Review of Outer Northern Metro Refugee Health Nurse Models

Final report

December 2017

This review is an initiative of the Outer Northern Metro Refugee Health Nurse Initiative Case Study Steering Group

Proudly supported by Hume Whittlesea Primary Care Partnership

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List of abbreviations used in this report

AMES	AMES Australia
CALD	Culturally and Linguistically Diverse
DHHS	Department of Health and Human Services
Dianella	Dianella Community Health
EFT	Equivalent full time
Foundation House	The Victorian Foundation for Survivors of Torture Inc
GP	General Practice/General Practitioner
Hillcrest	Hillcrest Health Service
LGA	Local Government Area
PANCH	Preston and Northcote Community Hospital
PVCH	Plenty Valley Community Health
RCH	Royal Children's Hospital
SLA	Statistical Local Area
TIS	Telephone Interpreting Service
VITS	Victorian Interpreting and Translation Service
YCH	Your Community Health (previously Darebin Community Health)

Executive Summary

The Outer Northern Metro Refugee Health Nurse initiative demonstrates what is possible when local services are stretched beyond their limits. The initiative was a response to the unprecedented number of refugees from Syria and Iraq who settled in the City of Hume in 2016 and 2017, completely overwhelming the capacity of the existing service system.

For these families, they had fled their homes, often lived in a state of limbo for several years before arriving in Australia to start a new life. Many of them have significant experiences of trauma, post-traumatic stress, disability, chronic and complex health needs and poor access to health care prior to arrival.

In the early phase of settlement when these families are adjusting to their new country, culture, language and community, they are also often facing complex and challenging circumstances within their immediate and extended family. Within this complexity is the need to ensure that the basic essentials of life are in place – housing, employment, financial support, education for their children, English language support and access to health care. Making progress towards these goals involves navigating highly complex, multi-sector, multi-agency systems across all levels of government and non-government organisations.

Partner commitment to undertake an evaluation of these models of care was strong. On behalf of the Outer Northern Metro Refugee Health Nurse Initiative Case Study Steering Group, the Hume Whittlesea Primary Care Partnership appointed the consultants, funded and managed this review process. This approach reflects the systems and partnership approach taken by the Primary Care Partnership enabling and supporting the service provision and planning of member services.

The response represented by the clinics that are the subject of this review was driven by a strong duty of care for this community. Resources were mobilised in a unique and responsive way to provide co-located, cross-catchment, partnership models of care that took Refugee Health Nurse clinics to the communities where services were needed. It required significant passion, leadership, good will, a capacity and willingness to think creatively and design a response that was pragmatic, rapid and effective. It required the nurses involved to step out of their comfort zone clinically and outside their familiar patch to provide care in the community where it was urgently needed.

From the first conversations in December 2016, the first clinic was operational within two months (February 2017). Over the past eight months through the service provision in three locations, this initiative has enabled over 430 refugees to undergo an initial health triage and assessment and be referred for required services to meet their needs. Significant health and wellbeing needs have been identified in this cohort who may otherwise remain on a waiting list for their initial assessment with the inherent risk that entails. Disability, mental health, chronic disease, mobility, aged care, general and preventative health needs have been identified and referrals initiated for further assessment and care. Access has also been enabled for practical supports such as aids and equipment to support members of these families address immediate needs and also reduce risk of critical events that might otherwise occur.

A series of challenges were faced in the implementation of these clinics. Dianella Health Service (Dianella), the service most critically affected by the spike in demand and with overwhelming waiting lists were unable to participate in the planning or implementation of this solution. IT issues related to connectivity and system access and the set-up of physical locations to implement this model of care had to be overcome. Also, the challenges for personnel operating outside of their usual catchment area and in unfamiliar facilities created a steep learning curve as each nurse navigated the local service system to identify appropriate pathways to refer clients to. It is a testament to the skills and commitment of the personnel involved in overcoming these challenges.

Challenges in terms of service capacity in the catchment still remain. This relates to continuing demand for the Refugee Health Nurse clinics as well as delays in access to allied health, other services and aids and equipment.

This unique, unprecedented situation and the creative responses it has resulted in, makes for a very interesting case study. It has generated a series of important learnings and unintended consequences that can inform:

- further approaches to cross-sector collaboration in refugee health
- future responses to spikes in demand that may occur in this or other regions
- evolving models of care for refugee health that optimise available resources.

The key findings from this review are:

- The unpredictability of humanitarian arrivals settlement patterns, and the need for agile and responsive models to meet the service demand that can result from intensive pockets of settlement over a short time period
- The importance of functional and well-established partnerships that can enable key stakeholders to work together, adopt a wider system and catchment-wide view and to create the basis for key work such as this review
- The outcomes of this review can contribute to current and future service and resource planning providing insights into options that can extend beyond and across traditional service catchment boundaries and highlighting innovative public and private partnerships to deliver timely care where it is needed most
- The importance of the role of the Refugee Health Nurse in providing an holistic assessment of needs that complement the clinical assessments undertaken by GPs in the early phase post-arrival
- That the models of care developed were not ideal models of care, nor were they intended to be. There are many ways in which this rapid response could be improved, however, as a measure to reduce unacceptable waiting times, identify a range of significant needs and provide a pathway to the required services for newly arrived refugees, they were highly successful
- Significant benefits that can arise from service delivery partnerships and co-location of services in relation to skill development, improving understanding of health professionals and settlement services, reducing duplication of effort and building capability in refugee health care
- The potential for public and private co-located models of care, demonstrated with lessons from the Hillcrest model informing future and better models of GP and Refugee Health Nurse co-location in general practice
- That despite many challenges, over 430 refugees received a Refugee Health Nurse assessment service within an eight-month period.

The following recommendations seek to facilitate a positive way forward specific to this initiative and to inform broader responses to refugee health:

1. That the demand for this service remains high and Refugee Health Nurse clinics should continue to provide timely access to health assessments for this cohort of refugees with capacity, demand and waiting lists to be reviewed periodically to determine the duration of this requirement.

2. That further evaluation is undertaken to assess the outcomes from the Refugee Health Nurse assessment process at an individual and family level, capture feedback from refugee clients who participated in the process and identify key flow-on effects in relation to service demand, avoidance of critical events, patient safety and experience.

3. That a planning process is undertaken at a regional level with representation from the range of key stakeholders as a collaborative process (Settlement Services, Community Health Services, General Practices with an interest in refugee health, Primary Health Networks, Foundation House and DHHS regional office). This would provide the opportunity to share information from this review, build on the significant good will created through this initiative and identify a strategic approach that builds upon the innovative approaches demonstrated in this review with an emphasis on creating a mix of models of co-located care to strengthen the system as a whole.

4. That funding models for Community Health in areas with high levels of refugee settlement are reviewed in order to create funding flows that will enable additional services to be offered to respond in a timely way to significant demand.

5. That the lessons learned from these clinics are shared with other jurisdictions as an example of a potential crisis response to significant influxes of refugees in a geographical area.

6. That this model is considered as part of a tiered approach to Refugee Health Nurse care recognising that not all refugees will need comprehensive multidisciplinary care and that the assessment process modelled in clinics reviewed herein could provide a first step in a model of care.

7. That co-located Refugee Health Nurse and general practice models are further explored in practices with bilingual GPs, guided by a memorandum of understanding and with an emphasis on upskilling the practice personnel (clinical and administrative) to provide timely, accessible and high-quality assessment, service provision and onward referrals for refugees. Ideally this would involve a joint Refugee Health Nurse and GP assessment process within the first month post-arrival in order to provide as comprehensive a service as possible.

8. That bottlenecks in the community health setting are identified and strategies addressed to reduce delays and barriers to accessing key services including allied health, psychology and aids and equipment.

9. That Primary Health Networks are engaged to explore mechanisms to improve the capacity of general practice to respond to the needs of refugee populations and to work in partnership to trial new innovative models of care.

10. That improved systems are implemented within each of the Refugee Health Nurse clinics to enable streamlined and improved practice such as the use of Connecting Care or other tools to support record keeping, referral processes, communications across services and follow-up.

11. That an evaluation of training and peer support available for health professionals working in the refugee health area is undertaken to identify gaps and areas for improvement and to shape a strategy to address the needs identified.

1. Introduction

This report presents the findings of a review of three partnership-based Refugee Health Nurse models in the City of Hume. This work has been funded by the Hume Whittlesea Primary Care Partnership under the auspice of Sunbury Community Health Centre.

This review was initiated to inform further understanding of the complex needs of arriving refugees and to plan for the current and predicted future demands for the City of Hume. The review has sought to describe crucial elements of three models in place in the Hume catchment, look at key literature, population trends and service data and identify barriers to and enablers of best practice in the current models. The findings of the review are intended to contribute to service planning and improvement in Hume as well as to the emerging body of evidence of high quality, safe, accessible and sustainable approaches to the provision of catchment-wide refugee services.

The models reviewed include:

- **Hillcrest** – Refugee Health Nurse from Your Community Health (YCH - previously Darebin Community Health) operating a weekly refugee health clinic from Hillcrest Health Centre - a group general practice with onsite pharmacy and pathology in Broadmeadows
- **The Hume Project** – Refugee Health Nurses employed by Plenty Valley Community Health (PVCH) operating multiple refugee health clinics from:
    - Craigieburn Health Service - a campus of Northern Health
    - AMES Australia settlement service – Dallas site.

2. Methods

Consultants Alison Coughlan and Julie Hassard were contracted to undertake this project on behalf of the Outer Northern Metro Refugee Health Nurse Initiative Case Study Steering Group, comprising representatives from: cohealth; YCH; PVCH; Victorian Government Department of Health and Human Services (DHHS), North Division; and Hume Whittlesea Primary Care Partnership (membership included in Appendix I). The objectives for this review and the key dimensions of interest explored are outlined in Table 1.

Table 1: Review objectives and key dimensions of interest

Objective	Key dimensions of interest
To summarise published evidence related to: • community-based refugee programs in an interface Local Government Area (LGA) catchment • public and private co-location models of Refugee Health Nurse care	• Learnings related to partnership and community models of Refugee Health Nurse care • Clinical, administrative and client-focussed domains • Government policy frameworks • Benefits, disadvantages, challenges and opportunities related to providing Refugee Health Nurse services
To profile each of the three Refugee Health Nurse models that are the focus of this review	• Features of each model of service operation – approach, human resources, funding and associated costs, relationships to other services, operational details, client characteristics, reach and uptake and management
To analyse and summarise findings to inform future considerations for refugee health care in the region	• Description of each model and comparison and contrasts between the three models of service delivery • Current and predicted refugee population in the City of Hume – implications for service demand • Contributors to service quality – barriers and enablers • Benefits and limitations of a structured partnership approach in the design and delivery of an integrated Refugee Health Nurse model of care

A mixed methods approach was adopted to inform the dimensions of interest in this review with the key methods summarised in Table 2.

Table 2: Methods

Method	Description
Data capture: desktop review	A high-level desktop review of key documentation including but not limited to: • Documentation provided by project stakeholders (published literature, reports, policy documents) • Reports and other documentation related to each of the nurse care models - activity, service delivery planning, reports • Reports to funders
Data capture: Site visits	The consultants visited the Refugee Health Nurses operating the three sites at AMES Australia Dallas, Craigieburn Health Service and Hillcrest Health Centre and also met with a number of key informants
Data capture: consultations	Structured interviews were conducted by telephone or in person to inform this review (See Appendix I for key informants and questions explored). Thorough literal notes were taken and a thematic analysis of responses conducted

Method	Description
Analysis	Data were analysed to inform a presentation highlighting key findings and questions for further exploration
Consultation Workshop	At a three-hour workshop on 3rd November 2017, the preliminary findings were presented for discussion with the Outer Northern Metro Refugee Health Nurse Initiative Case Study Steering Group. At this workshop, data were clarified, key questions were discussed and recommendations for the way forward formulated
Reporting	This draft report summarises all findings and recommendations arising. Once feedback has been received from the Steering Group, this report will be revised as the final deliverable for this Review

Note that the findings presented in the following sections of this report draw upon the data derived from all sources.

It is important to also note the limitations of this review. The review has relied on evidence from documentation and key informant meetings and interviews. Those involved as key informants represent a range of perspectives and organisations, but all have a key stake in this initiative and in its success. The true impact of this model of care was not able to be assessed beyond an understanding of the numbers of people receiving services and considering the implications of that. Partly this is related to the model not including follow-up components and so it is difficult to know whether recommendations made were followed up and health and wellbeing benefits realised for the refugees who participated in the process.

Further investigation would be required to enable an understanding of the true impacts at the individual and family level beyond anecdotal evidence and examples provided in this process.

3. Setting the scene – the City of Hume, humanitarian arrivals and the policy and service system context

This chapter sets the scene for the analysis of findings from this review through describing:

- Humanitarian arrivals to the City of Hume
- The health and wellbeing needs of refugees
- The policy context guiding health system capacity and responses to refugee arrivals
- Models of Refugee Health Nurse care.

3.1 Humanitarian arrivals to the City of Hume – trends and growth

The City of Hume is located on Melbourne's northern fringe, 15 kilometres from the centre of Melbourne. It has a population of 198,000, spans a total area of 504 square kilometres and is one of Australia's fastest-growing and most culturally diverse communities. Hume residents come from more than 160 countries and speak approximately 140 languages. Forty per cent of residents speak a language other than English.[i]

For the period 2001 to 2011, the City of Hume was the second most common area of residence for humanitarian arrivals to Victoria, with over 5,000 entrants during that decade representing 18% of the total arrivals. In 2010 to 2015, this pattern was consistent and almost 3,600 refugees were settled in the City of Hume in this five year period (16% of total arrivals).

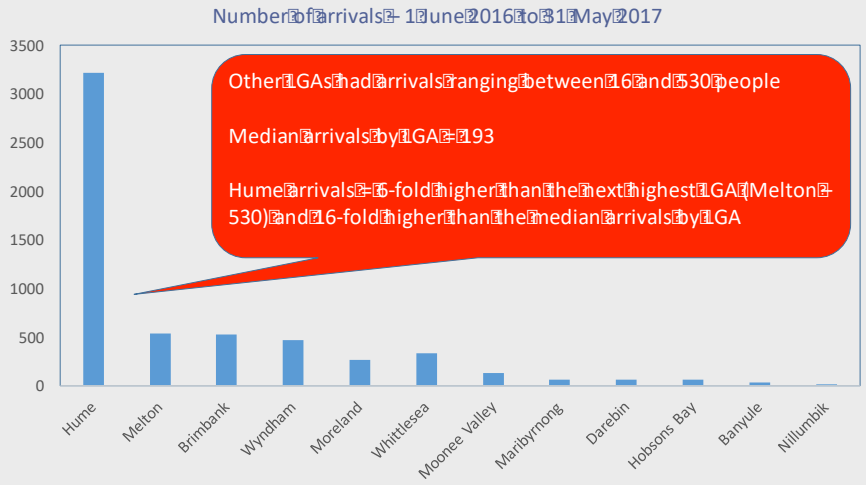
Note, that the numbers of humanitarian arrivals in City of Hume over the period 2010 to 2015 varied considerably each year with a range of 442 to 1,003 – a 2.3-fold difference.[ii] This speaks to the unpredictable nature of arrivals and patterns of settlement and the challenges with service planning that are inherent in this area.

In 2015, the Commonwealth government announced a one-off increase of 12,000 permanent humanitarian places for Syrian and Iraqi refugees over a two-year period commencing July 2016, 4,000 of whom would be settled in Victoria (in addition to the 4,000 refugees per year that would usually be settled in Victoria in the same time period). This represents growth of 150% in arrivals in that time period.[iii] A sizeable proportion of those arrivals were considered likely to settle in the north west metropolitan area of Melbourne in current areas where there are significant existing settlement of Syrian and Iraqi families.

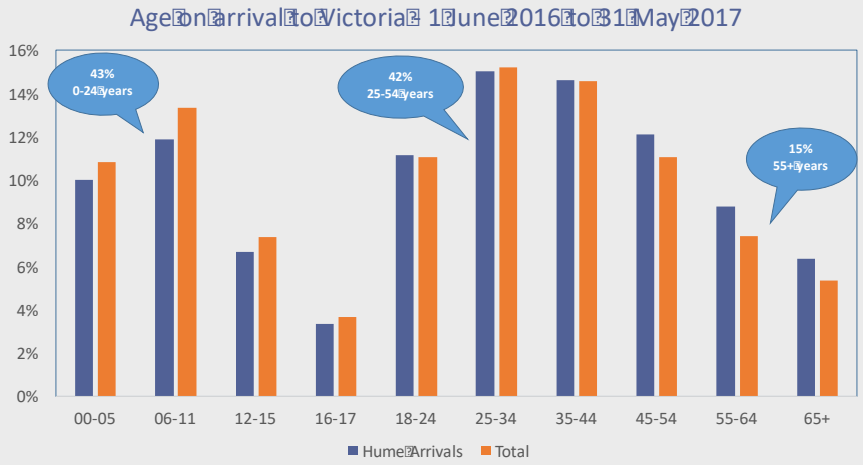
The actual refugee arrivals for the period May 2016 to June 2017 were analysed to inform the true impact seen in the City of Hume.[iv] As anticipated, the numbers were high with 5,678 refugee arrivals reported for this 13-month time period in Victoria. Box 1 highlights the profile of the arrivals to set this report and the refugee health nursing model of care developed to respond in context.

Box 1: Unprecedented humanitarian settlement in the City of Hume

- 5,678 refugees were settled in Victoria from May 2016 to June 2017
- These families settled in 12 of the 79 Victorian Local Government Areas (LGAs)
- 3,217 (57%) settled in the City of Hume in the two Statistical Local Areas (SLAs) of Broadmeadows and Craigieburn



- Of the refugees that settled in the City of Hume, they had a slightly older age profile than the total refugee population settled in Victoria in that same time period (see graph below)



- The population of refugees that were 55 years and older in this cohort or arrivals (15%) was 2.3-fold higher than refugees who arrived in Victoria in the prior decade (2001-2011)[ii]
- It is important to note that the Syrian and Iraqi refugee intakes have the highest number of people over 55 years in any humanitarian intake in Australia's history[v]

Unprecedented demand placed enormous pressure on the health system

The sheer volume of refugees coupled with the concentration of settlement in the City of Hume and the specific influx in Broadmeadows and Craigieburn created a level of unprecedented demand on settlement services, health services, schools, English language programs and all other associated services required to support the transition of these families into their new life in Victoria. Note that this area has also experienced population expansion as a significant Victorian growth corridor and so some services were already under pressure prior to this influx of refugees.

3.2 The health and wellbeing needs of refugees

Interview respondents were asked to describe the health and wellbeing needs of refugees with an emphasis on the cohort of Syrian and Iraqi refugees of most relevance to this review and the impact of refugee inflows to the City of Hume since 2016. The profile of this population and the health and wellbeing needs outlined below are drawn from the interview responses as well as the review of key literature and documentation.

Important elements of the profile of Syrian and Iraqi refugees

- Amongst the 2016/2017 cohort of humanitarian arrivals, a high proportion of people were well educated and many also had good access to quality health care including preventation and screening services in their country of origin
- This access was dependent on socioeconomic status and was noted as more likely to have been experienced in Syria than Iraq
- Families that seem to be doing well were noted as likely to be well educated and have children who speak English
- Health care access was also dependent on the individual circumstances of each family in the period between fleeing their home and arriving in Australia. This includes where they were living in that interim period such as in refugee camps or with family. At the time of arrival, it was noted by respondents in this review that the refugees had experienced variable access to health care in general in that interim period and, certainly, access to preventative health care such as immunisation programs was limited
- Significant experiences of physical trauma, injuries and disabilities were prevalent in this cohort as well as the psychological sequelae from these experiences
- Particular issues relating to the very high number of refugees arriving on Global special humanitarian programme visas were noted (See Box 2):

Box 2: Visa subtypes and profile of the Syrian and Iraqi refugee intake [vi]

There are five subclasses of Australian humanitarian and refugee visas. Two of these are described below and represent the main visas that humanitarian entrants to Australia hold. Of relevance to the context of this review is the high proportion of arrivals from Syria and Iraq who fall into the subclass 202 and thus are proposed by an individual or organisation residing in Australia. Consultations in this review indicated that the vast majority of entrants prior to this recent intake were fully supported by the Government (subclass 200). In this current cohort, there are a very high level of subclass 202 visas which in part explains the pattern of settlement which primarily is to areas in which the proposers have previously settled, creating geographical pockets with significant settlement and associated demand.

Refugee visa (subclass 200)
This visa is for people who are subject to persecution in their home country and are in need of resettlement. The majority of applicants who are considered under this category are identified by the United Nations High Commissioner for Refugees and referred to the Australian Government for resettlement consideration.

Global special humanitarian programme visa (subclass 202)
The Special Humanitarian Programme visa is for people who, while not being refugees, are subject to substantial discrimination and human rights abuses in their home country. People who wish to be considered for a SHP visa must be proposed for entry by an Australian citizen or permanent resident over the age of 18, an eligible New Zealand citizen or an organisation operating in Australia.

- The high level of arrivals on 202 visas has resulted in unique challenges. As reported by respondents in this review, overcrowding is a common issue in the proposer's residence with many instances of combined families spanning multiple generations living in a single residence. Expectations that proposers have for the integration of the newly arrived family into their home and community can differ and be challenging and multiple examples of significant conflict were described. In some instances, this has resulted in restricted social connections for newly arrived families and also barriers to negotiating modifications to the residence to accommodate for elderly or disabled family members. Family violence was also raised as an issue by multiple respondents in this review in these combined family situations.

"This is not what I thought it would be like. It's worse here."
(Paraphrased comment from interview respondent)

A series of key health and wellbeing needs noted by respondents, reflected expected situations for populations that have fled persecution and danger and have experienced variable access to quality health care. There are also specific areas of need that are distinctive to this cohort and they are described below, grouped into the key life stages as relevant (Table 3).

Table 3: Key health and wellbeing needs in the Syrian and Iraqi refugee cohort

Life stage	Health and wellbeing needs identified
Children and adolescents	**Disabilities** were noted as prevalent amongst children and include: • Physical disabilities due to injuries and trauma sustained • Congenital conditions • Developmental delays. Significant experiences of **trauma** were noted with related impacts on **mental health**. Examples were given of instances where this had a flow on effect to fellow students and teachers who were exposed to disturbing behaviours and stories reflecting the trauma experienced within the school environment. Access to catch-up **immunisation** was noted as a key presenting issue. **Access to education** was also raised as an issue – whilst not directly a health and wellbeing issue, it was recognised for the important social determinant of health that it is. For the most part, entry into school is contingent on completion of English language classes. Waitlists for these classes for children were reported as overwhelming, thus delaying access to schooling and increasing the period of time that children and adolescents are not actively engaged in education. **Carer responsibilities** of older children for their elderly relatives were identified as an area for concern.

Life stage	Health and wellbeing needs identified
Middle years	Many refugees in their middle years were noted as experiencing **mental health** issues and sadness. A resistance to take up the offer of counselling was reported with very few of those identified with complex needs accepting a referral to Foundation House or other counselling services. One nurse explained that many people are *'not in the headspace to want to talk about it'* and that they *'feel they're in a safe space, don't want to dredge up the past'.* Many in this age group experience **chronic disease and related risk factors** such as hypertension and high cholesterol. One nurse noted that as many newer arrivals are more focussed on urgent social needs, such as housing, employment and navigating Centrelink processes, they are not ready to focus on their health needs. **Poor self-esteem** issues prevalent among highly educated professionals was noted. **Dental health care** was raised as a high need, with multiple clients noted as having waited in Lebanon, Jordan or Turkey for two years without access to dental health care. Delays and challenges experienced in securing **employment** were noted as a key factor influencing wellbeing. *"They arrive and are happy to be here and happy to be safe. In five to six-months' time, things start to go haywire for them and lots of mental health issues emerge."* Most nurses indicated **family violence** was a pressing health issue.
Older age group	The older age of this cohort of refugees brings with it health issues related to **chronic illness, physical and mobility constraints**. While one nurse mentioned that those over 65 years are referred for My Aged Care all described the high number of referrals for **mobility aids, physiotherapy and occupational therapy services**, and lamented the current, excessive waiting lists for these services. They reported concerns for this frail aged cohort of clients, **at risk of falls and disability**. Many have complications related to **chronic disease**, especially **diabetes**, or demonstrate significant **risk factors for chronic disease**, such as hypertension and high cholesterol.

It is important to consider these health and wellbeing needs within some important elements of context that impact on the effectiveness of the health care system in accurately assessing and responding to needs:

- Language and cultural barriers to engagement:
    - Whilst language barriers can be overcome through interpreter use in a direct way during active service provision, there can be impacts from differences in cultural meaning or assumptions and biases that both parties bring to a conversation and the level of engagement achieved. It can also limit contact that might otherwise occur outside of usual consultations initiated by health professional or client to raise queries or clarify next steps or information provided
    - Literacy (health and health system-related) can impact on the understanding of clients as to the nature and purpose of each interaction they have with the health system as well as how to navigate the complexities of our system. Examples include how they understand the recommendations or referrals that are made or their experience of preventative health care

- Quality and completeness of health information available:

- Refugees arrive with a health manifest that documents personal and health information completed at a pre-arrival health check – the quality, completeness of information and availability of the Health Manifest can differ substantially and may be limited to basic information on which to make judgements as to need and required referrals[vii]
- More comprehensive medical records or other documentation of health issues are often not available dependent on the circumstances by which the refugee has fled their country and their prior access to such information
- This can result in very limited information about conditions that may have been diagnosed and treated or requiring ongoing treatment prior to arrival as well as respondents noting that there were multiple health conditions and disabilities that had previously been undiagnosed
- A strong reliance on self-reported health and wellbeing information was noted by multiple respondents in this review with the challenges inherent in that process in terms of evidence to support or understand the diagnoses and previous or current treatment strategies as well as the particular challenges with overcoming language and cultural barriers where significant health issues were present.

Mental health was a very significant issue raised by respondents in this review process as well as being a well-documented issue in the literature. Pre-migration experiences that can include significant trauma, persecution, war and famine can, in and of themselves, impact on the process of transitioning into Australian society. The culmination of direct experiences of torture, physical and sexual abuse, separation from family, living in camps and detention centres can result in post-traumatic stress disorder in many refugees which can be exacerbated by social and cultural isolation, stress relating to accommodation and finances and lack of support upon arrival.[ii]

3.3 The policy context – Victorian and national

At a Federal level in Australia, decisions are made each year as to the number of humanitarian entrants and the states and territories that they will be settled to. Australia's response to the Syrian crisis included a one-off increase of 12,000 refugees to be accepted as humanitarian entrants over a two-year period, with 4,000 of those to settle in Victoria.

The Commonwealth Government provides funding for **Settlement Services** which include the provision of a range of supports usually within the first six- to twelve-months post-arrival. Health is one of a number of areas covered in the settlement process with other areas of focus relating to housing, financial support, education (including English language support), employment, laws, culture, community and recreation. The health component includes the identification of health needs (based on the information available upon arrival), providing orientation to health and referrals for health services. A Commonwealth Key Performance Indicator requires Settlement Services to refer refugees for a GP appointment to conduct a comprehensive health assessment within one month of arrival in Australia. Funding for Settlement Services is provided on a per capita basis which enables funded service providers to upscale their resources to respond to significant influxes of refugees into a particular region and cope with the increased demand that results.

Victoria was the first state in Australia to create an action plan to support the health and wellbeing of refugees in 2005, with the current plan covering the period 2014 to 2018[viii]. Under the framework of successive Refugee Health and Wellbeing action plans, Victoria has supported the provision of a range of services to support the provision of accessible and timely services for new arrivals, build the capacity of mainstream and specialist health services in refugee health care and empower and support refugees and their families to improve their health and wellbeing.

Figure 1 (reproduced from the Victorian Action Plan[viii]) outlines the responses to refugee health needs in Victoria including mainstream and specialist service responses as well as relevant partners and supporting services.

Figure 1: Cross-sector responses to refugee health needs in Victoria[viii]

1. Mainstream health services	2. Specialised CALD and refugee programs and initiatives	3. Partners and sector support
• Community health services • Dental health services • General practice • Mental health and drug and alcohol services • Maternity services and maternal and child health • Acute services • Specialist health services • Vision and hearing services • Aged care services • Local government services	• Language services (interpreting services and translated health information) • Refugee Health Program (formerly Refugee Health Nurse Program) • Refugee Health Fellows Program • Refugee and asylum health seeker clinics: hospital, primary care and outreach • Specialised torture and trauma counselling and support	• Victorian Refugee Health Network • Local refugee health working groups • Community advisory groups and organisations • CALD and refugee capacity-building services • Settlement services and asylum seeker support programs • Primary health organisations • Primary Care Partnerships

The specific service responses and programs of most relevance as context for this review are further described below.

Primary care responses for new arrivals: Two key parts of the health service system respond to newly arrived refugee families in Victoria:

- Medicare-funded primary care services offered by General Practices (Commonwealth-funded)
- Community Health Services funded by the Victorian Government implementing a social model of health and providing a range of programs and services in the community including, but not limited to, allied health, nursing and counselling.

Additional support for refugees in Victoria is funded by the State Government (DHHS) through the **Refugee Health Program** (established in 2005) and offered through Community Health Services in 17 LGAs where there are high levels of settlement. The core components of this program include:

- Refugee Health Program Statewide Facilitator role (0.8EFT auspiced by cohealth)
- Refugee Health Nurses who undertake health and wellbeing screening and assessments, referral co-ordination, link with GPs and provide education, case management and advocacy
- Allied health professionals, allied health assistants and bilingual workers
- Service Coordination guidance and special projects undertaken by Primary Care Partnerships.

In addition, the following supports are funded within Victoria to support refugee health service provision:

- The **Victorian Refugee Health Network** was established in 2007 and auspiced by Foundation House (The Victorian Foundation for Survivors of Torture Inc). The Network provides services, resources, protocols, training and networking opportunities for professionals working with refugees
- Specialist service responses – refugee fellows, immigrant and refugee health clinics
- Refugee Minor Program.

In response to the additional intake of Syrian and Iraqi refugees and to support the additional capacity that was anticipated to respond to the influx of arrivals, the Victorian government announced funding of $10.9 million over four-years in the 2016-2017 state budget[iii] to support:

- The co-location of three Settlement Health Coordinators at AMES Dallas and Sunshine – this role was established to support the AMES Case Managers who do not typically have a health background to interpret the health information provided upon arrival, identify required referrals and navigate the pathways to access for each family. The role also provides input into the case management of refugees with complex health needs and capacity building within AMES and liaison with health services
- The appointment of a paediatric fellow as an addition to the Refugee Health Fellows program (a Royal Children's Hospital (RCH) fellow providing co-located services with Northern Health and in the community)
- Catch-up immunisation program
- Language services
- Mental health and psychosocial support programs
- Boost to child and family services funding.

There are a series of key challenges in setting policy and the planning and funding of services in relation to enabling the timely provision of high quality health assessments for newly arrived refugee families and in providing services to address needs identified including:

- The constantly changing demographic profile of refugees and patterns of settlement which can be hard to predict and plan in advance. This is more of a challenge with the growth in arrivals under 202 visas whereby the concentration of refugee populations in a defined geographic area is likely to occur and place significant pressure on services in that catchment. This is likely to continue as an issue with timely provision of data on the numbers, demographics and patterns of settlement unlikely to improve
- The multitude of stakeholders, funding models, responsibilities for the provision of services across levels of government, sectors and the variation in models of care across services – this can make it very difficult for the refugees to navigate themselves as well as for Settlement Services and health professionals to identify pathways to timely access to the right care in the right place
- The provision of community health service core funding via an agreement that is negotiated every three years and based on predicted service demand – this does not enable the flexibility and responsiveness needed in times of unprecedented demand and is in contrast to Settlement Services that receive funding on a per capita basis and so can increase their human resources to respond to periods of high demand.

3.4 Models of Refugee Health Nurse care

Interview respondents were asked to comment on what they considered were the critical elements of effective models of Refugee Health Nurse care. Table 4 summarises the responses grouped into the following categories:

- Personal characteristics and skills of the nurses
- Critical elements of the model of care
- Enabling infrastructure and supports.

Table 4: Critical elements of effective models of Refugee Health Nurse care

Category	Elements identified by interview informants
The nurses	• Skilled communicator • Highly developed clinical and assessment skills – a capacity to make quick and good judgements • Skilled at working with interpreters • High level of empathy and sensitivity • Good connections with and knowledge of local services • Positive and productive relationships with GPs and settlement services • Clarity around professional boundaries.
The model of care	• Comprehensive assessment • Identification of support requirements • Onward referrals to address needs identified • Follow-up and additional consultations as required to ensure the clients are receiving the care identified and their needs are addressed • Education for clients on the health system in Australia, services available and how to navigate the system • Education to improve the health literacy of refugee families • Checking immunisation status and facilitating catch-up as required • Flexibility and responsiveness to the population and their presenting needs • An holistic approach reflective of the social model of health • Integration of the service within a multidisciplinary team.
Enabling infrastructure and supports	• Clinic space • Effective, reliable technology • Low burden of supporting administrative processes – efficient practice • Timely access to services • Effective, appropriate and dependable interpreter services • Support and debriefing for the nurses • Cultural awareness of service personnel within the service in which the Refugee Health Nurse clinic is operating • Timely access to onward referral sources including, ideally, bilingual GPs as well as timely access to community health and other services and programs as needed.

It is important to note that the original intent and focus of this review was to look at these three clinics and to consider them within the context of other models of Refugee Health Nurse care. Respondents mentioned what they considered to be more ideal models of care such as the YCH service for refugees

and asylum seekers who can self-refer and receive assessment and care from a multidisciplinary team including a GP, Refugee Health Nurse, allied health clinicians and a case manager at PANCH. This and other models mentioned will not be described further here as it is not relevant to compare a single discipline, single consultation response to a crisis of demand for initial health assessments to ideal models of care. This concept is further explored in the coming sections of this report which has focused on these unique responses and the transferable lessons that have arisen from this review.

4. Outer Northern Metropolitan Refugee Health Nurse Models of Care

4.1 The inception of the three clinics (Hillcrest and Hume Project)

These three models of Refugee Health Nurse-led assessment were instigated through flexible, creative and rapid responses to an unprecedented and growing challenge.

"It is a crisis response – there was going to be a disaster headline. These people have been through enough torture and trauma that they were fleeing from. The camps had done the best that they could do and they arrive here with hope to an alien environment and country with no idea how to navigate. The situation was not ideal."

The unprecedented demand placed enormous pressure on local health services, which were stretched beyond capacity within their fixed funding model. The unexpected influx of arrivals impacted significantly on Dianella Community Health Service's capacity to meet the refugee health service demands due to the concentration of settlement in Craigieburn and Broadmeadows. An AMES respondent noted that *"they'd effectively closed their books."* AMES Case Managers were working with an increasing number of new arrivals and struggling to find pathways to timely refugee health nursing care through the existing community health channels in the catchment areas where the families were settling.

The establishment of the three clinics demonstrates an agile, decent, quick response to change - flexible service models borne from strong partnerships, grounded in altruism. Ultimately the models demonstrate a commitment by services outside the Hume catchment that value the health and wellbeing of new arrivals, higher than a focus on confinement of services to geographic boundaries. Initially, the clinics provided health assessments for families who had been on a waiting list. Over time, this has shifted to being newer arrivals – a more ideal application of this model of care.

The Hume Project

In December 2016 AMES Settlement Services Australia and DHHS requested assistance from PVCH to help alleviate the demand for refugee health assessments in the Dianella Community Health (Dianella) catchment. Whilst it was outside of PVCH's catchment area and thus responsibility, PVCH's Manager of Community and Clinical Services met with the PVCH Refugee Health team who agreed to assist. Some funding was identified that could be reallocated for this purpose and support through the PVCH Executive sought.

The outcome that was achieved was the provision of nine Refugee Health Nurse clinics per fortnight providing an initial health assessment and referral services to the refugee community in the Hume region, from February 2017. This is separate from and intended to be complementary to GP assessments that have ideally occurred in the first month following arrival. This included existing nursing staff who were able to take on additional hours to operate these clinics as well as an additional nurse, recruited externally, to join the team.

Initial joint service planning work between PVCH and Dianella regarding additional Refugee Health Nurse support into the Hume catchment, comprised canvassing shared clinical room space and shared work opportunities for nurses. However, these arrangements were not able to be implemented within timelines due to the sustained and pressing operational constraints experienced by Dianella. In this context Dianella, whilst not able to join the Project evaluation steering group, has provided clear endorsement for the planned delivery of additional Refugee Health Nurse supports by in the Hume metropolitan area.

One of the Settlement Health Coordinators at AMES Australia had previously worked at Dianella and was able to assist initially in drawing up health information guidance to support the Refugee Health Nurses.

Further locations were then considered. Consultations ensued with AMES, DHHS, Northern Health and the RCH Refugee Fellows that resulted in PVCH instigating two new co-located models of Refugee Health Nurse-led care (known as the Hume Project):

- A partnership with Northern Health to deliver a nurse-led refugee health assessment clinic from the Craigieburn Health Service. This clinic has run in parallel with a paediatric refugee clinic delivered by the RCH Refugee Health Fellow at Northern Health, Craigieburn[1]
- A partnership with AMES Australia to deliver nurse-led refugee health assessment clinics at their Dallas site.

Community Health GP clinic model

The YCH Hillcrest public private Refugee Health Nurse assessment model was initiated through connections between the Statewide Facilitator of the Refugee Health Program and the Hillcrest Clinic Director. The timing of discussions aligned with YCH's capacity to support one of their Refugee Health Nurses to operate a refugee health assessment clinic from Hillcrest.

A memorandum of understanding was developed between YCH and Hillcrest outlining the partnership and associated roles and responsibilities of the two agencies and the agreement to trial a six-month one-day per week co-location of the YCH Refugee Health Nurse at Hillcrest Health Centre in Broadmeadows. The partnership and ensuing arrangement, a creative response to the influx of refugees into the Hume region, was described by a key informant as a benevolent exchange, supported by the Director's commitment to the refugee community, rather than as a business enterprise.

Before the clinic commenced, the Refugee Health Nurse and the YCH Primary Care Manager consulted with the Practice Manager and conducted refugee health education for Hillcrest nurses and administrative staff who had not experienced refugee health service provision in the past.

Hillcrest Director and GP registrars met with the Victorian Refugee Health Network GPs for a briefing prior to the establishment of the clinic.

Nurses running the three clinics provide assessment for families of variable sizes (2-10 members) within a 90-minute allocated period. One family attends per clinic for assessment, with the rest of that day's clinic time allocated for initiating referrals, writing and faxing letters, and other administrative tasks. One nurse explained that she can spend up to 4-5 hours of administration after assessing a large family.

Nurses refer refugee clients to Dianella Community Health's allied health services for ongoing care. YCH clients assessed at Hillcrest are also referred to the Hillcrest GPs for ongoing care. To date very few refugees have taken up the referrals to see Hillcrest GPs, instead opting to see Arabic speaking GPs that they have previously connected with.

4.2 Comparing and contrasting the three clinics

Table 5 provides a summary of each of the three clinic models across a series of dimensions of the model of care, location, management, systems and tools supporting service provision and funding.

[1] The RCH Northern Health partnership preceded the approach to Northern Health for the Hume Project (the paediatric clinic commenced in January 2017 at Craigieburn and the Hume Project clinic followed in February 2017). The efforts of RCH to establish their clinic were considered to be important in enabling the PVCH Northern Health partnership.

Table 5: The Hume Project clinics and Hillcrest – a summary

	YCH Hillcrest	PVCH AMES	PVCH Northern Health
Location	Hillcrest Health Centre Broadmeadows General Practice with 9 GPs, 5 nurses, 6 administrative staff and a practice manager. Additional services include onsite pathology and pharmacy	AMES Australia, Dallas site	Craigieburn Health Service, Craigieburn (a campus of Northern Health)
Service model characteristics	YCH Refugee Health Nurse (0.2 EFT) operates a clinic once per week on a Friday	Nine clinics per fortnight offered in early months (0.9 EFT), currently eight clinics operating per fortnight (0.8 EFT)	PVCH Refugee Health Nurse (0.1 EFT) operates one clinic per fortnight (aligned time-wise with the RCH Paediatric Refugee Health Fellow's clinic)
Dates	Clinic established in April 2017 for a six-month period (completion date 24th November 2017)	Clinic established in February 2017	Clinic established in February 2017
Clinic reach	~70 refugees have been seen in this clinic by the Refugee Health Nurse. Only a small number of referrals to GP services within Hillcrest have been taken up	364 clients seen to end of October 2017 across the two PVCH-run clinics	
Refugee Health Nurse profile	Jamuna Parajuli is the Refugee Health Nurse operating this clinic. Jamuna has extensive experience as a Refugee Health Nurse including 10-years at YCH, 1-year at Dianella and 5-years' experience in working with Bhutanese refugees in a camp in Nepal In addition to this clinic, Jamuna also works 0.6 EFT for YCH including within the YCH PANCH refugee health clinic	Four Refugee Health Nurses operate these clinics: • Kiran Virik works 0.4EFT for this initiative providing two clinics per week • Muhamad Salom works 0.1EFT for this initiative providing one clinic per fortnight • Ros O'Toole works 0.2EFT for this initiative providing one clinic per week • Lisa Scott works 0.2EFT for this initiative providing two clinics per fortnight respectively In addition to these clinics at AMES, each of the nurses have other Refugee Health Nurse roles within PVCH or, for one, as a Settlement Health Coordinator at AMES	Ros O'Toole runs this clinic and has other Refugee Health Nurse responsibilities within PVCH including work within the City of Whittlesea and at AMES Dallas (Hume Project clinic)

	YCH Hillcrest	PVCH AMES	PVCH Northern Health
Management	YCH employs the Refugee Health Nurse and is responsible for human resource management. Professional supervision is provided by YCH Primary Care Manager	PVCH employs the Refugee Health Nurse and is responsible for human resource management. Professional supervision is provided by Director of Community and Clinical Services	PVCH employs the Refugee Health Nurse and is responsible for human resource management. Professional supervision is provided by Director of Community and Clinical Services
Referral mechanisms	Clients are referred by Case Managers from AMES Dallas, supported by Settlement Health Coordinators. Sometimes referrals are also received from Spectrum settlement support services	Clients are referred by Case Managers from AMES Dallas and managed via centralised intake	Clients are referred by Case Managers from AMES Dallas and managed via centralised intake
Model of care	Refugee Health Nurse conducts a single health assessment of one family on each clinic day. The family are seen as a group in a 90-minute consultation with interpreter support. Consultations ranged from 2 to 8 family members in this clinic	Refugee Health Nurse conducts a single health assessment of one family on each clinic day. The family are seen as a group in a 90-minute consultation with interpreter support. Consultations can be up to 9 family members in a single clinic	Refugee Health Nurse conducts a single health assessment of one family on each clinic day. The family are seen as a group in a 90-minute consultation with interpreter support. *"It could be a family of one or six"*
Interpreting services	Phone-based translators from TIS are booked prior to each session	VITS on-site interpreters are booked for each clinic using DHHS-funded refugee credit line	VITS on-site interpreters are booked for each clinic using DHHS-funded refugee credit line
Relationship to other services and/or providers	• Referrals flow primarily to Dianella, with some clients referred to Hillcrest GPs • Refugee Health Nurse communicates directly with the family's nominated GP to access and communicate information	Good working relationships with the AMES Case Managers and Settlement Health Coordinators	• RCH Paediatric Refugee Health Fellows operate their clinic (RCH and Northern Health partnership) in parallel with this clinic and provided a recent precedent for co-located services in partnership with Northern Health that paved the way for this clinic model to be established • On occasion, the Refugee Health Nurse will sit in on a consultation with a family who has been referred to the paediatric clinic

	YCH Hillcrest	PVCH AMES	PVCH Northern Health

Systems and tools to support the clinic model	• Hillcrest provide the clinic space and internet access
	• Nurse has own laptop and links in with YCH TRAK database
	• Assessment based on the Victorian Refugee Health Network Refugee Health Assessment tool with a focus on the non-clinical items of the assessment which are expected to be covered by the GP assessment process within the first month after arrival
	• Notes are taken by hand during the clinic attendance
	• After the family has left, referral letters are prepared and sent via fax primarily to Dianella allied health and other relevant services
	• The nurse also keeps a journal of handwritten notes and reflections on each clinic for reference
		• AMES provides clinic space (a non-clinical environment) and IT access linked to PVCH Client Management System
		• Refugee Client and Family Worksheet used as assessment tool, adapted from the Victorian Refugee Health Network Refugee Health Assessment tool
		• Client activity is logged into the PVCH TRAK database
		• Referrals created either:
		  ○ online via Connecting Care which links to allied health and other services and to the client file in TRAK (one of the Refugee Health Nurses)
		  ○ OR through the creation of letters that are scanned and faxed or posted with scanned copies uploaded to TRAK
		• PVCH purchased nursing equipment for clinic use
			• Northern Health provides clinic space and a computer that has been set up to enable the Refugee Health Nurse to log in to the PVCH system
			• Refugee Client and Family Worksheet used as assessment tool, adapted from the Victorian Refugee Health Network Refugee Health Assessment tool
			• Client activity is logged into the PVCH TRAK database
			• A template created by colleagues and included in TRAK is used for notes and to generate correspondence to GPs and Case Managers
			• Referrals are generally handwritten and scanned and faxed or included in a typed letter

Support within the service for the clinic and role	• Refugee Health Nurse works closely with a GP registrar within Hillcrest • 2 registrars have a particular interest in refugee health • The Director, practice nurse and reception staff are supportive of the model	• The support of the PVCH Director, Clinical and Community Services is valued	• Reception staff greet and direct patients to the clinic • The RCH Paediatric Refugee Health Fellow is supportive of the model • Support was also noted from peers at PVCH

	YCH Hillcrest	PVCH AMES	PVCH Northern Health
Funding and costs including in kind contributions	• Refugee Health Nurse funded by YCH • Interpreter services subsidised by DHHS with shortfalls covered by YCH • GP consultations (should they occur post-referral from this clinic) are Medicare funded • Clinic space, landline phone and internet access provided by Hillcrest (in kind)	• Refugee Health Nurses and required equipment funded by PVCH • Additional one-off funding provided by DHHS will enable service provision to meet continuing demand in 2018 • Interpreter services accessed using the DHHS credit line funded by DHHS • AMES provides clinic space, desk, phone, computer and reception support	• Refugee Health Nurse funded by PVCH • Additional one-off funding provided by DHHS will enable service provision to meet continuing demand in 2018 • Interpreter services accessed using the DHHS credit line funded by DHHS • Northern Health supports use of clinic space, desk, computer, phone and reception support

All three clinics evolved through the determination of leaders in community and refugee health at PVCH, YCH, AMES, cohealth and DHHS. Their commitment to the health of new arrivals created the basis for collaboration that enabled the rapid establishment of the three clinics in response to the spike in demand and unacceptable waiting times at Dianella. The three co-location models demonstrated out of the box thinking and cross-catchment service delivery – taking the service to the clients in need.

The three models initiated to address the demands for health care in the Hume corridor were all based on co-location and partnerships. The Hillcrest model was the only public private partnership and had the most engagement with GPs, compared to those within the Hume Project.

While all clinics had been operating for a relatively short time, approximately 430 clients had been assessed from February to October 2017, earlier than they would have if the clinics had not been established. This will have provided significant relief to Dianella and reduced waiting list size and pressure.

Table 6 provides an overview of benefits proposed by informants of the Hume Project and Hillcrest clinic models.

Table 6: Perceived benefits of the Hume Project and Hillcrest clinic models

Hillcrest YCH	Hume Project
• A benevolent model based on the goodwill of both partners • Co-location with GP services, GP upskilling, and therefore ability to build GP capacity in refugee health • Preparation of clinic staff through education on refugee health • Benefits for clinic staff from nurse's extensive expertise and support in refugee health and in booking and working with interpreters • Increased capability of GPs in refugee health • Nurse reports role extremely rewarding • ~70 clients assessed in 4 months	• Partnerships and support from Royal Children's Hospital and Northern Health • Strong, collegiate working relationships with AMES Dallas Case Managers • Nurses report rewarding role and pride in their work • Craigieburn location very accessible by public transport, close to clients' residences • Craigieburn co-location with the RCH Refugee Health Fellow's clinic was valuable for the nurse • The AMES Dallas co-location with staff was mutually beneficial for AMES settlement staff and the Refugee Health Nurses • ~ 350 clients assessed in 8 months

4.3 The role of partnerships in supporting integrated and sustainable models of care

Interview respondents were asked to comment on the role they saw that partnerships could play as well as what they have observed in relation to this particular initiative. The key themes arising included:

- Partnerships as enabling services to be taken to where the clients live and thus significantly improving accessibility
- The opportunity afforded by this situation and the resultant responses to demonstrate significant good will and a commitment by multiple service providers to pitch in and do what

they could to alleviate the situation with a focus on the critical needs for access for the families needing health assessments

- Highly valued partnerships created that have been critical to the success of this initiative as well as having other positive flow-on effects to the practice of Refugee Health Nurses, Settlement Services personnel (Case Managers and Settlement Health Coordinators), GPs and associated general practice staff and Refugee Health Fellows
- Improved communication, referrals and understanding of the challenges and needs of each discipline and service
- Reduced gaps and duplication of services and effort enabled by the partnership approaches considered to have increased the capacity for flexibility and responsiveness to identified needs.

4.4 What works well?

Interview respondents were asked to describe what they see working well in this model of care. The key themes arising included:

- Co-location of the clinics – this was highlighted as contributing to a range of benefits or improvements that were facilitated by the physical co-location including:
    - Communication
    - Understanding (of the role of each service and discipline, the value created and the challenges faced)
    - Continuity
    - Timely care
    - Access
- Collaboration across service providers who are working towards common goals in relation to the health and wellbeing of new arrivals
- The impact of the model on increasing the capacity of general practice to serve refugee populations within their practice
- The provision of health assessments for over 430 refugees in a timely way and their referral on to appropriate services as required
- Resource use – this initiative has clearly modelled a response that was created using a finite set of resources – *'doing the best we could with what we had to work with'*
- Funding for interpreter services – the DHHS VITS credit line was noted as a fundamental enabler of this initiative as interpreters are integral to service provision and the costs would have been prohibitive if the health services auspicing the nurses were carrying the full cost
- Having key leaders who acted as champions and were prepared to advocate for and enable the required support at all levels to make this initiative a reality in a very short time frame (December 2016 to February 2017)
- Taking a flexible approach to designing a model that would work with the resourcing available rather than a rigid or prescriptive approach from any of the parties involved.

4.5 Challenges experienced in the implementation of this clinic model

The three new clinic models were established rapidly and relied on existing and new collaborations and had only been running for up to eight months at the time of this evaluation project.

An analysis of the challenges identified by the Refugee Health Nurses, and other staff at each of the clinics is presented within this context.

Continuity of Care

Nurses reported that they would have preferred to be able to provide ongoing care to some of their clients, given the complex health care needs they encountered. All identified the 90-minute session allocated to assess a family, of often up to 8-10 members, as challenging, as it limited the quality of assessment they were able to provide for each individual and also introduced a barrier to the exploration of sensitive issues arising in the group context.

All nurses reported feeling frustrated by the inability to provide follow-up care, or to form an ongoing relationship with their clients. Some compared these limitations to models of care they provide in other clinics such as the PVCH outreach model in Whittlesea and the PANCH refugee health clinics, which were described as more realistic, offering greater insight into a family's dynamics, who would have had more of a sense they're being cared for.

Some cited particular concerns for the implications for good quality mental health care, given a one-off session with clients with mental health needs, who were not receptive to counselling during the assessment session.

Referrals – process and feedback

All nurses reported administrative aspects of the clinics that were not optimal, citing the time spent on manual methods for preparing and sending referrals, especially when larger families are assessed, requiring preparation of referrals for many individuals, for many services.

Delays, particularly for older clients who were falls risks was of particular concern. One nurse sensed that referrals may get lost in the system. Another who did not encounter these problems used the Connecting Care system whereby they can see when the referrals had been accessed.

The low health literacy of case managers has been identified as a barrier to effectively referring refugee clients into the health system, also reflected in the OPTIMISE partnership project report.[ix] Some nurses reported that the settlement services Case Managers had not been referring clients to them and sensed they were not aware of the role of the Refugee Health Nurse. They explained that after raising this with the Settlement Health Coordinators, most Case Managers now understand their role, and do refer clients to them, and some nurses receive feedback from Case Managers on their clients' progress. AMES Case Managers have also started to use Connecting Care. This has been directly influenced by working with one of the Refugee Health Nurses co-located at AMES Dallas and has improved the quality of referrals and capacity to review client progress.

Engagement with GPs

Most nurses lamented the poor connection with local general practitioners, citing insufficient if any information relayed to them from their clients' initial GP assessment. One nurse described that she regularly contacted GPs for information and cited incomplete initial assessments by some GPs. Nurses reported that they predominantly relied on clients to describe their health and medical situations, although some bought health records with them.

Some nurses assumed that GPs know about the availability of Refugee Health Nurse assessments, but prefer to refer to their co-located colleagues, or prefer not to complete the care plan required for referral to the nurse. Another said that '*GPs don't answer our referral letters*' and sensed that some clients were confused by GP care plans and unaware that they can change their GP.

The Refugee Health Nurse co-located with Hillcrest said she valued the ability to refer clients to, and work alongside, one GP in particular, who demonstrated an interest in refugee health.

Connection

All nurses interviewed reported feeling isolated to various degrees. They valued support from their community health managers, Refugee Health Nurse peers, Settlement Health Coordinators and Case Managers.

Professional education

Three of the four nurses interviewed were extremely experienced in refugee health. One had only been working in the field for around one year, and indicated some challenges, given her level of experience. While she indicated that the two-day training program offered by Foundation House was valuable, as it was not tailored specifically to nurses, most of her learning occurred on the job. It was suggested that additional training to deal with clients' complex emotional experiences would be beneficial.

The GP interviewed at Hillcrest indicated that her preparation to venture into refugee health was insufficient. While she found that meeting with a GP from the Victorian Refugee Health Network offered some basic education, she required more specific, practical infomation related to care pathways, specialist providers, useful contacts, guidelines on complex cases (for example, suspected tuberculosis), guidelines for local referrals and information about pathology test wait times. While the Refugee Health Nurse was helpful, she said that time she spent on researching the information she needed was frustrating.

Language services

Some interviewed, indicated that in some cases, the interpreter services were not optimal. Sometimes the interpreter was cancelled, some were provided with the wrong language, and in some cases male interpreters were allocated inappropriately for women's health consultations, which led to rescheduling of appointments for clients.

Ongoing GP care

The intention for the establishment of the Hillcrest model was that clients would be referred by the Refugee Health Nurse for ongoing care to the clinic GPs. This did not occur often, and when seeking reasons why, it was assumed that clients preferred to see a GP who speaks their language, or they return to their initial GP, or those whom their families attended.

Hillcrest staff, including a GP interviewed were very keen to be able to provide refugee health GP services to their community. The Refugee Health Nurse was disappointed that this was not happening as often as was intended.

The GP interviewed also indicated that a number of clients booking in for follow-up sessions would not present for their appointments. It may be that the clinic is still in its early days and that encouraging Case Managers to refer clients to the Hillcrest GPs for their initial assessment may improve the situation in the future.

Other challenges

Other challenges to the Refugee Health Nurse models identified during the interviews included:

- Limited time to assess the models, which had been running for between six and months at the time this review commenced
- Use of PCs rather than portable laptops by nurses required location in the clinic room to process referrals and conduct other administration
- Client confusion with so many services and providers within the system

- The physical location of Hillcrest – it was suggested that it may not be easily accessible by local refugee clients
- The sustainability of the business model for Hillcrest was raised
- Different rules for different models of Refugee Health Nurse assessment services
- Hume not funded for catch-up immunisation for adults.

4.6 Opportunities to enhance the co-located models of care

Given the challenges identified, those interviewed also made suggestions for opportunities to improve or enhance the co-located models of care.

Collaboration with GPs

- Consult with GPs to improve their understanding of refugee health clinics, find out what they need to become engaged with the models, and provide essential tools to support their service
- Ensure GPs involved in co-located services are well prepared
- Engage GPs who speak the clients' language or have refugee health experience.

Engagement with settlement health coordinators and case managers

- Educate all Case Managers about the Refugee Health Nurse clinics and assessment process and the GP co-location model
- Continue to enhance relationships with Settlement Health Coordinators.

Integrated model

Integrate aspects of other successful models of refugee health assessment that were cited during the interviews, if possible. Positive aspects of these models were described:

- the integrated approach, whereby GPs are on site with paediatricians, psychologists, allied health professionals who meet weekly, and whereby the GP sees clients with the nurse.
- all forms are pre-populated and every person is seen separately as an individual, rather than as a family group
- Refugee Health Nurses are more involved in follow-up and send reminders to clients for ongoing appointments.

Reduce isolation

Nurses proposed some suggestions to reduce their sense of isolation included:

- Adopt a buddy system and other models of peer support among nurses across clinics
- Engage regularly with the Refugee Health Nurses and provide updates on humanitarian arrivals
- Provide additional training for managing complex cases as required
- Utilise digital communication, such as skype sessions to facilitate connections.

Administration

- Reduce the reliance on manual administration processes and systems, to improve time management and efficiency and utilise core tools such as Connecting Care to streamline and improve information flow and accessibility
- Consider the use of laptops to improve flexible work practices, if resources enable this.

Appendix 1 – Project governance and key informants

The Outer Northern Metro Refugee Health Nurse Initiative Case Study Steering Group has overseen this project. The membership of the Group is included in Table A1.

Table A1: Steering Group membership

Steering group member	Title/role	Organisation
Max Lee (Chair)	CEO	Hume Whittlesea Primary Care Partnership
Kath O'Donnell	Manager, Primary Care	Your Community Health
Louise Sharkey	Director of Community and Clinical Services	Plenty Valley Community Health
Lindy Marlow	Statewide Facilitator, Refugee Health Program	cohealth
Angela Soupourmas	Senior Program Advisor, Health Integration and Partnerships, Hume Moreland Area	Department of Health and Human Services, North Division

Thirteen individual or group interviews were conducted via telephone or in person with a total of 15 key informants (listed in Table A2).

Table A2: Interviewees

Key informant	Title/role	Organisation
Sarah Daly	Senior Manager, Humanitarian Settlement Programs	AMES Australia
Natalie Henry	Settlement Health Coordinator	Dianella Community Health (Located at AMES Australia, Dallas)
Cathryn Liebau	Registrar	Hillcrest Health Centre
Jan McFeeter	Research and Policy Projects Officer	AMES Australia
Lindy Marlow	Statewide Facilitator, Refugee Health Program	cohealth
Kath O'Donnell	Manager, Primary Care	Your Community Health
Ros O'Toole	Refugee Health Nurse	PVCH (Located at Craigieburn Health Service)
Jamuna Parajuli	Refugee Health Nurse	Your Community Health (Located at Hillcrest Health Centre)
Muhamad Salom	Refugee Health Nurse	PVCH (Located at AMES Australia, Dallas)
Lisa Scott	Settlement Health Coordinator	PVCH (Located at AMES Australia, Dallas)
Louise Sharkey	Director of Community and Clinical Services	PVCH
Angela Soupourmas	Senior Program Advisor, Health Integration and Partnerships, Hume Moreland Area	Department of Health and Human Services, North Division
Kiran Virik	Refugee Health Nurse	PVCH (Located at AMES Australia, Dallas)
Bob Willis	Director and GP	Hillcrest Health Centre
Lisa DePetro	Practice Manager	Hillcrest Health Centre

Interviews explored the following questions in addition to further discussion relating to key elements of context and roles to usefully inform this review:

- What are the health and wellbeing needs of refugees in the City of Hume?

- What are the critical elements of effective Refugee Health Nurse models of care?
- How would you describe the model of care (under review in this project) and the similarities and differences between the three clinics?
- What is the role that you see partnerships can play in enabling integrated and sustainable models of care and how have you observed partnerships in action in these clinic models?
- What are your perspectives on the overall effectiveness of these models?
    - What works well?
    - What doesn't work so well?
    - What could be improved?
- Please comment on the capacity of the City of Hume to meet the needs of the current and anticipated population of refugees?

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