Coordinated Primary Health Care for Refugees:

A Best Practice Framework for Australia

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CONTENTS

ABBREVIATIONS

A&E	Accident and Emergency
ACIR	Australian Childhood Immunisation Register
ADT	Adult Diptheria and Tetanus
AHP	Allied Health Professional
APAIS	Australian Public Affairs Information Service
APHCRI	Australian Primary Health Care Research Institute
ARCHI	Australian Resource Centre for Healthcare Innovations
ASeTTS	Association for Services to Torture and Trauma Survivors
CBT	Cognitive Behavioural Therapy
CHS	Community Health Service
CPD	Continuing Professional Development
DIAC	Department of Immigration and Citizenship
DoHA	Department of Health and Ageing
GP	General Practitioner
HSS	Humanitarian Settlement Services
IHMS	International Health and Medical Services
LHN	Local Health Network
MAIS	Multicultural Australian and Immigration Studies
MBS	Medicare Benefits Schedule
ML	Medicare Local
MMR	Measles Mumps Rubella
MOU	Memorandum of Understanding
NGO	Non-government Organisation
NP	Nurse Practitioner

PASTT	Program of Assistance for Survivors of Torture and Trauma
PBS	Pharmaceutical Benefits Scheme
PCEHR	Personally Controlled Electronic Health Record
PHC	Primary Health Care
PN	Practice Nurse
RHeaNA	Refugee Health Network of Australia
RHN	Refugee Health Nurse
RHNP	Refugee Health Nurse Program
RMO	Resident Medical Officer
TB	Tuberculosis
TIS	Translating and Interpreting Services
UNHCR	United Nations High Commission for Refugees
WHO	World Health Organization
WRHC	Western Region Health Centre

Background

Refugees often have complex health and social welfare needs and struggle to access coordinated primary health care (PHC) services in the Australian community.

Australia has neither a consistent model, nor an agreed quality standard approach to the delivery of coordinated primary health care services to permanently resettled refugees. In the absence of these, the organisation of health care to refugees has evolved to fit the changing context of settlement patterns, geography, and Commonwealth, state and territory government policies. Unresolved gaps in PHC service coordination have resulted in service delivery duplication, unmet refugee health needs and public health concerns.

The implementation of Australia's National Primary Health Care Strategy (1) and Strategic Framework (2) provides an ideal opportunity to improve the integrated delivery of PHC to refugees across Commonwealth, state, territory, private and community sector contributions, and across health and non-health sectors.

Refugees in Australia

Refugees are people living outside the country of their nationality who, owing to a well-founded fear of persecution, are unable to avail themselves of the protection of that country (3). Since 1947 Australia has permanently resettled over 750,000 refugees (4, 5). In 2013-14 Australia continues resettle refugees through a Humanitarian Program intake of 20,000 places and an additional 4000 places for the family reunification of existing entrants (6).

Refugees settle in Australia as permanent residents through off-shore processing programs or after a period of on-shore assessment. In contrast, asylum seekers in Australia are those whose applications for refugee status have not yet been determined (7, 8). Previously, asylum seekers found to be owed protection by Australia were offered permanent residence in Australia as refugees, however recent changes in immigration policy mean that asylum seekers arriving by boat after 19 July 2013 will be sent to other countries for processing (9). Notwithstanding these policy changes, there are large numbers of refugees currently in the Australian community, and Australia continues to offer over 20,000 places annually for the resettlement of new refugees (7).

> *"Because of extreme threats to my safety I came to Australia in 2010. I had a very limited understanding of Australia… Housing, job and regular stable income were the biggest challenges that I faced… It was rough."*
>
> (Afghan refugee)

Historically, refugees have been received from regions of evolving humanitarian crisis. These have included post-war Europe, Central and South America, Lebanon, Vietnam, Laos, Cambodia, the Former Yugoslavia and Africa. Currently, Australia receives refugees predominantly from Asia and the Middle East, in particular: Burma, Iraq, Iran, Afghanistan and Sri Lanka (7).

Refugee groups include families with young children, single women, single men, and unaccompanied minors. On arrival, the majority of refugees are less than thirty years of age, speak little or no English, are of varied religious backgrounds, and have low socioeconomic status (10-14). Refugees settle in all states and territories, with NSW and Victoria receiving the largest numbers. Many settle in urban areas, with some in rural locations (10, 11).

This report is focused on the health care needs of permanent resident refugees in Australia. It does not address the additional needs of asylum seekers who may be living in immigration detention facilities or in the wider community.

Refugee health and primary health care needs

The vulnerability of Australian refugee populations follows from the physical and psychological sequelae of torture and trauma and the deprivation of food, clean water, sanitation, shelter, education and access to health care in countries of origin and transit. Women from refugee backgrounds are more likely to have experienced rape, torture, mutilation, sexual slavery, coercion of liberty and deprivation (15, 16).

Due to these experiences, refugees in Australia have health needs that differ from the wider population (17), including a higher prevalence of mental health conditions (18-22), specific infectious diseases (19, 22-24), nutritional deficiencies (23, 25), obstetric complications (25), and disability (10, 22, 26). Complex physical and psychological problems are often addressed only for the first time in Australia, with consequent demand on health and social services after arrival (27).

> *"Now there was one man who was admitted to hospital within the first week of being here. He had acute malaria, he had syphilis, he had acute TB, schistosomiasis and strongyloides, and some sort of blood disorder as well. You know, if there was no screening, there's four diseases that he could spread within the community".*
>
> (Practice nurse).

Permanent resident refugees are entitled to the same level of access to the Australian health system as other Australian residents (28). Despite this they struggle to access coordinated PHC (15, 29, 30). Effective access is challenged by limited English language proficiency, cultural differences, a lack of knowledge of the local health system, financial difficulties, and competing settlement priorities (15, 29, 31-35). Health assessments and preventive health care are difficult for them to obtain (17). Difficulties with family separation and accessing education, employment and social support further compromise their health (33).

Health providers can find it difficult to care for refugees (23, 36). Few are routinely trained to identify and deal with issues of concern to refugees (19). Quality care is further challenged by time constraints, differences in culture and language, difficulty using interpreters, and the complexity of physical, psychological and social problems (37, 38). The problems are compounded by the common observation that organisations providing care for refugees are poorly integrated (39) and have been criticised for their inadequate support for refugees as they move between services and sectors (19, 29).

Timely access to quality health care is an important building block to successful integration and settlement (29, 40). Good physical and mental health is vital for refugees to deal effectively with the challenges of settling in a new country and to participate fully in the economic, social and cultural life of Australia (10, 19). Providing services which promote the health and well-being of refugees is in the interests of both refugees and the community at large.

Strengthening primary health care for refugees

Access to quality PHC is an important determinant of health outcomes, health equity and a fundamental building block of any sustainable health system (41-44). Investments in PHC reap rewards in terms of improved health status (45, 46), reduced neonatal and all-cause mortality (47, 48), improved preventive care (49-51) and health care utilisation (46). These findings have encouraged policy advisors to make accessible, coordinated PHC an essential component of broader strategies of health care reform (52, 53).

The difficulties that refugees face in obtaining accessible and coordinated PHC services are mirrored in other parts of the health care system. A background piece to Australia's First National Primary Health Care Strategy, *Building a 21st Century Primary Health Care*

System, suggested that: “primary health care in Australia has tended to operate as a disparate set of services, rather than an integrated service system” (1), leaving its most vulnerable populations with a system they are unable to navigate. This work is framed by the Australian government’s desire to orient current models of health care to the delivery of accessible, high-quality, coordinated care to vulnerable populations.

Given the clear needs of the refugee population, our multidisciplinary team conducted this work to generate a framework for delivering accessible and coordinated PHC services to refugees in Australia. The framework incorporates characteristics of effective models and highlights key evidence based strategies for coordinating care across sectors.

In this work we aimed to identify the PHC service delivery models in use throughout the country, identify aspects of these models that are effective at improving access and coordinating care, develop a national framework for effective service delivery and develop a feasible strategy for implementation.

Our specific objectives were to:

- Conduct a **systematic review** of international evidence for organising effective, integrated primary health care for refugees.
- Establish **a deeper understanding of the current models** for delivering refugee primary health care in Australia.
- Develop **an evidence-based framework** for the delivery of accessible, coordinated primary health care to permanently resettled refugees in Australia.
- Present **a strategy for the implementation of this framework** across Australia, providing a national roadmap for organising best practice refugee primary health care, responsive to local community needs.

Our appendices provide additional technical data.

Definitions

The following definitions are used throughout this report.

A refugee is a person who has fled his or her home due to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, and who is unable or unwilling to return to his or her country of origin (3). In Australia this definition includes refugees and humanitarian entrants with permanent resident visas. This project primarily focuses on refugees who are permanent residents of Australia and within 10 years of their arrival.

An asylum seeker in Australia is a person whose application for refugee status has not yet been determined (4, 8). Asylum seekers arrive in Australia by boat or by plane with or without a valid entry visa. They may live in the community or be detained in immigration detention centres and other facilities. This report does not focus on asylum seekers.

Primary health care (PHC) is "a set of universally accessible first-level services that promote health, prevent disease, and provide diagnostic, curative, rehabilitative, supportive and palliative services" (54). We take Starfield's 1998 definition of PHC as being "that level of a health service system that provides entry into the system for all new needs and problems, provides person-focused (not disease-oriented) care over time, provides care for all but very uncommon or unusual conditions, and co-ordinates or integrates care provided elsewhere by others" (55). The narrower term of "primary care" relates to services delivered by family doctors and other primary care providers such as nurse practitioners, while the broader term of PHC relates to an approach to health policy and service provision which includes both services delivered to individuals and population-level "public health-type" functions (56).

A model of care describes the way in which a complex range of health services is organised and delivered (57). This may be defined by principles (such as equity, accessibility, comprehensiveness, coordination), the care delivery systems (e.g. multidisciplinary, on-line), the nature of consumers and the pathway of care they must negotiate (e.g. entry, referral etc.) and the range of services provided (e.g. medical specialist, generalist). These principles are underpinned by organisational and infrastructural elements which include:

- System: government, NGO, private.
- Organisation: team, network, integrated service.
- Health service funding/cost to clients.
- Provider workforce: e.g. GPs, nurses, social workers, allied health professionals.

A refugee focused health service is one which provides a tailored level of care for refugee clients above and beyond what mainstream services can often provide. This may include a focus on the refugee population, the use of staff highly trained to address refugee health issues, or the use of approaches that are more sensitive to the needs of refugees.

Generalist refugee focused health services are those oriented towards primary care principles of first contact accessibility, continuity, comprehensiveness and (55). Examples include the Refugee Health Clinics in several state funded Community Health Centres, and private general practices with a particular expertise in refugee health.

Specialist refugee focused health services differ from generalist services by being oriented towards a specific disease group or age range (e.g. Torture and Trauma Services, or refugee paediatric clinics).

Access to a service. Access is the opportunity or ease with which consumers or communities are able to use appropriate services in proportion to their need (58). It is influenced by system, provider and consumer characteristics. Andersen described a model in which health care utilisation is determined by population and health systems characteristics and is influenced by patient satisfaction and outcomes (59). The characteristics of PHC which determine accessibility have been described by Pechansky (60) and more recently by Gulliford et al. (61) as:

- *Availability* of a sufficient volume of services (including professionals, facilities and programmes) to match the needs of the population, and the location of services close to those needing them.
- *Affordability* - cost versus consumers' ability to pay, impact of health care costs on socio-economic circumstances of patients.
- *Accommodation* – the delivery of services in such a manner that those in need of them can use them without difficulty (e.g. appropriate hours of opening, accessible buildings).
- *Appropriateness* to socio-economic, educational, cultural and linguistic needs of patients.
- Acceptability in terms of client attitudes and demands.

Coordination of care involves coordination between multiple providers and services with the aim of achieving improved quality of care and common goals for patients (57). It may involve case management; care planning; informal communication between workers or services; team meetings, case conferences, inter-agency meetings; shared assessments and records; coordination with non-health services including language services (interpreters, translated health information); referral pathways and inter-service agreements.

Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality cost effective outcomes (62).

Quality of care is the consistency of clinical care with recommendations in evidence-based guidelines as well as the quality of interpersonal care (58).This includes patients' satisfaction with care (59). The Institute of Medicine defined health care quality as the extent to which health services provided to individuals and patient populations improve desired health outcomes. Care should be based on the strongest clinical evidence and provided in a technically and culturally competent manner with good communication and shared decision making (63).

Methods

This collaborative project has been designed using the principles of knowledge translation and exchange (63-66). With investigators in three Australian states and in Canada, the methodology has been designed in collaboration with policy advisors, health service providers, settlement service workers, social workers, refugee and primary care health services researchers, community members and a refugee with significant population health experience (66).

Our work built on our previous Australian Primary Health Care Research Institute (APHCRI)-funded systematic review of coordination of care within PHC and with other sectors (57) and was informed by current and recent work by the investigators in comparing key features of international models of PHC (67).

Study Design

This mixed methods study had three phases: a systematic review, in-depth interviews and a Delphi consultation process. The full methods are provided in Appendices 1-5.

Systematic review

We began by undertaking a systematic review to characterise: a) the components of existing models of delivering accessible, coordinated primary health care to refugees (and asylum seekers) in Australia, and b) the effectiveness of these components for coordinating care. The full systematic review report is in Appendix 1.

The review questions were:

1. *What implemented models of providing PHC to permanently resettled refugees in developed countries have been described, especially in Australia and New Zealand?*
2. *What is the impact of these models of PHC on: a) access to care, b) coordination of car, and c) quality of care of refugees in countries of resettlement?*

Our search strategy targeted a broad range of published materials, including peer-reviewed journal literature, 'grey' literature from electronic databases, websites of government and other agencies, a targeted journal search and snowballing from reference lists of included studies. Articles were screened by title and abstract and then verified by two researchers. From the 2,139 papers initially identified in the systematic literature review, 25 studies evaluated the impact of models, describing 15 Australian and 10 overseas models.

The draft report of the systematic review was circulated to the investigator and advisory group who met to discuss the findings; key stakeholders were consulted about the implications for policy and practice.

Interviews

Following the review we conducted in-depth interviews (n=22) with key refugee and health system informants to further identify models of refugee PHC in use across Australia. Participants were recruited through established national links with refugee health and wellbeing organisations, networks and peak bodies. Participants included government policy advisers (n=3); program and services managers and directors of refugee services (n=6); primary care physicians and directors (n=2); practice, refugee health and general nurses (n=3); settlement service representatives (n=3); and four representatives of the Afghan, Somali, Burmese and Sri Lankan refugee communities (gender balanced). Participants came from all states of Australia. Interviews were conducted face-to-face or by telephone. Appendix 2 further details the interview methods and Appendix 3 details the interview guides.

Delphi

The systematic review illuminated national and international 'best practice' in refugee PHC and the interviews provided a broad understanding of the many options for delivering accessible and coordinated care to refugees living in Australia.

Building on these findings, we then conducted a Delphi consultation process with Australian experts to gain consensus on priorities and approaches for helping Australia generate accessible, coordinated primary health care for refugees. The Delphi technique is a multistage process, designed to combine opinion into group consensus (68), generate new ideas and is well-suited to answer research questions that will benefit from combined expert opinion.

We sent two rounds of web-based surveys to 58 potential members of a Delphi panel (68, 69). The sample was purposive, to gain heterogeneity, and comprised of refugee community representatives, policy makers, health service providers, representatives of professional organisations, Medicare Locals, social services and settlement agencies across Australian states and territories. Twenty seven individuals responded to the first survey and 22 to the second. Appendix 3 provides further detail of the Delphi methods and Appendix 4 includes copies of each survey and associated results.

Analysis

We analysed the data for this report using an iterative process (70). For the systematic review, we began by identifying research questions and outcomes, constructing relevant search strategies, selecting articles based on relevancy, recency, and quality, abstracting and synthesizing data in order to respond to each of the research questions. We followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) checklist for reporting (71).

In-depth interviews were analysed using standard qualitative techniques for interview data (72, 73). Our coding framework was informed by the broad categories of the systematic review. Our understanding was further enhanced by a secondary analysis of recent research conducted by members of our research group on refugee experiences of PHC (74-77).

The Delphi surveys were analysed using simple descriptive statistics. A consensus level of 70% was set. Questions that met that level were either excluded from Survey 2, or reformatted. Thematic content analysis was conducted on free-text response questions. Survey 2 was considerably shorter, eliminating many of the questions where consensus had been reached and focussing on elements still requiring consensus.

Expert advisory group

Study design, implementation, and interpretation were informed by an expert advisory group. The group included: government health policy advisors, health service evaluation experts, Medicare Locals, health and non-health service providers, Program of Assistance to Survivors of Torture and Trauma (PASTT) providers, Humanitarian Settlement Services and a refugee community representative. Broader advice and consultation with stakeholders across Australia was facilitated by the Refugee Health Network of Australia (RHeaNA).

Ethical approval

Ethical approval was granted by the Monash University Human Research Ethics Committee, Number: CF12/0394 – 2012000175.

Results

Our findings are arranged in four sections: 1) a description of the current system for delivering PHC to permanently resettled refugees, 2) an assessment of the performance of the current system for delivering care, 3) a description of an enhanced model for delivering accessible and coordinated care to refugees, and 4) recommendations for how this enhanced model can be implemented.

SECTION 1: AUSTRALIA'S APPROACH TO DELIVERING PRIMARY HEALTH CARE TO REFUGEES.

Introduction

Australia has neither a consistent model, nor an agreed quality standard, for the delivery of PHC services to permanently resettled refugees. Currently, care is delivered through a loose coalition of Commonwealth, state, territory and private health services and programs.

Commonwealth policy mandates a series of steps for a refugee's settlement and integration into Australian society. The Department of Immigration and Citizenship (DIAC) is broadly responsible for refugee settlement and language services, while the Department of Health and Ageing (DoHA) provides Torture and Trauma services and underwrites the cost of primary care services through the Medicare Benefits Schedule, Pharmaceutical Benefits Scheme and other programs, and integrates health care through the recently established network of Medicare Locals.

Australia's delivery of PHC is guided by the National Primary Health Care Strategy and by the Strategy's recently published Strategic Framework (1, 2). Both were developed by DOHA in collaboration with states and territories. The National Primary Health Care Strategic Framework recognises the special health and PHC needs of refugees.

> *"There is a lot of variation how refugees access health care after arriving in Australia. In some places the newly arrived refugees are given information and are directed to health services immediately when they arrive. In other places things are not well organized, refugees can be in the community for two or three, even sometimes six months but they don't know what services they can access, and eventually find out about refugee health clinics through friends or schools."*
>
> (Somali community member and accredited interpreter)

Some state and territory governments have developed state and territory-wide approaches to refugee PHC. These include formal refugee health plans in Victoria and New South Wales, and explicit reviews in Tasmania and Western Australia (10-13). These documents have guided state health departments, government funded agencies and stakeholder organisations in the development and provision of services to improve the health of refugees, including refugee focused services and programs. Some of these plans are under revision or have lapsed.

Settlement services

Humanitarian Settlement Services (HSS) in every state and territory provide intensive practical support to help refugees settle into the community during the first 6 months following arrival. These services are funded by DIAC (78). Refugees are assigned HSS case managers who provide arrival reception, assistance with finding accommodation, property induction, an initial food package and start-up pack of household goods, assistance to register with Centrelink, Medicare, health services, banks and schools, and links with community and recreational programs (78).They assist with engaging with free English language courses through the Adult Migrant English Program (79).

> *"Our (settlement) model is a strength based model and we always embrace… the client's strengths and… life skills. (It is a) holistic and team-based approach (with) case managers (and)… community guide(s)….*
>
> *They play a key role to provide cultural support for the client, make them feel comfortable and welcome and also do the orientation".*
>
> (Settlement service worker)

HSS providers assist refugees to attend local health services for health assessment and treatment. They assist in coordinating client care across services. They provide information on local health services and emergency health care options, aiming to build the client's ability to independently navigate the health system.

After exiting the HSS program, refugees may be eligible to access general settlement support through other organisations funded by the DIAC **Settlement Grants Program** (80). Refugees with exceptional needs beyond the scope of HSS and Settlement Grants Program services may be eligible for additional assistance through the DIAC **Complex Case Support** program (81).

Refugee focused health services and programs

Various **refugee focused health care** delivery models have emerged in each state and territory to meet the health care needs of refugees. Many services began as ad hoc initiatives of government and non-government organisations in response to the identification of specific health needs within the community they care for. Currently there are numerous government funded refugee focused services and programs reflecting contextual differences such as patterns of refugee settlement, urban or rural locality (82), and funding models. A summary of the refugee focussed health services and their coverage across the nation is provided in Appendix 6.

Refugee focused health services generally address the initial period of settlement. They generally provide comprehensive health assessment and screening for children and adults (82-86), mental health services including direct referral to torture and trauma services (12, 74, 85, 87, 88), catch-up immunisation, culturally appropriate health information (89, 90), referral to broader health and social services, assistance with transport between services (85, 91-93), health case-management and client advocacy. Some provide specialist paediatric, antenatal, dental, tuberculosis and psychiatric services (84, 94, 95).

Some state and territory governments fund multidisciplinary sites that may be staffed by a combination of medical, nursing, allied health, administrative or bicultural workers. Some have refugee health nurses who provide health assessment and management, catch-up immunisation, health education, preventive care, the development of health and social welfare referral networks, health case management, professional development, agency capacity building and advocacy (74, 83, 86, 87, 92, 93, 96, 97). These staff and services work in close partnership with other health, settlement, and social services.

The Program of Assistance for Survivors of Torture and Trauma (PASTT) is a refugee focused mental health service that provides expert support services to people permanently resettled in Australia who are experiencing psychological or psychosocial difficulties associated with surviving torture and trauma before coming to Australia (98). Funded by the Department of Health and Ageing, care is provided by eight specialist rehabilitation services, which provide counselling and other therapeutic interventions, advocacy and group work, forming a network across Australia (99, 100). Refugees requiring this assistance are generally referred by settlement services, some self-refer, and the remainder are referred by health and other social welfare services.

Mainstream health services and programs

Mainstream general practice clinics provide general primary care services to refugees in the community. They may receive refugee clients directly from the community, from settlement services, or from refugee focused health services following an initial period of management. They have an important role in the care of refugees and have varying levels of skill in assisting refugees, from no special experience to high levels of expertise across physical health, mental health and social issues. They are the default option for care where no refugee focused health services or programs exist.

> *"We have a doctor who used to see refugee patients…. Soon her name spread around and we started to get a lot of refugees. I was ask to see some of the overbooked patients. So I got involved in seeing refugee patients as a result."*
>
> (General practitioner)

Psychologist and **dental services** are commonly required by refugees soon after their arrival. These services and necessary **allied health** services are generally provided to refugees by state and territory health services because of the high cost to clients and the unavailability of free interpreters in private allied health, psychology and dental services.

Public hospitals provide accident and emergency (A&E) services and tertiary care to refugees. Inadequate provision of primary health services to refugees can increase attendance at A&E services (74). Adequate client linkage to primary care services is also required to ensure follow up care is provided. This reduces the risk of hospital re-presentation (82, 83).

Permanent resident refugees have access to all **Medicare** funded services. Because of low socio-economic status, refugees generally prefer to use bulk-billing services in order to minimise out-of-pocket health care expenses. The Medicare Benefits Schedule (MBS) (101) also supports general practitioners (GPs) to conduct comprehensive Health Assessments for refugees and other humanitarian entrants within 12 months of the award of their permanent resident visa (102). Evidence-based templates and electronic resources are available to support these assessments (103).

The **Pharmaceutical Benefits Scheme (PBS)** provides refugees with access to the same range of government subsidised prescription medications as other Australian permanent residents (104). Nevertheless, there are usually out-of-pocket costs for prescription and non-prescription medications. Some health services further subsidise the cost of medicines or make them free of cost for refugees.

The **Immunise Australia Program** funded by DoHA provides access to free childhood, school and at-risk group vaccinations (105). Some states and territories provide additional funding to immunise older refugee children and adults not covered by the free national immunisation program (106). The Australian Immunisation Handbook recognizes that refugees may be incompletely vaccinated according to the Australian schedule or have incomplete records of vaccination, and may require catch-up immunisations on arrival in Australia (107). Some states and territories provide refugee catch-up immunisation through refugee focused health services, general practice clinics and local council programs. Communication between health services is facilitated for children under eight years of age by the Australian Childhood Immunisation Register (108).

Interpreter services

Access to interpreter services is an essential component of accessing quality care. When used, credentialed interpreters have been found to be more effective than relatives or no interpreters, particularly in the reporting of traumatic events and psychological symptoms (109). Their use is supported in Good Medical Practice: a Code of Conduct for Doctors in Australia (110), and reflected in all refugee focused health services in Australia (12, 74, 82, 83, 85-87, 91-93, 96) as well as in many international models (111-116).

National interpreting services are provided to some private health services through **Translating and Interpreting Service (TIS) National**. Funded by DIAC, TIS provides on-demand telephone interpreting services, as well as pre-booked telephone and on-site interpreting for people who do not speak English and for the English speakers who need to communicate with them (117). Fee-free services are available for private general practitioners, medical specialists and their staff when providing Medicare-rebateable services, and for pharmacists for the purpose of dispensing PBS medications (118).

State and territory government funded interpreters are provided in public community health and hospital settings. These services are provided by government programs or private interpreting agencies accredited by the National Accreditation Authority for Translators and Interpreters (119).

Health literacy education

Health literacy education is provided in a number of settings. DIAC provides pre-migration education (e.g. through the Australian Cultural Orientation Programme) (120), settlement agencies provide orientation to the Australian health system and local health services (78), English language schools include health-related topics in their curricula, general practices and community health centres provide health-related education during refugee client visits, community workers provide health education at community gatherings and events, and ethnic media disseminate important health messages through television, radio and print media.

> *"They have very limited knowledge of medical service(s) or the knowledge about how to seek medical help or misconceptions about medical check-ups. For example… I have to tell them, this is a medical check-up, and the blood test is the procedural thing to know what is happening inside."*
>
> (Sri Lankan community leader)

Networks

The **Refugee Health Network of Australia** (RHeaNA) is network of health and community professionals who share an interest and/or expertise in refugee health. RHeaNA provides a forum for the exchange of information between providers of refugee health care and other relevant stakeholders, advises policy-makers at Commonwealth, state and territory level on current and emerging issues in refugee health in Australia, and promotes a national refugee health research agenda (121-123).

The New South Wales and Victorian Departments of Health fund **statewide refugee health networks** which aim to promote the health of refugees by assisting refugees and the health professionals who work with them, and by bringing health and community services together to be more accessible and responsive to the needs of refugees (124, 125). South Australia has an unfunded network (126), while Queensland has recently ceased funding the network provided by Refugee Health Queensland. States and territories with lower settlement rates tend to coordinate relevant activities through refugee focused health services.

Medicare Locals are regional PHC organisations tasked to coordinate local PHC delivery and address local health care needs and service gaps (127). Several Medicare Locals in areas of high refugee settlement have supported the delivery and integration of health services to refugees within their local communities. Activities include provider education and support for delivering refugee PHC, refugee community health literacy programs, and local refugee health stakeholder networks (128-130).

Health professional associations including the Australian Medical Association, the Australian Nursing Federation and the Public Health Association of Australia have developed position statements on the health and wellbeing of refugees (131-133). The Royal Australian College of General Practitioners hosts a refugee health special interest group (134).

Research

There are a number of refugee health research groups and centres around Australia. Apart from the work of this research team and the Refugee Health Network of Australia there is little coordination of national refugee PHC research (121).

Conclusion

Each Australian state and territory has elements of refugee health related policies, refugee focused health services, mainstream health services, torture and trauma services, settlement services and social welfare agencies. Nevertheless, the delivery of accessible and coordinated PHC to refugees requires a high degree of integration between these elements. Improved integration is needed between Commonwealth and state-supported services, refugee focused and mainstream health services, health and non-health sectors, and with consumers and carers, supported by robust research and evaluation.

SECTION 2: THE EFFECTIVENESS OF THE DELIVERY OF HEALTH CARE TO REFUGEES IN AUSTRALIA

Introduction

The systematic review, interviews and Delphi surveys identified the following six factors as having a significantly negative impact on the access to and coordination of PHC services for permanently resettled refugees in Australia:

1. Inadequate access to primary health care services.
2. Limited availability of refugee focused health services.
3. Gaps in the transition of clients between services.
4. The need to build the capacity of the refugee health sector.
5. The need for a refugee responsive primary health care workforce.
6. Lack of a national refugee health strategy.

These factors will be elaborated on in reference to data in the following section.

1. Inadequate access to primary health care services

Our data suggested that the principal barriers to access for permanently resettled refugees relate to language and communication, lack of familiarity with the health system, problems with service affordability and financial disincentives for service providers.

Language and communication barriers

The systematic review findings emphasised the appropriate use of interpreters and bilingual staff in order to improve the access and quality of care for refugees. The review also identified that a lack of interpreters in the needed languages was a frequent barrier to optimal care. Communication challenges posed by low levels of English language proficiency are seen as the greatest barrier to access for refugees. Access to qualified interpreters is a systemic problem and was a pervasive and consistent concern of all informants. Their use seems patchy throughout primary care, with some providers reluctant to use interpreter services. Informants also indicated client and provider reservations about the quality of interpreter services, and insufficient interpreters for certain language groups as additional barriers to communication.

> *"One of the high-need patients at the clinic was a refugee from Somalia in poor health and was insulin dependent. He was sending all of his money back to his wife and family in Somalia, so he didn't keep money to buy food and he used a push-bike for transport to save on transport costs. He'd fall off his bike or become hypoglycaemic and get taken to various hospitals. Nobody was taking control of his health.*
>
> *One day he came into us and one of our GPs said 'This is rubbish! We have to take care of this man. He must come and see me every fortnight and we'll process things in an orderly fashion to make sure the visits happen.' "*
>
> (Practice nurse)

The following story, told by a Practice Nurse, illustrates the language difficulties faced by the Somalian refugee described in the text box above:

> *"(He needed) injections that cost $1,000 (each). He took the script down to the pharmacy. They filled it. They gave him the little eski and sent him home on a Friday saying: 'take this to your GP'.... It was written 'refrigerate' on the box of the needles, but he can't speak English let alone read English. So on Monday he came in with this soggy mess in the bottom of this eski.*
>
> *"(I) rang the pharmacist (who said,) 'Oh yes, I gave them to him.' I said, 'Well did you explain to him through an interpreter that he needed to refrigerate this?'*
>
> *(Pharmacist): 'He seemed to understand'. I said, 'Well at $1,000 a go, there are five of them in the box and he's left it in the eski on the floor in his flat.'*
>
> *Her words to me were, 'Oh but the instructions were written on the box'. I said, 'He can't understand English, let alone read English.'*
>
> *(Pharmacist): 'Oh well, I can't help that.'"* (Practice nurse)

Lack of familiarity with the health system

The systematic review found that interventions that oriented refugees to the health care system were likely to improve accessibility. However, interview and Delphi data identified low levels of health literacy and health system literacy posing a significant barrier to access. This is of particular concern for refugees disconnected from settlement support. Many are not fully aware of what they are entitled to in the Australian health care system and struggle with making and attending appointments.

Limited affordability and access to low or no cost services

Problems with service affordability affected access to PHC, specialist medical care, dental care, immunisations and pharmaceuticals. In the systematic review several studies identified the lack of availability of doctors who did not charge co-payments as one of the barriers for client transition to mainstream health services. In many studies affordability barriers decreased when clinicians worked pro-bono, or when services used students or volunteers.

Our consultations suggested that, in Australia, the affordability of GP services was closely linked to the availability of bulk-billing. Informants suggested that bulk billed clinical services were reasonably available in larger cities, but difficult to find in rural and remote locations. This practice nurse in a rural town illustrates this:

> *"We're always trying to find ways to reinforce the message about the (fact that the service is no-longer free after) 12 months. We've got brochures that outline what the refugee health service offers, and after 12 months they will need to pay the full fee and we've got that translated into different languages. It's reinforced through the Refugee Service; it's reinforced through the nurses and the clinic."* (Health service manager)

Cost was perceived as a consistent barrier to refugees' ability to access specialist medical services and dental care. The cost of non-PBS medications and immunisations was also a consistent barrier to accessing needed care. A Delphi participant described the following limitations of the PBS scheme:

> *"Design of PBS is based on the population health profile of the Australian population and there needs to be a special formulary that takes account of special needs (of refugees) as in the case of aboriginal Australians."* (Delphi participant)

Financial disincentives for service providers

There was an overwhelming message from interview and Delphi participants that the additional time taken (and hence additional costs) in assisting refugees at clinics diminished access to health care for refugees. Some private clinics saw refugee clients as being "bad for business", particularly in view of the additional time resources required to address their special needs within the MBS structure which financially rewards rapid throughput. Refugees often require longer consultations due to the complexity of health and social welfare needs, and the use of interpreters. Practitioners also spoke of the burden of additional administrative tasks relating to appointment reminders, follow-ups and transition support for many refugees, in particular during the early stages of settlement.

> *"Many clinics refuse to receive refugee patients and one of the main reasons is problems with communication and in particular the time involved in using interpreters. Our practice manager put together the financial modelling to see the refugee clients and proved that we are losing about $190,000 a year through seeing refugees."* (General practitioner)

Despite the perceived and direct financial disincentives, it was also clear that some primary care practices enthusiastically embraced refugee care.

2. Limited availability of refugee focused health services

Substantial data across the project strongly supported refugee focused health service locations as being the most appropriate service delivery model for newly arrived refugees in the first 6 months. We found that the following elements make these services effective in the delivery of health care to the newly arrived refugees: a) case management support, b) team-based approach to the delivery of care involving GPs, refugee health nurses and administrative staff experienced in refugee health, c) use of on-site and telephone interpreters strongly embedded in service delivery routines, d) clinically and culturally responsive staff and resources to accommodate the unique needs of the refugee clients, e) continuity of care and patient-provider trust, and f) staff personal interest and commitment to refugee health. The systematic review identified the use of trained refugee-specific workers as being fundamental to refugees being able to access, coordinated, high quality health care. The following interviewee illustrates this further:

> "*What's really nice about our model is the patient gets to know the refugee health nurse, the GP and the clinic nurses, so it starts to become quite familiar with the whole centre. So at some point down the track if the GP's not available, there's a good chance that the patient has actually met the nurse. And we have a sort of a triage model where the nurses are allowed quite a lot of autonomy, for example, if there are walk-ins to the clinic, and quite often these clients are walk-ins, the nurse can actually assess the client and either arrange that the GP sees them or gets them to come back. So it's a really good model…. I personally think it's very hard to do a health assessment all in one sitting and to actually build up that sort of relationship with the client, you actually need several visits.*" (General practitioner)

There was a high level of consistency between interview and Delphi respondents emphasising the requirement for refugee focused health services to be flexibly available to refugees beyond the first 6 months after arrival based on the complexity of their needs. Many were concerned about the implications of refugees being only seen by mainstream health services.

> ***"****Older, illiterate people with complex medical needs are the perfect storm and we should stop thinking that we were going to find GPs for those. We should acknowledge that there were some people who (are) going to need this kind of integrated service in the long run and those people with really complicated social situations and difficulty controlling their chronic illness ….*

> *We have a kind of a system of working out who should stay and who is suitable to go into mainstream general practice."* (General practitioner and service director)

Where available, refugee focussed health services played a key role in improving the rates of health assessment, early diagnosis of health conditions and follow-up of health issues. The findings of the systematic review emphasised their positive impact on increased service utilisation, coordination between different providers, and client satisfaction.

Limited availability and scope of refugee focused health services

We identified limited availability of refugee focused health services and long waiting lists as a barrier to access in some regions. This is particularly a concern for refugees with complex needs and sub-groups with special needs:

> *"There is a higher intake of single women under the women at risk visa. We do have a growing number of unaccompanied minors, the youth specific, we don't have any sexual health support for youth…. We do have gay and lesbian clients from refugee backgrounds... also aged clients. I mean it's a minority but still they need that support of specialised services."* (Settlement service worker)

Some nurse-only refugee health clinics were limited in the range of clinical services they could provide to refugees. Pathology and radiology test referrals and prescriptions for medicines could not be provided without doctors, and medical diagnosis and treatment was limited.

3. Gaps in the transition of clients between services

Individual refugees may have complex health and social needs, requiring care across a variety of services. The interviews and Delphi surveys identified significant gaps in transitioning clients and their health information between different health services and also between health and non-health services.

The Delphi consultations indicated strong convergence of views on the significance of case management support, clear referral protocols, and client health system education for effective transition of clients between health services. Data from Delphi surveys strongly supported formal procedures for clinical handover between services, resourcing mainstream services, and prior agreement with these services to receive refugee clients as components of successful transition.

> *"In terms of supported transitions, I think the issue of partnerships is one that's very crucial, so that people aren't necessarily left to navigate the system by themselves, but to make sure that everybody is involved in caring for a particular patient is talking to each other. So having some sort of clear referral system and contacts within each agency, so the service knows they're coming, that they can follow up."* (Delphi participant)

The case management approach was identified by the systematic review, interview data and Delphi surveys as the most effective strategy for successful transition between services. Case management promotes easier transition between PHC and hospital-based care (86) and improved communication and coordination of refugee client needs between health and social welfare services (74, 85-87, 93, 135). Services adopted a number of approaches to case management ranging from employment of refugee health nurses to low-cost measures using volunteers and administrative staff as transition coordinators.

Delphi respondents agreed that refugee focused health services are best placed to coordinate the transfer of clinical care and client health information between services. The role of coordinating the other non-clinical aspects of refugee transition should be clearly delineated and shared between refugee focused health services, refugee health nurses and

settlement services. While HSS case managers have come to perform some of these tasks there is confusion amongst workers about where the health case management role of HSS provider's stops, and where refugee focused and mainstream health services should take on this responsibility.

Effective procedures for the transfer of client health information between services were identified by the Delphi surveys as the most important requirement for successful coordination of transition between services. Interviews highlighted a fragmented picture and the failure of adopting standardised procedures for the transfer of client health information from immigration detention centres and International Health and Medical Services (IHMS) directly to non-detention health services, and from refugee focussed health services to mainstream GP clinics.

> *"At the moment the Medicare Local is trying to negotiate to get access to (their health) information. Once they are released from detention the information is given to the clients directly. They call them the brown envelopes so every client comes with a brown envelope with some of their medical information, so if they lose their brown envelope, that's it. I'm trying to say there is no streamlined system for us to get this information at firsthand."* (Settlement service worker)

Delphi text comments elaborated on the consequences of incomplete transfer of health information, namely, gaps in or duplication of service provision, leading to adverse health outcomes. Effective measures for the transfer of health information may result in cost savings and improved delivery of health care.

There was a high level of consistency among respondents concerning the role of clearly documented protocols in relation to who should be responsible for transferring health information, and how the information should be transferred. Interview and Delphi respondents strongly supported a system where complete health information was directly transferred between health services by health services, with settlement services having access to limited key health information and alerts.

4. The need to build the capacity of the refugee health sector

The topic of capacity building of the refugee health sector elicited extensive responses in the interviews and Delphi surveys. Substantial data across the project strongly affirmed that **interagency networks** play a pivotal role in augmenting the capacity of the sector.

These networks are salient in integrating the refugee health sector, especially in states and territories which lack a refugee health policy. Delphi text responses and interviews commented on the critical input of interagency networks in supporting needs analysis, planning, quality practice, resource development research and evaluation**.**

> *"They have a broad overview of gaps within the refugee health sector, and can identify strengths and good practice where it is emerging and applying it where appropriate."* (General practitioner and health service director)

Delphi respondents regarded the most important potential role of these networks as coordinating the development of consistent procedures for client health information transfer and provider education.

5. The need for a refugee responsive primary health care workforce

Data across the project indicated that the main priority for resource allocation to improve **workforce responsiveness** was in equipping providers with the skills and confidence to routinely use interpreters when necessary.

Knowledge of refugee health issues and the skills to address refugee specific physical and mental health concerns were identified as the second most important requirement of a responsive workforce. Knowledge of local refugee focused health and non-health services

and resources was also a requirement of workforce responsiveness. This knowledge enables effective referrals and for obtaining information required in addressing the needs of refugee clients:

> *"Some GPs, don't really know about settlement services, they're terrified of being asked to do a (refugee) health assessment. They don't know if the person that they're seeing has a bridging visa or this or that. The implication of that is they don't know who to call if the person has a problem. They don't know what services the person is eligible for."* (General practitioner)

6. Lack of a national refugee health strategy

The impact of a **national refugee health strategy** on access and coordination were widely discussed in interviews and Delphi surveys. The absence of a refugee health strategy adversely impacts access and coordination of health services:

> "*Queensland still doesn't have a refugee health and wellbeing framework (and the impact of that on the services) is terrible, it's fragmented, it doesn't give direction… people were duplicating things, people would go off and do their own thing… because we don't have a policy framework the government could very well turn around and say, we don't need these state wide positions, refugee health doesn't need coordination. So the sector is vulnerable to the whims of whoever is in power at the time.*" (Refugee focused health service coordinator)

The views of interviewees and Delphi experts converged on the following as the most important components of an enhanced national strategic response: 1) access to government funded interpreter services for private allied health providers, 2) generalist refugee focused health services in each state and territory, 3) recognition of the refugee population as a vulnerable group in the National Primary Health Care Strategy, and 4) individual health focused case management for all refugees from the time of arrival. These priorities will be discussed further in the subsequent sections of this report.

SECTION 3: AN EVIDENCE BASED FRAMEWORK FOR DELIVERING ACCESSIBLE, COORDINATED PRIMARY HEALTH CARE TO REFUGEES

We have highlighted the problems associated with the delivery of accessible, coordinated PHC to permanently resettled refugees in Australia. The following section builds on the evidence from our systematic literature review, in depth interviews, stakeholder consultations and Delphi consensus process. We present the key components for a model of refugee PHC that will help address the identified challenges to the delivery of accessible, coordinated PHC to refugees in Australia.

The model is situated within a broader framework, which acknowledges the importance of building a strong, accessible, consumer-focused integrated PHC system. We reiterate that the outlined policies and approaches are designed to address the needs of permanent resident refugees. Although we recognise that asylum seekers have many similar health needs to refugee permanent residents, specifically addressing the needs of asylum seekers is beyond the scope of our study.

PRINCIPLES

Our model of care is oriented to Australia's recently developed National Primary Health Care Strategic Framework (2) and to the National Primary Health Care Strategy (1). We conceptualise a consumer focused integrated PHC system as having three core domains: facilitative and consistent models of care delivery; priority given to integration and system coordination; and a focus on the refugee health consumer.

Our approach is underpinned by three principles, first enumerated by LeFavre (136):

- *Refugees should have access to all of the same primary health care services that are available to the local population, and that the nature and quality of these PHC services should be the same.*
- *If any refugee focused health service is provided, it should have as its goal the full integration of the refugee into mainstream primary care.*
- *The development of any PHC service model for people of refugee background requires a consumer focused holistic approach that integrates health, settlement and social welfare services, and advocacy across systems.*

Our model is designed to generate a predictable, evidence based approach to delivering care to refugees, facilitating long term relationships between consumers and primary care providers, and enhancing the health and wellbeing of this population.

Figure 1 shows the key service components of a PHC system attuned to the needs of refugee clients.

Figure 1: Proposed model for primary health care delivery to refugees in Australia

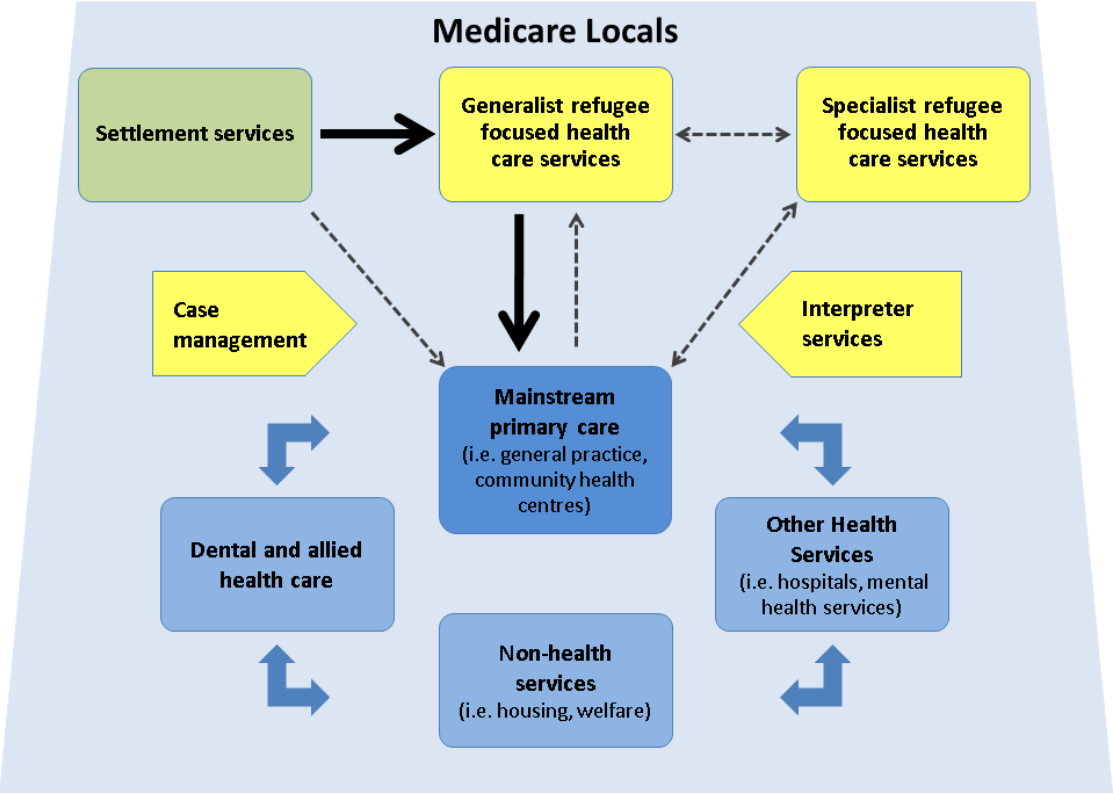

Figure 1 represents the flow of refugee clients following the granting of permanent resident status. Line arrows represent referral pathways, and the width of those arrows correlate with anticipated client flow. The case management and interpreter services entries reflect their importance in the delivery of care. Block arrows represent interactions between service, and the Medicare Local is seen as being the key integrative body at the regional level. In some settings this regional coordination may be more appropriately achieved by a state or territory based regional health service.

A MODEL TO PROMOTE ACCESSIBLE COORDINATED PRIMARY HEALTH CARE DELIVERY TO REFUGEES

Our proposed model of PHC for refugees brings together enhancements within and across three existing sectors: a) refugee focused health services, b) mainstream PHC services, and c) settlement services, while all three are central to the delivery of accessible, coordinated care, other elements, as represented in Figure 2 are fundamental to successful implementation.

Refugee focused health services are fundamental to the delivery of accessible high quality, health care to refugees. They have capacity to provide a more tailored level of care for refugee clients that mainstream health services. Across the nation these services vary in structure, governance and function (see Appendix 6).

Our model conceptualises these services as being clustered into those that have a generalist, PHC approach and others that have a predominantly specialist function. Some have elements of both.

> *"Refugees… really benefit from a specialist (health) service from the time of their arrival at the local area, wherever it is, from within seven days to six months. This is the crucial time when they really struggle: they have nothing, everything is new."*
>
> (Sri Lankan community representative)

Generalist refugee focused health services are those oriented towards primary care principles of first contact accessibility, continuity, comprehensiveness and coordination (55). Examples include Refugee Health Clinics in several state funded community health centres and private general practices with a special interest and expertise in refugee health. Services are offered on first contact (i.e. clients can self-refer), are generally offered from one location, and are designed to address most needs of the client. Many generalist refugee focused health services are multi-disciplinary and comprise teams of general practitioners, nurses, refugee health nurses, allied health providers and community health workers.

Our model requires that, where appropriate, generalist refugee focussed health services offer initial, transitional, PHC during the first 6 months from acceptance as a refugee in Australia. At a minimum, care should include a comprehensive health assessment, the oversight and administration of necessary preventive services (including immunisation) and (86), where appropriate, the coordination of referral to specialist refugee focused services (82-86). The services should work closely with interpreter services, settlement services and the refugee community.

The model specifies that clients then be transitioned from refugee focused to mainstream primary health care services after basic screening, prevention and necessary early treatment has been undertaken. The generalist refugee focused health services should then have an ongoing role as a resource for secondary consultation and expert support for mainstream health services. The generalist services may, in limited cases, continue to provide primary health care for refugee clients with complex health needs.

Specialist refugee focussed health services differ from generalist services by being oriented towards a specific disease group or age range (e.g. Torture and Trauma Services, or refugee paediatric clinics). We see them continuing to offer care on referral from generalist refugee focussed health services, and from mainstream primary or secondary care. Some services, such as Companion House in Canberra, integrate generalist and specialist care.

Refugee focused services were found to be essential, and we recommend that they be supported by governments in all regions of significant refugee settlement across Australia. The services should be structured to accommodate contextual variations in refugee settlement patterns, urban or rural locality and funding options. Where local refugee focused health services cannot be established, visiting and telehealth service options may be considered to continue to offer the functions of early screening, treatment, prevention and review.

> *"We are blessed in that… Companion House overall, is a hub for newly re-settled refugees. We are (their) general practice for the first 18 months in Australia and during that time we will do everything that is necessary to support (their) settlement process.*
>
> *The four services are medical services, counseling, community development and the children's programs… our service and all of those programs inter-digitate and people have joint consultations".*
>
> (General practitioner and director of medical services)

Recommendation 1: *Commonwealth, state and territory governments support the provision of generalist, refugee focused health services in all regions of significant refugee settlement.*

Recommendation 2: *Generalist refugee focused health services provide initial primary health care to refugees during the first 6 months of settlement, offering continuing care for selected refugee clients with complex needs, and actively assist in the transition of clients to mainstream health services for ongoing care.*

Mainstream primary health care services provide PHC services for the overwhelming majority of the Australian population. Our research points to a model whereby, following an initial period of screening, health assessment and management by refugee focused services (where available), ongoing refugee PHC becomes the responsibility of the nation's mainstream PHC services. Transfer for the vast majority of refugee clients would be performed within 6 months after arrival in Australia.

Ongoing generalist care is ideally situated within mainstream general practice and/or community health centres. As elsewhere in the Australian PHC system, mainstream providers can coordinate and actively liaise with refugee focused health services, dental and allied services and other components of the broader health care system.

Our consultations highlighted the complexity of care for refugees, and suggested that mainstream PHC services require a basic level of understanding of and responsiveness to the needs of refugees. The challenges faced by mainstream primary health care in dealing with refugee populations will ease if: a) case management and advice from refugee focussed health services are readily available, b) providers are skilled in the use of interpreters, c) providers have better access to knowledge concerning some of the challenges faced by refugees, and d) providers have access to resources to assist with management of individual refugees.

We acknowledge that this model of care situates refugee focused health services at the interface of HSS and the wider health care system. This departure from the normal process of delivering PHC to Australians has been made, not to fragment care, but in acknowledgement of the complex challenges of accessing coordinated PHC faced by refugee populations. It may well be that, in time, the clinical complexity of refugee population's decreases, and that the capacity of contemporary general practice will increase. With that situation the requirement for a refugee focused generalist role will reduce substantially.

> Recommendation 3: *Mainstream primary health care services lead the provision of continuing health care for refugees.*

The model endorses the contribution of **Humanitarian Settlement Services** and other agencies in assisting permanently resettled refugees to engage with health services from the time of their arrival in Australia. HSS case managers and community workers are key resources to the coordination of each individual's settlement needs (including housing, social security, food security, education, and health). However, because HSS workers lack health care expertise they rely on the health sector to lead the coordination of client health needs. Our model requires that settlement services: a) foster a close working relationship with refugee focused and mainstream health services, b) seek active partnerships with Medicare Locals and others working to integrate refugee PHC delivery at the local level.

> Recommendation 4: *Humanitarian Settlement Services actively collaborate with refugee focused and mainstream health services and seek active partnerships with Medicare Locals in coordinating refugee health needs during settlement.*

Interpreter services represent a special dimension of refugee PHC delivery. There is strong national consensus that improved access to and use of credentialed interpreters by all PHC professionals is of the highest priority in improving service access and quality care for refugees. Attaining this goal is made more difficult with: a) the limited availability of quality interpreters, b) perceived lack of utilisation by health care professionals (137), and c) restriction of the fee-free TIS National service to medical practitioners and their staff providing services under Medicare, and pharmacists dispensing PBS medications.

A successful model requires that language services are an integral part of all services to refugees. We recommend that DoHA, working with DIAC, should review conditions for the availability of fee-free interpreter services to different health professionals. We consider that

private allied health professionals, psychologists, accredited mental health providers and dentists should have access to TIS National services while providing services under Medicare. Key informants strongly supported the provision of fee-free TIS National interpreters for these professionals. A broadening of access could be piloted in areas of high non-English speaking migrant settlement.

Furthermore, existing and new PHC services and programs and to refugees should review whether language services are adequately funded. Corresponding interpreter workforce development is also an important consideration.

Recommendation 5: *Access to fee-free interpreter services in primary health care settings:*

a) is supported by the Department of Health and Ageing, the Department of Immigration and Citizenship, and state and territory governments.

b) is broadened to include MBS-funded allied health and psychology services, and Commonwealth-funded dental services.

ENHANCING THE MODEL OF CARE

Patient, provider and regional coordination and integration

Fostering health case management

Health case management is strongly endorsed by the evidence as being associated with improving communication and coordination between service providers, as well as improving access to preventive health services. Its value seems to be significant for those refugees with complex health or multiple health service needs. Health case management tasks for refugees include: (a) coordinating comprehensive health assessment activities, (b) ensuring the follow-up of identified health issues, and c) facilitating transitions between services

The evidence suggests that health case management for refugees may be best provided by refugee health nurses situated in refugee focused health services (74, 83, 85-87, 92, 93, 135). Health case management may only be required in the initial settlement period by refugees with complex health needs.

> *"Refugee health nurses are crucial, in fact I don't know what we'd do without refugee health nurses in the State of Victoria. They plug crucial gaps in case management especially where services are patchy."*
>
> (General practitioner)

Case management supporting the transition of care should involve: the prior checking of service eligibility criteria, obtaining the consent of the client and agreement with the service to accept the refugee client, making appointments, ensuring appropriate language services are arranged, providing appointment reminders, assistance with transport, ensuring the client can afford service costs, overseeing clinical handover, ensuring follow-up of health issues, facilitating the transfer of client health information between services, and educating clients about how to use the services independently.

Recommendation 6: *Generalist refugee focused health services help provide health case management across sectors for recently arrived refugees with complex needs.*

Easing client transitions between services

Our consultations highlighted the importance of smooth client transfer between services sectors within the model, in particular between HSS and refugee focussed health services and between refugee focused health services and mainstream health services. Transition

would be eased by cooperation and coordination of care between services, and clear protocols and procedures to support client and health information transfer.

There is a high level of consensus that complete health records or summaries need to be transferred directly between health services and generally not transferred via settlement services or refugee clients. Direct transfer mitigates concerns about privacy breaches and the loss of health records in transit. There is potential in the use of the Personally Controlled Electronic Health Record (PCEHR) to assist with health information transfer. However there are concerns about the acceptability of government managed health records to refugees, language barriers hindering client control of records, and inter-operability issues with non-health services.

Recommendation 7: *Generalist refugee focused health services develop clear protocols for the successful transition of refugee clients and their health information from refugee focused to mainstream health services.*

Promoting regional coordination

Refugees are settled in relatively distinct areas of Australia. While services have generally evolved to meet local needs, our model requires a degree of local planning and oversight to ensure that the service match the needs of the population. There is a clear role of both Medicare Locals and state based local health authorities. Medicare Locals have a role in developing local refugee focused service referral resources and providing avenues for health planners, health care providers, social service workers, and refugee community members to meet to work together to improve access to and coordination of health care services to refugees. Examples of cross organisational, local refugee health networks have emerged in parts of Australia (138). The Australian Medicare Local Alliance could further assist Medicare Locals to identify refugee populations in their area, and act as conduit for national collaboration through the sharing of refugee health resources and examples of best practices across regions.

Recommendation 8: *Medicare Locals and local health authorities work to integrate refugee focused primary health care in all local areas of refugee settlement.*

Networks for system integration

A networked approach will make it easier for Australian health care providers to deliver accessible, coordinated care to resettled refugees. Networks are becoming increasingly important in contemporary society (139) and offer stability and solutions to complex systems that require contributions from numerous occupational groups and sources of expertise (140).

The need for a **National Refugee Health Network** was highlighted by the literature and consultations as being important for providing a strategic and integrated approach to address the health and health care needs of refugees living in Australia.

> *"(Interagency networks) are a bit like the yeast in the dough; they have a role in facilitating things, bringing people together, so that ideas can be shared, research can happen."*
>
> (General practitioner)

Our consultations strongly supported the formalisation and funding of a National Refugee Health Network that brings national policy advisors, health planners, health care providers, settlement and social welfare services and members of the community together to address system integration. Such a network would articulate define and promote integrated and comprehensive national approaches to refugee health service delivery.

Many networked organizations comprise a central hub that help to create a common, shared strategy and the development and implementation of action plans driven by agreed priorities among a set of loosely coupled, generally self-managing groups (141). A National Refugee Health Network would require secretariat support, stable, modest, funding and direct liaison with DoHA and DIAC.

> Recommendation 9: *The Department of Health and Ageing helps support the formation and ongoing operation of a National Refugee Health Network to provide a strategic and integrated approach to the primary health care needs of permanently resettled refugees living in Australia.*

The National Refugee Health Network can build on the experiences of the **State and Territory refugee health networks**, several of which (particularly in Victoria and New South Wales (124, 125) have been proven to be effective in improving access to and coordination of health care for refugees. Networks in some other states are more fragile, some having become de-funded (e.g. South Australian Refugee Health Network) (126).

Formal state and territory inter-agency refugee health networks can further integrate the health services and programs to refugees and focus on addressing the system-wide enhancements recommended in this model. These networks should be linked with the national network, and also be responsive to local refugee health concerns.

> Recommendation 10: *All state and territory governments support state and territory refugee health networks to improve the integrated delivery of primary health care services and programs to refugees.*

System wide approaches

Reducing cost barriers to needed care

Given the significant socioeconomic disadvantage of resettled refugees, it is clear that lack of affordability is a pervasive barrier to refugees adequately accessing PHC. Our interview participants expressed concerns around the affordability of private generalist and specialist medical services, particularly in rural and remote areas. Our model is underpinned by a need to consider cost barriers to refugees accessing the breadth of PHC services and treatments (including medicines and vaccinations).

While we did not perform an economic analysis, our consultations suggested accessibility to state and territory refugee focused health services improves when services are delivered without cost to clients, and that mainstream health services to refugees should generally be covered by direct Medicare bulk billing or other government funding.

> Recommendation 11: *All health services and programs provide access to care at low or no-cost for refugee clients of low socioeconomic status.*

Building a refugee responsive workforce

A refugee responsive workforce can have numerous benefits for the quality of care delivered to permanently resettled refugees. Informants highlighted the importance of undergraduate training to prepare all health workers for an increasingly diverse Australia, so that graduates are able to recognise and manage the health and social issues of clients from a refugee background.

A refugee responsive health care workforce has appropriate knowledge, skills and attitudes in: (a) the use of interpreters, (b) cultural responsiveness, (c) clinical refugee health issues, and (d) awareness of the role of refugee focused health and social services. Based on our research we suggest that training is to be made available for all health professionals at the undergraduate level and is to continue through relevant post-graduate and professional development programs, and curricula be developed and delivered in collaboration and with

refugee focused services and settlement services. Medicare Locals have a role in facilitating the delivery of education.

> Recommendation 12: *Organisations involved in health professional education prepare graduates to be part of a refugee responsive primary health care workforce.*

> *"We also provide… some training. … A GP and nurse would go out and work with the doctors and the practice nurses and the practice managers on the type of things they can expect in working with new arrivals.*
>
> *(This included) clinical things… some of the challenges in working with interpreters, compliance with care, just things that come up in working with recent arrivals, or give links to resources around refugee health."*
>
> (Refugee focused health service manager)

Fostering refugee health literacy

Improving refugee health and health system literacy was highlighted in our consultations as crucial to empowering refugee individuals and communities to successfully engage with the health system and to make important decisions about their health.

While initial health and health system education is provided immediately before or after arrival in Australia, it needs to be reinforced by further education once the refugee is more settled. This can be done by health services and programs, settlement services, English language schools and in the community. State, territory or local networks may be the best at determining the most appropriate approaches in their region. Refugee communities also have a role to play in health service planning activities where appropriate.

> Recommendation 13: *All stakeholder organisations have a responsibility to address the health and health system literacy needs of local refugee communities*.

Promoting monitoring, evaluation and research to improve primary health care

Quality data collection and analysis is required to optimise any model of refugee PHC. Refugee demographic, epidemiological and service utilisation data collection is currently hindered by problems in being able to reliably identify refugees in health and administrative datasets (142). Improvements in routine data collection by organisations need to be further supported by the coordinated sharing of refugee related data at national, state, territory and local levels to improve service and program planning and delivery.

Further to refugee health data collection issues, refugee PHC evaluation and research is in its relative infancy in Australia. Given the general lack of evidence of effectiveness, a national refugee PHC research agenda would need to focus on the characterisation of quality refugee PHC practices, the identification of gaps in service and program delivery, and the effectiveness and cost-effectiveness of specific health care interventions for refugees. Such research needs to be consumer-focused and include community participatory approaches where appropriate.

> Recommendation 14: *The National Refugee Health Network contributes to the agenda for improved monitoring, evaluation and research in:*
>
> *a) Primary health care workforce capacity to address the needs of refugees,*
>
> *b) The effectiveness of primary health care delivery to refugees, and*
>
> *c) The cost effectiveness of refugee focused primary health care interventions.*

SECTION 4: EARLY IMPLEMENTATION

We have comprehensively reviewed the literature relating to and the systems for delivering accessible and coordinated PHC for permanently resettled refugees in Australia. Our reviews and consultations revealed a complex system not always ideally oriented to meet the needs of this vulnerable population.

The previous section outlined a proposed model and a series of enhancements designed to consolidate Australia's delivery of PHC to refugees. The model is oriented to Australia's new National Primary Health Care Strategic Framework. Its recommendations further impact on Commonwealth, state and territory agencies, health care providers, universities, professional organizations, settlement agencies and consumers. Implementation of such a model is complex and requires coordination of activities between all stakeholders.

This section details: a) first steps towards the implementation of a national integrated network with the capacity to articulate and lead the implementation of improvements to refugee PHC delivery, and b) early and important activities that can be undertaken to implement the model by key stakeholders.

The implementation of a National Refugee Health Network

The introduction of a formal National Refugee Health Network to provide a strategic and integrated approach to address the health needs of refugees in Australia is fundamental to the model we have promoted. One approach to achieve this is to create a multi-jurisdictional, multi-sectorial planning group comprising representatives from DoHA and DIAC, and from states and territories. The planning group would also include representatives from Humanitarian Settlement Services, refugee focused health services (including Torture and Trauma services), Medicare Locals, health professional organisations, refugee consumer groups and RHeaNA. The planning group would: a) articulate an endorsed national framework for the delivery of accessible, coordinated refugee PHC in Australia, and b) determine the governance, scope of activities and resourcing of a national network.

> *"Another feature we tend to see in successful programs is having involvement of people from refugee backgrounds in actually designing and also delivering the service to refugee communities. We find that's really crucial, partly because these can vary widely from one area to another, depending on the demographics of the groups that are settling there. So having that kind of input can really help I think to identify what is going to work and isn't for a particular area."*
>
> (Refugee Council of Australia)

The implementation of an integrated model of refugee primary health care by stakeholders

The modification of health systems is complex, and requires foundational work by key stakeholder organisations. Our integrated model of care requires existing settlement and refugee focussed services to be oriented to integration with the broader PHC sector, and for mainstream PHC services to be more responsive to refugee health needs. While our recommendations to achieve this are directed toward specific groups, he model requires collaboration between all parties to address these needs. Table 1 links these groups with specific recommendations and early implementation activities.

TABLE 1: SUGGESTED EARLY PRIORITY ACTIVITIES FOR KEY STAKEHOLDERS

ORGANISATION	RECOMMENDATION	EARLY ACTIVITY
Department of Health and Aging	9	Establish a planning group to: a) articulate an endorsed national framework for the delivery of accessible, coordinated refugee primary health care in Australia, and b) determine the scope, governance and resourcing of a National Refugee Health Network.
	2	Liaise with Health Workforce Australia to review the capacity of the existing mainstream primary health care workforce to provide refugee responsive and refugee focused health care to refugees.
Department of Immigration and Citizenship	1	Review Humanitarian Settlement Strategy provider policy regarding working relationships with local refugee focused health services, mainstream health services and Medicare Locals.
	5	Assess with the Department of Health and Ageing the implications of broadening the availability of fee-free interpreter services in priority allied health, psychology and dental services.
State and territory governments	2	Review the capacity of existing generalist refugee focused health services to provide initial primary health care to refugees.
	5	Review the adequacy of the provision of interpreters in primary health care services and programs.
	11	Review the capacity of health services to provide low-cost care to refugees of low socioeconomic status.
	10	Review the current condition of existing state and territory refugee health integration networks.
Medicare Locals and Local Health Authorities	2, 8	Assess the health needs of local refugees and the capacity of local health services to deliver appropriate and integrated care to refugees in areas of refugee settlement.
Humanitarian Settlement Service providers	1	Review the strength of working collaborations with local refugee focused health services, mainstream health services and Medicare Locals.
Refugee focused health services	3	Review the scope of transitional health care provided to refugees.
	6, 7	Review the capacity to provide health case management to refugees across the health sector.
Mainstream health services	4	Assess the ability to provide refugee responsive health care to refugee clients.
	11	Review the ability to provide low-cost health care services to refugee clients of low socioeconomic status.
Organisations involved in health professional training	12	Review the adequacy of curricula and training programs to support knowledge, skills and attitudes for a refugee responsive mainstream workforce.

CONCLUSION

Permanently resettled refugees have been a part of the fabric of Australian society particularly since the end of the Second World War. The recent increase in arrivals of displaced persons from areas of conflict in the Middle East and Asia have highlighted the strain placed on existing PHC services, at a time when those services are being realigned to meet contemporary population health needs.

We consider that our model and the recommendations to implement the model are an important step in optimising the health of permanently resettled refugees. As with an overseas framework of PHC services for refugees (143) we anticipate that our approach can be used for planning and commissioning, education and training, and to provide criteria for comparison and evaluation.

We remind the reader that there are clear limitations with this work. Our systematic review highlights the relative lack of published evidence across many of the components of the delivery of refugee PHC. Nevertheless, the key areas of case management, interpreters and refugee focused workers and services were recurrent findings of our research.

We gathered qualitative data primarily from experts and practitioners in the field, potentially opening the door to biased findings. However, our findings triangulated across methodologies and were challenged and refined by presentations to and interactions with policy makers, clinicians and researchers. A recently resettled refugee was also part of our core research team.

The need to generalise about refugee populations in this report overshadowed their diversity. In highlighting areas of need within Australian PHC settings we were also not able to tell the stories of resilience that abound in refugee communities. Nor were we able to focus on the special needs of asylum seekers – an area which requires further work.

This study highlighted the importance of context and flexibility. Our findings are specifically tailored to the Australian setting and its characteristics. Notwithstanding this, findings from our examination of the Australian setting again confirmed the conclusions of our systematic, international literature review.

Australia has an enthusiastic group of policy makers, clinicians and managers already attempting to organise services for this diverse group. Our report offers a robust, evidence-based opportunity for the development of a more effective system for the delivery of health care to permanent resident refugees, which will benefit the Australian community as a whole.

APPENDICIES

APPENDIX 1. SYSTEMATIC REVIEW

The impact of models of primary health care on access, quality and coordination of care for refugees in countries of resettlement.

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POLICY CONTEXT

This review focuses on the impact of primary health care (PHC) service delivery models for refugee populations on access, coordination and quality of care in countries of resettlement. Ensuring effective primary health care is an increasing concern both globally and in Australia as the number of humanitarian entrants increases to 24,000 per year. Refugees have a number of complex physical and mental health problems related to their refugee experience including persecution, trauma, deprivation, environmental conditions and poor access to health care. Primary health care services need to be able to meet these challenges both on arrival and in the transition to long term care. A diverse range of initiatives have been instituted by Commonwealth and State governments and by non-government organisations to address these.

KEY FINDINGS

We identified 25 studies which evaluated models of PHC delivery for refugees in destination countries. The models broadly addressed affordability, appropriateness and acceptability of primary care, and a variety of health and non-health services were provided.

The various strategies used to enhance access were measures to improve:

- Access including outreach services, use of interpreters and bilingual staff, no or low cost services, cost and availability of transport for appointments,
- Comprehensive care including multidisciplinary healthcare staff, longer consultations, patient advocacy and use of gender-concordant providers.

Use of Medicare-rebatable services and volunteers contained costs. These strategies have a positive impact on client satisfaction, increased utilisation of services and facilitated coordination between different service providers. However limited availability of interpreters in needed languages, shortage of doctors willing to charge government insurance only fees and unmet health needs remained major difficulties.

The integration between the different health care services and services responding to the social needs of clients was most frequently addressed by a case management approach conducted by a refugee health nurse or other health professional, often involving visiting the refugee client in their home in the community. The advantages of such interventions were improved communication and coordination between service providers, as well as improved access to preventive health services.

Interpreters and bilingual staff and training of staff in cultural responsiveness were used to facilitate access to and quality of health and social care. These models resulted in improved patient satisfaction, increased reporting of physical and psychological symptoms by the patients, improved referrals, improved physical and mental health, and increased access to health services.

The research reported in this paper is a project of the Australian Primary Health Care Research Institute, which is supported by a grant from the Australian Government Department of Health and Ageing under the Primary Health Care Research, Evaluation and Development Strategy. The information and opinions contained in it do not necessarily reflect the views or policies of the Australian Government Department of Health and Ageing.

The impact of models of primary health care on access, quality and coordination of care for refugees in countries of resettlement.

Harris MF, Joshi C, Russell G, Cheng I-H, Kay M, Furler J, Smith M, Chan B, Lo W, Pottie K, Vasi S, Wahidi S

POLICY CONTEXT

This review aimed to evaluate on the impact of primary health care service delivery models for vulnerable refugee populations on access, coordination and quality of care in destination countries. Ensuring effective primary health care is an increasing concern both globally and in Australia as the number of humanitarian entrants increases to 20,000 per year. Refugees have a number of complex physical and mental health problems related to their refugee experience including trauma, deprivation, environmental conditions and poor access to health care. Primary health care services need to be able to meet these challenges both on arrival and in the transition to long term care. A diverse range of initiatives have been instituted by Commonwealth and State governments and by non-government organisations to address these.

KEY FINDINGS

We identified 25 studies which evaluated models of PHC delivery for refugees in destination countries (10 overseas and 15 Australian). The characteristics of these models could be described in 6 main categories: service context, clinical model, workforce, cost to clients, health services and non-health services. These were then analysed according to their impact on access, coordination and quality of care.

Impact on access

There were 9 studies that evaluated impact on access. The models broadly addressed affordability, appropriateness and acceptability of primary care and a variety of health and non-health services were provided. The various strategies used to enhance access were outreach services (many in refugees homes), multidisciplinary staff, use of interpreters and bilingual staff, no or low cost services, free transport for appointments, longer consultation hours, patient advocacy and use of gender-sensitive providers. Use of government health insurance-only fees and volunteers contained costs. These strategies have a positive impact on client satisfaction, increased utilisation of services and facilitated coordination between different service providers. However lack of interpreters in needed languages, unmet health needs and shortage of doctors willing to accept fees from government insurance only remained major difficulties.

Impact on Coordination

Seven studied evaluated the impact of models of refugee care on coordination of health care services. The coordination between the different health care services and services responding to the social needs of clients was most frequently addressed by a case management approach conducted by a refugee health nurse or other health professional and often involving visiting the refugee client in their home in the community. Team coordination especially across agencies was also used. These interventions were associated with improved communication and coordination between service providers, as well as improved access to preventive health services.

Impact on quality of care

Nine studies evaluated the impact of models on quality of care. A common theme in most of these studies was that the use of culturally sensitive care and appropriate interpreters enhanced the quality of care. Interpreters and bilingual staff and training of staff in cross cultural management were also used to facilitate access to and quality of health and social care. These models resulted in improved patient satisfaction, increased reporting of physical and psychological symptoms by the patients, improved referrals, improved physical and mental health, and increased access to health services. Nonetheless, many patients continued to experience barriers including lack of physical access and persisting cultural and language barriers.

POLICY OPTIONS

Some improvements in access to PHC by newly arrived refugees have followed the incorporation of Medicare Health Assessments into Australian models of primary care for refugees. Nevertheless, significant barriers to access remain. More effort is needed to improve the acceptability and appropriateness of services and to provide outreach services. Case management is a commonly used model and appears to be broadly successful in improving access and coordination. This makes sense where there are relatively few refugees to case manage and where the focus is on coordination between services and integration of the refugee into the long term care. However, it is potentially expensive and the case coordinator needs to have some special training. These issues point to the importance of workforce planning and training in this field especially for nurses. At present, the education and training available for the workforce in many countries remains limited. While refugee focused services and providers may be useful, especially for the initial on-arrival assessment, other forms of delivering services based on and integrated with mainstream services are needed. The use of interpreters and bilingual workers is well-documented as essential in facilitating access to care and delivering quality care. Interpreter services can be on-site or through a telephone service, especially for more routine care.

METHODS

A systematic review of the published literature, including a review of published systematic reviews was undertaken with the aim to identify evaluated components of primary health care service delivery models for refugee populations in destination countries their impact on access, quality and coordination of care.

The research questions included:

1. What implemented models of providing PHC to resettled refugees in the developed countries have been described especially in Australia and New Zealand?
2. What is the impact of these models of primary health care on
3. Access to care
4. Coordination of care and
5. Quality of care
6. For the refugees in countries of resettlement?

We used the World Health Organisation's definition of a refugee as *a person forced to flee his or her home due to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, and who is unable or unwilling to return to his or her country of origin.*

A 'model of care' describes the way in which a complex range of health services are organised and delivered. This may be defined by principles (such as equity, accessibility, comprehensiveness and coordination), the care delivery systems (e.g. multidisciplinary, on-line, the nature of consumers and the pathway of care which they must negotiate (e.g. entry, referral etc.) and the range of services provided (e.g. medical specialist, generalist).

The review was preceded by consultations with a network of advisors. The search strategy targeted a broad range of published materials including: peer reviewed journal literature, "grey" literature from electronic databases, websites of government and other agencies. In addition to this there was a targeted journal search and snowballing from reference lists of included studies. Articles were screened by title and abstract and then verified by examining papers by two researchers.

From 2,139 papers initially identified, there were 25 studies which evaluated the impact of models. The draft report was circulated to the investigator and advisory group which met to discuss the findings and key stakeholders were consulted about the implications for policy and practice.

For more details, please go to the full report

The research reported in this paper is a project of the Australian Primary Health Care Research Institute, which is supported by a grant from the Australian Government Department of Health and Ageing under the Primary Health Care Research, Evaluation and Development Strategy. The information and opinions contained in it do not necessarily reflect the views or policies of the Australian Government Department of Health and Ageing.

The impact of models of primary health care on access, quality and coordination of care for refugees in countries of resettlement.

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Introduction

Many refugees have complex and multiple health care needs which are the consequence of inequities in the social determinants of health: experiences of persecution, torture and other forms of trauma, deprivation, unhealthy environmental conditions and disrupted access to health care. This review aims to identify evaluated components of primary health care service delivery models for refugee populations in destination countries their impact on access, quality and coordination of care. This will inform the development of a national framework for effective service delivery and a feasible strategy for implementation.

Background

The United Nations High Commission for Refugees (UNHCR) has identified 34 million "people of concern globally" of which it has estimated that approximately 10 million had refugee status at the beginning of 2011 (13). Australia signed the *Refugees Convention* on 22 January 1954, the sixth country to do so, and ratified the *1967 Protocol* on 13 December 1973. Accordingly, it has established a legal framework for the protection of refugees in domestic law. Since 1945, Australia has resettled over 750,000 refugees and humanitarian migrants (14). It has accepted over 13,000 refugee entrants each year (increasing in 2012 to 20,000) through the Commonwealth Humanitarian Program (15, 16).

Refugees are people outside the country of their nationality who, owing to a well-founded fear of persecution, are unable to avail themselves of the protection of that country (17). Refugees may have trouble navigating the new education, housing, social support services and health systems in their countries of resettlement (18). Previous research has highlighted the complex vulnerabilities of refugee populations living in developed countries such as Australia (19). People of refugee background are recognised as one of the most disadvantaged groups in Australia (20). Refugees living in Australia are racially and culturally and linguistically diverse, often having suffered extreme mental and physical trauma. Their vulnerability is further increased by having lived under conditions of uncertainty in Australia for different lengths of time under a variety of visa conditions (21). They are less likely than other migrants to have family and community support; generally have lower levels of literacy in their first language and less proficiency in English; and face greater challenges in finding housing and employment.

Health Status of Australian Refugees

Many of these individuals have complex and multiple health care needs which are the consequence of inequities in the social determinants of health: experiences of persecution, torture and other forms of trauma, deprivation, unhealthy environmental conditions and disrupted access to health care (22). There is also a high likelihood of pre-existing health conditions and, while there is considerable variability between different groups, many refugees suffer poor health , due in part to inadequate or non-existent health care in their country of origin (23). While it is acknowledged that service access issues can be present for other population groups, the diverse and complex health and well-being needs of people from refugee backgrounds necessitates specific attention (23-26). The majority of refugees originate from countries where even the most basic resources for health such as safe drinking water, shelter, adequate food supply and education are scarce. For a significant number of these refugees, previous poor access to curative and preventative health care may mean many of these health conditions have been untreated and refugee patients often require multiple investigations and referral for medical specialist care after arrival in their new country of resettlement (25). Many of the immigrants come from countries where chronic hepatitis B virus infection is prevalent; they are not immune and have not been immunized. Furthermore, immigrants are more likely to be exposed to hepatitis B virus in their households and during travel to countries where hepatitis B is prevalent. Refugees may already be aware of their HIV-positive status but may have limited knowledge of effective screening and treatment options. Moreover, HIV-related stigma and discrimination put immigrants and refugees at risk for delayed diagnosis and unequal treatment rates for HIV infection (27).

Refugees have a relatively high prevalence of mental health conditions (28-31), specific infectious diseases (21, 23, 29, 31, 32), nutritional deficiencies (21, 23), obstetric complications (3, 23), and disability (29, 33, 34). Refugees tend to report a poorer state of well-being and visit health care providers more frequently than the general population. Health issues such as malaria, Hepatitis B, schistosomiasis and other parasites, nutritional problems like Vitamin A, Vitamin D, iron and folate deficiencies and latent tuberculosis are common for many (23). They may suffer from chronic illnesses including hypertension, heart disease, diabetes and dental caries (29). Refugees may have physical injuries, mal-united fractures, musculoskeletal pains, acquired brain injury, sensory impairment or disability (29, 34). Larger family sizes and issues such as malnutrition, hookworm and other parasites can play a part in the developmental delay of some children. Additionally, many have incomplete or at least undocumented record of immunisations (25, 29, 35).

About one-third of the refugee and humanitarian entrants to Australia are women aged 12-44 years (36). Women from refugee backgrounds are likely to have experienced ethnic and religious persecution, rape, torture, mutilation, sexual slavery, coercion of liberty and deprivation. Previous qualitative research conducted in the Netherlands has identified three key elements that characterise refugee women's experiences of reproductive health care in a resettlement context: (i) the status of women as newcomers/non-citizens; (ii) their status as refugees; and (iii) their gender status and roles in the context of both their own ethnic communities and their new country (37). Pregnant women from refugee background may have been exposed to a range of medical and psychosocial issues that can impact maternal, foetal and neonatal health; including high parity; existing untreated complications related to pregnancy and childbirth; physical and emotional issues related to sexual violence; and the presence of female circumcision. They may have had limited access to preventive health activities such as cervical screening and breast cancer screening (23). In Australia, non-English speaking background migrants are known to be low users of preventive health services (38). Limited English proficiency, ignorance about the services, embarrassment about certain tests are some of the barriers to the use of services despite their availability (38, 39).

Psychological problems such as depression, anxiety and post-traumatic stress disorder are also prevalent for many refugees as a result of their exposure to war, violence and/or prolonged insecurity (40-42). Refugees from certain ethnicities may be at higher risk of substance abuse (41). It is important to note that often these psychological issues do not cease when refugees reach their country of settlement. In fact for many, psychological distress may intensify as they deal with the stressors of the early resettlement period (40, 43). The refugee and resettlement experiences can have a disruptive impact on refugee families, a particular concern because supportive family relationships play a critical role in health and wellbeing, particularly for dependents such as seniors and children and young people(3). Refugee women may also experience very high levels of violence from intimate partners, and may have come from backgrounds where they have been raped and sexually tortured (44). This has implications for psychological health. If the abuser is the woman's partner, there may be very complex help seeking behaviours. Further if a child or other relative is used as an interpreter then there may be limited capacity to discuss these issues.

Health service access

Refugees in the community (who are permanent residents and not asylum seekers) are entitled to at least the same access to health services as other Australian residents (45). At times and in some states where there is an overarching refugee health policy, they are given priority access according to need (34). However, they experience a number of issues when accessing health care (2, 46). The health systems of refugees' countries of origin and asylum may be very different to the Australian system and the differences can have significant implications for accessing health care in Australia. Limited language proficiency has an impact on health (47, 48) and on the quality and accessibility of care (49). It also influences access to the resources required for health, such as education, employment and social support (47).

A range of barriers and access issues to medical specialist and primary care services by newly arrived refugee people have been highlighted in the literature. These include:

- Language and cultural differences (50-52)
- Financial barriers (52)
- Literacy issues (40)
- Availability of effective health care (53)
- Readily accessible health care (54, 55)
- Transport (56)
- Childcare limitations (41)
- Reduced ability to trust service providers owing to prior experiences (40)
- Competing priorities (57)
- A lack of awareness of health services and limited ability to negotiate often complex health care systems (58)
- Lack of health provider understanding of the complex health concerns of refugees (52), and
- Shame (59)

Despite these needs, refugees struggle to access coordinated primary care services (1, 2, 22, 60), have limited access to health assessments (2) and experience barriers to preventive health care (3). The involvement of multiple service providers in providing multidisciplinary team care is not achieved because of problems with health service integration (4) and inadequate community support for refugees to move between services and sectors (3, 57). While recent research indicated that in Australia refugees accessed the hospital system at roughly the same rate as the general population, the increasing evidence of poorer health status and higher prevalence of a range of health problems found among

the refugee population suggests this group are potentially not accessing appropriate levels of care (26, 61).

In considering how to address these issues, it should be recognised that health professionals can find it difficult to provide services to refugees because of cultural and language differences, difficulties with using interpreters, difficulties understanding their health needs, the complexity of their inter-related physical, psychological and social problems, and time constraints (57, 62). Australian health care providers are not routinely trained to identify and deal with issues of particular concern to refugees (3).

It is especially important that their physical and psychological problems do not go undiagnosed and hamper the settlement experience. Enabling refugees access to timely and quality medical care is crucial to their successful integration and settlement, as optimal health and wellbeing provides a stronger basis for them to adapt and thrive in their new country (26, 57). Providing services which promote the health and wellbeing of refugees is in the interests of both refugees and the community at large. Good physical and mental health is vital for refugees to deal effectively with the challenges of settling in a new country and to participate fully in the economic, social and cultural life (3).

The rationale for a PHC model for refugees

The development of any primary health care service model for people of refugee background need to specifically attend to issues such as language and cultural differences, literacy and health literacy, availability, affordability, accessibility and gender factors.

Facilitators of improved primary health care delivery for refugees include addressing communication barriers, access to medical records, coordination of health care and facilitation of referral; consumer participation; culture and language appropriate service provision; capacity building and sustainability(56, 63, 64). Le Feuvre (2011) nominates two principles that should underline the provision of services to refugees (11). The first principle is that refugees should have access to all of the same primary care services that are available to the local population, and the nature and quality of these services should be the same. The second principle is that if any medical specialist service is provided, it should have as its goal the full integration of the refugee into the normal levels of mainstream general practice. He also describes four possible approaches that can be adopted depending on the broader context of heath service provision:

- A separate primary care system for refugees
- A stand-alone assessment service and resource centre
- Resourcing existing practices
- Nothing

Watters (2001) advocates for a more holistic approach that includes integrating health and social services and advocacy across systems (65):

- Greater involvement of settled minority ethnic groups in service provision
- Working across traditional health and social service boundaries to meet the expressed needs of clients
- Combining advocacy services to ensure that refugees gain the maximum benefits from existing health and social care services

Feldman (2006) conducted a literature review of primary health care for refugees and developed a framework for services (66). He noted that the framework can be used for education and training, planning and commissioning, and to provide criteria for comparison and evaluation. This framework consists of:

- Gateway services to facilitate entry into primary care
- Core primary health care services such as GPs and health centres
- Ancillary services such as language and information services, mental health and services for survivors of torture, and targeted health promotion and training of health workers.

In a study of relocation projects in two communities in Victoria, it was found that good will was not enough (67). Services and programs needed to be available to address the high risk of mental health problems, unemployment and lack housing experienced by newly arrived refugees. A number of models of care have evolved across Australia to address the primary health care needs of this vulnerable community.

Australia's National Primary Health Care Strategy provides an opportunity to evaluate the impact of the current models of health care on the delivery of accessible, high quality, coordinated care for refugees (20). The systematic review builds on our previous APHCRI funded systematic review of coordination of care within PHC and with other sectors(68) and will be informed by current and recent work by CIA, CIB and AIB in comparing key features of international models of PHC (69). Our consortium aims to develop an evidence based framework for the delivery of primary health care to refugees and to provide a strategy to guide its implementation.

Aims

This review aims to identify evaluated components of primary health care service delivery models for refugee populations in destination countries their impact on access, quality and coordination of care. This will inform the development of a national framework for effective service delivery and develop a feasible strategy for implementation.

Methods

We used a systematic approach, identifying research questions and outcomes, constructing relevant search strategies, selecting articles based on relevancy, recency, and quality, abstracting data and synthesizing data often in order to respond to each of the research questions. We followed the PRISMA checklist for reporting (70).

Research questions

The first question was to describe the models in use

1. What evaluated models of providing PHC to refugees in countries of resettlement have been described?

The remaining questions reviewed evaluated components of models

2. What is the impact of these models of primary health care on a) access to care b) coordination of care and c) quality of care for the refugees in countries of resettlement?

Definitions

In this review defined each of the following terms relevant to the research questions (See Box 1):

- Refugee
- Primary Health Care
- Model of Care
- Access to Care
- Coordination of Care
- Quality of Care

Box 1: Definitions used in Review

Refugee	A refugee is a person forced to flee his or her home due to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, and who is unable or unwilling to return to his or her country of origin (71). This includes humanitarian refugees with permanent residency visas, refugee asylum seekers (in community and detention) and refugees with temporary protection visas. This review is primarily focused on those refugees whose time since arrival in their destination country is less than10 years.
Primary health care	Primary health care is the level of the health service system "that provides entry into the system for all new needs and problems". Primary care provides person-centred care over the continuum of time, assistance for all common conditions, and co-ordinates and integrates care provided by others (1). We will take primary health care to include care provided in the community settings through general practice, private and publicly funded community, allied health and nursing services and non-government organisations. Activities carried out in PHC include: > Assessment of health on arrival including identification of infectious disease, mental health > Ongoing management of acute or chronic illnesses, mental illnesses, psychosocial illnesses, > Provision of preventive care. > Referral to or links with more specialized medical services > Referral, links to or provision of social care, housing, employment, education, or legal advice.
Model of care	A 'model of care' describes the way in which a complex range of health services are organised and delivered (65). This may be defined by principles (such as equity, accessibility, comprehensiveness and coordination), the care delivery systems (e.g. multidisciplinary, on-line, the nature of consumers and the pathway of care which they must negotiate (e.g. entry, referral etc…) and the range of services provided (e.g. medical specialist, generalist). These are underpinned by organisational and infrastructural elements which include: > Health service funding/cost to clients/ System: government, NGO and private > Provider workforce: e.g. GPs, nurses, social workers and allied health > Organisation: team, network and integrated service
Access to the service	Access is the opportunity or ease with which consumers or communities are able to use appropriate services in proportion to their need (66). As such it is influenced by both provider and consumer characteristics. Andersen described a model in which health care utilisation was determined by population and health systems characteristics and being influenced by patient satisfaction and outcomes (67). The characteristics of PHC which determine their accessibility have been described by

	Pechansky (1981) (68) and more recently by Rogers et al (69) and Gulliford et al (70) as: > Availability of a sufficient volume of services (including professionals, facilities and programmes) to match the needs of the population and the location of services close to those needing them > Affordability (cost versus consumers ability to pay, impact of health care costs on socio-economic circumstances of patients) > Accommodation – the delivery of services in such a manner that those in need of them can use them without difficulty (e.g. appropriate hours of opening, accessible buildings) > Appropriateness to socio-economic, educational, cultural and linguistic needs of patients > Acceptability in terms of consumer attitudes and demands.
Coordination of care	This involves coordination of care between multiple providers and services with the aim of achieving improved quality of care and common goals for patients (72). It may involve: > Case management > Care planning > Informal communication between workers or services > Team meeting, case conferences, interagency meetings > Shared assessments and records > Coordination with non-health services including language services (interpreters, translated health information), formal settlement services, torture and trauma services. > Referral pathways and inter-service agreements
Quality of care	We have defined quality of care as the consistency of clinical care with recommendations in evidence based guidelines as well as the quality of interpersonal care (73). This includes the satisfaction that patients have with aspects of care (74). The Institute of Medicine has defined healthcare quality as the extent to which health services provided to individuals and patient populations improve desired health outcomes. The care should be based on the strongest clinical evidence and provided in a technically and culturally competent manner with good communication and shared decision making (75).

Search methods for identification of studies

Electronic sources

This involved searching for primary studies through electronic databases followed by a limited snowballing exercise. Bibliographic databases that were searched included: Medline, CINAHL, EMBASE, Cochrane Library, Scopus, Australian Public Affairs Information Service – Health (APAIS-Health), Health and Society Database, Multicultural Australian and Immigration Studies (MAIS) and Google Scholar. Search terms for the various databases are included in Appendix 1. Reference lists of all included papers were searched.

Other resources (Grey literature)

The websites of key government, international bodies (including WHO, World Bank, IOM and UNHCR) and non-government organizations were searched. We also requested input from our stakeholder advisory committee, RHeaNA, and our international advisors to specifically identify websites, reports or studies.

Data collection

Obtaining studies and determining eligibility for the review

CJ screened the title and abstract of papers following the initial search. We included studies that referred to specific aspects of care for refugee populations AND the organisation and/or delivery of PHC. Twenty per cent of those excluded were reviewed and checked by MFH.

Papers and reports identified from all sources were retrieved and read fully to determine eligibility for inclusion. This was done initially by CJ and checked by MFH.

Inclusion criteria for considering studies for this review

Inclusion criteria for papers or reports were that they:

- Be about primary health care services
- Report research or evaluation findings
- Be published in English
- Be published between 1990 – 2011

The subjects of these studies were refugees based in the community in the main destination countries for refugees: Australia, US, Canada, Sweden, Norway, New Zealand, Finland, Denmark, Netherlands, the United Kingdom (UK).

We considered any model or interventions that were specifically directed towards refugees in the community including:

- New models of service delivery
- Policies or programs delivered through primary health care services
- Specific interventions provided to enhance access, quality of care or coordination of care for refugees

Outcome measures

Questions 2a, 2b and 2c involved evaluation of the impact of models or interventions on specific aspects of care: access, coordination and quality. We did not predefine the way in which these were evaluated and accepted measures of these based on service, provider or client assessment using either qualitative or quantitative methods.

Data extraction

The following information was extracted into an Excel database for included studies.

- Citation
- Country of study
- Location – urban, rural
- Description of participants – characteristics of patients including types of refugees, country of origin, years in country, age, gender, major health problems or concerns
- Description of services – primary health care, other community, type of health care providers
- Description of model of care – including structure, context, organisation, service delivery, quality of care
- Access - use, accessibility, availability, affordability, appropriateness
- Coordination - coordinator, care planning, team work, shared assessments, communication, referral pathways and resources, information systems
- Quality of care – quality of care, health outcomes
- Other interventions - including duration, frequency, intensity
- Cost

Quality

A quality checklist was used to assess the methodological rigor of the quantitative intervention studies (Appendix 2). These were checked by another experienced reviewer. However quality assessment could be performed on only 5 studies because of lack of complete information on quantitative outcomes.

Analysis

Because the outcomes were heterogeneous, a narrative synthesis was conducted.

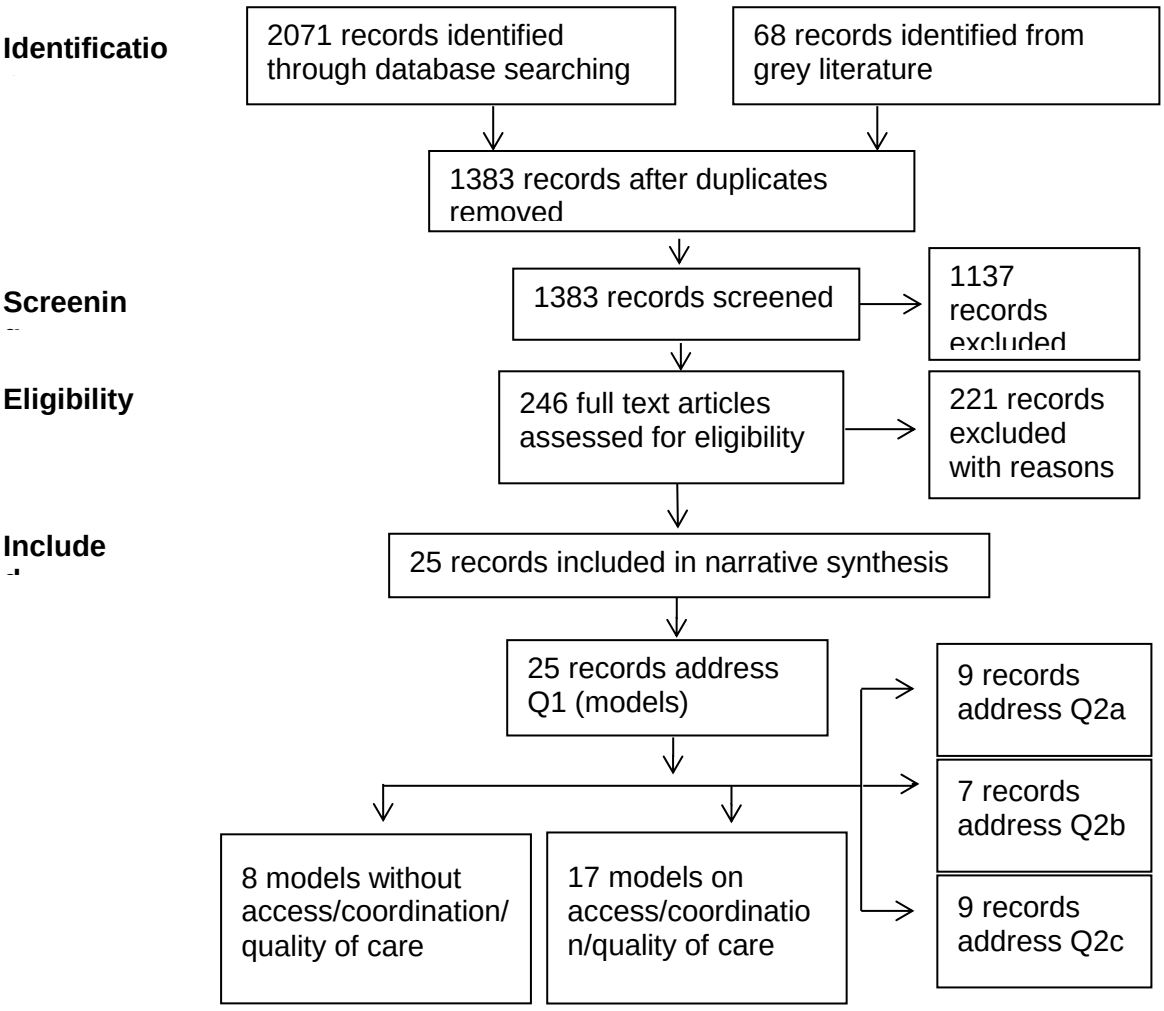
Results

Selection of papers

From the initial database search, 2071 papers were identified and 68 papers were identified from the grey literature. After removing 756 duplicates, 1315 papers in the black literature were screened from title and abstract. From these, 178 full articles were reviewed, 16 of which were included. 68 grey literature papers or reports were retrieved and reviewed. Nine of these were selected.

Thus a total of 25 papers were included in the final selection for question 1; 9 of these addressed question 2a (access); 7 addressed question 2b (coordination); and 9 addressed question 2c (quality of care). See Figure 1. The studies included in questions 2a, 2b and 2c were not mutually exclusive. See appendix 3 for the list of studies for each question.

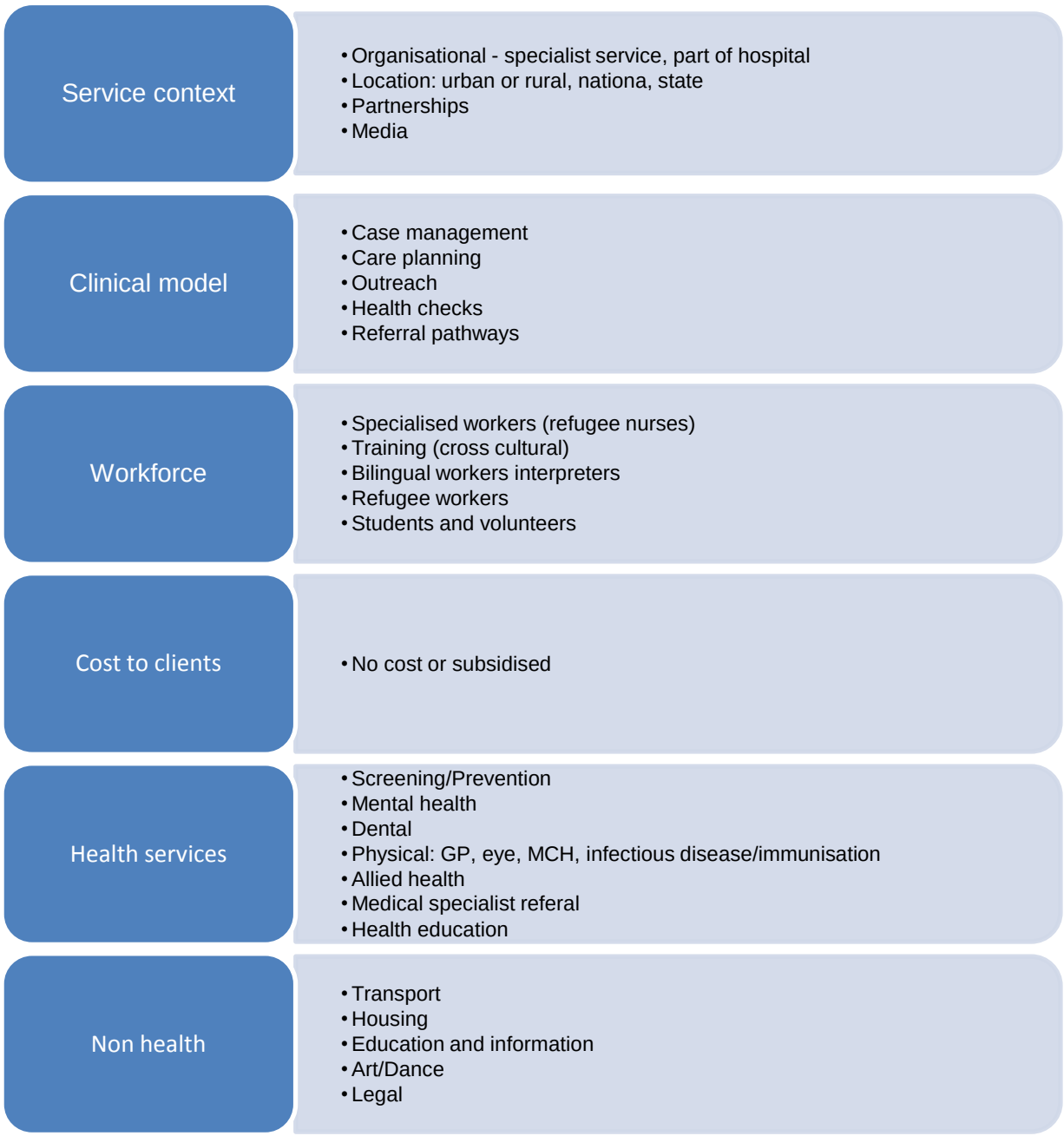
Figure 1: Selection of papers for review



Question 1: What evaluated models of providing PHC to refugees in countries of resettlement have been described?

There were 10 overseas and 15 Australian articles evaluating models of primary health care for refugees. The characteristics of these models could be described in 6 main categories: service context, clinical model, workforce, cost to clients, health services and non-health services (See Figure 2). These characteristics were described in both Australian and overseas studies.

Figure 2: Characteristics of models described



Case management and care planning were common features of the clinical models used. Ford 1995(76) described case management models providing medical screening, immunisation and referral in the US. Fox 2005 (5) described case management of refugee children (CBT, child parent homework) provided by multidisciplinary teams including mental health services and school staff. Grigg-Saito 2010 (6) described case management of refugees in the US including primary medical, mental health and substance abuse care; education, support and advocacy on diseases like HIV/AIDS, and self-management support for cardio-vascular disease and diabetes encompassing a self-management group. Pottie 2007 (77) described a case management model in Canada in which medical students provided the refugees with information on the health system and preventive services and were assisted to complete a cumulative patient profiles to help them ease their transition to community family physicians. Birman 2008 (9) also described the use of care plans to ensure a comprehensive range of services. In Australia, the majority of models used case management to coordinate a wide range of health (especially mental health, specialised services and access to GPs) as well as non-health services (Gould 2010 NSW (63); Kelly 2008 VIC (78); DH 2011 VIC (79); Cheng 2011 VIC (80); Robson 2011 VIC (7); Smith 2009 VIC (8); Samaan 2004 ACT (81)).

Clinical services were frequently provided by a multidisciplinary team (5, 9, 80, 82, 83). A number of studies described the role of specialised refugee health nurses in assessment and care coordination (8, 82). Negotiation of pro bono medical services was a key activity in the USA (76). In Australia, this is a feature of many models (Kelly 2008 VIC (78); DH 2011 VIC (79); Cheng 2011 VIC (80); ARCHI 2004 NSW (84); Robson 2011 VIC (7); Smith 2009 VIC (8); WRHC 2001 VIC (82)). Their roles routinely included assessment (of both health and social needs), immunisation, and case management of referral to others services and ongoing liaison and transfer to GPs. Training (including training in cross cultural communication) underpinned the capacity of many health staff to provide appropriate care (81).

The provision and use of interpreters and bilingual staff were key components of many models (Ford 1995 (76); Fox 2005 (5); Grigg-Saito 2010 (6); Birman 2008 (9); Eytan 2002 (85). Eytan (2002) (85) contrasted communication using interpreters, relatives or no interpreters at all. The later was assessed as less effective. The use of relatives enhanced reporting of traumatic events and psychological symptoms. However health trained interpreters were most effective which also increased the ability of health providers to detect and refer patients for psychological trauma. In Australia, interpreters and/or bilingual staff were used in most services (Cheng 2011 VIC (80); DH 2011 VIC (79); DHHS 2010 Tasmania (86); Gould 2010 NSW (63); Archi 2009 NSW (84); Smith 2009 VIC (8); Kelly

2008 VIC (78); WRHC 2001 VIC (82); Samaan 2004 ACT (81)). Sypek (2008) (87) described use of language-concordant GPs and the telephone interpreting service in rural towns in NSW. Robson (2011) (7) described the role of the Refugee Health Nurse being to advocate for the use of interpreters by GPs when they see refugee patients.

Bilingual and culturally appropriate information provision in written and video form was used to enhance health literacy and access to care (Geltman 2005 (88); Clabots 1992 (89)). In Australia, Sheikh and MacIntyre (90) describe the provision of ethnic media and working with community networks to advertise a refugee paediatric clinic based at a local children's hospital as well as providing health education.

Outreach into the homes of refugee people or the community with a comprehensive range of service was another common approach described (6, 76, 77, 91-93). These were delivered by a range of health professionals including health visitors, students and ethnic health workers. In Australia, outreach was a common model provided in conjunction with case management by refugee nurses (Robson 2011 VIC (7); Kelly 2008 VIC (78); Smith 2009 VIC (8); Samaan 2004 ACT (81); WRHC 2001 VIC (82)).

Mental health care (including counselling, CBT, psychiatry) was the most frequent health service described (Birman 2008 (9); Eytan 2002 (85); Fox 2005 (5)). In Australia mental health care was a feature of the service described by Samaan (2004) in Companion House in ACT (81). Barrett (2000) (94) described an anxiety prevention program for teenagers. DHHS (2010) (86) described coordination of referral pathways for torture and trauma counselling. Cheng 2011 (80) and DH 2011 (79) have mental health as a component of a range of services provided.

Screening and assessment was described in several papers (88, 92). Child health was the focus in several models (79, 90). A number of papers described models involving the provision of both health and non-health services (e.g. legal, housing, education, transport) (9, 91). In Australia many of the models involved screening or assessment and health as well as non-health services (often using a case management approach and in conjunction with settlement services) (Kelly 2008 VIC (78); ARCHI 2009 NSW (84); Samaan 2004 (81); Sypek 2008 (87)).

Free transport to the health centres was provided by many Australian models (8, 63, 78, 81, 82). Low or no cost to patients was adopted in a number of overseas and Australian models (63, 76, 78, 81, 82) (through use of Medicare-only payments or volunteers).

Question 2a: What is the impact of these models of providing primary health care on access to care for the refugees in countries of resettlement?

There were 9 studies which addressed question 2a.

Access to general practice:

Only one study focussed specifically on improving access to mainstream general practice (92). This was a UK based study on refugees from a varying number of countries and living in the UK for at least 3 years. *Intervention:* It used an asylum support nurse in a local primary care organisation to facilitate GP registration, conduct a health check-up and act as a conduit into primary care in general. *Outcome:* The results showed improved access to primary medical care services. Most of the respondents were registered with a GP, had general health checks and fostered trusting relations between patients and services.

Access to child health:

There was one Australian study which involved developing specialised child health services (Sheikh 2009 (90)). The study was targeted on newly arrived Sub-Saharan African refugees. *Intervention:* This was a paediatric refugee clinic which tried to focus on the language barriers faced by the refugees. It used ethnic media to increase awareness of and encourage utilisation of a new clinical service for refugee children and providing health education on common refugee health problems. *Outcome:* The results showed an increase in the clinic attendance and change in knowledge, attitude and belief about infectious diseases.

Access to multidisciplinary health and non-health services:

The remaining 7 studies involved multiple services (both health and non-health services) (7, 8, 43, 80-82, 86). Four of these studies (8, 81, 82, 86) were based on provision of coordinated services. Two of the studies (43, 81) had mental health as one of their components. The study by Robson (7) is about Refugee Health Nurse Program. *Intervention:* The DHHS study (86) was about the Tasmanian health sector which was catered by a mixture of government and community based services to the refugees providing health screening, medical treatment and community education. The Smith study (8) was a coordinated model of physical and psychological health care through an establishment of partnerships within the community and the development of relationships among the Victorian Foundation for Survivors of Torture, Community health centres, private GPs, hospitals and allied health services. A refugee health nurse was also used in this model. Medical treatment, health information and onsite and outreach services for mental

health and substance abuse were provided. The study by Sypek (87) had provisions of short term torture and trauma counselling for the refugees along with settlement support for some of them. The study by Samaan (81) was a service provision model integrated into a torture and trauma counselling service. In the study by Samaan, clients were provided with a wide range of services: psychosocial health assessment, interpreter-advocates, transport, telephone interpreters and vaccines as a result of coordination among various agencies. The study by Cheng (80) explains a comprehensive model including four levels of care and numerous providers at each level providing primary, secondary and tertiary services. The first level is the initial contact and services provided are: on arrival reception and assistance, information, accommodation services, case coordination and referral, utilizes case coordinator and community guide with a similar language and cultural background. The second level is the primary contact where initial needs identification is carried out by the Refugee Health Nurse Program (RHNP), social services like schools, refugee GPs, maternal and child health nurses etc. Refugee specific activities provided by the GPs are orientation to the Australian Health System, comprehensive health assessments, referral to appropriate health care professionals or services and the use of interpreters. They are supported by settlement, refugee health nurse, community health, hospital and interpreter services. RHNs work with each family's settlement case coordinator to perform initial assessments at community health centre or at the refugee's home. The third level is secondary contact for initial/further assessment and the services are provided by refugee clinic, laboratory testing centres (radiology, pathology etc., both public and private), complex case support agencies, GPs, primary mental health team, RHN supporting secondary services. The fourth level is tertiary contact for care planning and the services are provided by RHNs supporting care planning processes, mental health, allied health-optometrist, dietician, audiologist, dental, GPs etc. At all levels, interpreter service is provided. In Robson's study (7), the model of care by the RHNP included facilitation of holistic health assessment for newly arrived refugees in partnership ideally with a local GP, who will provide future health care to the refugee client; outreach services to engage with those who are initially unable to access on-site community health services are provided as per the need. Health assessment, immunization, medical treatment including dental, mental, drug and alcohol support and health education were provided. *Outcomes:* The coordinated model by Samaan resulted in client satisfaction, while the coordinated model by DHHS broadly met the needs of the clients. The coordinated model by Smith greatly facilitated the access to health service. However, the evaluation of model mentioned in Sypek described unmet needs for mental health services in a rural area. These studies revolved around similar barriers to access health services. DHHS, Sypek and Samaan reported lack of interpreters as a barrier to providing care; Sypek and Samaan reported lack of doctors willing to charge fees based on

government insurance rebates as a constraint; and Samaan mentioned cost of transport from rural areas as an impediment. Nonetheless, the availability of onsite interpreter (Samaan) resulted in clients reporting the communication to be safe and easy. The evaluation in Cheng's study showed that there was an increasing utilization of services at all of the service sites i.e., general practice, refugee health nurse program, refugee health clinic, maternity services. The evaluation of the RHN program showed that the location allows easy access to a range of multidisciplinary health professionals and the RHN is an active advocate for the appropriate use of Language Services by health professions in the area; local GPs feel that it has a positive impact on their ability to provide quality of care to their refugee clients.

Table 1: Impacts on access to PHC

Intervention focus	Citations	Intervention Models	Impact of intervention
1. Improving access to GP	O'Donnell 2007 (92)	Specialised workforce (92)	+ GP Registration (92)
2. Specialised MCH/ Paediatric services	Sheikh 2009 (90)	Media awareness of new service (90)	+ Increased clinic attendance (90)
3. Multiple services (health & non health)	Robson 2011 (7) Sypek 2008 (87) DHHS 2011 (86) Cheng 2011 (80) WRHC 2001 (82) Samaan 2004 (81) Smith 2009 (8)	Partnerships (82) Outreach (7, 81) Refugee nurse (7, 8, 80) Multidisciplinary (80) Education and information (7, 80, 82, 86) Interpreting services (80, 81, 86) Longer consultations (81) Transport (81) Patient advocacy (81) Multilingual staff (8, 80, 86) Both male and female GPs (8)	+ Client satisfaction (7, 8, 81) + Staff of other organisation confident on coordinating care with the centre (7) Barriers: cost, interpreter access, transport + Unmet mental health, dental and auditory needs (86, 87) + Utilisation of services(80) + Non-government sponsored less access to assessment (82) + Cultural competency in spite of receiving training (82) + Time management for staff due to longer consultations (82) + Interpreter access (43, 81) and onsite(81) -interpreting service non-representative and mode (82) + Information on transport, and on accessing different services (82) ± coordination with different service providers (82) Access: Difficult transferring patients to GPs due to shortage (81) and cost to patients (43, 81) Physical access for people with disabilities (81) Access due to remote location (81)

Question 2b: What is the impact of these models of providing primary health care on coordination of care for the refugees in countries of resettlement?

There were 7 studies which addressed question 2b. These involved the use of an individual case manager or team coordination.

Case management

Six of the studies involved case management coordinating care among health and non-health service providers (79-82, 84, 93). *Intervention*: In the ARCHI study (84), refugee health nurse coordinates with settlement service case workers to support children and their families to attend GP clinics. The nurse facilitates communication between GPs and hospital services, supports GPs in coordinating complex cases and providing immunisation. A community paediatrician coordinates care of children requiring sub-specialty assessments by providing tertiary referral service through a regular Refugee Child Health Clinic. In Cheng's study (80), refugee health nurse coordinates with four levels of services to provide a coordinated care for the refugee, from the first level which is initial contact, through primary, secondary and tertiary level of care, including a wide range of services, (health, education, settlement, interpreter, language services). In DH's study (79), refugee health nurse coordinates with accommodation, language, interpreter, dental health, mental health services. In Mitchell's study (93), Community Health Nurse (CHN) provides assessment of medical needs, health education, advocacy into health system, arranging specialised medical appointments, liaising with interpreters at the refugee flats. In Samaan's study (81), case manager provides psychosocial health assessment and facilitates the referrals to external health services, coordinates and provides transport, liaises with external organisations involved in the client's resettlement. In WRHC's study (82), refugee health nurse works with coordinator of the on-arrival accommodation to meet the health and non-health needs of the refugees.

Outcome: All but two studies (81, 82) only reported positive outcomes. In ARCHI study (84), there were positive health outcomes: 100% children and 95% adults were seen by a GP and had recommended blood test, the under immunised children received catch up vaccinations. In terms of cost, it claims to be cost effective and regarding the continuity of care, the report depicts that the model provided a continuum of care, from prevention and early identification through the management of chronic health conditions, as well as easier transition between primary health care in the community and hospital-based care. The study by Cheng (80) reports an increasing utilisation of services. The study by DH (79) reported good coordination among the various stakeholders. The study by Mitchell (93) states an ongoing consultation case coordination, where the workers alert each other to patient issues which

may impact on their different areas of service delivery. In Samaan's study (81), the clients were satisfied with the assistance and advocacy they received, felt medical services were well integrated, found the interpreters made the communication easy and safe. All agencies interviewed reported excellent collaboration with the Companion House. It claims that it is one of the cheapest services in the country in terms of funding from the government and provides timely health service delivery and emergency service outside its working hours. However, it faces difficulty in access due to the remote location, physical infrastructure (making it inaccessible for people with a disability), lack of interpreters of certain languages, doctors willing to charge government insurance rebate based fees and dental services.

In WRHC's study (82), the access was compromised due to the following reasons: refugees sponsored by the government have access to outreach health needs assessment, but those sponsored by family members, friends or independent organisations do not qualify for this service and statistics indicate that those who do not gain access to this service are less likely to access WRHC. Although the staff have received cross-cultural training, some still find it difficult to put the knowledge into practice, longer appointment sessions have been used as an important access strategy, however the staff are concerned about the increased pressure this puts on other clients and internal systems; most clients were not satisfied with the interpreting services because the language required was not available and the mode of interpreting; long waiting list for on-site services, inadequate follow up services, unnecessary referrals when an on-site interpreter could not be found. But the clients were satisfied with a number of things: they were happy about the types of services provided including referrals, schooling for children, orientation with respect to transport and social connectedness and the concise and easy-to-follow information provided to them to access the different services. Regarding the coordination, there were mixed results, some external providers acknowledged a good working relationship with the WRHC while many service providers were not aware of this service and its functions or misunderstood it

Team coordination

One of the studies involved team coordination (8). *Intervention*: In Smith's study, Refugee Health Access Team (a team of 5 refugee health workers) coordinates with various health and non-health agencies like hospital, education, housing and language.

Outcome: The study reported positive outcomes. In the study (8), clients were highly satisfied as they found the service approachable, appreciated the multilingual staff, and were willing to come from distant suburbs, even though there may be other health services located nearby. Effective coordination and management of the refugees' health and other needs was reported.

Table 2: Impacts on care coordination

Intervention focus	Citations	Intervention	Impacts of interventions
Case management	ARCHI 2009 (84) Cheng 2011 (80) WRHC 2001 (82) Samaan 2004 (81) Mitchell 1997 (93) DH 2011 (79)	Coordination across agencies by Community Health nurse/refugee health nurse/case manager providing assessment, coordinated care, liaison Cross cultural training Longer consultations (81) Education and information (80, 82, 84) Interpreting services (80, 81) Multidisciplinary (80, 84) Transport (81) Outreach (81) Patient advocacy (81)	+ Improved communication and coordination between providers (84) + Improved access to preventive care (health checks, immunisation) (84) + Lack of local access transport (81) + Non representative interpreters (81, 82) + Staff dissatisfaction with waiting time (82) + Lack of awareness by some service providers (82) + Utilisation of services (80) + Information on transport and accessing different services (82) + Coordination with different service providers (82) + Partner organisation report excellent collaboration (81) + Client satisfaction (81) + Bulk billing doctors (81)
Team coordination	Smith 2009 (8)	Case management across multiple services	+ Patient satisfaction; enhanced access to longer consultations, interpreters and ASL fluent physician

2c. What is the impact of these models of providing primary health care on quality of care for the refugees in countries of resettlement?

Nine studies reported on a heterogeneous range of quality of care measures (6-8, 76, 77, 81, 82, 85, 88).

Use of interpreter, bilingual or bicultural workers: A common theme in most of these studies was that the use of culturally sensitive care and appropriate interpreters enhanced the quality of care. *Intervention:* In Eytan's study (85), a comparison was made of the quality of communication provided by either relatives or trained interpreters or no interpreters at all. In WRHC's study (82), staff were provided cross-cultural training and interpreting services were provided and longer appointment sessions were used as an access strategy. In Smith's study(8), a team of five refugee health workers including an interpreter provided services, the GPs were of varied background and both male and female GPs were available. In Grigg-Saito's study (6), primary medical, mental health and substance abuse

service were provided using whole community approach. This approach was described as putting physical-psychological-spiritual needs at the centre of care and was based on relationship building to promote change and recognition of generational differences and the role of bilingual, bicultural community health workers with consultation with Buddhist monks.

Specialised refugee health workers: In Robson's study (7), services were provided by nurses with experience in working with culturally and linguistically diverse, marginalised populations. These nurses were based within existing community health services. In Geltman's study (88), public health screening and specialised medical services were provided by a small network of providers who had enhanced knowledge of refugee health issues. In the study by Samaan (81), on-site interpreters were made available and the doctors and case managers advocated on behalf of their clients to facilitate engagement with other services like housing, resettlement agencies, Centrelink and medical services.

Students: In Pottie's study (77), medical students trained in refugee health and cultural sensitivity helped newly arrived refugees to complete their medical summaries to ease their visit with community family physicians.

Outcomes: In Eytan's study (85), documented that the use of interpreters enhanced the reporting of physical and psychological symptoms, increasing referral to medical care and psychological care. The subjective rating of communication was poorest when no interpreter was used, better when relatives were used and best when trained interpreters were used. In WRHC's study (82), some of the staff found it difficult to put the knowledge on cross-cultural training to practice and the staff were concerned that the longer appointments would increase the pressure on other clients and on other staff. Many of the clients were not satisfied with the language and mode of availability of interpreting services (both language and mode), long waiting list for internal services, inadequate follow-up arrangements. Unnecessary referrals were more common when an on-site interpreter could not be found. However, in this model, the clients were satisfied with the types of services provided including referrals, schooling for children, orientation on transport and social connectedness and the concise and easy-to-follow information provided to them to access the different services. In Smith's study (8), the clients found the service approachable, appreciated the multilingual staff and were willing to come from distant suburbs, even though there might be other health services located closer. In Grigg-Saito's study (6), there was an 85% reduction in risk related to medical interpreter's service. The Robson's study (7) described that the clients, community service workers and GPs were satisfied with the referral and communication process. All community service workers and GPs felt confident knowing when and how to contact the RHN program either for health advice or to make referrals.

GPs felt that the diverse range of services helped them to provide better quality of care to the patients. In Geltman's study (88), the client satisfaction was reflected by the fact that most refugees opted to continue with those providers. The results of Pottie's study (77) show that all three target groups i.e. the refugees, health professionals and the medical students were satisfied with the intervention. The refugees felt that the intervention helped them access answers to their queries, helped them to better understand Canada's health care system and helped to facilitate their first visit to their doctor. Physicians found that this built a more trusting relationship between the clients and the refugees. The students reported an improvement in their knowledge and skills for brokering cross-cultural health. In Samaan's study (81), the clients found the communication easy and safe as a result of using on-site interpreters. Most clients were happy with the Companion House's assistance and advocacy.

Table 3: Impact on quality of care

Intervention focus	Citations	Intervention	Impacts of interventions
Case management	Eytan 2002 (85) Grigg-Saito 2010 (6) Pottie 2007 (77) Robson 2011 (7) Geltman 2005 (88) Samaan 2004 (81) WRHC 2001 (82) Smith 2009 (8) Ford 1995 (76)	Training in cultural sensitivity (7, 82, 88) Interpreters (8, 77, 81, 82) Whole community approach (7) Multidisciplinary (7) Multilingual staff (6, 82) Specialised refugee health nurses (7) Network of providers with enhanced knowledge (8, 76) Medical students (88) Outreach (76, 81, 88) Case managers for non-health services Transport (81) Longer sessions (81, 82) Education and information (82) Patient advocacy (81)	+ Patient satisfaction (8, 81, 88) + Reporting of physical and psychological symptoms, referral for medical and psychological care (77) + Other providers confident about when to refer and communication (7) + Non representative interpreters (81, 82) + Bulk billing doctors (81) + Physical access (remote location and PWDs) (81) + Staff managing longer consultations (82) + Waiting lists; inadequate follow up, unnecessary referral (82) + Physical and mental health (7) + Timely screening (76) + Information useful on accessing transport and other service (82) + Access to preventive and curative heath care (76)

Discussion

Summary of main results

The aim of this review was to identify evaluated studies of primary health care for refugees in destination countries, describe the models used and their impact on access, coordination of care and quality of care. There were many similarities among the evaluated models, with some variation according to the context and resources available. The integration between the different health care services and services responding to the social needs of clients was most frequently addressed by a case management approach conducted by a refugee health nurse or other health profession and often involving home visiting the refugee client in their home in the community. Interpreters and bilingual staff and training of staff in cross cultural management were also used to facilitate access to and quality of health and social care.

Refugees need to be able to access the same primary care services available to the local population. Thus clients of refugee specific services need to be able to transition into ongoing mainstream primary health care (11). However their transition is influenced by a range of factors including lack of knowledge about what services are available and/or how they work, language barriers, lack of appropriate services. Refugees may also be fearful of using existing services due to fear, distrust, negative experiences and lack of confidence, socio-cultural barriers and political, economic and administrative constraints on access to the health services themselves (95, 96). The models in our review broadly aligned with elements of the model proposed by Penchasky and Thomas (97) in the way in which they addressed access:

- Increasing awareness and health literacy in using health services with interventions involving media and health education
- Outreach to facilitate registration or clinic attendance
- Improving the acceptability and appropriateness through the use of interpreters and bilingual workers
- Co-ordinating service networks (often facilitated by RHNs) to improve access to range of service, transport (access)
- Reducing cost to clients by use of *pro bono* providers and not using co-payments

Coordination of care has been discussed in the literature describing models of care for refugees. For example there has been debate about integration between government and non-government services, the need for refugee specific health services and mainstream services (which may include medical specialists) and the balance of emphasis on initial assessment compared with providing ongoing long term care (66, 98). In this review we found that coordination of care was largely focused on integrating care across the large number of health and non-health services which may be involved. However some models

did attempt to coordinate access to mainstream health services including primary medical care. The two main coordination models were case management and team coordination. Four of the six case management models reported improved outcomes. Two Australian studies reported that coordination was compromised by limited access to services by some groups of patients and the capacity of staff to meet the needs of patients. Both of studies using a multidisciplinary team approach to coordination reported that services were able to meet clients' needs.

There was a diverse range of studies which evaluated impacts of service models on quality of care. These included use of interpreters, bilingual staff, cross cultural training of staff and specialised refugee health nurses and engagement with the community to improve the quality of care. These were associated with improvements in staff confidence, the detection of problems at assessment, clients' assessment of the quality of communication and interpersonal care. This is broadly consistent with international policy (95).

Limitations

We found a limited amount of literature on evaluated model especially from the international databases. There was a lack of literature on coordination tools and protocols and regional coordination. A larger number of studies were identified from web site searching and from our key informants in Australia, UK, Canada and NZ. Because the searching of the grey literature was less systematic and reliant on key informants, it is possible that other international grey literature was missed.

There were high levels of heterogeneity in the impacts and outcomes evaluated. This made any formal synthesis impossible. Thus a qualitative approach was used to analyse and compare the studies.

There was very little information on the cost of services or models. This meant that we were unable to make any cost comparative analysis between models.

In our study, we did not find an evaluated model of primary health care that focused on women and hence it was not possible to incorporate a gender analysis into the synthesis. Nevertheless, is important to note that some previous studies into migrant utilisation of health services have not included women when assessing health service access (61). A study into developing best practice model of refugee maternity care advocates for special services to address the needs of refugee women. It has pointed towards the need of a maternity care that comprises continuity of carer, adequate and appropriate interpreting service, cultural responsiveness and the provision of psychosocial support (36). However,

this model was not evaluated and thus not included in our study. Hence, when evaluating models in the future, gender issues should be considered.

Implications for policy and practice

Despite the limitations of the current evidence, there are some implications for policy and practice. Case management is a commonly used model and appears to be broadly successful in improving access and coordination. This makes sense where the focus is on coordination between services and integration of the refugee into the long term care. However it is potentially expensive and the case coordinator needs to have some specialised training. This points to the importance of workforce planning and development in this field especially for nurses. At present, the education and training available for the workforce in many countries remains limited (95). While specialised services and providers may be useful especially for the initial on-arrival assessment, other forms of delivering services based on and integrated with mainstream services are needed. The use of interpreters and bilingual workers is well-documented as essential in facilitating access to care and delivering quality care. Interpreter services can be on-site or through a telephone service, especially for more routine care (99). Use of informal interpreters such as family members can undermine the quality of care (100). When evaluating models in the future, gender issues should be considered.

Implications for research

There is considerable scope for further research. We found relatively sparse literature on evaluated models of refugee healthcare in destination countries. Most evaluations focused on patient satisfaction rather than other outcomes. There is a need for rigorously designed empirical studies, especially focused on the impact of innovative models on access and quality of care.

Conclusion

Australia currently accepts over 13,000 refugee entrants each year. People from refugee background are identified as one of the most disadvantaged groups in Australia. Many of these individuals have complex and multiple health care needs thus necessitating specific attention. They experience a number of issues when accessing health care though they are at times prioritised or entitled to at least the same access to health services as other Australian residents. Enabling refugees access to timely and quality medical care is crucial to their successful integration and settlement. Providing services which promote the health and well-being of refugees is in the interest of both the refugees and the country at large. This is more urgent with the expected increase in refugees in the near future.

The reviewed models of primary health care for refugees in the developed countries had many similarities. Case management and care planning were common features. A variety of health and non-health services were provided: health assessment and screening, mental health, dental health, maternal and child health, infectious disease, preventive services like immunisation and health education, housing, transport, legal assistance, and general education and information about living in a new country. The various strategies used to enhance access were outreach services (many in refugees homes), multidisciplinary staff, use of interpreters and bilingual staff, no or low cost services, free transport for appointments, longer consultation hours, patient advocacy and use of gender-sensitive providers. Use of Medicare-only payments and volunteers contained costs. These strategies have a positive impact on client satisfaction, increased utilisation of services and facilitated coordination between different service providers. However lack of interpreters in needed languages, unmet health needs and shortage of doctors willing to charge fees based on government insurance rebates remained major difficulties.

Specialised workers such as refugee health nurse, community health nurse and case managers were used to coordinate across multiple services. The advantages of such interventions were improved communication and coordination between service providers, as well as improved access to preventive health services. In order to improve the quality of care, a number of interventions were practiced: training the staff in cultural sensitivity, use of on-site and telephone interpreters and bilingual/multilingual staff, specialised refugee health nurses and health workers with enhanced knowledge and experience working with refugees, outreach services at the homes of the refugees, case managers for non-health services, free transport for appointments and longer consultation hours, engagement with the community, education and information and patient advocacy. Such efforts resulted in improved patient satisfaction, increased reporting of physical and psychological symptoms by the patients, improved referrals, improved physical and mental health, and increased

access to health services. Nonetheless, many patients continued to experience barriers including lack of physical access and persisting cultural and language barriers. This further indicates the need of services that are appropriate and acceptable to refugees rather than a top-down model of refugee health services, taking into consideration the social determinants of health in order to reduce inequity; and based on a life-course or temporal perspective for the major stages of the migration process: pre-migration, migration and post-migration.

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Systematic Review Appendix 1: Search Terms

1. Medline: 771 search results
   PHC:
   Primary health care mp. Or exp Primary Health Care/ or general practice mp. Or exp General Practice/ or exp Comprehensive Health Care/ or exp Physicians, Family/ or exp Family Practice/ or family medicine mp.
   Refugee:
   Refugee mp. Or exp Refugees/ or exp “Transients and Migrants” / or exp “Emigration and Immigration”/ or asylum seeker.mp.
   Model of care:
   Exp “Continuity of Patient Care”/ or exp Community Health Services/ or exp “Delivery of Health Care”/ or exp Patient Care Team/ or model of care.mp. or exp Long-Term Care/ or exp Models, Organisational/

2. CINAHL: 561 search results (limiting search to 1990 - 2011)
   PHC:
   (MH "Community Health Centers") OR (MH "Community Mental Health Services+") OR (MH "Community Mental Health Nursing") OR (MH "Health Information Networks") OR (MH "Community Health Nursing+") OR (MH "Community Health Services+") OR (MH "Community Health Workers") OR (MH "Community Networks")
   Refugee:
   (MH "Transients and Migrants") OR "transients and migrants" OR (MH "Refugees") OR "refugee" OR "asylum seeker" OR (MH "Emigration and Immigration") OR (MH "Immigrants, Illegal") OR (MH "Immigrants+")
   Model of care:
   (MH "Models, Psychological+") OR (MH "Models, Educational") OR (MH "Models, Structural+") OR (MH "Multidisciplinary Care Team+") OR (MH "Gender Specific Care") OR (MH "Health Care Costs+") OR (MH "Health Services Needs and Demand") OR (MH "Health Care Delivery+") OR (MH "Health Care Delivery, Integrated") OR (MH "Nursing Care Plans+") OR (MH "Nursing Care Delivery Systems+") OR (MH "Outcomes (Health Care)+") OR "model of care"

3. Embase: 578 search results
   PHC:
   exp primary health care/ or exp general practice/ or exp community health nursing/ or exp general practitioner/ or exp community care/ or exp family medicine/

   Refugee:
   asylum seeker*.mp. or "transients and migrants".mp. or "emigration and immigration".mp. or exp refugee/ or refugee*.mp.

   Model of care:
   exp patient care/ or exp model/ or exp "organization and management"/ or model of care.mp. or exp health care delivery/ or exp medical care/

4. Cochrane library: 14 search results
   primary care* or family medicine* or general practice* or community health*
   model of care

5. Scopus: 62 results
   “Primary care” or “primary health care”
   Refugee* or “asylum seeker*”

6. APAIS health: 8 search results (limiting search to 1990-2011)
   "primary care" or "primary health care" or "family medicine" or "general practice" or "community health" or "nursing service*e" or "allied service*"
   Refugee* or “asylum seeker*”

7. Health and society database: 31 search results
   "primary care" or "primary health care" or "family medicine" or "general practice" or "community health" or "nursing service*" or "allied service*"
   "asylum seeker" or "refugee" or "refugees"

8. MAIS (Multicultural Australian and Immigration Studies): 46 search results (limiting search to 1990-2011)
   "primary care" or "primary health care" or "family medicine" or "general practice" or "community health" or "nursing service*" or "allied service*"
   "asylum seeker" or "refugee" or "refugees"

Systematic Review Appendix 2: Quality Assessment Tool

Ref ID: _____

Author: _____

Year: _____

Reviewer: _____

RATINGS A) SELECTION BIAS

(Q1) Are the individuals selected to participate in the study likely to be representative of the target population?

Very Likely, Somewhat Likely, Not Likely

(Q2) What percentage of selected individuals agreed to participate?

80-100%, 60–79%, Less than 60%, Not Reported, Not Applicable

Rate this section (see dictionary)	Strong	Moderate	Weak

B) ALLOCATION BIAS

Indicate the study design

RCT Quasi-Experimental, Case-control, Before/After study (go to i) (go to C), No control group, Other:

_____ (go to C)

(i) Is the method of random allocation stated? Yes No

(ii) If the method of random allocation is stated is it appropriate? Yes No

(iii) Was the method of random allocation reported as concealed? Yes No

Rate this section (see dictionary)	Strong	Moderate	Weak

C) CONFOUNDERS

(Q1) Prior to the intervention were there between group differences for important confounders reported in the paper?

Yes, No, Can't Tell, Please refer to your Review Group list of confounders.

See the dictionary for some examples. Relevant Confounders reported in the study:

(Q2) If there were differences between groups for important confounders, were they adequately managed in the analysis?

Yes, No, Not Applicable

(Q3) Were there important confounders not reported in the paper?

Yes, No

Relevant Confounders NOT reported in the study:

Rate this section (see dictionary)	Strong	Moderate	Weak

D) BLINDING

(Q1) Was (were) the outcome assessor(s) blinded to the intervention or exposure status of participants?

Yes, No, Not Reported, Not Applicable

Rate this section (see dictionary)	Strong	Weak	Not Applicable

E) DATA COLLECTION METHODS

(Q1) Were data collection tools shown or are they known to be valid?

Yes, No

(Q2) Were data collection tools shown or are they known to be reliable?

Yes, No

Rate this section (see dictionary)	Strong	Moderate	Weak

F) WITHDRAWALS AND DROP-OUTS

(Q1) Indicate the percentage of participants completing the study. (If the percentage differs by groups, record the lowest).

80 -100%, 60 - 79%, Less than 60%, Not Reported, Not Applicable

Rate this section (see dictionary)	Strong	Moderate	Weak	Not Applicable

G) ANALYSIS

(Q1) Is there a sample size calculation or power calculation?

Yes, Partially, No

(Q2) Is there a statistically significant difference between groups?

Yes, No, Not Reported

(Q3) Are the statistical methods appropriate?

Yes, No, Not Reported

(Q4a) Indicate the unit of allocation (circle one)

Community, Organization/ Group Provider, Client, Institution

(Q4b) Indicate the unit of analysis (circle one)

Community, Organization/Group Provider, Client, Institution

(Q4c) If 4a and 4b are different, was the cluster analysis done?

Yes, No, Not Applicable

(Q5) Is the analysis performed by intervention allocation status (i.e. intention to treat) rather than the actual intervention?

Yes, No, Can't Tell

H) INTERVENTION INTEGRITY

(Q1) What percentage of participants received the allocated intervention or exposure of interest?

80-100%, 60-79%, Less than 60%, Not responded, Not Applicable

(Q2) Was the consistency of the intervention measured?

Yes, No, Not reported, Not Applicable

SUMMARY OF COMPONENT RATINGS

Please transcribe the information from the grey boxes on page 1-3 onto this page.

A) SELECTION BIAS

Rate this section (see dictionary)	Strong	Moderate	Weak

B) STUDY DESIGN

Rate this section (see dictionary)	Strong	Moderate	Weak

C) CONFOUNDERS

Rate this section (see dictionary)	Strong	Moderate	Weak

D) BLINDING

Rate this section (see dictionary)	Strong	Weak	Not Applicable

E) DATA COLLECTION METHODS

Rate this section (see dictionary)	Strong	Moderate	Weak

F) WITHDRAWALS AND DROPOUTS

Rate this section (see dictionary)	Strong	Moderate	Weak	Not Applicable

G) ANALYSIS Comments

_____

H) INTERVENTION INTEGRITY Comments

_____

WITH BOTH REVIEWERS DISCUSSING THE RATINGS:

Is there a discrepancy between the two reviewers with respect to the component ratings?

No, Yes

If yes, indicate the reason for the discrepancy

1. Oversight
2. Differences in Interpretation of Criteria
3. Differences in Interpretation of Study Appendix 3: List of studies

Evaluated Models without access/coordination/quality of care (8):

1. Barrett, 2000 (Black literature)
2. Birman, 2008 (Black literature)
3. Clabbots, 1992 (Black literature)
4. Companion House, 2009 (Grey literature)
5. Fox, 2005 (Black literature)
6. Goodkind, 2005 (Black literature)
7. Gould, 2010 (Black literature)
8. Kelly, 2008 (Black literature)

Evaluated Models with access/coordination/quality of care (17):

1. Archi, 2009 (Grey literature)
2. Cheng, 2011 (Grey literature)
3. DH, 2011 (Grey literature)
4. DHHS, 2010 (Grey literature)
5. Eytan, 2002 (Black literature)
6. Ford, 1995 (Black literature)
7. Geltman and Hosland, 2005
8. Mitchell, 1997 (Black literature)
9. O'Donnell, 2007 (Black literature)
10. Robson, 2011 (Grey literature)
11. Samaan, 2004 (Grey literature)
12. Grigg-Saito, 2010 (Black literature)
13. Sheikh and Macintyre, 2009 (Black literature)
14. Smith, 2009 (Grey literature)
15. Sypek, 2008 (Black literature)
16. WRHC, 2001 (Grey literature)
17. Pottie and Hosland, 2007 (Black literature)

Studies on access (9):

1. Cheng et al, 2011
2. DHHS, 2010
3. O'Donnell et al, 2007
4. Robson, 2011
5. Samaan, 2004
6. Sheikh and Macintyre, 2009
7. Smith, 2009
8. Sypek et al, 2008
9. WRHC, 2001

Studies on coordination (7):

1. Archi, 2009
2. Cheng et al, 2011
3. DH, 2011
4. Mitchell, 1997
5. Samaan, 2004
6. Smith, 2009
7. WRHC, 2001

Studies on Quality of Care (9):

1. Eytan et al, 2002
2. Ford, 1995
3. Geltman and Cochran, 2005
4. Grigg-Saito et al, 2010
5. Pottie and Hosland, 2007
6. Robson, 2011
7. Samaan, 2004
8. Smith, 2009
9. WRHC, 2001

APPENDIX 2. INTERVIEW PROTOCOL

PHASE 2: STAKEHOLDER INTERVIEWS

Interviews will incorporate the perspectives of refugee representatives and a broad range of key informants, including practitioners and policymakers involved in delivering and organising health and social care to refugees in Australia. Interviews will further inform the description of models, help to identify what is successful, identify what the barriers are to improving services, and assist with the development of a strategy for the implementation of the overarching framework.

2.1 Research Questions will build on emerging evidence from the systematic review; however it is likely that not all aspects of the delivery of care to refugees in Australia will be captured in the review. Interviews will therefore seek to:

a) Characterise the range of current models of care for resettled refugees in Australia,
b) Clarify the effectiveness of existing models in coordinating and delivering care to refugee populations, and
c) Identify perceived barriers to delivering coordinated primary health care to refugees.

In particular, **policymaker and stakeholder** questions will include: *What models of providing primary care to resettled refugees do you work with? How accessible is care provided in these models? How effective are they are coordinating care across health and non-health services? What are the barriers to delivering quality primary health care to refugees? How can these barriers be overcome?* **Practitioners** will be asked about: the *model of care provided by the service, (how patients access the service, the type of care provided and whether they receive ongoing care or how referral for ongoing care is made), the type of referrals made, the issues they consider to be important about health access for refugees, barriers they encounter and how they help to reduce these barriers, and what resources they think they require to provide quality care for refugees.* **Refugee community leaders** will provide *perspectives on the delivery of and access to coordinated PHC services*.

2.2 Methods: Semi-structured, in depth interviews will be conducted face-to-face and by telephone.

2.3 Sample: Interviews will be conducted with policy makers (n=5) and practitioners (n=up to 10) across Australia who have been identified through collaboration with our stakeholder advisory committee. Refugee community representatives (n= approximately 5; gender balanced) will also be interviewed to gain a more holistic understanding of models of care. The investigators have established national links with refugee health and wellbeing organisations, networks and peak bodies across three states, which will be consulted during this project and form the basis of recruitment strategies, including purposive and snowball methods. These groups have existing mechanisms of engaging with refugee representatives.

2.4 Data analysis: Will involve thematic analysis with the use of NVivo. A coding framework will be developed in consultation with the research team in the early stages of analysis. Once data has been coded and analysed the research team will develop axial and critical codes to assist with the developing theoretical understanding. Also, we will perfrom a secondary analysis of recent research conducted by members of our research group on refugee experiences of primary health care. This will focus on questions about barriers and enhablers of access and coordination of care of refugees. The findings will further inform the development of work in Phase 3.

APPENDIX 3. INTERVIEW GUIDES

Interview Guide - Policy Advisors

Project protocol: Interviews with will practitioners and policymakers will inform the following topics:

1. The description of models
2. Identify what is successful in the model
3. Identify what the barriers are to improving services
4. Assist with the development of a strategy for the implementation of the overarching framework.

Topic	Aim	Sample questions
THE INFORMANT		Describe your role
POLICY	**1. The prospect of having a cohesive framework in the absence of a refugee health policy** **2.The key components of such a policy framework** **3. Identify the key players in creating such a policy** **4. Procedures/ requirements for developing and adopting a national refugee health policy?**	1a. Pros and cons to having a national and/or state-wide refugee health policy framework (include an evaluation of what is currently works well and what is not?). 1b. Impact on coordinated PHC services for refugees. 1c. How in the absence of the above can we achieve consistency, comparability and exchange of information and resources? 1e. Impact on advocacy. 1f. Department of health, boards of CHS, service providers.
PROCEDURES AND IMPLEMENTATION STRATEGIES	**1. What strategies do you have to put in place in order to operationalize the policy? Discuss barriers and facilitators** **2. What are the essential components of a state-wide action plan or strategy**	2. Discus in relation to three stages: on arrival screening, referral to specialist services, integration into private GP clinics. Investigate these themes: uniform on arrival screening, electronic health records, GP and PN incentive payments, coordinated response to capacity building of GP clinics for example through outreach refugee health nurse services and Medicare locals, shared recourse including register of refugee friendly clinics to improve support at the point of entry into GP clinics.

Topic	Aim	Sample questions
KEY ISSUES IN SERVICE COORDINATION AND INTEGRATION	**1. Balancing regional responsiveness and fragmentation** **2. Components and mechanism of coordination** **3. What accountability mechanisms need to be put into place to ensure that local partners and organisations put the above structures in place?**	1. Assess the statement contrasting services that are regionally responsive, autonomous, and in control of community's needs at the same time acting in isolation, fragmentation and waste (reinventing the wheel)? 2a. Communication and collaboration: shared protocols, service agreements**,** working groups. 2b. Transparency and accountability Governance: management and operational factors guiding reporting requirements, key performance indicators. 2c. Distribution of funds: business plans. 2d. Information sharing, transparency**:** mechanisms to obtain comparable and consistent information and statistics about series and programs that feed into state and national level to inform policy and action plans. This includes: > Systematic data collection and a minimum dataset at the provider/service level. > Clinical guidelines and protocols and sharing of clinical effectiveness. > Guidelines on referral pathways and information exchange.
TRANSLATING RESEARCH FINDINGS	**1. How can this research contribute to developing a national refugee health policy?** **2. How can this research contribute to developing state-wide refugee health action plan?**	

Interview Guide – Service Providers

Project protocol: Interviews with will practitioners and policymakers will inform the following topics:

1. The description of models (policy makers and stake holders), services and programs (practitioners and service providers).
2. Identify what is successful in the model (policy makers and stake holders), services and programs (practitioners and service providers).
3. Identify what the barriers are to improving services,
4. Assist with the development of a strategy for the implementation of the overarching framework.

> Issues around data transfer between hub and spokes, or data transfer between different refugee health centres. The hub lack of any direct operational or management of spokes. How this impacted data transfer, how can it be dealt with?

> Implications of having refugee services which are only run by nurses is that they tend to be funded by DoHA, and the GPs in private clinics who complete the assessment get paid by Medicare, so the centres miss out on MBS items.

> One of the key issues to discuss with settlement services is around on-arrival assessment and barriers to universal assessment for all refugees: what they need is a refugee health service that they can refer clients to for assessments. What are the current pathways, what are the issues? Who do you refer to? What sort of incentives and strategies do you find helpful in ensuring clients attend assessment? What are some of the reasons people don't turn up?

> Settlement services; Discuss issues around the case workers linking refugees directly to private GP clinics for assessment and ongoing care, what are the advantages and drawbacks compared with being referred through specialist refugee health clinic after the completion of the initial assessment.

> What are settlement services required to do in relation to health services for the newly arrived: offer a list of GPs, etc.?

> Settlement services role (mandate, incentives such as continuation of DIAC funding, others??) in ensuring universal health assessment is offered to all the newly arrived.

> Research output and policy: what does this research needs to produce in order to influence policy, and in particular the creation of refugee health policy?

> What are the key requirements of successful cross-sectoral integration and collaboration? What do terms like common drivers, common principals and common understanding refer to (see Jill's interview) in the context of policy and service integration? What is the role of a policy framework in facilitating integration?

> Examine in detail the role of Refugee health network in Victoria in service coordination and integration, other key outputs?

Topic	Aim	Sample questions
UNDERSTANDING THE SERVICE/PROGRAM	Background Describe the activities and outputs of the service in offering accessible and coordinated care to refugees.	Background: > Describe the service. > How did the service evolve? > What gaps did it try to fill? > What is the goal of your service? > Your involvement and role within the service. How do clients enter the service? > Referral pathways What happens while they are in your program > Clinical activities: long consultations, AHP and pathology, dental, special cultural training for staff, referrals > Client advocacy > Health information and education > Language interpretation and translation > Addressing special needs of women and socio-economic disadvantage > Female staff > Cost > Transport needs > Workforce

Topic	Aim	Sample questions
		> Bilingual staff > Multidisciplinary(refugee support workers, Refugee nurse, practice nurse, social workers, volunteers, case managers, settlement workers, volunteers) Exiting the service and what happens after in relation to service integration and inter-organisational coordination: > community engagement and partnerships > Coordination tools: o Communication and sharing of patient information o Referral pathway (private GPs, torture and trauma, mental health, AHP, dental , specialists) o Individual case management working across services

Topic	Aim	Sample questions
ORGANIZATIONAL INFRASTRUCTURES AND PROCEDURES TO SUPPORT THE SERVICES	Understanding the **model** of service delivery Need a separate set of questions for IHSS providers and how they coordinate with screening services and other refugee health specialist agencies What is the role of Refugee health network in Victoria in providing overall coordination and integration? The issue of control and management of spokes? Is there a central management body?	Describe the key attributes of the model: > Governance and management model, > Financial model, sources of funding > community engagement and partnerships > specialised workforce > Details of protocols and partnerships that govern vertical integration (MOU, protocols) > Interagency communication tools > Outreach services > Conflict and conflict resolution
EVALUATION AND IMPLEMENTATION	In relation to your goals, what works well and why? What is the evidence of effectiveness? How do you evaluate effectiveness? What is not working well and why?	Addressing the barriers: If you had all the required resources (inputs), what would you put in place to ensure access and coordinated delivery of health care services to refugees. Addressing the barriers: policies and funding models
THE LARGER CONTEXT	Understanding the broader context of other refugee health services in Australia.	Other services/programs using a model like yours? Other models very different? What are the key differences? What is an ideal refugee health service? What is needed to implement what is working well for you in other locations in Australia? Anyone else we could speak to?

Interview Guide – Community Representatives

Topic	Aim	Questions
INTRODUCTION	Introduce the project. Refugees require multiple service providers. What are the things that improve access to coordinated care?	What is your position within your community? What is your involvement in refugee health? How long have you held this position?
REFUGEES EXPERIENCE OF DIFFERENT MODELS, PROGRAMS AND SERVICES	Explain what you mean by coordinated care: AMES-screening programs (level 1) - GPs, torture and trauma, mental health, hospitals, specialists (level 2). Culture, language, transport, etc. The key sub-groups with acute issues/needs within the community and their experience of the above subgroups.	Access and moving between level 1 and level 2? Explore access and coordination issues specific to women and men in your community.
SKILLS OF THE COMMUNITY LEADERS	Describe the nature of your involvement and collaboration with settlement agencies and PHC services, Medicare Locals, refugee specialist clinics, torture and trauma services etc.?	Do you have any formal relationships? Describe communication pathways. How do they respond to your requests? Describe any formal or informal support that you receive in your role as a community representative and support person, especially in aiding people who have been here for longer than 6 months and are no longer eligible to have a case worker.

Topic	Aim	Questions
EVALUATION AND EFFECTIVENESS	We are trying to establish that in relation to access and coordination of care across health and non-health services: what works well and why, and what is not working well and why. We are trying to establish the community leaders' criteria for evaluating services/programs.	How well is your community doing? What can your community do to improve access to, and movement, between services? Tell me how different approaches to service delivery (give concrete examples) impact access and coordination. What works, why? What does not work, why? What do they consider as evidence of effectiveness? How can you make it work or work better? If you had all the required resources (inputs), what would you put in place to ensure access and coordinated delivery of health care services to your community?

APPENDIX 4. DELPHI PROTOCOL

PHASE 3: DELPHI PROCESS

3.1 Design: A Delphi process will enable further development of the framework and identify the feasibility and relevance of implementing the strategies identified in the earlier phases of the work.

3.2 Sample: We will recruit a 25-30 member Delphi panel comprising Australian **refugee community representatives, policy makers, health service providers, representatives of professional organisations, Medicare Locals, social services and settlement agencies**. In addition Commonwealth and State government policy makers across departments of health and immigration, and representatives of Medicare Locals will be engaged in reflecting on the findings and designing an implementation strategy relevant to locations throughout Australia. The implementation strategy will also be designed in partnership with government and non-government refugee and asylum seeker organisations.

3.3 Method: As the Delphi technique is a multistage process, designed to combine opinion into group consensus and to generate new ideas, the consultation process will aim to derive agreement on the optimal range of models of primary care which should be provided for resettled refugees. The Delphi survey will be informed by pre-determined questions based upon Phases 1 and 2.
The following steps will be followed:

1. Identify a panel of experts or specialists: a broad range of stakeholder organisations from across Australia will be invited to nominate a representative to participate in the consultation survey.
2. Prepare and deliver the initial web based survey instrument (with additional paper and email copies available as required). Receive and analyse the first responses.
3. Prepare and distribute the second survey instrument for clarification and ranking of survey items suggested during the first wave, and asking for additional ideas and elaborations based on the initial survey responses. Receive and analyse the second set of responses (second wave of data).
4. Prepare and distribute a draft report for participant comment.

APPENDIX 5. DELPHI QUESTIONS AND DATA

DELPHI Survey One

Q1. ACCESS TO HEALTH CARE. Various strategies have been promoted to improve the accessibility of Australian primary health care services for refugees. Our interview data has identified all of the following strategies as necessary for improving access. Please rank from 1 to 8 to prioritise the activities where additional resources should be invested.

#	Answer	1	2	3	4	5	6	7	8	Total Responses
1	Making interpreter services available to all primary care professionals (including allied health professionals and psychologists)	9	4	6	4	2	2	0	2	29
2	Improving the quality of currently available interpreter services	2	3	4	1	2	5	7	5	29
3	Increasing the availability of free to low-cost primary care services in rural and regional areas	1	2	3	4	5	5	4	5	29
4	Providing case management assistance for refugees to attend primary care services	10	4	0	3	4	4	1	2	28
5	Increasing investments in health education and health system literacy programs for refugees	4	4	4	6	2	6	2	1	29
6	Increasing the number of bicultural health care providers	1	2	3	7	7	0	7	2	29
7	Increasing the availability of co-located multidisciplinary refugee health services	2	8	7	4	1	3	1	2	28
8	Increasing the availability of home visiting outreach services for refugees	0	2	2	0	5	4	6	9	28
	Total	29	29	29	29	28	29	28	28	-

Statistic	Making interpreter services available to all primary care professionals (including allied health professionals and psychologists)	Improving the quality of currently available interpreter services	Increasing the availability of free to low-cost primary care services in rural and regional areas	Providing case management assistance for refugees to attend primary care services	Increasing investments in health education and health system literacy programs for refugees	Increasing the number of bicultural health care providers	Increasing the availability of co-located multidisciplinary refugee health services	Increasing the availability of home visiting outreach services for refugees
Min Value	1	1	1	1	1	1	1	2
Max Value	8	8	8	8	8	8	8	8
Mean	3.07	5.28	5.28	3.46	4.00	4.90	3.61	6.18
Variance	4.28	5.42	4.06	5.89	4.14	3.52	3.95	3.56
Standard Deviation	2.07	2.33	2.02	2.43	2.04	1.88	1.99	1.89
Total Responses	29	29	29	28	29	29	28	28

Q2. Can you identify any other strategies to improve access that is not mentioned above?

Text Response
Create/increase Refugee Health Nurses in Local Health Networks to support the work of the range practitioners on PHC pathways; through providing/facilitating information, resources, training and networking support.
The development of a National Refugee Health Strategy which promotes access and equity principles. Funding for Refugee Health Nurses and RHN Nurse Practitioner positions - as the cornerstone of any multi d model of care - particularly in regional areas and larger metropolitan areas.
No
-
Access to well-coordinated and timely education, training and peer support/mentoring for health professionals and bi-cultural health care workers to ensure longevity and avoid burn out. Greater capacity to develop and implement health and wellbeing strategies across sectors e.g. settlement services and health providers having more opportunity for joint planning and partnering in the delivery of health care.
To work from a community development model whereby health professionals visit the Communities to provide information etc. Obviously people need to access health care facilities but there is a misunderstanding for most people about what health in Australia can provide and cannot provide. To have people visit the Communities to provide realistic information would be a very positive start.
Medicare items to reward clinicians for the use of qualified health care interpreters in primary health care. Providing health care for people of non-English backgrounds takes more time and the use of interpreters should be mandatory to ensure effective communication, but in private practice there is no appropriate remuneration of health clinicians for the additional consultation time.
Increasing access to dental services.
Training of GP regarding refugee health/comprehensive Health Assessment and use of face to face interpreter as part of their duty of care.
Provision of information and resources e.g. immunisation information in ALL languages of HSS arrivals in Australia.
Review of MBS funding models to better accommodate population cohorts with multiple health concerns, rebalance from current funding imperatives reliant on short consults. Address national issues around catch up immunisation funding. Address issues regarding costs associated with adding items to the PBS that relies on sponsorship from pharmaceutical companies. National review and potential investment in nurse practitioners in refugee health. Consideration of potential for telehealth initiatives to enhance access to interpreting and specialist medical services in rural & regional Australia.
Incentives for GPs to use the interpreting services already in place - or penalties for refusing to do so (yes, many do refuse!)
Not just quality of interpreter services, but quantity, suitable GP training, and incentives (financial & other) for GPs to use same.
We need an overarching national refugee health policy that is consistent with the national primary health care strategy. Future primary health care

strategic documents should overtly address the needs of the CALD and refugee populations in our diverse community.
No additional ones - they are the fundamental ones.
Community consultation about recurrent health issues.
Enrolled patient with per capita payment and quality KPIs training for practice nurses.
Education in the use of interpreters, cross-cultural awareness and specific refugee health issues to all primary care professionals, especially GPs. A specific item number for GPs for use of an interpreter to encourage use - say for $10 each time. Removal of the current practice from TIS of charging the GP for the interpreter if the patient does not turn up.
Availability of transport cost affordable in rural areas increased education for allied health providers e.g. dentist.
Increasing knowledge of health and non-health services of which health services to refer refuges to.
Improve orientation/education to Australian health care system for refugees upon arrival.
Bulk billing co-payment for consultations where interpreters are used - would increase the use of them and improve the efficiency of consultations.

Statistic	Value
Total Responses	22

Q3. HEALTH LITERACY. Health literacy can be defined as the ability to read, understand and use health care information to make decisions and follow instructions for treatment. Varied approaches to health literacy improvement have been advocated. Please indicate your level of agreement with the following statements.

#	Question	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Total Responses	Mean
1	Adult English language schools should incorporate health literacy messages in their English language classes	1	0	0	7	21	29	4.62
2	Department of Immigration and Citizenship (DIAC) should provide pre-immigration health system literacy education to refugees	1	5	7	7	9	29	3.62
3	Settlement workers should provide direct education and orientation to the health system to clients (one-on-one)	1	3	1	10	14	29	4.14
4	General practice/community health centres should provide direct education during refugee patient visits	1	1	3	11	13	29	4.17
5	Community workers should run health education events for refugees at community sites such as primary and secondary schools	1	1	4	10	13	29	4.14
6	Community workers should provide education during community events such as festivals and religious gatherings	2	2	7	11	7	29	3.66
7	Dissemination of important health messages through ethnic media (e.g. newspapers, radio, TV)	1	1	2	15	10	29	4.10
8	Bilingual health workers should provide one-on-one and group education to refugees	1	0	1	11	16	29	4.41

Statistic	Adult English language schools should incorporate health literacy messages in their English language classes	Department of Immigration and Citizenship (DIAC) should provide pre-immigration health system literacy education to refugees	Settlement workers should provide direct education and orientation to the health system to clients (one-on-one)	General practice / community health centres should provide direct education during refugee patient visits	Community workers should run health education events for refugees at community sites such as primary and secondary schools	Community workers should provide education during community events such as festivals and religious gatherings	Dissemination of important health messages through ethnic media (e.g. newspapers, radio, TV)	Bilingual health workers should provide one-on-one and group education to refugees
Min Value	1	1	1	1	1	1	1	1
Max Value	5	5	5	5	5	5	5	5
Mean	4.62	3.62	4.14	4.17	4.14	3.66	4.10	4.41
Variance	0.67	1.46	1.27	1.00	1.05	1.31	0.88	0.75
Standard Deviation	0.82	1.21	1.13	1.00	1.03	1.14	0.94	0.87
Total Responses	29	29	29	29	29	29	29	29

Q4. Can you identify any other strategies to improve refugee health literacy that are not mentioned above?

Text Response
Peer education programs in communities of recent humanitarian arrivals (say up to 3 years post arrival).
Group classes for health literacy through other organisations such as Migrant resource centres.
Appropriate resources which use pictorial rather than language based messages. Education is a two way street - awareness programs for staff in clinical settings to help them understand the barriers refugee clients face in accessing primary care services would help to enhance their role as providers of health literacy education – rather than blaming refugee clients for missing appointments, not following treatment orders etc.
-
A community development strategy to build the leadership (formal and informal) of key community members to become "health leaders" in their community. The process of supporting and empowering members of the community who are already regarded as "trustworthy" will facilitate access and trust of health care providers. This approach would be different to training and engaging bi-cultural health care workers. By increasing the critical and functional health literacy of key community members they become a bridge to mainstream services but not direct service providers.
Translated material, very clear and simple to read with basic guidelines.
Disseminate important health videos via phones.
Provision of health material in all the languages irrespective of the number of people.
Multilingual videos produced by health care workers.
Use of community advisory models to better inform approaches to addressing health literacy at a community level.
Refugee health nurses as educators.
Improved community engagement between local health services and local refugee communities needs to be actively facilitated to ensure the strategies used are relevant to the local needs.
Children, women and men need to be given targeted health literacy programs that deal with specific health issues that are likely to exist pre or on settlement as well as their treatment and management and also provide information about how health trajectories can change post settlement over the course of a lifetime and what health actions are required to support a healthier lifestyle.
Community capacity building strategies or projects to empower members of the community to take role in educating members of their communities. To have strategies to reach and empower illiterate, disabled refugees to get appropriate education on health and literacy.
Communication training for health care workers Assessment of health literacy in patients attending refugee health services and feedback to staff.

Resources need to be developed appropriate to refugee cultural norms and preferences.
Availability of health resources in multiple languages increase number of interpreters in rural areas not phone but face to face
Patient information sheet (in various languages) explaining Australian health care system
The above is a very broad definition of health literacy, with many of these elements not being achievable by the methods suggested. Orientation to the health system is a critical role for everyone involved in the early months of resettlement because it's very complex (in particular, the PBS repeat system makes no sense to patients - we need some simple material to give to patients to take home to reinforce how this works). A critical element that's been left out in the above list is self-education. There's an urgent need for readily available material on the Internet on how the health system works, and some more specific material on chronic diseases that they can access. Refugees are often very IT literate - mobile phones and apps have greater penetration in Africa than here, and people use Facebook to communicate with family and friends in the diaspora. Our health literature for complex health conditions (TB, HIV, hepatitis B and C, diabetes, renal disease) is very poor, in fact, I often link them up to Internet resources from NZ Department of Health or the US so they can learn more about their diseases)

Statistic	Value
Total Responses	19

Q5. WORKFORCE DEVELOPMENT. There is limited funding for training and workforce development activities. Please indicate in which of the following activities should additional resources be invested to improve the ability of the primary health care workforce to provide accessible and coordinated services to refugees?

#	Question	Unimportant	Of Little Importance	Moderately Important	Important	Very Important	Total Responses	Mean
1	Training students in relevant undergraduate courses to improve the knowledge of refugee health	0	0	3	12	13	28	4.36
2	Post-graduation training for health care providers to improve their clinical knowledge of refugee health issues	0	2	2	7	18	29	4.41
3	Development of referral resources and service directories to increase health providers awareness of refugee-specific services	0	1	4	8	16	29	4.34
4	Training for health providers in the best ways to work with interpreters	0	0	2	7	20	29	4.62
5	General cultural awareness and responsiveness training for health providers	0	0	2	10	16	28	4.50
6	Programs to facilitate training and employment of bicultural/bilingual healthcare providers	1	1	2	13	12	29	4.17

Statistic	Training students in relevant undergraduate courses to improve the knowledge of refugee health	Post-graduation training for health care providers to improve their clinical knowledge of refugee health issues	Development of referral resources and service directories to increase health providers awareness of refugee-specific services	Training for health providers in the best ways to work with interpreters	General cultural awareness and responsiveness training for health providers	Programs to facilitate training and employment of bicultural/bilingual healthcare providers
Min Value	3	2	2	3	3	1
Max Value	5	5	5	5	5	5
Mean	4.36	4.41	4.34	4.62	4.50	4.17
Variance	0.46	0.82	0.73	0.39	0.41	0.93
Standard Deviation	0.68	0.91	0.86	0.62	0.64	0.97
Total Responses	28	29	29	29	28	29

Q6. Can you identify any other strategies for training and workforce development that are not mentioned above?

Text Response
GP incentives for those having undergone accredited training that improves competency for working with refugees.
Post graduate nursing qualifications should be HECs funded. Online training programs in refugee health care for Drs and Nurses as part of approved CPD packages. Better coordination of tertiary undergraduate student placements in refugee health care settings. Hospital based education sessions which are practical and accessible for shift workers.
Providing health workforce, community service providers and refugee clients to come together to discuss issues at the practical level.
GPs and all health care professionals need basic training on HOW to ask questions of a refugee. A patient came to us with a high fever, feeling very ill. The GP asked, "have you been out of the country recently"? Patient ended up in A&E the next day with acute malaria. The GP should have asked, "when did you come into the country 'or 'how long have you been in Australia' Learning to ask Where the patient comes from and where was the patient born - 2 different disease sets.
-
Opportunities for peer mentoring and de-briefing for front line health professionals in addition to more formal training and education events. The complexity of the area lends itself to health professionals sharing strategies and also normalising their experiences.
The cultural awareness training needs to be more than a 'must attend' to tick a box of completion. Needs to be in-depth and look at cultural humility and our own values and biases rather than just focussing on the 'other'.
No
Training/Orientation to interpreters in health literacy/health system.
The topics above are fairly inclusive, and I'm assuming it includes mental health concerns. The cost imperatives should be addressed around cost-effective delivery, e.g. use of on-line training approaches, interpreting as a regular component of organisational orientation (as is the case for at least some Victorian Community Health Services).
Utility of above depends of course on targeting the most relevant health professionals (i.e. more relevant to some than others, and at different stages of training).
There is simply inadequate training available for all health providers at present and providers need support to engage with this training and they need access to information about where this training is available. Practices are often unwilling to engage with training unless they perceive a need and this is a barrier that needs to be recognised. Simply setting up training and hoping the providers will come will not work - engagement is essential.

Training of interpreters in health and mental health so that they are in a better position to interpret more effectively.
Mentoring, or body system between organisations working in the field case study register create web based resources including demographics and periodical refugee profiles statistics updates.
Use of migrant health workers.
On-line training opportunities with CPD points for nurses and GPs. Training in specialist colleges as well, including radiology.
Improved funding for the healthcare workforce to put into place appropriate strategies for improving access (e.g. time for receptionists to assist refugee clients) and coordination (e.g. time to provide the actual work required in practically coordinating a client's needs).
Formal facilitation of a national network of providers, with regular dissemination of information about emerging conditions and new policies. Refugee health changes rapidly; practitioners often feel they are out of date or struggling alone. Postgraduate training and resources are useful, but they are static solutions for a changing field of practice. The best thing that's happened to improve sustainability and knowledge has been the national network, and the various state networks - but all of these are voluntary organisations. We need a formally resourced information-sharing network to ensure that all refugee health providers have information that is up to date and are not all wasting time developing the same resources or mistreating conditions. The analogous networks are those established in public health to keep track of new and emerging diseases. We can run courses till we're blue in the face but they are very superficial and limited ways of building knowledge and capacity.

Statistic	Value
Total Responses	18

Q7. THE ROLE OF REFUGEE SPECIFIC HEALTH SERVICES. Upon their arrival in Australia, depending on the place of settlement, refugees receive healthcare through either specialised or mainstream health services. Please indicate your agreement with the following statements about the most appropriate ways to deliver health services to refugees.

#	Question	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Total Responses	Mean
1	Initially, all refugees should be seen only by mainstream health services on arrival	13	9	3	3	1	29	1.97
2	Initially all refugees should be seen by refugee-specific services for the first 6 months from arrival then transferred to mainstream services thereafter	3	3	7	6	10	29	3.59
3	Initially all refugees should be seen by refugee-specific services for the first 12 months from arrival then transferred to mainstream services thereafter	4	7	8	6	4	29	2.97
4	All refugees should be seen by refugee-specific services indefinitely, as needed	6	10	5	2	5	28	2.64

Statistic	Initially, all refugees should be seen only by mainstream health services on arrival	Initially all refugees should be seen by refugee-specific services for the first 6 months from arrival then transferred to mainstream services thereafter	Initially all refugees should be seen by refugee-specific services for the first 12 months from arrival then transferred to mainstream services thereafter	All refugees should be seen by refugee-specific services indefinitely, as needed
Min Value	1	1	1	1
Max Value	5	5	5	5
Mean	1.97	3.59	2.97	2.64
Variance	1.32	1.82	1.61	1.94
Standard Deviation	1.15	1.35	1.27	1.39
Total Responses	29	29	29	28

Q8. Do you have ideas for the most appropriate way to deliver health services to refugees that are not listed above?

Text Response
The difficulty is the dependence that may be developed on the refugee specific health service. 6 and 12 months is great - specialised knowledge, understanding and more comprehensive - but when having to transfer to mainstream services there is a lot of reluctance as by then strong relationships have been developed with the service and GP. Transfer can feel like punishment or that they no longer care. There also needs to be capacity within the health service to work on integration or transfer activities to enable understanding and smooth transition. Mainstream services often do not have specific refugee health knowledge and is another CPD option amongst many others to maintain specialised training. In some jurisdictions, there are not enough GPs to enable all refugee arrivals to access mainstream services, and not all will bulk bill.
My equal agreement with the last 3 statements above reflects that I believe 6-12 months is appropriate for most current (non-western) new arrivals. Specialist services should be able to extend this period 'as needed' which will depend on both client capacity and many extrinsic factors determining the availability of other appropriate options.
Our service offers initial screening and specialist services for refugees and humanitarian arrivals. They are also referred to GPs on arrival. If ongoing specialist treatment is required then they continue to receive treatment. Generalist medical issues are GP related.
Outreach models such as specialist refugee health nurses providing care for clients in outer suburban or regional areas where specialist services are not available. RHN's and RHN NP's can run refugee health screening clinics and link clients to appropriate mainstream services. Models such as Victorian and NSW refugee health programs which promote use of RHN's ideal.
To enable refugees to assimilate it would be beneficial to introduce them to 'the medical system as soon as possible. However, if the initial assessment for 'health 'is done through a specific refugee clinic this may reduce the amount spent on training ALL GPs. This however doesn't catch the 'sponsored 'refugees who come into Australia and are accidently identified after they have been here for months or even years. Spousal visas are a classic example here. I have identified quite a few of these people and have worked hard to have them assessed (and found to have several treatable diseased). Having a medical upon arrival should be mandatory for all people arriving in Australia regardless of their visa status.
-
On arrival it is imperative that individuals and families have access to a positive and culturally sensitive health service, as first experiences will be formative in their ongoing use and perception of health care in Australia. With added complexities of torture and trauma experiences it is even more critical that health care providers have a good understanding of the psychological impact. I would add that access to a health care service where people will see someone that "looks like them" also ensures better trust and connection and therefore employment of a diverse work force is essential. This initial connection will assist in facilitating trust in other health care providers and build bridges to mainstream services.
No

In the NT we are able to give four free immunizations to adults (ADT, Polio, Hep B and MMR), this usually finishes around 6months. In theory it is good to then transfer clients to mainstream GP's but by then most health care issues have already been addressed negating the need, but for complicated clients it's actually better they remain with the same GP for a longer period. Lucky in the NT the clients can remain with the same doctor (if they desire) after the refugee health program ends.
Initially all refugees should have comprehensive health assessment and plan before they are transitioned to main stream services.
There are a range of strategies required to increase the capacity of GPs to work with this client group, including improvements to the MBS funding model (as above) & the role of MLs. The introduction of nurse practitioners in refugee health nursing and the further development of specialist refugee health multidisciplinary hubs that require GP referral are required. Whilst the idea of refugee specific services is laudable it is unlikely to be able to ever respond to the needs of 24,000 plus humanitarian plus family migration arrivals, plus projected up to 20,000 asylum seekers, in dispersed locations across the country.
Model of initial assessment, and ideally case management of more complex cases, but with fairly rapid transition to mainstream - assuming latter is appropriately trained and resourced i.e. it depends on the location, settlement numbers, access to interpreters etc. - mix of models needed. So above it would have been good to have another option i.e. initial assessment followed by referral on.
Refugees should be seen by a refugee-specific service initially to ensure best practice care is provided and then this can guide the care provided later by the GP that the service links the refugee to. For most refugees who are basically well it is likely that only about 3 visits will be needed. These visits need to be supported by the case workers. The case workers also need to facilitate the subsequent visits to the GP for a few visits until the GP and patient are confident of the linkage. There needs to be excellent communication from the special service to the GP and the refugee should have a hand held record as well so that if the refugee travels in the early settlement period there is a good chance that the new GP will know where the initial care was provided and then the information appropriate for continuing care can be sourced. The refugee-specific service can provide relevant guidelines to the GP for F/U that is needed e.g. for hepatitis, strongyloides, mental health so that this is arranged appropriately. All immunisations need to be well documented.
The different models of refugee health service delivery means that Refugee Health Nurses could support clients earlier into mainstream services. This approach is different from point one in the question above because there is still some level of support for these clients. Orienting refugees to the health system is complex conceptually and depends on individual literacy and capabilities. Supporting health literacy is also a complex idea so there needs to be some level of support during settlement to enable refugees gain a better understanding and achieve effective orientation during settlement.
Care team model incorporated within community based health services short and long term case management model with continued monitoring and reviewing tools
An approach tailored to individual patient’s needs.
On the whole refugees should be linked to well supported primary care services. Refugee specific services should be available to support mainstream services e.g. refugee health fellows, refugee health nurses, refugee specific specialist clinics, torture and trauma services. Specialist clinics should focus on those w complex and or acute needs rather than see everyone.

Also in parallel, settlement support should extend for the amount of time required to achieve adequate specialised healthcare assistance.
Not a 'one size fits all' approach. Some refugees may benefit from accessing mainstream services earlier, whilst other refugees may require refugee-specific services for longer durations.
None of the above models is satisfactory, because the models need to be customised to the context. The problem with the above is "All". The model of refugee-specific services as a transitional model works well in a bounded jurisdiction like the ACT or the NT, or some regional settings. It's not going to be feasible in Sydney or in smaller regional resettlement areas. The risk with this model in large cities is that it ends up becoming a parallel service (i.e. a long term refugee health service) rather than a transitional service with large bottlenecks - you see this happening in some of the community health services in Melbourne. Transition out to the mainstream is very time-consuming - we have a half time worker whose sole role is transitioning people from our service.

Statistic	Value
Total Responses	20

Q9. COORDINATION OF TRANSITION FROM SPECIALISED REFUGEE HEALTH AND SETTLEMENT SERVICES TO MAINSTREAM HEALTH SERVICES. Our interviews have indicated that procedures for transfer of refugees from specialised refugee health services and settlement services to mainstream services vary across the nation. Please indicate the level of importance of the following in coordinating the smooth transition of refugees from specialised/settlement services to mainstream health services.

#	Question	Unimportant	Of Little Importance	Moderately Important	Important	Very Important	Total Responses	Mean
1	Co-location of specialised and mainstream health services	0	9	7	7	6	29	3.34
2	Documented procedures for transfer of client health information between services	0	1	4	3	21	29	4.52
3	Formal positions within specialised services to coordinate client transition to mainstream services	0	4	7	4	14	29	3.97
4	Prior agreement with the mainstream service to receive refugee clients	0	2	4	6	16	28	4.29
5	Formal procedures for clinical handover between services	0	2	4	7	16	29	4.28
6	Formal procedures for case management handover between services	0	3	5	8	11	27	4.00
7	Transfer of clients to culturally aware and responsive mainstream health services only	0	4	5	8	12	29	3.97
8	Clear definition of roles and responsibilities of services and programs in relation to transition	0	3	3	11	12	29	4.10
9	Facilitation of team communication such as through inter-agency meetings or case conferencing	0	5	5	8	11	29	3.86

Statistic	Co-location of specialised and mainstream health services	Documented procedures for transfer of client health information between services	Formal positions within specialised services to coordinate client transition to mainstream services	Prior agreement with the mainstream service to receive refugee clients	Formal procedures for clinical handover between services	Formal procedures for case management handover between services	Transfer of clients to culturally aware and responsive mainstream health services only	Clear definition of roles and responsibilities of services and programs in relation to transition	Facilitation of team communication such as through inter-agency meetings or case conferencing
Min Value	2	2	2	2	2	2	2	2	2
Max Value	5	5	5	5	5	5	5	5	5
Mean	3.34	4.52	3.97	4.29	4.28	4.00	3.97	4.10	3.86
Variance	1.31	0.76	1.32	0.95	0.92	1.08	1.18	0.95	1.27
Standard Deviation	1.14	0.87	1.15	0.98	0.96	1.04	1.09	0.98	1.13
Total Responses	29	29	29	28	29	27	29	29	29

Q10. Can you identify any other strategies to improve the transition of refugees into mainstream health services access that are not mentioned above?

Text Response
Specialist services should make transition a clearly stated objective from the very early stages of engagement with new arrivals and this needs to be reinforced as health literacy info / education is progressively provided prior to transition.
Continued education on cultural competency and communication with interpreters for all staff.
Refugee specific health services should be adequately resourced to provide capacity building support to main stream primary care providers to enable a smooth transition. Support such as training in how to book and use interpreters and managing common refugee health issues. Websites which are practical easy to navigate – updated with current provider list and practitioner resources.
Having ALL documentation come with the patient - especially those who come from detention. Many tests are done when in detention but are never forwarded to us as the GP. In recent months this situation has improved. Finding information is very challenging sometimes.
-
Hand held records for patients. Capacity to spend time with patients during the transition phase to provide health system literacy and access to bi-cultural health workers to assist in negotiating the transition. Clear return pathway if something is not going well. Consumer feedback mechanisms about their service experience.
A lack of communication between services is a major barrier and one that often results in 'doubling' up of services or people falling through the gap of no service. Communication of information, history taking, interventions, medical procedures etc. would result in cost savings as well as a more seamless service delivery.
No
Involvement of Community groups/organisation for long term support. Client education and preparation for transition to mainstream health services.
Start with primary care, and use specialist refugee health services for referral for those with more complex health and/or psycho-social concerns. Also needs to be investment in MBS and professional development, and support - role of MLs and refugee health fellows (VIC model).
Notes from specialised service should clearly include tests and diagnoses and follow up arrangements/referrals made. These notes should also include proposed advice on future management e.g. which immunisations and when and which blood tests and when. Transfer of this info should be checked by the coordinator who is aware of how that practice prefers to receive the info e.g. as a document / bloods downloaded / nurse contacted etc. The availability of an expert primary care clinician to advise on complex issues is essential so the GP provider (or other) can contact for advice.
Incorporate priority protocol according to the refugee health needs.

Electronic health records.
Start w mainstream services linkage thru settlement services. Use triage of new arrivals to determine who needs high level health support and who needs lower level support and allocate specialist resources accordingly.
Educating the client as to where the mainstream clinic is, how to get there, and how to make appointments there.
Clear explanation to refugees about the various services, to avoid confusion.
Have capacity for the receiving service to ring for advice or to access your treatment protocols after transition. Also a good idea to support short term placements of doctors at the receiving service in the refugee health service so that they become confident with managing this client group.

Statistic	Value
Total Responses	17

Q11. INDIVIDUAL CASE COORDINATION OF HEALTH ISSUES ACROSS HEALTH AND NON-HEALTH SERVICES. Individual refugees may have complex health and social needs, requiring individual case coordination across a variety of services. Indicate who has the most important role in the coordination of individual refugee needs across various services.

#	Question	General practice	Settlement services	State community health services	Refugee health nurse programs	Medicare Local	Torture and trauma services	Specialised refugee health services	Total Responses	Mean
1	Effective transfer of patient health information	3	4	0	8	1	0	12	28	4.71
2	Coordination of on-arrival comprehensive health assessment activities for all refugees	0	6	0	3	0	0	19	28	5.61
3	Assistance with getting to appointments	0	26	0	2	0	0	0	28	2.14
4	Educating clients about how to access and use health services independently	0	17	1	5	1	0	4	28	3.21
5	Monitoring client transition between services	0	10	0	10	1	0	6	27	3.96
6	Ensuring follow-up of health issues	5	2	1	9	0	0	10	27	4.37
7	Client advocacy for patients to gain access to	2	11	0	6	2	0	6	27	3.70

	services									
8	Allocation of identified case managers/case coordinators	0	17	0	3	1	0	6	27	3.44
9	Formal service agreements with humanitarian settlement	0	16	3	0	1	0	6	26	3.38

Statistic	Effective transfer of patient health information	Coordination of on-arrival comprehensive health assessment activities for all refugees	Assistance with getting to appointments	Educating clients about how to access and use health services independently	Monitoring client transition between services	Ensuring follow-up of health issues	Client advocacy for patients to gain access to services	Allocation of identified case managers/case coordinators	Formal service agreements with humanitarian settlement
Min Value	1	2	2	2	2	1	1	2	2
Max Value	7	7	4	7	7	7	7	7	7
Mean	4.71	5.61	2.14	3.21	3.96	4.37	3.70	3.44	3.38
Variance	5.10	4.54	0.28	3.29	3.65	5.40	4.45	4.41	4.49
Standard Deviation	2.26	2.13	0.52	1.81	1.91	2.32	2.11	2.10	2.12
Total Responses	28	28	28	28	27	27	27	27	26

Q12. Can you identify any other strategies and/or services that play a key role in the transfer of patients between health services that are not mentioned above?

Text Response
I believe that these strategies need to be played by more than the just the one service/stakeholder that could be chosen above. They need to be across services.
This is a muddy question in which response selections to individual items could be multiple, vary due to specific circumstances or could change over time. I abandoned it due to concern that it would not provide reliable data.
Volunteers provide assistance for folk getting to appointments.
Question 12 should have allowed multiple options per answer. 'Coordination' implies involvement of multiple players - no single agency is solely responsible. Case coordination is a collaborative approach. The lead agency will depend on local issues, resources and service models. Where specialist refugee health services exit these should take a lead role – as should state funded community health services. Hand held records and client appointments diaries have been used with varying degrees of success. Availability of pre migration health histories and transfer of this information through DIAC to initial on arrival providers is essential.
Some of the above could be shared roles e.g. all interested parties should be responsible for effective transfer of patient health records.
-
Medicare Locals have a key role in promoting better integration of care and in Qld they work closely with Hospital Health Services boards. At this level it is imperative that there is understanding and ownership of responsibility for areas of health care to avoid the passing of the "buck" between state and commonwealth programs. Although the HHS work locally with Medicare Locals it is imperative that there are mechanisms for broader coordination of resources and implementation of strategies that have worked across multiple local areas.
Social workers who are employed specifically in health to offer services to humanitarian entrants.
No
Community groups could be involved to address some of the social needs of the clients.
In our area the refugee health nurse program and specialised refugee health service are one entity.
Case co-ordination will rely upon the needs of particular clients, e.g. general primary care - GP, more complex health/psycho-social concerns - refugee health nurse or specialised clinic, torture & trauma related mental health - FASTT agency.
May be more than one answer to above e.g. First line above should be all, can't prioritise.

The general practice can't coordinate what they don't know if coming their way. Medicare Locals can assist but the settlement agencies need to work closely with everyone to ensure that the processes are running smoothly and this communication is very difficult - there needs to be an overarching person aware of the regional issues who ensures this is working. Often the only contact with the settlement agency is through an individual case-worker so this in not adequate.
I am not sure that this question works. I wasn't sure what it is trying to answer. It misses the fact that there is a DIAC Complex Case management program which deals with clients with very high needs. Needs may also vary across different service areas such as domestic violence combined with very poor literacy generally and torture and trauma.
As above
General practice is responsible for medical case coordination in the community. However it is unrealistic for general practice to play this role in relation to all needs.

Statistic	Value
Total Responses	17

Q13. TRANSFER OF HEALTH INFORMATION. Client health information may be poorly communicated or lost when transferring refugees between organisations or locations. Please indicate your level of agreement with the following approaches to transferring post-settlement individual refugee health information between services in Australia?

#	Question	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Total Responses	Mean
1	Complete health records should be given to the refugee patients only	7	12	4	5	1	29	2.34
2	Only a summary of health records should be given to the refugee patients	1	8	8	7	5	29	3.24
3	Health records should not be transferred via the individual	3	6	6	6	7	28	3.29
4	Complete health records should be given to the settlement services	9	15	4	1	0	29	1.90
5	Only a summary of health records should be given to the settlement services	5	9	4	9	2	29	2.79
6	Health records should not be transferred via the settlement services	5	5	2	10	7	29	3.31
7	Complete health records or summaries should be transferred directly to health services	1	2	1	10	15	29	4.24
8	Complete health records should be transferred via personally controlled electronic health record (PCeHR)	1	3	7	10	8	29	3.72

Statistic	Complete health records should be given to the refugee patients only	Only a summary of health records should be given to the refugee patients	Health records should not be transferred via the individual	Complete health records should be given to the settlement services	Only a summary of health records should be given to the settlement services	Health records should not be transferred via the settlement services	Complete health records or summaries should be transferred directly to health services	Complete health records should be transferred via personally controlled electronic health record (PCeHR)
Min Value	1	1	1	1	1	1	1	1
Max Value	5	5	5	4	5	5	5	5
Mean	2.34	3.24	3.29	1.90	2.79	3.31	4.24	3.72
Variance	1.31	1.33	1.84	0.60	1.60	2.15	1.12	1.21
Standard Deviation	1.14	1.15	1.36	0.77	1.26	1.47	1.06	1.10
Total Responses	29	29	28	29	29	29	29	29

Q14. Can you identify any other strategies to improve the transfer of patient information between health services in Australia that are not mentioned above?

Text Response
Some of these questions/answers would depend on the degree of process/relationship/links between services e.g. Settlement and health service.
Most of the above options need to be sensitive to individual circumstance and the best option determined according to informed client participation and consent.
Consent processes for Release of Client Information should be standardised and routinely followed to pre-empt smooth and efficient transfer of clinical information between health services.
The patient should be given a copy of their health record as sometimes an appointment is made with us but the patient decides to go elsewhere so we have the record but no patient. If the patient has a copy as well as where they are thought to be going for care - at least there is some continuum of care.
-
Building knowledge and awareness of health systems and pathways across settlement services and other non-health care related sectors is critical to facilitating access to care. The balance of patient confidentiality and consent needs to be explored in more depth as there is, in general, less than clear understanding of what is expected. This is equally true of refugee patients and some service providers.
The transfer of health information needs to be between health services to preserve privacy as well as information being lost. A commonly shared data base between appropriate services would be of great benefit.
In the NT the refugee nurse gives complete health records to the client with covering letter for follow up GP/Refugee Health Nurse.
Summary of health records should be given to all clients on transition.
Ideally there would be a system of direct transfer of health information from health practitioner to health practitioner, with settlement providers having key information/alerts that might impact on the individual's wellbeing. This is more likely with e-health approaches. It is important that clients have their own health records and assisted with a folder or similar so they know what it is if not in their first language. However, in the meantime, it is very important that health services can access health information from a central point, and currently that is settlement services, which is the service that private GPs are most likely to be aware of. Settlement services then need to have strict privacy protocols in place.
There are many reasons why the PCeHR cannot work as the refugee name varies and the electronic record can upload patient documents but only the main provider can alter the overarching info and who will be the main provider and who will this be changed or will all the data just end up locked with no current provider taking responsibility - given the way the current system is designed. Patient transfer of info needs to be supported by the clinical systems and the settlement agencies need to be clearly aware of this system to enable it without actually handling the data. The patient always has a right to the

data - complete or summary does not matter for most.
Again, I feel this question misses its mark. When Humanitarian entrants arrive there is a health manifesto that indicates that if a person requires immediate referral to a health service such as the State TB services or to a hospital (i.e. they have a serious illness and need an immediate check-up post arrival). This manifesto is only given to the Settlement Services and to the State Infectious Diseases personnel. It is not given to State refugee health services or private GPs. This is the first problem. The second problem is that a humanitarian entrant may have a health record given to them by the IOM for their pre-travel screening. This record sometimes is done well and sometimes isn't and sometimes there is no record because pre-travel health checks haven't been conducted to the extent required.
Establish a system to record and trace refugee's health records nationally possibly through Medicare? Immunisation records for Children and Elderly.
Like any other patient health information should be given to the refugee and to the providers involved.
Coordinators should be identified for each organisation.
Can use a combined approach - patient, settlement services, and direct transfer.

Statistic	Value
Total Responses	16

Q15. COORDINATION OF REFUGEE HEALTH SECTOR. Our interview data indicates that inter-agency networks across different agencies and services play a key role in building the capacity of the refugee health sector and improving collaboration and communication between services and providers. Please indicate your agreement with the following statements regarding activities of inter-agency refugee health networks.

#	Question	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Total Responses	Mean
1	Interagency networks are not important	20	8	0	0	1	29	1.41
2	Developing consistent procedures for the coordination of client health information transfer	0	1	1	11	16	29	4.45
3	Establishment of referral protocols	1	1	1	8	18	29	4.41
4	Facilitation of provider education in refugee health	0	2	0	8	19	29	4.52
5	Integration of health services and other programs for refugees	0	0	2	8	19	29	4.59
6	Ongoing evaluation of health services for refugees	0	1	1	11	16	29	4.45
7	Advising policy makers and informing government decision making	0	0	0	11	18	29	4.62

Statistic	Interagency networks are not important	Developing consistent procedures for the coordination of client health information transfer	Establishment of referral protocols	Facilitation of provider education in refugee health	Integration of health services and other programs for refugees	Ongoing evaluation of health services for refugees	Advising policy makers and informing government decision making
Min Value	1	2	1	2	3	2	4
Max Value	5	5	5	5	5	5	5
Mean	1.41	4.45	4.41	4.52	4.59	4.45	4.62
Variance	0.68	0.54	0.97	0.69	0.39	0.54	0.24
Standard Deviation	0.82	0.74	0.98	0.83	0.63	0.74	0.49
Total Responses	29	29	29	29	29	29	29

Q16. Can you identify any other activities of inter-agency networks that are not mentioned above?

Text Response
Generating and supporting practice development and research.
Maintaining a state based or national refugee health website which is practical easy to navigate – updated with current provider list and practitioner resources. Advocacy around refugee health policy and human rights issues.
-
Lobbying for increases in resources and increasing the profile of refugee health to ensure it is in line with changes to the humanitarian program.
No
Regular community consultation and feedback mechanism in place. Participation of Community Groups in the coordination meetings. Health diary for each client.
Establishment of services and service models in particular locations. Development of resources, undertaking needs analysis and local area planning including informing wider planning.
Sharing information about processes & protocols.
Facilitating transport and housing and immunisation to Centrelink is important.
Ongoing dialog between State and Federal policies to identify Gaps. Incorporate Refugee Needs in annual, short term, long term plans and health reforms.
Addressing emergent problems or issues in refugee health service delivery or refugee population health.
Am not very familiar with inter-agency networks.
* Combined advocacy for patients with complex health needs.* Early recognition of evolving conditions and health needs in refugee health.

Statistic	Value
Total Responses	13

Q17. WHO SHOULD PROVIDE INFRASTRUCTURE SUPPORT FOR INTER-AGENCY NETWORKS DISCUSSED IN QUESTION 8?

#	Question	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Total Responses	Mean
1	Federal government departments (i.e. Department of Health and Aging or Department of Immigration and Citizenship)	0	0	4	10	15	29	4.38
2	State/ territory government health department programs	0	1	5	12	11	29	4.14
3	State/ territory refugee health networks	0	3	6	9	10	28	3.93
4	Medicare Locals	0	0	8	14	7	29	3.97
5	Refugee-specific health services	1	2	6	13	6	28	3.75
6	Settlement services	2	7	6	6	7	28	3.32
7	Torture and Trauma services	2	7	11	5	3	28	3.00
8	Local Hospital Networks	1	8	7	8	4	28	3.21
9	Local Area Networks	0	6	4	13	4	27	3.56

Statistic	Federal government departments (i.e. Department of Health and Aging or Department of Immigration and Citizenship)	State/ territory government health department programs	State/ territory refugee health networks	Medicare Locals	Refugee-specific health services	Settlement services	Torture and Trauma services	Local Hospital Networks	Local Area Networks
Min Value	3	2	2	3	1	1	1	1	2
Max Value	5	5	5	5	5	5	5	5	5
Mean	4.38	4.14	3.93	3.97	3.75	3.32	3.00	3.21	3.56
Variance	0.53	0.69	1.03	0.53	1.01	1.71	1.19	1.29	1.03
Standard Deviation	0.73	0.83	1.02	0.73	1.00	1.31	1.09	1.13	1.01
Total Responses	29	29	28	29	28	28	28	28	27

Q18. Can you suggest other sources of infrastructure support for inter-agency networks which are not included above?

Text Response
-
No
No
Community Health Centres in the area.
Everyone needs to play their part and determining the role for each needs to involve discussion and this needs leadership at a federal level but relevant at local level.
Ethnic community associations, Refugee council.
This will also be different in each state. Certainly someone needs to do it but they need to be funded to do it and need to be objective, flexible, practical and collaborative in their approach.

Statistic	Value
Total Responses	7

Q19. NATIONAL REFUGEE HEALTH POLICY. What are the issues that national policy should address to enable the delivery of accessible and coordinated primary health care services to refugees?

#	Question	Unimportant	Of Little Importance	Moderately Important	Important	Very Important	Total Responses	Mean
1	Recognition of the refugee population as a vulnerable group in the National Primary Health Care Strategy	0	1	0	6	22	29	4.69
2	Establishment of national priority areas for refugee health	0	1	5	4	19	29	4.41
3	Support for a national-level refugee health sector coordination network	0	0	5	5	19	29	4.48
4	Procedures for transferring individual refugee health information from off-shore immigration assessment centres and detention centres to Australian health services	0	0	3	7	19	29	4.55
5	Specialised refugee health services in each state and territory	0	0	3	3	23	29	4.69
6	Individual health-focused case management for all refugees from time of arrival	1	1	3	7	17	29	4.31
7	Education and training to support a refugee responsive workforce	0	1	0	11	17	29	4.52
8	Medicare Australia funding to support refugee health nurses	0	1	4	10	14	29	4.28
9	Providing access to government funded interpreter services for private allied health providers	0	0	1	4	24	29	4.79

Statistic	Recognition of the refugee population as a vulnerable group in the National Primary Health Care Strategy	Establishment of national priority areas for refugee health	Support for a national-level refugee health sector coordination network	Procedures for transferring individual refugee health information from off-shore immigration assessment centres and detention centres to Australian health services	Specialised refugee health services in each state and territory	Individual health-focused case management for all refugees from time of arrival	Education and training to support a refugee responsive workforce	Medicare Australia funding to support refugee health nurses	Providing access to government funded interpreter services for private allied health providers
Min Value	2	2	3	3	3	1	2	2	3
Max Value	5	5	5	5	5	5	5	5	5
Mean	4.69	4.41	4.48	4.55	4.69	4.31	4.52	4.28	4.79
Variance	0.44	0.82	0.62	0.47	0.44	1.08	0.47	0.71	0.24
Standard Deviation	0.66	0.91	0.78	0.69	0.66	1.04	0.69	0.84	0.49
Total Responses	29	29	29	29	29	29	29	29	29

Q20. Can you identify other issues that national policy should address to enable the delivery of accessible and coordinated primary health care services to refugees not included above?

Text Response
MBS based incentives for working with interpreters and dealing with other complex clinical and cultural aspects of refugee health care in the early settlement period. These would need to be actively monitored and accompanied by appropriate sanctions to ensure compliance.
Refugee health policy should be supported by a human rights framework that is in keeping with international standards.
-
MBS - looking at building incentives for general practice to provide preventative health care and health literacy to vulnerable populations. Also more incentives in the system to work collaboratively and outreach.
Extension of Australian Childhood Immunisation Register (ACIR) to include all adult catch-up immunisations and standard schedule.
No
Use of interpreting services in all facilities. Dental health should be made a priority component of refugee health.
As above other key area is MBS reforms to better reflect GP, practice nurse and specialists time in seeing refugee background clients.
Many states have no formal organised medical assessment for refugees on entering the state. A nursing assessment is not adequate as the only assessment and a refugee specific service is vital for larger cities and regional areas need to be able to access the experience of these larger centres to ensure appropriate assessment is arranged. Health focused case management is essential as much of the case management goes on other activities at present. The concept of refugee health nurse varies in different states so this is a difficult concept without clarification but excellent if refugees have direct support from nurses. It is impossible to care for refugees without access to language e.g. interpreter.
No
Provision of cultural sensitive awareness to Health professionals, provision of access to Refugee to Age and Disability packages.
Access to medication that is refugee-specific on the PBS.
Health literacy education for refugees.

Statistic	Value
Total Responses	13

Q21. Is there anything else you would like to mention that impacts the accessibility and coordination of primary health care for refugees?

Text Response
Refugee clients place a significant burden on reception and administrative functions in PHC services. As these can constitute a barrier to access in some services, this needs to be taken into account in planning and funding.
In SA the dismantling of 'community health services' and the cost shift from 'primary health care' services to Medicare funded 'primary care' models is a bad move for marginalised groups such as refugee clients. Medicare locals have yet to prove their ability to promote better coordination of care in primary care settings. At the end of the day general practice is a fee for service business model which is at odds with the holistic care refugee clients require.
-
Resources that settlement service provider is able to allocate to supporting case management and the priority that health is given amongst competing settlement demands.
A national adult vaccination schedule (which IHMS also use in immigration detention), with online register. And an online register of mantoux testing.
Provision of simple and pictorial health messages developed in different languages for the clients. Health diary for each client.
Transport and cost.
Importance of Medicare Locals to include refugees in their Population Health planning processes.
Item number for patients when a TIS interpreter is used like a 10990 number that adds to the service better documentation of data in records for the refugee can be identified in data sets e.g. year of arrival, country of birth and language spoken and for children ethnicity and language spoken at home.
No
To increase capacity of intake in acute health care.
More funding for refugee health clinics & nurses.
Refugee client feedback - listen to what the refugee is saying about all of this.

Statistic	Value
Total Responses	13

Q22. Age in years

Text Response
43
66
56
55
54
53
39
44
46
47
36
54 year
54
54

Text Response
51
62
Wrong - should ask age group, not age
52
49
58
48 years old
60
59
57
52
38
40
49

Statistic	Value
Total Responses	28

Q23. Gender

#	Answer		Response	%
1	Male		8	29%
2	Female		20	71%
	Total		28	100%

Statistic	Value
Min Value	1
Max Value	2
Mean	1.71
Variance	0.21
Standard Deviation	0.46
Total Responses	28

Q24. Primary occupation

#	Answer		Response	%
1	Policy maker and policy advisor		4	14%
2	Service/program manager		9	31%
3	Community leader or member		0	0%
4	Clinician (specify)		16	55%
	Total		29	100%

Clinician (specify)
Nurse - Refugee health
Nurse / Manager
Registered Nurse
Refugee Health Social worker
GP
Staff specialist community paediatrician/Refugee health staff specialist
Refugee Health Nurse
Primary Health Care Worker
Nurse
Refugee Health Nurse
primary care
Medical
GP
nurse
GP
GP

Statistic	Value
Min Value	1
Max Value	4
Mean	2.97
Variance	1.46
Standard Deviation	1.21
Total Responses	29

Q25. Primary organisation

Text Response
Specialist refugee PHC service
Department of Health and Human Services
The Migrant Health Service - state funded specialist refugee health service
State government
General Practice, Salisbury Medical Centre
ACT Government Health Directorate
Mater Health Service
Launceston General Hospital
Queensland TB Control Centre At Refugee Health Qld until late 2012
Hunter New England Local Health District
I work both at Melaleuca Refugee Centre (In Darwin) as a health worker, and at the only Refugee Health Clinic in Darwin, (coordinating the program) as a Refugee Health Nurse
Migrant Health Service, Ambulatory & Primary Health Care Services, SA Health.
Tasmania Medicare Local - Clinical Services North Refugee Health
Mid North Coast Area Health Service
Victorian Foundation for Survivors of Torture
Lutheran Community Care
NSW Health
General practice environment
Withheld for reasons of anonymity
State Department of Health
AMES Settlement

Macedon Ranges and North Western Melbourne Medicare Local
Migrant Health Service, Adelaide
Medicare local
South Eastern Melbourne Medicare Local
NSW Refugee Health Service
Companion House Medical Service

Statistic	Value
Total Responses	27

Q26. State or Territory

#	Answer		Response	%
1	ACT		3	11%
2	New South Wales		6	21%
3	Northern Territory		1	4%
4	Queensland		4	14%
5	South Australia		6	21%
6	Tasmania		3	11%
7	Victoria		4	14%
8	Western Australia		1	4%
	Total		28	100%

Statistic	Value
Min Value	1
Max Value	8
Mean	4.21
Variance	4.47
Standard Deviation	2.11
Total Responses	28

Q27. Location

#	Answer		Response	%
1	Urban		23	79%
2	Regional centre		5	17%
3	Remote regional		1	3%
	Total		29	100%

Statistic	Value
Min Value	1
Max Value	3
Mean	1.24
Variance	0.26
Standard Deviation	0.51
Total Responses	29

Q28. Please indicate the length of your experience (in years) in the refugee health sector.

Text Response
9
7
13 years
25 years
> 10 years
16 years
3
15 years
5 years
6 years
9
3.5 years
15 years
6
12

Text Response
10
10
Several
25
10
10 or more years
12 YEARS
20
15 years
13
Have just commenced role, am a Registered Nurse with 25 years' experience
9 years
4.5 years
13 years

Statistic	Value
Total Responses	29

DELPHI Survey Two

Q1. ACCESS TO PRIMARY HEALTH CARE. Responses to our first survey emphasised the importance of access to interpreters and on the provision of case management assistance for refugee attendance at primary care services. There was little support for increasing the availability of home visiting outreach services for refugees. Below we have also included some alternatives suggested from the first survey. Please rank these strategies from 1 to 8 (1 being the most important and 8 the least important) so we can gain an understanding of where you consider additional resources should be invested to improve access to primary health care for Australia's refugees.

#	Answer	1	2	3	4	5	6	7	8	Total Responses
1	Refugee-specific primary care services in rural and regional areas (especially given the increase in the number of refugees that are now resettled in rural areas)	3	2	0	4	2	4	3	4	22
2	Access to qualified interpreters for all registered primary health care professionals	8	6	2	4	1	0	1	0	22
3	Essential, medications for refugees (for example medications for managing specific infectious disease and/or nutritional deficiencies or other)	0	0	4	2	2	2	5	7	22
4	Dental services for refugees	2	1	4	1	6	3	3	2	22
5	Adult catch-up immunisation for newly arrived refugees	0	3	0	4	6	3	4	2	22
6	Health system literacy programs to newly arrived refugees	2	3	5	4	1	3	3	1	22
7	Access to refugee health nurses	3	4	4	3	2	1	1	4	22
8	Education, training and peer-support for health professionals who come in contact with refugees in their work	4	3	3	0	2	6	2	2	22
	Total	22	22	22	22	22	22	22	22	-

Statistic	Refugee-specific primary care services in rural and regional areas (especially given the increase in the number of refugees that are now resettled in rural areas)	Access to qualified interpreters for all registered primary health care professionals	Essential, medications for refugees (for example medications for managing specific infectious disease and/or nutritional deficiencies or other)	Dental services for refugees	Adult catch-up immunisation for newly arrived refugees	Health system literacy programs to newly arrived refugees	Access to refugee health nurses	Education, training and peer-support for health professionals who come in contact with refugees in their work
Min Value	1	1	3	1	2	1	1	1
Max Value	8	7	8	8	8	8	8	8
Mean	5.00	2.45	6.05	4.77	5.18	4.14	4.09	4.32
Variance	5.81	2.64	3.76	4.28	3.20	4.31	5.99	5.94
Standard Deviation	2.41	1.63	1.94	2.07	1.79	2.08	2.45	2.44
Total Responses	22	22	22	22	22	22	22	22

Q2. WORKFORCE DEVELOPMENT. There is limited funding for training and workforce development activities. According to the results of our first survey, there was a clear message that an investment in all of the following activities is necessary to improve the ability of the primary health care workforce to provide accessible and coordinated services to refugees. Please now indicate which sector should have the primary responsibility for supporting and implementing the following activities ticking one box only.

#	Question	Tertiary sector (i.e. CAE, TAFE, University)	Postgraduate professional training programs	Refugee specific organisations (i.e. Torture and trauma services, settlement services, refugee health services)	Professional Associations (i.e. Australian Medical Association, Australian Nursing Federation)	Colleges (i.e. Royal Australian College of Nursing; Royal Australian College of General Practitioners)	Medicare Locals	Others (please specify below)	Total Responses	Mean
1	Programs to facilitate training of bicultural /bilingual healthcare providers	15	0	6	0	0	1	0	22	1.77
2	Training students in relevant undergraduate courses to improve their knowledge of refugee health issues	16	0	1	0	2	1	2	22	2.23
3	Post-graduation training for health care providers to improve their	0	9	1	2	7	2	1	22	3.77

	knowledge of refugee health issues									
4	Development of referral resources, service directories to increase health provider's awareness of refugee-specific services	0	0	7	1	3	9	2	22	4.91
5	Training for health providers in the best ways to work with interpreters	3	2	5	2	1	6	3	22	4.18
6	Cultural awareness and responsiveness training for health providers	4	3	10	0	1	3	1	22	3.18
7	Avenues for healthcare workforce, social services providers and refugee communities to meet together to discuss practical issues around health service delivery	0	0	8	0	1	9	4	22	5.05

Statistic	Programs to facilitate training of bicultural /bilingual healthcare providers	Training students in relevant undergraduate courses to improve their knowledge of refugee health issues	Post-graduation training for health care providers to improve their knowledge of refugee health issues	Development of referral resources, service directories to increase health provider's awareness of refugee-specific services	Training for health providers in the best ways to work with interpreters	Cultural awareness and responsiveness training for health providers	Avenues for healthcare workforce, social services providers and refugee communities to meet together to discuss practical issues around health service delivery
Min Value	1	1	2	3	1	1	3
Max Value	6	7	7	7	7	7	7
Mean	1.77	2.23	3.77	4.91	4.18	3.18	5.05
Variance	1.71	4.76	2.85	2.18	4.35	3.11	2.71
Standard Deviation	1.31	2.18	1.69	1.48	2.08	1.76	1.65
Total Responses	22	22	22	22	22	22	22

Q3. If you choose ‘other’ in the table above please specify and refer to the option number.

Text Response
2. Student training - best done as a collaboration between organisations. Not possible to deliver best practice training by one of those groups alone 3. Professionals training - as above. 4. Referral directories - collaboration between ML's, refugee and settlement services, and perhaps professional organisations. 5. Interpreter training - for refugees - works best as a collaboration between professional training body, health professionals experienced in using interpreters with refugees, and torture trauma services. 7. Discussion re service delivery - round table of services under aegis of ML perhaps
4. There is a role for Refugee specific organisations (i.e. torture and trauma services, settlement services, refugee health services) in providing some information (up to date information about current health and associated issues, best practice advice, etc.) as well as Colleges (i.e. Royal Australian College of Nursing; Royal Australian College of General Practitioners) in providing particular types of information (standards of care and knowledge and conduct in care). 5. Medicare Locals and the Colleges also need to ensure people's skills in this area remain updated. Doing once is not enough. Nobody has specific carriage but all should do so. 6. As above. 7. Refugee Health Network of Australia but again, this is a shared responsibility and the tertiary sector, colleges, refugee services, and Medicare Locals all have a role to play in providing avenues for these workers to meet together and discuss practical issues around health service delivery given that this care can be delivered in different contexts (i.e. general practice, specialist refugee health services, specific special programs such as refugee immunisation programs or dental care, etc.).
Option 7 - There are already existing networks - making all parties aware of them is the issue.
Training students. This should have a collaborative approach from Professional Associations, Colleges and Refugee Specific Groups. Development of referral resources: This should be done in conjunction with Medicare Locals and refugee specific organisations. These organisations know what is needed by themselves and Medicare Locals can assist in disseminating said resources. Working with interpreters: Again a unified approach with Refugee Organisations along with Medicare Locals. These organisations have the experience so don't reinvent the wheel. Tweaking the wheel is ok!
As these are ever changing issues the employee should facilitate the training on ongoing bases.

Statistic	Value
Total Responses	5

Q4. COORDINATION OF TRANSITION FROM SPECIALISED REFUGEE HEALTH AND SETTLEMENT SERVICES TO MAINSTREAM HEALTH SERVICES. The first survey results indicated that all of the following strategies are important for coordinating the smooth transition of refugees from specialised to mainstream health services. Please now rank these options from 1 to 8, where 1 is the strategy that you believe can most improve coordinated transition between specialised and mainstream services.

#	Answer	1	2	3	4	5	6	7	8	Total Responses
1	Co-location of specialised and mainstream health services	6	1	0	1	1	4	1	8	22
2	Protocols for the transfer of client health information between services	4	7	2	2	5	2	0	0	22
3	Protocols for case management handover between services	2	3	3	6	3	3	1	1	22
4	Formal positions within specialised services which have the responsibility to coordinate client transition to mainstream services	6	2	7	1	1	2	3	0	22
5	Prior agreements (i.e. memoranda of understanding) between specialised and mainstream services incorporating a clear definition of transition roles and responsibilities	0	4	3	4	3	2	4	2	22
6	Ensuring that transfer is only to mainstream services acknowledged as having awareness of health and social needs of refugee populations	4	1	2	2	2	3	3	5	22
7	Facilitated communication such as through inter-agency meetings or case conferencing	0	3	2	3	4	3	3	4	22
8	Involvement of community groups in client education, support and preparation for transition	0	1	3	3	3	3	7	2	22
	Total	22	22	22	22	22	22	22	22	-

Statistic	Co-location of specialised and mainstream health services	Protocols for the transfer of client health information between services	Protocols for case management handover between services	Formal positions within specialised services which have the responsibility to coordinate client transition to mainstream services	Prior agreements (i.e. memoranda of understanding) between specialised and mainstream services incorporating a clear definition of transition roles and responsibilities	Ensuring that transfer is only to mainstream services acknowledged as having awareness of health and social needs of refugee populations	Facilitated communication such as through inter-agency meetings or case conferencing	Involvement of community groups in client education, support and preparation for transition
Min Value	1	1	1	1	2	1	2	2
Max Value	8	6	8	7	8	8	8	8
Mean	5.09	3.14	4.05	3.32	4.73	4.95	5.23	5.50
Variance	8.85	2.98	3.47	4.51	4.11	6.81	4.18	3.21
Standard Deviation	2.97	1.73	1.86	2.12	2.03	2.61	2.05	1.79
Total Responses	22	22	22	22	22	22	22	22

Q5. COORDINATION OF REFUGEE HEALTH SECTOR. In our first survey there was a very high degree of agreement that the introduction of formal, inter-agency, refugee health networks would improve service coordination. Such networks exist in several Australian states and territories. Now, we would like you to consider the relative importance of potential tasks of inter-agency refugee health networks. Please rank 1 to 8 the following activities of inter-agency refugee health networks in order of importance, 1 being the most important.

#	Answer	1	2	3	4	5	6	7	8	Total Responses
1	Developing consistent procedures for the coordination of client health information transfer	6	4	0	0	4	1	1	6	22
2	Establishing referral protocols for successful transition of refugee clients between appropriate services	2	7	2	2	2	3	4	0	22
3	Facilitating provider education in refugee health	4	3	5	3	0	1	4	2	22
4	Advising policy makers on refugee health related issues	3	3	5	6	2	0	2	1	22
5	Generating and supporting service research and development	1	2	2	1	4	5	3	4	22
6	Developing resources, including a refugee health website, for refugee health providers	2	2	2	4	5	2	3	2	22
7	Advocating to increase the profile of refugee health issues	3	0	3	4	2	6	1	3	22
8	Facilitating regular community consultation	1	1	3	2	3	4	4	4	22
	Total	22	22	22	22	22	22	22	22	-

Statistic	Developing consistent procedures for the coordination of client health information transfer	Establishing referral protocols for successful transition of refugee clients between appropriate services	Facilitating provider education in refugee health	Advising policy makers on refugee health related issues	Generating and supporting service research and development	Developing resources, including a refugee health website, for refugee health providers	Advocating to increase the profile of refugee health issues	Facilitating regular community consultation
Min Value	1	1	1	1	1	1	1	1
Max Value	8	7	8	8	8	8	8	8
Mean	4.32	3.91	3.95	3.64	5.36	4.64	4.77	5.41
Variance	8.61	4.66	5.95	3.67	4.43	4.34	4.76	4.35
Standard Deviation	2.93	2.16	2.44	1.92	2.11	2.08	2.18	2.09
Total Responses	22	22	22	22	22	22	22	22

Q6. WHO SHOULD PROVIDE INFRASTRUCTURE SUPPORT FOR FORMAL INTER-AGENCY NETWORKS? In our first survey, respondents agreed that Federal and State health departments should provide infrastructure support for inter-agency networks. There was little consensus about the role of other organizations in delivering infrastructure support. Now we would like you to rank from 1 to 9 according to who should deliver infrastructure support for refugee inter-agency networks. 1 being the most important provider of infrastructure support.

#	Answer	1	2	3	4	5	6	7	8	9	Total Responses
1	Medicare Locals	6	6	1	4	4	0	0	1	0	22
2	Refugee-specific health services	9	4	5	2	1	1	0	0	0	22
3	Settlement services	0	3	2	3	7	2	3	1	1	22
4	Torture and Trauma services	0	0	1	5	2	7	4	3	0	22
5	Local Hospital Networks	0	6	3	3	4	1	2	3	0	22
6	Regional Health Authorities (i.e. Local Area Networks, state health regions)	6	1	6	1	1	5	2	0	0	22
7	The networks should source their own funding from their members	1	1	1	0	0	1	3	1	14	22
8	Community Health Centres	0	1	2	4	2	4	6	3	0	22
9	Ethnic Community Associations	0	0	1	0	1	1	2	10	7	22
	Total	22	22	22	22	22	22	22	22	22	-

Statistic	Medicare Locals	Refugee-specific health services	Settlement services	Torture and Trauma services	Local Hospital Networks	Regional Health Authorities (i.e. Local Area Networks, state health regions)	The networks should source their own funding from their members	Community Health Centres	Ethnic Community Associations
Min Value	1	1	2	3	2	1	1	2	3
Max Value	8	6	9	8	8	7	9	8	9
Mean	2.95	2.32	4.95	5.77	4.41	3.59	7.59	5.64	7.77
Variance	3.57	2.13	3.66	2.18	4.63	4.73	6.06	3.19	2.18
Standard Deviation	1.89	1.46	1.91	1.48	2.15	2.17	2.46	1.79	1.48
Total Responses	22	22	22	22	22	22	22	22	22

Q7. Can you suggest any other important sources of infrastructure support for inter-agency networks not included in the above list?

Text Response
The reality is that some of these organisations would not have the money to support interagency networks. In Victoria our network is supported admirably by the torture and trauma service, but not all FASSTT agencies I think are well-enough equipped to do this. The other issue is autonomy. Our group has an autonomy which we might lose if we had to rely on a community health centre or a regional health authority.
Cloud funding is the only thing I can think of. I am very doubtful that the State LHNs, Local Hospital Networks and state health regions and Medicare Locals would fund inter-agency networks and the others wouldn't have sufficient funding. This is not to say that these bodies would not support participation in these networks.
No
Philanthropic support.
It should be combined effort of Medicare Local, Settlement Community Heath and Refugee specific, Torture and Trauma and Ethnic communities.
Primary Health Care Centres if they are not same as Community Health Centres.
I'm not sure about this question, as clearly they need to be funded by State and Commonwealth, with legitimate use of Medicare Locals to fund this sort of activity or facilitate.

Statistic	Value
Total Responses	7

Q8. BROAD POLICIES. Please now rank the following 6 potential components of a national refugee health policy in terms of their likely impact on improving refugee health and well-being, 1 having the highest impact.

#	Answer	1	2	3	4	5	6	Total Responses
1	Support for a national-level refugee health sector coordination network	4	6	6	0	3	3	22
2	Improved procedures for transferring individual refugee health information from assessment centres to Australian health services	2	2	2	3	6	7	22
3	Specialised refugee health services in each state and territory	9	3	3	5	1	1	22
4	Individual health-focused case management for all refugees from the time of arrival	4	6	3	3	4	2	22
5	Education and training to support a refugee responsive workforce	2	0	3	7	7	3	22
6	Formal consultation with refugee communities in the design of national refugee health programs	1	5	5	4	1	6	22
	Total	22	22	22	22	22	22	-

Statistic	Support for a national-level refugee health sector coordination network	improved procedures for transferring individual refugee health information from assessment centres to Australian health services	Specialised refugee health services in each state and territory	Individual health-focused case management for all refugees from the time of arrival	Education and training to support a refugee responsive workforce	Formal consultation with refugee communities in the design of national refugee health programs
Min Value	1	1	1	1	1	1
Max Value	6	6	6	6	6	6
Mean	3.05	4.36	2.50	3.14	4.18	3.77
Variance	2.90	2.81	2.45	2.79	1.87	2.76
Standard Deviation	1.70	1.68	1.57	1.67	1.37	1.66
Total Responses	22	22	22	22	22	22

Q9. FEDERAL FUNDING REGULATIONS. Please now rank options 1-6 in order of their impact on improving refugee health and well-being, 1 having the highest impact.

#	Answer	1	2	3	4	5	6	Total Responses
1	Federal funding to support refugee health nurse positions	7	3	4	3	1	4	22
2	MBS incentives to increase the use of qualified interpreting services in all healthcare encounters, including private allied health providers, when required	7	8	2	1	3	1	22
3	MBS incentives for dealing with ongoing, complex clinical work related to the care of refugees	4	5	5	4	0	4	22
4	Free to low-cost adult catch-up immunisation for refugees	1	3	6	5	5	2	22
5	Free to low-cost dental services	3	2	3	5	5	4	22
6	Pharmaceutical Benefits Schedule (PBS) subsidy for essential medications for refugees	0	1	2	4	8	7	22
	Total	22	22	22	22	22	22	-

Statistic	Federal funding to support refugee health nurse positions	MBS incentives to increase the use of qualified interpreting services in all healthcare encounters, including private allied health providers, when required	MBS incentives for dealing with ongoing, complex clinical work related to the care of refugees	Free to low-cost adult catch-up immunisation for refugees	Free to low-cost dental services	Pharmaceutical Benefits Schedule (PBS) subsidy for essential medications for refugees
Min Value	1	1	1	1	1	2
Max Value	6	6	6	6	6	6
Mean	3.00	2.45	3.14	3.73	3.86	4.82
Variance	3.52	2.45	2.89	1.83	2.79	1.30
Standard Deviation	1.88	1.57	1.70	1.35	1.67	1.14
Total Responses	22	22	22	22	22	22

Q10. Can you suggest any other changes to regulations i.e. Medicare Benefits Schedule and Pharmaceutical Benefits Schedule that will have a substantial impact on improving refugee health and well-being?

Text Response
Current MBS has capacity to provide no 6 above but the explanations of the item numbers needs fuller clarification. Currently many essential medications are in community pharmacy so they need to be included in the PBS as special use items. Design of PBS is based on the population health profile of the Australian population and there needs to be a special formulary that takes account of special need as in the case of Aboriginal Australians.
Expanding free access to interpreter services for Allied Health Professionals e.g. social workers/psychologists in private practice, physiotherapists and dentists in private practice.
Essential vitamins e.g. Vitamin D should be under Medicare Benefits.
I consider refugee health nurses (i.e. community health nurses) to be a state responsibility. But adequate funding for practice nurses specialising in refugee health (as part of MBS reforms) and the introduction of Refugee Health Nurse Practitioners as a Commonwealth responsibility.

Statistic	Value
Total Responses	4

Q11. Age in years

Text Response
50
66
58
52
53
62
54
55
49
50

Text Response
44
64
55
34
48 years old
55
46
43
46
52

Statistic	Value
Total Responses	20

Q12. Gender

#	Answer		Response	%
1	Male		4	18%
2	Female		18	82%
	Total		22	100%

Statistic	Value
Min Value	1
Max Value	2
Mean	1.82
Variance	0.16
Standard Deviation	0.39
Total Responses	22

Q13. Primary occupation

#	Answer	1	2	3	4	Total Responses
1	Policy maker and policy advisor	4	0	0	0	4
2	Service/program manager	7	1	0	0	8
3	Community leader or member	0	0	0	0	0
4	Clinician (specify)	3	1	0	0	5
	Total	14	2	0	0	-

Clinician (specify)
RN
Nurse
Community Health Worker
General Practitioner

Statistic	Policy maker and policy advisor	Service/program manager	Community leader or member	Clinician (specify)
Min Value	1	1	-	0
Max Value	1	2	-	2
Mean	1.00	1.13	0.00	1.00
Variance	0.00	0.13	0.00	0.50
Standard Deviation	0.00	0.35	0.00	0.71
Total Responses	4	8	-	5

Q14. Primary organisation

Text Response
Doutta Galla Community Health Centre; Refugee Health Fellow VIDS, RMH; Foundation House Refugee Mental Health Clinic
State government
Government health department
Association for Services to Torture and Trauma Survivors (ASeTTS)
Senior Registered Nurse in a suburban GP Practice
Lutheran Community Care
state health department
Hospital
Companion House Medical Service NB: check boxes in last two questions don't work: I'm in the ACT; urban centre
Mater Health Services
Community Health
The Migrant Health Service Adelaide
AMES Settlement
Community Health
Primary Health Care Service
Department of Health and Human Services
Humanitarian Entrant Health Service (WA)
Queensland TB Control Centre
Victorian Foundation for Survivors of Torture

Statistic	Value
Total Responses	19

Q15. Please indicate the length of your experience (in years) in the refugee health sector.

Text Response
Almost 20
8
Provided policy advice for about 15 years or more
1
15 years+
10
Over 5 years
5
10
5 Years
12 years

Text Response
17 years
35
30 years
5 years
12 years in VIC
13 years
20 years
14
8
7 years
8 years specific to refugees. 30 years in health & community services delivery and planning roles.

Statistic	Value
Total Responses	22

Q16. State or Territory

#	Answer	1	2	3	4	5	6	7	8	Total Responses
1	ACT	1	0	0	0	0	0	0	0	1
2	New South Wales	1	0	0	0	0	0	0	0	1
3	Northern Territory	0	0	0	0	0	0	0	0	0
4	Queensland	3	0	0	0	0	0	0	0	3
5	South Australia	5	0	0	0	0	0	0	0	6
6	Tasmania	1	0	0	0	0	0	0	0	1
7	Victoria	2	0	0	0	0	0	0	0	2
8	Western Australia	1	0	0	0	0	0	0	0	2
	Total	14	0	0	0	0	0	0	0	-

Statistic	ACT	New South Wales	Northern Territory	Queensland	South Australia	Tasmania	Victoria	Western Australia
Min Value	1	1	-	1	0	1	1	0
Max Value	1	1	-	1	1	1	1	1
Mean	1.00	1.00	0.00	1.00	0.83	1.00	1.00	0.50
Variance	0.00	0.00	0.00	0.00	0.17	0.00	0.00	0.50
Standard Deviation	0.00	0.00	0.00	0.00	0.41	0.00	0.00	0.71
Total Responses	1	1	-	3	6	1	2	2

Q17. Location

#	Answer	1	2	3	Total Responses
1	Urban	14	0	0	16
2	Regional centre	1	3	0	4
3	Remote regional	0	0	2	2
	Total	15	3	2	-

Statistic	urban	Regional centre	Remote regional
Min Value	0	1	3
Max Value	1	2	3
Mean	0.88	1.75	3.00
Variance	0.12	0.25	0.00
Standard Deviation	0.34	0.50	0.00
Total Responses	16	4	2

APPENDIX 6. REFUGEE FOCUSED HEALTH SERVICE MODELS

State and Territory Refugee Focused Primary Health Care Service Models

Adapted from information provided by the Refugee Health Network of Australia, state and territory networks, and refugee health services and programs around Australia.

State/ territory approximate annual refugee intake	Refugee focused health service models	Workforce	Initial health screening and care	Continuing care	Specialised care	Uptake/ coverage
Australia wide 20,000 +	**Private general practice clinics with an interest in refugee health**, providing generalist, Medicare rebatable services	General Practitioners, practice nurses, allied health professionals	Health assessment, screening, management	Continuing primary health care	Referral for specialist medical care	Variable
Victoria 6,600-7,900	**Fourteen urban community health service refugee health clinics**: Greater Dandenong, Hume, Brimbank, Casey, Wyndham, Maroondah, Maribyrnong, Darebin, Whittlesea, Moreland, North Yarra, Mooney Valley, Melton, Plenty Valley	Refugee Health nurses and community health service staff including general practitioners, nurses, allied health, psychologists, counsellors, mental health workers, bicultural community health workers. (Varies per site)	Health assessment, pathology tests, radiology, immunisation, treatment, medicines	Continuing care provided by community health services or private GP clinics depending on need	Paediatrics, women's health, infectious diseases, TB screening, mental health, vitamin D. Priority access to oral health services. Optometry, audiology, dietetics, antenatal care. (Varies per site).	60 - 100% in some regions
	Four tertiary referral, hospital refugee health clinics: Royal Melbourne Hospital, Royal Children's Hospital, Dandenong Hospital, Geelong Hospital	Specialist doctors, Paediatricians, Refugee Health Fellows, dentists, social workers, refugee health nurse, community development workers, coordinators.	Health assessment, pathology tests, radiology, immunisation, treatment, medicines	Continuing care for complex cases. Referral to community health services and private GPs	TB screening, paediatrics, specialist medical services, Vitamin D, coordination with dental hospital, subsidised medications. (Varies per site).	Referred from primary care services as required
	Refugee focused health services in 7 regional centres, across private and community health services: Geelong, Shepparton, Bendigo, Mildura, La Trobe Valley, Ballarat, Swan Hill	GPs, practice nurses, refugee health nurses.	Health assessment and management	Continuing care provided by community health services or private GP clinics depending on need	Visiting paediatricians and infectious disease physicians. (Varies per site).	Up to 100% in some regions
ACT 150	**Companion House**, Canberra. Refugee focused health screening and primary care clinic, co-located with torture trauma services in the community	GPs, nurses, doctors, paediatric registrar, clinic coordinator, complementary therapist, counsellors, psychologists.	GP led refugee health assessment and primary care service, including health education, immunisation and outreach for first 18 months.	Ongoing care for patients with complex care needs.	Counsellors, children's program and educators. TB assessment, dental health, antenatal, post natal and psychological care on-site.	Nearly 100%

State/ territory approximate annual refugee intake	Refugee focused health service models	Workforce	Initial health screening and care	Continuing care	Specialised care	Uptake/ coverage
NSW 4,000 – 5,500	**Nurse-led refugee health assessment program**, NSW Refugee Health Service. Multiple community health centre sites across metropolitan Sydney	Refugee nurses, nurse manager, program manager, administration	Nurse-led initial health assessment, screening tests and medications. Usually 1-2 visits only.	Referral on to GPs and relevant public hospital clinics	Referral for torture trauma counselling, early childhood, paediatrics, TB screening , public dental clinics	High coverage of newly arrived refugees
	Five refugee primary care clinics at NSW Refugee Health Service and community health centres. Blacktown, Liverpool, Mt Druitt, Auburn, Fairfield.	GPs, refugee health nurses, project workers, bilingual educators, medical director	Initial screening done by nurse-led model above. GP health assessment and investigations as required for referred refugees. 1-2 visits only	No ongoing care for refugees. (Ongoing care for asylum seekers only). Referral and support provided to GPs. Referral to relevant public hospital clinics.	Referral for torture trauma counselling, paediatrics, TB screening, infectious diseases, public dental clinics	Referral as required
	Local Health District with Multiple community health service and private GP sites, Illawarra Primary Care.	GPs, nurses	GP initial health assessment and screening tests. Refugee Health Nurse case manages, provides immunisation and organises referrals as required.	Follow-up provided by GP or specialists.	TB physicians and other specialists	High coverage
	Three tertiary refugee child health clinics. Sydney Children's Hospital, Westmead Children's Hospital, Liverpool Hospital	Paediatricians, nurses, coordinators, administration	Health assessment, pathology, immunisation.	Ongoing care for patients with complex care needs; referral to GPs and refugee health nurses.	Paediatric specialists, TB screening.	Referred as required
	Three regional centres with refugee screening activities: Coffs Harbour, Newcastle, Wagga Wagga. Across private GP clinics, community health centres and hospitals	GPs, refugee health nurses, paediatrician	Variable models that may include initial nurse health assessment and pathology collection then follow-up medical assessment, treatment and Vaccination.	Referral to local GPs; continuing care when local GPs unable to assist	Referred to public dental clinic. TB screening.	High coverage in each region
Qld 1,900	**Refugee health nursing service** across: South Brisbane (Mater Health Services), Zillmere (Child Youth Health), Logan (Community Health), Toowoomba, Townsville, Cairns.	Nurses, administrator	Early nursing assessment service available for refugees and other limited visa number holders. Some services begin immunisation catch up.	Referral to community GPs for ongoing care. Refer to other agencies e.g. QPASTT, TB clinic for specific needs	Referrals to torture and trauma services	Unknown
	Mater Extended Care Refugee Health Service, South Brisbane	GPs, nurses and administrative staff.	Health assessment and primary care for particularly vulnerable groups without access to care in usual health services. Including immunisation and referrals as needed.	Referred back to treating GP if possible for ongoing care.	Visiting Paediatrician from Mater Hospital Referrals to specialist outpatient services at Mater Hospital.	Unknown

State/ territory approximate annual refugee intake	Refugee focused health service models	Workforce	Initial health screening and care	Continuing care	Specialised care	Uptake/ coverage
SA **1600-2000**	**Migrant Health Service**, Adelaide.	GPs, nurses, bicultural community health workers, psychology, social work.	Nursing clinics for initial health screening and pathology tests; subsequent GP medical assessment and care. Nurse-run well women's, immunisation and drop-in clinics. Community health workers provide health education sessions and casework support.	Transition to private GPs within 4 to12 months depending on complexity.	Therapeutic counselling. TB Clinic and Hospital referrals. Priority referral program for limited SA Dental Services. Visiting Optometry, Psychiatrist and Paediatrician. PASTT referrals.	40% covered by Migrant Health Service. 60% initial assessment covered by private GPs
WA **1,500**	**Humanitarian Entrant Health Service**, North Metropolitan Health Service, Perth. Co-located with WA TB Control.	Nursing, Medical director, RMO, Public health trainee	Health screen, mental health screen catch-up immunisation.	Refer to local GPs, community refugee health nurses and tertiary services for complex or long-term follow-up	TB screening and treatment. Infectious diseases	> 90% (adults)
	Paediatric refugee health clinic, Princess Margaret Hospital, Perth	Paediatricians, dietician, social worker, refugee health liaison nurse, community refugee health nurse, GP, Refugee Health and Infectious Diseases doctors	Multidisciplinary health assessment, catch up immunisations.	Continuing care dependent on complexity of issues.	Paediatrics, infectious diseases	> 85% (children)
Tasmania **270**	**Refugee screening clinic,** Clinical Services North Refugee Health, Launceston. Community based.	GP, nurses, administration, social worker, specialist doctors	Refugee health screening, tests.	Referral to private GPs with interest in refugee health for ongoing care	Routine Mantoux testing. Referral to specialist services at Launceston General Hospital if needed.	95%
	Refugee screening clinic, Hobart Hospital	Paediatrician, registrar, RMO, infectious diseases physician, clinical nurse consultant, social worker, refugee migrant liaison officer	Health assessment, pathology tests and TB screening. No catch-up immunisation.	Referral to private GPs with interest in refugee health	Paediatrics	100%
NT **140**	**Refugee health Clinic**, Vanderlin Drive Surgery, Casuarina. Close liaison with the Centre for Disease Control and Melaleuca refugee centre	Physician and public health nurse	Refugee health screening, Well Women's screening, blood tests, immunisation catch up, health promotion and education	12 months bulk billing service provided.	Malaria screening, Mantoux testing, well women's clinic, health promotion and education. Referrals to specialist services as required.	Nearly 100%

Program of Assistance to Survivors of Torture and Trauma (PASTT) Services Models

Adapted from information provided by the Department of Health and Ageing, and the Forum of Australian Services for Survivors of Torture and Trauma

	PASTT service models	Workforce	Initial mental health screening and care	Continuing care	Specialised care	Uptake/ coverage
Program of Assistance to Survivors of Torture and Trauma, 8 agencies covering every state and territory	**ASeTTS** (Association for Services to Torture and Trauma Survivors, WA), **Companion House** (ACT), **Foundation House** (Victorian Foundation for Survivors of Torture), **Melaleuca Refugee Centre** (Torture and Trauma Survivors Service of the Northern Territory), **Phoenix Support Service for Survivors of Torture and Trauma** (Tas), **QPASTT** (Queensland Program of Assistance to Survivors of Torture and Trauma), **STARTTS** (Service for the Treatment and Rehabilitation of Torture and Trauma Survivors, NSW), **STTARS** (Survivors of Torture and Trauma Assistance and Rehabilitation Service, SA)	Counsellor-advocates, psychologists, psychiatrists, general practitioners, nurses, allied health providers, complementary therapists, social workers, community development workers, other.	Psychological assessment, individual psycho-therapeutic interventions, group and family therapy, youth activities, natural therapies and community development.	Continuing mental health counselling and support.	Direct counselling and related support services for refugees who are experiencing psychological or psychosocial difficulties associated with surviving torture and trauma before coming to Australia.	National coverage

Program of Assistance for Survivors of Torture and Trauma. Department of Health and Ageing, Commonwealth of Australia
http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-torture

Forum of Australian Services for Survivors of Torture and Trauma
http://www.fasstt.org.au/home/index.php

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