

# Refugee Health and Wellbeing: A policy and action plan for Queensland 2017– 2020

## *Evaluation Report Summary*

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## Introduction

This report presents the findings of the evaluation of the *Refugee Health and Wellbeing: a policy and action plan for Queensland 2017–2020*. The evaluation aims to assess the impact of the introduction of the *Policy and Action Plan* on the healthcare experience of people from refugee backgrounds settling in Queensland.

The evaluation uses a before and after design (phase I: July to October 2018; phase II: December 2019 to February 2020) and a mixed-method approach which included: (i) a patient experience quantitative survey with recently arrived adults from refugee backgrounds (63 respondents in phase I; 69 in phase II); (ii) a patient experience semi-structured qualitative interview with a cohort of refugee background families (53 were interviewed in phase I; 47 in phase II); and (iii) an online survey with services and stakeholders (69 respondents in phase I; 54 in phase II). Surveys and interviews with people from refugee backgrounds were conducted by trained refugee-background peer researchers. Ethics approval was obtained from the Mater Misericordiae Human Research Ethics Committee.

## Summary of Findings

Overall, the analysis of the data collected indicates that the *Refugee Health and Wellbeing Policy and Action Plan for Queensland 2017–2020* has had a positive contribution to the healthcare experience of people from refugee backgrounds settling in Queensland.

### Patient Experience Survey Findings

Sixty-three (62% males) and 69 (58% males) individuals from refugee backgrounds participated in the patient experience survey in phase I and phase II respectively. The top countries of birth were Syria, Afghanistan and Iraq in phase I, and Iraq, Syria, Congo and Democratic Republic of Congo (DRC) in phase II. Phase II respondents had been in Australia for a significantly shorter period of time compared to Phase I respondents. There were no statistically significant differences in level of education, English language ability, self-reported general health status, and overall prevalence of long term health conditions between phase I and phase II respondents.

Between phase I and phase II there was a statistically significant increase in the proportion of participants who reported a higher number of visits to a GP, had been offered an interpreter when visiting a GP and a dentist, and who had received some of the dental care in a public dental service. There was also an increase in the proportion of participants who had been offered an interpreter when visiting a medical specialist and a hospital emergency department, and a decrease among those who were admitted to hospital, but these differences were not statistically significant. Only one respondent in phase I and none in phase II were offered an interpreter while seeking service from a pharmacy.

Overall, there was a statistically significant decrease in the number of respondents who stated that a health professional had helped them to coordinate their health care. This difference may be explained by the significantly shorter period of time phase II respondents had been in Australia, compared to phase I respondents.

## Patient Experience Qualitative Interviews Findings

Fifty-three families from a variety of ethnic backgrounds were interviewed in phase I and 47 (88.7%) were interviewed in phase II. At phase I, 85% of families lived in the greater Brisbane metropolitan area, while 15% lived in regional towns (Toowoomba and Cairns).

Overall, the majority of respondents had mostly positive experiences visiting healthcare professionals and services. When asked about their experiences visiting general practitioners (GPs), there was a statistically significant increase between phase I and II in the proportion of respondents who reported having a mostly positive experience. Respondents valued the support provided by case workers from the settlement services when navigating the healthcare system, feeling welcomed and respected by healthcare staff, the quality of the care received, having access to dental care and medications, and being assisted by interpreters during the appointments.

Some of the difficulties experienced by respondents included language barriers, lack of availability of interpreters or dissatisfaction with the quality of interpretation during some consultations, limited knowledge of the Australian healthcare system, long wait to get appointments with specialists and public dental clinics or when visiting hospital emergency departments, out of pocket expenses (e.g. medication), lack of continuity of care when visiting specialists in public hospitals, long wait for dental appointments (sometimes while in pain), and lack of affordability of private dentists.

Some respondents reported improvements between phase I and phase II in the quality of communication between health professionals and patients, cultural awareness of health services, use of interpreters, and overall standards of care. Other respondents had not seen improvements and were dissatisfied with the long waiting time for some appointments, limited availability of some health professionals, and increasing out of pocket expenses.

Some respondents living in regional areas identified a number of issues that impacted on their healthcare experiences such as limited availability of GPs, medical specialists and dental care, lack of interpreter services, long wait times for some appointments and elective surgery, limited transport and out of pocket expenses for prescribed medications.

## Services and Stakeholders Experience Survey Findings

Sixty-nine respondents in phase I and 54 in phase II completed the Services and Stakeholders Experience online survey. Compared to phase I, in phase II there was a greater proportion of respondents working in HHS/other hospital and general practice, and a smaller proportion working in Queensland Health, the non-government community sector, and as private providers.

Overall, between phase I and phase II, there was an increase in stakeholders' involvement in RHNQ activities, access to RHNQ resources, partnering with other agencies to improve refugee health outcomes, and development of local health strategies or programs to support people from a refugee background, although these differences were not statistically significant. Overall participation in training was similar in both phases, but healthcare practitioners' participation in refugee health clinical training increased significantly over time. There was also a statistically significant increase in the percentage of respondents whose services had monitored the needs of people from refugee backgrounds.

There was a statistically significant increase in the proportion of services whose clients were always/often not proficient in English, and in the provision of qualified interpreter by those services. There was also an increase in the proportion of stakeholders whose organisation had a language

services or interpreter policy, and in the language diversity of respondents' teams, although these difference were not statistically significant.

More than 80% of services in both phases collected country of birth, preferred language and interpreter requirements. Overall there was a small increase over time in the proportion of services collecting preferred language, interpreter requirements and ethnicity, and a moderate increase in date of arrival, but these changes were not statistically significant.

Regarding referral, there was a statistically significant increase in the percentage of referrals stakeholders' received from Queensland Health/HHS, non-government organisations, other government agencies, settlement services, and refugee community representatives.

Stakeholders identified a number of issues that RHNQ should continue addressing. These included language barriers; health literacy; better funding of programs and financial support for some services; service gaps in regional areas; addressing the health and social needs of asylum seekers; NDIS access; continue enhancing collaboration, communication and information sharing between services; cultural responsiveness and greater cultural diversity of workforce; additional training for healthcare staff; and continuing advocacy for better collection of refugee-related data.

## Conclusions

The following can be concluded in relation to the five key principles which underpin the Policy and Action Plan:

### Collaboration and partnerships

The 'services and stakeholders experience surveys' reported good levels of collaboration and partnerships, with a trend towards increasing involvement of stakeholders' in RHNQ activities, and in partnering with other agencies to improve refugee health outcomes. Over time, there was a significant increase in the percentage of referrals services and stakeholders received from Queensland Health/HHS, other government agencies, non-government organisations, settlement services, and refugee community representatives.

Collaboration and partnerships contribute to coordination of care for people from refugee backgrounds. Although there was a decrease between phase I and II in the percentage of 'patient experience survey' respondents who reported having a healthcare professional coordinating their care, this could be partially explained by the significantly shorter period of time phase II respondents had been in Australia, compared to phase I respondents.

### Cultural responsiveness

Data from the 'patient experience surveys' showed a significant increase over time in the proportion of respondents who had been offered an interpreter when visiting a GP and a dentist, and a trend towards an increase in the provision of interpreters when visiting a medical specialist and a hospital emergency department. 'Patient experience interview' respondents valued being assisted by interpreters during appointments, and some reported an improvement, between phase I and II, in the quality of communication between health professionals and patients, the cultural awareness of health services, and the provision of interpreters. Similarly, services and stakeholders reported a significant increase in the provision of qualified interpreters, and a trend towards an increase in the

proportion of organisations having a language service or interpreter policy, and in the language diversity of their staff.

However, important gaps in interpreting services remain in other healthcare settings such as pharmacies where provision of interpreters is almost non-existing. High levels of distress and dissatisfaction are experienced by clients from refugee backgrounds when qualified interpreters are not made available during healthcare consultations.

## Consumer and community voice

Data from the 'services and stakeholders survey' reported moderate to high levels of engagement of refugee background consumers and communities in service planning, development and/or evaluation. Importantly, there was a significant increase in the percentage of respondents whose services had monitored the needs of people from refugee backgrounds. Some of the strategies included formal and informal consultations with patients and community representatives.

## Continuous improvement

Just over half of stakeholders in both phases had attended a refugee health training or education session in the previous 12 months, with the majority stating they had applied the knowledge and skills learned. Importantly, healthcare practitioners' participation in refugee health clinical training increased significantly between phase I and phase II. There was also a trend towards increasing access and use of RHNQ resources by stakeholders, and development by services of local health strategies or programs to support people from refugee backgrounds.

Data on patients' country of birth, preferred language and interpreter requirements were collected by over 80% of services, while a lower proportion collected data on ethnicity and date of arrival in Australia. The stakeholders survey showed a moderate increase over time in the proportion of services collecting data on date of arrival and a small increase in the collection of preferred language, interpreter requirements, and ethnicity.

## Clinical excellence

Overall, the majority of respondents had mostly positive experiences visiting healthcare professionals and services. When asked about their experiences visiting general practitioners, there was a significant increase over time in the proportion of respondents who reported having a mostly positive experience. Respondents valued the support provided by case workers from the settlement services when navigating the healthcare system, feeling welcomed and respected by healthcare staff, the quality of care received, and having access to dental care and medications. In both phases, general practices and case workers from settlement services were the top sources of advice and guidance in relation to accessing healthcare services in Australia.

## Recommendations

### 1. A Refugee Health and Wellbeing policy & action plan beyond 2020

The good progress made by the *Refugee Health and Wellbeing Policy and Action Plan 2017–2020* in improving the healthcare experience of people from refugee backgrounds needs to be sustained. A new Policy and Action Plan beyond 2020 is needed, and it should build on the processes, strategies and activities that have shown a positive impact as described in this evaluation report.

Although the five principles of the 2017–2020 Policy and Action plan still apply, a new policy should have a stronger focus on the social and environmental determinants of health (including strategies to support the COVID-19 pandemic recovery of refugee communities), addressing the health and social needs of asylum seekers, building capacity of health services in regional areas, strengthening care coordination, continue improving the availability of interpreter services, and reducing barriers for people from refugee backgrounds with a disability to access the National Disability Insurance Scheme (NDIS).

## **2. Greater focus on the social and environmental determinants of refugee health**

Good progress has been made in addressing some of the downstream determinants of refugee health such as referral pathways and access to refugee-informed and culturally-safe primary healthcare services. A stronger preventative approach should include some of the upstream and midstream determinants such as health literacy (including COVID-19 pandemic and mental health literacy) for refugee communities, promoting healthy behaviours, better access to health services in regional areas, and advocacy to address the impact of immigration policies on asylum seekers and refugees.

## **3. Health and social needs of asylum seekers**

Asylum seekers continue to be impacted by harmful immigration policies. Greater efforts are needed to enhance service coordination to address their health and social needs, including adequate referral pathways.

## **4. Building capacity of services in regional areas**

Sustained efforts are required to enhance service access and the capacity of healthcare services in regional areas to provide refugee-informed and culturally-safe care to people from refugee backgrounds. These efforts may include increasing the number of refugee health nurses in regional areas. The refugee health nurse model of care has shown positive outcomes in improving access, quality of care and care coordination in healthcare settings (Au, Anandakumar, Preston, Ray, & Davis, 2019; McBride, Russo, & Block, 2016).

## **5. Care coordination**

Sustained efforts are needed to enhance care coordination for patients from refugee backgrounds using a variety of models (Joshi et al., 2013) including refugee health nurses.

## **6. Language services**

The evaluation has found positive progress on addressing language barriers and providing adequate interpreting services in some healthcare settings. Successful strategies should be maintained and greater efforts made in addressing the limited availability of interpreter services in a number of settings such as pharmacies and private pathology services among others.

## **7. Refugees with disability and the NDIS**

Specific strategies are required to address the substantial barriers people from a refugee background with a disability face while trying to access the NDIS (Federation of Ethnic Communities



Council of Australia, National Ethnic Disability Alliance, Refugee Council of Australia, & Settlement Council of Australia, 2019; Victorian Foundation for Survivors of Torture, 2019).

## 8. Training for healthcare professionals

Continuous practice improvement and clinical excellence require refugee-informed and culturally-safe healthcare sector development. More creative ways of engaging with and delivering training to healthcare professionals and services using a variety of technologies should be considered. This could include developing a depository of resources that can be used across the different Hospital and Health Services (HHS).

The full evaluation report is available at: <http://www.refugeehealthnetworkqld.org.au/publications/>

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