Queensland University of Technology
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EVALUATION OF THE POLICY AND ACTION PLAN:
THE HOW AND WHY OF PEER RESEARCH?
WHAT DOES THE BASELINE COLLECTION TELL US?

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- Services and stakeholders
- Peer researchers
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OUTLINE

- Aims of the evaluation
- Evaluation design and methods
- Peer researcher model
- Baseline data collection key findings

AIM OF THE EVALUATION

To assess the impact of the introduction of the ***Refugee Health and Wellbeing: a Policy and Action Plan for Queensland 2017–2020*** on the healthcare experience of people from refugee backgrounds settling in Queensland

To assess whether or not the policy has enabled five key principles:

- Collaboration and Partnerships
- Cultural responsiveness
- Consumer and community voice
- Continuous improvement
- Clinical excellence

EVALUATION DESIGN AND METHODS

- Pre (2018) and Post (2020)
- Mixed methods
- Trained peer researchers (n=14)
- Greater Brisbane, Toowoomba and Cairns
- Mater Misericordiae Human Research Ethics Committee approval

- Patient Experience Survey: Quantitative survey with a random sample of recently arrived refugee background participants (n=63)
- Patient Experience Qualitative Interview: Semi-structured qualitative interviews with convenience sample of refugee background families (n=53)
- Services and Stakeholders Experience Online Survey (n=69)

LIMITATIONS

- Data collected July–October 2018, one year after Policy officially launched. Difficult to ascertain whether or not some of the findings are the result of actions/strategies already implemented.
- Lower than expected response rate among services and stakeholders survey. Respondents were from a range of areas of practice including HHS/other hospital, general practices, Queensland Health, non-government community sector, and settlement services.
- No asylum seekers participated in surveys/interviews.

PEER RESEARCHER MODEL: ADVANTAGES

- Familiar socio-cultural settings
- Trauma-informed / shared experiences
- Invisibility – blending in
- Rapport with participants / access / trust
- Linguistic and non-verbal cultural competence
- Greater appreciation of complexity of participants' social world
- Cost-effective / interpretation of findings
- Building capacity of communities to research themselves

PEER RESEARCHER MODEL

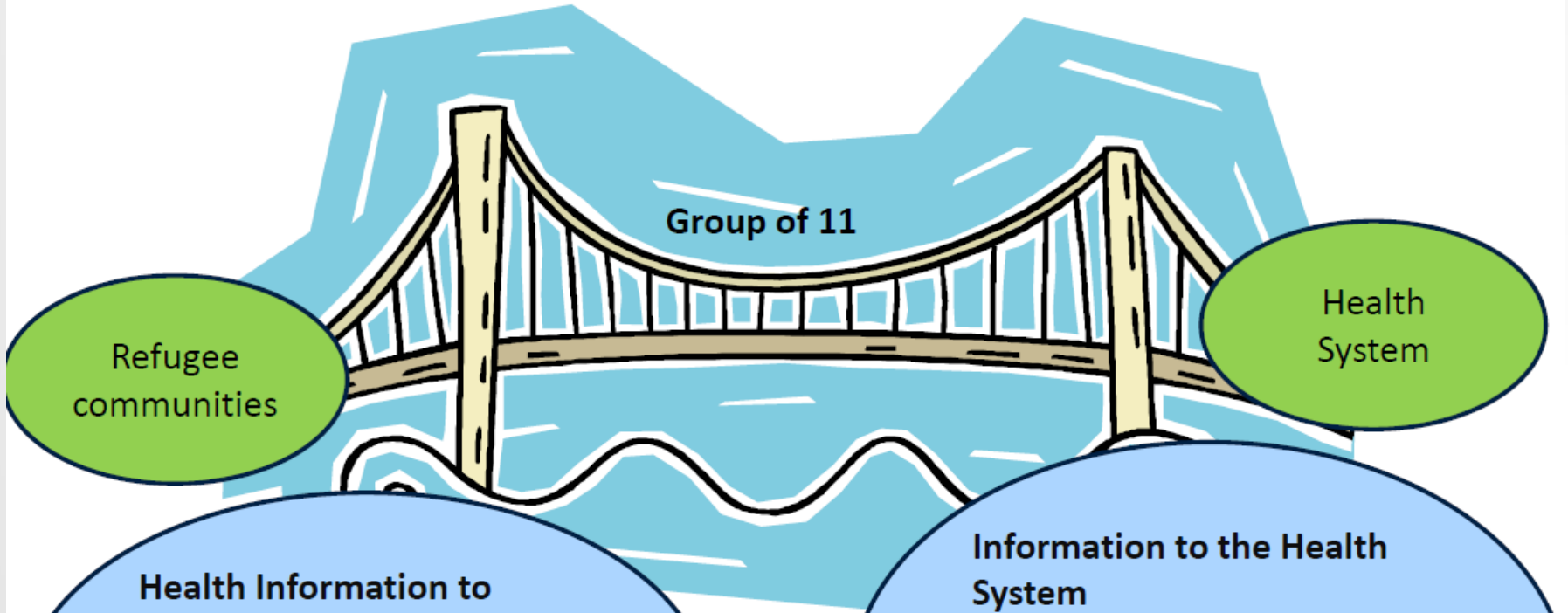
CHALLENGES/DISADVANTAGES

- Personalised relationships
- Multiple roles and no clear boundaries (researcher, community leader, friend, etc.)
- Participants' expectations
- Anonymity and confidentiality
- Sampling bias
- Filtering of findings
- Intra-community politics

STRATEGIES

- Training
- Supportive supervision
- Clarification of roles
- Clear communication with participants
- Reflective practice

The Bridge



Health Information to community

- Forums
- Pass on information informally to community
- Ongoing engagement

Information to the Health System

- Policy input
- Service input
- Clinical education
- Working groups
- University research

Key findings

Patients' experiences

94% Had visited a GP in previous 6 months

86% Had a preferred GP

55% Had visited a Dentist in previous 6 months

44% Had visited a Medical Specialist

GPs and case workers / settlement services were the best and most common sources of advice and guidance re: accessing healthcare

21% Had been in ED

21% Had been admitted to hospital

Patients' experience of health services – comparison between survey respondents and the overall Australian population*

Experience of health services	Respondents from refugee backgrounds (**18+ years – over last 6 months**)	Overall Australian population (**15 years and over – last 12 months**)*
Saw a general practitioner	94%	84.3%
Received a prescription for medication	79.4%	69.7%
Saw a medical specialist	44%	37.4%
Saw a dental professional	55%	50.1%
Visited hospital emergency department	21.3%	14.3%
Admitted to hospital	21.2%	12.5%

*ABS - Patient Experiences in Australia: Summary of Findings, 2017-18. 2018, ABS: Canberra

Difficult experiences

21% couldn't see a dentist when needed (mostly due to cost)

21% couldn't see a medical specialist when needed

27% couldn't get prescribed medication due to cost

Interpreter services offered when needed:

- Pharmacy (2%)
- ED (44%)
- GP (64%)

Language barriers

Lack of formal health check up on arrival

Developing trust due to past experiences

Lack of familiarity with Australian health care system

PATIENTS' EXPERIENCES

"Yes, my family have regular GP that we visit all the time. From the beginning we were referred by XXX to GP and find out he was good GP. Since then we did not think to change other doctor because I visited other doctors whom I did not like the way they approach us. My regular GP knows that I don't speak much English and that I have not been in Australia for long time as such he is very patient with me and takes his time when asking me some questions. He also books interpreter for my family all the time"

"The only issue is that my GP does not use interpreter. For example my first appointment, I visited my GP with my case worker and interpreter on phone will explain but since I have been here for sometimes my GP does not use interpreter anymore. If I don't understand, he writes on paper from Google translation. Possibly will be much better if my GP could provide me an interpreter"

Services and stakeholders experiences

64%

Saw clients not proficient in English in last 12 months

90%

Involved in at least one Refugee Health Network QLD activity

68%

Had partnered with other agencies to improve refugee health outcomes

SERVICES AND STAKEHOLDERS' EXPERIENCES

"We provide acute care services and health screening for newly arrived refugees (around 2-500 patients per year). In addition we provide ongoing care to patients of refugee background with one in seven of our consultations being delivered through interpreters. All of our staff have attended cultural awareness training and we are actively trying to improve health literacy, social cohesion and the availability of CALD health workers in our region…"

"One in seven of our consultations uses an interpreter. We use hundreds of interpreters every week. We often find XXX interpreters to be of poor quality, doing household tasks whilst doing interpreting by phone, or not available as they are such small language groups. We believe that XXX pays the lowest amount, hence the more experienced interpreters move from XXX to other providers. With the lack of compulsory health care training required of interpreters there is hugely variable quality and ability to really rely on interpreters. This needs to be addressed"

Gaps identified by services and stakeholders

- Funding of services/programs
- Language services
- Communication and collaboration
- Cultural responsiveness

- Health information and education
- Prevention
- Older refugees
- Disability

- Gaps in regional areas
- Greater dissemination of policy & action plan
- Workforce needs

- Good levels of collaboration & partnership
- Moderate to good levels of participation in RHNQ
- High proportion refugee background patients have a preferred GP who coordinates their healthcare

- Limited access to interpreters: pharmacies, EDs, private dentists, some GPs.
  Family members commonly used as interpreters.
- Most services collect: COB, preferred language, interpreter requirements

- Moderate to high levels of engagement of refugee background clients in service planning, development and/or evaluation

Services & stakeholders:
Low attendance to training sessions on refugee health and wellbeing

High access to RHNQ resources
These resources are highly valued

Patients report high levels of satisfaction with quality of healthcare services

Patients value:

- Caring/respectful attitude of healthcare staff
- Thoroughness of health assessments
- Clear and useful health advice

Concern – barriers when accessing prescribed medications, dental services and medical especialists


Thank
You!