HUME WHITTLESEA PHARMACY WAIVER PROGRAM

Evaluation

Louisa Timbrell,
Cabrini Outreach
ltimbrell@cabrini.com.au

Contents Page

Abbreviations

AMES- Adult Multicultural Education Services

ASRC- Asylum Seeker Resource Centre

BVE- Bridging Visa E

CASRHH- Cabrini Asylum Seeker and Refugee Health Hub

DHHS- Department of Health and Human Services

GP- General Practitioner

HWPCP- Hume Whittlesea Primary Care Partnership

HWPWP- Hume Whittlesea Pharmacy Waiver Program (the Program)

LGA- Local Government Area

LWB- Life without Barriers

NDSS- National Diabetes Services Scheme

PSA- People Seeking Asylum

SRSS- Status Resolution Support Service

TIS- Translating and Interpreting Service

WCC- Whittlesea Community Connections

Executive Summary

The HWPWP seeks to provide access to essential medication for PSA with no income that is prescribed by GPs practising in Melbourne's northern suburbs. Initially, the Program sought to be an answer to changes being made, which saw PSA exited from SRSS payments. It was assumed that the first effect of this would be PSA forfeiting purchasing medication in favour of food and shelter. The HWPWP assesses clients for eligibility and then provides a waiver letter by the Cabrini Outreach Program Assistant at WCC to the client. This waiver allows for his/her medication to be provided by Chemist Depot, Epping Plaza who invoices Cabrini Outreach.

This evaluation aims to assess the overall success of the Program now that it has been operating for 6 months while determining areas for improvement and learning. Further, was a requirement of the partnership funding agreement between HWPCP and WCC. The key questions that will be answered are:

- How effective is the Program at meeting the needs of the PSA community?
- Who is using the Program and why?
- What are the barriers to accessing the Program?
- How successful has the Program been in ensuring patients stay with a culturally appropriate GP?
- What was the cost of the Program and the illness profile?

The methodology used to answer these key questions were interviews with key stakeholders, translated surveys with clients and analysis of key data from the HWPWP database compared against Victorian PSA statistics.

Since its beginning, the HWPWP has had sixty-six clients using the Program, thirty-nine of which have presented more than once and are considered "returning clients." Client numbers slowly increase as more PSA become aware of the Program either through word of mouth or by being referred by an agency. A total of $8,948.49 was spent on medications for the first six months of operation. The average cost of each waiver is $50.10 and therefore, due to the high number of returning clients, an average of $135 per client. Clients have come from fourteen suburbs across Hume and Whittlesea and span from eight months old to sixty-eight with the most occurring age group being above forty-six years old. This is thought to be due to the likelihood of chronic disease being experienced in an older population and therefore, represent a greater need for prescription medication.

Overall, the evaluation received positive feedback regarding the HWPWP provided by both clients and the stakeholders interviewed. The majority felt that the Program is meeting its original objective of providing access to medication for PSA. The stakeholder interviews also revealed areas for improvement which on the whole seemed to pertain to the referral process and clarification on this process. Further engagement in local GPs and Chemist Depot, Epping Plaza would be beneficial. Only eight agencies have

referred into the HWPWP. The low number of referrals from agencies outside of WCC and CASRHH in Brunswick was unpredicted and therefore awareness amongst agencies, most specifically those providing SRSS payments, should be re-intensified. Meaning that as someone is exited from receiving SRSS payments, they can be referred into programs that seek to alleviate the follow-on effects.

From the clients, although with only a 23% response rate of surveys returned, positive feedback was seen on all parts. The clients are very happy with the impact the HWPWP has had on their lives and further, the ease of which they find the Program operates. They have either maintained relationships with their GPs or have been able to form such relationships. There seemed to be a general consensus of little point visiting a GP through bulk-billing for Medicare eligible clients when there was then, no means to pay for resulting prescriptions from such visits. Of value to the evaluation, it was revealed that if it were not for the Program, 66% of clients would simply not purchase medication. This is of particular concern seeing that thirty-eight clients have ongoing medical conditions (for example, Cardiovascular) and require regular prescription filling.

The HWPWP has produced results that demonstrate success of a program. The number of clients and amount waived per client has been significant, alongside the impact it has had on the individuals and families that use the Program. The original objective is being achieved. The main areas to be improved on include GP and pharmacy engagement, knowledge and awareness of referring agencies and improving the process for referrals including reporting back to the agency when their referral has been accepted.

Overall Objective and Key Questions for Evaluation

The intended objectives, purposes and key questions for the evaluation that were assessed and evaluated, are outlined in the Terms of Reference (see Appendix 1). The evaluation seeks to assess the overall success of the Program and determine areas for improvement and learning. We acknowledge the HWPCP's funding of the evaluation as part of the partnership funding agreement between the HWPCP and WCC.

Evaluation Methodology

An evaluation, especially in its initial stages, can assess whether program activities are being implemented as intended through focusing on the program's operations, implementation and service delivery to determine that is effective. The methodology used for this evaluation reflected this by measuring how accurately the objective had been achieved and whether the purposes of the HWPWP have been implemented using client feedback, stakeholder feedback and analysis of key data.

The evaluation methodology outlined in the Terms of Reference (see Appendix 1) adheres to the original grant application provided to the HWPCP. That is, to measure the effectiveness of the service and partnership, conduct interviews with key stakeholders from within the partnership, and gain feedback from clients in a way that is culturally and linguistically appropriate and sensitive. The original application stated that this would be undertaken either through focus groups (in first language) or through a translated survey. The methodology chosen produced both qualitative and quantitative data to be analysed and evaluated.

Stakeholder semi-structured interviews used a standard format (see Appendix 2). Stakeholders were identified by the Program Assistant and the General Manager of Cabrini Outreach as having some level of relevance to the Program and included staff from Cabrini Outreach, WCC, HWPCP, Chemist Depot Epping Plaza (formerly, Terry White Chemmart), referrers from DPV Health, CASRHH, ASRC and AMES and prescribing GPs from Epping Plaza Medical & Dental Centre. The interviews were semi-structured to give the evaluator flexibility in adjusting questions as necessary depending on the stakeholder being interviewed and their engagement in the program as well as the group they represent. Selected stakeholders who had less association with the program were not interviewed but rather, asked to provide answers to questions via email to maximise participation. Twenty-four Stakeholders in total were invited to participate. Eleven by interview and a further thirteen by email. Nine responses were received. Response rate overall was 37.5%, with an interview response rate of 45.8% and an email response rate of 18.1%.

To extend on the Terms of Reference (see Appendix 1), originally, a random sample of clients would be chosen over 3-4 days of the evaluator's presence at WCC with an interpreter present. However, logistically, this was difficult to perform most specifically following the exiting of the job by the Program Assistant not long after the 100-day cut off. Further, due to fewer clients presenting to the Program than originally thought by the evaluator. Therefore, surveys (see Appendix 3) were written and then translated into two of the top languages (Persian and Arabic) as indicated by the Program Assistant. It can be seen that these surveys are explicit in explaining their voluntary nature and a consent form (see Appendix 4) was signed prior to the survey being completed. Further, the evaluator ensured the client understood that it was not compulsory, aiming to relieve any "homework" stress for fear that the client would stop presenting to the HWPWP due to stress of not having completed the survey. Therefore, if a client returned without a completed survey, it was not spoken of further. A total of 9 clients were given these surveys 7 of whom covered families using the Program meaning that 34 clients were covered in the surveys. The remaining clients that did not receive a survey, did not present to the Program in the evaluation period or were new to the Program during this same period. A total of 3 surveys were returned to the evaluator covering 8 clients.

As the first 100 days drew to a close, the evaluator began collating a literature review (see Appendix 5) that explored the baseline need for the Program as well as best practice models. At its conclusion, it was evident that the HWPWP itself is a helpful service that bridges a gap. Ways in which to best perform such programs were highlighted and will be compared against the HWPWP in the discussion section of this report.

Finally, analysis of key utilisation data occurred using the Program Assistant's database of clients in Microsoft Excel. Results from which (along with all other data) will be further discussed.

Program Description and Background

The documented objective for the HWPWP as per Memorandum of Understanding (MOU) signed by both WCC and Cabrini Outreach, is that the HWPWP seeks to provide access to essential medication that is prescribed by GPs practising in Melbourne's northern suburbs for asylum seekers who have no income.

The HWPWP works by providing eligible clients with authorisation (that is, a waiver) to have the costs associated with filling their prescription billed to Cabrini Outreach by the nominated pharmacy (Chemist Depot, Epping). The service operates at WCC on Monday and Friday between 1000 and 1400 in which time, clients can present to the Program to have their prescription medications waived by the Program Assistant. This program was formed as a response to changes made to the SRSS program resulting in PSA gaining work rights but losing income support while awaiting the outcome of their claim for protection. They maintained access to Medicare and therefore a goal in this program was to maintain their primary

care relationship with their GP. This collaboration is a targeted integration of health assistance and place-based services to address a key gap in the health system for a particularly vulnerable group of people. That is, once exited from the SRSS, although maintaining access to Medicare, clients will have no way in which to fill prescriptions and what money they do have will see food and shelter prioritised.

As of March, 2019 there were 1,093 PSA (BE) in Whittlesea and a further 544 in Hume giving a total of 1,637 PSA on BE in the LGAs of Hume and Whittlesea originating mainly from Iran, Sri Lanka, Pakistan and Afghanistan[1].

Prior to stages of the HWPWP establishment, Cabrini Outreach was a part of the Sector discussions with the DHHS where funding was provided for pharmacy support to PSA with no income. Conclusively, ASRC held some limited funding on behalf of Cabrini Outreach. In the initial stages,

> *"…we were thinking about how to respond to the changing policies with people being exited from the SRSS program and which gaps resulting could we meet?"*- Stakeholder 6.

Two of the stakeholders interviewed had an assumption that CASRHH (in Brunswick) services[i] would be overwhelmed by patients who sought access to pharmacy waivers but could more effectively be served by a local, culturally appropriate GP. This would ensure that clients with Medicare and a relationship with a GP but with no income are able to purchase medications that are required.

Cabrini Outreach approached WCC for partnership due to their location near many PSA communities alongside already having a well-established connection with the PSA community in Epping and its surrounding areas. It was also beneficial for clients as they could be referred into the Program by WCC and equally, referred back to WCC for casework support, emergency relief, material aid or legal advice.

> *"*[At WCC] *I go to language classes also."*- Surveyed Client 3

During the interviews, which will be further elaborated on, all interviewed had a broad but relatively similar understanding of the purpose of the HWPWP which is reflected below:

- "[The purpose of the Program is to] *provide help* [through providing] *medication to people with no income source* [that] *are having trouble with money."*- Stakeholder 1.
- *"To provide pharmacy waivers for people seeking asylum who are financially vulnerable."*- Stakeholder 8.

[1] Illegal maritime arrivals on Bridging E visa. (2019). [PDF] Australian Government Department of Home Affairs, pp.15-16. Available at: http://Illegal maritime arrivals on Bridging E visa.

However, there were other purposes noted like the aforementioned improving of client accessibility stress on the CASRHH,

> *"A program that already exists* [CASRHH] *and then there was* [a further need in] *the north because Brunswick is hard for them so to…create better access."*- Stakeholder 4.

And also to,

> *"…keep developing* [Cabrini Outreach's] *profile in the northern suburbs."*- Stakeholder 6. It is assumed that this relates to future potential to provide secondary consults and handing patient over to a more accessible GP from CASRHH.

Others believed that the purpose has changed over time. On their initial perception,

> *"…it was more of an emergency essential medicine gap and* [this] *has changed to more ongoing."*- Stakeholder 7.

The key word there being 'emergency.' While still providing essential medication, it is not short-term in nature. This leads into the objective of the HWPWP. While similar answers were provided regarding the purpose, answers varied to the original documented objective when stakeholders were asked on what they believed the objective of the HWPWP was. As it stands, it seems that the original objective and intended purposes are being fulfilled even if different to what some stakeholders foresaw for the HWPWP.

The difference in answers may be due to stakeholders being involved at varying times in the creation of the HWPWP or after its conception. Some focused on partnerships and a partnership being the initial objective, while others stated that there would be differing objectives between Cabrini Outreach and WCC,

> *"…for Cabrini* [Outreach] *it is to provide medication and for WCC the objective is to provide… a bit of a wider response to asylum seekers.* [The Program] *is supporting* [WCC] *to assist people to navigate a service system to get their needs met… and also a pathway to casework support."*- Stakeholder 2.

As previously mentioned, although different answers were provided, the HWPWP still seems to be fulfilling the documented objective of providing access to essential medication that is prescribed by GPs practising in Melbourne's northern suburbs for asylum seekers who have no income. This evaluation will see to which extent this is being fulfilled.

On the 15th February, 2019, the HWPWP was launched. The launch was a success and within its first weeks of operation, over ten clients had had their medications waived by the Program.

Results and Analysis

How effective is the program in meeting the needs of the PSA community in LGAs of Hume and Whittlesea?

When interviewed on whether the HWPWP is meeting the needs of the community, many stakeholders agreed that it met a very specific need of the community rather than needs in general. That is, the Program meets the need for medication, and therefore healthcare (due to their ability to maintain a relationship with their GP as resulting prescriptions can be filled), to the PSA community within Hume and Whittlesea that have no income. Although, as a service collocated at WCC, the HWPWP works alongside WCC to meet greater needs of the PSA community.

- *"…I think* [the HWPWP has] *met the need by simply making medication available."*- Stakeholder 3.
- *"…by being accessible twice a week, and from my view has been able to assist all my clients that have been referred to it."*- Stakeholder 5.
- "[The Program] *meets needs very well for desperate people who are sick, not assisted by government"*- Stakeholder 8.

Conversely, there were comments that it was not meeting the needs as much as originally intended,

> *"I think it's meeting the needs of the community but it's been slow growth… originally we were thinking that the needs would be enormous and we would need to fundraise… we haven't got the penetration that we had initially thought that we would get"*- Stakeholder 6.

Or that there were further needs to meet,

> *"… I think the asylum seeker community has much broader needs than just medication… and that is what* [WCC] *sees. So yes, the objectives* [of the HWPWP] *have been met but not the needs of the population group."*- Stakeholder 2.

With that being said, it should be reiterated that the HWPWP did not seek to fulfil all needs of this population group but rather bridge a gap in providing medication to work alongside other available services and those at WCC. This question could have been too broad for the evaluation and should be noted that the HWPWP had sought meeting a very specific need and this has been done.

All stakeholders interviewed and surveyed agreed that the HWPWP was positive in reducing financial stress to clients, however, differing levels to which it relieves financial stress arose. That is, of those interviewed, some answered a definite yes to the question: "Do you think that the Program is effective in reducing financial stress to the clients?"

"Yes. That is the main purpose of the Program, which we have done."- Stakeholder 1.

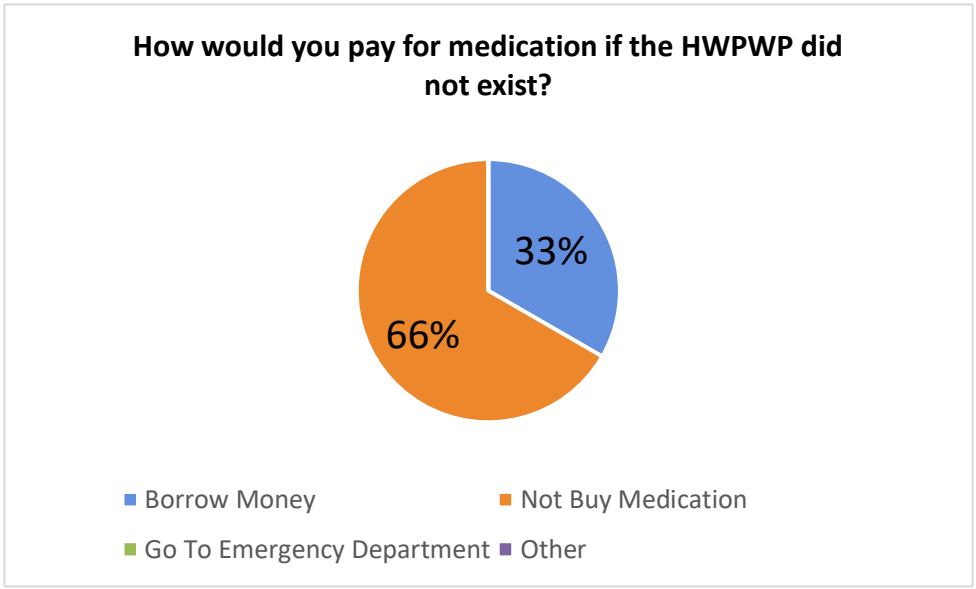
However, others pondered whether medication costs are a source of financial stress initially. It may compound stress and this may alleviate a level of stress but usually food and shelter would be considered more financially burdening.

- *"I can't comment on that. But I would anticipate, not really… We are talking about people that have no income at all. So yes, it's great to get a $6 script filled but they have rent of $300… no food, no means to pay their utilities.* [So, this program is] *just a tiny part*- Stakeholder 2.
- *"…maybe it's not really reducing financial stress because I think our assumption was that people would choose food over medication so it's given them access to medication where they wouldn't have access, but I don't know if it's reducing financial stress per se, because it's not something they would have been able to do with no money."*- Stakeholder 6.

Nonetheless, client surveys revealed 100% of clients responding that the HWPWP has reduced their financial stress. It can be deduced that while yes, food and shelter could be considered more of a financial burden, any form of help, especially one that is filling a gap that may have otherwise been discarded or overlooked can alleviate a level of financial stress and therefore meet a need within the community.

Further, when given options on how they would purchase medications if it weren't for the HWPWP (see Figure 1), "not buy medication" was the most popular response which means that even if not alleviating financial burden or stress, is definitely providing something that would otherwise not be considered which one may assume, has to alleviate some level of stress.

Figure 1- Options for filling prescriptions



Who is using the program and why?

At the time this report is being written, there are sixty-six clients registered in the HWPWP. Thirty-nine of these clients have presented to the HWPWP more than once and are considered "returning clients" meaning that more than half (59%) are returning, indicating some level of satisfaction.

Following the Interim Report (see Appendix 6) at the first 100 days of operation, it was concluded that the Program was not as far reaching as could be. Moreover, suburbs within closer proximity of WCC (located in Epping) represented a greater number of clients. For example, 35% of clients lived in Epping, alone. Clients at this time only lived across seven suburbs.

Table 1- Suburbs of Clients

Suburbs of Clients	% of Clients from suburb[2]	No. of Clients from suburb[3]	No. PSA (BVE) in suburb[4]
Lalor	24	16	212
Epping	23	15	206
Thomastown	14	9	191
Mill Park	12	8	134
Doreen	5	3	36*
South Morang	5	3	-
Broadmeadows	5	3	256**
St Albans	3	2	387***
Fawkner	1.5	1	37
Roxburgh Park	1.5	1	134****
Dallas	1.5	1	256**
Reservoir	1.5	1	120
Jacana	1.5	1	256**
Craigieburn	1.5	1	134****
Total =	**100**	**65**	**1,713**

** Includes Doreen, Mernda and Yan Yean, ** Includes Broadmeadows, Dallas and Jacana, *** Includes Albanvale, Kealba, Kings Park and St Albans, **** Includes Craigieburn, Mickleham, Roxburgh Park and Donnybrook*

Please note:

- *Where a suburb is outside of the LGAs of Hume or Whittlesea, the client's referring GP was within this area. These have been highlighted green in Table 1.*

[2] Data from HWPWP database
[3] Ibid.
[4] Data from Asylum Seekers Victoria- June 2019

Table 1 demonstrates the current range of suburbs (n=14) of clients (n=65). The number of suburbs had more than doubled with twenty-five new clients presenting since the Interim Report in July. This means that initial thoughts following the Interim Report regarding expanding the Program has either inspired action in those interviewed in spreading awareness of the Program, or that the Program itself is still developing and growing with time. To be eligible for the HWPWP, a client must live in the LGAs of Hume and Whittlesea or have a prescribing GP within these areas. This gives a possible forty-two suburbs that one can reside in meaning that the HWPWP is only reaching 28.5% of possible suburbs, if PSA live in all suburbs in the LGAs of Hume and Whittlesea. However, when comparing to the number of PSA living within these areas, Lalor and Epping are two of the suburbs with the highest number of PSA. Therefore, the HWPWP is reaching the largest population but should be noted that the suburbs with the highest number of clients are those located closest to Epping making transportation easy and therefore, could be attributed to this. Nevertheless, the HWPWP is increasing in number of suburbs as the number of clients increases and is in line with bringing in the most clients from suburbs where the greatest number of PSA live.

Table 2.1- Age of Clients

Age	No. of Clients[6]	% of Clients[7]	% PSA (BVE) in Victoria[8]
0 to 4	8	12	5.8
5 to 11	4	6	8.5
12 to 15	4	6	4.0
16 to 17	1	2	1.3
18 to 25	6	9	12.0
26 to 35	8	12	37.6
36 to 45	13	20	21.8
46+	22	33	9.0
Total =	**66**	**100**	**100**

Table 2.2- Breakdown of Age of Clients (46+)

Age	No. of Clients[5]
46 to 55	13
56 to 65	8
66 to 75	1
Total =	**22**

Another notable demographic feature includes age which shows an average of thirty-four years old however more relevantly, a range of eight months old to sixty-eight years old. This range is indicative of the flexibility of the Program and that the Program itself and the pharmacy supplying medications has the ability to cover the differing health needs that span generations.

[5] Data from HWPWP database
[6] Ibid.
[7] Ibid.
[8] Data from Asylum Seekers Victoria- June 2019

When comparing to the whole of Victoria it can be seen in Table 2.1 that the greatest number of PSA are between the ages of 26 to 35 (37.6%) but the HWPWP has the highest number falling in the 46+ category (33%) followed by 36 to 45 (20%). As previously discussed, the HWPWP has moved to more of an ongoing model whereby many clients with chronic conditions are returning each month to waive their prescriptions rather than emergent medications. Thereby, one could deduce that a greater number of these returning clients could therefore fit in an older age category. This program could be more attractive people of an older age (shown in the disparity in Table 2.1) between the client percentages compared to the Victorian. It is known by the Program Assistant that many of the older clients that present have children living as asylum seekers within Victoria but do not have medication needs and so have never been "clients" of the HWPWP. Again, why there is a clear difference between ages of the clients compared with Victoria.

When looking at gender, in Victoria, 76% of PSA on BVE are males with only 24% being female. When comparing to the HWPWP, the difference between males and females is much closer and more females use the HWPWP. This is shown in Table 3.

Table 3- Gender of Clients

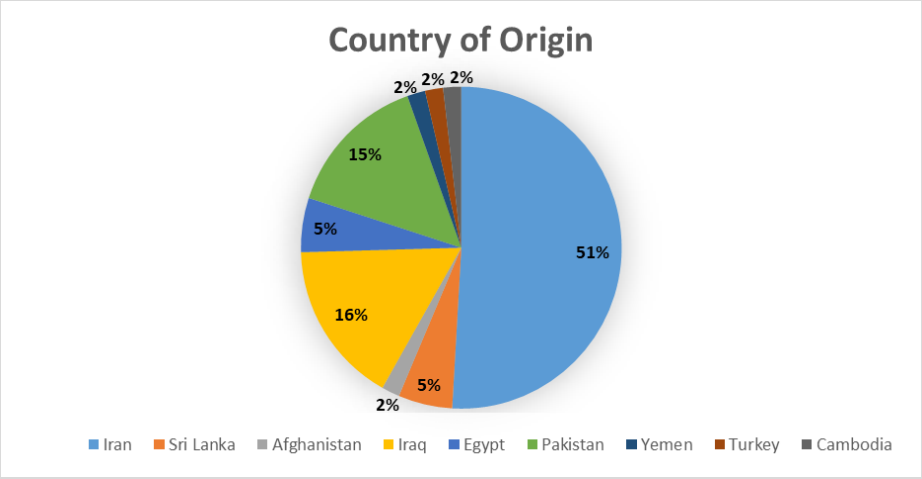
Gender	% of Clients[9]	% PSA (BVE) in Victoria[10]
Female	53	24
Male	45	76
Non-Binary	2	-
Total =	**100**	**100**

This follows national and Victorian averages where men are less likely to seek healthcare than women. That is, men are twice as likely to not see a GP. 20% of women will see a GP compared to only 9% of men. Moreover, are less likely to have a regular GP or clinic they attend.[11] Further, refugee and asylum seeker men are more likely to enter the workforce in Australia making them ineligible for this program as they would therefore receive an income. In 2016, 36% of asylum seeker or refugee men had found work compared to only 8% of women.[12]

[9] Data from HWPWP database
[10] Data from Asylum Seekers Victoria- June 2019
[11] Engaging Men In Healthcare- Information Resource Paper. 2015. Ebook. Melbourne: Department of Health & Human Services. http://file:///C:/LocalData/Engaging%20men%20in%20healthcare%20-%20information%20resource%20paper%20JUNE%202015.pdf.
[12] Daraganova, Galina, Pilar Rioseco, Michelle Silbert, and Jatender Mohal. 2019. "Building A New Life In Australia: The Longitudinal Study Of Humanitarian Migrants". Australian Institute Of Family Studies. https://aifs.gov.au/projects/building-new-life-australia.

Another feature to observe when determining who uses the HWPWP include clients' arrival method which shows 66% arriving by boat, 18% by plane and a further 15% where the data is not known or they were born in Australia. The average length of time in Australia for the clients of the HWPWP is currently at 5.2 years where a client was born overseas. Given the current political climate in Australia, there is a vast number of clients in the HWPWP that could face years of significant disadvantage given their arrival method.

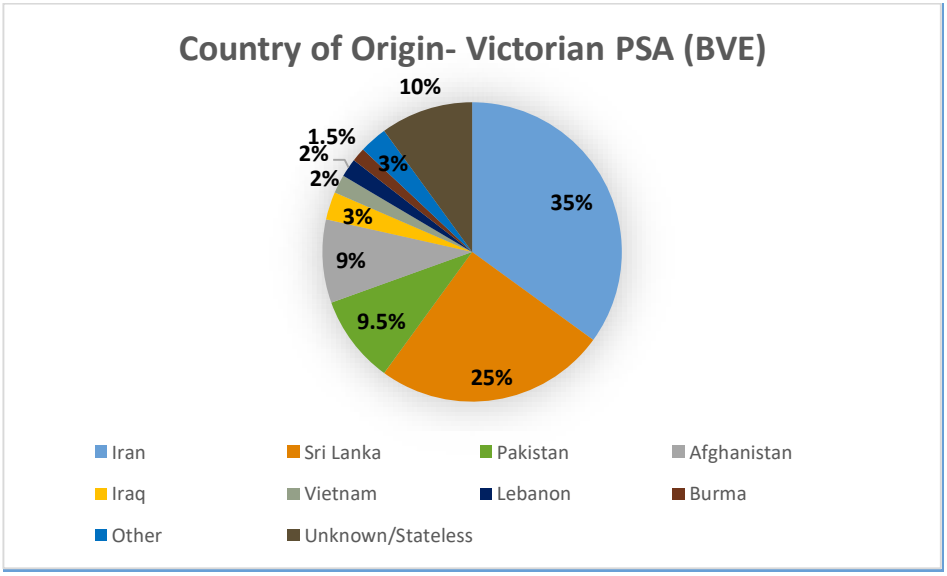
Figure 2- Country of Origin of Clients[13]



Please note:

- *Clients that are children born in Australia to Asylum Seeker parents have not been included in Figure 2.*

Figure 3- Country of Origin of all Victorian PSA (BVE)[14]



[13] Data from HWPWP database
[14] Data from Asylum Seekers Victoria- June 2019

Initially, when viewing Figure 2, it was interesting to see that such a significant number of clients originated from Iran, more than half. When comparing to Figure 3, it seems that Iranian represent the highest percentage of the PSA population in Victoria. However, the difference between 35% and 51% is significant. Without knowing the PSA demographic of Hume and Whittlesea (that is, certain nationalities can tend to settle together and form community clusters) in specific which in itself could have an even higher number of PSA from Iran compared to Victoria as a whole, it also could indicate that the Iranian community itself is tightly knit and has a good word of mouth capability. Further, that their English or ability to navigate the Australian health system is greater. This is the only country of origin however that aligns itself with the Victorian percentages. The second most occurring country of origin in the entire of Victoria is Sri Lanka, representing 25% of PSA but the HWPWP only sees 5% of clients from Sri Lanka. Further, the HWPWP sees its second most popular country of origin as Iraq representing 16% of clients where Iraq represents only 3% of PSA within the entire of Victoria. Further engagement could be needed to reach certain populations within Hume and Whittlesea.

What are the barriers to accessing the program?

Barriers noted during interview, mainly pertained to the eligibility limitations for example, location and income total, and knowledge of the Program, raising the question of how to better the knowledge of the community that such a program exists.

When considering knowledge, it can be reasoned that this is seen as a barrier due to the high level of referrals from WCC itself (see Table 4) and so knowledge is subjective to those PSA already accessing services at WCC or those receiving support from other referring agencies (see Table 4). Thereby, knowledge is frequent amongst services for PSA but whether it is present among the PSA communities themselves is unknown. On knowledge stakeholders commented that,

- *"Not knowing* [is a barrier]*."*- Stakeholder 3.
- *"I think it's just knowledge, really. Knowing that it exists and* [that] *they can access it."*- Stakeholder 6.

Two key questions asked of the stakeholders were how effective is the Program was advertised and secondly, how effectively the community were engaged. In summary, there is room for improvement in each of these areas. The HWPWP has been successfully advertised within WCC itself and to the CASRHH where referrals are frequent from both (see Table 4). Other referring agencies have been contacted and their referrals are slowly growing. Further penetration is needed into local GPs, although Epping Plaza Medical and Dental seems to be working well in this Epping hub and into the PSA community itself.

Table 4- Referrals to the HWPWP

Referring Agency	No. of Clients[15]
WCC	29
CASRHH	16
ASRC	8
AMES	3
DPV Health	3
Family already clients	3
Self	2
Salvation Army	1
LWB	0
Total =	**65**

Please note:

- *Two clients are represented twice in Table 4 as they were referred by ASRC and again by DPV Health.*
- *Where a referral has come from WCC, it could have come originally from a different agency.*

It can be seen in Table 4 that majority of referrals have come from WCC or CASRHH suggesting that awareness beyond these places has been limited and/or should be intensified should the Program continue. If not engaged in any of the above agencies, a person's ability to be informed and gain knowledge of the HWPWP is limited. It was noted that no referrals were received from LWB (see Table 4) who is a main provider of SRSS payments in the area (alongside AMES). It was assumed that as people were exited from SRSS support, they would be referred into other programs like the HWPWP.

This raises the questions as to whether the HWPWP has fully engaged the community. WCC itself is very engaged with the community and so placing the Program there has meant that clients have been referred into the Program faster than it would have grown on its own. It was also noted that through Cabrini's connections with CASRHH has meant that they also have a standing in the PSA community although engagement for this specific Program has been limited and so greater engagement with PSA GPs should be prioritised.

Other barriers noted during interviews were language and accessibility. Language in itself can be a barrier to knowledge however, it may also disable people from having the confidence to access services for fear that they will not be understood. The HWPWP uses TIS to alleviate this stress for presenting clients but language anxiety especially at first presentation is hard. This can also lead to mistrust of health services in general. On these barriers,

[15] Data from HWPWP database

- *"…not trust*[ing] *services, mightn't speak English, isolation… they could be living in Mernda and can't access transport.*"- Stakeholder 4.

Transport is another barrier that was raised by the stakeholders. Some clients rely on public transport which makes Epping a great location but others require being driven by family, friends or volunteers. One client in particular is over 65 and is blind due to Diabetes Type 2. Public transport is difficult because of these circumstances and so they wait to have their prescription filled by their family friend.

Finally, there was discussion around the eligibility criteria being a barrier in itself.

- *"Some asylum seekers have an income but it is limited and they still need help."* – Stakeholder 4.
- *"The biggest barrier is post code limitation. I think there's some limitation around… compliance requirements around showing no income and being an asylum seeker."*- Stakeholder 7.
- *"Only Hume/Whittlesea geographical boundaries."*- Stakeholder 8.

The criteria as a barrier is significant and was mentioned multiple time in interview but should be noted that the criteria is an intentional barrier. "Low or no income" is hard to define and income and perceived need for more financial assistance can be relative to a person's situation. Loosely, the criteria allows for clients earning less than the SRSS or Centrelink payments to be accepted and have their medications waived as the Program Assistant has stated that, "if we turn away clients gaining money through Centrelink or the SRSS payments, we should not then waive for medication for people that have a higher income than this." However, allows for self-reporting of low or no income and no proof is required.

Post code limitation is another barrier from the eligibility criteria however, due to the ability to use the HWPWP if a client's referring GP is within the area, this can lead to unintentional consequences of clients from an appropriate GP to an eligible GP. This will be further discussed but a more concrete and substantial criteria should be used for the HWPWP and further, the criteria should be made clear to the referring agencies so that ineligible clients are not referred into the Program causing excessive stress when they present to find they do not qualify.

The client surveys did not note any barriers in access however, those surveyed had been accepted into the HWPWP and were returning clients so may not have enough insight into this question.

How successful has the program been in ensuring patients stay with a culturally appropriate GP?

The initial conception of the program was that people being removed from SRSS would have built up relationships with their preferred GP usually based on easy access, bulkbilling or cultural appropriateness. The aim of the waiver program was to enable clients to continue with their preferred GP whilst still being able to access a pharmacy waiver program (not being enticed to change to CASRHH GP's for free medications). This question is difficult to evaluate given the small number of client surveys returned and as the question did not specify reasons for GP choice. All bar one (Surveyed Client 1) stated that they regularly saw a GP prior to using the HWPWP. Surveyed Client 1's answer will be further discussed and how the Program has conversely assisted him in gaining a relationship with a GP, rather than maintaining. The other clients did not make mention of why they regularly saw their GP. That is, whether it was because they felt they were culturally appropriate or due to other considerations such as bulkbilling or ease of access.

When looking at the database, where it has been noted which GP a client has seen for a prescription, sixteen clients have received prescriptions from the regularly referring Epping Plaza Medical and Dental Centre and see GPs speaking a range of languages including: English, Arabic, Bengali, Pashto, Urdu, Persian and Kurdish.[16] This can be seen as an indicator of the clients seeing a culturally appropriate GP however cannot be determined whether this has been maintenance of a relationship or similarly to Surveyed Client 1, gaining a relationship. The latter could be because of the convenient location being also at Epping Plaza making the prescription, waiver and medication receiving process easy rather than culturally appropriate in specific. Further, Epping Plaza GPs are bulk billing, have a range of GPs working at any one time, providing choice and have other services within their clinic.[17]

[16] "General Practitioners | Epping Plaza Medical & Dental Centre". 2019. Epping Plaza Medical Centre. https://www.eppingplazamedicalcentre.com.au/general-practitioners/.
[17] Ibid.

What was the cost of the Program and the illness profile?

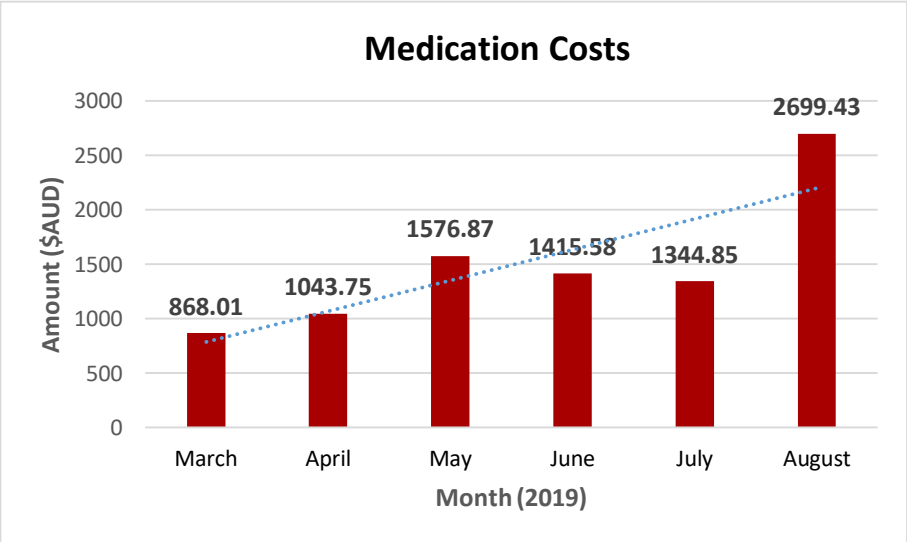
What was the cost of medications covered by HWPWP waivers?

Since the launch of the HWPWP there has been a steady increase in the amount of medications waived per month. This totals $8,948.49 for the first six months of operation (see Figure 4). This is because of an increase in clients accessing the Program as more agencies refer into the service alongside word of mouth among the PSA community. This increase is also likely to coincide with PSA being exited from SRSS although we have limited data recorded on this. Where SRSS status is known, twenty-nine clients are using the HWPWP following being exited from SRSS and is expected that more have been.

Clients have gained a relationship with the Program Assistant and WCC itself and understand the service and the ease of use allowing clients to return each month as the need arises or as their ongoing condition prescription medication repeats are due to be repurchased. A key tenet of the program was to ensure patients with chronic illness were able to fill their prescriptions.

> "[The process of receiving the waiver and then medication is] *easy*."- Surveyed Client 3.

Figure 4- Cost of waived medication for first six months of operation[18]



Twenty-three clients make up six families using the HWPWP, where it is known that they are a defined family unit. The average cost waived per family for medication has been $856.71 (Range: $232.82 - $1,675.35) which, when considering the stakeholder's differing opinions on financial stress, is significant. In comparison with other emergency assistance this is likely more than the utilities bills for a family. The

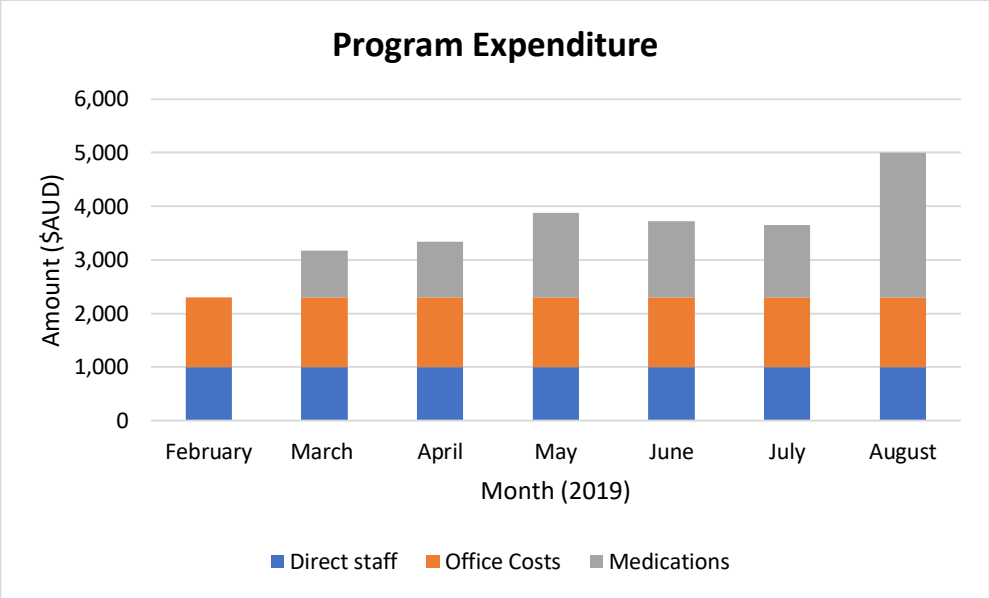
[18] Data from HWPWP database

average per waiver letter written is $50.10 and $135 total per client which is a substantial amount of money, especially for returning clients.

What was the cost of the program?

The ongoing program expenditure (evaluation and set up cost excluded) is reflected in Figure 5 which shows that with a greater utilisation by clients of the program i.e. medications waived, the program has become more efficient i.e. the overheads as a percentage of program expenditure is reduced.

Figure 5 – HWPWP expenditure



What was the illness profile of the program?

It is important to note that many clients using the HWPWP have ongoing, chronic conditions that require frequent prescription filling and are not just presenting as a one-off in a more emergent situation (see Table 5). Further, these conditions if untreated can lead to significantly worsened health outcomes and associated health costs. Similarly, untreated chronic conditions would limit the ability to work thereby furthering their disadvantages in society, and dependency. The HWPWP provides a significant impact especially when considering that majority of clients surveyed had stated that they would not buy medication if the Program did not run.

Table 5- Illness Profile of HWPWP clients [19]

Ongoing Medical Condition	Number of Clients
Cardiovascular	11
Diabetes	10
Vitamin Deficiencies	7
Depression	7
Long-term Pain	6
Anxiety	6
Skin condition	4
Asthma	4
Urinary	1
Total (ongoing medical conditions) =	**55**
Total (clients with ongoing medical conditions) =	**38**

Please note:

- *Conditions have only been listed if client has stated that they suffer from a condition, not if they have been prescribed a medication one could assume is for a condition*
- *Some conditions have been grouped under one subheading (for example, cardiovascular disease or diabetes)*

Case studies

Concerns and Incident Register

On the 8th August, 2019 a concern was raised by the Dispensary Assistant at Chemist Depot, Epping Plaza (then, Terry White Chemmart) regarding two clients, who frequently attend the Program and previously flagged by the Program Assistant in the database due to the frequency of these clients' visits for varying medications.

On this day, the Program Assistant waived, as usual, what was written on the prescriptions by the client's GP. The Dispensary Assistant later called explaining that two of the items were the same. Both were a glucometer for patients with Diabetes and that there should be no reason for one client to have two. The Program Assistant noted that on occasion, GPs will write for multiple brands to save back and forth behaviour if one brand was not available or in stock as there is only one pharmacy that participates in this Program.

[19] Data from HWPWP database

The Dispensary Assistant sought permission to order only one of these devices which was approved but did relay her concern that the devices may not have been intended for just this client's use. Further, that they have had some issues in the past in the pharmacy with both of these clients. It has later been deduced that this could be due to the lack of using available translation services.

Due to this concern along with the already noted pattern of frequent visits, an incident report was written by the Program Assistant noted this concern raised by the Dispensary Assistant but also the amount of times they had presented to the Program and the medications that had been waived at each visit. The Medical Director at CASRHH was engaged in a conversation with these clients' GP to see that there were not any longer term medication options for both of these clients due to their frequent visits. Further, although the Program Assistant stated that they had often used a phone translator, the GP at CASRHH reinforced that phone translators should be used with clients at pharmacies as well as Pharmacist's following usual protocol whereby they contact the prescribing GP if they feel there is an issue.

This incident was the first recorded concern/complaint regarding the HWPWP. It reinforced the need for a structure for governance and complaints management and procedures to engage GPs and the pharmacy.

Client Story

[Surveyed Client 1] arrived by plane in 2017 with his family of 5 from Pakistan. Since arriving, he did not regularly see a GP although having Medicare as he felt treating his Diabetes Type 2 was too expensive and so would only go to a GP in more emergent cases, rather than ongoing support for his Diabetes. The ASRC referred him into the HWPWP in April as he was not receiving any support through income, healthcare or medication. When he found out about the Program, he saw a GP who he explained the Program to. He now sees this GP monthly for ongoing Diabetes support and frequent check-ups. Further, his 3 children and wife now receive regular check-ups. His GP has helped him to understand his condition more and has prescribed additional medications that are not necessarily Diabetes specific for a more holistic approach to his health and wellbeing for example, through prescribing vitamins. In his survey, he states that he would not buy medication if it were not for this Program. Cabrini Outreach also assisted him in becoming a member of the NDSS which provides not only Cabrini Outreach with subsidised medication but increases the client's Diabetes education and awareness for now and the future.

> *"The Program has been beneficial because my medication is not ordinary. Without this Program, I could not receive medical assistance and healthcare at all as my medication is too expensive."*- Surveyed Client 1.

This man's experience is reflective and indicative of a client's perspective of the Program. While some stakeholders felt that there were bigger issues regarding the PSA community, he relays his gratefulness of the Program as it has allowed him to regain control over his health and has meant that the health of himself and his family is financially taken care of allowing time to focus on other areas of their lives. Further, means that someone with a chronic condition is getting the help and education they deserve. Although [Surveyed Client 1] began seeing a new GP when he was accepted into the HWPWP, it should be noted that most other clients reported maintaining a relationship with their GP they saw prior to the Program.

Other Key Findings

It seems that the HWPWP is meeting the overall objective of seeking to provide access to essential medication that is prescribed by GPs practising in Melbourne's northern suburbs for asylum seekers who have no income. Whether there is enough knowledge of this service within their communities, differed in opinion by the stakeholders and further, whether the service is reaching all that it can be. Additionally, if the Program is too limiting in its criteria.

Improvement suggestions were noted during interviews. Some significant improvements included:

- *"...with the compounding medication, we are still not able to supply those medicines for clients because our pharmacy cannot do compounding medication."*- Stakeholder 1. This causes the client to either pay for the medication themselves, or to return to their GP to receive a prescription for a different medication that will hopefully have the same function, promoting stress.
- *"…there's also a gap on Methadone...it wouldn't surprise me if there's more gaps."*- Stakeholder 7.
- *"No access to methadone/suboxone dispensing with this Program.*"- Stakeholder 9.

The capacity of Chemist Depot, Epping Plaza appears limited when considering these above improvement suggestions. Working alongside Epping Plaza Chemmart while few problems have arisen with them as a partner, the limitations of them as a pharmacy in general has caused some stress for clients. That is, initially not being NDSS certified and now still, unable to fill prescriptions for compounding medications and Methadone. On the pharmacy partnership,

> *"In retrospect I think that we* [reached out to a pharmacy] *poorly… considerations at the time were ease of client access…as close as possible to where they had to come to* [get] *their paperwork…some check of pricing* [was done] *but in retrospect…we didn't really sound out their capacity as a pharmacy."*- Stakeholder 7.

However, 100% of clients surveyed commented that they have found their interactions with staff at Terry White (now Chemist Depot) very good. One client even went on to say that,

> "*They understand the problems* [I have*] and help me with understanding my medication."*- Surveyed Client 1.

Therefore, a new pharmacy to accept waiver letters, with greater capabilities could be sought in order to alleviate some of the above mentioned complications.

Other areas for improvement included the ability to be more clinically-based,

- *"Capacity to provide more health services* [with] *more of a focus on health than just the pharmacy waiver."*- Stakeholder 2.
- "*Linking* [in] *with the refugee nurse network… I think there's some integration there with the specific services so while we're integrated well with WCC, I'm not sure we're integrated elsewhere."*- Stakeholder 7.

As the HWPWP grows, this should be considered. That there is capacity to have a more clinically-based program at the Epping base.

Some improvements pertained to WCC itself and how processes could be more effective,

- *"Having someone at WCC trained in the assessment processing guidelines that is able to respond to a walk in* [on days where the Program Assistant is not there]- Stakeholder 2.
- *"Having* [the Program Assistant] *three days a week and one of those days out posted in* [WCC's] *neighbourhood house… and better advertised or marketed somehow… so that asylum seekers could access* [the Program]*."* – Stakeholder 4.

Each of these suggestions would mean that the HWPWP could be accessed more frequently by clients. The suggestion regarding the Program Assistant attending the WCC neighbourhood house or their other events, for example their asylum seeker dinners, could prove effective in gaining more clients or at the least, increasing people's autonomy and awareness that such a program exists to enable those eligible, the ability to attend and better their health. Or alternatively, if they are someone that does not regularly take medication, or with absence of a chronic condition, to know that the Program exists means that if prescribed one-off medication in the future, know where to go in order to get it waived.

Another area noted for improvement by the Program Assistant with regards to the above improvements, is that some clients have expressed (vocally, not through survey) that Friday is a hard day to come as a lot of clients are practicing Muslims (as it is Prayer day). With that being said, the Program Assistant has advised them to come on Monday instead but Friday still seems to prove most popular. The Program Assistant has experienced whole Mondays with no clients presenting, even when with appointment and then Fridays having multiple clients presenting at any one time. Although effectively spread out across the week to ensure clients do not wait long, it was considered by the Program Assistant that having the

full eight hours on a Friday could prove more effective. This would also mean there was less rush to get there and disrupt Prayer.

However, when observing the dates of when waivers were written, 44% were written on Mondays with 55% written on Fridays (1% on days other than Monday or Friday, where Monday or Friday could not be attended). Meaning that although clients present slightly more on Fridays, the difference is not great enough to change to one day per week. It is important that the clients do not have a week's wait between times where they can receive their waiver letter. Unless of course the improvement suggestions are filled whereby staff at WCC are able to write waiver letters. However, clients can access Emergency Relief at WCC.

When previously discussing barriers to the HWPWP, it was noted that the criteria in itself can be a barrier and that referring agencies should be made aware of this criteria. It seems that when interviewing on improvements, processes used by the referring agencies were also noted for improvement,

- *"I would prefer a simple referral form so that* [the Program Assistant] *does not have to ask the same questions. For someone who is vulnerable it could be painful or embarrassing to have to repeat their situation to strangers."*- Stakeholder 8. While the agencies do have a referral form, so long as they send through documentation (eg. Confirmation that person is seeking asylum through their visa or immigration card) it seems that this needs to be reiterated to some referrers as some have just by word of mouth been sending people and therefore this is why their situations have been repeated to the Program Assistant.
- *"The process is straightforward but* [the referrers] *don't seem to get confirmation that a client has been accepted into the Program."*- Stakeholder 9.

It is clear that there are guidelines in place for the assessment process. Although some education and clarification would be useful. A confirmation of acceptance process is to be created for the referring agencies.

Taking these improvements into account, it still seems that the HWPWP is successful with the client feedback received, costs of medications waived and number of clients including number of returning clients but the above improvements should be noted by the relevant people at Cabrini Outreach and WCC in order for the HWPWP to grow and perform at its best capability.

Discussion

At the conclusion of the literature review conducted (see Appendix 5), a number of factors were concluded to being imperative to success of material aid style programs. This discussion will compare the HWPWP to the findings of the literature review.

The literature concluded,

- *Success being seen when components [of a program] include flexibility in the system structures and processes, and ease and frequency of access by and to clients*.[20]

  The HWPWP criteria is already fairly flexible due to the "self-reported" nature of low or no income. It could better the systems between the referrers and the Program Assistant in the assessment process to eliminate repetition of sensitive information by the clients as suggested by Stakeholder 8. Ease of access has rated well. Clients stated that they found the process of receiving their waiver and then moving onto the pharmacy as uncomplicated and as easy as possible. Frequency of access has been hard to evaluate. It was suggested by some stakeholders to have the Program Assistant's presence more frequently or to train others at WCC in the assessment process as discussed previously.

- *Considering chronic medical conditions as just as relevant as communicable disease when looking towards long-term medical-based programs.*[21]

  The HWPWP rates highly on this factor as it allows for returning clients rather than one-off waives and majority of clients have noted suffering from at least one chronic condition (see Table 6).

- *Inconsistent use of interpreters in a pharmacy setting, poor navigation of the Western healthcare system, especially with regard to accessing medication, cultural barriers and discordant illness beliefs, medication non-adherence*[22] *and limited health literacy*[23] *is common amongst PSA populations and so programs should not only note these things but base their practices of combatting them.*

  Inconsistent use of interpreters in a pharmacy setting has been experienced in the HWPWP. The pharmacy should use their TIS in order for the client to understand the medication they are receiving

[20] Hohm, Charles F., Paul Sargent, and Robert Moser. 1999. "A Quantitative Comparison Of The Effectiveness Of Public And Private Refugee Resettlement Programs: An Evaluation Of The San Diego Wilson Fish Demonstration Project". Sociological Perspectives 42 (4): 755-763. doi:10.2307/1389583.
[21] Smith, Mitchell, Winston Lo, and Jessica Bindra. 2013. "Prescribing For Refugees". Australian Prescriber 36 (5): 146-147. doi:10.18773/austprescr.2013.060.
[22] Bellamy, Kim, Remo Ostini, Nataly Martini, and Therese Kairuz. 2015. "Access To Medication And Pharmacy Services For Resettled Refugees: A Systematic Review". Australian Journal Of Primary Health 21 (3): 273. doi:10.1071/py14121.
[23] Smith, Mitchell, Lo & Bindra. 2013. "Prescribing For Refugees"

and any additional instructions. Further, to prevent and alleviate stress when there is limited understanding regarding a certain medication not being available and an alternate (for example, generic brand) will be given or that it will be ordered for later collection. The Program Assistant has noted times where a client has returned to WCC, stressed that they were receiving Panamax instead of the waived and prescribed Panadol. This would not have been an issue had the pharmacy used the translation services that are available.

Other areas noted in this factor are poor navigation of the Western healthcare system and medication non-adherence. Due to the ease of the Program being conveniently located for many clients and the time the Program Assistant takes in explaining the Program, it seems that these factors have been noted and considered. Especially when considering Surveyed Client 1's story whereby, he would not have been accessing medication had it not been for the HWPWP so the Program not only understands limited health literacy is common but acts as a resolution for such a situation.

Finally, the HWPWP has aimed to alleviate this further by ensuring clients maintain relationships or gain relationships with culturally appropriate GPs as discussed.

- *An appropriate assessment system being in place regarding reasons for accepting clients in the form of a criteria or survey.*[24]

  There is a criteria in place but it is loose in its gaining of material evidence to so prove a client matches the criteria. As discussed, there are discrepancies in the criteria like what constitutes "low income." Low income is relative to a person's situation so the criteria is clear on not accepting anyone receiving SRSS or Centrelink payments. The criteria used should be concrete for referrers and referrers should use the agency referral form to avoid situations where a client is referred into the service that is then found ineligible generating unnecessary stress on a vulnerable population group.

- *Assessment being conducted by the referring volunteer/worker to determine eligibility for the program.*[25]

  To extend on the previous point, a stronger, more concrete assessment and eligibility criteria should not reiterated on to the referring agencies so that eligibility can be concluded prior to referral. Moreover, the referrers should make use of the referring agency form.

[24] "Doorways Handbook- Emergency Relief Delivery". 2019. The Salvation Army. https://www.sarmy.org.au/en/Social/Doorways-Handbook/TSA-Emergency-Relief-Delivery/.
[25] "Family Assistance Hotline- Good Works". 2019. St Vincent De Paul Society. https://www.vinnies.org.au/page/Find_Help/NSW/Food/Family_Assistance_Hotline/.

Further, a process the Program Assistant follows whereby the referring agencies are informed of the outcome of those they have referred into the Program.

- *Cash and money donations at times have no guarantee of the ways in which is spent after but material aid in itself can be successful.*[26]

  The HWPWP noticeably rates highly on this factor. The Program involves no cash to clients and only the waiver letter itself. This is to ensure prioritisation of health needs as food and shelter remain significant needs but are not addressed through the HWPWP.

- *A consistent preference for cash being experienced (rather than other forms of material aid) as it allows for greater flexibility, autonomy, opportunity to invest the aid and often greater dignity (no long distribution lines) while also being easier and cheaper to transport. However, health care professionals being sought out directly for medications and when it comes to health and medical care, cash would be insufficient.*[27]

  As per previous point, the HWPWP involves no direct cash or money to clients. As this is involving healthcare and pharmaceuticals, the Program upholds this factor and advice from the literature given that cash or money donations may not be either spent altogether on healthcare, or spent on the wrong type of medication. This program allows people to maintain relationships with health professionals.

- *Interpreters where health professionals cannot speak the client's language are essential and if not used can contribute to treatment non-adherence, adverse events or failure to follow instructions, with potential medicolegal implications.*[28]

  Although already discussed, use of TIS is essential in the HWPWP. It should be encouraged more to the pharmacy given that situations have arisen before whereby confusion has resulted following pharmacy visits. The fact that two pieces of literature have noted this as significant when performing such a program further sheds light on its importance.

[26] "Soup Vans- Good Works". 2019. St Vincent De Paul Society. https://www.vinnies.org.au/findhelp/view/90.
[27] Versluis, Anna. 2014. "Formal And Informal Material Aid Following The 2010 Haiti Earthquake As Reported By Camp Dwellers". Disasters 38 (s1): S94-S109. doi:10.1111/disa.12050.
[28] Smith, Mitchell, Lo & Bindra. 2013. "Prescribing For Refugees"

The aforementioned noting that the HWPWP has allowed clients to maintain a relationship with a culturally appropriate GP or at the least, gain a relationship also allows for this factor to be maintained.

- *Duplication of therapy can occur and so requesting a medicines list will reduce this complication[29] on first time visits.*

  This factor is vert GP-based for the HWPWP as GPs are responsible for medications. The HWPWP sub consistency of GP and the pharmacy, Chemist Depot, Epping Plaza are required as part of MOU:

  "3.2 Terry White Chemmart Epping Plaza will:

  ii) Make use of Safe Script when processing scripts and also review scripts and consult with the prescribing practitioner to ensure appropriate use and avoidance of harmful effects. "

Conclusion

To summarise, the HWPWP has produced results that would prove success of the program as it was envisaged. The number of clients and amount waived per client has been increasing and significant, alongside the impact it has had on families that use the Program. Positive feedback has been provided by the clients, stating their gratefulness and positive outlook on the HWPWP. Further positive feedback has been received from the stakeholders interviewed. Although varying understandings of the objective of the HWPWP by the stakeholders was seen, the original objective of providing access to essential medication prescribed by GPs practising in Melbourne's northern suburbs for asylum seekers who have no income, has been achieved. The main areas to be improved on include GP and pharmacy engagement, knowledge and awareness of agencies and bettering the process for referrals including reporting back when a referral has been accepted. These should be further observed by the relevant people at Cabrini Outreach and WCC.

[29] Ibid.

Bibliography

Bellamy, Kim, Remo Ostini, Nataly Martini, and Therese Kairuz. 2015. "Access To Medication And Pharmacy Services For Resettled Refugees: A Systematic Review". Australian Journal Of Primary Health 21 (3): 273. doi:10.1071/py14121.

Daraganova, Galina, Pilar Rioseco, Michelle Silbert, and Jatender Mohal. 2019. "Building A New Life In Australia: The Longitudinal Study Of Humanitarian Migrants". *Australian Institute Of Family Studies*. https://aifs.gov.au/projects/building-new-life-australia.

"Doorways Handbook- Emergency Relief Delivery". 2019. The Salvation Army. https://www.sarmy.org.au/en/Social/Doorways-Handbook/TSA-Emergency-Relief-Delivery/.

Engaging Men In Healthcare- Information Resource Paper. 2015. Ebook. Melbourne: Department of Health & Human Services. http://file:///C:/LocalData/Engaging%20men%20in%20healthcare%20-%20information%20resource%20paper%20JUNE%202015.pdf.

"Family Assistance Hotline- Good Works". 2019. St Vincent De Paul Society. https://www.vinnies.org.au/page/Find_Help/NSW/Food/Family_Assistance_Hotline/.

"General Practitioners | Epping Plaza Medical & Dental Centre". 2019. *Epping Plaza Medical Centre*. https://www.eppingplazamedicalcentre.com.au/general-practitioners/.

Hohm, Charles F., Paul Sargent, and Robert Moser. 1999. "A Quantitative Comparison Of The Effectiveness Of Public And Private Refugee Resettlement Programs: An Evaluation Of The San Diego Wilson Fish Demonstration Project". Sociological Perspectives 42 (4): 755-763. doi:10.2307/1389583.

Illegal maritime arrivals on Bridging E visa. (2019). [PDF] Australian Government Department of Home Affairs, pp.15-16. Available at: http://Illegal maritime arrivals on Bridging E visa.

Smith, Mitchell, Winston Lo, and Jessica Bindra. 2013. "Prescribing For Refugees". Australian Prescriber 36 (5): 146-147. doi:10.18773/austprescr.2013.060.

"Soup Vans- Good Works". 2019. St Vincent De Paul Society. https://www.vinnies.org.au/findhelp/view/90.

Versluis, Anna. 2014. "Formal And Informal Material Aid Following The 2010 Haiti Earthquake As Reported By Camp Dwellers". Disasters 38 (s1): S94-S109. doi:10.1111/disa.12050.

Resources used:

HWPWP Database (excel)

Asylum Seekers Victoria- June 2019 (excel) provided by Tom Roth, General Manager Cabrini Outreach

Appendices

Appendix 1- Terms of Reference

EVALUATION SCHEDULE AND TERMS OF REFERENCE

Project: HWPWP Evaluation

Evaluator: Louisa Timbrell

Commissioner of the evaluation
Cabrini Outreach/WCC as per the Hume Whittlesea Primary Care Partnership (HWPCP) Grant

Duration of the evaluation
20 days (due 22 September)

Period of the evaluation
15/02/2019 – 27/05/2019 (first 100 days)

Overall objective and purpose
To evaluate whether the activities of the program are being implemented as intended.
To evaluate the partnership between Cabrini Outreach, WCC and Terry White Chemmart.
To evaluate the role of health practitioners, referral service and input of service.
To evaluate ongoing needs, barriers and opportunities for expanding the program.

Key evaluation questions
How effective is the program in meeting the needs of the people seeking asylum community in LGAs of Hume and Whittlesea?
Who is using the program and why?
What are the barriers to accessing the program?
How successful has the program been in ensuring patients stay with a culturally appropriate GP?
What was the cost of the program and the illness profile?

Methodology
Stakeholder* semi-structured interview using a standard format by the evaluator to address above key evaluation questions. Semi-structured to give evaluator flexibility in adjusting questions as necessary depending on the stakeholder being interviewed and the group they represent.

Anonymous client survey with an interpreter present at distribution. Random sample to be taken based on presenting clients over 3 – 4 days of evaluator's presence at WCC. Survey will include opinion-based questions to gauge how they are finding the program.

Literature review for best practice using the Boolean search terms:

- ti(refugee* OR asylum seek* OR immigra*) AND ti(medicat* OR drug* OR pharm* OR treat*) AND ti(health* OR ill* OR disease* OR sick* OR infect* OR mental* OR disease*)
- ti(refugee* OR asylum seek* OR immigra*) AND ti(financ* OR money* OR income* OR econom* OR fund*)

With adjustments to be made as necessary (for example, extending search to include terms in abstract rather than just the title). Searches will take place in databases: CINAHL Complete, Medline Complete, ProQuest Australia and New Zealand Database, ProQuest Political Science Database, ProQuest Public Health Database and PubMed.

Data analysis and a review of key utilisation data will be conducted. Data will include client records and pharmacy invoices to be collected by the evaluator from the program assistant.

Expected results and deliverables

Understanding the effectiveness of the program.
Recommendations for improvement and continuation of the program.
Effectiveness of policies, procedures and practices.
Case studies of lived experience.

Intended use and dissemination

For both Cabrini Outreach and WCC to understand how effective the program has been to date and any improvements that can be made

Production of internal and external document

- Internal: Cabrini Outreach, WCC and HWPCP
- External: Potential funders, policy makers and for service providers and users

Criteria for evaluators

Internal Evaluation

Appendix 2- Stakeholder Interview Questions

HWPWP Evaluation
Key Stakeholders- Semi-Structured Interview Questions

1. From your perspective, what is the main purpose of the program?

2. Could you please explain your engagement or involvement with the program?

3. From your perspective, what were the baseline needs for the program?

4. From your perspective, what were the objectives set out for the program?

5. How did the program begin and why? Was it Cabrini Outreach or WCC that initiated partnership?

6. Could you please explain the process of getting the program to where it is today, from your perspective?

7. In your opinion, in what way/s do you think the program is meeting the needs of the community?

8. In your opinion, in what way/s do you think the program is not meeting the needs of the community?

9. In your opinion, from the best of your knowledge being that you aren't physically at WCC, how effective is the program at:
   a. Advertising the service?
   b. Engaging the community?
   c. Reducing financial stress to the clients?
   d. Allowing clients to maintain visiting their regular GP?

10. What improvements do you think could be made to the program from your end?

11. Are you aware of anything negative happening with the clients and if so, how was this dealt with?

12. What, if any, challenges have been experienced in the running of the program? How were these overcome?

13. What barriers exist that are preventing people from using the program?

14. Have you received any feedback (either positive and/or negative) in the past regarding the program? If yes, please explain this feedback.

15. With regards to partnerships, do you feel the systems between organisations are efficient and effective from both an organisational and client perspective and why?

16. In your opinion, is the program is meeting the original objectives that were set out and how? Or, if no, how do you think this could be improved upon?

17. Is there anything else you wish to comment on about the program for the evaluation? You can email me later if you think of anything.

Appendix 3- Client Surveys (all languages)

Project: Hume and Whittlesea Pharmacy Waiver Program Evaluation

Evaluator: Louisa Timbrell
Cabrini Outreach Intern
154 Wattletree Rd
Malvern VIC 3144
9508 3531
ltimbrell@cabrini.com.au

Thank you for participating in this evaluation. Your participation is voluntary and you can choose to withdraw or not participate at any time. It is completely confidential.

Please answer all questions as truthfully and honestly as you can.

1. **How did you learn about/discover the Pharmacy Waiver Program?**

_____
_____
_____

2. **Do you believe the Program has been of benefit to you?**
   - ☐ Yes
   - ☐ No

Please explain why/why not:

_____
_____
_____

3. **How would you pay for medications if this program did not exist?**
   - ☐ Not buy medication
   - ☐ Go to emergency department
   - ☐ Borrow money
   - ☐ Other: _____

4. **How have your interactions with the staff at Whittlesea Community Connections/Cabrini Outreach been?**
   - ☐ Very good
   - ☐ Good
   - ☐ Not good
   - ☐ Bad

Please explain your answer:

_____
_____
_____

5. How have your interactions with the staff at Terry White Chemmart been?

- ☐ Very good
- ☐ Good
- ☐ Not good
- ☐ Bad

Please explain your answer:

_____
_____
_____

6. Do you find the process of receiving your waiver and getting your medication easy?

- ☐ Yes
- ☐ No

Please explain why/why not:

_____
_____
_____

7. Before participating in the program, did you have a regular GP that you saw?

- ☐ Yes
- ☐ No

Please explain why **OR** why not:

_____
_____
_____

8. If the program were not operating, how would you access healthcare?

_____
_____
_____

Thank you for participating in this evaluation. If you have any questions, please contact the evaluator, Louisa Timbrell.

-End of survey-

المشروع : تقييم برنامج Hume and Whittlesea Pharmacy Waiver

المقيم " مسؤل عن التقييم" : Louisa Timbrell

Cabrini Outreach Intern
154 Wattletree Rd
Malvern VIC 3144
9508 3531
ltimbrell@cabrini.com.au

شكرا لك على المشاركة في هذا التقييم. مشاركتك طوعية ويمكنك اختيار الانسحاب أو عدم المشاركة في أي وقت. انها سرية تماما.

يرجى الإجابة على جميع الأسئلة بصدق وأمانة بقدر ما تستطيع.

1. كيف عرفت / اكتشفت برنامج الإعفاء من الصيدلة؟
_____
_____
_____

2. هل تعتقد أن البرنامج كان ذا فائدة لك؟

- ☐ نعم
- ☐ لا

يرجى توضيح السبب / لماذا لا:
_____
_____
_____

3. كيف تدفع ثمن الأدوية إذا لم يكن هذا البرنامج موجودًا؟

- ☐ لا تشتري الدواء
- ☐ الذهاب إلى قسم الطوارئ
- ☐ اقتراض المال
- ☐ آخر:_____

_____
_____
_____

4. كيف كان تفاعلك مع الموظفين في Whittlesea Community Connections / Cabrini Outreach ؟

- ☐ جيد جدا
- ☐ جيد
- ☐ ليس جيد
- ☐ سيئ

يرجى توضيح إجابتك:
_____
_____
_____

5. كيف كان تفاعلاتك مع موظفي Terry White Chemmart؟

- ☐ جيد جدا
- ☐ جيد
- ☐ ليس جيد
- ☐ سيئ

يرجى توضيح إجابتك:

_____
_____
_____

6. هل تجد عملية تلقي والحصول على الدواء سهلة؟

- ☐ نعم
- ☐ لا

يرجى توضيح السبب / لماذا لا:

_____
_____
_____

7. قبل المشاركة في البرنامج ، هل كان لديك طبيب عام أعتدت رؤيته؟

- ☐ نعم
- ☐ لا

يرجى توضيح السبب أو لماذا لا:

_____
_____
_____

8. إذا لم يكن البرنامج موجودا ، كيف يمكنك الوصول إلى الرعاية الصحية؟

_____
_____
_____

شكرا لك على المشاركة في هذا التقييم. إذا كان لديك أي أسئلة، يرجى الاتصال بالمقيمة ، لويزا تيمبريل.

- نهاية المسح -

پروژه: ارزیابی برنامه بهداشتی هوم و ویتلیزی

مسوؤل ارزیابی : لویسا تمبرل

کارمند کبرینی آوت ریچ

154 Wattletree Rd
Malvern VIC 3144
9508 3531
ltimbrell@cabrini.com.au

از اشتراک شما درین ارزیابی سپاس. اشتراک شما داوطلبانه بوده و هر زمانی که خواسته باشید می توانید از اشتراک خودداری نماید. این ارزیابی محرم و محفوظ است.

لطفا به همه پرسش ها صادقانه پاسخ دهید.

9. چگونه در مورد این برنامه بهداشتی اطلاع حاصل نمودید؟

_____
_____
_____

10. آیا این برنامه برای شما مفید بوده است؟

- ☐ بلی
- ☐ نخیر

لطفا شرح دهید:

_____
_____
_____

11. اگر این برنامه وجود نمی داشت، چگونه برای دارو و درمان پول می پرداختید؟

- ☐ هیچ دارو نمی خریدم
- ☐ به بخش عاجل شفاخانه می رفتم
- ☐ پول قرض می گرفتم
- ☐ دلیل دیگر _____

12. ارتباط و تجربه شما با کارمندان ویتلیزی کامیونیتی کنکشن و کبرینی آوت ریچ چگونه بود؟

- ☐ بسیار خوب
- ☐ خوب
- ☐ بد نبود
- ☐ بد بود

لطفا شرح دهید:

_____
_____
_____

13. ارتباط و تجربه شما با کارمندان تیری وایت چیمارت چگونه بود؟

- □ بسیار خوب
- □ خوب
- □ بد نبود
- □ بد بود

لطفا شرح دهید:

_____
_____
_____

14. آیا روند دریافت دارو و خدمات بهداشتی از طریق این برنامه ساده و آسان است؟

- □ بلی
- □ نخیر

لطفا شرح دهید:

_____
_____
_____

15. قبل از اشتراک درین برنامه، آیا پزشک معالج داشتید؟

- □ بلی
- □ نخیر

لطفا شرح دهید:

_____
_____
_____

16. اگر این برنامه وجود نمی داشت، چگونه به خدمات بهداشتی و طبی دسترسی پیدا می کردید؟

_____
_____
_____

از اشتراک شما درین ارزیابی سپاس. برای معلومات بیشتر، لطفا با مسوول ارزیابی، لویسا تمبرل، به تماس شوید.

پایان ارزیابی

Appendix 4- Client Consent Forms (all languages)

CONSENT FORM

Project: Hume and Whittlesea Pharmacy Waiver Program Evaluation

Evaluator: Louisa Timbrell
Cabrini Outreach Intern
154 Wattletree Rd
Malvern VIC 3144
9508 3531
ltimbrell@cabrini.com.au

Name of participant: _____

1. I consent to participate in this evaluation.
2. I understand that the purpose of this evaluation is to assess the progress of the pharmacy waiver program.
3. I understand that my participation is for evaluation and service improvement purposes only.
4. In this evaluation I will be required to answer the questions in the survey.
5. I understand that my participation is voluntary and that I am free to withdraw from this evaluation at any time without explanation or prejudice and to withdraw any unprocessed data that I have provided.
6. I understand that the data from this evaluation will be stored at Cabrini Outreach and on request, can be made available.
7. I understand that the confidentiality of the information I provide will be safeguarded subject to any legal requirements; my data will be password protected.
8. I understand that given the small number of participants involved in the study, it may not be possible to guarantee my anonymity.
9. My identity will be kept confidential and I will only be named as a client of the program.
10. I understand that after I sign and return this consent form, it will be retained by the evaluator.

Participant signature: _____ Date: ____/____/_____

ARABIC

نموذج الموافقة

المشروع : تقييم برنامج Hume and Whittlesea Pharmacy Waiver

المقيم " مسؤل عن التقييم" : Louisa Timbrell

Cabrini Outreach Intern
154 Wattletree Rd
Malvern VIC 3144
9508 3531
ltimbrell@cabrini.com.au

اسم المشترك: .....

1. أوافق على المشاركة في هذا التقييم.
2. أنا أفهم أن الغرض من هذا التقييم هو تقييم التقدم المحرز في برنامج الإعفاء من الصيدلية.
3. أدرك أن مشاركتي هي لأغراض التقييم وتحسين الخدمة فقط.
4. في هذا التقييم ، سأكون مطالبًا بالإجابة على الأسئلة في الاستبيان.
5. أتفهم أن مشاركتي طوعية وأنني حر في الانسحاب من هذا التقييم في أي وقت دون أي تفسير أو تحيز وسحب أي بيانات غير موفرة قدمتها.
6. أدرك أنه سيتم تخزين البيانات من هذا التقييم في Cabrini Outreach ويمكن توفيرها عند الطلب.
7. أتفهم أن سرية المعلومات التي أقدمها ستكون محمية وفقًا لأي متطلبات قانونية ؛ ستكون بياناتي محمية بكلمة مرور.
8. أفهم أنه نظرًا لقلة عدد المشاركين في الدراسة ، فقد لا يكون من الممكن ضمان عدم الكشف عن هويتي.
9. ستظل هويتي سرية ولن يتم تسميتي إلا كزبون للبرنامج.
10. أفهم أنه بعد التوقيع وإرجاع نموذج الموافقة هذا ، سيتم الاحتفاظ به من قبل المُقيّم.

توقيع المشترك: .....التاريخ / /

PERSIAN

ورقه رضایت

پروژه: ارزیابی برنامه بهداشتی هوم و ویتلیزی

مسوول ارزیابی : لویسا تمبرل

کارمند کبرینی آوت ریچ

154 Wattletree Rd
Malvern VIC 3144
9508 3531
ltimbrell@cabrini.com.au

نام اشتراک کننده:_____

1. من راضی ام که در این ارزیابی اشتراک کنم.
2. من آگاهم که مرام این ارزیابی بررسی دستاورد های برنامه بهداشتی هوم و ویتلیزی می باشد.
3. من آگاهم که اشتراک من در این ارزیابی فقط به منظور بهبود بخشی و خدمات بهداشتی و طبی میباشد.
4. از من تقاضا به عمل می آید تا به پرسش های ارزیابی پاسخ بدهم.
5. من آگاهم که اشتراک من به گونه داوطلبانه بوده و هر زمانی که خواسته باشم میتوانم، بدون قید و شرط، از ارایه معلومات خودداری نمایم.
6. من آگاهم که معلومات که در این ارزیابی جمع آوری میگردد نزد کبرینی آوت ریچ محفوظ بوده، و در صورت تقاضا میتوان بدان دست یافت.
7. من آگاهم که معلومات ارایه شده تحت هر شرایط قانونی محرم و محفوظ می باشد.
8. من آگاهم که بنابر شمار اندکی اشتراک کننده در این ارزیابی هویت اشتراک کننده گان ناشناخته نخواهند ماند.
9. هویت من محرم بوده و در نتایج ارزیابی از مشتریان خدمات به عوض نام اشتراک کننده گان حرف زده خواهد شد.
10. من آگاهم که پس از امضا و تسلیمی، هذا ورقه ارزیابی نزد مسوول ارزیابی محفوظ می باشد.

امضای اشتراک کننده: _____ تاریخ:_____/____/____

Appendix 5- Literature Review

Hume Whittlesea Pharmacy Waiver Program Evaluation

Literature Review

Methodology

Searches took place using the Boolean search terms:

- ti((refugee* OR (asylum seek*) OR immigra*) AND ti(medicat* OR drug* OR pharm* OR treat*) AND ti(health* OR ill* OR disease* OR sick* OR infect* OR mental* OR disease*))
- ti((refugee* OR (asylum seek*) OR immigra*) AND ti(financ* OR money* OR income* OR econom* OR fund*))

With adjustments made as necessary. That is, the search used on occasion terms in the abstract rather than just the title. Further, the search originally included the term "migra*" however was removed due to the search bringing up irrelevant articles (for example, about migratory birds). Searches took place in databases: CINAHL Complete, Medline Complete, ProQuest Australia and New Zealand Database, ProQuest Political Science Database, ProQuest Public Health Database and PubMed.

Results from which were narrowed down to eight articles. Articles were initially chosen where their title or abstract provided relevance to the review. Australia-based and recent (<5 years) articles were favoured but international articles were observed if relevance could be established. That is, when observing literature that analysed the refugee/asylum seeker experience and the health effects or common diseases or in cases where the countries of origin (similar to those in Australia) were discussed as a factor. Further, if the article discussed the asylum seeker journey in general.

Three common themes of relevance pertaining to the health of People Seeking Asylum (PSA) will be discussed. They are, diseases and health issues of PSA, financial situations and cost as a barrier for PSA accessing healthcare and other barriers and accessibility issues experienced by PSA. These will be further discussed.

It should be noted that although the Hume Whittlesea Pharmacy Waiver Program (HWPWP) focuses on PSA, refugees have been included in search terms as although different in visa status, countries of origin, experiences and journey can be similar. Further, including the term 'refugee' allowed for a greater search to be conducted and then a focus on PSA was made at the discretion of the evaluator.

A third search took place using Boolean search terms:

- ti((aborigin* OR (torres strait islander*) OR homeless* OR (vulnerable person*) OR (asylum seek*) OR refuge*)) AND ti((material aid) OR (financ* help) OR (food voucher) OR (food van) OR (food parcel) OR (emergency relief))

This allowed the evaluator to look beyond asylum seeker specific programs but rather similar material aid-style programs already operating within Australia; how they operate and how successful they have been in providing aid to vulnerable groups within Australia to create a basis for best practice. A general Google search for grey literature was also performed for this section as examples of current existing Melbourne-based

programs may not have been examined for peer-reviewed journals. Further, searches extended beyond Australia where necessary and relevance could be justified.

Background

The reality of the asylum seeker experience sees people fleeing acts of terrorism, war, ethnic cleansing and genocide[30]. Since Federation (1901), Australia has resettled upward of 750,000 refugees[31] with an estimated current 12 million refugees across the world, today[32]. It is imperative for health professionals and their associated organisations to advocate for healthcare, most specifically mental illness prevention for the PSA and refugee population[33]. The situation in Australia and its associated detention centres, implemented by the Australian Government have been described as contrary to international law by the UNHCR[34]. Further, frequent transfers between detention centres, separate detainees from access to services including legal support and family and community support[35]. Moreover, Australia has a history of explicitly selecting migrants based on country of origin, race and religion and for others, the government uses harsh treatment as a deterrent[36].

In current programs, success can be seen when components include flexibility in the system structures and processes, and ease and frequency of access by and to clients is seen[37]. Currently, health screening for PSA arriving in Australia include a history and physical examination, chest x-ray for those older than 11, HIV and syphilis tests for those older than 15, latent TB for those between the ages of 2 and 10 with flexibility to have other tests ordered as required[38]. Currently, these tests are not country of origin specific and it is argued that more focus should be placed on this factor[39]. For example, one of the most common screening programs performed in the European Union (EU) targets TB however only one-third of EU countries screened for other infectious diseases when they are of a higher prevalence in countries of origin[40]. Moreover, chronic medical conditions are just as relevant as communicable disease from the PSA's perspective especially when looking towards long-term medically based programs[41].

---

[30] Assiri, Anne Marie. 2014. "Asylum Seekers And Mental Illness In Australia: A Nursing Response". Australian Nursing And Midwifery Journal 21 (9): 32-35. https://search.informit.com.au/documentSummary;res=IELHEA;dn=189712096985600.

[31] Smith, Mitchell, Winston Lo, and Jessica Bindra. 2013. "Prescribing For Refugees". Australian Prescriber 36 (5): 146-147. doi:10.18773/austprescr.2013.060.

[32] Assiri, Anne Marie. 2014 "Asylum Seekers", 32-35.

[33] Ibid.

[34] Ibid.

[35] Ibid.

[36] Ibid.

[37] Hohm, Charles F., Paul Sargent, and Robert Moser. 1999. "A Quantitative Comparison Of The Effectiveness Of Public And Private Refugee Resettlement Programs: An Evaluation Of The San Diego Wilson Fish Demonstration Project". Sociological Perspectives 42 (4): 755-763. doi:10.2307/1389583.

[38] "Asylum Seekers". 2018. PDF. 3rd ed. Sydney: NSW Refugee Health Service. https://www.swslhd.health.nsw.gov.au/refugee/pdf/Resource/FactSheet/FactSheet_03.pdf.

[39] Smith, Mitchell, Lo & Bindra. 2013. "Prescribing For Refugees"

[40] Eiset, Andreas Halgreen, and Christian Wejse. 2017. "Review Of Infectious Diseases In Refugees And Asylum Seekers—Current Status And Going Forward". Public Health Reviews 38 (1). doi:10.1186/s40985-017-0065-4.

[41] Smith, Mitchell, Lo & Bindra. 2013. "Prescribing For Refugees"

The literature is limited and the independent effect of fleeing and living as a refugee is inadequately represented in literature[42]. Few studies take into account reasons of migration where associated health issues could be found[43]. There is a strong need for public education about antibiotics when observing those prevented from seeking medical advice and the increase in self-medication causing irrational use of antibiotics within refugee and asylum seeker camps[44]. Although Australia has an already existing, strong screening process, gaining results from this screening is significant[45].

When observing the use of medicines in resettled refugees and PSA in Australia, there are six main points to consider, including appropriate communication, accommodation of cultural needs, health literacy competency including health seeking behaviour practice, establishing trust with refugees and PSA, implications of non-adherence to medication use and limitations of programs[46].

Health concerns

The asylum seeker experience lends itself to a vulnerability of mental illness and when first arriving in Australia, there is an extremely high risk of (if not already with) developing psychiatric illness with long term poor outcomes[47]. Further, the combination of past trauma with Post-Traumatic Stress Disorder (PTSD) and major depressive episodes are shown to cause greater medical complications as elevated heart rates are strongly correlated[48]. Detention centres operated within or remotely by Australia are managed like prisons, subjecting PSA to the aforementioned psychiatric illness alongside physical assault and sexual harassment[49]. Further issues surrounding PSA in detention stem from political propaganda for example, self-harm behaviours (especially when seen in children) are negated as politically motivated causing health problems within this community to be not considered serious or with validation and contributes to further suicide ideation[50]. The main health concerns for PSA are:

- Psychological disorders (Depression, Anxiety and PTSD) due to situations in country of origin and the stressors associated with culture shock and settling into a new environment (along with the aforementioned institutional issues and factors). Further, the added stress of awaiting determination of migration status and effectively living in limbo[51].

[42] Eiset, Halgreen & Wejse. 2017. "Review Of Infectious Diseases"
[43] Ibid.
[44] Al Baz, Maysun, Michael R. Law, and Rawan Saadeh. 2018. "Antibiotics Use Among Palestine Refugees Attending UNRWA Primary Health Care Centers In Jordan – A Cross-Sectional Study". Travel Medicine And Infectious Disease 22: 25-29. doi:10.1016/j.tmaid.2018.02.004.
[45] Tiittala Paula, Karolina Tuomisto, Taneli Puumalainen, Outi Lyytikäinen, Jukka Ollgren, Olli Snellman, and Otto Helve. 2018. "Public Health Response To Large Influx Of Asylum Seekers: Implementation And Timing Of Infectious Disease Screening". BMC Public Health 18 (1). doi:10.1186/s12889-018-6038-9.
[46] Bellamy, Kim, Remo Ostini, Nataly Martini, and Therese Kairuz. 2015. "Access To Medication And Pharmacy Services For Resettled Refugees: A Systematic Review". Australian Journal Of Primary Health 21 (3): 273. doi:10.1071/py14121.
[47] Assiri, Anne Marie. 2014 “Asylum Seekers”, 32-35.
[48] Ibid.
[49] Ibid.
[50] Ibid.
[51] “Asylum Seekers”. 2018.

- Musculo-skeletal problems (from injury or torture), gastro-intestinal disorders, chronic diseases, women's health issues, dental problems[52]
- Infections including Hepatitis B (1.4% of recent settlers), HIV (0.3%), Syphilis (1.0%) and Tuberculosis (TB) (0.6%)[53] where the prevalence of TB rises during conflict thus, an even further concern for asylum seeker population[54]
- Malaria although very much related to the means and route of transportation, can represent a risk of outbreaks due to reintroduction if not treated accordingly[55]
- Other: Vaccine preventable childhood diseases (Measles and Rubella), Shigella, Cutaneous Diphtheria, Louse-born relapsing fever, Leishmaniasis, MRSA and ESBL/CPO and STDs (Chlamydia, Gonorrhoea, Syphilis, Giardia intestinalis, Entamoeba histolytica)[56] and Vitamin D deficiency[57]

Many of the above health concerns require antibiotics, mental health specific (including anti-psychotics), and other medications to ensure not only a healthy life for those seeking asylum but for the population in which they join as they settle.

Cost as a barrier

Cost is seen as a barrier for those seeking asylum for a multitude of reasons. Firstly, the mode of transport to Australia, that is, via plane or boat can lend itself to how one is treated once arriving in Australia. Then, the ways in which someone can live and thrive once settled (to an extent) within the Australian community. More specifically, how can one thrive in a society with regards to their health when health is seen as a commodity rather than a human right? Studies show that when receiving a higher level of financial assistance (of any form), refugees in settlement programs had a significantly higher level of being placed in jobs and at a faster rate[58]. It is feared that PSA will cease use of essential medications due to cost and follow-on effects of this could see PSA not attending visits with their General Practitioner (GP) as a result, due to an inability to then fill any prescriptions resulting from such visits[59].

The Australian Prescriber states that one of the main issues surrounding the discussion of prescribing medications to resettled refugees and PSA is the cost of medication[60]. When reviewing infectious diseases in refugees and PSA, recommendations included systems to ensure health assessment immediately after arrival to the host country (as previously mentioned) however more relevantly, recommended free of charge access to diagnosis and treatment of any communicable disease[61]. More money should be spent on emergent treatment of disease as not only maintaining the dignity of the person seeking asylum but to also prevent the spread of infectious disease to the population in which they are joining. Even when subsidised, large families

[52] Ibid.
[53] Tiittala, Tuomisto, Puumalainen, Lyytikäinen, Ollgren, Snellman & Otto Helve. 2018.
[54] Eiset, Halgreen & Wejse. 2017. "Review Of Infectious Diseases"
[55] Ibid.
[56] Ibid.
[57] Smith, Mitchell, Lo & Bindra. 2013. "Prescribing For Refugees"
[58] Hohm, Sargent & Moser. 1999. "A Quantitative Comparison"
[59] "Asylum Seekers". 2018.
[60] Bellamy, Kim, Ostini, Martini & Kairuz. 2015. "Access To Medication"
[61] Eiset, Halgreen & Wejse. 2017. "Review Of Infectious Diseases"

may face excessive costs hindering adherence[62]. A subset of PSA live in community without Medicare[63]. Some may get assistance through organisations like the Australian Red Cross but there are less options for pharmaceutical-specific programs[64]. Cheapest effective treatment options should be offered to help promote adherence to treatment[65].

There is some debate surrounding the cost-effectiveness of screening[66]; that the infectious disease risks to public health has accompanied the migrant crisis in Europe causing a fear of spread of infectious disease causing people to question the validity of the current screening processes and programs creating more fear and uncertainty of PSA[67]. This furthers the inability for PSA to gain any form of income generating a cycle of disadvantage.

Other barriers and accessibility issues

As shown above, cost and financial situations are a barrier to accessing medications and healthcare but there are other barriers in place that should be acknowledged in order to understand the situation as a whole.

With frequent transfers between detention centres, detainees are separated from access to services including legal support and family and community support increasing the threat of deportation and through restricting access to adequate health services and legal support, further psychological distress occurs[68]. Depending on visa type and changes to the Status Resolution Support Service (SRSS), PSA may not have access to Medicare meaning they can only receive emergency care and therefore not ongoing medication[69]. Further, with the aforementioned low income associated with PSA, medications can be forfeited for food and shelter. It is also suggested that a lack of language and cultural understanding among resettled refugees and PSA may affect the quality use of medicines[70].

To extend on a previous point, in the same article by the Australian Prescriber, other issues surrounding the discussion of prescribing medications to resettled refugees and PSA include language difficulties and inconsistent use of interpreters in a pharmacy setting, poor navigation of the Western healthcare system, especially with regard to accessing medication, cultural barriers and discordant illness beliefs and medication non-adherence[71]. Traditional medicine use was discussed as well as the influence of family, peers and/or community on health behaviour and outcomes identified as both a facilitator and barrier[72]. Other cultural and religious beliefs can play a part in people not seeking or adhering to medication use, for example when fasting

[62] Smith, Mitchell, Lo & Bindra. 2013. "Prescribing For Refugees"
[63] Ibid.
[64] Ibid.
[65] Ibid.
[66] Tiittala, Tuomisto, Puumalainen, Lyytikäinen, Ollgren, Snellman & Otto Helve. 2018.
[67] Ibid.
[68] Assiri, Anne Marie. 2014 "Asylum Seekers", 32-35.
[69] "Asylum Seekers". 2018.
[70] Bellamy, Kim, Ostini, Martini & Kairuz. 2015. "Access To Medication"
[71] Ibid.
[72] Ibid.

during Ramadan[73]. It should also be noted that traditional medicines can interact with prescribed drugs creating another dimension to not a barrier, but rather a harmful situation to use of medications[74].

Without further healthcare services and development and research, the prevalence of communicable diseases in PSA and refugee communities will continue to remain the subject of speculation rather than fact[75]. The diagnosis of an unfamiliar condition and not having knowledge on how to manage it is a common scenario seen amongst the recently settled PSA population[76]. Limited health literacy can be a barrier in itself[77]. That is, to not understand the reasons for healthcare and its associated treatments like use of medications. Further, the concept of preventative health may not be well understood[78].

Material Aid and Emergency Relief Examples

Similar to the HWPWP to be evaluated, other programs exist to provide aid of some form. This section will observe the practices that material aid and emergency relief programs follow to formulate a basis for such programs and their successes and challenges to eventually compare against the HWPWP.

Salvation Army[79]

- An example of emergency relief that currently exists is the Salvation Army's Doorways whereby lives are transformed and care for people is performed without discrimination. Support of clients in times of crisis is undertaken, while concurrently assisting clients to build their individual capacity and resilience.
- Through using some of their key features, they operate to uphold the above principles. These features include early intervention, capacity building and developing health and wellbeing, trusting relationships, client-centred approaches, strengths-based approaches, maintenance of cultural appropriateness and collaborating in effective partnerships.
- It is imperative to maintain dignity and encourage self-reliance when engaging in an emergency relief programs.
- Doorways focuses on disadvantaged and vulnerable sub-groups of the community including those in situational poverty, entrenched poverty and generational poverty.
- It should be noted that an appropriate assessment system should be in place regarding reasons for accepting clients in the form of a criteria or survey.

[73] Ibid.
[74] Smith, Mitchell, Lo & Bindra. 2013. "Prescribing For Refugees"
[75] Eiset, Halgreen & Wejse. 2017. "Review Of Infectious Diseases"
[76] Smith, Mitchell, Lo & Bindra. 2013. "Prescribing For Refugees"
[77] Ibid.
[78] Ibid.
[79] "Doorways Handbook- Emergency Relief Delivery". 2019. The Salvation Army. https://www.sarmy.org.au/en/Social/Doorways-Handbook/TSA-Emergency-Relief-Delivery/.

St Vincent de Paul Family Assistance[80]

- For those experiencing financial hardship, a home visit by volunteers to provide relevant assistance can take place.
- Emergency relief may be given in the form of food parcels, food vouchers, and assistance with utility bills, clothing, furniture and referral to other services.
- Assessment is conducted by the referring volunteer to determine eligibility for the program.

St Vincent de Paul Soup Vans- "Vannies"[81]

- Dedicated Soup Fan Volunteers provide assistance to people who might be facing tough times.
- Breaking through the barriers of loneliness and isolation, a meal is provided alongside conversation.
- Further material aid is provided through the form of a meal, blanket, toiletries, snacks and hot beverages.
- These Soup Vans are able to operate due to the support of volunteers, sponsors, donors and suppliers.
- It again reiterates the notion that cash and money donations at times have no guarantee of the ways in which is spent after but material aid in itself can be successful.

RISE: Refugees, Survivors and Ex-detainees Food Bank[82]

- The Food bank has been running since 2011 with a rapid increase in people accessing the service with over 2700 PSA and refugees registered.
- Those accessing the service are usually PSA on bridging visas in need of food and shelter or those in community detention with no source of income.
- The Food Bank aims to address the initial critical needs of refugees and PSA within our community by providing access to free dry food and fruits and vegetables. Examples include: rice, oil, sugar, pasta, milk, tea, coffee, tuna and fruits and vegetables. Material aid is also provided through the form of toiletries including toothpaste and toothbrushes, shampoo and conditioner, soap, hair brushes amongst others.
- RISE relies on generous donations dropped off at their office in Melbourne by the general public. Funds are donated by the general public also which assists in buying of this material aid.
- The rapid increase in clients accessing the service speaks volumes of its success as a material aid program.

Haiti Disaster, 2010[83]

The 2010 Earthquake in Haiti caused the death of 250,000 people with at least 300,000 further with injuries. Following the disaster, 5 million people were displaced. This section highlights how material aid was received and emergency relief performed in an emergent situation, however is useful in reflecting the successes of such programs to be viewed in conjunction with the pharmacy waiver program.

[80] "Family Assistance Hotline- Good Works". 2019. St Vincent De Paul Society. https://www.vinnies.org.au/page/Find_Help/NSW/Food/Family_Assistance_Hotline/.
[81] "Soup Vans- Good Works". 2019. St Vincent De Paul Society. https://www.vinnies.org.au/findhelp/view/90.
[82] "Food Bank". 2019. RISE- Refugees Survivors And Ex-Detainees. http://riserefugee.org/what-we-do/food-bank/.
[83] Versluis, Anna. 2014. "Formal And Informal Material Aid Following The 2010 Haiti Earthquake As Reported By Camp Dwellers". Disasters 38 (s1): S94-S109. doi:10.1111/disa.12050.

- There was a consistent preference for cash (rather than other forms of material aid) as it allows for greater flexibility, autonomy, opportunity to invest the aid and often greater dignity (no long distribution lines). Further, it was preferred by government and aid agencies as it is easier and cheaper to transport than in-kind assistance but there is a risk of local inflation.
- Also, the risk of it being spent for 'anti-social' purposes like on drugs or alcohol tends to deter agencies away from such contributions.
- Exception to the above is medical care, for which health care professionals are usually sought out directly with associated medications.
- Within the first 7 weeks following the earthquake, 72% (of those interviewed) received material assistance of some form including tents, tarpaulins, food, household items, toiletries and medical care.
- Effectiveness of the received material aid was difficult to evaluate as many of the recipients did not rate on a ten-point scale suggesting they were not very satisfied and aid in the form of cash would have been preferred.
- Cash transfers rated more effective with proven results that the cash was not 'wasted' but rather, used efficiently to improve nutrition, health, education and as start-up capital.

The grand scale however of such a mass of people affected in a small amount of time causes a greater need through ease and speed of cash handouts. It has been noted that cash should be given out with caution and material aid is recommended so that there is an understanding of how donations are being used. Further, when it came to health and medical care, cash was not provided.

Other points of interest found during original database searches included the fact that interpreters where health professionals cannot speak the client's language are essential and if not used can contribute to treatment non-adherence, adverse events or failure to follow instructions, with potential medicolegal implications[84]. Due to the mobile nature of refugees' situations, duplication of therapy can occur and so requesting a medicines list will reduce this complication[85]. Both of these factors along with the found advantages and best practice models are ways in which the Hume Whittlesea Pharmacy Waiver Program should be operating.

Summary and recommendations

It is evident through the above research that the there is a need for the HWPWP, itself. PSA experience a greater number of health and medical issues compared with the rest of the Australian population and should be considered a minority group in this regard. Most specifically considering they more commonly are on low or no incomes. When evaluating the HWPWP, the aforementioned principles of effective practices for programs regarding pharmaceuticals, pharmaceuticals for refugees and PSA, programs in general for refugees and PSA and other material aid and emergency relief programs should be noted for comparison. These principles and noted factors include:

[84] Smith, Mitchell, Lo & Bindra. 2013. "Prescribing For Refugees"
[85] Ibid.

- Success being seen when components [of a program] include flexibility in the system structures and processes, and ease and frequency of access by and to clients[86]
- Considering chronic medical conditions as just as relevant as communicable disease when looking towards long-term medical-based programs[87]
- That in the past, when receiving a higher level of financial assistance (of any form), refugees in settlement programs had a significantly higher level of being placed in jobs and at a faster rate[88]
- Programs having systems to ensure health assessment immediately after arrival to the host country [with] recommended free of charge access to diagnosis and treatment of any communicable disease[89]
- Inconsistent use of interpreters in a pharmacy setting, poor navigation of the Western healthcare system, especially with regard to accessing medication, cultural barriers and discordant illness beliefs, medication non-adherence[90] and limited health literacy[91] is common amongst PSA populations and so programs should not only note these things but base their practices off combatting them
- An appropriate assessment system being in place regarding reasons for accepting clients in the form of a criteria or survey[92]
- Assessment being conducted by the referring volunteer/worker to determine eligibility for the program[93]
- Cash and money donations at times have no guarantee of the ways in which is spent after but material aid in itself can be successful[94]
- A consistent preference for cash being experienced (rather than other forms of material aid) as it allows for greater flexibility, autonomy, opportunity to invest the aid and often greater dignity (no long distribution lines) while also being easier and cheaper to transport. However, health care professionals being sought out directly for medications and when it comes to health and medical care, cash would be insufficient[95]
- Interpreters where health professionals cannot speak the client's language are essential and if not used can contribute to treatment non-adherence, adverse events or failure to follow instructions, with potential medicolegal implications[96]
- Duplication of therapy can occur and so requesting a medicines list will reduce this complication[97] on first time visits.

[86] Hohm, Sargent & Moser. 1999. "A Quantitative Comparison"
[87] Smith, Mitchell, Lo & Bindra. 2013. "Prescribing For Refugees"
[88] Hohm, Sargent & Moser. 1999. "A Quantitative Comparison"
[89] Eiset, Halgreen & Wejse. 2017. "Review Of Infectious Diseases"
[90] Bellamy, Kim, Ostini, Martini & Kairuz. 2015. "Access To Medication"
[91] Smith, Mitchell, Lo & Bindra. 2013. "Prescribing For Refugees"
[92] "Doorways Handbook- Emergency Relief Delivery". 2019
[93] "Family Assistance Hotline- Good Works". 2019
[94] "Soup Vans- Good Works". 2019
[95] Versluis. 2014. "Formal And Informal Material Aid"
[96] Smith, Mitchell, Lo & Bindra. 2013. "Prescribing For Refugees"
[97] Ibid.

Conclusion

If the HWPWP respects the aforementioned factors alongside having positive outcomes following the evaluation interviews, surveys and key utilisation data analysis, it will be seen to be a success. Further, if the above needs can still be established within the communities of Hume and Whittlesea with respect to no policy changes being made to PSA then it will be clear that the HWPWP is working efficiently and recommended that it should continue operating, provided these policy changes do not occur.

BIBLIOGRAPHY

Al Baz, Maysun, Michael R. Law, and Rawan Saadeh. 2018. "Antibiotics Use Among Palestine Refugees Attending UNRWA Primary Health Care Centers In Jordan – A Cross-Sectional Study". Travel Medicine And Infectious Disease 22: 25-29. doi:10.1016/j.tmaid.2018.02.004.

Assiri, Anne Marie. 2014. "Asylum Seekers And Mental Illness In Australia: A Nursing Response". Australian Nursing And Midwifery Journal 21 (9): 32-35. https://search.informit.com.au/documentSummary;res=IELHEA;dn=189712096985600.

"Asylum Seekers". 2018. PDF. 3rd ed. Sydney: NSW Refugee Health Service. https://www.swslhd.health.nsw.gov.au/refugee/pdf/Resource/FactSheet/FactSheet_03.pdf.

Bellamy, Kim, Remo Ostini, Nataly Martini, and Therese Kairuz. 2015. "Access To Medication And Pharmacy Services For Resettled Refugees: A Systematic Review". Australian Journal Of Primary Health 21 (3): 273. doi:10.1071/py14121.

"Doorways Handbook- Emergency Relief Delivery". 2019. The Salvation Army. https://www.sarmy.org.au/en/Social/Doorways-Handbook/TSA-Emergency-Relief-Delivery/.

Eiset, Andreas Halgreen, and Christian Wejse. 2017. "Review Of Infectious Diseases In Refugees And Asylum Seekers—Current Status And Going Forward". Public Health Reviews 38 (1). doi:10.1186/s40985-017-0065-4.

"Family Assistance Hotline- Good Works". 2019. St Vincent De Paul Society. https://www.vinnies.org.au/page/Find_Help/NSW/Food/Family_Assistance_Hotline/.

"Food Bank". 2019. RISE- Refugees Survivors And Ex-Detainees. http://riserefugee.org/what-we-do/food-bank/.

Hohm, Charles F., Paul Sargent, and Robert Moser. 1999. "A Quantitative Comparison Of The Effectiveness Of Public And Private Refugee Resettlement Programs: An Evaluation Of The San Diego Wilson Fish Demonstration Project". Sociological Perspectives 42 (4): 755-763. doi:10.2307/1389583.

Smith, Mitchell, Winston Lo, and Jessica Bindra. 2013. "Prescribing For Refugees". Australian Prescriber 36 (5): 146-147. doi:10.18773/austprescr.2013.060.

"Soup Vans- Good Works". 2019. St Vincent De Paul Society. https://www.vinnies.org.au/findhelp/view/90.

Tiittala Paula, Karolina Tuomisto, Taneli Puumalainen, Outi Lyytikäinen, Jukka Ollgren, Olli Snellman, and Otto Helve. 2018. "Public Health Response To Large Influx Of Asylum Seekers: Implementation And Timing Of Infectious Disease Screening". BMC Public Health 18 (1). doi:10.1186/s12889-018-6038-9.

Versluis, Anna. 2014. "Formal And Informal Material Aid Following The 2010 Haiti Earthquake As Reported By Camp Dwellers". Disasters 38 (s1): S94-S109. doi:10.1111/disa.12050.

Appendix 6- Interim Report

Interim Report of the Hume Whittlesea Pharmacy Waiver Program
HWPCP Grant

Summary of activities being undertaken

On the 15th February, 2019, the Hume Whittlesea Pharmacy Waiver Program was launched. The Program aims to alleviate the stresses associated with low or no income experienced by People Seeking Asylum (PSA) most specifically following changes made to the Federal Government's Status Resolution Support Service (SRSS) whereby PSA have been left with no ability to support themselves. The launch was a success and within its first weeks of operation, over ten clients had had their medications waived by the Program.

The Cabrini Outreach Program Assistant is responsible for the day to day undertaking of the Program at Whittlesea Community Connections (WCC). They assess eligibility of presenting clients and once recognised as eligible (for the most part this includes, asylum seeker status and no form of income either through work or other payment types), he or she writes a waiver letter to Terry White Chemmart listing all essential medications as written on prescriptions presented. Then, once Terry White has processed the medications and provided an invoice, a requisition form is completed by the Program Assistant in order to reimburse Terry White for their expenses by Cabrini Outreach.

To date, the Program Assistant has performed well by establishing a system for undertaking the aforementioned duties. There have been forty-six clients referred (by an agency or through self-referral) to the Program. Two have been rejected from the Program due to unsuitability with the criteria and a further four clients have had medications waived in the past, but have since been withdrawn from the Program due to now not meeting the criteria. That is, the clients have since found work that allows them to earn money beyond what is considered a low income by this criteria. Where necessary, these clients have been referred on to a caseworker at Whittlesea Community Connections (WCC).

A number of clients that have accessed the pharmacy waiver program have received assistance from WCC. Assistance has included material aid, financial assistance (Utility relief grants, Asylum Seeker Brokerage, Emergency relief, Telstra vouchers) and casework support.

With regards to other activities, there is currently nothing further being undertaken beyond the Program Assistant's role except for initial outreach to possible referring agencies and General Practitioners (GPs). In brief, some of the stakeholder interviews being conducted for the evaluation currently being undertaken (to be further discussed) have shown possible ways in which to expand the Program and engage a wider community. For example, by participating in events and activities organised by WCC. These possibilities will be further explored in the final report that will discuss the findings of the evaluation. This interim report will explain the evaluation and its activities, methodology and progress.

Results of activities including qualitative and quantitative data

As previously mentioned, to date, forty-six clients have used the Program with four now deemed ineligible. A total of 117 presentations and waiver letters have been written with 304 separate prescriptions being waived. The age of the clients vary, with whole families participating in the Program. The database of clients shows an average age of 33.5 with a range of <1 – 68 years old and so proves that the Program itself is not only far reaching across age demographics but evidently covers the differing pharmaceutical needs spanning across generations.

As per the criteria, all clients' suburbs fall within the local government areas (LGAs) of the cities of Hume and Whittlesea. This means that there are a possible forty-two suburbs that clients can reside in in order to be eligible for the Program.

Figure 1: Client residential locations

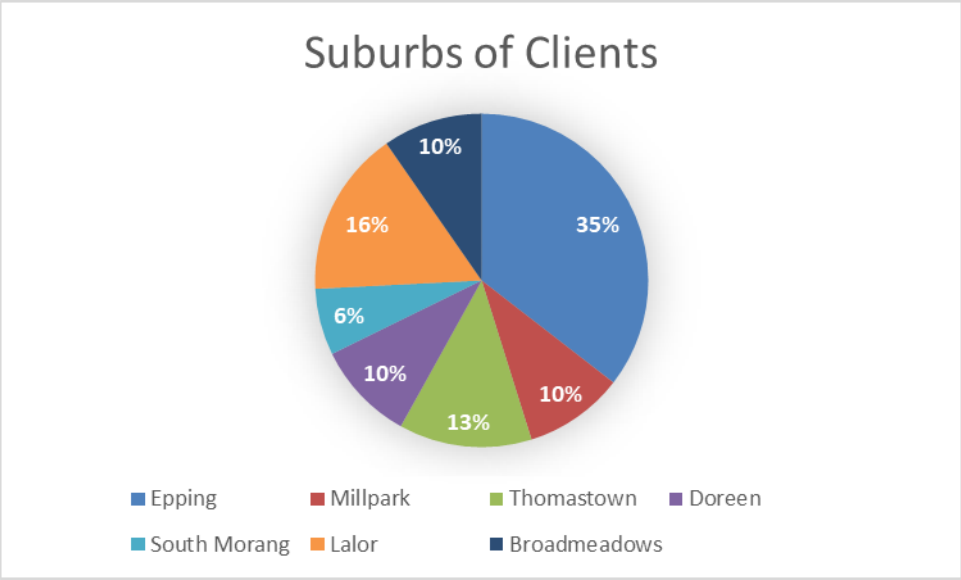


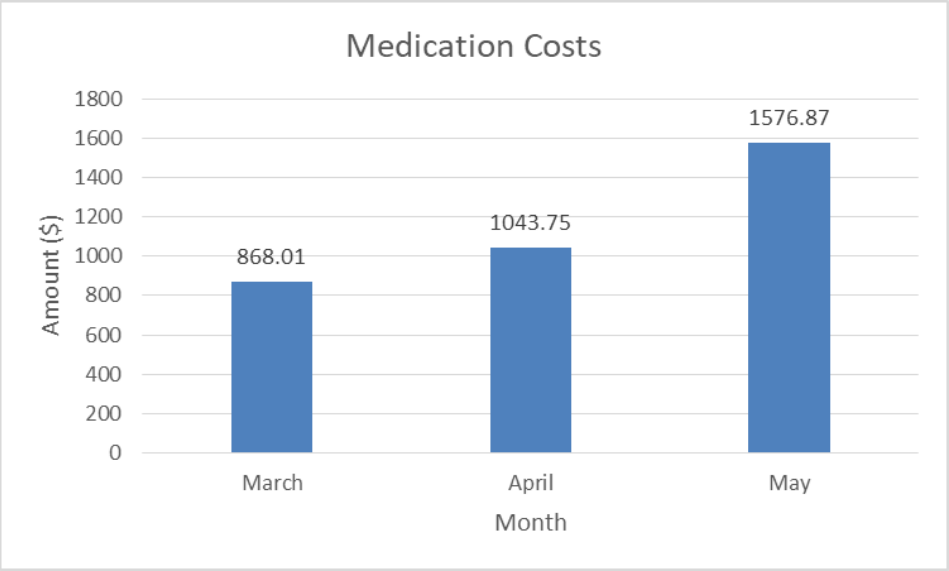
Figure 1 demonstrates that although receiving clients from different suburbs (n = 7), the Program may not be as far reaching as could be. Moreover, suburbs within close proximity of WCC (located in Epping) represent a greater number of clients. For example, 35% of clients live in Epping, alone. This is followed by Lalor and Thomastown at 16% and 13%, respectively, which neighbour Epping, are closer to Epping than the others and have direct public transport options. In part this is due to these areas having affordable rental housing or share housing. Engagement in within the LGA of Hume could be necessary and become more apparent during the final report evaluation however currently, this has been identified as an area of improvement for the Program in one of the stakeholder interviews.

In general, the feedback received from clients has been positive in both the beginnings of the evaluation and as reported by the Program Assistant in their interview. The clients are happy with the ease of the process, and although it can be time consuming, feel that it alleviates financial stress to an extent. In some of the stakeholder interviews that have been performed, there is mention that pharmaceuticals are a financial stress in amongst many others (for example, shelter and food) and this will be noted and further discussed in the final report. However, from a client perspective, the Program works efficiently. Further, feedback has been provided back to referring agents with the same positive comments being received. The only negative feedback received so far is not pertaining to the Program itself, but rather to greater issues stemming from the GP not prescribing something perceived to be required by the client, or Terry White either not in supply of, or not able to, supply certain medications (for example, compounding medications) however, the success of the Program has far outweighed some of the minor complications

that have arisen and these have been dealt with appropriately and as necessary, with ease. Again, to be further discussed on completion of the evaluation, in the final report.

At the time this report is being written, a total of $4,192.70 worth of medication costs have been waived by Cabrini Outreach. This includes $868.01 in March, $1,043.75 in April and $1,576.87 in May (see figure 2). The increase in the amount per month indicates the success of the Program as more clients are using the service alongside a greater amount of medication being covered.

Figure 2: Medication costs



Any evaluation activities undertaken including methodology and findings

At the completion of the Program, having been operating for 100 days (27th May, 2019), the evaluation began. The evaluation terms of reference (see appendix 1) outlines the objectives and purposes of the evaluation before listing some key questions to be answered. It details who will be interviewed or surveyed and the ways in which this will be undertaken.

The evaluation methodology outlined in the terms of reference adheres to the original grant application provided to HWPCP. That is, to measure the effectiveness of the service and partnership interviews with key stakeholders from within the partnership, and gain feedback from clients in a way that is culturally and linguistically appropriate and sensitive. The original application stated that this would be undertaken either through focus groups (in first language) or through a translated survey. To extend on the terms of reference, it can be seen that originally, a random sample would be chosen over 3-4 days of evaluator's presence at WCC with an interpreter present. However, logistically, this was difficult to perform most specifically following the exiting of the job by the Program Assistant not long after the 100-day cut off. The surveys are now written and have been translated into two of the top languages (Persian and Arabic) as indicated by the Program Assistant and for returning clients, while the Program Assistant is writing the waiver letter and photocopying prescriptions, they (if they wish) will complete the survey that is explicit in explaining its voluntary nature. Because of the presence of the Program Assistant in this completion, an interpreter can be used if deemed necessary by the client.

As the first 100 days drew to a close, the evaluator began collating a literature review (see appendix 2) that explored the baseline need for the Program as well as best practice models. At its conclusion, it was evident that the Program itself is necessary and remains needed in the population. In the original grant application, it was noted that if policy changes were made, the Program could be deemed not required for this specific demographic, however as it stands, is still a necessary Program to be running. Further,

ways in which to best perform such Programs were highlighted and will be compared against the Program in the final report of the evaluation.

Currently, stakeholder interviews have been completed with WCC and begun for Cabrini Outreach. Terry White staff have been contacted for interview, however, these have not been completed yet and have had to be postponed. Due to the 'drop in' nature of the Program, it is difficult for the Program Assistant to predict who and how many clients will present each day. This furthers the need for the written client surveys (rather than interviews) as they can be distributed by the Program Assistant without need for the Evaluator to be present. Further, the 'drop in' nature has seen only a limited number of completed surveys due to a greater number of new clients presenting to the service (ineligible to provide feedback) and a limited number of returning clients. Therefore, the evaluation at this stage has been limited by the number of presenting clients eligible to provide feedback. Following the completion of stakeholder interviews with Cabrini Outreach, the remaining stakeholders, as outlined in the terms of reference (see appendix 1) will be contacted for interview. Surveys will continue to be distributed by the Program Assistant to returning clients. Data analysis of key utilisation data has also begun and the basics of which can be seen above. There is aim to complete all surveys and interviews within the next month. An overview of activities to be undertaken and the predicted sequence of events across the period of the evaluation are shown in the Gantt Chart (see appendix 3).

A complete breakdown of funds expended will be provided in the final report.

Appendices

1. Terms of Reference
2. Literature Review
3. Gantt Chart

[i] CASRHH only provides waiver letters to clients who are under the care of GPs or Psychiatrists at the CASRHH.