REVIEW OF THE NSW REFUGEE HEALTH PLAN

EVIDENCE REVIEW

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FINAL
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URBIS

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ACRONYMS

AOD	Alcohol and other drugs
CSDH	Commission on Social Determinants of Health
HSP	Humanitarian Settlement Program
IOM	International Organisation for Migration
LHD	Local Health District
MHRHW	Monash Health Refugee Health and Wellbeing Service
PCMH	Patient-Centred Medical Home
PHC	Primary Health Care
PTSD	Post-traumatic stress disorder
PHRC	Philadelphia Refugee Health Collaborative
RHP	Refugee Health Plan
SHP	Special Humanitarian Program
SIS	Specialist and Intensive Services
STARTTS	Service for the Treatment and Rehabilitation of Torture and Trauma Survivors
TIS	Translating and Interpreting Service
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organisation

DEFINITIONS

The following definitions have been adopted for the purpose of the Evidence Review.

- "Health inequalities": refers to "differences in health status or in the distribution of health determinants between different population groups" (WHOb, n.d.)
- "Health inequities": refers to "avoidable inequalities in health between groups of people within countries and between countries" (WHOa, n.d.)
- "Model of care": is used broadly to refer to the way health services are delivered (Agency of Clinical Innovation, 2013, p.3). A model of care may be defined by (Joshi et al., 2013, p.91):
  - principles (such as equity, accessibility, comprehensiveness, coordination)
  - care delivery systems (e.g. multidisciplinary, on-line)
  - the nature of consumers and the pathway of care which they must negotiate (e.g. entry, referral, etc.)
  - the range of services provided (e.g. medical specialist, generalist).
- "Model element / service element": these terms are used interchangeably to refer to the distinct components of a model of care or approach to service delivery (e.g. the type of health professionals delivering services, the type of care delivered etc.)

EXECUTIVE SUMMARY

The NSW Government recognises that access to quality healthcare is critical to the successful resettlement of refugees into the community. Its commitment to supporting the health and wellbeing of refugees is reflected in the NSW Refugee Health Plan 2011-2016 (the existing RHP), which established a best-practice model for responding to the needs of refugees. The model identified a range of service elements, supporting infrastructure, and preventive and community measures that would enable improvements in refugees' health outcomes. Combined, these various model elements provided a holistic approach for refugee healthcare in NSW.

Urbis was commissioned by the NSW Ministry of Health (the Ministry) to review the existing RHP and to develop a new NSW Refugee Health Plan (the new RHP). The review of the existing plan will comprise an assessment of progress and achievements to date, including through funded enhancements to specialised refugee health services.

This evidence review was undertaken to inform the development of the new plan. It builds on a comprehensive review of the literature that was undertaken in 2009 (Owen et al. 2009) and examines the evidence that has emerged since the existing RHP was developed. A particular focus was placed on identifying best-practice approaches to delivering health care to refugees and refugee-like populations.

Overall, the evidence considered as part of this review generally supported the model outlined in the existing RHP, with many authors noting the importance of multi-faceted, comprehensive and coordinated approaches to supporting refugees (e.g. Russel et al., 2013; Woodland et al., 2010).

In addition, a range of service elements were found to improve service access and, in doing so, create an enabling environment for improvements in refugees' health outcomes. These included:

- the use of interpreters and/or bilingual workers
- care coordination and service navigation
- coordinated and integrated service delivery
- holistic approaches that respond to the social determinants of health
- promotion of health literacy and help-seeking pathways
- culturally competent service delivery and improved understanding of the refugee experience among health professionals
- capacity building in the mainstream health system
- community engagement and collaboration.

The findings of this review will be further tested during the community consultations that are occurring as part of the development of the new RHP.

1. INTRODUCTION

Across the globe, the number of people forcibly displaced as a result of persecution, conflict, or generalised violence (including refugees, asylum seekers, and internally displaced people) is at an unprecedented level (UNHCR, 2018). By the end of 2017, the United Nations High Commissioner for Refugees (UNHCR) estimates that 68.5 million people were forcibly displaced (UNHCR, 2018). Of these, 24.5 million were considered to be people from a refugee background, with over two-thirds (68 per cent) of all people from a refugee background coming from one of five countries: the Syrian Arab Republic, Afghanistan, South Sudan, Myanmar and Somalia (UNHCR, 2018).

Under the 1951 Geneva Convention, the term 'refugee' is used to describe any person who,

> *"owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it."*
>
> (Article 1A (2) Convention Relating to the Status of Refugees, 1951)

Australia has a long history of accepting refugees. Since the end of the second world war, over 800,000 refugees and displaced persons have settled in Australia (Parliament of Australia, 2015). Ensuring the health system can respond to the needs of these refugees is critical to their successful settlement in Australia (Joshi et al., 2013). This not only includes facilitating timely access to care at the time of settlement, but also ongoing access to effective and culturally appropriate services.

1.1. REFUGEES IN NSW

Australia's commitment to settling refugees is facilitated under the Australian Government's Humanitarian Program, which is comprised of two distinct components:

- **offshore resettlement** for people outside of Australia, including the refugee and special humanitarian program (SHP) categories, and
- **onshore protection** for people inside Australia.

Each year, the size and composition of the Humanitarian Program is determined by the Commonwealth Government. This includes setting a minimum intake of refugees, which has been around 13,750 people in recent years (Department of Home Affairs, 2018). The Humanitarian Program is designed to operate flexibly so that it can "respond effectively to evolving humanitarian situations and global resettlement needs" (Department of Home Affairs, 2018, p.8). In 2015 for example, Australia increased its commitment to accept refugees specifically in response to the humanitarian crises in Iraq and Syria. An additional 12,000 places were created for refugees from these countries, leading to a spike in number of people granted visas under the offshore protection component of the program (see Table 1) (Department of Home Affairs, 2018).

Table 1 – Humanitarian Program outcomes by component 2013-14 to 2016-17

Category	2013-14	2014-15	2015-16	2016-17
Offshore protection				
Refugee resettlement	6,484	5,985	8,267	9,653
Special Humanitarian Program (SHP)	4,500	4,996	7,270	10,604
Onshore protection	2,752	2,750	2,003	1,711
Total	**13,736**	**13,731**	**17,540**	**21,968**

Source: Australian Department of Home Affairs. (2018). *Discussion Paper: Australia's Humanitarian Program 2018-19, 2018.* Retrieved: https://www.homeaffairs.gov.au/reports-and-pubs/files/2018-19-discussion-paper.pdf

New South Wales settles a large number of the refugees who are granted protection under the Program. In total, around 11,190 refugees were settled in NSW in 2016-17; representing a significant proportion (~43 per cent) of Australia's total humanitarian intake that financial year (NSW Government, 2017). Nearly all these refugees were Syrian and Iraqi (~90 per cent), many of whom were proposed by families living in South Western Sydney, and particularly Fairfield (NSW Government, 2017). In addition to these metropolitan areas, a number of refugees have settled in regional communities. As was noted by Piper (2017), movement to regional areas may be initiated by government as part of a planned settlement experience, may be a personal decision on the part of the individual, or be influenced by local initiatives that support refugee settlement (e.g. Sanctuary Refugee Support Groups in Coffs Harbour, Lismore and Armidale) (Piper, 2017, p.5). Example communities include Bhutanese in Albury and Yazidis in Wagga Wagga (Piper, 2017, p.4).

Ongoing efforts from NSW Health (and other services) will be required to meet the demands of an increasing refugee population, and to respond to the specific health needs of recent arrivals. Therefore, the Ministry of Health has committed an additional $32.4 million over four years (2016-2020) (NSW Treasury, 2016, p.21). This includes funding for "specialised health services, including health nurse screening, interpreting services, therapeutic interventions for physiological problems, vaccinations and specialist paediatric clinics" (NSW Treasury, 2016, p.21). These services, targeted at the refugee population, will be evidence-based and culturally-sensitive.

Responsibility for refugee health crosses all levels of government in Australia, and also involves the non-government, community and private sectors. In addition to mainstream health services, such as Australia's universal public health insurance scheme (Medicare), refugees have access to a range of generalist and specialist refugee services.

At the Commonwealth level, for example, the Australian Government provides targeted support to humanitarian entrants through the Humanitarian Settlement Program (HSP), including the Specialist and Intensive Services (SIS) component. Participants in each of these programs are linked with case managers and community workers who provide them with a range of supports including:

- assistance accessing government funded health services
- orientation to Australian life
- support accessing housing and social services (Renzaho, 2016).

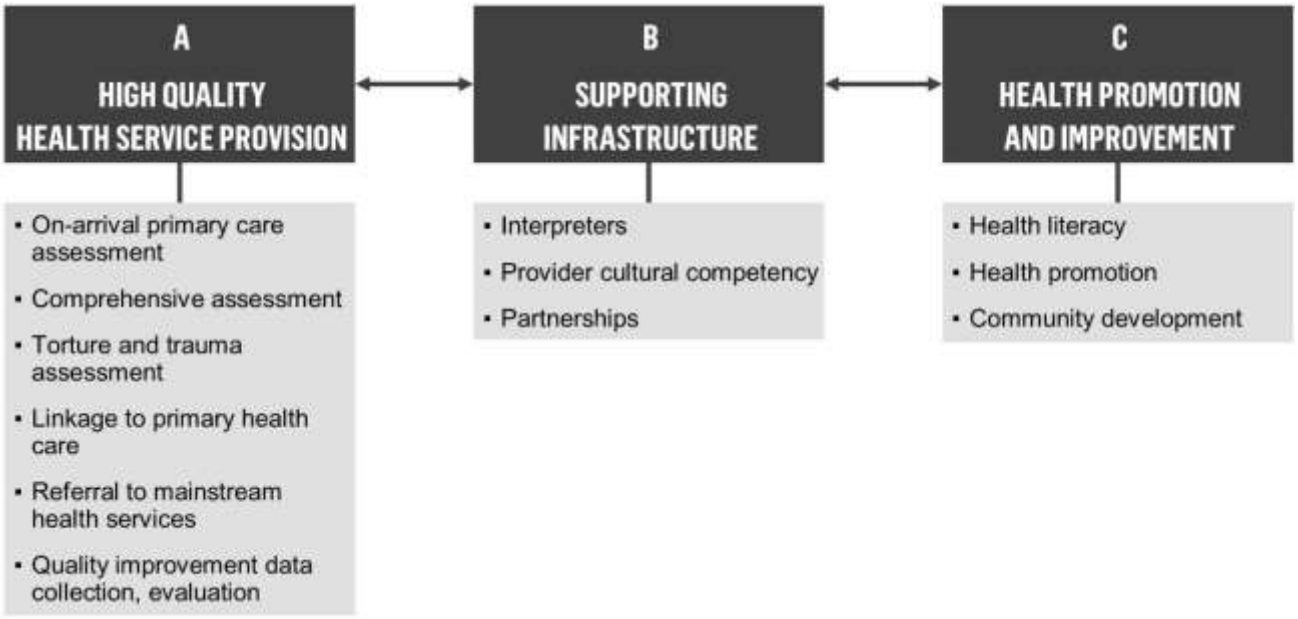
It should be noted that the HSP and SIS component are designed to be time-limited supports, with the ultimate goal being to transition refugees to mainstream services. Refugees who are on either a Temporary Protection Visa (subclass 785) or Safe Haven Enterprise Visa (subclass 790) are not eligible for either he HSP or SIS. The Australian Government also provides some support to health professionals: for example, the Australian Refugee Health Practice Guide, launched in 2018, aims to support doctors, nurses and other primary care providers in delivering ongoing care to people from refugee backgrounds (Foundation House, 2018).

1.2. REFUGEE HEALTHCARE IN NSW

At a state level, the NSW Government is committed to the successful resettlement of refugees, including supporting positive health and wellbeing outcomes among this group. This is achieved through specialist services targeted at refugee groups (e.g. the NSW Refugee Health Service), support for Affiliated Health Organisations (e.g. the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS)) and community organisations working with refugees, as well as state-wide efforts to promote collaboration within and between health and other government portfolios.

The existing RHP, established in 2011, is central to the Government's efforts in this area. The Plan sets out a best-practice model for refugee health service provision that was informed by a review of the evidence at the time. The best-practice model proposed was underpinned by a strong focus on co-ordination and collaboration between services, and identified a range of service elements, supporting infrastructure, and preventive and community measures that were found to have a positive impact on the health and wellbeing of refugees (see Figure 1).

Figure 1 – Best-practice model for refugee health service provision



Taken from NSW Department of Health, 2011 p.24

By examining the evidence published since the existing RHP was developed, this review seeks to assess the extent to which this model remains best-practice, including identifying opportunities for strengthening or improving the approach currently adopted under the RHP.

1.3. REFUGEE HEALTHCARE IN OTHER AUSTRALIAN STATES AND TERRITORIES

Across Australia, a range of approaches have been taken by state and territory governments to respond to the specific and complex health needs of refugees. With varying annual intakes of refugees in each state and territory, each government takes a different approach to providing health services to refugees. An overview of the key services provided in each state and territory is provided in Table 2 (overleaf).

Table 2 – Overview of approaches to refugee healthcare in other state and territory jurisdictions

STATE/TERRITORY GOVERNMENT	ANNUAL INTAKE[1]	STATE-FUNDED SERVICES
VICTORIA Department of Health & Human Services	**5,050** Refugees (approximately 31% of the national total)	This is discussed in detail in Section 2.1.4.
QUEENSLAND Department of Health	**2,200** Refugees (approximately 13.5% of the national total)	The Queensland Government has an overarching commitment to achieving a community that is inclusive of all cultures, languages and faiths (Queensland Department of Communities, Child Safety and Disability Services, 2016). This commitment is set out in ***Our story, our future: Queensland's Multicultural Policy*.** Under this policy, the Queensland Government aims to support people from a refugee background and asylum seekers in reducing barriers and creating opportunities for participation and contribution to economic, social and cultural life in Queensland (Queensland Department of Communities, Child Safety and Disability Services, 2016). The ***Refugee Health and Wellbeing: A policy and action plan for Queensland 2017-2020*** establishes the strategic direction for the health of people from a refugee background in Queensland (Queensland Department of Health, 2017). The main focus of this plan is to establish a state-wide refugee health and wellbeing network and adapt services to meet the needs of people from a refugee background (Queensland Department of Health, 2017). The Refugee Health Network Queensland sits at the centre of this plan, building capacity, improving partnerships, and facilitating coordination of care across health, refugee settlement agencies, refugee communities and the non-government sector (Queensland Department of Health, 2017). The Queensland Department of Health also provides **health assessments** to people from a refugee background within 12 months of arrival in Australia. This is delivered by refugee health specific services in partnership with General Practitioners and other primary care health professionals. Other services provided include the **Mater Refugee Complex Care Clinic** which supports people from a refugee background with complex health needs (Queensland Department of Health, 2017). Case management, treatment and specialist referrals are some of the services provided to respond to these complex health needs (Queensland Department of Health, 2017). **Refugee Health Connect** is another support service for people from a refugee background, assisting with sourcing appropriate primary health providers for health assessments and ongoing care (Queensland Department of Health, 2017).

[1] These numbers were collated from a combination of data reports from the Department of Social Services, Australian Government including: 'Permanent Settlers (All Streams) in all States/Territories with a Date of Settlement between 01 January 2018 and 31 December 2018, 'State of Residence of Permanent Settlers (All Streams) in all States/Territories with a Date of Settlement between 01 January 2017 and 31 December 2017.' Permanent Settlers (All Streams) in all States/Territories with a Date of Settlement between 01 January 2016 and 31 December 2016.' and 'Settlement Monthly Report: Settlers by Migration and State of Residence' for April 2010 to March 2015.

STATE/TERRITORY GOVERNMENT	ANNUAL INTAKE[1]	STATE-FUNDED SERVICES
SOUTH AUSTRALIA Department of Health	**1,400** Refugees (approximately 8.5% of the national total)	The **Refugee Health Service** in South Australia provides primary health care services for people from a refugee background who have recently arrived in Australia (South Australian Department of Health, n.d.). These services include health assessments, care for refugees with complex conditions and infectious diseases, responding to the health consequences of torture, trauma and gender-based violence, and daily nurse home visits for clinical assessment. To prevent the spread of disease, the **New Arrival Refugee Immunisation Program** offers vaccines to newly arrived people from a refugee background in South Australia (South Australian Department of Health, n.d.). The service allows individuals to attend appointments with family groups, provides access to interpreter services and offers catch-up vaccines where required.
WESTERN AUSTRALIA Department of Health	**1,050** Refugees (approximately 6.5% of the national total)	To identify the health issues faced by newly arrived people from a refugee background, the **Humanitarian Entrant Health Service** provides a free health assessment for people from a refugee background and humanitarian entrants (Western Australian Department of Health, n.d.). This assessment is for those who were resettled in Western Australia under the Australian Government's Humanitarian Program and Special Humanitarian Program (Western Australian Department of Health, n.d.). The Child and Adolescent Community Health**, Refugee Health Team,** connects newly arrived people from a refugee background and humanitarian entrants with community and specialist health care services. A nurse visits a family for an initial home visit (Western Australian Department of Health, n.d.). The purpose of the home visit is to discuss a range of health service options such as immunisation, child and school health services, dental and optometry services, women's health services and mental health (Western Australian Department of Health, n.d.). The **Refugee Health Clinic** at the **Prince Margaret Hospital for Children** provides holistic health care for children from a refugee background and their families. The clinic works closely with the Humanitarian Entrant Health Service (Western Australian Department of Health, 2018). Support for women from a refugee background and their newborns is in the process of being improved through the **Women's and Newborns Health Network** (Western Australian Department of Health, 2018). This network has sponsored a system-wide Clinical Senate on the need to better support disadvantaged women, particularly women from a refugee background and migrant women, and their newborns (Western Australian Department of Health, 2018).

STATE/TERRITORY GOVERNMENT	ANNUAL INTAKE[1]	STATE-FUNDED SERVICES
TASMANIA Department of Health & Human Services	**450** Refugees (approximately 2.8% of the national total)	People from a refugee background can receive a free comprehensive health assessment on arrival through the **Refugee and Humanitarian Arrival Clinic** (Tasmanian Department of Health and Human Services, 2015). This involves three visits, treatment, follow-up and referral to primary health providers and specialists (Tasmanian Department of Health and Human Services, 2015). The **Bi-Cultural Community Health Program** provides support to newly arrived people from a refugee background, to help them understand and access health and welfare services (Tasmanian Department of Health and Human Services, 2015). The program also works with services and communities to improve their capacity to identify emerging health issues and how best to respond to these issues (Tasmanian Department of Health and Human Services, 2015). The **Refugee and Migrant Liaison Officer** works at the Royal Hobart Hospital to enable acute care staff to provide appropriate services to people from a refugee background and migrant patients (Tasmanian Department of Health and Human Services, 2015).
AUSTRALIAN CAPITAL TERRITORY Department of Health	**190** Refugees (approximately 1.2% of the national total)	The main service that supports refugees in the Australian Capital Territory is a non-government funded organisation known as Companion House. Companion House has a range of free services that focus on medical and counselling support (Companion House, n.d.). There is a particular focus on supporting people who have survived torture, trauma and human rights violations (Companion House, n.d.).
NORTHERN TERRITORY Department of Health	**80** Refugees (approximately 0.5% of the national total)	There is no overarching refugee health plan in the Northern Territory; however, the *Northern Territory Suicide Prevention Strategic Framework 2018-2023* identifies people from a refugee background as a group of people at increased risk of suicidal behaviour (Northern Territory Department of Health, 2016). This framework therefore underscores the need for targeted prevention for high-risk groups such as people from a refugee background (Northern Territory Department of Health, 2016). The *Northern Territory Refugee Vaccination Policy* establishes a coordinated approach to assessing and delivering immunisations for newly arrived people from a refugee background in the Northern Territory (Northern Territory Centre for Disease Control, 2016). It delineates the roles and responsibilities of each organisation and service delivering immunisation and outlines a schedule for immunisation of refugee groups (Northern Territory Centre for Disease Control, 2016). The **Northern Territory Refugee Health Program**, funded by the Northern Territory Department of Health, is the main service that provides support for newly arrived people from a refugee background in the Northern Territory (PHN Northern Territory, 2016). It aims to ensure that these people receive comprehensive and coordinated primary health care (PHN Northern Territory, 2016). This includes health assessments, immunisation, referral to specialist services, and care coordination led by a nurse (PHN Northern Territory, 2016). The **Tuberculosis and Leprosy Unit** also ensures that newly arrived people from a refugee background are screened for tuberculosis, leprosy and nontuberculous mycobacteria (Northern Territory Department of Health, 2018.

1.4. REFUGEE HEALTHCARE IN VICTORIA

The following section details the refugee healthcare system in Victoria, which is known to be mature and comprehensive.

Refugees in Victoria

A substantial number of refugees settle in Victoria each year (Department of Health and Human Services, 2015). Humanitarian program entrants settling in Victoria are primarily from Burma, Afghanistan, Iraq and Iran (Department of Health and Human Services, 2015). The refugee intake in Victoria continues to grow, with the increase in settlement of additional Syrian and Iraqi people from a refugee background (Department of Health and Human Services, 2016). A large number of refugees in Victoria are settled in rural and regional areas such as Greater Dandenong, Greater Geelong, Casey, Melton and Hume (Victorian Department of Premier and Cabinet, 2015).

The Policy Context

The *Victoria Refugee and Asylum Seeker Health Action Plan 2014-18* (the Victorian Plan) sets the Victorian Department of Health & Human Service's strategic commitment to refugee and asylum seeker health (Victorian Department of Health & Human Services, 2014). This Plan will continue to be referred to until an updated plan is published. The Victorian Plan aims to improve the physical and mental health of refugees and asylum seekers.

The five priority action areas of the Victorian Plan include:

1. **Accessibility:** all refugees and asylum seekers can access the appropriate service at the appropriate time, regardless of geographical and language barriers (Victorian Department of Health & Human Services, 2014).
2. **Expertise:** deepen the knowledge and expertise in refugee and asylum seeker healthcare and strengthen training and capacity for general and specialist health services (Victorian Department of Health & Human Services, 2014).
3. **Service coordination:** coordinate local area needs assessment and service planning and expand approaches to service coordination across Victoria to enhance client care (Victorian Department of Health & Human Services, 2014).
4. **Cultural responsiveness:** increase the cultural responsiveness of the Victorian health system through training of staff and consultation with communities (Victorian Department of Health & Human Services, 2014).
5. **Health literacy and communication:** consult with refugees and asylum seekers to respond to health literacy and strengthen communication with health service providers (Victorian Department of Health & Human Services, 2014).

If these priority actions are successfully implemented, it is hoped that refugees and asylum seekers in Victoria will experience improved health outcomes.

Approach to Refugee Healthcare in Victoria

The Victorian Department of Health and Human Services administers the Community Health Program (CHP), a key Victorian program that aims to deliver effective primary care services to priority populations (Department of Health and Human Services, 2015). These priority populations include Aboriginal and Torres Strait Islander people, people with intellectual disability, children in out-of-home care, people with mental illness, refugees and asylum seekers and people experiencing or at risk of homelessness (Department of Health and Human Services, 2015). The CHP is delivered by community health services as well as state- and Commonwealth-funded initiatives (Department of Health and Human Services, 2015).

A range of health services are delivered under the CHP such as general counselling, allied health and nursing services (Department of Health and Human Services, 2015). There is a particular focus on refugee and asylum seeker health under the CHP, with the main aims of the program involving:

- addressing physical, social and mental health needs
- supporting comprehensive health assessments and timely health interventions for newly arrived refugees
- improving the capacity of refugees and asylum seekers to understand and access the healthcare system in Victoria and have autonomy over their own health and decision-making regarding their health
- providing care that is culturally responsive, accessible and responds to the needs of refugees and asylum seekers
- strengthening access to health services for refugees and asylum seekers through supporting specialist case management, settlement and asylum seeker services
- supporting coordination and continuity of care between providers
- Providing support to refugees and asylum seekers as they interact with services and promote the health and wellbeing of refugees and asylum seekers through appropriate policies and practices
- contributing to a service system that is coordinated and collaborative (Department of Health and Human Services, 2015).

Under the CHP there are several key specialised services that support refugees and asylum seekers, particularly newly arrived refugees. The Victorian Government's $10.9 million investment over four years (commencing Financial Year 2016-17) into health and human services for refugees has developed and continues to develop and expand these services (Victorian Department of Health and Human Services, 2016). The following are the key services that aim to support refugees under the CHP:

- **General practice:** health assessments and referrals are provided by general practitioners to newly arrived refugees. To ensure health and wellbeing is sustained, general practice also provides follow-up care for refugees to necessary services (Victorian Department of Health and Human Services, 2015).
- **Language services:** language service facilities are provided under the CHP to support culturally and linguistically diverse communities (Victorian Department of Health and Human Services, 2015).
- **Refugee Health Fellow Program:** fellows at the Royal Children's and the Royal Melbourne hospitals and Monash Health assist services and practitioners to support people from a refugee background who have recently arrived in Australia. Clinics are also held by a part-time paediatric specialist to support refugee families across the northern metropolitan area in Victoria (Victorian Department of Health and Human Services, 2015).
- **Refugee Health Program:** nurses, allied health professionals, interpreters and bicultural workers deliver the program; nurses play an important part in conducting the initial health screening and connecting people from a refugee background to general practice and specialist services. The state-wide refugee health program facilitator supports the Refugee Health Program in providing agencies with capacity-building and professional development services (Victorian Department of Health and Human Services, 2015). In 2016, the Victorian Government committed to investing $1.7 million over four years in a new orientation, triage and referral model for the Refugee Health Program (Victorian Department of Health and Human Services, 2016). This involves employing three experienced refugee health nurses to provide the connection between community health services delivering Refugee Health Programs, AMES Australia settlement services and the wider referral to health and human services (Victorian Department of Health and Human Services, 2016).
- **Refugee Health Services** - **sub-regional clinical hubs:** community health centres and hospital-based services known as sub-regional clinical hubs, provide support for refugees. Community health services provide outreach and medical specialists, and hospital-based services serve as a central point of care coordination across hospital services (Victorian Department of Health and Human Services, 2015).

- **Refugee Settlement Services**: The Adult Multicultural Education Services with its partners, provided settlement support to refugees such as case management, information, short-term accommodation, English classes, employment support and referrals to recreational activities services (Victorian Department of Health and Human Services, 2015).
- **Regional Refugee Health Networks and Working Groups**: these networks coordinate and collaborate across the sector to develop local services for refugees, and also to support capacity-building and workforce development services (Victorian Department of Health and Human Services, 2016).
- **Victorian Foundation for Survivors of Torture**: The Foundation provides counselling support to respond to the torture and trauma experienced by refugees before their arrival in Australia. In particular, support referral for refugee children and young-people at-risk of serious mental illness is provided (Victorian Department of Health and Human Services, 2016).
- **Victorian Refugee Health Network:** auspiced by the Victorian Foundation for Survivors of Torture, the network encourages health and community services to collaborate to provide accessible and responsive services for refugees (Victorian Department of Health and Human Services, 2015). The Immunisation Working Group, convened by the Network, has a catch-up immunisation program that creates comprehensive catch-up immunisation schedules (Victorian Department of Health and Human Services, 2016).

The Department of Health and Human Services funds a range of other specialist refugee health and community care services including:

- **Hospital and outreach immigrant and refugee health clinics:** outpatient clinic services are provided through these clinics to respond to issues such as hepatitis B, tuberculosis and parasite screening, vitamin D deficiency and immunisation (Victorian Department of Health & Human Services, n.d.).
- **Multicultural Health and Support Service:** the service provides sexual health education, information and support to people from a refugee background and migrant communities (Victorian Department of Health & Human Services, n.d.).
- **Language services credit line:** eligible services funded by the Department of Health and Human Services, provides telephone interpreting, on-site interpreting and translation services to people from a refugee background (Victorian Department of Health & Human Services, n.d.).
- **Health translations directory:** an online portal that provides translated health information so that refugees and other culturally and linguistically diverse communities can make informed decisions about their health (Victorian Department of Health & Human Services, n.d.).
- **Refugee Minor Program:** targeted child and family service support is provided to unaccompanied refugee children and young people (Victorian Department of Health and Human Services, 2016).

The refugee healthcare system in Victoria is mature and comprehensive, targeting many of the specific and complex needs of refugees in Victoria.

2. UNDERSTANDING REFUGEE HEALTH

The specific and complex health needs of refugees resettling in Australia are well documented in the literature. While a detailed analysis of these needs is beyond the scope of this review, this section provides context to the new RHP, which will consider common health issues experienced by refugees in more detail. Acknowledging that the health and wellbeing of refugees is shaped by a broad range social factors and experiences, this section also provides a brief outline of the social determinants of health. In so doing, it establishes a holistic framework for not only understanding the health inequities experienced by refugees in Australia, but also the health disparities among and between different refugee groups.

2.1. COMMON HEALTH NEEDS OF PEOPLE FROM A REFUGEE BACKGROUND

A wide literature exists on the inequitable health outcomes experienced by many people from a refugee background. As highlighted by the NSW Refugee Health Service, the experiences and backgrounds of refugees arriving in Australia may place them at increased risk of a range of health conditions, including:

- psychological disorders, such as anxiety, depression and Post Traumatic Stress Disorder
- physical consequences of torture and armed conflict, such as musculoskeletal pain or hearing loss
- infectious diseases, such as intestinal parasites, hepatitis B or malaria
- under-immunisation
- poor nutrition
- undetected or poorly managed chronic diseases, such as high blood pressure or diabetes
- poor dental health as a result of poor diet and nutrition, lack of fluoridated water, poor dental hygiene, limited dental care and, in some cases, torture to the mouth
- growth and development issues in children as a result of malnutrition or previous illness
- disability in adults, adolescents or children (NSW Government and NSW Refugee Health Service., 2018, p.1).

These health needs do not present only during the immediate arrival and early-settlement period. Rather, many can have long-lasting and persistent effects, and some may increase or change over time (Guajardo et al., 2016). As such, it will be critical for the new RHP to consider specific health issues as they present across the settlement experience and promote long-term support for refugees. While identifying and assessing specific health issues is not within the scope of this review, mental health and wellbeing has been included as an illustrative example of a notable health issue for consideration.

Illustrative example: Mental health and wellbeing among refugee communities

The high rates of mental illness experienced by people from a refugee background are well documented in the literature (Guajardo et al., 2016; Shawyer et al., 2017, Fazel et al., 2012; Ziaian et al., 2012), with research suggesting that the increased risk of mental illness among this group may not only be a consequence of exposure to trauma, psychological distress and personal disruption, but also to resettlement experiences (Bogic et al., 2014).

One recent study surveyed 135 refugees and asylum seekers attending a Refugee Health Service in Melbourne to "obtain estimates of the prevalence of mental disorders" (Shawyer et al., 2017, p.76). The Kessler-10 (K10) and PTSD-8 were used and results were compared to an Australian-born matched group using data from the 2007 National Survey of Mental Health and Well-Being. The researchers found a "high absolute and relative risk of mental illness" among the refugee and asylum seeker participants; for example, the rate of mental illness was 50.4 per cent as measured by the K10 (Shawyer et al., 2017, p.76). While these results are not generalizable, they nonetheless were found to substantiate "the increased need for mental health screening and care" in both the health service that that participants attended, as well as potentially other refugee clinics (Schawyer et al. 2017). The researchers note that the provision of "complex psychotherapy to refugee and asylum-seeker populations in an array of foreign languages is a challenging task requiring a considerable investment in terms of staff training and ongoing service provision" (Schawyer et al. 2017, p.86).

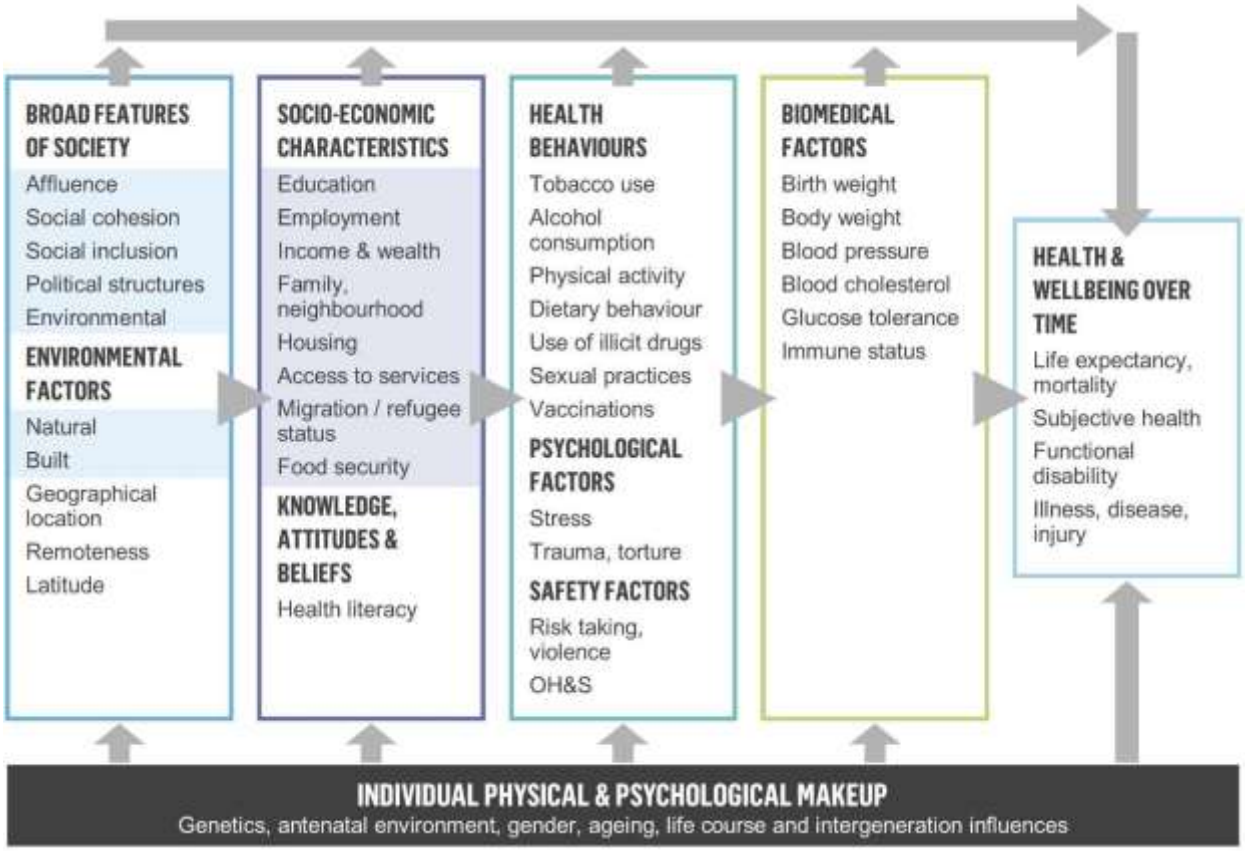
The experience of mental illness can have a lasting impact on the overall wellbeing of refugee communities. This was highlighted in a recent study by Guajardo et al. (2016), which explored the level of psychological distress in two group of Iraqi refugees who had been settled in Australia for varying lengths of time; specifically, one group had recently arrived (n = 225, average length of stay = 0.55 months), and other had experienced a longer period of resettlement (n = 225, average length of stay = 58.5 months) (Guajardo et al. 2016, p.4). The results of the study "appear[ed] to indicate that those Iraqi refugees with longer periods of resettlement in Australia are experiencing higher levels of psychological distress" than those who had recently arrived (Guajardo et al. 2016, p.4). In response, the researchers suggest the need for a "method of screening for distress in the immediate to longer resettlement period (post 2 years of arrival), [which] would enable services to provide appropriate mental health interventions to improve well-being and in turn to increase refugee capacity for independence, functionality and productivity" (Guajardo et al. 2016, p.9).

2.2. SOCIAL DETERMINANTS OF HEALTH

In 2005, the Commission on Social Determinates of Health (CSDH) was established by the World Health Organisation (WHO) to collate the latest evidence on how the international community could best respond the health inequities that existed across the globe; that is, the avoidable *inequalities* in health that are observed among and between different groups (WHOa, n.d.). Viewing health equity as a matter of social justice, the CSDH reflected a growing recognition that these health inequities "arise because of the circumstances in which people grow, live, work, and age, and the systems put in place to deal with illness" (WHO, 2008, p.3).

The social determinants of health recognise that an individual's health outcomes are influenced by biological and physiological factors, as well as a complex interplay of political, social, economic and cultural forces such as wealth, gender and education (WHO, 2008; see Figure 2 below). As an example, from 2010-12, there was a life expectancy gap at birth of around 9.3 years between Aboriginal and non-Aboriginal men in NSW, and 8.5 years between Aboriginal and non-Aboriginal women (Centre for Epidemiology and Evidence, 2018; citing: ABS, 2013). Additionally, in 2016, men and women in the highest socio-economic quintile in NSW had a life expectancy at birth that was on average 4.8 and 3.1 years more than men and women in the lowest socio-economic quintile respectively (Centre for Epidemiology and Evidence, 2018).

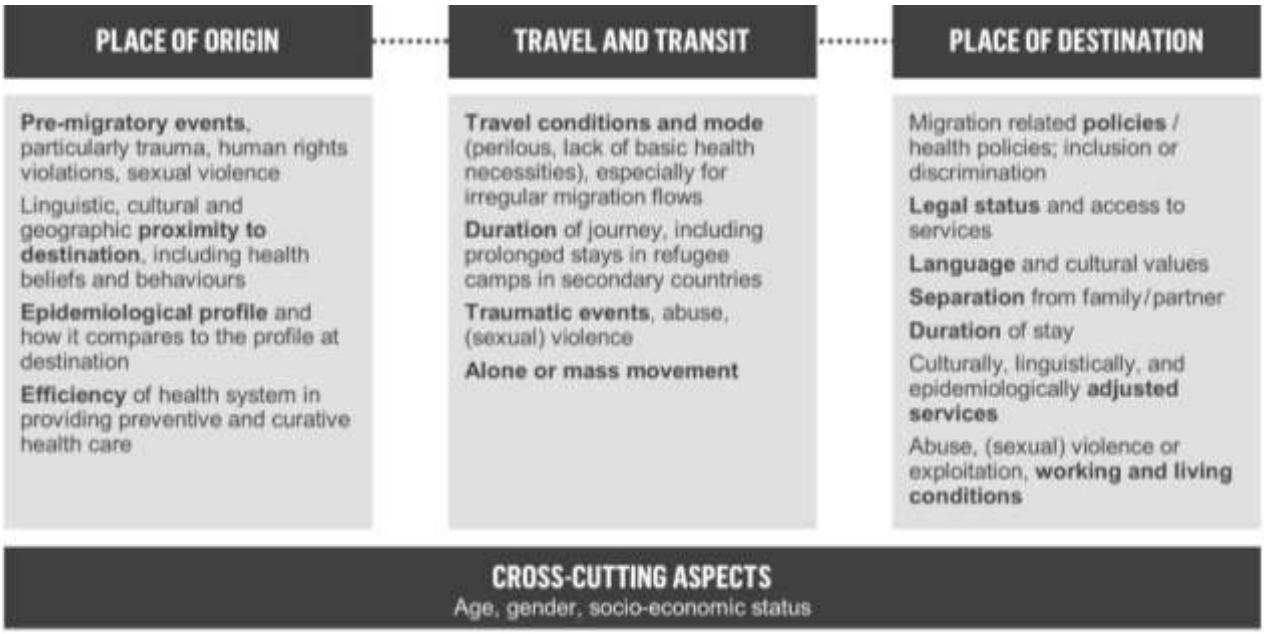
Figure 2 – The determinants of health



2.3. MIGRATION AND REFUGEE STATUS AS A SOCIAL DETERMINANT OF HEALTH

It is widely recognised that the experience of migration directly influences the health and wellbeing of refugees. This does not only extend to the impact of pre-settlement experiences, in which refugees may have limited access to health services, experience trauma and violence, and / or be subjected to protracted periods of displacement. The health outcomes of refugees can also be "exacerbated" (WHO, 2018; Taylor & Haintz, 2018) by a range of factors in the countries where refugees eventually settle. These may include experiences of social exclusion, xenophobia and isolation, difficulties gaining employment or poor working conditions, racism and discrimination, barriers accessing appropriate healthcare, and experiences of extreme uncertainty by those on temporary visas.

Figure 3 – Migration as a social determinant of health



Adapted from: International Organisation for Migration (IOM). Site: https://www.iom.int/social-determinants-migrant-health

As an example, research suggests that refugees experience a range of barriers when accessing General Practitioners (GPs) in Australia. In their review, Russel et al. (2013) note the following barriers that are commonly cited in the literature:

- language and cultural differences
- financial barriers
- literacy issues
- availability of effective healthcare
- readily accessible healthcare
- transport
- childcare limitations
- reduced ability to trust service providers owing to prior experiences
- competing priorities
- a lack of awareness of health services and limited ability to negotiate often complex healthcare systems
- lack of health provider understanding of the complex health concerns of refugees
- shame (Russel et al., 2013, p.43).

These barriers have direct implications for the models of care that are most likely to meet the needs of refugee populations; specifically, services will need to address these barriers in order to promote access and engagement, and ensure the individuals receive culturally appropriate care.[2]

[2] It should be noted that some of the barriers experienced by people from a refugee or refugee-like background lie outside NSW Health's direct sphere of influence, including access to GPs which is primarily a focus of the Commonwealth Government. However, strategies can be implemented to mitigate the impacts of these barriers, such as providing access to translators/interpreters in order to overcome language barriers and developing health promotion materials that improve overall health literacy in target communities.

2.4. THE DIVERSITY THAT EXISTS WITHIN REFUGEE COMMUNITIES

Finally, when considering the health of refugees, it is important to acknowledge the diversity that exists among and between different communities. Refugees not only come from a diverse range of backgrounds (see for example, Table 3 below), but also experience the social determinants in unique ways. As an example, a recent study found that gender, literacy levels and refugee status "added layers of disadvantage" when it came to the experiences of women from a refugee background in accessing health care in Canada (Floyd & Sakellariou, 2017, p.195). While refugees often require high levels of physical, psychological, social and legal support, their migration and settlement experiences, cultural backgrounds and needs may vary.

Examples of characteristics which contribute to varying needs among and between groups of people from a refugee background include gender, age, religion, cultural background, health beliefs and practices, and experiences with (and the structure of), the health system in an individual's country of origin.

Table 3 – Most common nationalities within the offshore component 2016-17

Rank	2013-14	2014-15	2015-16	2016–17
1	Afghanistan	Iraq	Iraq	Iraq
2	Iraq	Syria	Syria	Syria
3	Myanmar	Myanmar	Myanmar	Afghanistan
4	Syria	Afghanistan	Afghanistan	Myanmar
5	Bhutan	Congo (DRC)	Congo (DRC)	Bhutan
6	Iran	Eritrea	Bhutan	Congo (DRC)
7	Congo (DRC)	Bhutan	Somalia	Eritrea
8	Eritrea	Iran	Iran	Ethiopia
9	Somalia	Somalia	Ethiopia	South Sudan
10	Ethiopia	Ethiopia	Eritrea	Somalia

Notes:

- Visas counted include subclass 200 (Refugee), 201 (In-country Special Humanitarian Program), 202 (Global Special
- Humanitarian Program), 203 (Emergency Rescue) and 204 (Woman at Risk).
- The country of birth of principal visa applicants is applied to secondary visa applicants.
- The 2015–16 and 2016–17 figures in this table includes visas granted towards the annual offshore resettlement component of the Humanitarian Program, and the additional 12,000 places for people displaced by conflict in Syria and Iraq.
- Congo (DRC) refers to the Democratic Republic of Congo.

Source: Australian Department of Home Affairs. (2018). Discussion Paper: Australia's Humanitarian Program 2018-19, 2018. Retrieved: https://www.homeaffairs.gov.au/reports-and-pubs/files/2018-19-discussion-paper.pdf

In response to this diversity, the new RHP will need to consider the specific needs of different refugee cohorts and communities. While a range of priority groups will need to be included in the Plan, for the purpose of this review, young people from a refugee background have been included as an illustrative example.

Illustrative example: Young people from a refugee background

As at November 2016, 14,100 young people had recently arrived in Australia on a humanitarian visa (Australian Institute of Family Studies, 2018; citing: ABS 2017). These young people from refugee backgrounds have "enormous potential to actively participate in Australian society" (Australian Institute of Family Studies, 2018). However, they often arrive with specific health needs owing to their experiences of migration, as well as have unique needs that present post-settlement (Australian Institute of Family Studies, 2018).

The specific and complex health needs of young people from a refugee background are well documented in the literature. These health needs include:

- higher rates of mental illness (particularly post-traumatic stress disorder)
- lower rates of health service utilisation
- elevated rates of substance misuse
- increased levels of aggressive and anti-social behaviours, stemming from acculturation stress
- low levels of access to information and understanding of safe sexual health behaviours
- issues relating to gender identity, particularly when negotiating this against cultural or religious beliefs, as well as a new cultural context (i.e. one's new host community).

(Riggs et al., 2015; Noto et al., 2014; Nunn et al., 2014; Correa-Velez et al., 2010; McMichael & Gifford, 2009)

Given the distinct needs and experiences of this group, as well as the significant number of refugees who are arrive as children and young people, the new RHP should consider their inclusion as a priority group.

This section demonstrates the complexity of refugee health and, more specifically, the way in which a broad range of social factors not only influence the health and wellbeing of refugees, but also their ability to access services. For this reason, it is widely acknowledged that addressing the health needs of refugees requires comprehensive and multifaceted approaches, as well as intersectoral action (Taylor & Haintz, 2018; Russel et al., 2013). It is also critical for services to acknowledge the unique needs of different refugee groups (e.g. by responding to their distinct cultural norms). This includes embedding sufficient flexibility into their models of care so that services are able to respond to changes in refugee cohorts and experiences over time.

3. APPROACHES TO REFUGEE HEALTHCARE

Over time, a range of services have been developed to respond to the unique and complex health needs of refugees. This section provides an overview of a selection of frameworks and service delivery models that have either emerged and / or been reviewed since the existing RHP was developed. Models were selected that had either been subject to evaluations or were developed based on extensive reviews of the literature. A specific focus was placed on identifying components of the models that have been found to either facilitate improvements in health outcomes or improve access to services among refugee communities.

3.1. MODELS FOR REFUGEE HEALTHCARE IN AUSTRALIA

A framework for delivering primary health care for refugees

In their 2013 article, Russel et al. provide a 'best practice framework' for delivering primary health care (PHC) services to refugees in Australia. The framework presented in Figure 4 below draws on elements from three sectors that were identified to be critical to the effective delivery of care to refugees, namely: (a) refugee focused health services (including generalist and specialist supports); (b) mainstream PHC services; and (c) settlement services (Russel et al., 2013, p.24).

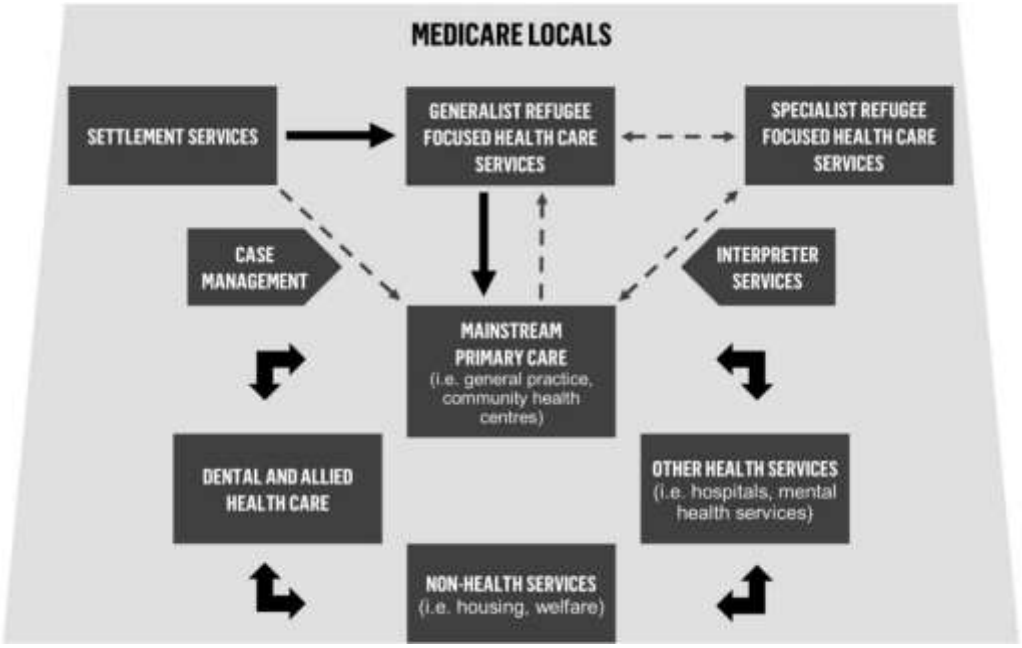
Similar to the model included in the existing RHP, under the proposed framework, refugees ideally transition into mainstream PHC after an initial period of support from refugee focused health services. The role played by refugee-focused services was identified to be "essential" (Russel et al., 2013, p.25). The authors suggest that generalist refugee services should provide care to refugees in the first six months of settlement, including delivery of "a comprehensive health assessment, oversight and administration of necessary preventive services (including immunisation) and, where appropriate, the coordination of referral to specialist refugee focused services" (Russel et al., 2013, p.25). Specialist services (e.g. STARTTS) should ideally provide continuous care to select refugees with complex needs, with a focus on more actively supporting the transition of these refugees into mainstream services.

The framework proposed by Russel et al. (2013) was based on a substantive narrative synthesis of PHC models for refugees. The synthesis found the use of care coordination, specialist refugee health workers, and interpreters and bilingual staff are "most frequently associated with improved access, coordination and quality of care" for refugees (Joshi et al., 2013, p.88). Other model elements identified to be common to existing PHC models are screening and health assessments, outreach in conjunction with specialist refugee healthcare nurses, non-health services, free transport, and low- or no- cost service provision (Joshi et al., 2013, p.88). Many of these model elements seek to address the barriers experienced by refugees when accessing health services.

Drawing on this evidence, the model promotes a range of service elements that contribute to an enabling environment for improvements in refugees' health. These include:

- the inclusion of **free interpreter services**, which was supported by a broad consensus in the literature to be "of the highest priority in improving service access and quality care for refugees" (Russel et al., 2013, p.26)
- a focus on the concept of **case management** and **system level integration** to improve coordination among and between services, and ensure continuity of care; the authors note that case management was "strongly endorsed" in the literature and is particularly important given the complex and multiple needs of refugees (Russel et al., 2013, p.27)
- **delivery of services at low- or no- cost to refugees** in order to address the significant financial barriers experienced by many refugees
- **workforce development and training** to facilitate a health system that is responsive to the distinct needs of refugee populations, including ensuring that health professionals are supported to deliver culturally appropriate care
- a focus on **improving health literacy** among refugee communities, including knowledge and understanding of the service system
- **ongoing monitoring and evaluation efforts** to facilitate continuous improvements of PHC services for refugees (Russel et al., 2013).

Figure 4 – Proposed model for primary health care delivery to refugees in Australia



Source: Russel et al., 2013, p.24

The Monash Health Refugee Health and Wellbeing Service Model (MHRHW) for refugees in South-East Melbourne

The Monash Health Refugee Health and Wellbeing Service (MHRHW) is a specialist refugee health service in South-East Melbourne that aims to provide holistic care to refugees with complex needs. Resourced by a multidisciplinary team, the service model comprises a range of integrated services, including the following:

- **Primary health care assessments and services**, including comprehensive assessment of clients' physical, social and mental health, immunisations and referrals where required.
- **Specialist tertiary services** that are co-located with the primary health care services. These include an adult infectious disease and internal medicine clinic, psychiatric support, and a paediatric clinic.
- **Capacity building** in the mainstream health system and within tertiary education institutions to support the development of a workforce that understands, and can respond to, the specific needs of refugees and refuge-like populations.
- A **strong focus on client engagement and community development** in order to address the social determinants of refugees' health. Efforts to facilitate client engagement include "established referral pathways, triage processes, appointment confirmation calls, transportation support, bicultural workers and consistent use of onsite interpreters" (McBride et al., 2017, p.324).

Similar to the models outlined in the existing RHP and by Russel et al. (2013), these services are designed to provide "intensive transitional care," with the ultimate goal of supporting clients into mainstream services (McBride et al., 2017, p.324).

In a recent article, McBride et al. (2017) explored the experiences of refugees who had accessed MHRWH. The review, which explored participants' perceptions of care, included analysis of client feedback surveys (n=159), as well as semi-structured interviews with clients who had attended a minimum of three appointments (n=18). The researchers found that there were strong levels of support for the model, with 90 per cent of the clients surveyed indicating they were satisfied with the services they received, and 83 per cent reporting that their health concerns had been adequately addressed (McBride et al., 2017). Notably, almost three quarters (72 per cent) of the clients had "connected with a community general practice since leaving MHRHW" (McBride et al., 2017, p.326). Some of the model elements that were valued by clients included the respectful, friendly nature and care shown by staff, the ability to access onsite interpreters, the use of bilingual workers, and the benefits experienced from more coordinated care, including having access to a multidisciplinary team (McBride et al., 2017).

While acknowledging the need for further research into health outcomes, overall, McBride et al. concluded that the defining elements of MHRHW's service model were highly valued and supported as best practice refugee healthcare (McBride et al., 2017, p.326). Although some elements may not be "feasible" for implementation in mainstream services, the researchers concluded that "defined referral pathways, cognisance of client health literacy, and ensuring strong rapport within the healthcare provider and client relationship will improve quality of care for asylum seekers, refugees and service users within healthcare more broadly" (McBride et al., 2017, p.327).

Nurse-led initiative to improve healthcare service delivery to newly arrived refugees

The Refugee Health Nurse Liaison Initiative was developed in response to ongoing issues experienced by asylum seekers and refugees accessing and utilising care, particularly at Monash Health's Dandenong Hospital (McBride et al. 2016). The initiative involved the recruitment of Registered Nurses with "experience in refugee health and understanding of vulnerable communities" (McBride et al. 2016, p.712) to work within the hospital and contribute to two overarching goals:

- enhance the care delivered to refugee populations
- build capacity within the hospital, and health system more broadly, to respond to the distinct needs of this population (McBride et al. 2016).

A mixed-methods, descriptive study was undertaken to evaluate the program's pilot phase (July 2013 – June 2014), including to understand what worked well or not so well about the model, and how it might be improved. The study included analysis of rigorous record-keeping on the activities undertaken by the nurses, as well as patient surveys to understand the experiences of refugees and people from a refugee-like background who were supported under the program. In total, 946 patients were referred to the program from a range of backgrounds. The top three countries of origin identified were Afghanistan (51%), Sri Lanka (12%) and Iran (11%) (McBride et al. 2016, p.714).

The evaluation found that the program has contributed to improvements, with the findings supporting the "potential value in the role of the Refugee Health Nurse Liaison in addressing care coordination, enhancing the patient experience, and improving organisational capacity to more effectively respond to asylum seeker and refugee patients" (McBride et al. 2016, p.717). Progress under the program included:

- improved identification of patients from a refugee background
- a high number of referrals into primary healthcare settings, including increased opportunities for engagement in preventive health
- improved connections between service providers within, and external to, the health system (McBride et al. 206).

Additionally, the research found that "nurses are in a unique and influential position within the acute environment, and can support patients through the development of trusting, therapeutic relationships, and applying a social determinants framework" (McBride et al. 2016, p.720).

A framework for supporting health service delivery to newly arrived refugee children in Australia

Following a review of national and international literature, as well as service models within Australia, Woodland et al. (2010) developed a best-practice framework for addressing the needs of newly arrived children from a refugee background in Australia. The Framework was designed to support "service development and evaluation by highlighting priorities for action in improving access, equity and quality" of health care for this particularly vulnerable cohort (Woodland et al., 2010, p.564). The ten elements that were found to provide a best-practice framework are shown overleaf.

Ten framework elements for delivering health services to refugee children

- routine comprehensive health screening for refugee children
- co-ordination of initial and ongoing health care
- integration of physical, developmental and psychological health care
- consumer participation
- culturally and linguistically appropriate service provision
- inter-sectoral collaboration
- accessible and affordable services and treatments
- data collection and evaluation to inform evidence-based practice
- capacity building and sustainability
- advocacy.

(Woodland et al. 2010)

These elements support the holistic and multi-faceted approach to refugee health, which is advocated for in the existing RHP, as well as in the literature informing this review.

School screening program for young people from refugee backgrounds

The Optimising Health and Learning program was established to address the health inequities experienced by young people from a refugee background, and to improve the learning outcomes of this group. The program, which was guided by Woodland's Framework outlined above (Woodland et al., 2010), adopts an intersectoral approach in which nurses deliver health screening in school settings, supported by a diverse range of multidisciplinary program partners. Health assessments are delivered onsite at Intensive English Centres (IECs) in NSW, which prepare newly arrived young people for entry into mainstream school (Woodland et al., 2016). Since 2016/17 school screening is also delivered onsite at targeted High school and Primary schools with high refugee populations, including non-Government schools. The three key objectives of the program comprised:

- increase the detection of specific health conditions which are likely to impact on student health and learning to manage or refer conditions as appropriate
- increase linkage of newly arrived students and their families with primary health care (general practitioners)
- improve coordination of care for the target group across primary health care and public health services, including specialist/tertiary services (Woodland et al. 2016, p.73).

A mixed-methods evaluation was undertaken to understand early-implementation and design of the program, as well as its impact (Woodland et al., 2016). The evaluation included 294 young people from a refugee background who had attended one of two IECs in NSW and had participated in the program.

The evaluators found that the program was "well implemented" and had met its three objectives as outlined above (Woodland et al. 2016, p.72). Specifically, the researchers observed that "there were high levels of program participation (90%), and the yield from routine health screening was high (80% of participants screened positive for two or more health conditions)" (Woodland et al. 2016, p.72). The IECs were found to be an effective setting for screening and an entry-point into the health system, with the researchers observing that the "school-based nurses are in a strategic position to promote access to health care and contribute to a health promoting environment within a school" (Woodland et al. 2016, p.76). The high yield from the screening undertaken was found to "reinforce" the critical importance of routine screening, and the role it can play in supporting the health of young people from a refugee background.

3.2. INTERNATIONAL MODELS FOR REFUGEE HEALTHCARE

The Philadelphia Refugee Health Collaborative (PRHC)

In 2007, the Nationalities Service Centre and Thomas Jefferson University's Department of Family & Community Medicine piloted a new refugee clinic model in Philadelphia (PRHC, 2014). The model, which is underpinned by close partnerships between resettlement services and healthcare providers, recognises that "refugees with multiple medical conditions require greater coordination between healthcare providers and case managers working to facilitate housing, employment and education in addition to increased medical services" (DiVito et al., 2016, p.1). As such, it seeks to create a joined-up system in which the two services work collaboratively together.

Key elements of the model are detailed below.

Key elements of the Philadelphia Refugee Health Collaborative (PRHC)

- A medical provider hosts a regular weekly/bi-monthly clinic for refugees
- The refugee clinic is a closely coordinated partnership between the resettlement agency and medical provider, including:
  - day-to-day communication and regular staff meetings to troubleshoot problems
  - a designated staff member from the resettlement agency functions as the "clinic liaison" providing on-site assistance to help new refugee patients with registration, scheduling follow- up appointments, and filling prescriptions
- The refugee clinic is housed in a health system providing access to a large network of specialty practices
- The refugee clinic provides opportunities for residents to train in global health and cultural competency
- **The refugee clinic provides comprehensive screening, immediate attention to chronic/acute needs and a long-term medical home** (PRHC, 2014).

Notably, the use of a Patient-Centred Medical Home (PCMH) "allows clients to access a screening appointment by the same physician from whom they will continue to receive primary care" (DiVito et al., 2016, p.1). When combined with the 'clinic liaison' role, in which an individual not only coordinates the partnership between the clinic and resettlement agency, but also actively supports refugees to access the clinic's services, the model facilitates continuity of care and minimises service fragmentation. Following a successful pilot involving one resettlement agency and a refugee health clinic, PRHC has expanded to include all three resettlement agencies and eight clinics in Philadelphia (DiVito et al., 2016). Key outcomes of PRHC have reportedly included a reduction in the time it takes for refugees to access an initial health screening, expedited access to preventive health screenings (e.g. for breast and cervical cancer), more effective management of chronic conditions, and improved collaboration, trust and mutual support between service providers (DiVito et al., 2016). As DiVito et al. observe:

> *by providing access to high-quality, community-centred health care, PRHC has successfully decreased the time to initial health screenings, connected refugees to a patient-centred medical home, and addressed complex medical needs of refugees, while improving the knowledge and capabilities of health care providers and community partners (DiVito et al., 2016, p.1).*

C.A.R.E (Culturally Appropriate Resources and Education) Clinic, Idaho

In 2009 a new prenatal and paediatric clinic was established in Idaho; namely, the C.A.R.E (Culturally Appropriate Resources and Education) Clinic. Similar to the nurse-led initiative outlined above, the C.A.R.E Clinic is a "nurse-led clinical program that provides convenient, one-stop access to a seamless continuum of healthcare service and education provided in a group setting" (Reavy et al., 2012 p.2). Central to the model is the use of a Clinical Heath Adviser role, which is a person who contributes to the health status of refugee mothers, infants and families through comprehensive care coordination and outreach to increase access to maternal/child health and family services, and to assist health care providers to deliver culturally appropriate care responsive to refugee maternity and paediatric patients *(SARMC Policy, 2010; cited in: Reavys et al., 2012).*

To facilitate a culturally safe environment, the role can only be filled by women. This is because many of the refugee women who access the Clinic have "experienced trauma in their home countries and many come from patriarchal, gendered cultures" (Reavys et al., 2012 p.7).

In a 2012 study, Reavys et al. sought to understand the impact of the Clinical Health Adviser role, which has been acknowledged as a large part of the program's success. The research particularly looked to understand any differences between this role and the role of the model's Certified Medical Interpreters, who act as translators. The study comprised observations, focus groups, and individual interviews with health advisers and members of the healthcare team, as well as retrospective patient chart reviews to assess patient outcomes (Reavys et al. 2012, p.1).

The researchers found that the use of Clinical Health Adviser was "an important step in modelling a culturally safe method to meet the healthcare needs of the vulnerable, displaced refugees" (Reavys et al. 2012, p.10). This was because the Clinical Health Advisers helped:

- health workers understand different cultures
- provide a stronger voice for refugees
- bridge cultures and establish trust in the healthcare system on the part of the refugee
- refugees navigate the healthcare system
- fostered a feeling community among maternal and paediatric patients (Reavys et al. 2012, pp.8-9).

The success of the model was found to be validated by the retrospective patient chart reviews, in which the rate of missed clinical appointments dropped from 25% to 2.5% (Reavys et al. 2012, p.10). The Clinical Health Adviser was identified as key influence on this change, as a major reason refugees had previously missed appointments was a lack of transportation, which the Clinical Health Advisers now assisted with (Reavys et al. 2012, p.10). Linked to this, the researchers observed a sustained 100% compliance rate for childhood immunisations in the first year of a child's life, which was linked to decreases in language and transportation barriers, as well as decreases in no-show rates (Reavys et al. 2012, p.10). The researchers concluded that they were "confident that the role of the C.A.R.E Clinic Health Advisor has contributed to these outcomes" (Reavys et al. 2012, p.10).

Refugee Health Clinic Model, Ontario

A 2013 study by McMurray et al. explored the impact of a new refugee health clinic that was developed in response to the barriers to care experienced by Government Assisted Refugees (GARs) in Ontario, Canada. The refugee health clinic operated part-time as a complementary service within an existing family medical practice (McMurray et al. 2013). The service model applied comprised a partnership between:

- **the dedicated refugee clinic,** including physicians who provided comprehensive care to GARs. The medical staff working at the clinic were "experienced in diagnosing and treating GARs and have established protocols and guidelines" for responding to the specific health needs of this population (McMurray et al. 2013 p.578)
- **a refugee receiving centre** called Reception House, including case workers who enabled access to the refugee clinic and were found to perform a "critical role supporting [the] new Canadians to navigate the health system" (McMurray et al. 2013 p.578). This included accompanying refugees to appointments, arranging translators, and coordinating care with an array of specialist and ancillary services
- **other services in the community** that provided ancillary supports, such as specialist mental health services and allied health professionals (McMurray et al. 2013).

To understand the impact of the clinic, the study analysed and compared outcomes achieved by refugees 18 months prior to the clinic being established, with those of refugees arriving 18 months after its establishment (McMurray et al. 2013). Data analysed included detailed logs completed by settlement workers outlining the needs and appointments of all refugees, along with exit interviews with refugees one year after arriving in Canada (McMurray et al. 2013).

Two key changes observed by the researchers included:

- a 30 per cent decrease in wait times to see a health care provider
- an 18 per cent increase in refugees finding a permanent family physician in the community in the year after their arrival (McMurray et al. 2013, p.579).

These notable improvements were "attributed to strong relationships developed with the local physician community, timely transfer of comprehensive assessment and treatment records, and ongoing consultation between refugee health clinic and community family physicians post-transfer" (McMurray et al. 2013, p.583). The later finding was particularly significant given there was an ongoing shortage of family physicians in the area at the time.

In addition to these findings, "referrals to non-physician primary care providers (therapists, dentists, optometrist) nearly doubled after the clinic was established" (McMurray et al. 2013, p.538), which the researchers suggest could be attributed to "either better access to providers, diagnoses that required more treatment, or a combination of both" (McMurray et al. 2013 p.538). Finally, levels of understanding and the ability to navigate the health system also improved among the refugees (McMurray et al. 2013).

The researchers concluded,

> *The time-limited, but intense health needs of GARs, require an integrated community-based healthcare intervention that includes dedicated health system navigators to support timely, more culturally appropriate care and successful integration (McMurray 2014, p.576).*

3.3. IMPLICATIONS FOR THIS REVIEW

A number of key themes emerged from these models, which provide insight into best-practice approaches to refugee health. These include the critical importance of a multi-faceted and holistic service delivery model that:

- responds to the unique needs of refugees, by providing patient-centred and culturally competent care in both mainstream and specialist services
- includes a mixture of generalist and specialist refugee specific services at the time of settlement (and on an ongoing basis where required, e.g. to undertake comprehensive health screenings and provide specific support to refugees with complex needs)
- addresses the barriers commonly experienced by refugees when accessing care (e.g. through the use of interpreters or bilingual staff)
- utilises care coordination and system navigators to promote continuity of care
- promotes close collaboration and working partnerships between service providers both within, and external to, health to facilitate integrated care
- supports refugees to transition into mainstream services for ongoing care in the community
- promotes capacity building within the mainstream health system and community to ensure best-practice delivery of refugee services.

4. ENABLERS OF EFFECTIVE REFUGEE HEALTH SERVICES

The health inequities experienced by many refugees populations are often compounded by the difficulties they experience accessing care. Within Australia, refugees have been found to face a number of barriers to healthcare, such as a lack of familiarity with the health system, language difficulties, financial constraints, and low levels of health literacy (Milosevic, 2012, p.147). In a systematic review of the literature, Hadgkiss and Renzaho (2015) found that "the reported uptake of primary care services among refugees in Australia ranged between 55 and 73 per cent across studies of varying rigour and quality" (Hadgkiss & Renzaho, 2015; cited in Taylor & Haintz, 2018, p.15). It is critical that the barriers experienced by refugees are addressed if health services are to engage this population and ensure that their health needs are met. This section provides an overview of some of key service elements that have emerged in order to overcome these barriers. Referred to in this review as 'enablers' of service access, the six key service elements are outlined below.

4.1. THE USE OF INTERPRETERS AND BILINGUAL WORKERS

Language difficulties commonly act as a barrier to accessing care (Gartley & Due, 2017; Clark et al., 2014). In 2014 for example, Clark et al. undertook research to better understand the barriers experienced by refugee women accessing primary health care in South Australia, including both GP and pharmacy services. The research, which involved focus groups with 36 refugee women, found that an inability to speak or comprehend English was the "main barrier" experienced (Clark et al., 2014). This was particularly the case for refugee women from Burma and Afghanistan. Women in this group identified language to be the "biggest single barrier" to accessing primary care, with many experiencing difficulties scheduling GP appointments due to poor levels of proficiency in English (Clark et al., 2014, p.93). For this reason, several studies note the critical role of interpreters and/or bilingual workers (Gartley & Due, 2017; Clark et al., 2014; Joshi et al., 2013), who have been found to have a positive impact on both the rates of service utilisation and the levels of service satisfaction among refugees (Joshi et al., 2013, p.90-91). Interpreters and bilingual workers should be available across the health system, including both primary and tertiary settings.

4.2. CARE COORDINATION AND SERVICE NAVIGATION

Refugees settling in Australia often have complex health needs and require support from multiple professionals and services (both within and outside health). This can be difficult to manage, particularly given other barriers refugees commonly face such as a lack of familiarity with the health system and language difficulties. To overcome these challenges and facilitate continuity of care, many refugee health models include care coordination and service navigation as central elements. In their narrative review of existing models, Joshi et al. (2013) note that care coordinators "provided easier transitions between the primary health care and hospitals, good coordination among stakeholders, and improved team work where workers alerted each other of patient issues" (Joshi et al., 2013, p.92). There is some evidence that "health case management may be best provided by refugee health nurses situated in refugee focused health services" (Russell et al., 2013, p.27).

People who help navigate the health system are useful for communities beyond newly arrived refugees. Research by Henderson and Kendall suggest that "even long-standing CALD [culturally and linguistically diverse] communities" could benefit from such a service due to their experience of low levels of familiarity with the health system and barriers accessing care (Henderson and Kendall, 2011 p.195). The research included focus groups with four CALD communities (Sudanese, Afghani, Pacific Islander, and Burmese) in Logan, Queensland. During consultations, "a clear role for bilingual community-based navigators was identified by CALD participants to address concerns about the health system, and to improve accessibility and health service usage" (Henderson and Kendall, 2011, p.195). The researchers suggest that bilingual, community-based navigators could help to overcome challenges identified during the consultations. For example, some of the participants expressed a preference for a "bilingual person whom they knew and trusted and who was from their own community to interpret for them in person," as distinct from phone services in which there is limited contact with the interpreters (Henderson and Kendall, 2011). The researchers conclude that "navigators would be able to respond appropriately, supporting people to navigate the health system, educating health professionals and building the capacity for future health promotion within the community" (Henderson, 2011 p.195).

4.3. COORDINATED AND INTEGRATED SERVICE DELIVERY

Linked to this, the experience of a fragmented health system can also be a barrier to care, particularly among refugees who have complex needs. A recent study found that service fragmentation provided "additional 'run around' for comorbidity clients from refugee backgrounds" and placed this population at "great risk of 'falling through the gaps'" (Posselt et al., 2017, p.290). The study, which explored the needs of young people from a refugee background with comorbid mental health and substance use problems in South Australia, found that the experiences of a siloed system not only occurred between mental health and alcohol and other drug (AOD) services, but also between specialist refugee and mainstream health services (Posselt et al., 2017, p.290). In response to experiences such as this, there is strong support in the literature for integrated services that promote continuity of care for refugees (Russel et al., 2013; Joshi et al., 2013). While there is strong recognition across NSW Health of the importance of delivering truly integrated care (NSW Health, 2014, p.5), it should be noted that this approach would necessitate substantial changes to NSW Health service models, and would likely require significant resources.

4.4. HOLISTIC APPROACHES THAT RESPOND TO THE SOCIAL DETERMINANTS OF HEALTH

As noted above, the health and wellbeing of refugees is influenced by a broad range of social factors. There is strong support in the literature for a holistic approach that recognises the social determinants of health experienced by refugees (Cheng et al., 2018). A consideration of a social view of health necessarily includes addressing "barriers that are exacerbated by migrant status including prohibitive cost; poor and confusing organisation of services; language barriers; perceived low quality of care, and social isolation" (Cheng et al., 2018, p.18).

4.5. PROMOTION OF HEALTH LITERACY AND HELP-SEEKING

The need for efforts to promote health literacy and help-seeking among refugee communities were also identified in the literature (Taylor & Haintz, 2018; Russel et al., 2013; Drummond et al., 2011). This included efforts to introduce refugees to the health system so that individuals are "empowered to successfully engage with the health system and to make important decisions about their health" (Russel et al., 2013, p.30). As an example, in their study involving 51 West African people from a refugee background settled in Western Australia, Drummond et al. (2011) observed a range of barriers to help-seeking behaviour, including "shame or fear of what family and friends might think, fear of being judged by the treatment provider, [and] fear of hospitalisation" (Drummond et al., 2011, p.206); particularly, with respect to treatment of sexually transmissible infections and mental health issues. To help address these beliefs, the authors recommend health education and promotion efforts to improve understanding and reduce the stigma around help-seeking behaviour. In light of the language barriers identified in Section 4.1, it is critical that any health education and promotion efforts and/or materials are delivered in appropriate languages.

Lloyd et al. (2018) observed that there has been a growing recognition in recent years that health literacy also extends to "the ability of the health system and its services to respond to patients' different levels of health literacy" (Lloyd et al. 2018, p.1). That is, health literacy is best seen as "a dynamic, two-way relationship, affected by both organisational factors (e.g. tailoring of communication and care to patients' needs) and community factors (e.g. individuals' ability to perceive and seek care)" (Lloyd et al. 2018, p.1). The importance of capacity building and improved understanding within the health workforce will be explored directly below.

4.6. CULTURALLY COMPETENT SERVICE DELIVERY AND UNDERSTANDING OF THE REFUGEE EXPERIENCE AMONG HEALTH PROFESSIONALS

The critical role of delivering culturally competent care was a key theme in the literature. This includes ensuring that health workers have a strong understanding of the distinct needs of refugees, as well as the referral pathways within the broader service landscape (Taylor & Haintz, 2018; Russel et al., 2013). One study exploring the experiences of Afghan men and women accessing services in Melbourne highlighted the importance of identifying whether a person was from a refugee background and, if so, gaining an understanding of their migration experience (Yelland et al., 2014). As the authors concluded, "being aware of a client's migration experience and the social context of their lives, particularly if they have a refugee background, can assist health professionals to tailor care to meet specific needs." (Yelland et al., 2014, p.355). This was further confirmed by the findings of the Refugee Health Nurse Liaison model described above, which

similarly highlighted a need to identify whether a person was from a refugee background, as well as their broad life circumstances (McBride et al., 2016). That is, the research found that "responding to the surrounding issues impacting patients was crucial to adequately address their health and well-being" (McBride et al. 2016 p.716).

4.7. CAPACITY BUILDING WITHIN THE MAINSTREAM HEALTH SYSTEM

Linked to the above, and sitting as an overarching enabler, a focus on capacity building within the mainstream health system receives support in the literature. It is particularly important given the policy focus on transitioning people from a refugee background from specialist services into the mainstream system.

Strengthening the ability of the mainstream system to deliver culturally competent care should be a key area of focus. As McBride et al. (2016) observe, the literature suggests that there is a "need for ongoing cultural competency training and education within the healthcare workforce to ultimately improve the patient experience for asylum seekers and refugees" (McBride et al., 2016, p.717). This study further demonstrated that a focus on capacity building should include ensuring the right structures are in place for identifying the distinct needs of refugees (e.g. processes for identifying whether an individual is from a refugee background and health screening for individuals within this group), as well as efforts to improve collaboration and referral pathways within and beyond health (McBride et al. 2016).

4.8. COMMUNITY ENGAGEMENT AND COLLABORATION

Finally, research suggests that a focus on community engagement, collaboration with refugee communities and partnerships with other refugee service providers can support improvements in health outcomes. This was demonstrated in a study by Cheng et al. (2015), which found that the experiences of refugees and people from a refugee-like background are informed by the health systems in their country of origin. Specifically, the researchers found that "the transition from a community-based primary healthcare system overseas to an Australian system structured by attending primary care facilities poses substantial barriers to accessing and utilising healthcare for Afghan refugees" (Cheng et al., 2015, p.263). As a path forward, the adoption of community engagement practices was recommended – that is, strong working relationships between the Afghan community and the health sector (Cheng et al. 2015). It was suggested that a focus on partnership and collaboration could assist in ensuring timely health service access, and improved health outcomes for Afghans in Australia (Cheng et al., 2015).

4.9. IMPLICATIONS FOR THIS REVIEW

Taylor and Haintz (2018) observe "that decisions regarding health and access to healthcare services are not simply a matter of personal preference or convenience, but are influenced by multiple and varying environmental, organisational and policy factors" (Taylor & Haintz, 2018, p.26). As is demonstrated in this section, refugees experience a diverse range of barriers accessing healthcare that are well documented in the literature. Service elements that seek to address these barriers and, in turn, promote increased access among refugees include:

- the use of interpreters and/or bilingual workers
- care coordination and service navigation
- coordinated and integrated service delivery
- holistic approaches that respond to the social determinants of health
- promotion of health literacy and help-seeking pathways
- culturally competent service delivery and capacity building within health
- capacity building within the mainstream health system
- community engagement and collaboration.

5. CONCLUSION

Experiences through migration (e.g. persecution, displacement) can directly influence the health and wellbeing of refugees, who are impacted by a complex interplay of physical, psychological and socio-cultural factors at each stage of their migratory journey. These factors can include limited access to health care and basic necessities, experiences of trauma and violence, poor travel conditions, and protracted periods of displacement. The health of refugee and refugee-like populations can also be impacted by their experiences upon settlement, many of whom face social exclusion and isolation, difficulties gaining employment or poor working conditions, and barriers accessing appropriate healthcare.

As noted above, the NSW Government is committed to the successful resettlement of refugees, including supporting positive health and wellbeing outcomes among this group. Central to these efforts is the development of a new RHP, which will build upon the existing RHP. Within this context, this evidence review was undertaken to identify enablers and barriers to achieving positive health outcomes among refugees.

Overall, there is a strong level of alignment between the models of care included in this review and the model outlined in the existing RHP. The research included in this review collectively suggests that positive health outcomes are most likely to be achieved for refugee and refugee-like populations when a multi-faceted and holistic service delivery model is combined with systematic efforts to decrease barriers to health service access. The models and enablers identified in this review provide support for a health system that:

1. responds to the unique needs of refugees by providing patient-centred and culturally competent care in both mainstream and specialist services
2. includes a mixture of generalist and specialist refugee specific services at the time of settlement and on an ongoing basis where required, e.g. to undertake comprehensive health screenings and provide specific support to refugees with complex needs
3. addresses the barriers commonly experienced by refugees when accessing care e.g. through the use of interpreters or bilingual staff
4. utilises care coordination and system navigators to promote continuity of care
5. promotes close collaboration and working partnerships between service providers both within and external to health to facilitate integrated care
6. supports refugees to transition into mainstream services for ongoing care in the community
7. promotes capacity building within the mainstream health system and community to ensure best-practice delivery of refugee services
8. adopts a holistic approach which responds to the social determinants of health, including the need to promote a whole-of-government response to settlement
9. fosters community engagement, collaboration and partnerships with other refugee service providers,
10. promotes health literacy and help-seeking pathways so that individuals from a refugee or refugee-like background are empowered to be active participants in their health and care.

It should be noted, however, that this review is limited by the small number of impact evaluations that have been undertaken to assess different models of care. Studies instead tended to be informed by systematic reviews of the literature or qualitative studies that explored the experiences of a limited number of refugees and, specifically, their perceptions of the care they received. It will therefore be important to further test the conclusions of this review, and explore evidence of outcomes for refugee consumers, through the other research activities planned for this project, including consultation with refugee community members and health professionals, as well as analysis of service data.

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This report has been prepared with due care and diligence by Urbis and the statements and opinions given by Urbis in this report are given in good faith and in the reasonable belief that they are correct and not misleading, subject to the limitations above.

APPENDIX A REFERENCES

Australian Department of Home Affairs. (2018). Discussion Paper: Australia's Humanitarian Program 2018-19. Retrieved: https://www.homeaffairs.gov.au/reports-and-pubs/files/2018-19-discussion-paper.pdf

Australian Department of Home Affairs (2017). Australia's Offshore Humanitarian Program 2016-17. Retrieved: https://www.homeaffairs.gov.au/research-and-stats/files/australia-offshore-humanitarian-program-2016-17.pdf

Australian Government Department of Health. (2016). No Jab, No Pay- New Immunisation Requirements for Family Assistance Payments. Retrieved

from: http://www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/67D8681A67167949CA257E2E000EE07D/$File/No-Jab-No-Pay.pdf

Bretag, M. (2014, January 09). Australian Human Rights Commission Asylum seekers and refugees guide. Retrieved from https://www.humanrights.gov.au/our-work/asylum-seekers-and-refugees/asylum-seekers-and-refugees-guide

Bogic, M., Njoku, A. & Priebe, S. (2015). 'Long-term mental health of war-refugees: a systematic literature review.' BMC International Health and Human Rights. 29(15).

Burchill, J. & Pevalin, D.J. (2014). Demonstrating Cultural Competence within Health-Visiting Practice: Working with Refugee and Asylum-Seeking Families. Diversity and Equality in Health and Care.

Castañeda, H., et al. (2015). 'Immigration as a Social Determinant of Health.' Annual Review of Public Health.

Caulford, P. (2014). 'Helping Newcomers Overcome Barriers to Health Care.' Paediatric Child Health. 19(8). Paediatr Child Health Vol 19 No 8 October 201

Centre for Disease Control. (2016). 'Northern Territory Refugee Vaccination Policy.' Department of Health, Northern Territory Government. Accessed at: https://digitallibrary.health.nt.gov.au/prodjspui/bitstream/10137/974/1/Northern%20Territory%20Refugee%20Vaccination%20Policy.pdf

Clark, A., Gilbert, A., Rao, D. & Kerr, L. (2014). ''Excuse me, do any of you ladies speak English?' Perspective of Refugee Women Living in South Australia: Barriers to Accessing Primary Health Care and Achieving the Quality Use of Medicines.' Australian Journal of Primary Health. 20.

Companion House. (n.d.) 'About Us.' Accessed at: http://www.companionhouse.org.au/medical/ Correa-Velez, I., Gifford, S., & Barnett, A.G. (2010). 'Longing to belong: social inclusion and wellbeing among youth with refugee backgrounds in the first three years in Melbourne, Australia.' Social Science and Medicine. 71(8).

Department of Health & Human Services, Victorian Government. (n.d.) 'Victorian Refugee Health and Wellbeing Action Plan.'

Department of Health & Human Services, Victorian Government. (n.d.) 'Refugee and Asylum Seeker Health and Wellbeing.' Accessed at: https://www2.health.vic.gov.au/about/populations/refugee-asylum-seeker-health

Department of Health & Human Services, Victorian Government. (2015). 'Refugee and Asylum Seeker Health Services: Guidelines for the Community Health Program.'

Department of Health & Human Services, Victorian Government. (2016). '2016-17 State Budget: Refugee and Asylum Seeker Health and Wellbeing in Victoria.'

Department of Health & Human Services, Victorian Government. (2014). 'The Victorian Refugee and Asylum Seeker Health Action Plan 2014-2018.'

Department of Health and Human Services, Tasmanian Government. (2015). 'Bi-Cultural Community Health Program.' Accessed at: https://www.dhhs.tas.gov.au/publichealth/public_health_archive/refugee_health/bi-cultural_community_health_program

Department of Health and Human Services, Tasmanian Government. (2015). 'Refugee and Humanitarian Arrival Clinic (RAHAC). Accessed at: https://www.dhhs.tas.gov.au/publichealth/public_health_archive/refugee_health/refugee_and_humanitarian_arrival_clinic_rahac

Department of Health and Human Services, Tasmanian Government. (2015). 'Refugee and Migrant Liaison Officer.' Accessed at: https://www.dhhs.tas.gov.au/publichealth/public_health_archive/refugee_health/refugee_and_migrant_liaison_officer

Department of Health and Human Services, Tasmanian Government. (2016). 'Public Health Services: Multicultural and Refugee Health.' Accessed at: https://www.dhhs.tas.gov.au/publichealth/healthy_communities/multicultural_health

Department of Health, Government of South Australia. (n.d.) 'Refugee Health Service.' Accessed at: https://www.sahealth.sa.gov.au/wps/wcm/connect/Public+Content/SA+Health+Internet/Health+services/Refugee+Health+Service/

Department of Health, Government of Western Australia. (2018). 'Princess Margaret Hospital Refugee Clinic.' Accessed at: https://ww2.health.wa.gov.au/Articles/N_R/Princess-Margaret-Hospital-Refugee-Clinic

Department of Health, Government of Western Australia. (2018). 'Women's and Newborns Health Network.' Accessed at: https://ww2.health.wa.gov.au/Articles/U_Z/Womens-and-Newborns-Health-Network

Department of Health, Government of Western Australia. (n.d.) 'Humanitarian Entrant Health Service.' Accessed at: https://ww2.health.wa.gov.au/Articles/F_I/Humanitarian-Entrant-Health-Service

Department of Health, Government of Western Australia. (n.d.) 'Refugee Health.' Accessed at: https://ww2.health.wa.gov.au/About-us/Child-and-Adolescent-Health-Service/Child-and-Adolescent- Community-Health/Community-health-nursing/Refugee-health

Department of Health, Northern Territory Government. (2018). 'CDC Programs and Units.' Accessed at: https://health.nt.gov.au/professionals/centre-for-disease-control/cdc-programs-and-units/tuberculosis-and- leprosy-unit

Department of Health, Northern Territory. (2018). 'Northern Territory Suicide Prevention Strategy Framework 2018-2023.' Accessed at: https://digitallibrary.health.nt.gov.au/prodjspui/bitstream/10137/7055/1/Northern%20Territory%20Suicide%20Prevention%20Strategic%20Framework%202018-2023.pdf

Department of Health, Queensland Government. (2017). 'Refugee and Asylum Seeker Health Services.' Accessed at: https://www.health.qld.gov.au/public-health/groups/multicultural/refugee-services

Department of Health, Queensland Government. (2017). 'Refugee Health and Wellbeing: A Policy and Action Plan for Queensland 2017-2020.' Accessed at: https://www.health.qld.gov.au/data/assets/pdf_file/0031/646078/refugee-policy.pdf

Department of Immigration and Border Protection, Australia. (n.d.). *Australia's Humanitarian Programme 2016-17*. Retrieved from: https://www.homeaffairs.gov.au/ReportsandPublications/Documents/discussion-papers/discussion-paper-humanitarian-programme_2016-17.pdf

Department of Social Services, Australian Government. (2018). 'Permanent Settlers (All Streams) in all States/Territories with a Date of Settlement between 01 January 2018 and 31 December 2018.'

Department of Social Services, Australian Government. (2017). 'State of Residence of Permanent Settlers (All Streams) in all States/Territories with a Date of Settlement between 01 January 2017 and 31 December 2017.'

Department of Social Services, Australian Government. (2016). 'Permanent Settlers (All Streams) in all States/Territories with a Date of Settlement between 01 January 2016 and 31 December 2016.'

Department of Social Services, Australian Government. (2015). 'Settlement Monthly Report: Settlers by Migration Stream and State of Residence.'

DiVito, B. MPH, BSN, RN, Payton, C. MPH; Shanfeld, G. MPH, Altshuler. M. MD and Scott, K. MD. (2016). 'A Collaborative Approach to Promoting Continuing Care for Refugees: Philadelphia's Strategies and Lessons Learned'. *Harvard Public Health Review*. (7). Retrieved from: http://harvardpublichealthreview.org/a-collaborative-approach-to-promoting-continuing-care-for-refugees-philadelphias-strategies-and-lessons-learned/.

Drummond, P.D., Mizan, A., Brocx, K. & Wright, B. (2011). 'Barriers to Accessing Health Care Services for West African Refugee Women Living in Western Australia.' *Health Care for Women International.*

Fazel, M., Reed, R.V., Panter-Brick, C. & Stein, A. (2012). 'Mental health of displaced and refugee children resettled in high-income countries: risk and protective factors.' *The Lancet*. 379(9812).

Floyd, A. & Sakellariou, D. (2017) 'Healthcare Access for Refugee Women with Limited Literacy: Layers of Disadvantage.' *International Journal for Equity in Health*. 195(16). Retrieved from: https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-017-0694-8

Foundation House. (2018). 'Australian Refugee Health Practice Guide Launched.' Accessed at: http://www.foundationhouse.org.au/news/australian-refugee-health-practice-guide-launched/

Gartley, T. & Due, C. (2017). 'The Interpreter is Not an Invisible Being: A Thematic Analysis of the Impact of Interpreters in Mental Health Service Provision with Refugee Clients*.' Australian Psychologist Journal*. 52.

Guajardo, M.G.U., Slewa-Younan, S., Santalucia, Y. & Jorm, A.F. (2016). 'Important considerations when providing mental health first aid to Iraqi refugees in Australia: a Delphi study. International Journal of Mental Health Systems.' 54(10).

Griswold, K.S., et al. (2018). 'Strengthening Effective Preventive Services for Refugee Populations: Toward Communities of Solution.' *Public Health Reviews*. 39(3).

Hach, M. (2012). 'Common threads: the sexual and reproductive health of immigrant and refugee women in Australia.' *Multicultural Centre for Women's Health: Melbourne.* As cited in https://ama.com.au/position-statement/sexual-and-reproductive-health-2014#_edn51

Hagdkiss, E. & Rehanzo, AMN. (2014). 'The physical health status, service utilization and barriers to access care for asylum seekers residing in the community: a systematic review of the literature' *Australian Health Review.* 38, 142-159.

Hartcher, N. (2017) *Immunising Australia: Improving Australia's Vaccination Rates*. The McKell Institute. Retrieved from: https://mckellinstitute.org.au/research/articles/immunising-australia-improving-australias-vaccination-rates/#_edn42

Henderson, S. & Kendall, E. (2011). 'Culturally and Linguistically Diverse People's Knowledge of Accessibility and Utilisation of Health Services: Exploring the Need for Improvement in Health Service Delivery.' *Australian Journal of Primary Health.* 17(2). p.195-201.

International Organization for Migration. (n.d.) *Social Determinants for Migrant Health*. Retrieved from: https://www.iom.int/social-determinants-migrant-health

Joshi, C., et al. (2013). 'A Narrative Synthesis of the Impact of Primary Health Care Delivery Models for Refugees in Resettlement Countries on Access, Quality and Coordination.' *International Journal for Equity in Health*. 88(12). Retrieved from: http://www.equityhealthj.com/content/12/1/88

Joyce, A., Earnest, J., De Mori, G. & Silvagni, G. (2009). 'The Experiences of Students from Refugee Backgrounds at Universities in Australia: Reflections on the Social, Emotional and practical Challenges'. Journal of Refugee Studies. 23(1).

Killedar, A. & Harris, P. (2017). 'Australia's Refugee Policies and their Health Impact: A Review of the Evidence and Recommendations for the Australian Government.' *Australian and New Zealand Journal of Public Health*. 41(4).

Kirmayer, L.J., et al. (2011, July 25). 'Common Mental Health Problems in Immigrants and Refugees: General Approach in Primary Care*.' Canadian Medical Association Journal*.

Lloyd, J. et al. (2018). 'How can communities and organisations improve their health literacy?' Public Helath Research & Practice. 28(2). 1-5.

Mace, A.O., Mulheron, S., Jones, C. & Cherian, S. (2014). Educational, developmental and psychological outcomes of resettled refugee children in Western Australia: A review of School of Special Educational Needs: Medical and Mental Health input. *Journal of Paediatrics and Child Health.* Retrieved from: http://onlinelibrary.wiley.com/doi/10.1111/jpc.12674/full

Mahimbo, A., Seale, H. & Heywood, A.E. (2017). 'Immunisation for Refugees in Australia: A Policy Review and Analysis Across all States and Territories.' *Australian and New Zealand Journal of Public Health*. 41(6).

McBride, J. Russo, A. & Block, A. (2016). 'The Refugee Health Nurse Liaison: a nurse led initiative to improve healthcare for asylum seekers and refugees.' *Contemporary Nurse*. 52(6), p.710-721.

McBride, J., Block, A. & Russo, A. (2017, July 31). 'An Integrated Healthcare Services for Asylum Seekers and Refugees in the South-Eastern Region of Melbourne: Monash Health Refugee Health and Wellbeing.' *Australian Journal of Primary Health*.

McMichael, C. & Gifford, S. (2009). 'Narratives of sexual health risk and protection amongst young people from refugee backgrounds in Melbourne, Australia.' Culture, Health & Sexuality. 12(3).

Mengesha, Z.B., Perz, J., Dune, T. & Ussher, J. (2017). 'Refugee and Migrant Women's Engagement with Sexual and Reproductive Health Care in Australia: A Socio-Ecological Analysis of Health Care Professional Perspectives.' *PLoS ONE Journal*. 12(7).

Milosevic, D., Cheng, I. & Smith, M. (2012). 'The NSW Refugee Health Service: improving access to primary care.' *Australian Family Physician*. 41(3). 147–149.

Noto, O., Leonard, W. & Mitchell. A. (2014). Understanding the support needs of Lesbian, Gay, Bisexual and Transgender (LGBT) young people from refugee and newly arrived backgrounds. Australian Research Centre in Sex, Health and Society.

NSW Department of Health (2011). *Refugee Health Plan 2011-2016.* North Sydney: NSW Government. Retrieved from: http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2011_014.pdf

NSW Health. (2014). *NSW State Health Plan Towards 2021.* North Sydney: NSW Government. Retrieved from: https://www.health.nsw.gov.au/statehealthplan/Publications/NSW-state-health-plan-towards-2021.pdf

NSW Government. (2017, November 9). *Refugee Settlement: NSW is Proud to Play an Integral Role in Resettling the Refugees Fleeing the Conflict in the Middle East.* Retrieved from: https://www.nsw.gov.au/improving-nsw/projects-and-initiatives/refugee-settlement/

NSW Government. (2018, August 14). *Life Expectancy by Aboriginality, 2010-2012*. Retrieved from: http://www.healthstats.nsw.gov.au/Indicator/bod_lexbth/bod_lexbth_atsi_snap

NSW Government and NSW Refugee Health Service. (2018, January). *Factsheet No. 1*. Available at: https://www.swslhd.health.nsw.gov.au/refugee/pdf/Resource/FactSheet/FactSheet_01.pdf

NSW Treasury. (2016). *NSW Budget 2016 – 17, Budget Paper 1,5. Budget Position and Outlook, Box 5.11 at 5-21*. Retrieved from https://www.treasury.nsw.gov.au/sites/default/files/pdf/2016-2017_Budget_Papers_BP1_Budget_Statement.pdf

Nunn, C., McMichael, C., Gifford, S.M., & Correa-Velez, I. (2014). 'I came to this country for a better life' : factors mediating employment trajectories among young people who migrated to Australia as refugees during adolescence.' *Journal of Youth Studies*. 17(9).

Owen et al. (2009). 'A Review of the Literature and Practice on Models of Care for Refuge Health.' Centre for Health Service Development, University of Wollongong.

Parliament of Australia. (2015, June 10). *Asylum Seeking and refugees: what are the facts?* Retrieved from https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/rp1415/AsylumFacts#_Toc413067445

Philadelphia Refugee Health Collaborative Model. (n.d.) 'The Philadelphia Refugee Health Collaborative Model' Retrieved from: http://philarefugeehealth.org/?page_id=60.

Phillips, C.B., Smith, M.M., Kay, M. & Casey, S. (2011, August 15). 'The Refugee Health Network of Australia: Towards National Collaboration on Health Care for Refugees.' *Medical Journal of Australia.* 195(4).

Phillips, J. (2015, March 2). *Asylum Seekers and Refugees: What are the facts?* Parliament of Australia. Retrieved from: https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/rp1415/AsylumFacts#_Toc413067448

PHN Northern Territory. (2016). 'NT PHN Refugee Health Program.' Accessed at: https://www.ntphn.org.au/nt-phn-refugee-health-program

Posselt, M., et al. (2017). 'Improving the Provisions of Services to Young People from Refugee Backgrounds with Comorbid Mental Health and Substance Use Problems: Addressing the Barriers.' *BioMed Central Public Health Journal*. 280(17).

Queensland Department of Communities, Child Safety and Disability Services. (2016). 'Queensland Multicultural Policy: Our story, our future.' Accessed at: http://www.communities.qld.gov.au/resources/multicultural/policy-governance/qm-policy.pdf

Renzaho, A. D., N (2016). 'Addressing the needs of Syrian and Iraqi refugees in the Nepean Blue Mountains region' Penrith Wentworth Healthcare Limited.

Riggs, E. et al. (2015). 'Breaking Down the Barriers: A Qualitative Study to Understand Child Oral Health in Refugee and Migrant Communities in Australia.' *Ethnicity & Health Journal.* 20(3).

Riggs, E., et al. (2012). 'Accessing Maternal and Child Health Services in Melbourne, Australia: Reflections from Refugee Families and Service Providers.' *BioMed Central Health Services Research*. 117(12).

Retrieved from: http://www.biomedcentral.com/1472-6963/12/117

Russell, G., et al. (2013). *Coordinated Primary Health Care for Refugees: A Best Practice Framework for Australia*. Australian Primary Health Care Research Institute.

Shawyer, F., et al. (2014). 'A Cross-Sectional Survey of the Mental Health Needs of Refugees and Asylum Seekers Attending a Refugee Health Clinic: A Study Protocol for Using Research to Inform Local Service Delivery.' *BioMed Central Psychiatry Journal*. 356(14).

Shawyer, F., et al. (2017). 'The Mental Health Status of Refugees and Asylum Seekers Attending a Refugee Health Clinic Including Comparisons with a Matched Sample of Australian-born Residents.' *BioMed Central Psychiatry Journal*. 17(76).

South Australia Health, Government of South Australia. (n.d.) 'New Arrival Refugee Immunisation Program (NARI).' Accessed at: https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+topics/health+conditions+prevention+and+treatment/immunisation/immunisation+programs/new+arrival+refugee+immunisation+program

Suleman, S., Garber, K.D. & Rutkow, L. J (2018). 'Xenophobia as a determinant of health: an integrative review.' *Public Health Policy,* 39(407).

Taylor, J. & Haintz, G.L. (2018). 'Influence of the Social Determinants of Health on Access to Healthcare Services Among Refugees in Australia.' *Australian Journal of Primary Health.* 24.

United Nations High Commissioner for Refugees. (1951). *Convention and Protocol relating to the Status of Refugees*. Retrieved from http://www.unhcr.org/en-au/3b66c2aa10

Victorian Department of Health and Human Services. (2017). *2016-17 State Budget: Refugee and asylum seeker health and wellbeing in Victoria.* Retrieved from: https://www2.health.vic.gov.au/about/publications/factsheets/2016-17-budget-launch-refugee-asylum-seeker-fact-sheet

Victorian Refugee Health Network. (n.d). *Settlement Health Coordinator Pilot*. Retrieved from: http://refugeehealthnetwork.org.au/settlement-health-coordinator-pilot/

World Health Organization (a). (n.d.). *Social Determinants of Health: Key Concepts.* Retrieved from: http://www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/

World Health Organization (b). (n.d.). *Health Impact Assessment: Glossary of Terms Used.* Retrieved from: http://www.who.int/hia/about/glos/en/index1.html

World Health Organization. (2008) *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health*. Retrieved from: http://apps.who.int/iris/bitstream/handle/10665/43943/9789241563703_eng.pdf;jsessionid=6DF20B86E9CC0A3202CB6F183A2B0241?sequence=1

Woodland, L. et al. (2010). *Health service delivery for newly arrived refugee children: A framework for good practice.* Journal of Paediatrics and Child Health. 46. Retrieved from: https://onlinelibrary.wiley.com/doi/epdf/10.1111/ j.1440-1754.2010.01796.x

Yelland, J., et al. (2014). 'How do Australian Maternity and Early Childhood Health Services Identify and Respond to the Settlement Experience and Social Context of Refugee Background Families?' *BioMed*

Central Pregnancy and Childbirth Journal. 348(14). Retrieved from: http://www.biomedcentral.com/1471-2393/14/348

Ziaian, T., et al. (2012). 'Resilience and Its Association with Depression, Emotional and Behavioural Problems, and Mental Health Service Utilisation among Refugee Adolescents Living in South Australia'. *International Journal of Population Research*. 2012

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