such as disabilities, illnesses or existence of young children, are often not communicated to service providers. This has meant, in a number of instances, that the arrangements made for the clients prior to arrival are inappropriate and alternative arrangements have to be made post-arrival. Often this incurs additional costs and may mean that arrangements are unsatisfactory to the clients (eg quality or type of accommodation).

It is not clear how widespread or frequent this problem is. Service providers gave a mixed picture of the extent to which misinformation and often short notice of arrivals affected their work. Some reported that it was an inconvenience but they were able to manage, while others reported that the problems occurred with a frequency that created significant difficulties for their staff. Correct information on the following issues was thought crucial:

- size of family – adequate accommodation and furnishings need to be provided, transport arrangements need to accommodate large families;
- age and gender of children and adults – to ensure appropriate accommodation arrangements

- relationship of family members to each other – again, to ensure appropriate accommodation arrangements
- disabilities and illnesses – to arrange for appropriate care and accommodation
- language group
- accurate arrival dates/times.

Some of these problems are outside the control of DIMIA. For example, entrants do not always provide accurate information themselves, because they are concerned that this will affect their ability to be given a visa. Further, DIMIA is not responsible for arranging and notifying arrival times and dates. These are managed by the International Organisation for Migration (IOM) or in the case of SHPs, families or proposing organisations.

Nevertheless, any ongoing problems experienced as a result of inadequate or incorrect information received from overseas posts, combined with short notice of arrivals, may prevent providers making appropriate arrangements prior to entrants' arrival and can result in unsatisfactory arrangements being made. While some areas of confusion can be expected there appears to be a clear need to ensure key information is as correct as is humanly possible.

Recommendation 7

Information

DIMIA should identify whether there are any ways of improving the accuracy of information provided by Overseas Posts..

Managing uneven flow

There are unavoidable peaks and troughs in the flow of entrants into Australia, and this ebb and flow has always existed. To a limited degree, service providers affect the flow, in that some providers request that fewer entrants be sent over the Christmas period or at other times. As well, posts typically process a larger number of entrants at the end of the financial year, followed by a slump at the beginning of the next financial year. Further IOM, which organises the travel for humanitarian entrants, often bulk buys seats so that entrants may arrive in groups rather than evenly over a period of time. Other ad hoc factors such as September 11 have also impacted on the flow. However, a general seasonal pattern emerges that tends to be broadly repeated each year, so some predictability is possible. The peaks and troughs of the arrivals is largely a characteristic of the humanitarian program and providers must develop flexible approaches to accommodate ebbs and flows, and the consequences for staffing and, in particular, provision of accommodation.

According to service providers, the uneven flow creates problems in predicting required staffing and volunteer levels and the inability to guarantee staff employment. The most common response has been to employ a small core of experienced staff and a pool of casuals to draw upon in times of high demand. While this was a satisfactory solution for some providers, it was highly unsatisfactory for others, particularly those who employ specialist staff. Further, providers reported that it is difficult to retain good staff because of their inability to offer stable employment conditions. Some providers believed that these problems were likely to lessen as they gained more experience in managing IHSS contracts. Essentially these problems have consistently been a feature of provision of services for this

group of clients and may require a more flexible approach to management on the part of service providers.

A number of service providers continue to experience problems due to the uneven flow of entrants and the linking of income to activity (ie payment according to the number of arrivals). Grants based funding provided certainty of income, if not certainty of numbers (and service providers were paid a set sum regardless of whether the numbers of clients exceeded or fell short of expectations). Under the present arrangements, providers are paid per entrant, or per entrant household, so that if numbers go up, service providers' incomes also rise, and conversely if numbers fall short, incomes could potentially drop, although in practice this has not happened. In fact, service providers can and do receive a higher level of payment under this arrangement than under grants based funding.

However the new method of payment is perceived by service providers as carrying a higher level of risk and thus introduced a level of uncertainty for service providers. Providers felt exposed and the lack of guaranteed income, whether or not in the end they were likely to benefit, caused considerable unease. In response to providers' concerns, DIMIA introduced Guaranteed Business Levels (GBLs) in July 2002 to alleviate some of the problems. This meant that DIMIA would guarantee a level of business for each provider and prepay 60% of the guaranteed business at the beginning of the financial year, with the balance paid either quarterly or the following January. GBLs were designed to minimise the business risk to providers caused by fluctuations in arrival numbers and provide some certainty about the level of payments. Most IHSS service providers accepted the offer of GBLs, though there were some variations in the conditions between contracts. Some service providers opted to continue with the previous arrangement.

While there are peaks and troughs in arrivals, the reality is that under the new arrangements, service providers are at least paid for each entrant or entrant household referred to them. In practice they are financially better off, the problem lies in managing the uneven flow of income.

Recommendation 8

Managing Uneven Flow

DIMIA needs to examine whether there are any means by which the peaks and troughs of entrant flows might be evened out. If peaks and troughs are unavoidable but predictable there needs to be improved communications regarding these patterns to service providers. As well, more flexible managerial systems need to be put in place by service providers to assist them to manage the variations more effectively.

Data management

The Humanitarian Settlement Client Information System (HUSCI) was primarily designed as an accountability tool for DIMIA and Finance rather than as a management tool for service providers, albeit that it was developed at the request of various providers so they could report to the Department as per their contract requirements. Notwithstanding this, service providers felt that there is a need to simplify the reporting system and to tailor it better to the capacities and needs of the agencies, that is, have it serve as both an accountability and management tool.

A number of service providers reported that HUSCI does not allow them to print reports relevant for their own management purposes. This means they need to repeat processes in order to provide reporting data required by their contract, then record data and keep file notes to assist them in management. This is more problematic for smaller agencies, which may not have access to sophisticated data collection processes or the necessary levels of administrative support.

As an example, HUSCI reporting on accommodation contracts is premised on the assumption that the same service provider will provide temporary accommodation and assist clients to move into long term accommodation. In NSW for instance, this is not the case. Long term accommodation providers in NSW find that they are unable to adequately indicate the outputs of their service delivery, because they have limited or no access to information about the clients' temporary accommodation.

Most DIMIA State Offices also reported finding the HUSCI database difficult to manage. It was felt that the database generated extra work for DIMIA State Office staff, particularly in ensuring that the data collected from service providers are accurate. On some occasions, State Offices have found significant inconsistencies with data provided by service providers. At State integration/settlement committee meetings, agencies have indicated to DIMIA State staff that HUSCI reporting is difficult and places strain on agencies, particularly those with limited resources to ensure accurate recording of the data. Changes and upgrades to HUSCI are said to be slow, causing delays for staff in DIMIA as well as service providers. (Turnover in staff within service agencies also results in the need for ongoing training in the use of any data collection system, adding to the problems.)

The process of improving reporting mechanisms should involve consultation with service providers to identify needs and capacities. Furthermore, some service providers would be able to provide good practice models for databases. Consideration should be given, for example, to enabling service providers to use the database and data collection tools for their own accounting purposes in order to avoid duplication, particularly where agencies receive multiple sources of funding.

In short, HUSCI data management system was identified by service providers and departmental staff alike as problematic.

Recommendation 9

Reporting and Accountability Requirements

More effective ways of ensuring appropriate reporting and of meeting accountability requirements by service providers need to be implemented. These reporting mechanisms should meet the needs of both DIMIA and service providers.

Training

There continues to be confusion around the issue of training – principally in relation to who should provide training in particular matters and at what level they should be provided (local, state or national). A number of service providers identified a need for a national level forum which would allow service providers to share information and good practice. It was thought that issues such as competitiveness and reluctance to share information could be better managed at a national forum than if the meeting were organised at a local or regional level. However it is understood that such a conference was organised by DIMIA, and service providers then said that they would prefer to

consider issues at a local level. Further communication with service providers on this issue may be required, bearing in mind that a national conference is a costly exercise.

Other initiatives thought to have potential included:

- a web bulletin board
- a national/State newsletter
- planning/showcasing forum
- video conferencing similar to Telemedicine (currently being investigated by Transcultural Mental Health Centre and effectively being carried out by the DHA in partnership with State Health and the Australian Medical Association)
- DIMIA Central Office presence at planning and other meetings
- regular feedback to service providers.

It was widely reported that State settlement planning meetings and other interagency forums are not as effective and outcome focused as they could be. It was suggested by many key informants that these meetings should more closely focus on improving coordination, integration and case management as well as providing opportunities for peer review and professional support for relevant staff including DIMIA, IHSS service providers and others.

Further training in relation to HUSCI was also widely thought to be needed. There appeared to be confusion among some service providers regarding their own responsibility to train staff. For example, quality control in relation to data collection and reporting has become an issue as a result of differing levels of skill and experience among agency workers. However, given the need for rethinking data collection and management issues (discussed above), training might best be considered in the context of any changes that are implemented.

There was very limited understanding in the field of what support Deakin University would provide under the SSP.

Relations with DIMIA

The relationship between service providers and DIMIA was generally considered positive and professional. At a national level, service providers have generally found DIMIA staff to be supportive, understanding and flexible. Some agencies, such as Resolve and Deakin, still have their contracts managed nationally.

At a State level, service providers' relationships with the State DIMIA staff has varied. Some agencies have had stable and regular contact with staff and consistent contract management. Others have experienced less consistent contract management and infrequent contact due to staff changes within DIMIA.

A consistent approach across all States and Territories to contract management is likely to have a positive impact. In order to ensure equity in service delivery, accountability and reporting structures should be as consistent as possible, so that service providers have a benchmark to aim for and spend comparable time on reporting tasks.

It would also seem appropriate to develop a focus on improving communication and dialogue between service providers and State DIMIA staff to facilitate integration, negotiation, communication and settlement planning.

Pricing level and structure

A common view of service providers was that the pricing level and structure under the IHSS contracts do not reflect service requirements. In part, pricing related problems appear to have been caused by under estimation of costs at the time of tendering and/or by DIMIA negotiating down the unit prices covered by IHSS contracts. The evaluators were not in a position to determine whether these shortfalls were due to inefficiencies in the way the services were provided, or whether it was due to inadequate pricing. The key areas of shortfall as seen by service providers are summarised below.

- A number of service providers maintain that there is inadequate provision within the unit costing for developmental activities such as training, co-ordination between service providers and integration with mainstream providers, as well as the significantly higher than anticipated need for interpreting services.
- A number of providers felt that pricing did not adequately provide for implementation, adaptation, and in some instances development of appropriate administrative and management systems.
- In some regional areas, service providers have found the compensation for the higher costs of delivering services to be inadequate eg travel and associated costs (such as overnight accommodation) when picking up clients from the airport.
- Some service providers raised concerns over gaps that emerge when clients move within or between States/Territories. When movement is *within* a State, service providers are required under their contracts to share costs. However it has been problematic for service providers to work out the proportion of service required to be provided. Clients and service providers have indicated that in the case of family breakdown, they find it difficult to identify the relevant services to assist each of the parties.
- In some instances, particularly in some of the smaller States/Territories, service providers have experienced the movement of entrants *between* States/Territories, within the first six months of arrival. Both clients and service providers have identified this as a limitation to accessing services. For instance, in South Australia, entrants receive crockery and linen under IHSS even before they move into longer-term accommodation. If they then move interstate, they cannot access HFS because the HFS provider in SA has already been paid. EHA1 providers report that they provide services to clients under EHA1 regardless of whether they have moved from interstate – if another agency has already invoiced DIMIA, they do not charge DIMIA for these clients. It is not clear how frequently this occurs, but it appeared to be of significant concern in States/Territories which see greater overall movement of new arrivals such as the Northern Territory.

Larger, better-resourced and more experienced service providers were said to have been better placed to negotiate contracts which adequately covered their costs, although this is not reflected overall in the contract prices. A few providers who offer a range of short- and long-term settlement services, and who were generally well-established and experienced providers in this field, acknowledged that the only way they were able to maintain IHSS services was by using funding from other services or areas of the service until IHSS income came through or, in some instances, on an on going basis.

On the other hand, some smaller or less experienced agencies have experienced considerable difficulties: for example, they did not anticipate the impact of an erratic pattern of arrivals on their cash flow, and may not have had other funding sources to rely on. They also may lack adequate administrative or managerial infrastructure to support the service. It is probably reasonable to expect that as service providers gain more experience in tendering and managing IHSS contracts, the degree of uncertainty will lessen.

As already noted, many agencies cited the shift to a *unit costing* model as the source of many problems. While unit costing might, in itself, result in difficulties in managing income, it is also important to determine whether the absolute dollars available are sufficient or not. For example, some services (eg IIOA, EHA) services received a unit price per *entrant* rather than per family. This means that there should be economies of scale in servicing families (particularly large families).

On the other hand singles and couples would attract lower levels of funding (compared to larger families) despite, possibly, requiring equivalent levels of assistance or contact. At issue, then is the degree to which it is the method of determining income, the prices set for services or the management skills of service providers that causes the major problems.

One of the most consistent findings in the evaluation was that service providers felt that unit pricing levels and structure were not appropriate for the level of service required by the entrant. It was also felt, by a number of service providers, that DIMIA has been reluctant to fully take this issue on board and openly discuss and negotiate with service provider on the issue. It was not possible, in the course of this evaluation, to conduct an in-depth analysis of the validity of the claim of under-resourcing. Any such analysis would also need to examine appropriate levels of servicing, administration practices and efficiency, among other matters.

Recommendation 10

Pricing

A separate analysis needs to be undertaken of the structure and level of IHSS pricing to determine their appropriateness for service delivery arrangements.

5 The individual IHSS services

5.1 Initial Information and Orientation Assistance

5.1.1 Service description

IIOA is provided by a Commonwealth contracted provider. The aim of IIOA is to assist entrants to access the services they need in the initial stage of settlement. As part of this process, the IIOA provider is required to coordinate with other service providers, including other IHSS service providers and other government, community service and volunteer (CSR) service providers.

IIOA providers have the responsibility for service coordination and ongoing support until identified settlement needs have been addressed through the provision of information, assistance and referrals. The handover of the coordination role by the IIOA provider to any other service can take place any time within the first six months of arrival. The decision to hand over responsibility before the end of the six month period is determined by the entrant's needs.

All Refugee category entrants are eligible for IIOA after arrival in Australia. SHP entrants are eligible if they are referred for assistance to the service by the Proposer Support Service provider with the agreement of DIMIA. This will generally occur where it can be demonstrated that support for an SHP entrant by their proposer has broken down.

Entrants who have been released from immigration detention facilities on grant of a permanent Protection Visa in Australia, who do not have family or friends to assist them with information and orientation are also eligible for IIOA. However, holders of TPVs are not eligible for IIOA services.

5.1.2 Role of the IIOA service provider

The primary tasks of IIOA providers are to:

- prepare information for the Commonwealth to distribute to entrants prior to their departure. This information will include how the entrant will be met on arrival, accommodated and what steps to take in the event of not being met on arrival
- make arrangements to meet the entrant on arrival at the airport or other points, or at immigration detention facilities, and either assist with transit arrangements or transport entrants to their initial accommodation. Where appropriate, the IIOA provider must locate overnight accommodation in emergency cases for transiting entrants
- in consultation with the AS provider, ensure that the entrant has the skills and knowledge to utilise the accommodation and facilities
- ensure that the entrant is adequately skilled and informed about accessing assistance should accommodation facilities not function properly
- explain to the entrant about the conditions of their stay in the accommodation
- ascertain and address the entrant's need for emergency clothing and/or immediate medical attention

- provide the entrant with an individually tailored information, assistance and referral service based on a needs assessment and through a service coordination and case management approach. The needs assessment should consider issues such as income support, Medicare, banking, community support (CSR function or other), health assessment including EHA1 services, assistance to set up a household (HFS), education and training (schools, AMEP, other), employment, interpreting and translation services, other settlement services, community housing, childcare, transport, immigration and any other aspects such as understanding western systems, the law and road rules
- conduct an exit interview with the client to conclude the assessment and individually tailor information, assistance and referral and a case handover meeting with the new case manager within a week of referral.

5.1.3 Issues raised in relation to IIOA services

Provision of information, assistance and referral

Clients generally found the provision of information, assistance and referral based on their needs appropriately carried out. In particular, the willingness of IIOA providers to be creative in the way in which they deliver services and address client needs was seen positively eg the use of volunteers and casual bilingual staff, introductions to key staff from relevant agencies rather than basic written information with a name and number. However some clients expressed concerns about particular aspects of the information provision.

The major concern expressed by clients related to the feeling of being 'bombarded' by a large amount of information on arrival. A number indicated they felt an 'information overload':

It was like being under a siege at the beginning. Lots of information. Very little time to think and understand. Too many places to sign the name and write the name. Never fully understand why or what it is for. Then they leave us in six months. We are only starting to understand the information then. If we have to go to someone new to ask for clarification and explanations, then we cannot be open and honest. Sometimes we are also afraid to ask someone new about what was told to us six months ago. They should ask us, if we need more time, before they leave us alone to cope.

(Client)

There was also said to be a need to ensure that contradictory information is not provided by the various agencies and individuals who deal with the client in this early stage. For example, it was said in one location that there had been instances where the AS provider had provided information to a client that contradicted the advice provided by the IIOA service provider, leaving the client confused. It was suggested that contractual obligations and division of tasks need to be clearly enunciated. This also touches on a more complex issue relating to overlapping jurisdictions of IIOA and AS contracts, which is discussed elsewhere in this paper.

Some clients also felt the provision of information in their home to be threatening and invasive, particularly during the initial stage. It was said that the period following arrival is an important time for them as families, as many have been separated, sometimes for years, prior to arrival.

We have not been a family for many years. This is our time to talk as well. This is our time to get to know each other as well. We need information but in small doses. We need to do

things and see people, but at one step at a time. We need to establish our own family rules too. Otherwise there will be no point to the information we get. Our home is our home and we should feel comfortable there so that we can get on with our lives. Having every government officer and community worker in our house makes us feel that our home is not ours.

(Client)

On the other hand, a few service providers said that clients were grateful that people visited them during the initial period when they were often confused and lacking in confidence. A few clients suggested that they should be given the opportunity to choose where to have information provided to them.

Needs assessment

Many IIOA providers reported that ascertaining and addressing the entrant's needs for emergency clothing and immediate medical attention was one of the more difficult tasks. Many entrants who access IIOA services have medical and health related issues. IIOA providers link entrants to medical and health services, but they find that accompanying families to appointments can be very time consuming and makes them unavailable to other clients. Often, particularly in the States with larger numbers of new arrivals and in regional areas, this tends to be at the expense of the most recent entrants and compromises the principle of equity of service. Typically the IIOA provider undertakes this role until the EHA provider takes over case management of clients' health needs. The gap between these two areas of responsibility is discussed in 6.4 below. The issue of needs assessment should be linked to the concept of improving 'case management' discussed at Section 5.1.

5.2 Accommodation Support

5.2.1 Service description

AS is designed to help entrants establish themselves in stable, affordable and appropriate longer-term accommodation as soon as possible after their arrival. This may include the provision of temporary accommodation for the immediate period following their arrival.

The service is delivered differently in each State and Territory. In some States a commercial service provider manages the initial accommodation and the longer-term accommodation support funded under IHSS is provided by separate community organisations. In other States one service provider provides both short and longer-term accommodation. In some States, a mixture of both these models operates.

5.2.2 Role of the Accommodation Support service provider

In general, the primary tasks of a short term AS provider are to:

- provide furnished accommodation immediately on arrival until longer-term stable accommodation is found (either by the service provider or someone else)
- provide an entrant with a standard agreement approved by the Commonwealth, which formalises the entrant's stay until they move into longer-term stable accommodation
- provide the entrant access to culturally and religiously appropriate food supplies for the first week or until income support is received

- consult with the Commonwealth prior to commencing eviction proceedings.

Service providers who are responsible for finding and securing longer-term accommodation are generally required to:

- consult with the household to identify their accommodation needs
- work with real estate agents or housing authorities to identify appropriate options
- assist the household to enter into a lease for the selected accommodation
- assist with the transition from immediate to longer-term accommodation
- advise other appropriate IHSS service providers of the new address
- work with housing providers, State / Territory Housing authorities, community housing services and private sector rental providers to generate housing options and reduce discrimination towards entrants when housing is allocated.

5.2.3 Issues raised in relation to AS services

Issues related to the provision of short and long-term accommodation are dealt with separately.

Short-term accommodation

Various types of short-term accommodation are offered around the country, including government-leased flats, houses rented privately and motels.

Clients who were placed in accommodation clusters with other newly arrived humanitarian entrants generally said this worked well for them. Although this accommodation may be basic, being placed in a single location has made it easier for entrants to make contact with service providers and to get help in finding their way around a new community.

Clients who had been given interim accommodation in motel units were less satisfied. This option was regarded as inappropriate and unsatisfactory: clients argued that at this point in time it was important for them and their families to have time on their own, as a family. Motel units offered them very little privacy.

A range of clients expressed the view that they would have preferred being placed directly into longer-term accommodation. This option has been trialled by one AS provider, but found not to be viable. In the first instance, entrants' needs had to be assessed *prior* to their arrival in Australia, on the basis of information gathered by the overseas posts. The inadequacy of this information meant that the accommodation chosen, and the nature of the family group, often did not match up. A second problem was that clients were placed in the position of having to sign a private rental agreement soon after arriving in Australia.

In one case, a family signed up within two hours of getting off a plane. This is inappropriate given that families are often traumatised and don't understand the private rental market. In their first few days they are just bombarded with information.

(AS provider)

Other concerns expressed included the fact that some initial accommodation was in areas where public transport and access to services and support networks is limited. A consistent problem was

that entrants do not have access to telephones that allow them to make outgoing calls. This was of particular concern for people in areas where transport was poor, or in the event of emergencies. Several service providers suggested that one way to solve this would be to provide access to phone cards and show entrants how to use them.

Generally the short term accommodation was satisfactory for a short period, although a small number of clients and stakeholders reported that the cleanliness of some of this accommodation was a problem.

Some service providers also felt that the initial food package is inadequate and inappropriate. Anecdotes were also provided that highlighted problems and potential dangers around the provision of 'emergency' food and household products – eg cleaning fluid being mistaken for a drink.

Lastly, the ebbs and flows in the number of entrants raised particular problems where short-term accommodation was provided through dedicated housing stock. If the number of entrants exceeded the number of housing units available, more costly accommodation had to be found. If the numbers of entrants were lower, housing might be sitting vacant.

Longer-term accommodation

The major problem that emerged in relation to finding entrants suitable long-term accommodation was the requirement to find them somewhere to move to within four weeks of arrival. The rationale for this requirement was to provide stability for entrants as soon as possible by making longer term accommodation available as quickly as possible. Where entrants remain in short term accommodation for long periods of time, they naturally establish networks around the accommodation, children enrol in local schools and it becomes increasingly disruptive to move to a new environment. That said, despite the target of finding suitable accommodation within four weeks, no entrant has been forced to move at the end of four weeks and in some cases where there have been special circumstances, entrants have remained in their initial accommodation for lengthy periods.

Service providers said the contract requirements in relation to the location of housing sometimes made it difficult for them to find affordable accommodation within the four-week time frame. The tight rental markets in some locations, such as Canberra, made finding appropriate accommodation even more difficult. Further, the payment structure under IHSS has penalised two AS providers, in that they receive less money if entrants are in short-term accommodation for more than four weeks.

In addition the four-week limit posed difficulties for people who experienced delays in getting tax file numbers and the family tax benefit. Details such as these are needed for proof of income levels and, in some instances, to obtain housing bond assistance.

A significant problem in all locations related to housing large families, single people and people with disabilities. This was said to be particularly acute in regional/rural areas, because of the lack of options. Service providers identified the need for development work around this issue at a local, State and national level. State Housing authorities are, for the most part, not in a position to respond to the needs of entrants. They already have significant waiting lists and well established priorities. Another area requiring work is the development of partnership services with real estate peak bodies to either improve understanding or facilitate special accommodation arrangements for large families and others for whom accommodation is in short supply. In this respect, it should be noted that development work is a requirement under some of the AS contracts.

Service providers felt that the cost to them of finding accommodation for large families was not adequately reflected in their funding. Some also expressed concern that the amount that entrants had to save to pay for an accommodation bond, four weeks' rent and utility connection costs was very high and current contract prices did not address any potential shortfall. Other problems exist with small (one and two person) households. While it might be easier to find appropriate accommodation, the level of disposable income with small households is, of course, much lower.

Concerns raised by clients from large families included the decision to locate some in small flats, particularly for short term accommodation. Closed and contained spaces were confining for some families. When they were used to open spaces, living in confined environments increased stress levels and therefore made initial settlement harder. AS providers have found that they are sometimes assisting clients with managing neighbour disputes caused by the cramped environments. Children unintentionally damage the property, which then has caused real estate agents to become uncooperative. Some clients also found adapting to Western ways of living extremely difficult. They said it would have helped if they had had the opportunity to think about these things beforehand, through information gained at overseas posts. Finding the right assistance to manage such difficulties was important for clients. Many stated that they do not wish to be a burden on the system and expressed concerns about their capacity to adapt.

Because of the numerous difficulties in finding appropriate accommodation, some entrants said they felt they should accept whatever is offered.

I got access to public housing within four months of arrival because I was considered a special case. I have seven children, of whom five are boys. I have severe arthritis and problems with incontinence. The unit had one bathroom with a toilet. I should not complain. However, managing my incontinence, with one toilet and five grown up boys makes it harder for me everyday. My heart breaks. Then, on top of that, I have to manage three flights of stairs. Sometimes I have to skip AMES classes because of the stairs and the incontinence. It is so hard sometimes, especially in an emergency. This also makes me lonelier and sadder.

(Client)

Gaps and overlaps in IHSS contracts

Service providers and stakeholders identified a number of examples of overlaps, gaps and ambiguities in the AS contract.

Confusion arose in one capital city over the role of the AS provider and the HFS provider in relation to the provision of essential items such as bed linen and kitchen goods. Both service providers provide these goods, but there is confusion over what the client can take with them when they leave temporary accommodation.

Another area of confusion is an overlap between the AS and IIOA service providers in relation to responsibility for ensuring information about accommodation is provided and understood.

It is better to let the AS provider deal with everything that is about the accommodation. The IIOA provider has enough to do without worrying about the tasks of an AS provider. Where there might be instances that an IIOA provider should address the task of another IHSS contractor, that specific contract should indicate it.

(CSR Volunteer)

Such problems obviously do not arise where the IIOA and AS contracts are managed by the one service provider, which again raises the question as to whether greater clustering of certain contracts should be considered.

Problems also arose in relation to installing and educating clients about goods supplied under the HFS contract. Neither the AS nor the HFS service provider appears to have responsibility for this task. IIOA providers, volunteers and others have witnessed cases where goods have arrived but not been unpacked.

Conclusion

While AS providers have reported that providing the service has been more expensive and difficult than foreseen, they have nonetheless largely managed to fulfil their obligations. This has been in spite of difficulties such as the ebbs and flows of new arrivals, limited housing stock in many areas, higher rental prices and the fact that some families are more difficult to house.

Options

In the last two AS contracts to be awarded in Perth and Brisbane, the service model has been somewhat different in that one provider has delivered both short term and longer term accommodation with some slightly different terms and conditions. To date this appears to have been successful, although it is relatively new. If this model continues to be successful, it may well address some of the concerns outlined above, particularly in relation to the four week issue and the penalty which some service providers currently face.

The main difficulty with this model is that it requires property skills and infrastructure as the provider assumes the lease and all the attendant responsibilities for the short term accommodation. In practice, this would make it difficult for smaller community groups to provide this type of service. However it would not preclude smaller organisations forming consortia with potential commercial providers to provide AS services.

Recommendation 11

Accommodation Support Services

Where appropriate, short-term and longer-term accommodation support services should be combined to provide a continuous accommodation support service for entrants and to assist in dealing with some of the challenges in delivering this service.

5.3 Household Formation Support

5.3.1 Service description

The HFS service aims to provide entrants with a level of basic household items to assist them in establishing a household. The average amount allocated to the service provider per household unit is \$1,200, which was calculated on the basis of additional assistance being available from voluntary, community and other services.

The HFS service is administered differently across States/Territories. In one State the contract was negotiated whereby the HFS provider delivers a standard package to the household based on the number of individuals in that unit. In the States with smaller numbers of entrants (eg SA, Tasmania, WA) the HFS provider carries out a needs assessment prior to supplying the goods. In the larger States, NSW for example, the contract requires a needs assessment, but the very low unit price constrains any flexibility, effectively producing a standard package.

All refugees, SHP entrants and persons released from immigration detention facilities on Permanent Protection Visas are eligible for HFS. Temporary Protection Visa holders are not eligible for this service.

The IIOA provider refers entrants to the HFS provider when longer term accommodation is arranged. The household formation goods are typically available to the entrant when they move into permanent or longer term accommodation. The HFS provider therefore is required to liaise with the AS provider to coordinate the timing of entrant's movement to permanent accommodation.

5.3.2 Role of the HFS service provider

The role of the HFS provider is to:

- assess the extent of need for HFS for all eligible household units
- assess the best way of providing the household goods taking into account the entrant's preferences
- provide eligible households with options including through direct provision and/or other ways (donations).

5.3.3 Issues raised in relation to HFS services and their outcomes

Adequacy of the package

Significant concerns were raised in relation to the adequacy of the household items provided to entrants under HFS. Firstly, there was concern over the total amount available – that \$1,200 per household, even as an average, was too little. It was argued that, while it was anticipated that some entrants might already own or have access to some household goods, the reality is that nearly all have arrived with almost nothing. Added to this are the problems of high needs among many households (for additional items) and the difficulty in obtaining quality second hand goods in many areas.

Secondly, there was considerable concern that the HFS package did not include goods that were considered by many to be basic items (eg cots for families with babies, heaters and extra blankets in areas that became cold, washing machines for large families, bed bases). This was a problem regardless of whether needs assessments are carried out or not: even where service providers carry out needs assessments, the amount available was said to be insufficient to cover many items. DIMIA may need to consider the adequacy of the benchmark for HFS.

Tailoring goods to meet needs

Needs assessments are theoretically carried out in all but Queensland. Carrying out a needs assessment has a number of advantages, namely that families receive the goods they most need

rather than a standard package based on the number of people in the household. In practice, however, some service providers supply some goods as a standard package – eg in Adelaide kitchen and linen packs are supplied prior to the family’s arrival, and the remainder is provided once a needs assessment is carried out.

One practical problem experienced by some service providers has been gaining access to families to conduct needs assessments. Often HFS providers find themselves unable to interview the family for some time as other needs take priority. This inevitably delays the delivery of goods to the family, as the service provider needs time to locate, purchase and arrange delivery of household items.

Some service providers reported that they would prefer to give families a combination of money, vouchers and goods as this provides entrants with choice and enhances self respect.

Barriers to providing goods

Providers reported difficulties in some areas in providing the household goods needed. Service providers in some of the larger States reported that legislative provisions limit the purchase of second hand goods, particularly electrical goods, meaning a larger portion of the allocation must be spent on buying new goods.

It is also difficult to find quality second hand goods in some areas – particularly in regional areas where options are limited, and in some metropolitan areas where demand for second hand goods exceeds the supply of these goods.

Service providers have also found that clients often compare the goods they receive under HFS and ask for similar things. For this reason, in small regional areas, service providers often have to provide goods of similar standards, regardless of need. Where volunteers are asked to deliver this service, trying to access goods of similar quality in areas where this might be limited places huge burdens on volunteer capacity.

Top-up goods

It is an expectation of the service that community organisations will continue to supplement HFS goods in the normal course of their work. However, in practice, this does not always occur. On some occasions this has been because the goods are not available. In some instances other community organisations do not assist because they perceive that this is the job another service provider is paid to do. Where the delivery of HFS was divided up among different community organisations and their volunteers, which had variable resource bases, some groups were in a better position than others to ‘top up’ goods.

The assumption that HFS goods will be ‘topped up’ results in some families waiting unreasonable periods of time to receive some basic items.

Service provider’s capacity

Some service provider indicated that they do not have adequate capacity to purchase – then store and deliver-goods. In particular, when bulk purchases are made there were some concerns (and costs) associated with storing goods until they are required.

Delivery of goods

Household goods are sometimes not delivered in a timely manner, that is, prior to or on the day the family moved into their longer-term accommodation. This was largely attributed to limited staffing within some provider organisations. Some stakeholders reported that they have discussed the matter with the HFS provider a number of times but that the situation has not improved.

HFS and volunteer organisations

HFS has reportedly created extra work for volunteers as many have assumed responsibility for being on hand to check and receive HFS items whilst at the same time continuing to collect, store, restore and transport furniture and household goods.

Insurance coverage has also emerged as an issue for some volunteer groups. Despite taking on responsibility for *checking* and *receiving* HFS items, one CSR group said the HFS service provider in its area would not provide insurance coverage to volunteers undertaking this role. This group has asked DIMIA to clarify whether its Comcover insurance policy covers volunteers who provide support at the request of entrants.

HFS has reportedly sometimes created rifts between volunteer groups. In one instance, a volunteer group has asked an HFS service provider to sign a Memorandum of Understanding, which involves extending insurance coverage to volunteers. The service provider has allegedly refused to do so. In some instances HFS service providers said they are unwilling to ask CSR groups for assistance because of concerns about insurance.

Options/Summary

The first problem in relation to HFS is the inadequacy and inflexibility of the funding - \$1,200 is barely adequate for a household of one person, given the increasing need of recent entrants. Further, while most other parts of IHSS are funded per entrant, this service type is funded per household, compounding the problem. Consideration should therefore be given to:

- increasing the amount of funding
- recognising that the amount available also should relate to the size and composition of the family.

The appropriate funding units ie household groupings, could be identified in conjunction with service providers.

Recommendation 12

Household Formation Support

DIMIA should consider increasing the amount of money made available under HFS.

The HFS unit price should be tied to the size and composition of the household.

Secondly, if the principles of need and equity are to be addressed in the provision of the service, then consideration should be given to developing the notion of a basic kit of household goods with the possibility of optional items, which depend on the need of the individual household. A basic kit might include beds (and bases), chest of drawers, refrigerator (of standard size), tables, chairs, linen, china, and cutlery. Optional items might include a washing machine, cot(s), baby seats, TV, radio and a larger refrigerator. Entrants would be able to choose from among these items the household goods which reflect the composition and need of their family.

There are clearly some difficulties inherent in this proposal. For example, it implies that there is equity of cost for the optional items, although identifying a notional value and/or number of items will help to address this. Further, it may well exacerbate the problems and costs of storage outlined above. It is nevertheless worth exploring and both the items to be included and the mechanisms for making this work could be developed in conjunction with service providers.

Recommendation 13

Basic Household Items

DIMIA should work with service providers to identify basic household items which must be available to all clients. Further they should also identify a list of optional items, from which entrants can select a specified number to a certain value that most effectively meet the needs of their particular household.

5.3 Early Health Assessment and Intervention

5.4.1 Service description

This service is designed to ensure that entrants are aware of their immediate physical and psychological health needs and have the skills, knowledge and confidence to access the relevant health services, including torture and trauma counselling, in order to address current and ongoing health needs.

This service is available to all Humanitarian Service entrants including holders of TPVs.

5.4.2 Role of the EHAI

The role of the EHAI is to:

- provide entrants with information about health services available to them in Australia, the effects of torture and trauma on everyday functioning, and their entitlement and how to access a health assessment under the IHSS
- provide entrants with an assessment of their health requirements including a physical health screening and a comprehensive psychological and psychosocial health assessment and make referrals to meet the entrant's existing and emerging health needs

- provide a range of short-term psychological and psychosocial interventions including counselling for survivors of torture and trauma
- provide training to a range of service providers including mainstream health services, general and specialised medical practitioners, settlement service providers, IHSS funded services and other relevant services to increase their awareness of refugee health needs and improve their ability to provide effective and appropriate services to this group
- provide advice, information products, consultancy and activities/initiatives to improve the responsiveness of mainstream services to Humanitarian Service entrants' health needs and access to health services.

5.4.3 Issues raised in relation to EHAI

The evaluation found that clients of this service were very satisfied with the support they had received from EHAI providers, particularly the providers' cultural sensitivity and understanding of the experience of survivors of torture and trauma. The wide range of intervention strategies used by EHAI providers also reflected their sensitivity to the variety of cultural backgrounds and the potentially alien concept of face-to-face counselling for some clients. In addition, clients appreciated that EHAI providers adopted a holistic approach to the provision of their support by looking at and sometimes providing support concerning other aspects of the client's settlement experience. While this is not really the role of the EHAI provider under the current model and it can often lead to duplication with some of the contract responsibilities of other IHSS providers, clients' attraction to this style of settlement service reinforces the need for case coordination in the IHSS model.

Some issues emerged which relate in particular to the design of the EHAI service and its integration with other IHSS services and mainstream health services.

Entrants' immediate physical health needs

The current system under the *Migration Regulations* for carrying out medical examinations of humanitarian entrants before they arrive in Australia does not ensure that any or all health problems are identified and addressed. Although undertakings to undergo further specific medical checks upon the entrants' arrival in Australia are often placed in entrants' files, there is no process for following up to ensure that this happens. Privacy considerations have meant that there has not been an automatic transfer of information to the appropriate IHSS provider.

Often humanitarian entrants have lived in camps for a considerable length of time and this frequently affects their health. Some, but not necessarily all, of pre-existing health problems, may be identified before leaving for Australia. Indeed, data from EHAI providers indicate that over 80% of EHAI clients need to be referred to a GP soon after arrival. This is supported by the longitudinal survey of immigrants to Australia reported in *Life in a New Land* (National Institute of Labour Studies, commissioned for DIMIA, 2002) which found that humanitarian entrants were more likely than other migrants to have a pre-existing long-term health condition and to have suffered from a medical condition since arrival in Australia.

Several stakeholders claimed that it is important from the point of view of public health interest that entrants are provided support as quickly as possible to follow up with treatment of any conditions they may have acquired in the challenging conditions they lived in before arriving in Australia. Many refugees have lived in areas where various diseases are endemic. Medical checks are carried out for

a range of medical illnesses prior to travel and entrants undertake to have follow up treatment if required on arrival in Australia. However, not all entrants do this. If an entrant elects to defer or not to have a health screening/assessment through the EHAI service and if they do have health problems, failure to provide a prompt physical health examination may not be in their best interests or those of the broader Australian community.

Recommendation 14

Medical Information Requirements

DIMIA needs to ensure that information on medical examinations conducted overseas (and any undertakings made) is provided to the most appropriate IHSS service before or upon the entrant's arrival in Australia and that the IHSS facilitates any follow up action.

Application of the EHAI model

The way that the EHAI service is currently designed reflects the IHSS principle of client choice and entrants only receive a health screening/assessment if they elect to have one after having received information from the EHAI provider. EHAI providers report that about 60% of entrants provided with information elect to have a health screening/assessment and the others either do not take up this opportunity or defer it until other needs such as housing and employment are resolved. Given the data on the high health support needs of this group, 60% flow on for physical health support is of concern. Health conditions left untreated for some time may worsen considerably and undermine the ability of the entrant to rebuild their life in Australia. The evaluation found that there is a gap in the way that the model is designed in relation to addressing the early health needs of entrants. The IIOA provider is contracted to link entrants to emergency medical assistance if needed in the initial 24 hours after arrival and the EHAI contract allows the provider up to two weeks after referral to contact the entrant with information and assistance on health services available. In the interim period, entrants can have urgent medical needs and at present the model does not clearly identify any provider with responsibility for addressing these needs.

This gap in the design of the model needs to be addressed as soon as possible to overcome the current situation in which IIOA providers can be required to deliver support beyond their contract responsibilities, and entrants may experience considerable anxiety shortly after arriving in Australia having to navigate their way through a medical system with no support.

As stated above, 80% of the clients screened for health issues by EHAI providers require referral to a GP who then conducts a physical health examination and refers to any specialist health services as required. There is the issue of whether it is necessary to have the EHAI model involve a physical health screening leading to referral to a GP for a physical health examination if the process could be done earlier by the IHSS service offering a client linkage to a GP on arrival.

It would be more efficient and useful to offer all entrants, on arrival, the options of a referral to a GP or health clinic which can offer a full physical examination and referral to specialist services as required rather than having an initial screening by an intermediate agency. Clearly there would still be an ongoing need for training/consultancy advice to GPs and other health professionals working with this client group.

It may be appropriate to offer the physical and psychological/psychosocial support separately rather than in combination as in the current EHAI model. This would give greater flexibility for entrants to access the physical and psychological/psychosocial support when required. For example, an entrant wanting to defer receiving support with their psychological/psychosocial issues would be less likely to delay receiving support with their physical health issues.

Recommendation 15

Improving Physical health Support

There is a need to review IHSS contractual arrangements to ensure that entrants are offered linkages to ongoing physical health support on arrival in Australia. This would include determining whether it may be more appropriate to offer separately the physical and psychological support components of the IHSS.

Training/consultancy

The evaluation identified that the training and advice/consultancy given by EHAI providers was of a very high standard but only a minority of the hours were delivered to medical health services (around 30%). Others receiving the training covered a very broad range of agencies including legal services and schools. This raises the issue of whether EHAI should concentrate training efforts on health-related services. It needs to be recognised however that the well being of the client relies on sensitive service delivery from a range of other services as well as those directly involved in health support. Training to these services on the needs of the clients with refugee backgrounds is therefore important. An issue for DIMIA is to what extent the IHSS should provide this training or whether it is the responsibility of others who need to be more vigilant in this regard.

Recommendation 16

Training Component of EHAI

DIMIA should review the training component of EHAI and determine whether the training efforts of EHAI service providers should more strongly target workers in the health sectors rather than the non-health sectors.

The EHAI service is examined in more detail in the second part of this evaluation covering the Commonwealth funded services for survivors of torture and trauma. It is important that EHAI is focussed on from two perspectives:

- integration within IHSS
- how effectively it works in the continuum of the Commonwealth funded services for the survivors of torture and trauma.

5.4 Proposer Support

5.5.1 Service description

Under the SHP entrants are supported in their applications by an Australian resident or Australian organisation. These supporting people or organisations are known as 'proposers'. PS is designed to assist proposers to fulfil their role of enabling entrants to settle. Under PS proposers have access to pre-arrival information and post-arrival resources through an information package, a telephone help-line, referral mechanisms and CSR support.

This assistance is available to all proposers who are directly supporting entrants under the SHP including proposers under the Split Family provision of the Humanitarian Program.

5.5.2 Role of the Proposer Support service provider

The role of the PS provider is to:

- Provide proposers with information and guidance prior to the humanitarian entrant's arrival on how to assist those entrants to settle in Australia. This information and guidance should be based on the needs of proposers and entrants and should consider:
 - the impact of settlement on the entrant family
 - issues proposers may face settling entrants
 - realistic expectations in relation to assisting entrants
 - how proposers can assist entrants to access a whole range of services (including translation and interpreter services, emergency services, income support, Medicare, financial services, budgeting advice, community support services, CSR, health assessment and EHA services, HFS, education and training, employment, community services, housing, childcare and immigration advice).
- Provide a post-arrival help service through which further information and problem solving guidance to assist entrants to settle is made available to entrants and their proposers.
- Identify cases where the proposer is not able to directly support the entrant even with appropriate information and guidance.
- Refer entrants to DIMIA State/Territory offices when proposers are not able to support entrants.

5.5.3 Assumptions underlying PS

The PS service is premised on the following assumptions:

- proposers will assume the costs and responsibilities associated with bringing proposed entrants to Australia and then meeting their initial settlement needs
- PS providers will be able to contact the proposer
- PS providers will know when proposed entrants are arriving.

Entrants under the SHP proposers are required to pay for and arrange flights to Australia, and also meet the costs of the entrants' pre-visa medical checks. It is also expected that the proposer will be responsible for meeting the SHP entrant(s) at the airport and arranging short-term and longer-term

accommodation, and linking them with essential services. In actuality many proposers are either not able or not willing to provide adequate settlement support when their proposed entrant(s) arrives onshore. Nonetheless, because of the expectation that proposers will meet entrants' needs, services are designed to provide support to proposers not entrants. As a result, entrants often do not receive adequate support.

In order to provide services, it is assumed that the PS provider will be able to contact the proposer. DIMIA is notified when a 202 visa is granted and the notification includes the name and address of the proposer. DIMIA then notifies the PS provider that the visa has been approved and provides the details of the proposer. The details which are provided, however, are those which had been given by the proposer at the time of initial lodgement of the application. There is in some cases a significant period of elapsed time between when the application is lodged and when the visa is granted. There may be a further extended period between the granting of the visa and the arrival of the entrant(s). During the time between visa lodgement and arrival of the entrant(s), the proposer may (and frequently does) move. In reality it is often difficult for PS providers to locate proposers to provide support and therefore not all proposers receive PS.

Finally, PS assumes that DIMIA and/or the PS service provider will know when proposed entrants are arriving. As noted earlier, the proposer arranges the travel for the SHP entrant(s). When the proposer chooses to use IOM as the agent for arranging travel, DIMIA will be aware of the entrants' travel details and pass these details on to the PS provider. The proposer may, however, choose to use any travel agent. For the large number of entrants whose flights are arranged through other agents, neither DIMIA nor the PS provider necessarily knows that an arrival is imminent, making timing of service provision problematic.

5.5.4 Issues raised in relation to proposer support services

Proposers are often unable to provide adequate support

As noted above, the PS service is based on the assumption that proposers are able to adequately support the on-arrival settlement needs of their entrants. However in practice this is not always the case. Service providers and stakeholders consistently reported that proposers have difficulty in providing the required level of support and assistance to entrants, often because many proposers are recently arrived refugees themselves.

Proposers are often refugees... - they need support themselves... Most proposers don't have the capacity, expertise and support to provide support adequately. A typical example is that the proposer comes as a refugee, does casual part-time work, and has a house with basic furniture. The proposed family comes over – there's an overcrowded house and [the entrant] can't live in the same house. The proposer's income is insufficient to support the new family.

(PS provider)

Other impediments include the following:

- *Poor English skills are a major problem.* Most of the information provided to proposers under PS is in written form and in English. Although PS providers report that they make an effort to ensure that the proposer understands the information in the package they provide, how well this information is understood depends on a number of factors, including the proposer's English skills, the availability of interpreters and translated materials, and proposer literacy levels. This is a

particularly critical problem for proposers who are illiterate, and for some smaller ethnic groups who do not have a written language.

- *Tendency to only link entrants with services that the proposers have used themselves.* An EHAI provider reported that from its observations proposers never refer clients to services with which they have not had personal contact. Notwithstanding the information provided by PS, proposers might not be fully familiar with all of the appropriate services that entrants may require. Many proposer supported families are reportedly not linked to HFS or EHAI. This has occurred with some entrants who arrived and required urgent medical attention.
- *The complex networks of services and the unclear boundaries between services* that are available or unavailable to proposed entrants confuses and frustrates proposers, especially as they may have arrived as refugees themselves and had access to the full range of IHSS services. The fragmentation of IHSS services discussed previously presents particularly significant problems for proposers as they do not always know where to go for assistance.
- *Problems with accessing accommodation.* As they do not have access to AS, proposer sponsored families experience particularly acute difficulties in securing accommodation. As discussed above, finding accommodation can be a very challenging task even for AS providers. Competing in the private rental market is a complicated and difficult task, which many proposers and entrants are not equipped to undertake. Entrants may experience particular difficulty in finding accommodation in situations where the proposer/entrant relationship has broken down.
- *Poor financial circumstances and living conditions.* Proposers may often be in a poor financial and material situation to support entrants. For instance, proposers may have significantly indebted themselves purchasing airfares and medical screenings for the entrants. They may have raised the money at the expense of their own well-being and living conditions (given that they may have had difficulty securing employment, been reliant on welfare payments and needed to settle themselves). Further they may have had continuing responsibilities to support family members living overseas.

The families arriving now are putting their lives on hold to bring their other family members through.

(PS provider)

Volunteers and service providers reported that entrants often arrive to very poor conditions. Some proposers are found to have little or no food available, no refrigeration, or inadequate space to accommodate the entrants.

- *Proposers may also be experiencing a range of other stresses and problems.* For instance, stakeholders reported that family violence issues are a major concern with proposer sponsored families.
- *Proposers may not always understand the level of commitment required to assist an entrant* through the initial settlement process.
- *Proposers' circumstances may have changed since the original application process,* given that there is often a significant delay between this process and the entrant's arrival.
- *Proposers may deliberately over-state (or be overly optimistic about) their capacity to support entrants.* This may arise from the fact that guaranteeing to provide proposer support may be the only way to enable family members of the proposer to come to Australia.

Proposers do it [state they can provide support] because that's the only way to get their family out here.

(PS provider)

The overwhelming pressure to assist family members leads some proposers to propose more families than they could reasonably support (serial proposers). As a result, the entrants in these situations may receive inadequate support.

- *Reluctance to acknowledge problems.* The problems faced by proposers are also compounded by proposers' reluctance to acknowledge that they are having difficulties and seeking assistance. They may be afraid that this may affect the visa of their proposed entrant and their ability to act as a proposer again in the future.

The difficulties which exist in ensuring that proposed entrants receive adequate support are often compounded for cases which are proposed by groups or organisations. Some community organisations receive great pressure from community members to sign proposals because of the mistaken belief that such a proposal will have a greater likelihood of receiving a favourable decision. In some instances the individuals who originally requested that the community organisation propose the case on their behalf have been unable or unwilling to actually provide support once the entrants arrive onshore. This is further complicated by the fact that some community groups have in the past not kept adequate records of proposed cases and as a result may not know which individual the proposed entrant is linked to. Pressure on the community groups by their members may also result in the number of proposals exceeding the number which the group and community is able to support.

Although it is apparent that there is a large number of proposers who are not capable of providing settlement support, there is no legislative requirement for such capacity to exist. An assessment of the proposer's capacity to provide support is conducted by overseas posts prior to referral (generally only on the basis of the information provided by the proposer on the proposal form). This assessment is only used, however, to recommend to the relevant DIMIA State/Territory office the level of services which the entrants receives. As mentioned above, one of the roles of the PS provider is to identify cases where the proposer is no longer able to directly support the entrant, and to refer these cases to the DIMIA State/Territory office. In reality, however, many PS providers never meet the proposers face-to-face and rely on the proposers to self-identify that they are unable to provide support.

Even if an overseas post or PS provider recommends that an entrant receives additional IHSS services, it may not be possible under current funding arrangements for these additional services to be provided to all proposed families who need them. This results in inequity in the standard of settlement services which are provided to proposed cases, inequity which the IHSS was introduced to remove.

Timing of service delivery

Flights for SHP entrants are the responsibility of the proposer. Unless these are arranged through IOM, DIMIA is not aware of any impending arrival of SHP entrants. It appears that PS service providers do not routinely seek this information from proposers. As a result it is difficult for PS providers to effectively time service delivery. If information is provided immediately after the case is referred, then it may be forgotten by the time the entrants arrive. If, alternatively, the service is not provided at this time, then it is possible that the entrants may arrive before the proposer is provided with the information necessary to assist them.

A further consequence of inadequate notice of the entrants' arrival is that the case may not be linked to other essential services in a timely manner. It may, for example, be necessary for HFS to be provided before the family arrives in order for them to be accommodated in the proposers' home. If neither the PS provider nor DIMIA is aware of an impending arrival, it is not possible for such a linkage to be made.

Not all proposers receive PS support

Not all proposers receive PS support. This is for three reasons:

- There has not always been a seamless process for linking PS service providers with proposers following grant of a visa. In the past this meant that some cases only came to attention through ad hoc means, such as if they happened to contact another agency. This gap has now been closed and checks are in place to identify these cases so that they are linked with PS services shortly after the entrants arrive onshore. The number of cases affected in this way is diminishing.
- As described above, the contact details of proposers may be inaccurate by the time of referral to the PS provider. This may make it difficult or impossible for the proposer to be contacted.
- Where the proposer is a group or organisation, which has proposed on behalf of an individual, it may be unclear who (if anyone) is going to provide support to the entrants. This is compounded by groups for whom the only contact point is a PO Box. In these instances it is difficult – or impossible – for the PS provider to provide effective assistance.

PS does not provide support to entrants themselves

As the PS service is provided to the proposer, rather than the entrant, it is effectively at arm's length. As such, PS does not assist with the entrant's material needs.

The benefits of PS are largely dependent on the ability of the proposer. If the proposer has significant financial means and a reasonable degree of functioning within society, then PS will provide a useful service in informing them of their responsibilities as a proposer. If, on the other hand, the proposer does not have the capacity to fulfil their responsibilities, then PS provides no tangible benefit to them or the entrants. In particular, proposers who sponsor very large numbers of cases would experience very little benefit from receiving the same set of information again. At the same time the large number of proposals which the proposer is supporting may mean that the material needs of the entrant are not met. PS in its current form does not serve to address this.

Further PS is dependent on the service provider being able to deliver the service to the proposer. As noted above, there is a range of reasons why the proposers may not receive this service and why, when they do, the flow-on benefits may be less than adequate.

In its current form PS provides very limited benefit to the proposers, and the resources may be better used in assisting the proposed entrants directly.

5.5.5 Options for PS

Clearly as it stands the PS service is not working. As humanitarian visa allocations revert from unneeded TPVs to SHPs, the number of proposed entrants will increase. The scale of the problem facing DIMIA and PS providers in meeting the needs of these entrants will likewise continue to grow. Should these problems not be addressed, it is likely that new entrants in some emerging communities will experience increasing disadvantage.

Ideally SHP entrants should have access to all IHSS services. In this manner DIMIA would be able to ensure that it meets its duty of care to all humanitarian entrants. Given the number of SHP entrants, however, this could easily double the current budget. Therefore other options should also be discussed.

As many of the existing problems arise from several flawed assumptions within the SHP, any changes to improve the support provided to SHP entrants must take into account this program as a whole, as well as post-arrival services. Tension exists between the need to ensure that proposers are able and willing to meet the needs of entrants, and the need to maximise program numbers.

A number of suggestions was made in relation to improving the assessment of proposers. One option is for PS providers to assess the capacity of proposers to provide support with a face to face interview before the entrants arrive, and if necessary to refer the entrants to DIMIA for additional services (an enhancement of current arrangements). This kind of enhancement would require an increase to the PS unit price to cover the cost of a face-to-face interview. It would also require a pool of discretionary funds available to DIMIA State/Territory offices to allow provision of additional support to all cases that required it. A drawback of this option is that it would serve as a disincentive to proposers to provide the support themselves. A similar option suggested, is that the PS provider should assess whether the proposer has in fact carried out the settlement tasks required, through at least one home visit. This suffers the same drawbacks as the last option, with the addition that it is retroactive in that arrangements would have to fail (and the entrants' settlement therefore hampered) before additional assistance could be provided.

A further option is that SHP entrants be identified as a client group under an enhanced role of the IIOA provider (most of whom are currently providing PS in any case). The provider could assess the needs of the entrant and the capacity of the proposer (or contact for Refugee cases) and provide appropriate assistance to either of them as necessary. By effectively combining the Refugee and SHP client groups into one, the service provider could better manage resources (including linking entrants with volunteers) so that the necessary support could be provided directly to SHP entrants if the proposer was not capable of providing support. Likewise, guidance, rather than direct assistance, could be provided to Refugee entrants who have a family member or friend in Australia able to provide IIOA support. As such it would not require a significant increase in funding.

Any improvement to the way in which PS is currently delivered will heavily depend on:

- the ability of the provider to locate the proposer
- the provider knowing in advance when the entrants will be arriving.

One option for achieving this is for DIMIA to change its visa processing procedures to require that proposers contact the PS provider directly, before the visa could be granted. This would allow the provider to:

- verify that a genuine proposer exists
- provide information and assistance in a timely manner
- better identify cases where the proposer is not capable of providing support

- request that the proposer informs the PS provider when travel arrangements are made, so that they may be linked with further services.

It is not likely that this option would significantly diminish the number of SHP cases being approved, but it would provide greater certainty that appropriate support will be provided to entrants. This option would incur extra costs due to the need for the PS provider to meet with proposers face-to-face, however, would realise a saving in the fact that resources would not have to be dedicated to tracking down proposers who have relocated to different addresses (or even States).

Taking into account the above, the most viable measures to ensure that a minimum level of support is received by all SHP entrants are:

- abolish the current method of providing support to SHP cases
- combine Refugee and SHP entrants as a single client group under an enhanced IIOA service, and give providers greater flexibility in assessing the needs of clients and allocating resources (including linking entrants with volunteers) in a way to best serve these needs
- introduce a requirement for proposers to contact IIOA/PS providers before visa grant.

Recommendation 17

Improving Proposer Support

The PS service as it currently stands should be abolished. In future both Refugee and SHP entrants should be assisted by IIOA providers. Greater flexibility should be provided in the delivery of this service. IIOA providers would be responsible for assessing the settlement support available to Refugees and SHP entrants from family or friends, and for providing guidance to maximise that support. For entrants (both Refugee and SHP) who require additional support, the provider would be responsible for making sure that entrants have the appropriate information and are linked with other services for which they are eligible. Entrants with comparatively lower needs could be linked with volunteer groups for the provision of these services.

5.6 Community Support for Refugees

5.6.1 Service description

In developing the IHSS model, particular attention was paid to maintaining and wherever possible increasing the valuable role played by volunteers in assisting refugees to settle in Australia. The CSR service was established so that volunteers could provide friendship and practical social support to entrants to help them become fully participating members of the local community and understand the Australian culture. For example, a CSR volunteer might accompany entrants on their early shopping trips in Australia to help them become familiar with the items available and how to purchase them. They might also accompany entrants to a meeting of a local community organisation and introduce them to their members. This support is fundamental to the entrant benefiting from the range of IHSS

services available to them. In addition, CSR volunteers can provide information to the local community about the refugee experience and the role of CSR groups.

In providing this assistance, CSR volunteers complement the role of IHSS service providers. By providing an informal support system, CSR groups are intended to help to alleviate the sense of loss of community and extended family that entrants often experience.

Because CSR groups are registered by DIMIA for the achievement of these outcomes they are included in DIMIA's COMCOVER insurance while they are carrying out bona fide CSR activities. However as noted previously, this creates a level of ambiguity in that CSR groups are not accountable to DIMIA.

5.6.2 The role of CSR groups

The CSR service provides a framework for the achievement of the following outcomes:

- entrants become fully participating members of the local community by accessing various social, cultural, sporting and other organisations
- the local community becomes more aware of the refugee experience and the support provided by CSR groups.

Whilst all CSR groups would be expected to provide support leading to the achievement of the first outcome, the latter outcome is optional.

As well as participating in the CSR service, CSR groups and their individual members are able to work directly with IHSS service providers to assist in the delivery of their contracted services.

5.6.3 Issues raised in relation to CSR

Prior to the SSP contract being awarded DIMIA State and Territory offices were responsible for recruiting, registering and training CSR groups. Whilst most State offices were quick to register volunteers interested in becoming members of a CSR group, in some States very little support or training was provided to them beyond initial information and orientation training.

A few State DIMIA offices embraced the new arrangements and added responsibilities. They did this by arranging regular meetings with the volunteers so that they could discuss any issues or concerns that they might have, and encouraging IHSS service providers to use these volunteers in delivering their contracted services. Conversely, a number of IHSS service providers, CSR groups and even DIMIA staff did not fully appreciate the way in which it was envisaged that CSR groups would operate and relate to other service providers. In at least one State this is still the case today.

Staff changes, a clear understanding of the roles and responsibilities of CSR groups, contract content, insufficient training and information and the delay in awarding the SSP contract could all be cited as contributing factors to the slowness in the CSR service becoming fully operational. Some State/Territory Coordinators had only just taken up their jobs. In others recruitment was still underway. This meant that the responsibility for recruiting, registering and training CSR groups remained with DIMIA State offices. Therefore it is difficult to comment on whether the CSR service will operate effectively in the longer term.

However, as with all volunteers under the IHSS, there is a need for a clear definition of the roles, responsibilities, accountabilities and expectations if their contribution is to be meaningful. Further, volunteers should not be used in lieu of paid workers.

The transition to the IHSS has left a number of volunteers 'out in the cold' for a range of reasons, including concerns about levels of professionalism, quality control, capacity to resource volunteer management and contractual limitations. Volunteer involvement appears to be crucial to the success of IHSS. In many instances, service providers acknowledged that they could not deliver services without their assistance, while in others, service providers do not involve volunteers and experience considerable difficulties making their resources stretch to fulfil their contracts.

CSR was developed in response to this, but it has not as yet successfully 'captured' the full contingent of volunteers. While there is significant participation by volunteers in many localities – and in a number of instances IHSS works only *because* of the input of volunteers – they often operate outside CSR. In part the problems can be traced to the CSR Coordination and Support service not yet functioning as expected, as professional development around volunteer involvement has not transpired. As well, there is a lack of incentive for volunteers to operate under CSR when they can continue, as they have historically done, to operate outside the service.

As noted previously, some former CRSS groups have not adjusted well to the change and inevitably will become redundant. Other challenges faced by the CSR service include ensuring that there are appropriate linkages with the other IHSS services, particularly the IIOA and PS providers, if they are to play an active and meaningful role in the settlement process. If this does not occur it is likely that the CSR service will become a parallel service, operating in isolation and finding it increasingly difficult to maintain a meaningful relationship with their clients.

Recommendation 18

Community Support for Refugees

DIMIA should continue to monitor the development of the CSR network and this should be undertaken with an awareness that a large proportion of volunteers currently operates independently of CSR. Ways to strengthen relationships with providers should be explored.

5.7 Service Support Provider

5.7.1 Service description

The SSP service is aimed at ensuring that:

- IHSS service providers are equipped to meet the service needs of Humanitarian Program entrants in the initial stages of settlement, and their obligations as contracted service providers, employers, and partners where relevant
- entrants' settlement is enhanced by expanding the capacity of the voluntary sector to deliver services by being responsible for the recruitment, coordination and registration process of CSR groups, through the establishment of a CSR contact in each State/Territory and by providing training and support to CSR groups.

SSP services are available to all IHSS service providers and CSR groups including contracted organisations and their nominated partners and volunteers and voluntary groups working directly for IHSS service providers.

There are two SSPs. One is a national provider, based in Melbourne and, through a consortium of agencies, delivers SSP services to all States and the ACT. The other SSP is based in the Northern Territory and is responsible for delivering all IHSS services, including SSP services in the Territory.

5.7.2 Role of the Service Support Provider

The role of the SSP is to:

- conduct assessments of the training and information needs of IHSS service providers directly relevant to the delivery of IHSS contract services in order to identify training and information priorities and the frequency of the need for training and information
- develop a training information delivery plan based on the training needs assessment to enhance the capacity of IHSS service providers to meet their IHSS contractual obligations
- develop and implement a monitoring and evaluation strategy to assess the effectiveness of the training and improve planning and delivery of future training needs
- make available information resources to enhance the capacity of IHSS service providers to meet their obligations as IHSS contracted service providers and to CSR groups to assist them in the delivery of IHSS services
- develop and implement a CSR recruitment plan in consultation with other IHSS contractors
- establish and maintain a CSR register and train CSR groups as required
- administer and report on payments made to CSR groups
- facilitate access by CSR groups or refer CSR groups to IHSS service providers to enable CSR groups to negotiate agreements to assist IHSS service providers where applicable in the delivery of their contracted services
- monitor the service provided by CSR groups
- provide advice to assist CSR groups in completing their annual CSR Report.

5.7.3 Issues arising in relation to service support

Impact of delays

There were a number of administrative matters that delayed the implementation of the SSP service. Consequently, it was one of the last IHSS contracts to be let. As a result there were some difficulties in coordinating the operations of the SSP service. As the SSP is responsible for the day-to-day management and coordination of the CSR service, the delay in recruiting State/Territory CSR Coordinators meant that the CSR service was also affected. During the course of the evaluation a common finding was that little or no action had been taken regarding CSR – at best, local CSR Coordinators had just been appointed. Difficulty in securing office space and in recruiting CSR Coordinators also contributed to the delay. In addition feedback suggests that in some States the part time State/Territory CSR coordinators positions should be increased to full-time to meet the needs of a State-wide service.

Consultations with volunteers suggested that the CSR service has been adversely affected through this delay. The evaluators met some would-be volunteers who had 'signed on' and undergone police checks many months earlier and had no contact with anyone regarding their roles as volunteers. Although they were still interested in working as volunteers, their enthusiasm has been dampened by the lack of action.

Some stakeholders and service providers were critical of the attachment of volunteers to the SSP service. In particular, the notion that a contractor external to any IHSS service deliverer could effectively recruit and train a body of volunteers was seen as being possibly unworkable. Fundamentally, these stakeholders consider that volunteers are integral to the operation of specific services and community groups and should not be a separate body with limited roles to play.

A further problem is that there continues to be a significant number of volunteers (generally the previous CRSS volunteers) who have not yet and maybe never will come under the CSR service. As a consequence the SSP provider will only be able to coordinate a portion (and possibly only a minority) of active volunteers. Whether this will change once the SSP becomes fully operational is yet to be seen. SSP will however be able to offer training to volunteers working directly with IHSS service providers.

Training and information needs of IHSS service providers

The other main area of responsibility of the SSP is to identify both training and information needs and then to deliver training. In many localities this needs assessment had taken place, in some instances only shortly before the evaluation fieldwork.

In carrying out the needs analysis, the SSP provider reported encountering the following:

- that IHSS service providers had not been adequately trained on the IHSS model or its implications
- that not all IHSS service providers were adequately skilled to manage purchaser-provider contractual services
- that service providers had very few opportunities to debrief and consult with DIMIA staff on difficulties experienced with service delivery
- that not all IHSS service providers are aware of all the relevant aspects of the IHSS program (eg overseas posts, other service providers and the role of volunteers).

A number of IHSS service providers have found that the delay in implementing SSP has meant that their training needs are now different from those they had earlier. Most IHSS service providers state that their training needs are now more professionally based rather than service-related. The SSP provider reported that in completing the training needs analysis most service providers are looking for professionally stimulating training rather than service-related courses. That is, the training sought is to assist with improving practice, standards and service delivery.

The training needs [requiring attention of SSP] are not to skill unskilled staff. That responsibility lies with the service provider who employs those staff. [The issue is] more that IHSS contractors wish to have access to research papers, new models and methods of service delivery and opportunities to improve and enhance skills through peer group discussion and case analysis.

(Service Provider)

In developing training plans, the SSP has been looking at creative ways to address the needs of IHSS contractors. These include:

- providing opportunities for service providers (staff) to access tertiary level competency based training, where staff can obtain credits for work experience and complete distance education through tertiary institutions
- the development of tertiary level training packages, with modules that can be delivered singularly as well as within a whole package. This provides opportunities for staff to complete single modules in their own time or through their employer
- the development of a web bulletin board to keep service providers up-to-date with training opportunities, research and new developments.

At least one IHSS service provider raised the issue that, despite a needs assessment having been undertaken, the training program that was then proposed seemed to ignore the needs for training that the service providers and their staff had identified.

There appears to be a risk that the speed with which the contractor can translate the needs assessments into the actual delivery of the requested training might be too slow and that the actual training plans developed may not reflect real and current needs.

APPENDIX A

METHODOLOGY

A1 Methodology

A1.1 Overview of methodology

This section details the methodology undertaken in conducting the Evaluation of the *Integrated Humanitarian Settlement Strategy* and the Commonwealth-funded services for survivors of torture and trauma.

The brief identified the following components to the fieldwork:

- initial consultation phase
- review of background data and documentation
- finalisation of evaluation framework
- development of an evaluation Website, including an open invitation to make written submissions
- field trips to each State/Territory to conduct:
 - group interviews with clients who have used the services
 - in-depth consultations with management and staff from selected IHSS (both contracted and voluntary) and EHAI/PASTT providers
 - in-depth interviews with other local key stakeholders
- interviews with relevant DIMIA and DHA service staff and other national key stakeholders.

The details of each of these components are discussed below.

A1.2 Initial consultation phase

The initial consultation phase included the following key tasks:

- Project briefing with key staff from both DIMIA and DHA, where comprehensive background information and the policy context for the evaluation were provided.
- Teleconferences with both the IHSS and Torture and Trauma Reference Groups. The members of these groups are experts in the field and provided the consultants with valuable background information and key issues for consideration for the evaluation methodology, including the selection of clients.
- Meetings with both Reference Groups to assist with the recruitment of clients and the design of question guides.

A1.3 Review of background data and documentation

The following activities were carried out for this phase of the evaluation:

- familiarisation with the IHSS and EHAI/PASTT services
- brief review of the nature and placement of refugee and humanitarian entrants
- review of the policy context of the services

- identification of statistical, financial and other service data.

A1.4 Finalisation of evaluation framework

To finalise the evaluation framework the following steps were taken:

- Clarification and confirmation with the Departments about the research tasks, processes and protocols to be followed.
- Clarification with the Reference Groups about client recruitment.
- Defining the roles and responsibilities for the consultants and Departmental staff.
- Confirming the fieldwork locations and organisations to be visited.
- Finalising a timetable for the completion of key milestones.

A1.5 Evaluation website

The website content comprised an evaluation overview, the terms of reference, the methodology, links and information on making a submission (including the question guides). This content was similar to the information mailed out to service providers, volunteer groups and stakeholders.

The website was functional from 4th November 2002.

Urbis Keys Young received numerous inquiries regarding the evaluation and a total of 30 written submissions were received (12 responses from CSR groups, 7 responses from service providers and 11 other stakeholder responses).

A1.6 Fieldwork

Twelve locations were identified in which to conduct fieldwork. These were spread across Australia and provided a suitable balance of regional and metropolitan areas:

- Sydney (NSW)
- Canberra, Wagga Wagga³ (ACT)
- Hobart, Launceston (Tas)
- Melbourne (Vic)
- Adelaide (SA)
- Perth (WA)
- Darwin (NT)
- Brisbane, Cairns, Toowoomba (Qld)

The fieldwork was undertaken during November 2002 by four Urbis Keys Young researchers.

A clear procedure was developed for recruiting, liaising with and interviewing members of each of these groups. This is described below.

³ Although Wagga Wagga is in NSW it is included in the ACT region and serviced from the ACT.

A1.6.1 Clients

Clients of Services for Survivors of Torture and Trauma

Small focus groups of approximately six clients were arranged to explore client satisfaction with IHSS and services for survivors of torture and trauma. All clients who attended were offered financial compensation for their time and costs incurred. This was not referred to as 'payment' so as not to complicate the client's experience of the group.

Clients of the Integrated Humanitarian Settlement Strategy.

IHSS clients to be interviewed were arranged independently of IHSS services through the Adult Migrant Education Program (AMEP). AMEP contacts were provided to Urbis Keys Young by DIMIA from the AMEP National Directory.

Urbis Keys Young established contact with each area's AMEP representative by phone or e-mail. The AMEP representatives were asked to find clients who met the following criteria:

- had been in the country for a period of between six and twelve months (so they had passed the *initial* stage of settlement, and were looking back on their experience); and
- had arrived under the following visa categories - Refugee (sub class 200, 201, 203, 204), Special Humanitarian Program (sub class 202) and Temporary Protection visas (sub class PV or TPV); and
- had either used or are currently using one or more of the IHSS services (namely accommodation support, household formation support, initial information and orientation assistance, early health assessment and intervention, community support for refugees and proposer support); or
- had not accessed IHSS services.

Participants were to meet additional country of origin and demographic criteria, as follows.

State	Country of Origin	Other specifications
NSW	Iraq	
VIC	Ethiopia and / or Somalia	
TAS	mixed	
NT	Horn of Africa countries	
QLD / Brisbane	Sudan	women
QLD / Cairns	mixed	young people
QLD / Toowoomba	mixed	men
SA	Former Yugoslavia	
WA	Bosnia Herzegovina	

In consultation with the AMEP contact a suitable date, time, interpreter and venue were arranged for each visit. In general, the group was held in an AMEP facility with which clients would be familiar. Urbis Keys Young distributed information sheets (covering the nature of the group and specific details of each group meeting) to AMEP contacts who invited suitable clients. An additional group targeting Household Formation Support clients was arranged in Sydney through St Vincent de Paul.

The following table indicates the number and country of origin of client attendees.

State		Attendance (Country of origin)
NSW	Sydney	7 (Iraq)
	Sydney HFS	7 (Sudan, Somalia)
ACT	Wagga Wagga	5 (Iraq, Sierra Leone, Sudan, Ethiopia)
VIC		4 (Ethiopia, Somalia)
TAS		7 (Africa, Kosovo)
NT		6 (Horn of Africa)
QLD	Brisbane	6 (Sudan)
	Cairns	2 (Sierra Leone)
	Toowoomba	3 (Sudan)
SA		7 (Former Yugoslavia)
WA		7 (Former Yugoslavia)

In accordance with privacy and confidentiality practices, the EHAI/PASTT providers had the major responsibility for recruiting clients to give feedback on their services. The following criteria enabled the agencies to recruit suitable candidates and to ensure a mix of client ethnicity.

Service providers were asked to find clients who met the following criteria:

- had arrived under the visa categories Refugee (sub class 200, 201, 203, 204), Special Humanitarian Program (sub class 202) and Temporary Protection visas (sub class PV or TPV), and longer term residents with refugee like backgrounds; and
- had accessed Commonwealth funded services for survivors of torture and trauma, (namely the short term counselling provided under EHAI and / or long term counselling provided under PASTT); or
- had not accessed EHAI or PASTT services.

Additional specifications of country of origin, gender and age were as follows:

State	Country of Origin	Other specifications
NSW	Croatia and/or Sri Lanka and/or Vietnam	
ACT	Former Yugoslavia and/or Kosovo	
VIC	Horn of Africa countries	women
TAS	Sierra Leone	under 30 years
NT	Sudan	under 40 years
QLD / Brisbane	Afghanistan	men
SA	Iraq	
WA	Bosnia-Herzegovina	over 40 years women

In consultation with each agency, a suitable date, time and venue was arranged. It was determined that all venues should be external to services for survivors of torture and trauma facilities to ensure clients understood the independent nature of the evaluation. Interpreters and catering were arranged as the EHAI/PASTT providers considered necessary.

In general, services identified all clients who met the criteria and then emailed a coded list of clients to Urbis Keys Young. Urbis Keys Young randomly numbered the client list and each agency invited clients in the order they had been numbered. Clients were asked to participate and provided with an information sheet explaining the evaluation, nature of the group, venue and time. Three EHAI/PASTT providers used a different procedure (Northern Territory, Queensland and ACT). These services recruited clients directly to the discussion group without the element of random numbering.

AMEP representatives and the Multicultural Disability Advocacy Association (NSW) were also asked to identify clients who were eligible to access services for the survivors of torture and trauma and had either used or not used the services. While contact was made with these agencies (their role in recruiting clients for the IHSS Client group was always prioritised), very few clients were organised through these services to attend the client group meetings for survivors of torture and trauma.

Attendance at each group was as follows:

State/Location	Attendance/Country of origin
NSW/Sydney	7 (Former Yugoslavia)
ACT	7 (Former Yugoslavia)
VIC	6 (2 Ethiopia, 3 Eritrea, 1 Somalia)
TAS	7 (6 African, 1 Bosnia)
NT	8 (Sudan)
QLD / Brisbane	7 (Afghanistan – men)
SA	6 (Iraq)
WA	5 (Serbia – women)

A1 . 6 . 2 Service providers

IHSS service providers

Prior to Urbis Keys Young's contact with IHSS Service Providers, DIMIA notified all services of the variety of ways to be involved in the evaluation, explaining that some would be visited and that all could participate through telephone interviews or written submissions.

A selection of services were to be visited, chosen in order to achieve a good mixture, in terms of:

- the range of IHSS services provided (one to several service components)
- the type of auspicing body (migrant service, church or other organisational entities)
- location (metropolitan, regional and rural areas)
- ethnicity of client base.

Those selected were e-mailed and contacted by phone to introduce the evaluation and establish appropriate meeting times. Both the management and staff of each centre were invited to participate. All services were provided with the evaluation brief and question guide. The services which were not visited were encouraged to submit a written response.

The following service providers were visited during the evaluation:

State/Territory	Location	Organisation
NSW	Sydney	<ul style="list-style-type: none"> • NSW Migrant Resource Centre Association Inc • Anglicare Migrant Services • St Vincent de Paul (NSW)
ACT	Wagga Wagga	<ul style="list-style-type: none"> • Ethnic Communities Council of Wagga Wagga
VIC		<ul style="list-style-type: none"> • South Eastern Region Migrant Resource Centre • New Hope Foundation Inc • Deakin Consortium
QLD	Brisbane	<ul style="list-style-type: none"> • Multicultural Development Association Inc
	Toowoomba	<ul style="list-style-type: none"> • Anglicare Western Region, Toowoomba
	Cairns	<ul style="list-style-type: none"> • Centacare Cairns (The Roman Catholic Trust Corporation for the Diocese of Cairns operating as Centacare Cairns)
SA		<ul style="list-style-type: none"> • Migrant Resource Centre SA Inc • Australian Refugee Association Inc
WA		<ul style="list-style-type: none"> • The Gowrie (WA) Inc
TAS		<ul style="list-style-type: none"> • Migrant Resource Centre, Tasmania
NT		<ul style="list-style-type: none"> • Torture and Trauma Survivors Service of the NT (now Melaleuca Refugee Centre)

Services for survivors of torture and trauma

DIMIA contacted all of the EHAI/PASTT providers prior to the evaluation regarding their involvement. The small number of service agencies enabled each one to be visited (there is one Commonwealth-funded EHAI/PASTT provider in every State and Territory capital). Urbis Keys Young made initial contact by telephone, followed by confirmation letters which included interview guides for both staff and management. Providers were encouraged to prepare for the interviews and several services also gave information on their activities to Urbis Keys Young to facilitate background research. Both management and staff were invited to participate. In addition a researcher was funded separately by DIMIA to assist in providing information from the EHAI/PASTT providers.

The following services were visited:

State/Territory	Organisation
NSW	STARTTS (Service for the Treatment and Rehabilitation of Torture and Trauma Survivors) NSW
VIC	VFST (The Victorian Foundation for Survivors of Torture)
QLD	QPASTT (Queensland Program of Assistance to Survivors of Torture and Trauma)
SA	STTARS (Survivors of Torture and Trauma Assistance and Rehabilitation Service) SA
WA	ASETTS (Association for Services to Torture and Trauma Survivors) WA
TAS	Phoenix Centre TAS
NT	TTSSNT (Torture and Trauma Survivors Service of the NT now Melaleuca Refugee Centre)
ACT	Companion House ACT

A1.6.3 Stakeholders

IHSS and Services for Survivors of Torture and Trauma stakeholders

A combined meeting of stakeholders of both the IHSS Services and the survivors of torture and trauma services was held in each area. These sessions were up to two hours long, were held at a venue external to services and were conducted in accordance with the question guide.

Each service provider who was to be visited (both IHSS Services and EHAI/PASTT providers) provided Urbis Keys Young with a list of their stakeholders. All those identified were invited by e-mail or post, and were sent an evaluation brief and interview guide. RSVPs were requested. A list of those invited is attached at Appendix A.

The following table indicates the total number of combined stakeholders invited in each location and the total number of stakeholders who attended.

Location	Number of stakeholders invited	Number of stakeholders that attended
Sydney	47	14
Wagga Wagga	5	3
Melbourne	68	18
Brisbane	14	6
Cairns	2	1
Toowoomba	5	1
Adelaide – Community groups	Approx 7	0
Adelaide – Service providers	Approx 14	7
Perth	18	2
Hobart	16	1
Canberra	9	3
Darwin	14	9
<i>TOTAL</i>	<i>225</i>	<i>65</i>

Additional stakeholder interviews were conducted with key individuals/groups if they were unable to attend the meeting.

It should be noted that although a stakeholder meeting was not planned for Toowoomba, all stakeholders were sent an introductory letter and interview guide and were invited to put in a written submission or to contact Urbis Keys Young. One stakeholder interview occurred while the Urbis Keys Young researcher was visiting Toowoomba.

National Stakeholders

DIMIA, DHA and the Reference Groups identified national stakeholders of both IHSS and services for the survivors of torture and trauma. A total of 34 people were identified and invited to take part in the evaluation by telephone interview or written submission. A total of 27 people participated, including all DIMIA state representatives (either via a visit while researchers were on location or by phone interview).

Appendix B lists all the organisations consulted in these interviews.

Members of volunteer groups

Meetings with volunteer groups were arranged across Australia, in Canberra, Launceston, Hobart, Adelaide, Perth, Darwin, Brisbane and two in both Sydney and Melbourne (to ensure accessibility). A meeting date and time was established in conjunction with other fieldwork, often in the early evenings or late afternoon; again independent venues were utilised.

DIMIA provided Urbis Keys Young with contact details of all formally recognised volunteer groups. Each group was sent a letter introducing the evaluation and giving the time and date of the local meetings. The interview guides followed once they had been finalised. All volunteer groups were asked to RSVP. However, as fieldwork approached, few RSVPs had been received. In response, follow-up phone calls were made to the groups' key contacts in the majority of locations.

While there were no planned volunteer group consultations for the Wagga Wagga visit, all volunteers were notified that our researcher would be in the area and were invited to contact Urbis Keys Young if they would like to have a face-to-face discussion. Volunteer groups were also identified as stakeholders by the Wagga Wagga service provider and were therefore invited twice. Two volunteer groups attended the stakeholder meetings.

While Cairns and Toowoomba had no formally recognised volunteer groups, IHSS service providers in the areas put Urbis Keys Young in contact with those informally working in partnership with the services. They were informed of the review by post and one interview was arranged in Toowoomba.

The CSR Co-ordinators were also visited in Tasmania, Adelaide and Perth.

The following table records the number of volunteer groups invited and the number who attended the meeting.

Location	Number of volunteer groups Invited	Number of groups attending
Sydney Central/North	22	1
Sydney (West)		1
Wagga Wagga	4	2
Canberra	4	3
Launceston	19	3
Hobart		5
Melbourne (Dandenong)	18	5
Melbourne (Preston)		3
Adelaide	2	2
Perth	16	3
Northern Territory	8	6
Brisbane	12	6
TOTAL	105	40

APPENDIX B

IHSS Services and Commonwealth funded Torture and Trauma Services Stakeholders Consulted

IHSS Services and Commonwealth funded Torture and Trauma Services Stakeholders Consulted

Location	Number Attending	Organisations Represented
Sydney	14	<ul style="list-style-type: none"> • Centrelinks (Bankstown, Auburn and MSO Illawarra) • NSW Police (Burwood Station) • Evans Intensive English Centre • Department of Education and Training, Multicultural Services • Department of Education and Training, Cabramatta Intensive English Centre • Botany Migrant Resource Centre • Refugee Council of Australia • Mercy Refugee Service • NSW Refugee Health Service
Wagga Wagga	3	<ul style="list-style-type: none"> • Lutheran Parish of Wagga Wagga • Sacred Heart Refugee Group • NSW Health
Melbourne	18	<ul style="list-style-type: none"> • Western Region Community Health Centre • Springvale Dandenong Dental Clinic • CATT Team, Southern Mental Health • Saltwater Mental Health Service • Austin CAMHS • General Practice Divisions, Victoria • Monash Division of General Practice • Royal Children's Hospital • Steering Committee for GP Training • AMES Victoria • AMES Employment • Dept of Education • Broadmeadow Centrelink • Australian Red Cross, Victoria • Refugee and Immigration Legal Centre Inc. (RILC) • Flemington-Kensington Legal Service • Refugee Health, Western Region Health Service

Location	Number Attending	Organisations Represented
Brisbane	6	<ul style="list-style-type: none"> • Centrelink Multicultural Services • St Vincent de Paul • Brisbane City Council • Milperra State High School • Australian Red Cross
Cairns	1	<ul style="list-style-type: none"> • Centrelink
Toowoomba	1	<ul style="list-style-type: none"> • Garndoo Jawrowair Childcare
Adelaide	7	<ul style="list-style-type: none"> • CAMHS – Child and Adolescent Mental Health Service • Advanced Secondary School of English • English Language/BIT • General Community Health • SA Legal Services Commission • LM Training • Migrant Health Service, Central Market
Perth	2	<ul style="list-style-type: none"> • Northern Suburbs Migrant Resource Centre • Southern Metropolitan Migrant Resource Centre
Hobart	1	<ul style="list-style-type: none"> • Housing Tasmania
Canberra	3	<ul style="list-style-type: none"> • Belconnen Community Service • Migrant Resource Centre, Canberra • Centacare, Canberra
Darwin	9	<ul style="list-style-type: none"> • Australian Migrant English Service • NT University Medical Centre • Anglicare NT • Centrelink • Special Intensive English Unit and School Counsellor Darwin High School • Office of Ethnic Affairs • Multi-cultural Council of NT

APPENDIX C

National Stakeholders Consulted

National Stakeholders Consulted

The following organisations were consulted:

- Department of Immigration, Multicultural and Indigenous Affairs (DIMIA)
- Department of Health and Ageing
- Department of Education and Workplace Relations
- Department of Human Services VIC
- Department of Human Services WA
- Refugee Resettlement Advisory Council (RRAC)
- Centrelink Multicultural Services Segment
- Multicultural Disability Association
- Federation of Ethnic Communities' Councils of Australia
- Translating and Interpreting Service DIMIA
- Vic Health Promotion Foundation
- Refugee Council of Australia
- Townsville Multicultural Support group
- Volunteering Australia
- Trans-cultural mental Health