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| Refugee and asylum seeker health services  Guidelines for the Community Health Program |
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| Acknowledgements  These refugee and asylum seeker health guidelines have been developed in consultation with representatives of the Community Health Program, community health services, other health service providers, key experts in the field and partner program areas in the Department of Health and Human Services.  The Department of Health and Human Services acknowledges the considerable time and effort of those involved in planning and developing the guidelines.  Disclaimer  The Department of Health and Human Services has completed a preliminary revision of the suite of Community Health Program Guidelines. The suite of guidelines includes:   * *Community health integrated guidelines: direction for the community health program* * *Refugee and asylum seeker health services: guidelines for the community health program* * *Child health services: guidelines for the community health program*   + *Care for people with chronic conditions: guidelines for the community health program*   Further revision and updates will be made as actions under the Victorian Auditor General’s Office audit of the Community Health Program are progressively implemented. |
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# Introduction

Australia has a long history of settling refugees from countries affected by war and civil strife, with the majority residing in Victoria and NSW (Department of Immigration and Citizenship 2011).

Most people offered permanent settlement ultimately settle very successfully in Australia. However, on their arrival, refugees and asylum seekers may have:

* relatively poor health and complex health needs
* had limited or interrupted access to healthcare, particularly illness prevention and health promotion
  + additional needs around access and care, due to language and cultural issues and stresses associated with resettlement, asylum and refugee experiences. This includes experiences of torture and trauma (Russell et al. 2013).

Addressing health issues at an early stage can help to promote health and wellbeing and optimise the chances of successful resettlement.

Health and access to healthcare are also basic human rights.

# Purpose of the guidelines

These guidelines are for all services delivered through the Community Health Program to meet the needs of people from refugee and asylum seeker backgrounds. This term refers to those people who have arrived on humanitarian visas, people seeking asylum and those who come from a refugee background who arrive on another visa type, including family migration and skilled migration (Department of Health 2014).

The guidelines will be particularly useful for:

* helping staff understand the specific health needs of refugees and asylum seekers
* enhancing the community health sectors understanding of services available to support refugees and asylum seekers
* guiding program managers to develop, plan and monitor services for refugees and asylum seekers
  + assisting staff who are funded through the Refugee Health Program (such as refugee health nurses and allied health personnel).

Given the integrated nature of services, the guidelines will also be potentially relevant for other programs delivered through community health services.

The guidelines:

* support and promote services to meet the needs of refugees and asylum seekers in local populations
* define the contribution of community health in providing support and care to refugees and asylum seekers
* ensure a consistent approach to refugees’ and asylum seekers’ healthcare across the Community Health Program
  + detail how community health services work with other specialist services for refugees and asylum seekers and the wider health and human service system.

The guidelines recognise the differences between community health services in Victoria, including:

* services provided across areas with high and low levels of refugee and asylum seeker settlement
* existing responses to meeting the health needs of refugees and asylum seekers including levels of expertise and capacity
* the size and characteristics of local refugee background populations
* the way services link with other refugee and asylum seeker services in the region
  + local service infrastructure to support refugees and asylum seekers.

Each organisation should aim to provide a flexible response, and a mix and level of service delivery that aligns with local priorities and partnerships.

These refugee and asylum seeker guidelines complement the overarching *Community Health Integrated Program guidelines*. The documents are designed to be used in conjunction with each other, and with other key documents outlining the range of responsibilities and requirements of funded organisations.

The *Community Health Integrated Program guidelines* aim to improve consistency across the state in planning, program design and service delivery, and to clarify expectations for coordinated service provision.

## About community health services

Community health services deliver a range of primary health and community-based support services that meet local needs, including services for refugees and asylum seekers. They are a major platform for the delivery of state-funded, population-focused and community-based health and human services in Victoria.

The Community Health Program provides over one million hours of allied health, counselling and nursing services each year. The program focuses on providing person-centred and well-coordinated care, using flexible service models that are grounded in current evidence. Refugees and asylum seekers are one of six priority access groups for the Community Health Program.

In areas of high refugee and asylum seeker settlement, the Community Health Program provides additional funding through the Refugee Health Program, which provides nursing, counselling and other allied health services to support the coordinated care for refugees and asylum seekers.

## Alignment with key strategic frameworks

The Community Health Program makes an important contribution to delivering on key strategic frameworks and policies of the department through its delivery of services that are flexible, locally responsive, person centred and integrated. In particular, the Community Health Program contributes to meeting the aspirations of Health 2040 (link) – better health, better access and better care. It does this by:

* integrating primary health and social care for disadvantaged Victorians, many of whom have complex needs
* improving access to primary care services, including offering services to disadvantaged or isolated people and communities
* providing support in managing chronic disease, and enabling some lower acuity care to be moved into community settings

In addition, the Community Health Program contributes to the delivery of the [Victorian Public Health and Wellbeing Plan](https://www2.health.vic.gov.au/about/health-strategies/public-health-wellbeing-plan) <https://www2.health.vic.gov.au/about/health-strategies/public-health-wellbeing-plan>. The Community Health Program supports the strategic directions of the plan by providing primary and preventative health services, including earlier and more connected support that is tailored to the health and wellbeing needs of local communities



# Aim and objectives of refugee and asylum seeker health services

The aim of the Community Health Program is to provide a coordinated, evidence-based approach to healthcare delivery that improves health and wellbeing outcomes.

The specific objectives of the Community Health Program in relation to refugee and asylum seekers are as follows.

## Service delivery

* Provide direct services that address physical, social and mental health needs.
* Support comprehensive assessment and intervention as soon as practical after arrival.
* Improve the capacity of refugees and asylum seekers to understand and access the healthcare and human services systems and to manage their own health and make informed decisions about their own healthcare.

## Client care

* Provide care that is culturally responsive, accessible and sensitive to needs that may arise out of the refugee, asylum seeker and settlement experiences.

## System support

* Support specialist case management, settlement and asylum seeker services to strengthen refugees’ and asylum seekers’ access to health services.
* Support coordination and continuity of care between providers.
* Support refugees and asylum seekers in their interactions with other services, and encourage policies and practices that promote health and wellbeing.
* Contribute to a coordinated, collaborative approach across the service system.

## Scope of these guidelines

These guidelines are not a detailed guide to clinical practice. There are a range of existing resources providing step-by-step guidance to individual service providers engaged in support and care of refugees and asylum seekers.

Websites links to these resources are listed in ‘Appendix 2: Web resources’. These guidelines are intended to:

* provide background information for community health services regarding refugees and asylum seekers, including settlement trends and entitlements
* outline the principles that underpin good practice
* identify other providers involved in supporting refugees and asylum seekers and provide guidance for achieving coordinated and integrated care
* define the role of services provided through the Community Health Program in responding to refugees and asylum seekers.
  + outline government expectations of services receiving Community Health Program funding.

These guidelines also include two checklists to support community health services planning and service delivery to ensure that systems, policies and practices are in place to support good practice, and to support development of coordinating mechanisms across the service system.

The guidelines focus on services for individual refugees and asylum seekers and their families.

Community health services should consider refugees and asylum seekers in population-level health promotion planning that includes activities undertaken with organisations, communities and systems outside the healthcare system to build healthy environments.

This is important because evidence shows that refugees’ and asylum seekers’ health is not only affected by their pre-arrival experience, but also by factors they are exposed to after arrival, such as food insecurity and racial intolerance (Gee et al. 2006; Fuller-Thomson et al. 2011; Jatrana et al. 2013; Porter and Haslam 2005).

The policy context for population health promotion planning is outlined in key policies and frameworks that guide illness prevention and health promotion in the Victorian community.



# Target population

People from refugee backgrounds may have entered Australia as:

* humanitarian program entrants, who are assessed and selected overseas and granted permanent protection. This also includes people who enter with a valid entry visa by plane who subsequently successfully apply for protection under the terms of the international refugee convention, and people who enter without a valid visa (typically by boat) who are granted protection, which may be temporary
* asylum seekers who arrive by boat or plane with or without a valid visa. These people subsequently apply for asylum under the terms of the international refugee convention. Asylum seekers living in the community may be in community detention, on a bridging visa or temporary protection visa.
  + family migration program or skilled/business migration program entrants.

The numbers, countries of origin and backgrounds of new arrivals vary in response to changing international circumstances and Commonwealth Government refugee and asylum seeker policy.

However, government data shows that:

* since the 1980s, between 10,000 and 15,000 humanitarian program entrants have been accepted each year, and almost a third have settled in Victoria
* the number of asylum seekers arriving by boat has increased markedly in recent years, with 9,357 people who arrived by boat residing in Victoria at 30 September 2014
* some of Australia’s annual intake of family and skilled migrants comprising 60,185 and 128,973 entrants respectively (Department of Immigration and Border Protection 2014) in 2012–13 come from the same countries from which Australia settles or has settled humanitarian program entrants. Some of these people have had experiences similar to humanitarian program entrants. For example, in the year 2000 it was estimated that around one in eight family stream migrants were from refugee backgrounds (NSW Health 1999)
  + for the past five years, the top-four source countries for humanitarian program entrants settling in Victoria are Burma, Afghanistan, Iraq and Iran. The main places of birth among asylum seekers arriving by plane are Pakistan, Iran, Egypt and China. The main places of birth for asylum seekers arriving by boat are Iran, Sri Lanka, Afghanistan and Pakistan
* some entrants are highly educated and experienced in their trade or profession. Others may have had limited or disrupted access to education and employment in countries of origin and asylum
* refugees and asylum seekers settle across Victoria, with around 15 per cent of humanitarian entrants settling in rural and regional areas
  + the main local government areas in which entrants currently settle are Greater Dandenong, Hume, Maroondah, Brimbank, Greater Geelong, Casey, Wyndham, Maribyrnong, Whittlesea, Mildura and Greater Shepparton.

## Health issues of the target population

### On-arrival health issues

New arrivals may be in relatively poor physical and mental health because of experiences of war, civil unrest and extended periods in refugee camps or countries of asylum.

Many people will have been exposed to traumatic experiences, including torture. Refugees and asylum seekers may have had limited access to healthcare, and come from or through countries that struggle to meet basic healthcare needs. They may also have been ineligible for care in countries of asylum.

Some of the health and social issues that refugees and asylum seekers face are beyond the remit of the Community Health Program. However, community health services need to be aware of these issues when providing care and referral, and work in partnership with other services.

Health issues that may be of particular concern to refugees and asylum seekers include:

* mental and emotional health
* infectious and vaccine-preventable disease
* chronic disease
* oral health
* vision and hearing
* alcohol and drug use
* somatic manifestations of pain
* maternal and child health
* sexual and reproductive health
* diet and nutrition issues
* vitamin D deficiency
* social isolation
* disability and developmental concerns (Russell et al. 2013; Victorian Foundation for Survivors of Torture 2012).

### Post-arrival factors influencing health

Refugees and asylum seekers face a range of disadvantages on arrival resulting from the interplay of language and cultural issues, the disruption associated with the refugee and resettlement experiences and adverse conditions in the community.

These factors include:

* barriers to participation in employment and education
* limited connections with family and community
* stresses associated with adjusting to a new culture and country
* housing and financial insecurity
* social isolation and barriers associated with limited English
  + racism and social stigma (Victorian Foundation for Survivors of Torture 2012).

Asylum seekers face additional stresses including:

* prolonged uncertainty about their future in Australia
* limited access to basic resources required for health, such as housing and income
* mental health implications of detention experiences, particularly if detention is prolonged
* varying access to Medicare and potential loss of direct access to Medicare if their bridging visa expires, as a result of administrative processing delays
* lack of options for reuniting with or sponsoring family members to Australia (Victorian Foundation for Survivors of Torture 2012).

### Groups with particular needs

Groups that may have particular needs include:

* children and young people, including unaccompanied minors
* women, especially those lacking family or community support
* pregnant women
* people with existing health conditions or disabilities
* older people
* people who are lesbian, gay, bisexual, transgender or intersex (LGBTI)
* individuals on visas limiting their period of protection and access to basic resources, such as work rights, Medicare, family reunion and so on.

### Access and client-care issues

Refugees and asylum seekers face barriers to access including:

* language barriers – 90 per cent of new entrants have no or very limited English (Department of Immigration and Border Protection 2014; Department of Health 2014)
* experiences of trauma and torture that may have ongoing impacts on access to care and participation in treatment, especially invasive treatment (such as dental care) or treatment of mental health and psychosocial issues
* limited access to transport and other geographical barriers in accessing healthcare, particularly in rural and regional areas and for people with low or no income
* varying access to Medicare
* the competing demands of settlement, such as attending English language classes, obtaining work or managing family concerns
* new arrivals may lack familiarity with Australian healthcare systems and have difficulty accessing complex service pathways and appointment systems. They may also lack understanding of some health concepts such as health promotion and disease prevention
* cultural differences and beliefs may impinge on some aspects of healthcare (Victorian Foundation for Survivors of Torture 2012).

## Policies and entitlements

### Commonwealth Government

The Commonwealth Government is responsible for immigration policy.

The entitlements of individual refugees and asylum seekers are determined by the category of their visa and the time of arrival.

Visa categories, policies and entitlements change frequently. Visit the [Victorian Refugee Health Network](http://refugeehealthguide.org.au/asylum-seekers/#Mode_of_arrival_and_entitlements) <http://refugeehealthguide.org.au/asylum-seekers> or the Department of Health and Human Services’ ‘[Refugee and asylum seeker health and wellbeing’](http://www.health.vic.gov.au/diversity/refugee.htm) page <https://www2.health.vic.gov.au/about/populations/refugee-asylum-seeker-health> for more information.

Entitlements may also vary when a person moves from one visa to another. However, in broad terms:

* permanent humanitarian program entrants have the same rights and entitlements as all permanent residents of Australia. They can apply to sponsor family members and are offered support to settle in Australia
* depending on their visa category and time of arrival, asylum seekers may face restrictions in key areas including their right to work, to access income support, Medicare eligibility, case management support and other entitlements. They are also currently ineligible to sponsor family members to Australia or to hold a health care card as they are not permanent residents
* family and business stream migrants are permitted to work, but may face restrictions on access to Medicare and income support payments for a certain period after arrival.

### Victorian Government

Both humanitarian and mainstream migration program entrants are eligible for the same services as other Victorians. There is also a network of specialist services to support refugees and asylum seekers.

In addition, the Victorian Government has adopted several special access initiatives for refugees and asylum seekers, shown in Table 1.

Table 1: Victoria’s special access initiatives for refugees and asylum seekers

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| Issue | Initiative |
| Priority of access | Refugees and asylum seekers receive priority access for dental and all other community health services (such as nursing, allied health, counselling, child health services, chronic disease programs). Refugees and asylum seekers have high clinical needs and/or disadvantage and require timely assessment and access to services. For more, see the Community Health Program’s [Demand management framework](https://www2.health.vic.gov.au/about/publications/policiesandguidelines/towards-a-demand-management-framework-for-community-health-services) < https://www2.health.vic.gov.au/about/publications/policiesandguidelines/towards-a-demand-management-framework-for-community-health-services>. |
| Fee waivers | In addition to priority access, refugees and asylum seekers receive a full fee waiver for both general and specialist dental services. Fee waiver policies for Home and Community Care Program for Younger People and Primary Health Programs apply as normal. Visit the Department of Health and Human Services’ [‘Dental health’ page](https://www2.health.vic.gov.au/primary-and-community-health/dental-health) <https://www2.health.vic.gov.au/primary-and-community-health/dental-health> for more information. |
| Free access for hospital services | For asylum seekers without Medicare cards, government policy indicates that services in Victorian hospitals are provided for free, see policy for detail. Visit the Department of Health and Human Services’ [‘Refugee and asylum seeker health and wellbeing’ page](https://www2.health.vic.gov.au/about/populations/refugee-asylum-seeker-health) <https://www2.health.vic.gov.au/about/populations/refugee-asylum-seeker-health> for more information. |
| Free access to ambulance services in emergency situations | Asylum seekers currently have free access to ambulance services for emergency transport, if they are not in the Community Detention Program or other Commonwealth Department of Immigration and Border Protection funded programs and otherwise have no capacity to pay. Visit the Department of Health and Human Services’ ‘[Ambulance charges’ page](https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/ambulance-and-nept/ambulance-payment/changes-to-charging) <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/ambulance-and-nept/ambulance-payment/changes-to-charging> for more information, and to download the Ambulance payment guidelines. |
| Catch-up immunisation program | A refugee and asylum seeker catch-up immunisation program is funded to ensure older children, adolescents and adults have free access to specified vaccines. Visit the Department of Health and Human Services’ ‘[Immunisation’ page](file:///C:\Users\andrewmacrae\MEGA\jobs15\190305_deb_formatting\01\Immunisation'%20page) <https://www2.health.vic.gov.au/public-health/immunisation> further information on eligibility. |
| Oral health resources | The Victorian Refugee Health Network has resources for identifying clients who are refugees and asylum seekers – both those who need an initial assessment and course of care, and those who need continued priority support due to continued clinical and social risk. Visit [the Victorian refugee health network website](http://refugeehealthnetwork.org.au/search/oral+health/) <http://refugeehealthnetwork.org.au/search/oral+health/> further information, and to download the resources. |
| Special access for asylum seekers to other Victorian Government programs | Special access for asylum seekers includes:   * [public transport concessions](https://www.ptv.vic.gov.au/tickets/myki/concessions-and-free-travel/) <https://www.ptv.vic.gov.au/tickets/myki/concessions-and-free-travel/> * [disability aids and equipment](https://services.dhhs.vic.gov.au/eligibility-and-applications) <https://services.dhhs.vic.gov.au/eligibility-and-applications> * [kindergarten fee subsidy](https://www.education.vic.gov.au/parents/child-care-kindergarten/Pages/how-much-kindergarten-cost.aspx) <https://www.education.vic.gov.au/parents/child-care-kindergarten/Pages/how-much-kindergarten-cost.aspx> * [housing and other homelessness assistance](http://www.housing.vic.gov.au/financial-help-private-renters) <http://www.housing.vic.gov.au/financial-help-private-renters>. Refugees, as permanent residents, already have access to these services. |
| Guide to asylum seeker access to health and community services | Asylum seekers have special access arrangements for some health and community services, as outlined in these guidelines. Visit the Department of health and Human Services’ ‘[Refugee Health Program’ page](https://www2.health.vic.gov.au/primary-and-community-health/community-health/population-groups/refugee-health-program) <https://www2.health.vic.gov.au/primary-and-community-health/community-health/population-groups/refugee-health-program> for further information.  Also visit the Victorian refugee health network [Clinical Quicklinks page](http://refugeehealthnetwork.org.au/clinical-quicklinks/) <http://refugeehealthnetwork.org.au/clinical-quicklinks/>. |
| Guidelines for health services in community detention | See the [Guidelines for Victorian public health services on community detention](https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Guidelines%20for%20Victorian%20Public%20Health%20Services%20on%20Community%20Detention) <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Guidelines%20for%20Victorian%20Public%20Health%20Services%20on%20Community%20Detention> for more information, including reimbursement arrangements. |



# Demand management

Demand for a service is reflected in the number of people seeking a service, and the amount and type of services they require. Demand is influenced by a range of factors including people’s preferences, the needs of the community and population growth. Demand for a service may be greater than the level of service available, and may need to be managed. Demand management involves both equitable determination of who is a clinical priority for a particular service, and further decisions about the best response for the population as a whole.

Community health services must implement a priority approach to effectively manage demand.

The Community Health Program is required to ensure that access to care is prioritised appropriately and that all needs are considered. Tools are available to assist staff and practitioners prioritise according to need. They provide decision-making support to help guide good and consistent practice across a service. A key aim is to make sure that people most in need of care receive it quickly and at a time when it will be most effective. Importantly, the use of robust demand management strategies guarantees that the available resources are used as effectively as possible.

In some areas, large groups of refugees and asylum seekers may arrive at the same time.

Demand can be managed in these circumstances by undertaking health system orientation and triage on a group basis. Demand can also be effectively managed through triage systems as detailed in Figure 3. Developing strong partnerships with settlement services and local general practitioners (GPs) may also help by engaging a larger number of services in meeting the demand for clinical care.

Tools developed by the Department of Health and Human Services include:

* [*Towards a demand management framework for community health services*](https://www2.health.vic.gov.au/about/publications/policiesandguidelines/towards-a-demand-management-framework-for-community-health-services) <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/towards-a-demand-management-framework-for-community-health-services>
  + [*Community health priority tools*](https://www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-program/ch-demand-management) <https://www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-program/ch-demand-management/priority-tools-for-community-health-services>

Waiting lists are an important part of effective management of demand for a service. If a service is unable to offer appointments at the time of initial contact, waiting lists should be established. Any waiting list should be managed actively, including:

**Providing information to the client**

* + Staff and practitioners should provide information regarding anticipated waiting time and the specific service contact details. It may also be appropriate to provide detail on available options for interim management while awaiting care, which may include referral to an additional service provider.

**Reviewing the client’s level of urgency**

* + Where a person is already on a waiting list, family, carer or referrer should be encouraged to contact the organisation if their condition or circumstances change. Services with lengthy waiting lists should consider contacting people directly to review their needs and priority at pre-determined time intervals.

**Communicating with referral source**

* Staff and practitioners should provide timely feedback to the referral source regarding confirmation of the referral and the anticipated waiting time.

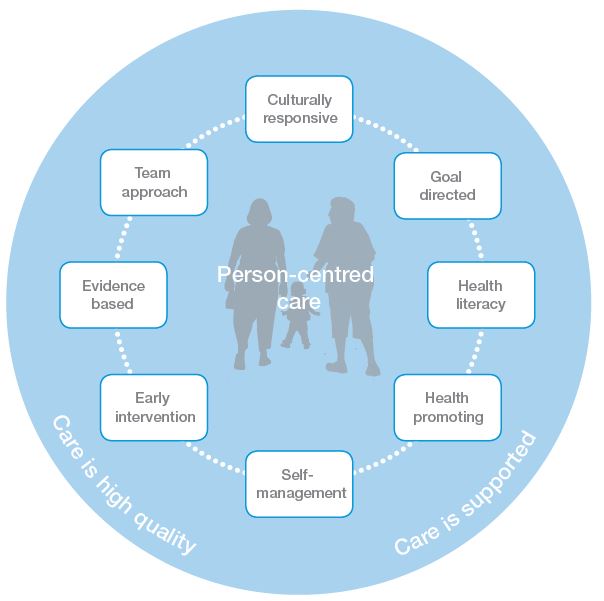
Case study: Demand management

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| In 2012, two projects were developed in response to a rapid and unpredicted release of a large number of asylum seekers from detention facilities in Australia. The Asylum Seekers Integrated Healthcare Pathway, established in September 2012 in the Greater Dandenong region is a partnership between Monash Health, South Eastern Melbourne Medicare Local (SEMML),  the Adult Multicultural Education Service (AMES) and the Australian Red Cross. The Health Orientation and Triage for Asylum Seekers project (HOTAS) is a similar project established in North and West Melbourne in December 2012. The Victorian Refugee Health Network provided a forum to share these approaches to working with this large group of newly arriving asylum seekers to Victoria.  HOTAS involves a larger partnership with Australian Red Cross, AMES and five community health services (Western Region Health Centre, Doutta Galla Community Health Service, ISIS primary care, Dianella and Darebin Community Health service). Western Region Health Centre (now cohealth) coordinates the program, with funding provided by Northern Melbourne and Inner North West Melbourne Medicare Locals for the initial six months. The project is supported by the statewide refugee health nurse facilitator and the Victorian Refugee Health Network  The geographical areas covered by the projects provide a statewide support mechanism to asylum seekers on their release from detention. Both projects use a common framework, encompassing health orientation information, triaging and referrals, delivered with a flexible approach to best suit the local context and the evolving health needs of those being triaged.  Over 1,800 asylum seekers have attended the health orientation and triage sessions in the north and west of Melbourne and the Greater Dandenong region from September 2012 to May 2014.  Health information sessions are delivered with interpreters in relevant languages. The triage sessions inform participants about the Victorian health system, and how to be referred to health services if necessary. Refugee health nurses meet with people to discuss health concerns.  A GP provides medical services when required, including reviewing medication and assessing serious health concerns and, if necessary, immediate referral.  Both projects provide a rapid response to an immediate need. Efficiencies have been achieved by combining triage and health orientation in one program. The projects prioritise people with urgent health needs and rapidly link them with health services, which reduces the risk of delayed identification and development of more severe problems requiring costly treatment.  Clients, supported by case workers, are also linked with local community health services and general practice.  These projects successfully develop the knowledge and capacity of a number of groups, including asylum seekers and case workers. It provides asylum seekers with basic information around certain health issues and support to navigate the health system. It develops the capacity of case workers around the complexity of diverse health issues and appropriate referral pathways. It enables a more thorough follow-up for the health issues of individual clients. The high volume of clients seen, together with the partnership arrangements, make it possible to identify and respond to needs and issues arising – for example the release of families as well as single men – either by tailoring services or referring issues to relevant organisations for their attention and resolution.  These projects provide a good example of many different agencies working successfully together, across primary health and state government, to meet a clear need and deliver tangible results.  Taken together, the two projects illustrate the value of building and sharing practice across the state to provide innovative solutions. Both projects have been evaluated and are available on the Victorian Refugee Health Network:   * + [HOTAS evaluation report](http://refugeehealthnetwork.org.au/asylum-seeker-health-orientation-and-triage-model-for-northern-and-western-metropolitan-melbourne-evaluation-report/) <http://refugeehealthnetwork.org.au/asylum-seeker-health-orientation-and-triage-model-for-northern-and-western-metropolitan-melbourne-evaluation-report/>   + [Asylum Seekers Integrated Healthcare Pathway 2012 summary report](http://refugeehealthnetwork.org.au/summary-report-asylum-seekers-integrated-healthcare-pathway-july2013/) <http://refugeehealthnetwork.org.au/summary-report-asylum-seekers-integrated-healthcare-pathway-july2013/> |

# Principles of the Community Health Program

The Community Health Program principles of care are the foundation for person-centred practice, and apply to all aspects of service delivery and support across the program. A full exposition of the principles is contained in the *Community Health Integrated Program guidelines* and highlighted in Figure 1 below*.* This section of the refugee and asylum seeker health guidelines describes the principles from the perspective of services specific to refugees and asylum seekers. Community health services need to align with these principles of care in all aspects of planning, program design and service delivery.

Figure 1: Principles of care as outlined in the Community Health Integrated Program guidelines



The refugee and asylum seeker guidelines are informed by further overarching principles and goals underpinning policy and program development in Victoria. These include:

* the right to health as a fundamental human right[[1]](#footnote-1)
* the value of consumer, carer and community participation as a democratic right and as a means of achieving accountability, quality care and good outcomes
* the Department of Health (2011) consumer participation policy [Doing it with us not for us: strategic direction 2010–13](https://www2.health.vic.gov.au/about/publications/researchandreports/Doing-it-with-us-not-for-us-Strategic-direction-2010-13)<https://www2.health.vic.gov.au/about/publications/researchandreports/Doing-it-with-us-not-for-us-Strategic-direction-2010-13>
* the principles informing the Victorian active service model
  + the importance of culturally responsive care.[[2]](#footnote-2)

The Community Health Program aims to provide services that are high quality, affordable and delivered in a flexible way that responds to the need of individuals and their communities.

Service models are structured in ways that acknowledge people with complex needs often require a more flexible and coordinated approach.

The principles of the Community Health Program align with current evidence and can be applied to the delivery of services and support at both the individual level and the organisational level.

At the individual level, refugees and asylum seekers should receive healthcare that:

* is accessible, timely, high quality and evidence-based
* uses interpreters when required and is culturally responsive and sensitive to needs that may arise from the refugee and asylum seeker experiences
* promotes health literacy, self-management and participation
  + promotes access to other systems and resources required for health and wellbeing, including the opportunity for ongoing referral and secondary consultation.

At the organisational level, providers of the Community Health Program should:

* ensure staff have appropriate expertise, skills and support to provide healthcare to refugees and asylum seekers including professional development
* be accessible, culturally and linguistically relevant to address the health needs of refugees and asylum seekers
* engage with communities in the planning and development of services
  + provide services that are informed by a social model of health.

At the wider health system level, providers of the Community Health Program should work with:

* other providers to ensure a coordinated approach to health service provision
* settlement/case-management services to promote health service access and literacy
  + the wider health service and settlement system to ensure that the rights, entitlements and needs of refugees and asylum seekers are met.

These principles are particularly important when:

* developing, implementing, and monitoring and evaluating healthcare for refugees and asylum seekers
* creating mechanisms to ensure that services provided by all relevant agencies are well coordinated.

Appendix 4 outlines the application of these principles at an individual, organisation, systems and partnership level.

## Person centred

To maximise health and wellbeing, services should consider the whole person, and examine need through a holistic lens. This approach recognises that a range of social factors may be implicated in poor health, especially chronic disease (such as housing or employment status). Integration and partnerships are especially important when working with people with multiple and complex health needs.

The health and wellbeing of refugees and asylum seekers is likely to be affected by a range of social factors both prior to and following arrival in Australia.

Optimal care will involve collaboration between refugee settlement and asylum seeker case management services, specialist refugee health services, torture and trauma counselling and primary care services, as well as with mainstream health and human services, such as maternal and child health and hospitals. Providers of the Community Health Program need to support effective integration and sound partnerships with these agencies.

## Culturally responsive

Providers of the Community Health Program should respect, and remain relevant to, the health beliefs and practices, culture and linguistic needs of particular communities.

Culturally responsive approaches will:

* maintain links with refugee communities to better understand the emerging healthcare practices and needs of particular groups
* ensure systems and resources are developed to support interpreters and translated materials.

## Evidence based

Evidence-based care means using the best available evidence, integrated with expertise, to make decisions about the care of an individual.

Evidence-based approaches will:

* keep abreast of evidence about particular groups and undertake regular evaluation, monitoring and review to ensure an understanding of current and emerging health needs of refugee and asylum seeker communities
  + seek information from refugee communities and other service providers to inform practice.

In delivering high quality, evidence-based care consideration should be given to continuous quality improvement and innovation to improve the quality of practice.

## Team approach

A team approach involves a dedicated team of practitioners working collaboratively with the person to identify needs, achieve goals and enhance quality of care and care outcomes. This also ensures integration and coordination of healthcare.

Team approaches will:

* work collaboratively with other agencies and allied health, medical and human service personnel to address the needs of refugees’ and asylum seekers’
* promote a collaborative approach within community health services.

## Goal-directed care

The health assessment process should be followed by goals, actions and interventions to address the issues identified.

Goal-directed approaches will:

* develop goals collaboratively with the person, their carers, families and other service providers
* identify clear, concise and measurable goals to provide direction and the opportunity to reflect on achievements within the episode or course of care.

## Flexible care

Flexible service provision is a key principle of person-centred care and is required to meet the needs of the client population.

Flexible approaches will ensure:

* a variety of service delivery approaches, including group work, outreach and family work.

## Self-management

Supporting the person, their carer and family to take responsibility and control of health issues empowers them, and assists them to be as independent as possible, rather than creating dependency on the health system.

Building self-management approaches will:

* help to counteract experiences of dependency that many refugees and asylum seekers have had
  + in the early post-arrival period, provide a more intensive level of support than for Australian-born clients or longer-term residents, as refugees and asylum seekers may have limited proficiency in English and lack of familiarity with public transport, healthcare and other systems in Australia.

## Health literacy

Health literacy involves people being able to navigate, understand and use health information and services to make effective decisions and take appropriate action about health and healthcare.

Health literacy approaches will:

* ensure the infrastructure, policies, processes, materials and relationships that make health literacy possible are supporting refugees and asylum seekers to make appropriate decisions about their own healthcare
* bear in mind that refugees and asylum seekers will face additional difficulties including language, cultural difference and unfamiliarity with the Australian healthcare system.

## Timely care

Services and support should be timed to maximise their impact. Early intervention in the issue, life course or disease will minimise adverse effects and promote ongoing health and wellbeing.

Timely approaches will:

* engage refugees and asylum seekers early and in a culturally responsive manner so that issues do not become enduring barriers to settlement
* create positive early contact so that effective ongoing engagement is more likely. Initial health assessments are critical for linking people into the health system
* consider needs and capacities at different stages of settlement. For example, refugees and asylum seekers may be more receptive to illness-prevention screening or mental health interventions after their immediate needs of housing and income support are met
* take into account that some refugees and asylum seekers may be unfamiliar with the concept of early intervention and prevention, given limited healthcare arrangements in many countries of origin.

## Health promotion

Practitioners should use health promotion strategies to address primary, secondary and tertiary prevention in an opportunistic way.

Research shows that the health and mental health of refugees and asylum seekers can deteriorate over time in Australia, due to the loss of protective factors in the country of origin, such as extended family support, and exposure to new risks in Australia like racial intolerance, processed food, socioeconomic disadvantage or limited family support. Many of these new risks are due to social factors rather than individual behaviours. Health promotion approaches will:

* ensure mechanisms are in place to address these issues through community development and policy advocacy strategies.

## Care is supported

Care should be supported by appropriate infrastructure (for example planning, models, buildings, partnerships), a skilled and experienced workforce (for example supporting professional development and training) and up-to-date technology (for example telehealth, e-coordination tools).

Supported care approaches will:

* use innovative models, in particular outreach, telehealth and family-centred care
* support health professionals to meet the complex healthcare needs of refugees and asylum seekers (Russell et al. 2013).



Case study: Applying the principles

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| **Engaging with communities to plan and develop services**  In response to concerns expressed by community members, the Western Region Health Service (now cohealth), implemented the Supporting Traditional African Mediators Program, which aims to minimise family violence in African/Australian communities.  Staff undertook extensive consultation with people from different African countries, the Victorian Foundation for Survivors of Torture and the Immigrant Women’s Domestic Violence Service.  The project steering committee decided that a training program for elders and leaders was the most effective way to achieve the project aims.  Project staff developed, implemented and evaluated strategies to build the knowledge, community capacity and skills of traditional African mediators to enable them to undertake family violence prevention work within their own communities.  Eighty leaders and elders completed the training. The participants were recruited through the project steering committee, networking within the community, self-referral, recommendations from other course members, information sessions and discussions with the course coordinator. As far as possible an equal proportion of women and men were involved in each training cohort.  The family violence prevention training combined a range of delivery methods, including group discussion, direct teaching, small group exercises, brainstorming sessions, experiential learning and case study presentations. Training consisted of five three-hour sessions on Saturdays, as requested by the community.  Throughout the program, community members were involved to plan, develop and implement culturally relevant training for community leaders. The project improved the capacity of participants to provide information, referral and interventions that promote non-violent conflict resolution and respectful relationships between men and women in their communities.  This method of community consultation and project planning has since been implemented with communities from Burma. |

## Collaborative practice

New clients who are refugees and asylum seekers need comprehensive health assessment, including screening for serious health concerns, catch-up immunisations and referral for specialist review and follow-up care, as well as allied health services and counselling.

This healthcare journey needs to be supported by health services’ orientation, health education and care coordination.

There are a number of key services and programs with a specialist role in supporting refugees and asylum seekers, especially in the early period of settlement. Key services in post-arrival refugee healthcare and coordination are outlined in Appendix 1.

Case study: Health orientation, triage, referral and service coordination

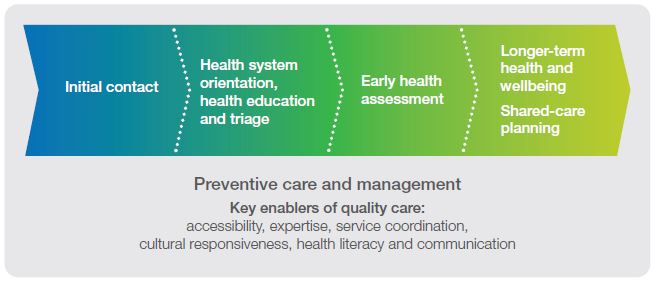
|  |
| --- |
| Ahmed and Jasmyna are Iranian refugees in their mid 30s. They attended one of the Asylum Seeker Health Orientation and Triage sessions with their 10-year-old daughter Astera. They had spent three months on Christmas Island after travelling by boat from Indonesia, where they had been living for a period of time.  The family was seen by a refugee health nurse. Jasmyna was in the early stages of pregnancy, and was referred for follow-up antenatal care at the local hospital, where Astera could also have a comprehensive health assessment and catch-up immunisation.  Ahmed described a history of chest pain and numbness in his arms. He stated that he did not have the chest pain at the time, but had been experiencing it while in detention and in the past had been on medication. No further investigations or treatment were provided while he was in detention.  Ahmed presented as slightly underweight, but had a good colour generally and was not in pain. The nurse established a family history of heart disease. The nurse discussed this with a general practitioner (GP), organised an appointment for a medical assessment, requested an interpreter and gave Ahmed details of the appointment and instructions on how to get there.  The case worker allocated to the family was informed of the appointments for Ahmed, Jasmyna and Astera.  The GP sent Ahmed for an electrocardiogram and requested blood tests at the local pathology service.  The refugee health nurse told Ahmed and his case worker where these services were and how to get there. A follow-up appointment with the GP was also required.  The GP prescribed some medication for heart disease and sent a referral to a cardiologist at the local hospital.  Through an interpreter, the nurse explained the referral process to Ahmed, told him about the potential waiting time and asked him to discuss any letters from the hospital with his case worker or the refugee health nurse.  The nurse informed Ahmed of the dose and frequency of his medication and told him how to access the GP if he needed a medical consultation. Ahmed was also told how to access an ambulance if he needed help outside the GPs working hours.  The GP undertook catch-up immunisations for Astera. The nurse contacted the family again to ensure links had been made with the antenatal services at the local hospital. |

# Working with partners

## Service integration

Ideally, the refugees’ and asylum seekers’ healthcare journey occurs in a four-staged approach as illustrated in Figure 2. The specific roles and responsibilities for the delivery of the key elements should be determined by community health services in partnership with other relevant services.

Figure 2: The refugee and asylum seeker healthcare journey



The approach is aligned with service coordination practice. Visit the Department of Health and Human Services’ ‘[Service coordination’ page](https://www2.health.vic.gov.au/primary-and-community-health/primary-care/workforce-development/service-coordination-online-learning-modules) < https://www2.health.vic.gov.au/primary-and-community-health/primary-care/workforce-development/service-coordination-online-learning-modules >> for more information and resources to guide and support service coordination.

Initial contact with community health programs occurs soon after arrival when the settlement or case-management agency makes a referral to the community health service.

These agencies provide initial orientation for new arrivals and arrange referral to primary healthcare services. Providers of the Community Health Program have an important role to ensure settlement and case-management agencies have accurate information, receive appropriate workforce development and support, and that referral pathways are clear.

This is a good stage at which to commence engaging refugees and asylum seekers in healthcare through self-management and participation approaches.

People arriving through the humanitarian program are assessed by settlement case managers to identify the level and urgency of need and arrange referrals to community health services and/or GPs.

For asylum seekers, there are now well-established health orientation and triage programs run by community health services in conjunction with asylum seeker support agencies that provide this initial point of contact and information.

In other areas, newly arrived asylum seekers are referred by case-work services to community health or in some instances by a GP.

Note that new arrivals may not present for the first time until later in settlement due to competing priorities.

Health system orientation, health education and triage approaches vary, depending on the numbers of new arrivals in a particular location.

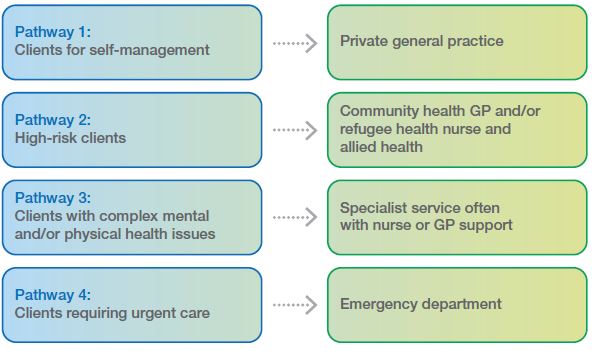
New arrivals need to be given orientation to health services, and access to health education. A range of approaches may be used in provision of health orientation and education including:

* health orientation included as part of the asylum seeker triage programs offered by community health services in partnership with asylum seeker agencies
* community health services offering tours and service orientation programs for new arrival communities
* community health services providing training to casework staff about health services to build their capacity to support their clients
* health system orientation and education included in individual care
  + consideration of access to health education programs for refugees and asylum seekers based on need, for example, chronic disease management programs, women’s health or men’s health.

Triage may be undertaken individually or in a group, and there are now group triage programs for asylum seekers on release from detention in a number of areas.

A range of approaches are taken to triaging individual asylum seekers, humanitarian entrants and others of refugee background, depending on local services and arrangements between community health services, general practices and settlement and asylum seeker support agencies. Figure 3 shows the pathways of care following triage.

Figure 3: Pathways of care – triage process



Refugees and asylum seekers are not offered routine, centralised health screening and assessment in Australia.

All new arrivals should be offered comprehensive health assessment, treatment and referral with a GP conducted in accordance with:

* the [*Australian refugee health practice guide*](http://refugeehealthguide.org.au/about-this-practice-guide/) <http://refugeehealthguide.org.au/about-this-practice-guide/>, the updated version of *Promoting refugee health: a guide for doctors and other healthcare providers caring for people from refugee backgrounds* (2012) and *Caring for patients in general practice: a desktop guide* (2012) and their previous editions.
* [the Royal Australian College of General Practitioners (RACGP)-endorsed refugee health assessment form](https://www.racgp.org.au/clinical-resources/clinical-guidelines/guidelines-by-topic/view-all-guidelines-by-topic/refugee-health/refugee-health-assessment) <https://www.racgp.org.au/clinical-resources/clinical-guidelines/guidelines-by-topic/view-all-guidelines-by-topic/refugee-health/refugee-health-assessment>.

This assessment is rebatable through the Medicare Benefits Schedule, via extended item numbers which can be accessed for this purpose.

GPs undertaking these assessments may be located in community health services or private practice.

Community health services may make referrals to local GPs and play a role in strengthening private GPs’ capacity to provide this care (for example through liaison with local practices, partnerships with primary care partnerships and primary health networks).

Health assessment should include offering catch-up immunisation consistent with the current Australian immunisation handbook catch-up guidelines for people with no or limited documented history of previous vaccines. Visit the Commonwealth Government Department of Health’s [catch-up immunisations page](https://beta.health.gov.au/health-topics/immunisation/health-professionals/catch-up-immunisations) <https://beta.health.gov.au/health-topics/immunisation/health-professionals/catch-up-immunisations> for more information.

## Shared-care planning

Many new arrivals require access to a range of allied health services and/or require further specialist assessment and care. To provide a more coordinated approach, a number of community health services have established multidisciplinary refugee health teams including outreach specialist services. In some locations these specialist clinical hubs are provided in hospital settings.

Providers of the Community Health Program have a key role in care coordination including working in partnership with GPs and hospital-based refugee health clinical hubs.

## Case coordination

Many community health services have established a team approach to responding to the needs of refugees and asylum seekers. This may include nurses, allied health assistants, bicultural health workers, women’s health nurses and other allied health professionals such as physiotherapists, occupational therapists, psychologists, dieticians and social workers. Such an approach can help to meet increasing demand, respond to case complexity, strengthen cultural responsiveness and ensure optimal use of limited resources.

As indicated in the following case study, care coordination supports overall service provision, particularly by:

* organising an initial health assessment in the early stage of settlement
* providing support and referral for complex clients, after the initial assessment has occurred
* coordinating individual services provided by community health service staff
* leading liaison with other agencies providing care to community health service refugee and asylum seeker clients
* having input into development and delivery of wider local, regional and state coordination mechanisms to ensure that services are streamlined with no gaps, and that they operate within the state coordinating procedures identified
* providing professional development and support to health and settlement personnel, including secondary consultation where appropriate
  + providing organisational development, advice and support to agencies to strengthen their capacity to meet the primary healthcare needs of refugees and asylum seekers, at the local level.

Planning for longer-term health and wellbeing is undertaken when people no longer require the intensive support provided by specialist refugee programs.

Efforts may be required to ensure that ‘mainstream’ services are sensitive to the needs of refugees and asylum seekers. Providers of the Community Health Program have a role in:

* supporting people to make the transition from specialist support services
* ensuring that their own services and programs are accessible to refugees and asylum seekers
  + strengthening the capacity of local ‘mainstream’ services to provide care to refugees and asylum seekers through workforce development and support.

Case study: Case coordination: managing complex needs – the role of refugee health nurses

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| --- |
| A 23-year-old Ethiopian woman was referred to a community health service by a GP requesting that the Refugee Health Nurse (RHN) assist the woman to engage with a liver specialist. The RHN was advised that the woman was seeing a local housing provider and had complex health needs.  During home visits, the RHN gained information regarding the client’s health, migration and social history. She had come to Australia on a spouse visa. After 18 months the marriage broke down and the woman became homeless. At the time she was living alone in transitional housing and suffered from extreme isolation.  While married, her partner was emotionally abusive resulting in her not being able to attend English classes or social outings. She had also been an active member of her local church, but due to her increasing ill health she had been unable to attend services. She had some friends, but stated that they were all busy studying or working. The woman was chronically depressed about her health and social situation and frequently called a relative in Ethiopia for emotional support.  After gaining consent from the client, the RHN liaised with a range of former health providers and compiled a medical history. The client had liver cirrhosis, portal hypertension, pancytopenia, chronic depression and had been treated for different parasites. She had been provided services by a local hospital and had been seen at the gastroenterology, haematology, eye, infectious disease and dietetics departments.  In response to the client’s mental and physical health, the RHN re-established links with the range of health service providers required and ensured that appropriate referrals were made. The client was also referred to the local mental health service where she participated in Youth Program activities and to an African women’s group run by the community health service.  Links were also re-established with the housing worker and a settlement services worker who provided support for the client in accessing Centrelink payments and re-enrolling in English language tuition. A case conference was then organised with the client, the settlement and housing agency staff and the client’s GP. The client discussed her ongoing needs and a care plan was developed indicating the roles and responsibilities of each service provider.  The client is now halfway through her English language course, attends church again and reports that she is comfortable with the health provider arrangements put in place. She still lives in transition housing and calls her family in Ethiopia every week for support. |



# Models of care

## A checklist approach to systems, policies and procedures

The checklist approach outlined here invites providers of the Community Health Program to reflect on the systems, policies and procedures they have in place that will lead to positive outcomes for refugees and asylum seekers.

The items in the checklists have been sourced from a range of documents developed by state and Commonwealth governments, specialist organisations including the Centre for Culture, Ethnicity and Health and the Victorian Refugee Health Network, and a range of community health services located across the state. They are designed to support development of best practice in the provision of health services to refugees and asylum seekers.

The checklists will assist providers of the Community Health Program to ensure that current structures, policies and procedures, as well as levels of service coordination, meet best practice standards.

The checklists are not designed to provide advice on how these refinements should be undertaken. Appendix 2 presents a range of resources that can be used for this purpose.

## Using the checklists

A senior staff member should be given responsibility for working with other staff members from across units and areas of work to complete the checklists every year, and provide advice to the relevant executive staff on areas for reform.

The checklists should also be used to assist in the development of health plans for refugees’ and asylum seekers’ at the organisational level.

## Checklist 1: Systems, policies and procedures for positive outcomes

### Organisational values

Organisational values which indicate commitment to delivering quality services to vulnerable groups are essential in creating the context in which community health services and staff operate. These values are also essential in underpinning the development of service systems and models of care that meet the needs of refugees and asylum seekers.

| Organisational values | Yes | No | NA |
| --- | --- | --- | --- |
| The vision statement of your service includes focus on equity. |  |  |  |
| The vision statement of your service includes focus on servicing the needs of vulnerable groups. |  |  |  |
| Your organisational values include a focus on equity. |  |  |  |
| Your strategic plan prioritises service provision to refugees and asylum seekers. |  |  |  |
| Your code of conduct for all staff includes expectation that all clients will be treated with dignity and respect regardless of their backgrounds. |  |  |  |
| Your CHS has public materials that express the organisation’s commitment to addressing the health needs of refugees and asylum seekers. |  |  |  |
| Funding allocated to refugees and asylum seekers service provision is seen as a priority. |  |  |  |

Adapted from the Centre for Culture, Ethnicity and Health 2012, Cultural competence in health service provision: tip sheet series.

### Governance and leadership

Effective service provision to refugees and asylum seekers requires a whole of organisation approach. To successfully implement systems, policies and procedures to ensure services are meeting the needs of refugees and asylum seekers, ‘an authorising environment’ needs to be in place with the governing body illustrating commitment to and knowledge of this area of policy practice.

|  |  |  |  |
| --- | --- | --- | --- |
| Governance and leadership | Yes | No | NA |
| The board of your CHS and subcommittees includes refugee and asylum seeker representation. |  |  |  |
| Board members are well informed about the health and access needs of refugees and asylum seekers and emerging policy issues. |  |  |  |
| Your board supports allocation of financial resources and development of fee structures which ensure appropriate access and service delivery to refugees and asylum seekers. |  |  |  |
| Individuals at the executive level are responsible for implementing and monitoring service provision to refugees and asylum seekers. |  |  |  |
| Teams or committees of mid or higher level staff are assigned responsibility for coordinating work with refugees and asylum seekers. |  |  |  |
| There is a staff member with responsibility to ensure that regular reports are provided to stakeholders on health service provision to refugees and asylum seekers and policy issues arising. |  |  |  |
| The board ensures that policy issues arising from health service provision are followed up on by relevant staff and communicated through relevant channels. |  |  |  |

Adapted from the Centre for Culture, Ethnicity and Health 2012, Cultural competence in health service provision: tip sheet series.

### Planning and monitoring

Having systems, policies and procedures in place to underpin planning and monitoring enables community health services to be flexible when required to respond to changing circumstances, including unexpected increases of refugee and asylum seeker clients and new and emerging populations not previously requiring service.

| Planning and monitoring | Yes | No | NA |
| --- | --- | --- | --- |
| Your population-level health plan, or equivalent, includes focus on refugees and asylum seekers. |  |  |  |
| Refugees and asylum seekers staff and consumers with knowledge of issues pertaining to refugees and asylum seekers are represented on relevant internal and external planning and monitoring committees. |  |  |  |
| Your CHS has business or operating plans indicating roles and responsibilities of staff in the provision of services to refugees and asylum seekers. |  |  |  |
| Budget allocations for refugees and asylum seekers service provision are allocated according to your business or operating plans. |  |  |  |
| You have capacity to amend service models to accommodate changes in the number and profile of refugees and asylum seekers clients at any given time. |  |  |  |
| Administration and service delivery systems are tailored and continually adapted to meet the health needs of refugees and asylum seekers. |  |  |  |
| Evaluation mechanisms are in place to capture baseline data to assist in service evaluation and reform. |  |  |  |
| Data obtained from clients and the wider community are used to inform local planning and service delivery reforms, as required. |  |  |  |
| There is a member of staff with responsibility to ensure that appropriate systems are in place to monitor and evaluate services provided. |  |  |  |

Adapted from the Centre for Culture, Ethnicity and Health 2012, Cultural competence in health service provision: tip sheet series.

### Community and client engagement

Engaging with refugee and asylum seeker communities to identify their healthcare needs and concerns will contribute to the design of services that improve health outcomes. Likewise, engaging refugee and asylum seeker clients in development of their individual health plans will ensure that their needs are met.

|  |  |  |  |
| --- | --- | --- | --- |
| Community engagement | Yes | No | NA |
| Consumer input, in a range of forms, is highly valued and actively sought by your CHS. |  |  |  |
| Policies are in place regarding client and community input to all levels of service delivery including the planning and delivery of healthcare. |  |  |  |
| Regular community needs assessments are conducted. |  |  |  |
| Regular consultations are undertaken with refugee and asylum seeker communities with feedback from these consultations being documented for consideration by the executive team. |  |  |  |
| Individual care and treatment plans are developed with clients and amended with client input, as required. |  |  |  |

Adapted from the Centre for Culture, Ethnicity and Health 2012, Cultural competence in health service provision: tip sheet series.

### Accessible services

Provision of accessible and well-targeted healthcare is fundamental to securing positive health outcomes for refugee and asylum seeker clients. A range of documents have been developed to assist organisations to ensure that services are accessible to clients. Key elements of focus are included in the checklist below.

| Accessible services | Yes | No | NA |
| --- | --- | --- | --- |
| ‘Front of house’ staff engage appropriately with refugee and asylum seeker clients who visit the CHS without an appointment. This includes organisation of phone interpreters and appointments as required. |  |  |  |
| Clients are provided with appropriate forms of information regarding their service entitlements and what they can expect from the CHS and its staff. |  |  |  |
| Staff check to ensure that clients understand information imparted to them. |  |  |  |
| People can see the service or service information from the street. |  |  |  |
| The service is close to public transport. |  |  |  |
| Clients are informed about public transport options. |  |  |  |
| Clients who cannot access transport to attend appointments are provided with home visits, taxi vouchers or public transport tickets. |  |  |  |
| Your CHC provides outreach services from other venues where clients are located. |  |  |  |
| There is a policy which allows staff to undertake home visits for vulnerable clients. |  |  |  |
| Referral and registration processes are easy to understand. |  |  |  |
| As an alternative to scheduled appointments within your CHS, time is allocated for open appointments to see clients on a drop-in basis. |  |  |  |
| Extended appointment times are available for clients with complex needs. |  |  |  |
| Someone in the CHC is responsible for identifying barriers in accessing services and working with staff to overcome these barriers. |  |  |  |
| Services provided are free or affordable (including for asylum seekers who are Medicare ineligible). |  |  |  |
| The CHS focuses on creating an environment which indicates to refugees and asylum seekers that their presence in the service is welcomed and their needs are understood. |  |  |  |
| Refugees and asylum seekers feel that their language needs, values and behaviours are understood, respected and acted upon. |  |  |  |

### Communication

Cross-cultural communication is critical for all aspects of service delivery. It can break down barriers and improve access to services. It also ensures that clients have information required to have input to their own healthcare and supports better health outcomes for clients.

| Communication | Yes | No | NA |
| --- | --- | --- | --- |
| Staff who are interfacing with refugee and asylum seeker clients have undergone training to assist identification of the clients’ preferred language and levels of literacy and English proficiency. |  |  |  |
| Clients are able to communicate in their preferred language in all interactions with your CHS. |  |  |  |
| Mechanisms are in place to ensure the communication needs of clients are met (for example, client surveys, file audits). |  |  |  |
| Language assessments are undertaken with all refugee and asylum seeker clients to identify their interpreting needs. |  |  |  |
| All CHS staff providing services to refugee and asylum seeker clients, including administrative and reception staff, are able to contact the telephone interpreter service, as required. |  |  |  |
| Your CHS employs bi-lingual staff. |  |  |  |
| You have a policy to guide the role of bi-lingual staff in service delivery and all other interactions with refugee and asylum seeker clients. |  |  |  |
| Interpreters are provided in all aspects of service to refugee and asylum seeker clients requiring language support. |  |  |  |
| Health information for the general public is also available in languages of refugee and asylum seeker clients. |  |  |  |
| Health information materials are appropriate to the literacy level of refugee and asylum seeker clients. |  |  |  |
| You have review mechanisms in place to check the integrity of translated material. |  |  |  |
| Training on cross cultural communication, including how to work with interpreters, is provided to staff engaging with refugee and asylum seeker clients. |  |  |  |
| Protocols are in place to guide when and how to elicit sensitive information from clients. |  |  |  |
| You have a member of staff with responsibility to ensure that all relevant communication is tailored appropriately to the needs of refugees and asylum seekers. |  |  |  |

Adapted from the Centre for Culture, Ethnicity and Health 2012, Cultural competence in health service provision: tip sheet series, the Western Region Health Centre Victoria (now cohealth) 2011, Bilingual staff policy and procedure and the Western Australia Department of Health (2014) Community Health Policies, Procedures and Guidelines for At Risk Groups: Guidelines for delivering community health.

### Staff development

High quality services to refugees and asylum seekers relies on access to well-qualified, trained and supported staff who are able to deliver services in a culturally competent and sensitive manner.

| Staff development | Yes | No | NA |
| --- | --- | --- | --- |
| You have skilled and responsive staff who demonstrate awareness and sensitivity to refugee and asylum seeker clients. |  |  |  |
| Staff are able to identify clients who are likely to be refugees and asylum seekers. |  |  |  |
| Staff demonstrate competence in skills and behaviours when working with refugee and asylum seeker clients. |  |  |  |
| Training needs assessments are used to identify the development needs of staff. |  |  |  |
| Training in refugee and asylum seeker service provision is available to all staff providing services to refugee and asylum seeker clients. |  |  |  |
| High-quality training is sought and delivered including focus on: the impact of the refugees and asylum seekers experience; common health and mental health  issues for refugees and asylum seekers; cultural responsiveness; appropriate use of language services; and the roles of CHS personnel and wider sector agencies  providing services to refugees and asylum seekers. |  |  |  |
| There are mechanisms in place to ensure that staff have adequate supervision and support. |  |  |  |
| You have protocols in place which alert staff to occupational health and safety issues when providing services to refugees and asylum seekers and these protocols are included in staff orientation. |  |  |  |
| You have a member of staff allocated responsibility to ensure that staff development is provided and undertaken. |  |  |  |

Adapted from the Centre for Culture, Ethnicity and Health 2012, Cultural competence in health service provision: tip sheet series.

### Organisational infrastructure and service coordination mechanisms

Effective service provision to refugee and asylum seeker clients is assisted by the presence of organisational systems, policies and procedures which support and guide the work of all community health service staff engaging with refugees and asylum seekers. They also ensure that service provision to individual clients is well coordinated, thus enhancing service delivery by avoiding duplication or not providing the service that the client needs.

| CHS organisational infrastructure | Yes | No | NA |
| --- | --- | --- | --- |
| Budget is allocated to service provision to refugees and asylum seekers in line with the CHS business plans. |  |  |  |
| You provide free or affordable services. |  |  |  |
| You have an information management system which allows staff to enter and use data relevant to individual refugees and asylum seekers in a consistent and standardised way. |  |  |  |
| You have policies guiding intake of refugee and asylum seeker clients. |  |  |  |
| You have information management systems in place that support the provision of multidisciplinary care. |  |  |  |
| \* If so, do staff enter, review and use individual refugees and asylum seekers data in a consistent and standardised way? |  |  |  |
| All staff use the same information management system. |  |  |  |
| \*If not, do you align these systems to avoid confusion and uncertainty? |  |  |  |
| Staff work plans are derived from the strategic and business plans of the CHS. |  |  |  |
| Roles and expectations of staff in delivery of services to refugee and asylum seeker clients are clear. |  |  |  |
| You have team meetings with all staff engaged in service provision to refugee and asylum seeker clients. |  |  |  |
| There is a mechanism in place to identify gaps in systems, policies or procedures which require development. |  |  |  |
| You have a member of staff allocated responsibility to ensure that services provided to refugee and asylum seeker clients are coordinated within the CHS. |  |  |  |

Adapted from the Centre for Culture, Ethnicity and Health 2012, Cultural competence in health service provision: tip sheet series.

### Feeding into broader policy

Community health services are well placed to understand the strengths and limitations of national and state policies affecting the health of refugees and asylum seekers and make visible the policy reforms required to ensure that the health and wellbeing needs of refugees and asylum seekers are met.

|  |  |  |  |
| --- | --- | --- | --- |
| Feeding into broader policy | Yes | No | NA |
| You use data from service users, communities and CHS staff, to underpin policy discussions. |  |  |  |
| There is a system in place to identify and document current and emerging issues relevant to wider refugee and asylum seeker health policies and programs. |  |  |  |
| You have a mechanism in place to raise local and systemic policy issues with the board as they emerge. |  |  |  |
| Your CHS has raised broader policy issues affecting refugee and asylum seeker healthcare in the past 12 months. |  |  |  |
| There is someone in your CHS responsible for raising policy issues with the Victorian Refugee Health Network. |  |  |  |

Adapted from the Centre for Culture, Ethnicity and Health 2012, Cultural competence in health service provision: tip sheet series.

### Monitoring and evaluation

Monitoring and evaluation are essential functions to ensure that activities are meeting the needs of refugee and asylum seeker clients. A systematic approach to implementing and reviewing implementation of these guidelines will provide the necessary information to underpin service operations and activity.

|  |  |  |  |
| --- | --- | --- | --- |
| Monitoring and evaluation | Yes | No | NA |
| There are mechanisms in place at your CHS to review this check list and identify areas requiring further development. |  |  |  |
| There are mechanisms in place within your CHS to monitor your success in developing and implementing new activity identified in this checklist. |  |  |  |

Adapted from the Centre for Culture, Ethnicity and Health 2012, Cultural competence in health service provision: tip sheet series.

Case study: Engaging clients in the planning and development of services

|  |
| --- |
| The provision of timely, accessible and culturally appropriate health services to refugees and asylum seekers presents a challenge to healthcare providers worldwide. In recognition of the unique experiences and health needs of each refugee population in Corio/Norlane, a series of focus group discussions and individual interviews were held with members of four of the largest refugee communities in the region.  The primary healthcare experiences, barriers towards service utilisation and suggestions on the delivery of appropriate healthcare were investigated.  Despite the significant physical and mental health issues experienced and the countless acts of discrimination encountered on a daily basis, participants were pleased to participate and provided invaluable information to be used by Barwon Health in the ongoing development of services.  While the research was valuable in establishing enduring relationships with participants, opportunities and recommendations for future action were identified and include:  development of a Refugee Health Community Consultation Framework to support structured and regular consultations  monitoring of demographic trends to ensure health interventions are appropriately targeted  implementation of cultural awareness training to assist development of inclusive and respectful service provision which strives to overcome barriers to service utilisation  development of a peer educators program to assist in the delivery of health education sessions for refugee groups  development of strategies to increase service utilisation and input to future consultations by men  giving priority focus to those experiencing significant vulnerability such as women at risk, asylum seekers, unaccompanied minors and people with a disability.  The project proved to be an invaluable exercise and will be repeated on a regular basis. |

## Checklist 2: Service coordination checklist

Local, regional and statewide service coordination is essential to healthcare delivery and an area of practice that has been identified as requiring further development.

Strengthening coordination is one of the key goals of the Community Health Program. This is especially important for:

* refugee and asylum seeker clients who often have complex health needs that require multiple referrals and follow-up
  + health services, which must respond to changes in national immigration policy that can impact on the numbers of refugee and asylum seeker clients requiring service and their entitlements.

While the need for coordinated healthcare is critical, in times of uncertainty this becomes even more urgent. To meet the health needs of refugees and asylum seekers, systems to support healthcare coordination must be in place.

There are a range of resources to support service coordination including the *Victorian service coordination practice manual* (2012), which define practices which support Victorian service providers to work together in a coordinated way to give consumers a streamlined and integrated response. The Community Health Practice Indicators enable organisations providing the Community Health Program to measure key service delivery and care-coordination activities that make up the service-user journey. These indicators together with the following checklist aim to assist community health services to improve service provision to refugees and asylum seekers.

### Service coordination mechanisms

Formal mechanisms to coordinate health service provision are essential to ensure that refugees and asylum seekers health needs are identified and met, duplication of service is avoided and efficiencies are generated.

| Service coordination mechanisms | Yes | No | NA |
| --- | --- | --- | --- |
| You disseminate information on the role of your CHS in the provision of healthcare to refugees and asylum seekers to other health service providers, settlement agencies and community organisations. |  |  |  |
| The role of settlement services, general practitioners, specialist health providers and other refugee and asylum seeker services are understood by your staff. |  |  |  |
| You have formal protocols in place with refugee and asylum seeker agencies and other health providers to ensure effective referral and information exchange occurs. |  |  |  |
| \* If so, are these protocols adhered to? |  |  |  |
| The role of general practitioners and specialist health providers is understood by your staff. |  |  |  |
| You have case management and triage protocols in place to guide your work with other refugee and asylum seeker health providers. |  |  |  |
| You have protocols with general practitioners and specialist health providers to ensure referral of clients is streamlined and refugee and asylum seeker clients are accessing the service they need. |  |  |  |
| \* If in place, are these protocols adhered to? |  |  |  |
| There are mechanisms in place to develop and monitor service and referral agreements between relevant agencies. |  |  |  |
| \* If so, is there a staff member responsible for ensuring that these mechanisms are working? |  |  |  |
| There are mechanisms in place to provide formal feedback on complaints resulting from activities undertaken or neglected by other health providers or settlement agencies. |  |  |  |
| There is collaboration, information sharing and trust between your CHS and other health and settlement providers. |  |  |  |

### Mechanisms for engagement with cross-sector agencies

It is widely acknowledged that socioeconomic issues impact on health. Consequently, community health services often work with cross-sector organisations to change environments that limit the capacity of refugees and asylum seekers to achieve optimal health.

| Mechanisms for engagement with cross-sector agencies | Yes | No | NA |
| --- | --- | --- | --- |
| Staff from your CHS are aware of the broader systems and services relevant to the health of refugees and asylum seekers, including settlement and asylum seeker support agencies, education, housing, employment and welfare services. |  |  |  |
| Your service is connected to a Regional Refugee Health Network or working group. |  |  |  |
| Your service participates in the projects or activities of the Victorian Refugee Health Network. |  |  |  |
| Staff from your CHS work with schools in order to address refugees and asylum seekers health issues. |  |  |  |
| Staff from your CHS work with housing services to identify strategies to address housing shortages for refugee and asylum seeker clients. |  |  |  |
| Staff from your CHS refer clients to Centrelink to discuss procedural issues associated with benefit applications and payments. |  |  |  |
| You convene or participate in regular coordination meetings with other providers in your local area or region. |  |  |  |
| Relationships with cross sector organisations are maintained by your CHS. |  |  |  |
| There is a member of staff allocated responsibility for maintenance of cross-sector relationships. |  |  |  |
| When issues arise in other sectors that have impact on the health of refugees and asylum seekers, there is a system for alerting your CHS to these issues. |  |  |  |
| When issues arise in other sectors that have impact on the health of refugees and asylum seekers, CHS staff raise these with the executive or the board. |  |  |  |

### Mechanisms for information exchange and skill development

Any effort to coordinate service provision is dependent on information being exchanged among relevant services and a shared understanding being developed regarding current and future challenges that require a coordinated response.

| Mechanisms for information exchange and skill development | Yes | No | NA |
| --- | --- | --- | --- |
| Your CHS participates in Regional and / or Victorian Refugee Health Network meetings and forums. |  |  |  |
| You use, share and promote resources developed by the Victorian Refugee Health Network. |  |  |  |
| You advise the Victorian Refugee Health Network of issues of concern that arise during provision of health services that require a state response. |  |  |  |
| Staff from your CHS participate in Victorian Refugee Health Network forums and other events where information is exchanged. |  |  |  |
| Staff from your CHS are able to keep up-to-date with policy changes and associated impacts on health service provision. |  |  |  |
| You share training opportunities with staff from settlement services and other health agencies. |  |  |  |
| Your staff provide resourcing and training to internal employees and external agencies. |  |  |  |

Case study: Regional coordination mechanisms

|  |
| --- |
| The Eastern Region Refugee Health Network, (ERRHN) is a collaboration between AMES, the Migrant Information Centre, the Primary Care Partnership, the Refugee Health Nurse,  Foundation House, Medicare Locals, the Department of Health and Human Services, Blackburn English Language School, Swinburne University nurses (who work with refugees attending the English language program), Victoria Police, Inspiro Community Health Service, GPs, practice nurses, maternal and child health and immunisation services of Maroondah Council, and other community health providers involved in supporting refugees and asylum seekers, such as the health promotion, dental health and counselling teams.  The network meets every three months for information sharing, networking and to develop advocacy activities. A recent action was the development of the report Factors that impact on access to immunisation of newly arrived refuge communities. Through this report, members were invited to speak with federal government members, the Department of Health and Human Services and the report was featured on an SBS World News program to highlight the need for full funding of all immunisations required by refugees and asylum seekers.  The ERRHN has also led to important, new and targeted service coordination, referral systems and service provision in the eastern region of Melbourne. Collaborative relationships and formalised partnerships have been fundamental to the approach with a multidisciplinary,  multi-agency team being operational. |

# Receiving government support

## Outcome priorities

Services provided to refugees and asylum seekers through the Community Health Program will contribute to addressing relevant priorities for refugee and asylum seeker health and wellbeing.

## Funding

The Community Health Program reaches across the state and funds the delivery of nursing, allied health and counselling services, along with accompanying language services, including bicultural workers and interpreting services. This funding should be used flexibly to provide support and services that are responsive to local needs including refugee and asylum seeker health.

Some providers of the Community Health Program that service areas where large numbers of refugees and asylum seekers are settling also receive targeted resources through the Refugee Health Program.

## Accountability

These guidelines have been developed to guide the delivery of the Community Health Program to refugee and asylum seeker clients and the development of best practice. All organisation receiving Community Health Program funding are required to identify refugees and asylum seekers in data submitted through the Community Health Minimum Data Set. Performance measures for the Refugee Health Program include hours of service provided to refugees and asylum seekers,with targets set consistent with the current allied health and nursing unit price.

## Reporting and evaluation

Community health services will adhere to the reporting requirements of the Community Health Minimum Data Set. The following specific data variables will be accessible to the Department of Health and Human Services to contribute to operational management of refugee health services across the statewide program. These variables include:

* service user demographics (age, sex, priority, etc)
* service provided (discipline, duration, outcome)
  + system performance (demand, wait for assessment and/or service).

Organisations should maintain sufficient records in order to adequately undertake future evaluation and/or reviews of the services provided to refugees and asylum seekers. Internal review and program development is recommended to ensure quality service and support for refugee and asylum seeker population health. The *CHIP guidelines* provide further direction regarding continuous quality improvement and innovation.

## Fees

Organisations should adhere to the Community Health Fees Policy. Visit [the Department of Health and Human Services’ website](https://www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-program/community-health-fees-policy) <https://www2.health.vic.gov.au/primary-and-community-health/community-health/community-health-program/community-health-fees-policy> for further information. This fees policy is an integrated approach to setting fees for consumers and service providers. It is to be implemented as a whole and not as individual components. The policy contains principles which provide a consistent framework within which service providers are to operate.

* Inability to pay cannot be used as a basis for refusing service to people assessed as requiring a service.
* Where fees are to be charged, it should be done in accordance with a scale of fees appropriate to the consumer’s level of income, amount of service used, and any changes in circumstances and ability to pay.
* Organisations should provide a written statement regarding the fee to be charged for any service and the payment procedures. All consumers should be informed of the fees applicable to them at the time of assessment or commencement of the service.
* Fee revenue can be used to enhance service delivery, either by providing additional services, or by measures to improve service delivery.



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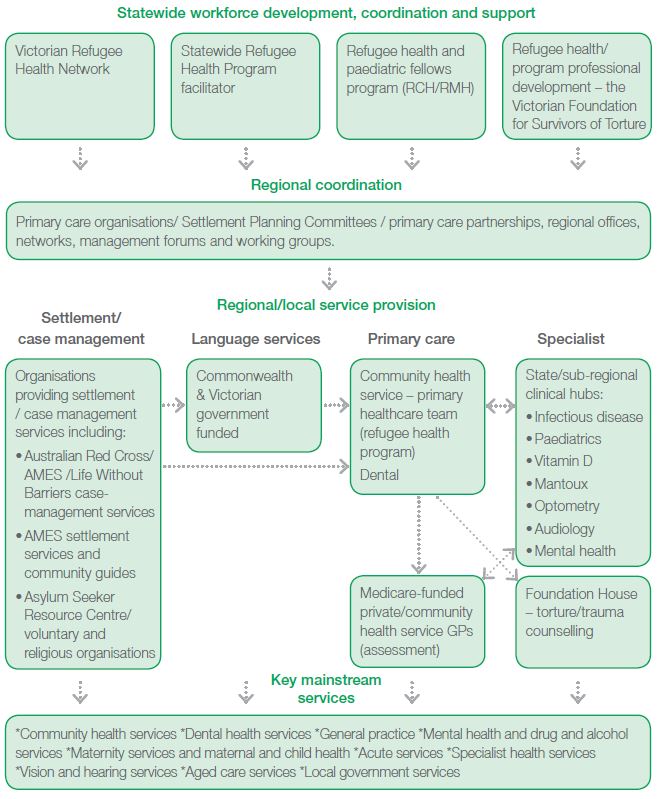
Victorian Foundation for Survivors of Torture 2012, [*Promoting refugee health: a guide for doctors, nurses and other healthcare providers caring for people from refugee*](http://www.foundationhouse.org.au/promoting-refugee-health-guides/) *backgrounds*,<[www.foundationhouse.org.au/](http://www.foundationhouse.org.au/resources/publications_and_resources.htm)promoting-refugee-health-guides/>.

# Appendix 1: Key services

Figure 4 outlines the key services and programs with a specialist role in supporting refugees and asylum seekers, especially in the early period of settlement.

These services work closely with other generalist primary care, community support and specialist services such as hospitals, maternal and child health and mental health services.

Figure 4: Key services in post-arrival refugee healthcare and coordination



\* Access to specific services is influenced by visa category. Refer to the section on policies and entitlements for further information.

Note that some refugee and asylum seeker clients will not be eligible for all services. The term, level and nature of the service will vary according to the person’s visa category and mode and time of arrival in Australia.

## Key specialised services

### Asylum seeker case work services

Asylum seekers are provided with case work support by the Adult Multicultural Education Service (AMES), the Australian Red Cross, Life Without Barriers, the Asylum Seeker Resource Centre and other community and religious-based organisations.

Depending on eligibility, these services can include provision of:

* welfare payments
* referral to health and legal services
* material aid such as furniture and clothing
* accommodation
* English language classes and tuition
* orientation to the community and the local neighbourhood
* provision of, or referral to, activities which increase social connection.

### Detention health providers

Asylum seekers living in held detention or in community detention receive health services through contracted service providers funded by the Department of Immigration and Border Protection.

Health services can be reimbursed for services provided to asylum seekers living in held detention or community detention.

When people are released from detention, it is critical that their medical records are provided to community based health services.

This enables improved continuity of care including follow-up of current health concerns.

### General practice

General practitioners provide early comprehensive health assessment and referral to specialist providers. They also provide follow-up care to support longer-term health and wellbeing.

### Language services

The Victorian Government provides interpreting services for practitioners delivering healthcare services.

The Commonwealth Government provides interpreting services for Medicare-funded general practice and specialist services.

The Community Health Program has access to language service facilities for culturally and linguistically diverse communities and, in addition, the Refugee Health Program has specific funding to support refugee health practitioners.

Divisions of general practice and Medicare locals have access to interpreting services through the Commonwealth Government Access to Allied Psychological Services (ATAPS) initiative.

Sector-wide development and sharing of translated material is facilitated through the Victorian Government’s Health Translations Service. Visit the Department of Health and Human Services’ [Health Translations website](file:///C:\Users\andrewmacrae\MEGA\jobs15\190305_deb_formatting\01\Health%20Translations%20website) <http://www.healthtranslations.vic.gov.au> to access translated material.

### Refugee Health Fellows Program

Refugee health fellows are currently located at select Melbourne Metropolitan Hospitals.

The refugee health fellows and paediatric fellows provide education, training and secondary consultation for health professionals as well as providing clinical services.

### Refugee Health Program

The Refugee Health Program (formerly the Refugee Health Nurse Program) commenced in 2005, in response to the poor health and complex health issues of arriving refugees.

The Refugee Health Program operates in areas with high numbers of newly arrived refugees and/or asylum seekers, as well as in areas that have secondary settlement refugee populations.

The program is based in community health services and includes nursing and allied health.

Other community health nursing, counselling and allied health services provided through the Community Health Program may also form part of a refugee health team.

### Refugee health services – subregional clinical hubs

Many community health centres and hospital-based services provide multidisciplinary refugee health services including primary care and specialist medical services described as sub-regional clinical hubs (see Figure 4).

Those based in community health services have outreach or sessional medical specialists, providing the opportunity for integrated care across primary and specialist services. Hospital-based services will often serve as a point of care coordination across hospital services.

The Asylum Seekers Resource Centre also operates a health centre reliant on volunteer time from primary and specialist providers and philanthropic funding.

### Refugee Settlement Services

Refugees entering Victoria are provided with settlement services by the Adult Multicultural Education Service (AMES) in conjunction with its partners. Services provided by the AMES Consortia include the provision of:

* case management
* information and orientation support provided by community guides in the language of the refugee
* short-term accommodation and support in locating longer term housing
* English language classes and tuition
* support to access employment and securing school placements for children
* provision of, or referral to, recreational activities that assist social connection
* referral to legal, health and other community agencies.

### Regional refugee health networks and working groups

Regional networks often involve collaboration between:

* Department of Health and Human Services.
* community health services
* Medicare Locals
* primary care partners
* settlement and asylum seeker support agencies
* torture and trauma counselling
* other health and community services
* universities
  + other state and Commonwealth government departments

These networks coordinate and develop services for refugees and asylum seekers at the local level, and are also a forum for workforce development to support system capacity.

### Statewide Refugee Health Program Facilitator

The facilitator plays a statewide role to support the Victorian Refugee Health Program.

This involves providing organisational development, advice and support so that agencies can:

* strengthen their capacity to meet refugees’ and asylum seekers’ primary healthcare needs
* contribute to professional development of health and settlement personnel involved in a coordinated approach
* provide secondary consultation to these personnel as appropriate.

### Victorian Foundation for Survivors of Torture

The Victorian Foundation for Survivors of Torture (VFST) provides specialised counselling and related services to people who have experienced trauma, persecution or war-related trauma before arrival in Australia.

VFST also provides secondary consultation and professional and organisational development across the education, health and community services sectors, in conjunction with the statewide refugee health program facilitator, refugee health fellows and other specialists.

### Victorian Refugee Health Network

The Victorian Refugee Health Network is a statewide body auspiced by the VFST. The network facilitates collaboration among health and community services with the goal of providing more accessible and responsive services to refugees and asylum seekers.

The network develops and disseminates information, undertakes specific projects, supports working groups to address issues and liaises with government to progress refugee and asylum seeker health policy and programs. Visit [the Victorian refugee health network](http://refugeehealthnetwork.org.au/summary-report-asylum-seekers-integrated-healthcare-pathway-july2013/%3e) <http://refugeehealthnetwork.org.au/> for more information.

# Appendix 2: Web resources

[Centre for Culture, Ethnicity and Health](https://www.ceh.org.au/)  
<https://www.ceh.org.au>

Specialist information, training and support on cultural diversity and wellbeing.

[Health Translations](http://www.healthtranslations.vic.gov.au/)  
<https://www.healthtranslations.vic.gov.au>

A searchable database containing links to multilingual online health resources from government departments, peak health bodies, hospitals, community health centres and welfare agencies. Also includes a unique tool to help identify a client’s preferred language.

[Primary Care Partnerships](https://www2.health.vic.gov.au/primary-and-community-health/primary-care/primary-care-partnerships)  
<https://www2.health.vic.gov.au/primary-and-community-health/primary-care/primary-care-partnerships>

Information and resources to support service coordination.

[Victorian Foundation for Survivors of Torture](http://www.foundationhouse.org.au/)  
<https://www.foundationhouse.org.au>

Services for people who have experienced trauma, persecution or war-related trauma prior to arrival in Australia. The website includes resources and information regarding professional and organisational development.

[Victorian Government Active Service Model Resources](https://www2.health.vic.gov.au/ageing-and-aged-care/home-and-community-care/hacc-program-for-younger-people/hacc-program-guidelines/hacc-quality-and-service-development/active-service-model)  
<https://www2.health.vic.gov.au/ageing-and-aged-care/home-and-community-care/hacc-program-for-younger-people/hacc-program-guidelines/hacc-quality-and-service-development/active-service-model>

Useful websites, publications and contacts to support agencies in the ongoing implementation of an active service model approach.

[Refugee](https://www2.health.vic.gov.au/about/populations/refugee-asylum-seeker-health) [and asylum seeker health and wellbeing](https://www.health.vic.gov.au/diversity/refugee.htm)  
<https://www2.health.vic.gov.au/about/populations/refugee-asylum-seeker-health?>

Information on Victorian and some Australian government policies and programs and relevant links related to refugee and asylum seeker health.

[Victorian Refugee Health Network](http://refugeehealthnetwork.org.au/)  
<https://refugeehealthnetwork.org.au/>

Up-to-date links to clinical information, policies and entitlements, information on referral sources (including immigrant health clinics), a library of resources and links to professional networks and current activities. A regular e-bulletin is also published.

[Victorian Transcultural Mental Health](http://www.vtmh.org.au/)  
<https://www.vtmh.org.au>

A statewide unit that supports area mental health and psychiatric disability support services in working with culturally and linguistically diverse consumers and carers throughout Victoria.

# Appendix 3: Publications

## Government publications

Department of Education and Early Childhood Development 2011, *Refugee status report: A report on how refugee children and young people in Victoria are faring*, State Government of Victoria, Melbourne.

Department of Health 2008, *Towards a demand management framework for community health services*, State Government of Victoria, Melbourne.

Department of Health 2009, *Community health priority tools*, State Government of Victoria, Melbourne.

Department of Health 2009, *Cultural responsiveness framework: guidelines for Victorian health services*, State Government of Victoria, Melbourne. Note: A summative evaluation of the *Cultural responsiveness framework* has recently been completed. A new participation and equity policy will be developed over 2015 and will include a program of work to support its implementation.

Department of Health 2011, *Doing it with us not for us: strategic direction 2010–13*, State Government of Victoria, Melbourne. Note: A summative evaluation of Doing it with us not for us has recently been completed. A new participation and equity policy will be developed over 2015 and will include a program of work to support its implementation.

Department of Health 2011, *Strengthening diversity planning and practice: a guide for Victorian Home and Community Care services*, State Government of Victoria, Melbourne.

Department of Health 2012, *Victorian service coordination manual 2012*, State Government of Victoria, Melbourne.

Human Rights Commission 2006, *Charter of Human Rights and Responsibilities*, State Government of Victoria, Melbourne.

Office of Multicultural Affairs and Citizenship, *Effective translations: Victorian Government guidelines* [*on policy and procedures*](http://www.multicultural.vic.gov.au/images/stories/documents/2014/omac%20effective%20translations%20guidelines%20on%20policy%20and%20procedures%20%20online.pdf), State Government of Victoria, Melbourne.

Office of Multicultural Affairs and Citizenship, [*Using interpreting services: Victorian Government*](http://www.multicultural.vic.gov.au/images/stories/documents/2014/omac%20using%20interpreting%20services%20guidelines%20on%20policy%20and%20procedures%20online.pdf)[*guidelines on policy and procedures*](http://www.multicultural.vic.gov.au/images/stories/documents/2014/omac%20using%20interpreting%20services%20guidelines%20on%20policy%20and%20procedures%20online.pdf), State Government of Victoria, Melbourne.

West Australia Department of Health 2014, *Community health policies, procedures and guidelines for at risk groups: guidelines for delivering refugee community health*.

## Field publications

Australian Commission on Safety and Quality in Healthcare 2011, *Australian Charter for Healthcare Rights in Victoria*.

Centre for Culture, Ethnicity and Health 2010, *Cultural competence in health service provision: tip sheet series*.

Russell G, Harris M, Cheng I-H, Kay M, Vasi S, Joshi C, Chan B, Lo W, Wahidi S, Advocat J, Pottie K, Smith M, Furler J, 2013. Coordinated primary health care for refugees: a best practice framework for Australia. Report to the Australian Primary Health Care Research Institute

Victorian Equal Opportunity and Human Rights Commission 2013, *Guidelines for general practices: complying with the Equal Opportunity Act 2010 when providing services*.

Victorian Foundation for Survivors of Torture 2012, *Promoting refugee health: a guide for doctors, nurses and other healthcare providers caring for people from refugee backgrounds*, 3rd edition.

Victorian Foundation for Survivors of Torture 2012, *Caring for refugee patients in general practice: a desktop guide*, 4th edition.

Western Region Health Centre Victoria (now cohealth) 2011, *Bilingual staff policy and procedure*. Available on intranet.

# Appendix 4: Outline for service provision for refugees and asylum seekers in Victoria

Principles underpinning service provision for refugees and asylum seekers

|  |  |  |
| --- | --- | --- |
| Individual level | Organisational level | Systems and partnerships |
| Refugees and asylum seekers should receive healthcare that:  is accessible, timely, high quality and evidence-based  is culturally responsive and sensitive to needs that may arise from refugee experiences  promotes health literacy, self-management and participation  promotes well-coordinated access to other systems and resources required for health and wellbeing. | Providers of the Community Health Program should:  ensure staff have appropriate skills and supports to provide healthcare to refugees and asylum seekers  be accessible, culturally and linguistically relevant and able to meet the health needs of refugees and asylum seekers  engage with communities to plan and develop services  provide services informed by a social model of health. | Providers of the Community Health Program should work with:  **settlement/case-management services** to promote health service access and literacy  **the wider health service and settlement system** to ensure the rights, entitlements and needs of refugees and asylum seekers are met  **other providers** to ensure a coordinated approach to health service provision  **cross-sector providers** addressing the social determinants of health. |

Models of healthcare: priority short-term outcomes

| Individual level | Organisational level | Systems and partnerships |
| --- | --- | --- |
| Outcomes include that:  individuals understand and access the healthcare system  communication takes place in the service user’s language and is culturally responsive  support and care is appropriate according to need  refugees and asylum seekers are supported to transition from specialist support to routine care  opportunities are provided for service users to strengthen their health literacy and skills in managing their own health  engagement takes place with families of specific refugee and asylum seeker clients,  as appropriate. | There are mechanisms in place to ensure that:  healthcare provided through the Community Health Program is coordinated, culturally responsive and supported by language services  community health service staff are aware of and meet their responsibilities in the provision of services to refugee and asylum seeker clients  effective teamwork in the provision of services to refugee and asylum seeker clients is maintained  client feedback on healthcare and coordination is sought and fed into quality improvement strategies. | Providers of the Community Health Program, settlement/ case-management services and other health agencies work together to ensure that refugees and asylum seekers are provided with coordinated care that meet their needs.  Relationships and mechanisms are in place with other providers and networks to ensure effective delivery of services at the state and regional level.  Issues affecting the health of refugees and asylum seekers are made visible to policymakers and governments. |

Anticipated long-term outcomes

|  |  |  |
| --- | --- | --- |
| Individual level | Organisational level | Systems and partnerships |
| Refugees and asylum seekers:  are aware of and use services required to support health and wellbeing  are aware of physical and mental health issues and preventative approaches to illness  use the same services and programs as provided to other members of the community  are able to make informed decisions about their own health  report service satisfaction and are able to communicate their health needs  have improved physical and mental health, including lower levels of preventable conditions. | Staff have the skills and support to provide timely, culturally responsive services that meet the needs of refugees and asylum seekers.  Systems, policies and procedures underpinning provision of healthcare to refugees and asylum seekers are embedded in service operations.  Cross-sector organisations are aware of the framework underpinning community health services to refugees and asylum seekers and adopt components of the framework to improve their own service access and provision. | The service system is well resourced and coordinated.  Service coordination mechanisms are documented and monitored across the state.  Emerging policy issues are effectively communicated to government and other relevant authorities.  Victoria is identified as a leader in health service provision to refugees and asylum seekers.  Emerging health and social issues are promptly addressed. |

# Appendix 5: Text-equivalent descriptions of figures

**Figure 1: Principles of care as outlined** in the Community Health Integrated Program guidelines

The principles of care are for person-centred care that is high quality and supported.

* The principles include:
* culturally responsive
* goal directed
* health literacy
* health promoting
* self-management
* early intervention
* evidence based
  + team approach.

**Figure 2: The refugee and asylum seeker healthcare journey**

The refugee and asylum seeker healthcare journey is:

* initial contact
* health system orientation, health education and triage
* early health assessment
  + longer-term health and wellbeing and shared care planning

This takes place within a frame of preventive care and management.

Key enablers of quality care are:

* accessibility
* expertise
* service coordination
* cultural responsiveness
* health literacy
  + communication.

**Figure 3: Pathways of care – triage process**

The triage process is as follows:

* Pathway 1: clients for self-management should be referred to private general practice
* Pathway 2: high-risk clients should be referred to a community health GP and/or refugee health nurse and allied health
* Pathway 3: clients with complex mental and/or physical health issues should be referred to a specialist service often with nurse or GP support
  + Pathway 4: clients requiring urgent care should be referred to the emergency department.

**Figure 4: Key services in post-arrival refugee healthcare coordination**

The statewide workforce development, coordination and support level comprises:

* Victorian Refugee Health Network
* Statewide Refugee Health Program facilitator
* Refugee health and paediatric fellows program (RCH/RMH)
  + Refugee health / program professional development — the Victorian Foundation for survivors of torture.

This level feeds into the regional coordination level, which comprises:

* primary care organisations
* settlement planning committees
* primary care partnerships
* regional offices
* networks
* management forums
  + working groups.

This level feeds into the regional/local service provision level, which comprises:

* settlement / case management, being made up of organisations providing settlement / case management services including
  + - Australian Red Cross, AMES, Life without Barriers case management services
    - AMES settlement services and community guides
    - Asylum Seeker Resource Centre / voluntary and religious organisations
* language services — Commonwealth and Victorian-government funded
* primary care — community health service, primary healthcare team (refugee health program), dental
  + - Medicare funded private/community health service GPs (assessment)
* Specialist — state subregional clinical hubs, including infectious disease, paediatrics, vitamin D, mantoux, optometry, audiology, mental health
  + - * Foundation House — torture/trauma counselling

This level feeds into the mainstream service level, comprising:

* community health services
* dental health services
* general practice
* mental health and drug and alcohol services
* maternity services and maternal and child health
* acute services
* specialist health services
* vision and hearing services
* aged care services
* local government services.

1. For further information, access the Victorian Equal Opportunity and Human Rights Commission publication: [*Guideline for general practices: complying with the* Equal Opportunity Act 2010 when providing services](https://www.humanrightscommission.vic.gov.au/index.php/our-resources-and-publications/brochures/item/905-guideline-for-general-practices-complying-with-the-equal-opportunity-act-2010-when-providing-services) <https://www.humanrightscommission.vic.gov.au/index.php/our-resources-and-publications/brochures/item/905-guideline-for-general-practices-complying-with-the-equal-opportunity-act-2010-when-providing-services>. [↑](#footnote-ref-1)
2. Victorian Government’s [*Strengthening diversity planning and practice: a guide for home and community services 2011*](https://www2.health.vic.gov.au/ageing-and-aged-care/home-and-community-care/hacc-program-for-younger-people/hacc-program-guidelines/hacc-quality-and-service-development/diversity-in-hacc/diversity-planning-practice) <https://www2.health.vic.gov.au/ageing-and-aged-care/home-and-community-care/hacc-program-for-younger-people/hacc-program-guidelines/hacc-quality-and-service-development/diversity-in-hacc/diversity-planning-practice>. Information to guide the use of interpreting and translating services can be found in the whole of government language services policy, [*Effective translations: Victorian Government guidelines on policy and procedures*](https://www.multicultural.vic.gov.au/projects-and-initiatives2/improving-language-services/standards-and-guidelines/using-interpreting-services/using-interpreting-services-page-1)<https://www.multicultural.vic.gov.au/projects-and-initiatives2/improving-language-services/standards-and-guidelines/using-interpreting-services/using-interpreting-services-page-1>. [↑](#footnote-ref-2)