



victorian refugee
health network

Final Report

Refugee Oral Health
Sector Capacity
Building Project

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Key terms

CALD	Culturally and linguistically diverse
CEH	Centre for Culture, Ethnicity & Health
DH	Victorian Department of Health
DHSV	Dental Health Services Victoria
MCRI	Murdoch Childrens Research Institute
Project	Refugee Oral Health Sector Capacity Building Project
TEP	Targeted Education Program
VFST	Victorian Foundation for Survivors of Torture (Foundation House)
Network	Victorian Refugee Health Network
WCHS	Whitehorse Community Health Service
WRHC	Western Region Health Centre

Executive Summary

This document summarises the outcomes and recommendations of the *Refugee oral health sector capacity building project*, a collaborative project undertaken by the Victorian Refugee Health Network in partnership with Dental Health Services Victoria (DHSV). The project was funded by the Victorian Department of Health, with the aim of supporting Victorian public dental services to work effectively for and with clients of refugee and asylum seeker backgrounds.

The project achieved several outcomes, which are detailed below, and has put forward several recommended courses of action to ensure ongoing oral health sector development in this field.

The first key outcome of the project was the development of new resources that support the Victorian public oral health sector. A Model of Care, two Factsheets on identifying and working with clients of refugee and asylum seeker background, and a central resource repository were developed by the Project Worker with assistance from the Project Advisory Group. The Model of Care and the complementary Factsheets were designed to support services to implement Priority Access and Fee Exemption policies. Further, the proposed Model of Care places a focus on oral health education which assists to minimise late-stage and costly interventions, consistent with developments in relation to Minimal Intervention Dentistry (MID). The Model of Care encourages dental staff to observe and assess clients for clinical and social risks that may impact on the client's oral health care and/or client ability to renegotiate complex appointment systems for follow up care; and, based on this assessment, to set up recall for clients who show high oral health risk (including any identified clinical and social risks). The Model of Care also aims to provide services with guidance to assist in ascertaining when those of refugee background can be assessed as no longer requiring Priority Access. The Model of Care has been positively received by practitioners and services, however needs to be incorporated into policy and guidelines in order to support its implementation.

In addition to the Model of Care and Factsheets, a collection of refugee oral health literature and resources have been collated into a repository on the Victorian Refugee Health Network website www.refugeehealthnetwork.org.au. The project identified a need for additional pictorial, translated and interactive web-based oral health information to be developed, especially on the topic of health education for people of refugee backgrounds. Oral hygiene maintenance, how to navigate the oral health care system, and what to expect before and after a dental treatment are suggested themes.

Another key output was the development, trialling and evaluation of the Refuge Oral Health Targeted Education Program (TEP) – a professional development curriculum for oral health service staff. Evaluation of the TEP showed that staff who participated in the program demonstrated an increase in (a) knowledge, (b) confidence and (c) understanding of practice in working with clients of refugee and asylum seeker backgrounds.

There is a high demand for oral health training and evidence from this project shows that the TEP is not only informative, but also effective in changing perception and practice in oral health service delivery. The TEP should be implemented across Victoria in services responding to high numbers of refugee and asylum seeker clients. While there is a need to make the TEP widely available, this also has resource implications and it is suggested that these could be partially addressed by making some of the learning modules available online.

The project also identified the need for regional or statewide forum(s) to promote the findings of the project and promote good practice across services. It will be important to continue to develop opportunities for dental professionals, researchers, government and refugee related services to come together to share clinical expertise, emerging issues, clinical presentations, case studies and service developments, specific to working with clients of refugee and asylum seeker background.

A lack of formalised pathways between dental, intake, Refugee Health Nurses and settlement services was highlighted during the TEP as an area for further development, and for consideration in other services.

Finally, this project highlighted significant gaps in Australian research in relation to the following areas: the oral health status of new and recently arrived refugee background populations (noting changing demographics now and in the future); evidence regarding approaches to providing better access, appropriate clinical care and addressing oral health literacy for refugee background population (including oral health promotion and education); and in new and emerging approaches such as Minimal Intervention Dentistry (MID).

The recommendations below provide next steps in implementation in the areas of policy, referral pathways, professional and organisation development, resources and research.

Policy

Recommendation 1: The Refugee Oral Health Model of Care be implemented by public oral health services, noting the importance of health education and client pathways.

Recommendation 2: The Refugee Oral Health Model of Care be incorporated into relevant policy, procedures and guidelines by the Department of Health and Dental Health Services Victoria.

Recommendation 3: The Department of Health (DH) and Dental Health Services Victoria (DHSV) clarify fees for Dental Hospital services. Currently fees may be charged for specialist services at the Dental Hospital, although Department of Health policy identifies refugees and asylum seekers as being fee exempt for public dental services.

Referral Pathways & Access

Recommendation 4: There is a need to strengthen referral pathways between settlement services and oral health services, including the need for more detailed referral information to assist with triage (for example, details of whether the person is in pain may determine how their care is prioritised).

Recommendation 5: DH/DHSV consider producing, at least annually, a data report regarding service utilisation by refugees and asylum seekers by location which can be compared to settlement locations to assist in service planning locally, regionally and statewide.

Professional & Organisational Development

Recommendation 6: The Targeted Education Program that was trialled as part of this project be further developed and evaluated in one or more services in 2012-13.

Recommendation 7: The Victorian Refugee Health Network and DHSV consider running a forum in 2013 to disseminate findings of the project and promote research and examples of innovative practice in working with refugee background populations.

Recommendation 8: Foundation House and DHSV consider further development of content for the Refugee Oral Health Targeted Education Program to include shorter seminar sessions and content that may be delivered online or provided as print-based resources.

Recommendation 9: The Australian Dental Association and the Australian Dental and Oral Health Therapists Association consider the inclusion of content regarding refugee oral health in their professional development activities and resources.

Recommendation 10: Dental schools consider the inclusion of refugee oral health curriculum in under-graduate training for all oral health students.

Resources

Recommendation 11: The Victorian Refugee Health Network maintain the Oral Health webpage with active links to DHSV internet, intranet and extranet as a repository for research and resources for practitioners.

Recommendation 12: DHSV and Oral Health services continue to develop multilingual print, DVD/online and pictorial resources focussing on service information, oral health education and follow up care and lodge these on the DHSV website.

Research

Recommendation 13: DHSV, Victorian Refugee Health Network, academics and practitioners explore opportunities to support research in the following areas: the oral health status of new and recently arrived refugee background populations, noting changing demographics now and in the future; evidence regarding approaches to providing better access, appropriate clinical care and addressing oral health literacy for refugee background population; including oral health promotion and education, and approaches such as Minimal Intervention Dentistry.

1. Introduction

The aim of this project was to support Victorian public dental health services to work effectively with clients from refugee and asylum seeker backgrounds. This project was undertaken in partnership with Dental Health Services Victoria and funded by the Victorian Department of Health.

The need for this project was identified in 2010 by the Oral Health Working Group of the Victorian Refugee Health Network comprising primary health care, public oral health services, refugee settlement support services, refugee health nurses, Dental Health Services Victoria and the Victorian Department of Human Services (now Department of Health). The working group identified the particular challenges for refugees and asylum seekers in accessing oral health services in Victoria, the need to build the capacity of oral health services to provide appropriate responses and the need for provisions to increase access to oral health services for this client group.

In 2010, the Department of Health implemented two policies to provide greater access to services for this client group, designed to (a) to identify refugees and asylum seekers as a priority access group and (b) provide a fee exemption at public dental health services across the state (State Government of Victoria 2012a; State Government of Victoria 2012b). As a priority access group, people with refugee and asylum seeker background are entitled to the next available appointment for general and denture care. The Department of Health also funded the *Refugee oral health sector capacity building project* (hereafter the project) to support implementation of these policies.

Stage One of the project included a literature review, resource mapping and needs analysis undertaken with oral health services and Refugee Health Nurses in relation to working with refugee background populations. Stage Two of the project included the development of a refugee oral health Model of Care with two accompanying factsheets, development of an Oral Health webpage and resource library and the development of a curriculum, trial and evaluation of a Targeted Education Program (TEP) for Oral Health services.

2. Literature review

The Refugee Experience

Common experiences for refugees include seeing homes and communities destroyed and spending many years living in refugee camps or in volatile urban situations. Mobility and opportunities for employment are limited, and displaced people often do not have access to health or education services. Many [refugees] have been subjected to rape and torture, witnessed friends and family being murdered or been separated from family when fleeing their homes.

- Commonwealth of Australia, 2011

The refugee experiences outlined in the box above are impossible to forget, and have significant implications for the health and oral health of people from refugee backgrounds. Limited access to food and clean water in cities and in camps, limited access to health care and no access to oral health care, coupled with poor oral health literacy and the impacts of torture and trauma including trauma to the teeth and mouth contribute to levels of dental disease, and the potential fear of oral health services, even after settlement in Australia (Foundation House 1998; Lamb, Whelan et al. 2009).

Newly arrived refugees and asylum seekers often have a high prevalence of dental disease, poor oral health and significant oral health care needs (Davidson et al. 2006; Lamb & Smith 2002). Oral health problems commonly reported among refugees include dental caries, periodontal diseases, malocclusion, orofacial trauma, missing and fractured teeth, and oral cancer (Davidson et al. 2006). Davidson et al (2006) compared the oral health status of refugee groups in Australia to the general

population, to Indigenous Australians and to special needs populations, and reported that the dental health of refugees (particularly untreated decay) compared poorly with the comparison groups. In Australia, over the course of 2005-2006, dental caries were listed amongst the most frequent physical health conditions treated in asylum seekers at Australian detention centres (Bowers & Cheng 2010).

It is important to note that while refugees and asylum seekers are not a homogenous group and individuals have a range of differing health issues and needs, there are some common factors impacting on the oral health of people of refugee backgrounds.

The poor oral health status of refugees is shaped by the interplay of a range of factors (Davidson et al. 2006). Pre-arrival experiences of refugees that negatively impact on oral health status may include exposure to poor diet, inadequate health care, disruption to existing health services, living in poverty for extended periods of time, and dental problems resulting from the physical repercussions of torture and trauma experienced prior to arrival in Australia (Williams & Infirri 1996; Davidson et al. 2006; Davidson et al. 2007). During resettlement, newly arrived refugees and asylum seekers face several competing demands which will often take priority over health issues and seeking health care (Davidson et al. 2007). Unemployment, underemployment and financial constraints also present significant financial barriers to accessing health services in Australia, including oral health services (Murray & Skull 2005; Lamb & Smith 2002). Cultural differences in health belief systems and practices, language barriers, and issues with limited trust of health care providers due to past negative interactions with healthcare providers, can further present barriers for people of refugee and asylum seeker backgrounds in accessing culturally appropriate and responsive services for oral health needs (Murray & Skull 2005; Lamb & Smith 2002).

As oral health problems may have resulted from direct experiences of physical, psychological and other forms of trauma, seeking and undergoing oral health care can in itself be a distressing experience for people of refugee and asylum seeker background (Davidson et al. 2006). The Boston Centre for Refugee Health & Human Rights together with the Boston University School of Dental Medicine, highlight some of the treatment considerations particular to the delivery of oral health services with refugees and asylum seekers. Some of the issues include:

- dental examinations may cause acute emotional reactions and withdrawal
- the typical dental examination may trigger memories of psychological and physical torture to the head, face, mouth or teeth
- a bright overhead light, as used in dental examinations, could potentially bring forth a memory of interrogation or torture
- questions about dental history and oral facial scars may draw forth fears of being reported to government authorities (The Boston Centre for Refugee Health & Human Rights 2011).

It is essential that trauma-sensitive care is delivered by oral health services in order to avoid any scenarios that may potentially retraumatise individuals, and that do not disregard clients' past experiences of trauma (Lamb, Whelan & Michaels 2009).

Given the poor health status of refugees and the implications of poor oral health for overall health and quality of life, working to improve the use and access of refugees to oral health services is essential (Davidson et al. 2007).

3. Project overview



The aims of this project were to strengthen oral health service access and delivery for people of refugee backgrounds including asylum seekers. The project complements other initiatives that have directly engaged refugee background communities in relation to access to services and approaches to health education and care (see for example, Hobbs 2010; Rogers 2011; McCaughey Centre 2012).

A Project Advisory Group (PAG) was established to oversee and direct the Project, which included oral health staff and clinicians, researchers, settlement services, DHSV and DH.

Stage One of the project (December 2010-March 2011) included an online survey completed by oral health services, oral health practitioners and refugee health nurses in areas of significant refugee settlement. A literature review was undertaken and refugee oral health resources were mapped to identify any gaps in supporting materials for oral health staff and clients.

The project planned to analyse usage rates of refugee background communities across Victoria. However, the data did not provide an identifier for refugees, and problems were identified with data collected by country of birth, so further analysis was not possible. The new data set introduced in July 2011 through the Victorian Dental Health funding and Accountability Reform 2011 includes refugee and asylum seeker as a data variables (State Government of Victoria 2011); though this information was not available for use in this project, it will likely be available by 2013.

The results of the online survey of health services, practitioners and refugee health nurses identified some very good practices and policies that exist in Victoria around working with refugee and asylum seeker clients. Challenges articulated by survey respondents included language barriers, cross-cultural communication and lack of understanding of other cultural oral health practices. Oral health staff also expressed a need for further learning and professional development around understanding refugee experiences, working across cultures, and varying health practices.

Survey results were supported by local and international literature, which recognises that communication between oral health staff and clients is a key barrier to good service access and delivery. Furthermore, the literature review demonstrated a need to firstly increase oral health service access for clients of refugee and asylum seeker backgrounds (Lamb and Smith 2002; Sheikh-Mohammed, MacIntyre et al. 2006; Davidson and Skull 2007; Hobbs 2010; Henderson and Kendall 2011; Johnston, Smith et al. 2011; Spike, Smith et al. 2011); and secondly, to respond appropriately to the poor oral and general health (Williams and Infirri 1996; Wolf 1996; Kingsford Smith and Szuster 2000; Davidson, Skull et al. 2006; Lamb, Whelan et al. 2009; Johnston, Smith et al. 2011).

For the details of the methods and results of Stage One of this project please refer to *Project Progress Report: Refugee Oral Health Sector Capacity Building Project 2011* (Rich 2011).

Stage Two of the project (September 2011–June 2012) aimed to implement and evaluate a Targeted Education Program (TEP) to improve the capacity of oral health services to work with clients of refugee and asylum seeker background, and to develop and collate refugee oral health resources on a central space, the Victorian Refugee Health Network website, with links to key DHSV websites. This report focuses on Stage Two of the Project.

Please refer to: *Appendix 1: Project logic framework* for a detailed description of the strategies, activities, outputs and means of verification of both stages of the project.

4. Resource mapping & development

The literature review, needs analysis survey and baseline survey for the TEP provided the basis for the resource mapping. In addition, DHSV made a formal request for literature by email to all dental services managers across Victoria requesting resources. Finally, referrals through word of mouth, including through networks of Project Advisory Group members, oral health services and refugee health staff who participated in this project identified useful materials for inclusion in the review.

All resources have been mapped and collated onto a central space – the Victorian Refugee Health Network website with links to be made to DHSV intranet, extranet and internet. (See Section 5.3: Victorian Refugee Health Network website).

Both the resource mapping and needs analysis identified a gap in oral health promotion resources and tools to assist dental staff to identify and support clients of refugee and asylum seeker background. Oral health staff were concerned with how to identify a client of refugee and asylum seeker background for the purposes of the priority group access and fee exemption policies. To support oral health staff to identify priority access clients, and create some boundaries that do not exclude people from the entitlement (nor burden community health services) a Model of Care and two complementary factsheets informed by the Project Advisory Group (PAG) were developed.

4.1 Model of Care

The PAG developed a refugee oral health Model of Care (see Figure 1: Model of Care) to support staff to implement priority access, provide culturally sensitive assessment and ensure ongoing service access and delivery. The model:

- promotes a greater focus on health education (for example: community oral health education sessions; in the dental chair health education)
- recommends observation and assessment of social and clinical risk factors that impact on oral health care as the basis for continued priority access for individuals from refugee backgrounds. These are factors that impact on oral health which would be ascertained as part of any oral health assessment and treatment (for example: level of anxiety with oral health care; indicators of possible history of torture & trauma and oral health literacy)
- highlights the need for both clerical and clinical staff to work in collaboration with referring agencies to improve service access and delivery with clients (for example to services such as: refugee health nurses; general practitioners; asylum seeker and refugee settlement services).

4.2 Factsheets 1 & 2

Two factsheets were developed to complement the Model of Care and to introduce Victorian policies applicable to people of refugee and asylum seeker background; provide guidance on how to identify people in this client group for data entry and appointment booking; and outline some key considerations for oral health staff working with refugee survivors of torture and trauma.

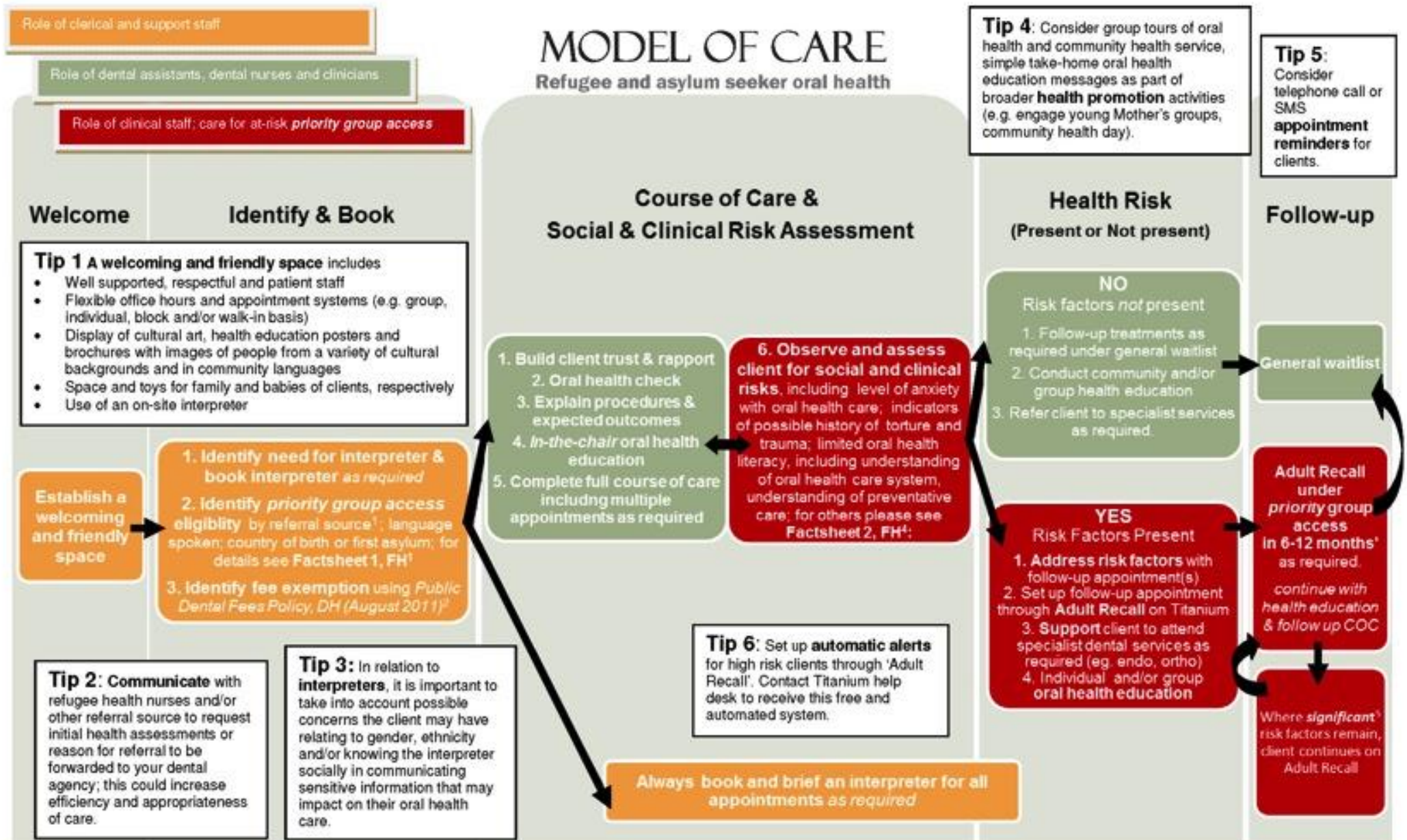
[Oral Health Factsheet 1: *Identifying clients of refugee and asylum seeker background*](#)

(See Appendix 2: Oral Health Factsheet 1)

[Oral Health Factsheet 2: *Working with refugee and asylum seeker clients*](#)

(See Appendix 3: Oral Health Factsheet 2)

Figure 1: Model of Care (visit <http://refugeehealthnetwork.org.au/model-of-care-refugee-and-asylum-seeker-oral-health/>) to download



¹JAMES Settlement Services, Migrant Resource Centre, Red Cross Migration Support Programs/ Foundation House (FH), Refugee & Immigration Legal Centre (RILC), The New Hope Foundation, Asylum Seeker Resource Centre (ASRC), Hotham Mission Asylum Seeker Project, English Language schools, Immigrant & Refugee Health Nurses and clinics & others.

²Victorian Refugee Health Network. (2012). Fact Sheet: Refugee Oral health: Identifying clients from refugee and asylum seeker background. Accessible on the Victorian Refugee Health Network www.refugeehealthnetwork.org.au [to be released June 2012].

³State Government of Victoria, Public dental fees policy, Department of Health, August 2011. See http://www.health.vic.gov.au/dentistry/downloads/fees_policy_for_dental Jul 2011.pdf

⁴Victorian Refugee Health Network. (2012). Fact Sheet: Refugee Oral health: Working with clients from refugee and asylum seeker background. Accessible on the Victorian Refugee Health Network www.refugeehealthnetwork.org.au [to be released June 2012].

⁵**Significant** = relative to the rest of your clients, this person is at high risk of poor oral health due to an interplay of clinical and social risk factors.

4.3 Resource library on the Victorian Refugee Health Network website

The needs analysis identified a lack of resources for oral health staff and clients, including a lack of translated or bilingual information in community language whether pictorial or in diagram, and limited resources to assist with working cross culturally, and more specifically with clients from refugee backgrounds. A number of resources were identified as part of this project, generally falling into the following categories:

- oral health policy, plans & guidelines
- bilingual & translated oral health information
- cultural competency & organisational development
- interactive learning (web-based learning)
- health promotion and community engagement
- dental health and torture & trauma
- links to peak bodies in refugee and asylum seeker oral health.

All of the resources shared by professionals working with refugees and asylum seekers, and others that were identified are all now available on the Victorian Refugee Health Network website (www.refugeehealthnetwork.org.au).

The Network website was identified as an appropriate forum for refugee oral health resources to be linked and shared. The Network brings together health, community and settlement services to build their capacity to provide more accessible and appropriate health care for people of refugee backgrounds.

Links include: Department of Health resources, Dental Health Services Victoria (intranet, extranet and internet); and links to other peak organisations. For a complete list of resources see Appendix 5: Resource Map.

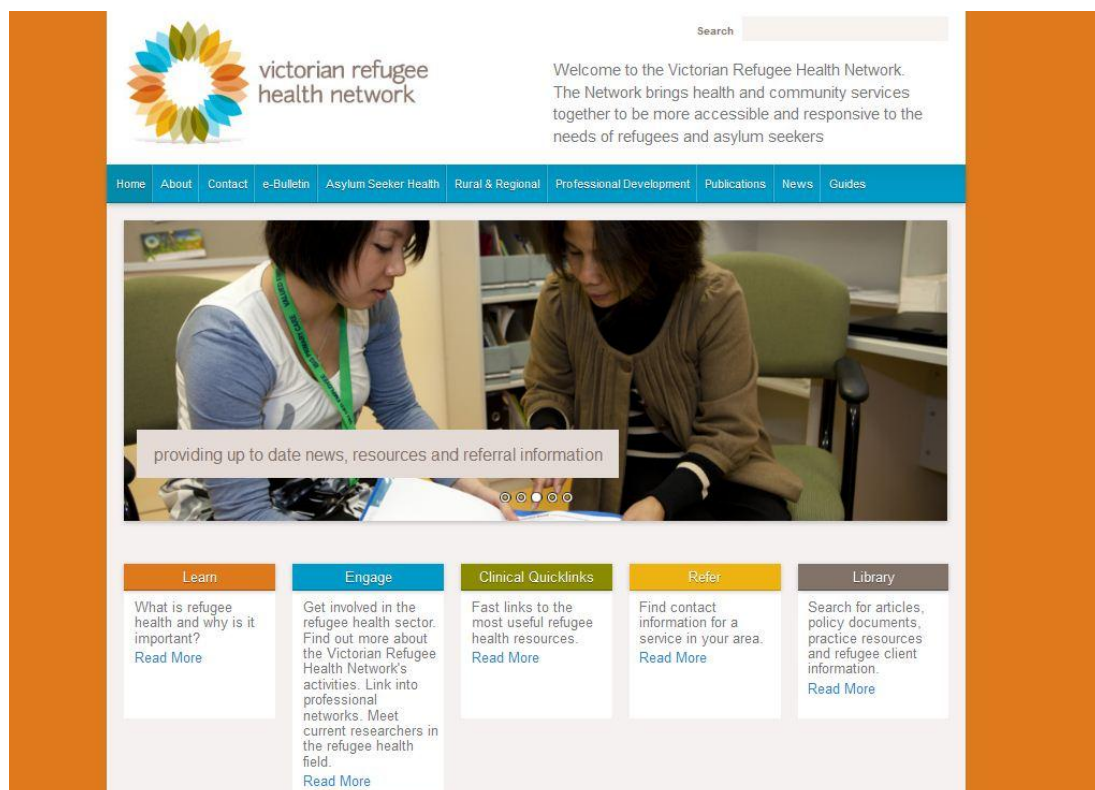


Figure 2: Victorian Refugee Health Network website snapshot www.refugeehealthnetwork.org.au

5. Targeted Education Program

Oral health staff who responded to the survey in the initial needs assessment reported wanting to gain a greater knowledge of refugee experiences, working cross-culturally (including the use of interpreters) and develop an appreciation of cross-cultural oral health practices. Based on the recommendations of the PAG and literature around learning and professional development in a healthcare setting, a refugee oral health Targeted Education Program (TEP) was developed.

Brach and Fraserirector (2000) identify training of clinicians as one of nine key components to enable effective work practices with patients from culturally and linguistically diverse (CALD) communities. Learning and professional development is essential and required to strengthen a workforce who can then deliver appropriate and effective care.

There is evidence that supports interactive learning techniques that run over an extended period of time and in a sequential manner (Groll and Grimshaw 2003). Working in small groups, using case studies, reflecting on individual practices and comparing between current and good practice have all been suggested to be more effective than traditional passive and didactic learning (Groll and Grimshaw 2003; Armson, Kinzie et al. 2007).

5.1 Method

5.1.1 Curriculum

The Refugee Oral Health TEP aimed to support public Oral Health services to provide more effective services for people of refugee backgrounds, including asylum seekers. In consultation with the PAG, a six module (three-day) program including didactic, observational and reflective learning was developed, building on existing core curriculum developed by the Victorian Foundation for Survivors of Torture (VFST). The program was facilitated by an experienced facilitator and counsellor-advocate from the VFST who has experience in working with refugee survivors of torture and trauma. Guest facilitators and presenters with specialist expertise were also involved in training delivery. Each learning module contained interactive components, such as small group work, or reflective exercises that offered an opportunity for participants to apply their formal learning to their day-to-day practice.

The TEP consisted of six facilitated sessions and a self-directed exercise delivered over two months with front of house and clinical staff:

- Understanding Refugee Experiences
- Refugee Health, clinical issues & health education*
- Working cross-culturally*
- In the Chair, Working with the Impact of Torture & Trauma*
- Service Access & Delivery
- Site visit by 3 staff with report back to the group.

*These sessions were for clinical staff only.

For an overview of these modules see Appendix 6.

The delivery of TEP used a 'whole-of-service' approach. The follow-up reflection session will focus on how the lessons learnt in the TEP have been incorporated into service and practice changes.

5.1.2 Participants

The TEP was delivered at an agency level, rather than to groups of professionals from different agencies. The participating agency was recruited by a call for an expression of interest. A letter was circulated to oral health service managers and refugee health nurses asking services to nominate

themselves or other services (See Appendix 7). Interested services were given 30 days to express interest.

Several services expressed interest. A selection criterion was used to select the initial trial site, as follows.

1. Located in an area with significant refugee settlement
2. Able to commit to whole-of-service participation (e.g. management, administration and clinicians)
3. Interested in reflecting on current practice and potential barriers and facilitators to services for refugee background communities as an outcome of participation
4. Able to commit to four to six 3-hour modules (timing to be determined and dependent upon staff roles and any training already completed)
5. Commitment to participation in pre and post evaluation
6. Ability to relieve staff for the duration of the complete program

Western Region Health Centre's Oral Health Program (WRHC) was selected to pilot the TEP based on these criteria. The participants of WRHC were made up of a team of 26 people drawn from clerical services, management and oral health staff (dentists, dental assistants, dental nurses, dental intake), as well as course facilitators Liz Alexander and Sue Casey, and project worker Thuy Nguyen.



WRHC Oral Health Team with Program facilitators, June 2012 Back row L to R: Jenny, Grace, Claire, Liz, Martina, Shalini, Branka, Mohgat, Sharon, Sarojani, Gabriel, Donna, Jo Ann

5.2 Evaluation

The Program was monitored and evaluated with a pre and post program questionnaire. A three month follow up evaluation was attempted in November 2012, however many staff were on leave and so follow up will be pursued in the first quarter of 2013. Feedback was also sought from participants as the program progressed. The purpose of evaluation of the Oral Health Targeted Education Program was twofold.

- Inform and improve the content and delivery as training progressed (*process*)
- Determine the effectiveness of the program (*impact*)

The evaluation included a mix of questions to ascertain changes in knowledge, understanding and confidence in working with refugee background clients and considering service access issues.

Open –ended questions and multiple choice questions using a Likert scaling system were used in the questionnaire. Questions that were asked were similar to ‘please rate your level of knowledge of

current public dental policies'; 'please rate your level of understanding of refugee experiences'; or 'please rate your level of confidence in working across cultures'.

Questions that sought to collect information to inform and improve content and delivery were open-ended, including questions around previous training, what was working well or not working well in the dental clinic in working with refugee and asylum seeker clients, and what participants wanted to achieve through the TEP. Short answers collected through open-ended questions provided valuable qualitative information.

Follow-up evaluation is due for completion in late 2012, 3-months following the program. Results will be collected, analysed and evaluated against the results from the baseline and follow up surveys (See Appendices 8-10 for surveys).

Surveys were planned to be undertaken online. However, the online survey response required multiple reminders by the Service Manager, and some pre-course questionnaires were filled out by hand prior to the first session.

Response rates

Base-line survey: A total of 26 of 28 responses were collected from the baseline survey with a response rate of 93%

Follow up survey: A total of 23 of 28 responses were retrieved from the follow up survey with a response rate of 82%.

Three-month survey: 13** of 24 responses were collected from the three-month follow up survey, indicating a response rate of 54%.

***Some staff had moved to new roles or were on leave at the time of the follow-up survey. Follow up feedback will be pursued in the first quarter of 2013.*

5.3 Qualitative responses from Baseline questionnaire

The qualitative data was manually cleaned, de-identified and coded with a respondent ID. Themes and quotes were manually extracted and analysed. Recurring themes came up for both things that are working well with refugee and asylum seeker clients and things that are challenging.

The four main themes identified through the baseline survey were as follows.

1. Communication
2. Use of interpreters
3. Oral health literacy
4. Working cross-culturally

5.3.1 Communication

In the baseline survey staff reported good communication helps to work well with refugee and asylum seeker clients, including the use of empathy, friendliness and taking the time to explain what will be done. When asked what some challenges working with clients of refugee and asylum seeker background are, oral health and clerical staff reported:

"Communicating", Client Services Team Leader

"Language barriers", Oral Health Assistant

"Language barriers", Oral Health Therapist

"Language barriers", Oral Health Nurse & Client Services

Baseline responses also identified concern around understanding client needs:

“Understanding their [refugee clients’] problems and needs”, Oral Health Therapist

“Understanding some of the fears they may be presented with”, Oral Health Assistant

5.3.2 Use of interpreters

Some staff reported working with interpreters was most helpful when working with clients of refugee and asylum seeker backgrounds. Interestingly, others respondents identified working with interpreters as a key challenge, including interpreter availability (specific dialects), the need for additional appointment time when working with an interpreter and issues around examples of poor quality of interpreting services. Some issues that staff found most challenging in working with asylum seeker and refugee clients were:

“Unhelpful/unprofessional interpreter”, Oral Health Nurse

“Sometimes interpreters do not relay information properly”, Oral Health Therapist

“Dialects, making sure people book the correct one”, Client Services Staff

“To determine correct dialect & some languages very few interpreters available”, Client Services staff

“Time consuming: occasionally run over time if client or interpreter is running late, takes longer to explain treatment and oral hygiene messages”, Oral Health Therapist

5.3.3 Oral health literacy

There was an overall concern regarding oral health literacy. Oral health literacy includes an understanding of the Australian oral healthcare system and knowledge and understanding of oral health concepts and practices. When oral health staff were asked ‘name three issues you find most challenging in working with asylum seeker and refugee clients’, responses included:

“Clients lack of understanding of dental system, i.e. long waiting lists and numerous appointments”, Oral Health Therapist

“They [refugee clients] don’t know enough information about the public dental system here in Victoria”, Oral Health and Therapist Team Leader

“Making the client understand the importance of coming to these visits” Oral Health Team Leader

“Patients not understanding the way it works in Australia and wants to get everything on the same visit” Dentist

“Patients not used to basic oral health instructions”, Oral Health Therapist

“Sometimes they [refugee clients] don’t know their own medical history – difficulty in making some of them understand the importance of oral hygiene and practice oral hygiene properly”, Oral Health Therapist

“They understand that they have priority access, but do not understand that due to a high volume of clients we see here that even having priority access means you may be waiting a month or more for an appointment (if you are not in pain)”, Oral Health Therapist

“They [refugee clients] have high expectations of the level of dental care (crowns, bridges, RCT’s and implants), they do not align with the DHSV guidelines and our operating guidelines. Some clients get agitated when we have to explain for example that we are not able to RCT [root canal treatment] their infected wisdom tooth and that extraction is the best treatment option. They usually reply that in their country that have had many infected teeth RCT’ed.”, Oral Health and Therapist Team Leader

A number of responses identified approaches to working with clients with limited health literacy and in some instances, low levels of literacy.

*“Explain clinical findings using pictures as well as interpreter interpreting information verbally”,
Oral Health and Therapists Team Leader*

5.3.4 Working cross-culturally, understanding of refugee experiences & the impact of torture & trauma

The theme of working across cultures and with people who may have limited oral health literacy and have experienced traumatic events associated with refugee experiences was reflected in some baseline responses, including comments such as:

“Be friendly”, Oral Health Assistant

“Take time to understand and listen”, Oral Health Assistant

“Interaction”, Oral Health Team Leader

“Explain what will be done beforehand”, Oral Health Nurse

“Letting them know they are in control by stopping every time”, Oral Health Nurse

Meanwhile, other staff found it very challenging working across cultures. Some respondents appear to blame clients while other respondents wanted to improve their understanding of and support for refugee and asylum seeker clients, responses included:

“[Refugee clients] not taking appointment times seriously; not showing up; not at all worried the appointment is missed.... They just expect another appointment or interpreter even when [they] are told it costs a lot of money”, Oral Health Assistant (Dental Intake)

“We need to be a little firmer. Don’t do them [refugee clients] any favours by giving in all the time. Dr X got firmer and turned them away and made them make another appointment. I think it should make a difference”, Client Services Staff

“[Clients’] different thinking”, Dentist

“Somewhat limited understanding of the trauma issues facing these clients”, Oral Health Staff

“Lack of understanding on my behalf, of what they have been through and suffered”, Oral Health Therapist

When asked what support staff needed to improve their work with, many respondents wanted to learn more about refugee experiences to be more confident to work with people from different cultures and varying past experiences, including:

“A better understanding of cultures and situations that make it necessary for people to be forced to seek refuge/asylum in a foreign country and the difficulties they face in resettling.” Client Services Staff

“Understanding refugees better”, Oral Health Assistant

“A full understanding of the system as to when they first arrive and what they need to go through before even considering visiting us for dental care. e.g. housing, schooling and so on” Oral Health Team Leader

“Better understanding of issues that refugees face when arriving and how we can improve services”, Oral Health Team Leader

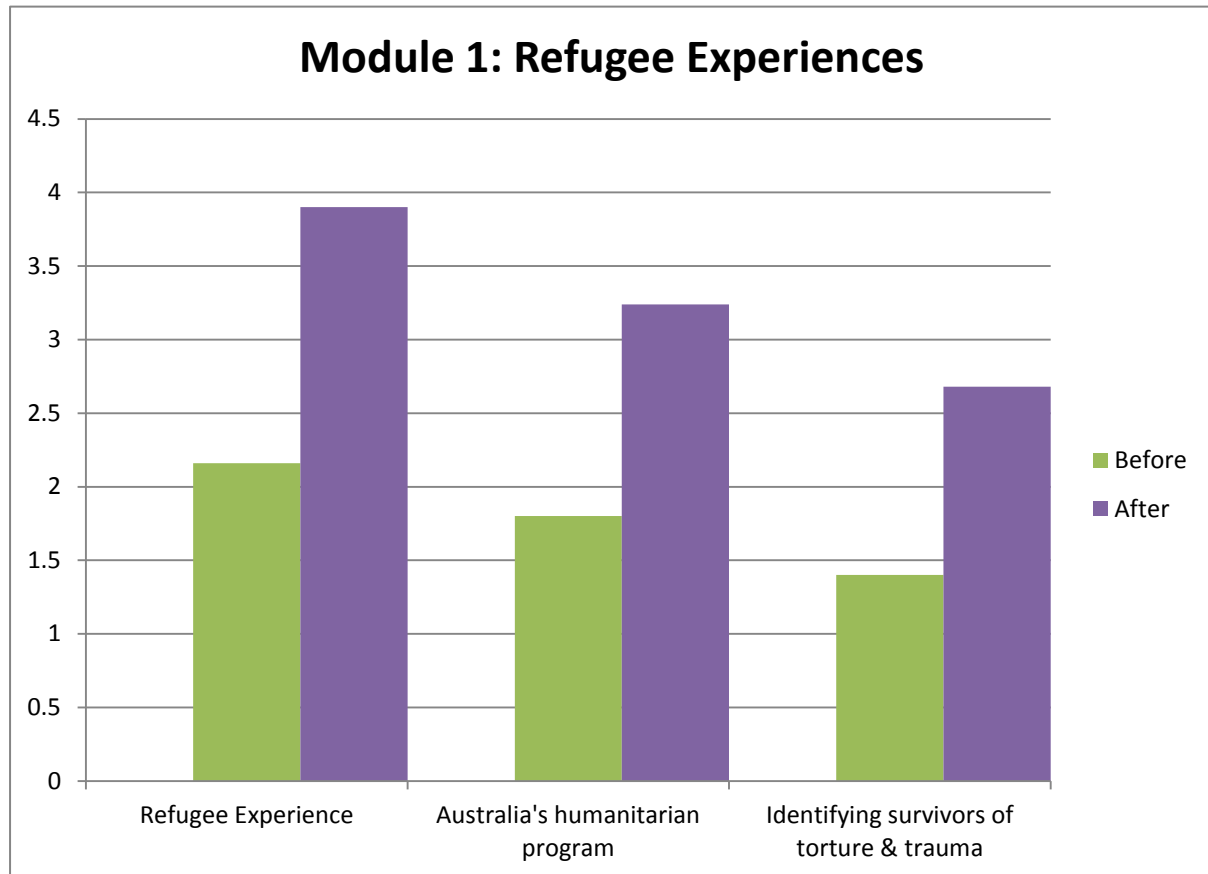
5.4 Quantitative data from pre- and post- questionnaires

Questionnaires were completed using an online survey instrument. Questions relating to knowledge, understanding and confidence used a Likert rating system and the average scores were compared before and after TEP. In the tables on the following pages, the following key should be used:

1= Low, 2= Some, 3 = Reasonable, 4= High, 5= Very High.

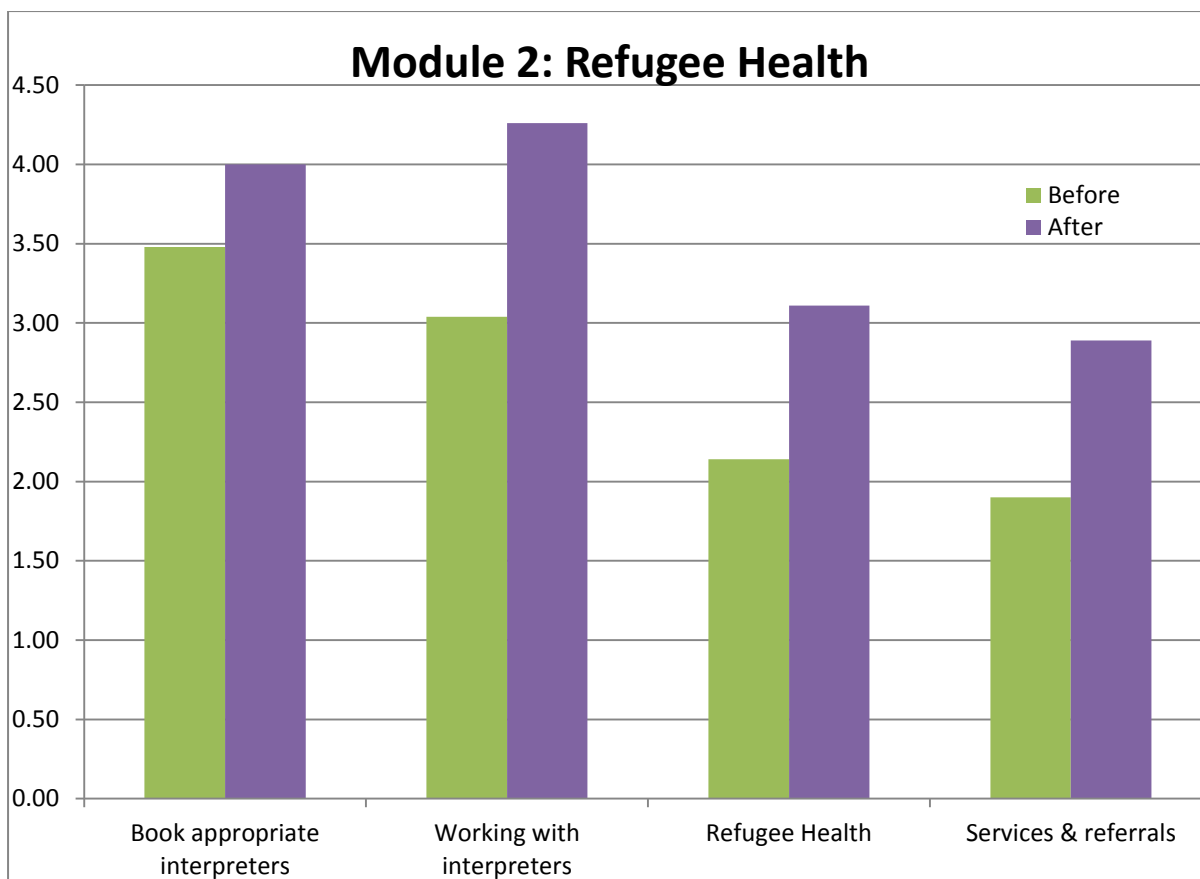
5.4.1 Client perception & overall shift post-TEP

Results showed an increase in participant's knowledge of, understanding of, and confidence in all areas following participation in the Targeted Education Program.



Some reflections:

Participants shifted from an average score of 'some' understanding of refugee experiences to a 'high' level of understanding. An understanding of Australia's humanitarian program by the team was only 'reasonable' following participation in the program, which may reflect more comfort with the meaning of the term 'Australia's humanitarian program'. However, this material was presented when there were many changes to asylum seeker policy, so is probably an appropriate level of understanding for oral health staff, who now have information about where to seek further information when required. The increase in confidence in identifying survivors of torture and trauma moved from 'low' to 'reasonable'. As such recognition is practice based it will be interesting to see if this has increased further with the follow-up evaluation or whether it indicates a need for further professional development in this area.



Some reflections:

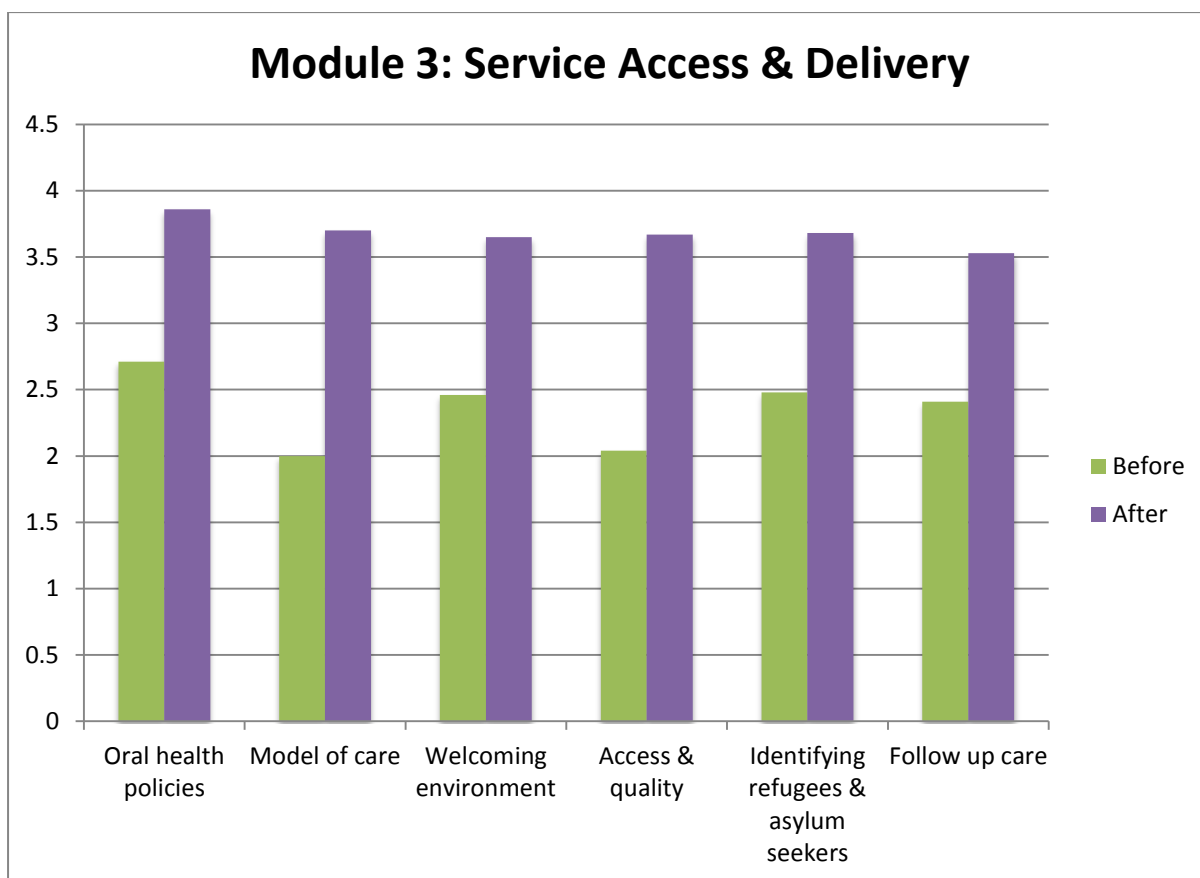
Book appropriate interpreters & working with interpreters: Staff had undertaken specific training in working with interpreters prior to participating in the TEP. Although time-limited, the TWP content focussed on the particular issues in working with refugee background populations, particularly potential sensitivities around gender, ethnicity and confidentiality. However, given the many challenges in the interpreting industry more widely, particularly in relation to supply of appropriately experienced and credentialed interpreters in new arrival languages, there are some issues which can only be partly addressed by practitioners and front of house staff and the services in which they work.

Participants provided feedback on the session on the *Refugee Health* material stating that it would be helpful to have a greater emphasis on oral health implications in this session. This content will be further developed for future sessions. It also highlights a gap in published clinical resources and research in this area, including the oral health status of new arrival populations, approaches to care and health promotion.

In relation to *services and referrals*, there was discussion regarding Western Region Health Centre intake service as a key point of referral for oral health staff, building better links with the Refugee Health Nurse and with local settlement services for new arrival refugees.

There was also a need to improve information given in referrals to dental services from settlement services, by including patient history, preferred language, work/school schedule or psychosocial issues to inform priority for care (emergency appointments) as well as oral health treatment and care.

There is an expectation of improvement in this score once these relationships and referral practices have been further developed which will be interesting to note in the follow-up evaluation.



Some reflections:

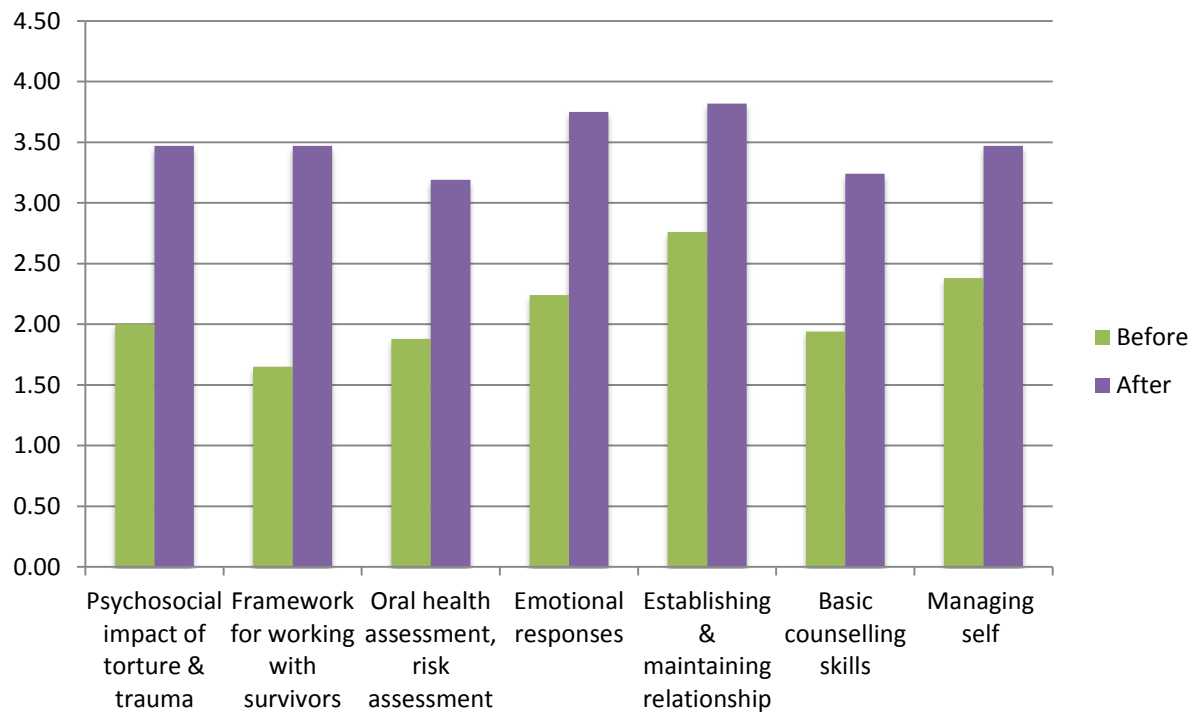
These questions sought responses based on the question ‘What is your level of understanding of the following? Oral health policies, a Model of Care for working with refugees and asylum seekers, elements of a welcoming/accessible environment, factors that may improve access & service quality, assessing the need for priority access and fee exemption and assessing the need for and proactively planning for follow-up care’.

This module had two parts. Firstly a small group of staff visited another oral health service to meet and discuss approaches to working with refugee and asylum seeker clients and observe the workings of the host practice. This group of staff then reported their observations to the rest of the TEP participants.

The entire group then focussed on identifying and then developing a workplan around approaches to addressing perceived barriers to access and optimal service delivery for refugee and asylum seeker clients.

All six areas of knowledge shown in the chart above moved from an average response of ‘some’ understanding (with ‘reasonable’ in the case of oral health policies) to an average response of ‘high’ understanding after completion of the TEP.

Module 4: Working with the Impact of Torture & Trauma

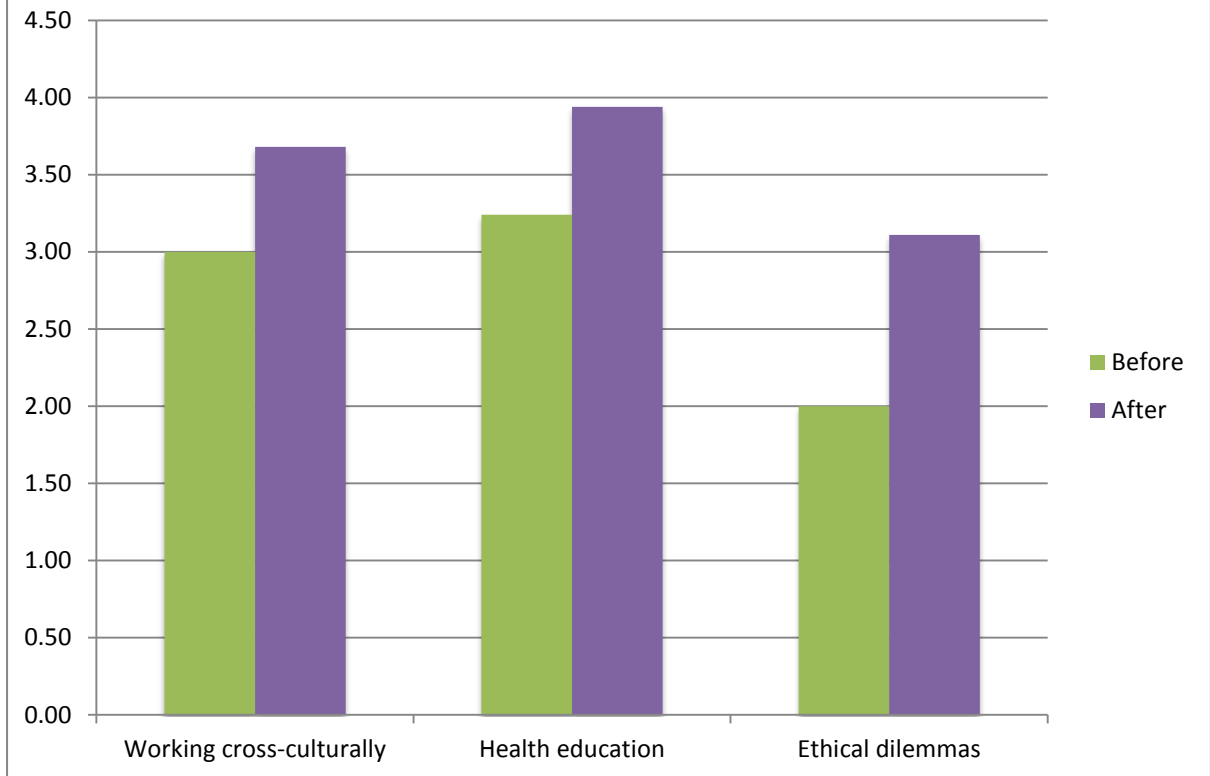


Some reflections:

This module was undertaken by clinical staff only. It included exploration of a framework for recovery for refugee survivors of torture and trauma, case studies and role play.

There were significant changes in the level of knowledge, understanding and confidence in these areas of practice by participants. Prior to the session, typical responses indicated 'some' knowledge, understanding or confidence across 5 of 6 topics. A slightly higher level of confidence was indicated with 'establishing and maintaining relationships' (an average response of a 'reasonable' level of confidence). Post-TEP this had shifted to an average response of 'reasonable', and closer to a 'high' level of 'understanding of your emotional responses to refugee and asylum seekers and implications for practice' and level of confidence in 'establishing and maintaining relationships with traumatised clients'.

Module 5: Working cross-culturally



Some reflections:

This module included a session which explored cross-cultural understandings of oral health and reflective exercises around participants' own cultural understandings and potential biases (for example, media stereotyping). There was also a presentation by the Refugee Health Nurse at Western Region Health Centre on approaches to health education, using the 'Teach Back' method.

Participants had on average a 'reasonable' understanding of working cross-culturally and knowledge of health education prior to participation in the TEP. This increased, almost across the board to a 'high' level of understanding after participation in the TEP. Participants only had on average 'some' understanding of ethical dilemmas in working with this client group prior to the TEP. After participation in the TEP this understanding increased to a 'reasonable' level. In many ways, ethical dilemmas need to be further informed by practice and reflection, and it is suggested that this theme might inform future professional development activities.

5.5 Summary evaluation

The quantitative data presented above shows changes in knowledge, understanding and confidence across areas. Similar themes were demonstrated in the qualitative data.

When asked 'what are you doing differently since the TEP', some responses included:

"Taking more time with refugee clients, more careful with interpreters, thinking more in depth about the issues/concerns they might have when coming into the centre", Client Services Team Leader

"Understanding body language much better and not taking offence to something I may find rude but it may be a form of respect for them (e.g. not looking directly into your eyes when talking)", Oral Health Therapist

"... a wider range of knowledge about what particular individuals may have been through prior to time in Australia. Taking control of interpreters, ensuring patient is introduced and asking more general questions about travelling to appointments, schooling, employment, etc.", Oral Health Therapist

"Nothing different. I am more aware of potential reasons for patient anxiety though", Dental Assistant

"Certainly working with a far greater knowledge and compassion for these people. I admire them greatly that they are able to even contemplate attending the dentist after the traumatic experiences they may have had. Also, the learning we have had in communicating with these people... that we are here to gain their trust with us over a period of time ... we now know that it is time we need to spend with them", Oral Health Team Leader

"Trying to be more flexible with the clients when booking or organising an appointment", Dental Assistant

"Be more friendly to clients, try to engage them in conversation, take their permission before touching them", Oral health Assistant

"Altering documents to have more pictures rather than words and help with explanation. Increased liaison between Refugee Health and Oral Health; ensure intake understand referral processes" Oral Health Management

Finally, when oral health staff were asked what they would like to be doing differently, the most frequent responses were to increase time spent with clients and increase access and use of pictorial or translated information. Staff also identified the need for continued learning and professional development, and initiatives to improve referrals into and out of dental health care.

In summary, participants gained knowledge, understanding, and built confidence in all areas covered in the Targeted Education Program.

5.5.1 Where to from here?

Key changes in practitioner and organisational practice will be informed by the three month follow-up evaluation. Indications of attitudinal changes and a sense that participants are more informed form a very positive basis for service development.

Building relationships with local settlement services was identified as a key action in the workplan completed as part of Module 3: Service Access & Delivery. Strengthened relationships will further support referral pathways, alongside further developing internal referral pathways with the refugee health nurse program and intake service.

There were a number of areas that will be informed by further practice and reflection that may be supported by further professional development opportunities and/or reflections at team meetings. These included identifying survivors of torture and trauma, ethical dilemmas and referrals.

The Targeted Education Program is to be run for a second time in late 2012 with Southern Health oral health services. A second trial will enable further curriculum development. Whilst there are a number of areas that will be further refined, the following areas have been identified as requiring particular attention:

- further development of the 'refugee health' content to make it more relevant to oral health (and further clinical resources informed by research regarding oral health needs of new arrival populations)
- need to strengthen the modules focussing on oral health literacy including oral health education, this session also highlighted the need for more practice based research.

Further recommendations from the entire project can be found on page 2-3 of this report.

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