FINAL EVALUATION REPORT

Armidale Refugee Health Program

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July 2022

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These parties contributed to the elaboration and finalisation of the evaluation design, gave their views and insights on different aspects of the Armidale Refugee Health Program, and provided feedback on the draft evaluation report.

Affirmation

The final evaluation of Armidale Refugee Health Program project responds to the Multicultural and Refugee Health requirement to report on the results of the project. In addition to accountability to the Multicultural and Refugee Health, the results of the evaluation are intended to be used for improving refugee health initiatives.

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Introduction

The present evaluation report is developed based on the review of Armidale hospital files, and is primarily based on the interviews of refugees and focus groups with the project's beneficiaries, partners and other stakeholders.

The report is to be shared with the Multicultural and Refugee Health Service, implementing and partner agencies, as well as to all those stakeholders who expressed their interest in the results of evaluation at the evaluation planning workshops.

Abbreviations

ADL	Activities of Daily Living
ED	Emergency Department
GPs	General Practitioners
HNELHD	Hunter New England Local Health District
HSP	Humanitarian Settlement Program
ISIS	Islamic State of Iran and Syria
NAATI	The National Accreditation Authority for Translators and Interpreters Ltd
NDIS	National Disability Insurance Scheme
OT	Occupational Therapy
PT	Physiotherapy
SSI	Settlement Services International
STARTTS	NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors

Executive Summary

The program evaluated was a regional multi-disciplinary Refugee Health Program. A successful grant submission to NSW Ministry of Health in 2019 enabled Hunter New England Local Health District (HNELHD) to establish a part-time multi-disciplinary team incorporating: occupational therapy (0.1 FTE 2019, increased to 0.2FTE in 2021), physiotherapy (0.2 FTE 2019, increased to 0.4FTE in 2021), speech pathology (0.2FTE 2021) and social work (0.63 FTE 2019) to complement existing Refugee Clinical Nurse Specialists (1.2 FTE). The Armidale Refugee Health Program has a common goal to provide quality care for refugees resettled in Armidale, NSW.

The final evaluation of Refugee Health Program was undertaken for accountability and learning purposes. It used both qualitative and quantitative methods of data collection which included a review of Armidale Hospital medical records, semi-structured interviews with refugees and focus groups with key stakeholders.

The evaluation identified that post arrival, the majority of refugees access the Emergency Department (ED) for issues that could be appropriately managed in General Practice (n= 35, 89%), highlighting the critical need for support to access GPs and education about the Australian health care system. Interpreter use was variable such that a reliance on escorts was noted for 15% of ED presentations and no/unknown use of interpreters was noted in 43% ED presentations.

Evaluation findings indicate the benefit of early access to allied health for prompt diagnosis and treatment of conditions across the lifespan including congenital and developmental conditions, mental health and chronic disease. In response to a high prevalence of chronic pain in the Ezidi community, a chronic pain service has been established. The Armidale Refugee Health Program worked extensively within the Armidale community to foster access to key services such as General Practitioners (GPs), medical specialists and the National Disability Insurance Scheme (NDIS). A key aspect was the time taken to coordinate assessments and completing necessary supporting paperwork and applications. Furthermore, the Armidale Refugee Health Program contributed to health promotion activities in the community. This was primarily achieved through opportunistic approaches in forums conducted at TAFE where many refugees are required to attend English program.

Stakeholders praised the efforts made by the team to meet with, educate and connect with GPs to promote acceptance of refugees as patients. Other key benefits pertained to the assistance they provided coordinating NDIS and health promotion activities. The use of home visiting to provide health care was perceived as essential to establish trust and rapport that underpinned future engagement by refugees with future health care. Significant gaps still remain regarding refugee access to necessary health care as some services refuse to accept refugees due to interpreter costs and complexity of need.

Evaluation Background

Even in the safety of an Australia context, the health and wellbeing of people of refugee background is intimately linked with their ability to access high quality, coordinated health care[1]. Many refugees struggle to access general practitioners, medical specialists, community health services and hospitals due to problems related to language barriers, cultural differences, and the complexity of understanding the Australian healthcare system[2-4]. Provision of quality primary care to people from refugee backgrounds care has been found to be inconsistent, with many providers having incomplete knowledge of refugee health requirements. Furthermore, interpreters are underutilised[5], and coordination between sectors is often delayed and fragmented[6].

Access to appropriate health care for refugees is critical as many have developed complex, multiple health issues as a consequence of war and conflict and their exposure to persecution, trauma, unhealthy environmental conditions and deprivation in addition to disrupted and inadequate access to health care. These factors are likely to compound effective transition to a new country. While some specialised services exist to meet the health needs of those of refugee background, the majority of healthcare for refugees occurs within mainstream services[7]. Specialised services dedicated to refugees are typically located in major metropolitan areas, and despite the availability of outreach and training strategies, they remain less available to refugees who settle in rural and regional areas of NSW[7]. Furthermore, previous research has demonstrated that refugees under-utilise health services due to a lack of familiarity with the health system and reduced ability to self-advocate[8]. Additional barriers to health care access pertains to a lack of appropriate health information, education materials, knowledge about community health resources and access to transport[8].

Armidale Refugee Health Team

Following arrival in the Armidale community, refugees are supported by the Humanitarian Settlement Program (HSP) resettlement provider, Settlement Services International (SSI). SSI has a contract with the Department of Home Affairs to provide resettlement supports including early post arrival health assessments and assistance in navigating the health system for 6 to 18 months following arrival[9]. Refugees also have access to one-off time based Medicare Benefit Schedule item numbers that allows a GP to complete a refugee health assessment within the first 12 months[10].

Participants in this study were Ezidi refugees who were eligible for general HSP settlement support including: help with transport to initial accommodation upon arrival, provision of initial accommodation (typically for a period of 6 months, although this is variable), assistance with finding longer term accommodation, property inductions, orientation to life in Australia, access to schooling and English education, and other case support.

In NSW and in other Australian states and territories, refugee health nurses provide early health contact and triaging, health care advice, support and follow up of refugees to ensure referral services are accessed and treatment advice is followed. In Armidale following an initial health assessment (including pathology screening for infectious diseases, nutritional status and general health determinants) and some nurse-initiated treatment, refugees are referred to GPs in the

community for ongoing care. In addition, in Armidale refugees may be referred to the recently established, free part-time public hospital allied health team dedicated to providing health services for refugees including the provision of occupational therapy, physiotherapy, speech pathology and social work. Nationally recognised (NAATI) interpreters are ideally used whenever required, onsite, by videoconference or over the telephone.

The questions underpinning this evaluation are:

(1) When why and by whom is the identification and management of refugee health issues implemented in a hospital setting following settlement;

(2) What are refugee experiences of access to the Armidale Refugee Health Program access and does it make a difference to health and well-being;

(3) What are some of the health professional experiences of the Armidale Refugee Health Program and does it make a difference to health service delivery.

1. Study Design

This mixed methods study explored the refugee experience of access to the Armidale Refugee Health Program. Firstly, a retrospective electronic medical record audit was conducted to understand reasons for hospital presentation post arrival to Australia in order to give context to early health needs. Secondly, semi-structured interviews were conducted with refugees (n= 17). The purpose of the semi-structured interviews was to understand perceptions and experiences of refugee access to the Armidale Refugee Health Program and whether they believe it made a difference to their health and well-being. Focus groups (n=2) were conducted with key stakeholders who referred to the Armidale Refugee Health Program. The purpose of the focus groups was to explore stakeholder's experiences of access to the Armidale Refugee Health Program and whether it made a difference and assisted them in the services they provided.

1.1 Ethical considerations

Careful attention was paid to ethical considerations given the sensitivities of conducting research with refugees. We paid particular attention to issues of coercion and informed consent including the provision of assurances of confidentiality and anonymity. We reinforced that service access was not related to, or impacted by participation in the project. This research was conducted with the assistance of a Refugee Health Team to assist in accessing the local Ezidi community. We used a multistage informed consent process, allowing time for consideration before participation in an interview. Members of the Armidale Refugee Health Team, who had established a relationship based on trust, phoned potential participants who had utilised the Armidale Refugee Health Team themselves, or who had children who had accessed members of the team. Phone calls were made with the assistance of a NAATI trained interpreter to explain the study, the consent process and

invite participation. There was an opportunity to ask questions. Participants were made aware that their participation was voluntary, and that they could withdraw at any time and have their data removed from the study. They were also reassured that their current and future access to health, for them and their children, would not be affected by participation or withdrawal from the study.

Participants who provided verbal consent were later phoned to confirm the interview and their consent to participate. At this time participants were reminded that their participation was voluntary, and that they could withdraw at any time and have their data removed from the study. Written informed consent was obtained prior to the interview including consent for interviews to be audio-recorded. Ethics approval for the study was obtained from the Hunter New England Ethics Committee (2021/STE02669).

2. Data collection processes

2.1 *Quantitative: Hospital file audit*

Participant details were retrieved from the Armidale Refugee Health Program patient list of refugees. Consecutive refugees (from first record of arrival) were selected who met the following inclusion criteria: Person from the Ezidi community as listed on the Armidale Refugee Health Team patient and presentation to the Armidale Hospital Emergency Department (ED) or admission under the care of a medical unit between March 2018 and October 2021. Only data relating to the first (index) presentation for each person were eligible for inclusion (i.e., no repeat admissions per patient). All data were extracted directly from hospital electronic medical records by two assessors using a standardised template. Data were extracted regarding the preferred language spoken, timing and frequency of interpreter access, reasons for interpreter use, the healthcare professions that accessed the interpreting service as well as presenting conditions, investigations and procedures ordered, and referrals made.

2.2 *Qualitative Interviews*

Participants were individuals or their families who had received input from the Armidale Refugee Health Team. Participants who had accessed varied members of the team were invited to participate by members of the Armidale Refugee Health Program, as described above, forming a convenient sample. Although ethics approval included scope to interview children, for pragmatic reason only parents were interviewed. This decision was made following pilot interviews where it was observed that participants were uncertain of how health care services were accessed, including a lack of understanding of nature of the professional groups who provided services. We felt this uncertainty would be amplified in children. In response, we triangulated participant reports with the verification by the Armidale Refugee Health Program of the services provided.

Interviews were conducted at the Armidale Community Health Centre by an experienced qualitative researcher (JW). For ethical reason participants were given the option of a trusted member of the

Refugee Health Team, familiar to the participant, sitting in, however no participants took up this option. All interviews took place in a private room to prevent intrusion or distraction and to ensure participant privacy and comfort. The interviews were conducted, where possible with both parents present, representing their own health needs and that of their families. To minimise the risk of distress, interview questions did not initiate discussion of traumatic experiences. After asking demographic question to help establish rapport, the interview progressed. Open-ended question, using an Interview Guide (Appendix 1) explored how the family perceived their health challenges, what services they had accessed and why, and their hopes for the future with regards to health service access.

2.3 Focus groups

Recruitment for the first focus group was open to professional stakeholders working in resettlement agencies that provide support refugees. Recruitment for the second focus group was open to health professionals providing clinical services to refugees based in Armidale. All participants were invited to participate by response to an e-mail invitation by SSI and the Primary Health Network respectively. Detailed information was given about the study and time of the focus group, which was, conducted over zoom. Consent was implied from response to the focus group invite.

3. Data analysis

3.1 Quantitative

Descriptive statistics including means, standard deviations and frequency counts were used to describe hospital experiences including the timing and frequency of interpretation access, reasons for interpreter use and for which healthcare professions, as well as presenting conditions.

3.2 Qualitative

Interviews ranged from 20 to 45 minutes in length, and focus groups were 60 mins and were audio recorded with permission, and transcribed verbatim and identifying data was removed. Data was coded data using an inductive thematic analysis[11]. This involved (i) identifying units of meaning by reading the transcripts line-by-line, (ii) grouping units into categories to assist with data retrieval, irrespective of the research question, and (iii) examining relationships between codes to form themes. Firstly, transcripts were read line by line analysis and interpretation of the transcripts that identified a broad range of codes from the data. Using a word document, codes was issued with a four-letter label or code to facilitate data retrieval between the transcripts (for example, the experience of gratefulness was given the code GRTE). Categories were identified following the exploration of connections between the codes (for example all codes that impact uncertainty with the health system impact of fatigue). Through regular discussion with broader team, the final step examined relationships between categories to form themes. Coders captured exemplar quotes

supporting each theme. Trustworthiness of our data was achieved using several strategies, including immersion in data; reflexive analysis, peer debriefing and member checking[12, 13].

4. Results

4.1 Quantitative

Of the 50 refugee files audited, data was collected from 39 (5 did not wait for treatment in ED, 6 were a file selection error such as incorrect record selected). The mean age was 16 years (range 0-46); 50% were female, all were from Iraq. Among the eligible refugees, 3 underwent day surgery (orthoscopy, dental extraction, shrapnel removal), 4 were admitted following ED presentation (appendicitis, maternity, fever of unknown cause, abdominal pain investigations) and the remaining 32 presented to ED but were not admitted. Review of reason for ED presentation demonstrated that the majority (n= 35, 89%) of ED presentations were preventable and could have been managed in general practice (abdominal pain, dental pain, cold symptoms, urinary tract infection, falls during play or sport, vomiting, x-ray review, dysmenorrhea pain, joint pain). Non-preventable ED presentations (n=4) included accidental overdose, motor vehicle accidents, high fever accompanied with labor. Adverse events were noted in 3 ED presentations (hyperventilating with panic, parent refused treatment for child, distress post cochlear implant possible due to poor health literacy and not understanding healing time frame), 1 day surgery admission (pulled out IV cannula which was unable to be reinserted due to language barrier), 2 hospital admission (distress requiring NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) support, discharged self against medical advice). Two of the ED presentations had only arrived in Australia within the previous week. We were unable to ascertain whether or not refugees had access to a local GP and their level of health literacy which may have influenced the reason ED presentation. Interpreters use (phone and in person) was indicated for 21 refugees, escorts were indicated for 6 refugees (4 siblings, 1 spouse, 1 escort) and no or unknown/undocumented use of interpreters was indicated for 17 refugees.

4.2 Qualitative Interviews

In total, 17 semi-structured interviews were conducted. All participants were recipients of Australian government humanitarian visas and being supported by Humanitarian Settlement Program (HSP). Limited demographic characteristics are provided to help protect anonymity. All participants identified as Ezidi and were from Iraq. The parents in the families were between 23 and 57 years of age and had 1–12 children per family. Most refugees had been in Australia between 2 and 5 years. Parent education levels ranged between year 6 and 12 in Iraq. Women typically performed home duties and men had limited opportunities for unskilled work such fruit picking or labouring.

Four key themes emerged related to refugees' access to the Armidale Refugee Health Program and the broader health system.

1. Factors promoting adjustment to and confidence in an Australian health system

2. Health support across the life span: benefit of access to a multi-disciplinary team
3. Challenges to negotiating the health system
4. Ongoing health and lifestyle concerns – influenced by understanding and education

We have used data extracts from the interviews to illustrate each theme. The sections below include interview quotations represented as "P" for "participant family" and a participant number, e.g., "P1". For ease of reading, the English has been corrected from the original spoken form, which had many grammatical errors, and in some cases had been translated into English from the participants' own language.

1. <u>Factors promoting adjustment to and confidence in the Australian health care system</u>

All participants reported feelings of "stress" (P11) towards how they would access health care in a new country. Difficulties were attributed to lack of familiarity with the health care system, language barriers and feelings of isolation from support systems.

> So initially it was very difficult because when you just move into a new country everything is new and it is like kind of you do not know what to do. (P2)

> It was very difficult; we didn't know the language and it was the first time for us travelling in our life. It was a new country, and we didn't have anyone to support us. It was a very difficult time. (P8)

Despite the uncertainty of unfamiliar processes towards health care access, participants were reportedly confident they would get the help they needed based on what they had heard or been taught in their home country or "refugee camp." (P13)

> We knew that this is a very good country, and everybody has the right to get treated with respect and dignity. We knew they would help us here and give us the support we need so we are very thankful for everything have done for us. (P14)

Most participants reported a range of barriers towards accessing health care in their country of origin, and were hopeful about their opportunities for health care on arrival in Australia. Barriers included perceived limitations regarding accessing doctors, in part due to cost and medical technology.

> The equipment [technology] is more advanced here [Australia], there is access to more, kind of, up-to-date equipment. Also, the doctors here have more experience. The doctors back in Iraq, they have to advance their English before they can learn how the [new] equipment works. (P1)

> Back home in Iraq we would hardly see doctors often. If we were in pain, we just moved on because it was too much effort to go to the doctor. (P2)

Indeed, several participants reported they waited until they arrived in Australia in order to access treatment that was difficult obtain in Iraq due to cost or lack of expertise. Example of conditions included the need for orthopaedic surgery, specialised post-polio treatment, cochlear implants and heart surgery. Participants expressed gratefulness for treatment that enabled them to embrace life in a new confidence to be able to engage in school and work.

> In Iraq they wanted to do a surgery, but we had to pay for it, and we couldn't afford paying for the surgery. So, we waited until we came to Australia, and we received the surgery here. We are very thankful for all the support. (P11)

Most participants reflected on the support they received from SSI and the Armidale Refugee Health Nurses who were their first point of contact with the Australian health system. Key benefits reported included receiving an initial assessment of health needs for all family members, having referrals coordinated and gaining access to a local GP. For most participants registration paperwork toward GP access was completed by the Refugee Health team.

> When first we came here, [the nurse] was supporting us. She helped us with all the paperwork and health care records. She arranged the appointments for us, and she wanted to make sure that we got all the support that we needed …to find the causes of the problems we are having and make sure we got the right treatment. (P12)

Once established with a GP most participants were able to independently seek assistance for themselves and their family as required.

> When first we came here, [the nurses] were supporting us. They were making the appointments for us and helping us with that, but now we know how to do it. So, whenever we need to make an appointment with the GP for our kids, we are able to do that and take them to the appointment, but in the beginning, they were helping us with that. (P9)

For many participants the initial assessment, including pathology tests, was an opportunity for review and management of existing health concerns. For other participants, the initial assessment provided an opportunity for health concerns to be identified or to have a diagnosis confirmed. For example, some participants were diagnosed with heart disease, diabetes, intellectual disability or vitamin deficiencies for the first time on arrival in Australia. Participants readily embraced the treatment they required in order to recover and progress their life in Australia

> I have some issues with vitamins [deficiency]. When I arrived, I couldn't move properly because I had some issues with my back. So, that [vitamin deficiency] make the bones ache and become weak. (P13)

> So, the main thing would be my leg, I can get my leg fixed. Then after I can get married, I can have my own family and get my own house and yeah be independent. (P2)

For other participants, access to the Australian health care system enabled diagnosis of complex health issues such as epilepsy, asthma, stroke post birth, deafness, cerebral palsy and chronic incontinence. In many cases participants reported that such conditions had been over-looked, under-treated or not diagnosed in Iraq.

> Yeah, so, they didn't diagnose it [epilepsy] there [in Iraq]. [My daughter] would get headaches and would fall over with …. but we didn't know the reason. I would have taken her to the doctors, and they would just give her flu medicines, something like Panadol. I would also put a cold wash on her forehead. (P5)

> The first year after he was born there was no access to health checks, so we didn't know that he was deaf. (P8)

> We were told there was spot of blood somewhere on her brain that wasn't moving [occluded]…. that caused her [daughter] right side to feel weak. Back in Iraq they didn't tell us much, they just told us that her brain is not developing well. (P9)

While participants were grateful for the support and help, they received on arrival, they also reported feelings distress and confusion, particularly in the early stages of their relocation, when they felt disorientated. Participant reports highlighted the challenge of accessing health services in an unfamiliar country when unable speak English.

> We didn't know the language and once I had an appointment, the SSI arranged a driver to take me to the appointments. I thought the driver would stay with me until I finished the appointment, but he just drove me and then left. It was very hard; I didn't know what I should do. (P14)

Another participant relayed the challenge of using public transport to travel to a tertiary health service in Newcastle for health care. In this scenario they missed their train and struggled in an unfamiliar setting. Since being registered with NDIS they reportedly receive better orientation and support.

> Once I was in Newcastle I was trying to come back from Newcastle to Armidale, but I missed my train and there wasn't anyone who would support me or help me. It was a really difficult time for me…. once we were with NDIS, we got a new caseworker, and she was very helpful for us. (P8)

Many participants reported that support from the local Ezidi community was instrumental in facilitating their transition and familiarity with the how to access local health care. Participants noted the benefit of knowing members of the community who were often able to speak some English and could explain the process or provide support by attending appointments, or had a car to help with transportation.

> So, initially it was other people who came here before us, it is the community people who arrived here before us, they were very helpful and explaining things and telling us this is what we do here. (P1)

> Someone in our Ezidi community took us there with his own car and his English was better than us at that time. He drove us there; we went to the doctor with us. (P2)

2. <u>Health support across the life span: benefit of access to multi-disciplinary Refugee Health Team</u>

All participants expressed gratitude at being able to access a diverse range of nursing and allied health services however they reportedly continued to struggle to understand the role of each team member.

> The only problem is that we don't know everyone's name, but everyone's been helpful, everyone in the team have been very equally helpful. (P1)

> I can't remember all their names or say their names, but there have been a lot of people who have tried to help me get better. (P3)

Access to the Armidale Refugee Health Team promoted early access allied health in contrast to being placed of a waiting list for community services. In the first instance, participants reported that access to Refugee Health Team social worker was critical for getting help to navigate the health care system and receive support towards community transport to attend appointments. Initially, many participants reported they did not have their own car and were unfamiliar with how to access local transport, especially when required to travel to access tertiary health services in Newcastle. Most participants reportedly obtained a license and a car at a later date which promoted their independence. Participants also valued support from the Refugee Health Team to negotiate access to visiting or regional specialists and avoid travelling long distances, to unfamiliar cities.

> When we first came here, going to Tamworth was easier than going to Newcastle, but it was still a bit difficult for someone who has just come to a new country. (P8)

Access to allied health, such as occupational therapy (OT), physiotherapy (PT) and speech pathology, reportedly promoted early access to assessment and treatment in contrast to being referred to community health, where wait lists applied. For example, the prescription of adaptive equipment for

existing disabilities facilitated "independence (P3)" which hadn't been possible in Iraq where such equipment was not available.

> We have chair that you can sit in the shower and wash. We have never seen this stuff [equipment] in our country. The government that we grew up in, we did not get any help with anything and this….so the Australia Government has been helping us a lot. (P2)

For other participants, especially families who had children with disabilities, allied health treatment involved training in activities of daily living (ADLs) such as dressing which hadn't been available in Iraq. This was integral as children aged for example teaching one girl with development disabilities to use sanitary products.

> [The therapist] was showing her [daughter] how to wear her underwear and take them off and what to do. (P9)

Many participants reported health issues in response to trauma. For example, some children experienced pica, an eating disorder that involves eating items that are not typically thought of as food. For children with pica access to an OT, speech pathologist and dietician reportedly involved therapy to provide education of eating and receiving nutrients through food. Advocating access to childcare, including completing paperwork and applications for fee subsidies, was also reported to be invaluable as allowed their daughter to observe other children playing and eating.

> So, they were playing with her…bringing her different foods and seeing which one she is going to eat, organising childcare. So, they helped us a lot. (P1)

Access to allied health was also reportedly beneficial for "behavioural issues, she is not normal, she kind of …gets angry [acts out violence observed]" (P1), mental health needs and treatment for injuries sustained during conflict. Key services provided included referrals for mental health support, including NDIS applications, and therapy to address chronic pain and muscle weakness.

> For a period before the genocide started, they [children] were feeling very well, but after the genocide started, their situations, it just got worse. (P14)
>
> I had a bullet in my back, so it's been seven years now, and since then I have been getting the chronic back pain. (P3)

Early access to allied health from the Refugee Health team enabled accessed to support for physical conditions such physiotherapy for chronic pain, strengthening and mobility exercise due to physical limitations due to past accidents or other health conditions.

> No, I am getting better and feel healthier at the moment. I do exercise, I attend a class a physiotherapist. (P13)

> He [physio] also made me a boot for that leg so when I was walking with the leg in the boot, I was walking straight. (P2)

Some participant's children experienced developmental issues and conditions such as intellectual disability, cerebral palsy, epilepsy and deafness resulting in the need for cochlear implants. Participants reported a key benefit with regards to accessing the Refugee Health team for assessment, treatment and referral. Therapists also played a key role in facilitating NDIS application for long term support. Access to allied health was critical for assisting with arranging assessments to help confirm a diagnosis and complete the paperwork since participants didn't understand the process or have adequate language in the early days post arrival.

> She can walk, she talks, but her talking and her age do not match. She just started becoming a client with the NDIS. The refugee health team have help us with the application for the NDIS. (P10)

Likewise access to the refugee health team reportedly facilitated prompt access to a local GP. Indeed, the Refugee Health Team played a critical role in negotiating with and advocating for local GPs to accept refugees as new patients. As such all refugees in Armidale have access to a GP in contrast to other settlements cities where access to a GP is initially through a refugee health clinic and long-term primary health care is less accessible. While participants reported that they were often inundated with the need for appointments for themselves and their family on arrival, these were closely coordinated by the Refugee Health team and GPs, including completing forms and organising community transport.

> Yes, it was [the nurse] who found a GP for us and then the GP referred us to the specialist. [The nurse] helped arrange our appointments and made sure we are seeing the right person. In one month, I had seven appointments and [the nurse] organised them all. (P12)

In addition to acute issues participants benefitted from education toward the management of chronic disease such as heart disease and diabetes.

> No, we haven't seen anyone to talk with us about this stuff, but it's just like when we go to our GP, they will tell us … this is good and this is not good thing for your health, but otherwise we haven't seen anyone to talk about this. (P12)

3. <u>Challenges to negotiating the health system</u>

Despite the benefits participants reported from access to the Refugee Health Team participants also recounted practical difficulties on arrival when accessing the diverse range of health services for their families. In the initial days, many participants would, "Just walk to the appointments." (P10)

> The first year it was very difficult for me, I did not have a car and I was taking care of six kids. Sometimes when they had an appointment, I needed to walk to the school to get them [children] from school and then walk to the appointment. Sometimes it was raining, and the weather was very cold, it was just very difficult to walk through that weather. I think that was the hardest thing. Since I got my car, and my driving licence, things have got better. (P15)

While most participants reported that they always had access to an interpreter, either in person or over the phone, others reported scenarios when they did not have access to an interpreter such as when presenting to the maternity ward or the ED. Over time many participants had grasped some English, facilitated by the attending the compulsory TAFE English course, but still struggled when an interpreter was not available.

> When I gave birth, it was Saturday and they told me there is no interpreter available because it's the weekend. So, my friend came with me. (P16)

> In ED you have to wait. So, after he [son] was getting worse, I was scared. I mean I can try my best [interpreting] for me and my family but …. (P13)

Other participants reported that even when an interpreter had been booked, they often didn't speak Kurdish Kurmanji which meant they were not able to understand the interpreter. One participant explained that men had more exposure to different dialects through their work in Iraq, in contrast to women who were often at home. This participant expressed that access to an interpreter who spoke the correct dialect language was particularly important for women, especially over the phone when it was not possible to gauge body language.

> It's hard to explain, so we mostly use body language. If on the phone, we can't see each other, so it's hard. Even if the sound is different, especially for women, who haven't worked. For men, yeah, they work with Iranian, Syrian and Turkish people, so we know their sounds, but women never have, so that's very difficult for them. I prefer face-to-face [interpreters]. (P13)

In response, appointments had the potential to be cancelled leading to delays in health care access.

> Lots of appointments we cancelled because of that [interpreter]. (P13)

Participants also reported difficulty with the appointment booking system for health care appointments. In most cases participant were sent appointment information via SMS, and sometimes mail, which was challenging to understand when they lacked proficiency in English. A phone call reminder was perceived as more helpful.

> There were a lot of times I forgot about my appointments even though they send me like text messages reminder, but sometimes it is hard for me to understand. Sometimes I will give it my kids and ask them to read it for me. When they give me like a call to remind me of the appointments that is helpful, it will be easier for me to come to my appointments but when they send me text messages sometimes it is hard. (P17)

Many participants reportedly relied on their children to interpret and manage appointment booking and attendance. Alternatively, they used "Google translate to translate something." (P15)

> Initially we were getting help with the appointments and everything, but now my daughter, she is in charge of making the appointments and taking us to the appointments. (P5)

Some participants were from large families and when each family member had health care needs, participants reported that it was often difficult to interpret and balance multiple appointments. While participants reports didn't label having carer burden, their expressions highlight the emotional and practical burden of caring for others and facilitating access to appointments. Many male participants adopted the role of carer and reported they frequently had to leave work or TAFE to assist their family. This was a source of stress and concern towards progressing learning English and earning a wage.

> My husband is a full-time worker, and he is the one who drives. So, whenever she [daughter] has an appointment, he has to leave his work and drive them to the appointment. (P9)

> Most of my time is spent for taking people to appointments… so I have to take time from my TAFE to take someone to the appointment, bring them back, take the other one. It's very difficult for me because when I am at TAFE instead of focusing on TAFE stuff I keep thinking about the kids, their pain and the family's problems. So, it's hard to remember things and memorise things. If I didn't have these issues, I would do much better at TAFE. (P1)

4. <u>Ongoing health and lifestyle concerns – influenced by understanding and education</u>

Participant reports suggested gaps in knowledge towards how to access complex health care issues and other support. For example, one participant reported her daughters had all experienced facial injuries from a car accident when fleeing the Islamic State in Iraq and Syria (ISIS). Her daughters very self-conscious about their scars and the mother wanted to know if the scars could be treated.

> I was hoping they do a kind of cosmetic surgery for my daughters because their scars are pretty obvious, but they said they can't do anything. (P5)

Other participants perceived that treatment had completed, such as speech therapy for one participant's son. In these scenarios some participants didn't understand why therapy had stopped and what their ongoing options were.

> [My daughter] was seeing [Speech Pathologist], but she didn't improve much. It's been a while and we haven't seen [Speech Pathologist]. We are not sure why; we don't know what happened. (P8)

Other participants didn't appear to understand the long-term effects of some condition, such as cerebral palsy and questioned the quality of therapy when progress was perceived to be lagging.

> Yes, we have worked with a caseworker from NDIS. The case worker said they told us someone who will see [daughter] for her speech. We told them we want to see someone [Speech Pathologist] who is really good that can help her. (P10)

Likewise, participants struggled with access to NDIS and how to advocate for services needed. Many participants expressed concern about the delays in getting approved for NDIS and the impact on their children, waiting treatment.

> Once there was a meeting, there was like so many people who were supporting her like the ____ people from Newcastle from NDIS. We told them that she needs more support, she also needs support like because she is hitting puberty, so her period has started and she needs a lot of support with that, so ____(P9)

Many participants were concerned about their future and how to secure more consistent or permanent housing.

> He is saying, his wife is the carer of his son, she doesn't work, she doesn't do anything much, she doesn't report for the Centrelink, she has pensions _____. He is saying if one day if we wanted to apply for ______ and get a new house would we be able to get more support for that? Or not. P8

4.3 *Focus Groups*

Two focus groups (n=5) were conducted over zoom, due to COVID restrictions. One focus group involved a single representative from the Armidale Sanctuary Humanitarian Settlement, Family Support Services, SSI, Northern Settlement Service and the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS). The second focus groups involved health professionals from a single GP practice (3 GPs, 1 nurse, 1 practice manager). A moderator and experienced qualitative researcher (JW) conducted the focus group. The moderator was not associated with the implementation of the Refugee Health Team; this assisted to reduce bias and facilitated open discussion that allowed participants to express their opinions.

Three key themes emerged:

1. Developing trust and community connects

2. Intensive and holistic support
3. Complex refugee needs

Developing trust and community connections

Stakeholders were overwhelming in their appreciation of the efforts made by the Refugee Health Team to meet with, educate and connect with GPs to promote acceptance of refugees as patients and considered it a “crucial piece of work.” (Focus group (FG) 1)

> Getting GPs to accept the referrals. There was a real backlog at one stage, and I think there was quite a lot of work for them to get that to where it is now. (FG1)
>
> For us I guess the standout assistance that they provide is that link to local GPs, which is something that is I guess quite different to most other locations. (FG1)

Stakeholders reflected that lack of access to GPs remained a significant issue in other refugee settlement locations as no-one had taken the time to meet with and engage with local GPs, thus impacting ongoing care.

> In Sydney for example, people go into I guess a health clinic based within the hospital and the downside of course is that individuals and families do not get their own local GP … it is a lot more difficult to have emerging needs addressed. (FG1)
>
> At Coffs Harbour they do not really have local GPs available to sort of refer into either. So, families sort of have that initial assessment and then they are just left to fend for themselves really. (FG1)

Stakeholders perceived the team to be responsive and flexible when addressing the diverse needs of the refugee community. For example, refugees were required to attend English at TAFE however continuity of attendance was often impacted by the presence of physical and psychological issues among refugees. Since teachers did not know students’ medical status, stakeholders reported barriers and difficulties in managing challenging scenarios, such as panic attacks. In response the Refugee Health Team nurses established regular health promotion talks which were perceived as being invaluable. Example of topics included kidney health, nutrition, mental health, vaccinations etc.

> Yeah so, we have a lot to do with [the nurses] in the beginning. We found that TAFE was actually a big gap between people just turning up for English lessons. Many had health issues and so on and that often resulted in ambulance was being called and you know people having seizures and all sorts of panic attacks and things. That was the gap that is still not well resolved because we could not access people’s health records and things, so you know. [The nurses] were invaluable because they actually came in during the day and made connections with the students and gave some great talks to the students on whatever they felt was the need in the community at that time. Sometimes it was about kidney health, nutrition, you know mental

> health you know things like that, you know introduction to those kinds of things and also, they were invaluable at times in the beginning of vaccination and COVID, so talking about you know just coming in and getting _____. (FG1)

Similarly, the team was praised for instigating education and health promotion towards emerging issues across a diverse array of age specific issues such as school transition and domestic violence.

> Also, with kids as well it was really valuable coming in and talking about kids' health and in transition to school. [The social worker and nurse] set up a healthy relationships training sort of thing you know at TAFE to address domestic violence. We did not have the expertise. (FG1)

The refugee health team's ability to provide home visits was perceived as essential to establish trust and rapport that underpinned future engagement by refugees with health care.

> I think a big part of developing that trust is that they completed home visits as opposed to families having to go to a clinic. I think that changed the relationship quite significantly. (FG1)

> The community nurses were absolutely essential for the refugees as a whole but they gained a lot of trust and I think they [refugees] still go to them for advice and assistance. (FG1)

However, the participating GP was not clear on the availability of access to allied health and how to make a referral or the team.

> I did not know that we have an OT especially for the refugees and a speech pathologist I didn't know that. (FG2)

<u>Intensive and holistic support</u>

Stakeholders were grateful for the links formed with the team. This was especially noted with regards to obtaining assessments for people with disabilities that were integral to NDIS applications.

> Particularly when working with people who were trying to access the NDIS. The refugee health team provided the interface with the University of New England, they actually paid for the interpreter service. We could not have afforded to do it unless refugee health had not provided … and most say it was a wonderful service. (FG1)

Stakeholders perceived the team to be responsive and efficient, despite the large caseload for small team which was perceived as being 'thinly stretched."

> They were very thinly stretched at one point and the caseloads that the two nurses was very large, but they were still very patient and responsive around it all. (FG1)

The Refugee Health Team model was perceived to be unique and effective in meeting the diverse needs of a refugee population including providing treatment or identifying who refugees needed to be referred to.

> So, in general I think as long as it is staffed adequately it seems to be a model that works and might be a bit unusual. I think it is the model suits this particular refugee demographic too where you have got people need that really intensive support with their health needs but also with referral to other agencies that can help them. (FG1)

Indeed, stakeholders reported that the availability of access to the refugee health team enabled them to clarify health and social aspects that assisted guide their care provision.

> We will ring up and we will ask them, you know do you know this family are there any other underlying issues that we are not aware of, what is your general perception around this because it just gives you a much more holistic picture of the family if you are aware of any underpinning health issues. (FG1)

Stakeholders perceived that the refugee health team promoted access to allied health, in contrast to going on a waitlist for community allied health. Stakeholders noted the lack of access to allied in regional towns and hence a reliance on private allied health. However, access to private allied health was not considered an option due to the cost of interpreters [Note: from 1 July 2022 privately employed allied health care providers will have access to the Australian Government's Free Interpreting Services (FIS).]

> I guess generally most small towns operate on private practices providing allied health roles, but you cannot get a free interpreter. If you were to, out of the goodness of your heart, decide to take on a non-English speaking patient you would probably end up paying twice as much in interpreting costs as you would make for the actual appointment, so it was just financially unviable. (FG1)

However, stakeholders perceived ongoing wait lists, particularly with regards to accessing specialty services such as the pain clinic and optometry, due to the large size of the settlement in Armidale. Indeed, access to pain support was considered a large and ongoing issue. While services for optometry had been sourced from Sydney this was perceived as a temporary "stop gap measure." (FG1)

> They have a pain clinic going – it is maybe half a day a week for a community of 600 people where the need is so significant. The backlog of work for that is quite significant. I guess the only other thing that isn't provided, and I guess there is a stop gap measure in place now is optometry. (FG1)

> We have an arrangement with Brian Holt foundation at that moment so they will come up and complete bulk billed assessments with an interpreter and provide glasses. But it took a lot of work to get that up and running and we are not quite sure when the funding for that would run out. (FG1)

Complex refugee needs

Stakeholders reported that the Armidale Refugee Team were a key source of their referrals that ensured that the complex needs of refugees were being addressed. Key areas included support for early childhood intervention, disability support and domestic violence.

> The referrals that we received were often around things like early childhood, things that do not traditionally sit with health, but were a great concerned to that team, getting little children into proper early learning and we received referrals about refugee families where there was a person with a disability or people with as I said experiencing domestic and family violence referrals. (FG1)

While stakeholders greatly appreciated access to the Refugee Health Team, they felt there had been a delay in establishing integral services, such as an allied health team.

> I think the important thing to look at here is the speed at which those allied health services became available here in Armidale was very, very slow. I know there was a lot of sort of toing and froing within health to sort of negotiate those services. (FG1)

Indeed, many stakeholders expressed concern that the refugee health service would be cut or “scaled down,” (FG1) over time.

> The other thing and it is slightly off topic I guess it is a kind of never present anxiety for our organisation would be if health decided to, you know, if the arrival of new immigrants was delayed in any way and the refugee health unit was scaled down because it is really hard to gear up again operationally once you scale down. (FG1)

Stakeholders reported that the learnings from Armidale as a settlement site should be made readily available to future settlements sites in order to avoid the delay in getting new settlement sites established and making the necessary connection with GPs etc. Indeed, stakeholders felt that Armidale could have been more prepared based on learning from previous settlement sites. Instead, they perceived that there was a delay in getting services established and they now feared losing services that had taken time to be implemented and integrated into routine care.

> I guess Armidale was identified as a test regional site for refugees to settle in regional areas. It has been fairly tragic to have to battle through some of these barriers, you know some of

> them were unknown and we didn't know they were going to exist, but it would be very painful for other services if it was to start up in another regional town … they would have to go through that same process, as spending years advocating services that were required sort of quite early on in the phase. (FG1)

> There were issues clearly presented in places like Toowoomba and other areas with settlement that we could have drawn. I guess more of a readiness here before we started up. So, it would be great shame to lose that level of readiness and have that scale down because that would be really unfortunate, I think. (FG1)

Stakeholders noted that despite the availability of designated refugee services, people still fell through the gaps. Access to assessment necessary for NDIS applications were perceived as a key barrier. Stakeholders expressed concern that services such as NDIS where not prepared or receptive to the challenges of dealing with refugees as clients. Common factors that they reportedly negated was the challenges related to the lack of identity and health documentation, due to clients coming from war torn countries with different health systems, as well as awareness of cultural issues.

> I think the big challenge with the NDIS staff. I perceive that space is going to become much difficult because everyone comes with no English just about and very little medical history. It is very difficult to differentiate what is a disability, what is a language barrier, what is trauma, you know. There are some families that have received NDIS quite quickly, but it is a very obvious assistance like deafness or a physical disability. The ongoing needs of some community members are probably going to be far greater than I guess than what the existing services have the capacity to do – especially in the realms of NDIS. NDIS is a space where providers struggle to provide support for as well, they do not actually know how to work with multicultural communities either. (FG1)

While stakeholders reported that much had been done by themselves and the Refugee Health Team to support refugees access and coordinate appointments, there was still a barrier to health care access and patients were "not follow-up" (FG1) if they missed an appointment.

The participating practice reported they accepted by far the majority of the refugees primarily since one of the GPs was fluent in Kurdish Kurmanji however they felt more could be done by other GPs. Furthermore, this practice continued to bulk bill all refugees and provided a weekly interpreter to arrange follow-up and confirm appointments etc. Ongoing challenges related to the involvement of an interpreter which often meant appointments went over time.

> If the patient books 15 minutes and I have to speak to the interpreter and the interpreter speaks to the patient and then back to the interpreter … it takes a while.' (FG2)

Lack of refugee understanding of the health system remained a barrier, especially when large families

attended the one appointment for an array of health conditions or when they turned up without an appointment. Participants noted refugees were more likely to heed instructions towards engaging with the health system from a white, male health practitioner.

> And that is one of the other problems, they do not have the idea of booking individuals. So, a family of 5 would only have 15 minutes, and I am stuck in the room with the family of five everyone has their own complaints, and we are jumping from the mum to dad to daughter. I am trying to organise them, so at least one at a time. And then next time we have to organise each one of them so definitely the idea of the health system and how it works in Australia is a very big challenge for them to understand … firstly who is the GP, what is the difference between GP and emergency, so at the beginning emergency was in chaos because everyone was shot to the ED. (FG2)

Many refuges still struggled with medication management and understanding the names and reasons for different medications. In many cases the participating GPs made a request to the Refugee Health nurses to do a home visit and follow-up understanding of medications.

> I will ask the refugee nurse to visit this family and check they can take the medication correctly. (FG2)

Likewise ongoing familiarity with where to access pathology services etc. was noted to be an ongoing problem.

> Like it has been 4 years and sometimes they still say, where do I take this again and I say it is the same lab that we talked about last year and the year before. (FG2)

Ongoing specialist access was also an issue of concern as many refused to accept refugees as clients due to their need for an interpreter and the complexity of their needs.

> They are straight forward in saying they are too complex, need an interpreter… I have a very small practice and I cannot deal with such. (FG2)

Ongoing access to counselling was a perceived gap in care and participants perceived there was a lack of access to specialist mental health services for people who had experienced trauma.

> But they are basically running out of counsellors…. I am back to waiting on the waiting list for STARTTS. They are a wonderful organisation don't get me wrong, but they do not have enough staff. (FG2)

The participating GPs worked closely with the 'Healthwise' care coordinator, who had been given desk space in the practice, as many refugees struggled to plan and coordinate what was needed for a consult they have been referred.

> Healthwise, [Healthwise care coordinator], she is called the care navigator and she is probably one of the best services that I had to help so far. So now at the end of the consult when they say, where is the doctor and how do I contact them? I will say, go to [Healthwise care coordinator] and book this appointment and I will email the forms to [Healthwise care coordinator]. She will do the phone call, help them with the paperwork and so on…. She helps follow-up their appointments and things." (FG2)

Discussion

Findings from this evaluation highlight the benefit of refugee models of care that include access to dedicated multi-disciplinary teams in managing healthcare. We identified that access to early allied health facilitated prompt assessment and treatment of identified health concerns, as well as facilitating access to ongoing support services through as GPs and the NDIS. Specifically, a key role of the multi-disciplinary team was the 'behind the scenes work[14]' necessary to collected demographic and health assessment data needed to complete the extensive paperwork needed to access GPs, NDIS support etc. Indeed, many Ezidi refuges were not sufficiently proficient in oral or written English, nor had they arrived with the supporting heath and identification documentation required to complete complex paperwork. Refugees continued to struggle with understanding health system process and often had unanswered questions about future needs. Husbands and children took on carer roles which were often burdensome.

Understanding what health services best help newly settled refugees is paramount for guiding the ongoing provision of refugee care especially since we are still learning how to best respond to and effectively manage the needs of refugees[15]. This is of further of importance since over half of refugees in Australia settle in rural areas despite the knowledge that rural areas may lack resources and services to adequately cater for their needs including health services, access to housing and employment[16-18]. Known barriers towards accessing and health services among refugees include: language and communication challenges, financial barriers, difficulties navigating unfamiliar health systems, poor access to transport and cultural challenges[19, 20]. Furthermore, the majority of Ezidi refugees have been exposed to traumas such as the capture and murder of relatives, imprisonment, torture and war and the manifestation of trauma may be exacerbated in unfamiliar settings[21]. Our findings echo with previous studies highlighting the altered physical and psychosocial health of refugees[22]. In this evaluation refugees experienced ongoing psychological conditions, including post-traumatic stress disorder (PTSD), and physical conditions such as developmental conditions, musculoskeletal and pain issues, injuries from trauma related events, scars and malnutrition[23] which benefited from access to allied health. Such needs were identified in females and males and ranged from childhood to adulthood and varied in the amount of time needed to treat, with many requiring ongoing care and support.

The significant health needs among people from refugee backgrounds have been previously documented including difficulties accessing primary and complex care[24]. Barriers to community based allied health care in this study included community health wait list and refugees being unable to afford private allied health or specialist care. Similarly private allied health or specialist care was sometimes not provided to refugees to due to interpreter costs and a lack of financial incentives or rewards for providing care for complex patients. Our study identified the availability of allied health alleviated having to wait for community-based services. Likewise, growing expertise in the Refugee Health Team, promoted greater cultural understand towards the unique needs of the Ezidi refugee community such as family centric care and access to interpreters, provided by the public system.

Consistent with emerging evidence, we demonstrated that refugees have difficulty accessing the NDIS as it was designed to be a consumer-led system where the best support outcomes require competency in English language skills, sophisticated advocacy skills and extensive knowledge of health systems in order to obtain the best outcomes, and yet these are the very competencies that most newly-arrived refugees do not possess[25, 26]. The Refugee Health Team played a critical role in arranging assessments and completing essential paperwork for the NDIS. Indeed, it has been identified that up to 50 hours of additional support is required for refugee families to meet the requirements to complete the online NDIS application process, which is often further compounded by an absence of the necessary supporting documentation towards medical histories of diagnosis and service use[25]. The importance of assistance to access mental health NDIS funding support cannot be understated.

Social isolation and disconnection have been shown to contribute poor health[27] and we were pleased to identify the benefit of support provided by the local Ezidi community specifically with regards to familiarisation with the local context and in providing transport . However, participants in this study appeared to take a passive role during their consult and appeared unaware of the appropriate use of hospital emergency departments. Such results highlight gaps towards how well integrated care is promoted and suggest a need to better support refugee participation in their health care [28]. Indeed, when patients are adequately prepared and educated towards self-management then there is scope to empower them in managing their health [29]. Overall ongoing investments in providing health promotion and adjustment support are warranted.

Stakeholders noted differences in services provided by the Armidale Refugee Health Program compared to anecdotal reports from other settlement sites. The capacity to conduct home visits was considered integral to establishing trust that promoted integrate care with refugees. Likewise dedicated time was observed to be given to establish networks with GPs and provide community-based health promotion education. However, stakeholders were concerned re the potential for scaling down of team in the future. Overall, this evaluation identified a high level of networking between staff, much of it being informal. This may be underpinned by staff commitment to a shared mission and an ethos of mutual respect.

High-quality care can be achieved through a range of service models, as evident in this evaluation. The elements identified in this evaluation provide a framework for future service development in order to reduce the gap between health needs and currently available services[30]. Specifically, there is a need for early assessment and treatment of complex physical and mental needs and access to

early rehabilitation. The provision of dedicated support also promotes seamless, integrated care that spans the continuum of care and has a patient focus. The benefit of access to dedicated refugee health clinics has been previously documented[31]. Results from a Canadian study showed that access to a dedicated health clinic for government assisted refugees reduced wait times to see a health care provider by 30 %[31]. In that study referrals to physician specialists decreased by 45 % however those referred were more likely to require multiple referrals due to increasingly complex medical needs. Referrals to non-physician specialist health care providers nearly doubled following the availability of the clinic. These results are supported by a scoping review by Batista *et al* [32] which identified that primary health care that is underpinned by teamwork and interdisciplinary collaboration helps address health needs that impacted by the social determinants of health thus, having the potential to reduce disparities in refugees[32].

This study generates important in-depth insight into refugee access to health care in an Australian context, especially the need for access to a multi-disciplinary team. Use of interpreters in this study enabled participants with limited or no English language ability to give their opinions and allow their experiences to be shared, therefore adding to the body of knowledge available. Participants were recruited by members of the Refugee Health Team and so it could be argued that only participants who would respond positively about the service were selected. Likewise, the specific nature of some health issues discussed might not be relevant in other refugees. However, there was no indication that participants felt obliged to participate and all participants appeared willing to share their story in the interview; demonstrated by smiling, no rush to finish the interview, and being forthcoming with sharing their experiences.

This study did not explore barriers to accessing health services related to health professionals' knowledge and skill, as well as the context of resettlement. Few facilitators to improving refugee access to health services have been identified.

Conclusions and Recommendations

Evaluation findings indicate the benefit of early access to allied health for prompt diagnosis and treatment of conditions. A key feature of the Armidale Refugee Health Program was their extensive work within the Armidale community to foster access to key services such as General Practitioners (GPs), medical specialists and the National Disability Insurance Scheme (NDIS). A key aspect was the time taken to coordinate assessments and completing necessary supporting paperwork and applications. Furthermore, the Armidale Refugee Health Program contributed to health promotion activities in the community. We recommend that other refugee settlement sites are provided access to dedicated refugee allied health services.

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