

# Refugee Health and General Practice Development Program

## Final Report

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on behalf of the  
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## **Program Steering Committee:**

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- Dr John Stanton, Manager, General Practice Unit, Department of Human Services
- Dr John Carnie, Manager, Infectious Diseases Unit, Department of Human Services,
- Dr Graham Tallis, Infectious Diseases Unit, Department of Human Services
- Ms Sue Ekkel, Asylum Seekers Assistance Scheme, Australian Red Cross
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- Ms Annerose Reiner, Program Manager
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## Executive summary

This is the final report and evaluation of the *Refugee Health and General Practice Development Program* (GP Program), a state-wide inter-divisional initiative undertaken in collaboration with allied health, infectious disease and mental health experts and general practice organisations.

The Western Melbourne Division of General Practice was the lead agency, with the Victorian Foundation for Survivors of Torture, being contracted to undertake significant components and serve as a program base. The Program was funded by the Commonwealth Department of Health and Aged Care.

The Program was overseen by a steering committee comprising representatives of each of the collaborating organisations and was centrally coordinated by a Program Manager based at the VFST.

It was implemented between March 2000 and September 2001, with the following aims:

- Supporting Victorian general practitioners (GPs) to provide comprehensive and coordinated care to Humanitarian program entrants and other patients from refugee like situations
- Enhancing the capacity of Victorian GPs to contribute to the early identification and management of physical and psychological health problems in recent arrivals and other patients from refugee backgrounds.

The range of program activities identified in the funding contract were implemented as follows:

PROGRAM ACTIVITY	IMPLEMENTATION
Establishment of program base and identity	<p>Accommodation established at VFST.</p> <p>Program Manager (0.8 EFT) appointed.</p> <p>Program logo and letterhead designed.</p> <p>Population data compiled.</p> <p>Data base of GPs and allied health care workers established.</p>
The development of a state-wide network of GPs with a particular interest in refugee health care	<p>Refugee Health and General Practitioner Network formed, comprising 12 active and 114 corresponding members.</p> <p>Terms of reference developed.</p> <p>Five meetings held.</p> <p>Ongoing communication via e-mail.</p>

PROGRAM ACTIVITY	IMPLEMENTATION
Development of clinical guidelines for general practitioners caring for refugee patients	<p>Guidelines developed and documented in the form of <i>Caring for Refugee Patients in General Practice: A Desk-top Guide</i>.</p> <p>Guidelines piloted in 18 general practice settings with 72 refugee patients.</p> <p>Guidelines refined on the basis of the pilots and prepared for publication (800 copies).</p> <p>Contributed to surveillance study conducted by the Royal Melbourne and Royal Children's Hospitals, on the basis of which detailed management guidelines for infectious disease developed.</p>
A system for up-dating the Guidelines with infectious disease and mental health experts	Immigrant Health Clinics established at Royal Children's and Royal Melbourne Hospitals have agreed to assume responsibility for ongoing guidelines development.
Professional development programs for GPs	<p>Two professional development programs developed, piloted and documented, including:</p> <ul style="list-style-type: none"> <li>▪ An advanced level program for GPs with a particular interest in the psychological and human rights aspects of refugee health care.</li> <li>▪ A practice visit program designed to be delivered to GPs and practice staff on an outreach basis by allied health professionals.</li> </ul> <p>43 GPs and practice staff participated across both programs.</p>
Research and advocacy to identify and address constraints faced by GPs in providing care to refugee patients	<p>Research was one of the objectives of the practice pilots.</p> <p>Findings recorded in the form of a report to serve as a basis for advocacy with government and general practice organisations.</p> <p>Meetings held with Victorian Department of Human Services to discuss the establishment of a refugee health assessment program to be delivered through key public hospitals and community health centres. Proposal currently under consideration.</p>
Development of systems for information exchange, peer support and debriefing among GPs	<p>Provided in context of GP Network (see above).</p> <p>Ongoing arrangements for providing this support explored in the practice pilots and documented in report.</p>

PROGRAM ACTIVITY	IMPLEMENTATION
Dissemination	<p>800 copies of first edition of the <i>Caring for Refugee Patients in General Practice: A Desk-top Guide</i> distributed to GPs across Victoria through Divisions of General Practice and program professional development activities.</p> <p>Posted on the web-site of the RACGP.</p> <p>Other dissemination activities conducted throughout the Program (see report).</p> <p>Plan for the dissemination of the revised desk-top guide and other program resources developed.</p>
Program Evaluation	<p>Subject of this report.</p> <p>Framework developed by evaluation expert and implemented throughout the Program.</p>

Overall some 169 GPs had contact with the Program with 55 GPs participating actively across the pilots and professional development activities.

The Program has three specific resource outcomes as follows:

- A resource manual documenting the professional development programs for replication in Victoria and nationally.
- A report of the general practice pilots, including an analysis of the key policy implications.
- *Caring for Refugee Patients in General Practice: A Desk-top Guide*, with the revised edition incorporating the findings of the general practice pilots and other program activities.

For reasons discussed further in this report there were some delays in program commencement and the practice pilots were of a significantly larger scale than anticipated in the funding contract. Accordingly, the above resources are currently being finalised, with the VFST meeting the outstanding salary costs associated with coordinating this process.

The Program has resulted in a high degree of momentum around refugee health, and is identified as a central contact point for health care providers and others.

Together the program activities have resulted in the development of a cohesive group of GPs with a high level of interest and expertise in refugee health care. As well as serving as an important resource to refugee patients, these GPs are an identifiable group whose expertise could be tapped by government for policy and service development initiatives in refugee health.

Formal evaluation of the Program indicates a high degree of satisfaction among key stakeholders. There has also been considerable interest nationally, with copies of the *Caring for Refugee Patients in General Practice: A Desk-top Guide* being published by the Program, on behalf of, and distributed by refugee health agencies in each state and territory (some 2,000 copies were distributed in this way with the NSW Refugee Health Service requesting a similar arrangement for the revised edition).

Critical to the success of the Program (and in particular the Refugee Health and General Practitioner Network) was the existence of a central base for bringing key players together and coordinating program activities. If this base were to continue, however, further funding would be required.

A number of opportunities were identified in the course of the Program to build on its knowledge and resource base and extend program initiatives to a wider range of GPs, in particular those in rural Victoria.

These are identified in Appendix 1 of this report. A submission developed by the collaborators to seek funding to extend the Program was developed. However, to date funding has not been forthcoming.

# 1 Introduction

## 1.1 Background to the Program

In 1998, the Western Melbourne Division of General Practice (WMDGP) and the Victorian Foundation for Survivors of Torture (VFST), a counselling and support agency for people subject to trauma and torture prior to their arrival in Australia, collaborated to produce the *Refugee Health and General Practice Handbook* and an accompanying professional development series.

At this time, a number of general practitioners in the Western Melbourne Division were seeing patients from conflicts in the Former Yugoslavia, the Middle East and East Africa. Many were struggling to meet their needs, dealing often for the first time, with people with war related trauma and complex settlement support needs; with infectious and parasitic diseases rarely seen in Australia and with sensitive cultural issues such as female genital mutilation. Most of these patients, being in the process of learning English, had specific language needs. The VFST, meanwhile, were experiencing some difficulties in identifying GPs to whom they could refer clients.

The aim of this early collaboration between the VFST and the Division was to enhance the capacity of general practitioners in the Western Region to care for refugee patients. In the course of its implementation, however, it became increasingly apparent that while written resources and professional development were important, other improvements were also required to enable general practitioners to provide appropriate and sensitive care to people from refugee backgrounds. Further, with new arrivals settling across Victoria, refugee health was clearly a concern to a number of other Victorian General Practice Divisions.

Accordingly, in 1999 the WMDGP and the VFST sought the involvement of other Victorian Divisions and relevant infectious disease, mental health and general practitioner organisations to develop a proposal for funding for the *Refugee Health and General Practice Program*, a state-wide initiative incorporating a range of strategies to support general practitioners working with refugee patients.

Developed with the assistance of the VFST, the submission was lodged by the WMDGP, as the lead agency, on behalf of itself and the Monash, Dandenong, Greater South Eastern and North-West Melbourne Divisions of General Practice.

The Program was funded by the Commonwealth Department of Health and Aged Care through the General Practice Innovations Pool and was administered by the Australian Division of General Practice Ltd.

The VFST was subsequently contracted by the participating Divisions to provide support and assistance in the coordination and implementation of the Program and to serve as its administrative base.

While funded for a two-year period from June 1999 to August 2001, owing to some delays in finalising contractual arrangements, the Program commenced operation in March 2000.

This report documents and evaluates activities undertaken since the commencement of the Program in March 2000.

## 1.2 Program evaluation

The contract specified that an evaluation be conducted upon completion of the Program. The Centre for Development and Innovation in Health (CDIH) attached to the Institute for Primary Care; Latrobe University was contracted to work with program staff to draft an evaluation framework shortly after the commencement of the Program. The framework was subsequently approved by the Program Steering Committee.

Data for the evaluation was collated throughout the various phases of the Program.

Since the evaluation needed to be completed within the funding period, emphasis was placed on evaluating the process of the Program and its strengths and weaknesses. Where possible, however, assessment of Program impact has also been made.

The purposes of the evaluation were:

- To demonstrate the extent to which accountability requirements to the funding body were met.
- To assess the extent to which the Program objectives were met.
- To identify the strength and weaknesses of the Program.
- To identify if the strategies used to meet the objectives were relevant.
- To assess whether the overall Program implementation and facilitation was satisfactory.
- To provide information to determine future directions.

The specific tools and information sources used to evaluate each of the Program components are documented in relevant sections of this report. They included a range of quantitative and qualitative approaches including:

- checklists
- questionnaires
- face-to-face and phone interviews
- focus groups
- a journal maintained by the Program Manager
- records maintained in the course of the Program (eg minutes, attendance lists).

The evaluation involved representatives of all key groups involved in the Program including members of the Steering Committee, GPs, staff of the VFST and participating Divisions of General Practice.

## 1.3 Why the Refugee Health and General Practice Development Program?

Australia accepts some 12,000 people from refugee backgrounds through its Humanitarian program annually. Other people from 'refugee-like' circumstances also enter through the mainstream family migration program. It is estimated that around one in eight of the 32,000 people entering through this program in 1999-2000 originated from countries from which Australia currently accepts refugees (DIMA 2000; NSW Health 1999).

Humanitarian program entrants originate from regions such as the former Yugoslavia and the Horn-of-Africa where they have endured conflict and persecution. It is estimated that one in four have been subject to torture or severe human rights violations, with almost three in four having been subject to traumatic events such as forced dislocation, prolonged political repression, refugee camp experiences and loss of or separation from family members in violent circumstances (VFST 1998; Reid and Strong 1987). Many will not have had access to high quality, patient orientated health care for many years. Studies show that, as a consequence of these experiences, people from refugee backgrounds have a relatively

high rate of physical and mental health problems (Lehn 1997).

As the first health professional most people will see following their arrival in Australia, GPs have an important role in providing health care and in serving as a gateway to medical specialists, allied health and social support professionals.

In the context of a general practice consultation, people from refugee backgrounds have a number of special needs. They

- will usually require a professional interpreter.
- may have physical and psychological sequelae associated with trauma and torture.
- may need a thorough medical examination. Formalised post arrival health screening is no longer offered in Victoria. Pre-arrival screening is limited and selective, being conducted for the purposes of selecting the person for entry to Australia. With the exception of serious communicable disease, there is no post arrival follow up of issues identified in the course of screening.
- may be struggling with the practical tasks of settling into Australia and not know where to get assistance.
- may have limited understanding of the culture and structure of the Australian health care system and the role of the general practitioner within it.
- may require an approach to consultation and management which accommodates the impact of past trauma, prior experience of health care, cultural and language differences and the stresses of settlement.

The experience of the VFST and GPs working with them suggested that there may be a number of barriers to providing this care including:

- That GPs may not identify refugee patients presenting to their practice.
- The relatively poor remuneration under Medicare for the longer consultations and extra-consultation activity required to accommodate the language and other complex needs of refugee patients.
- Limited information upon which to base health assessment (particularly in relation to infectious diseases).
- Difficulties in engaging a professional interpreter.
- Difficulties in working in a coordinated fashion with allied health care providers.
- Limited professional experience among GPs in caring for people effected by war-related trauma.
- Limited access to the peer support and debriefing that may be required when working with highly traumatised patients.

The purpose of the *Refugee Health and General Practice Program* was to engage relevant General Practice Divisions and mental health and infectious disease experts to develop a number of activities with the aims of:

- Supporting Victorian GPs to provide comprehensive and coordinated care to Humanitarian Program entrants and other patients from refugee like situations.
- Enhancing the capacity of Victorian GPs to contribute to the early identification and management of physical and psychological health problems in recent arrivals and other patients from refugee backgrounds.

## 1.4 Planned program activities

In the contract between the WMDGP (as the lead agency) and the Australian Division of General Practice it was agreed that the following program activities would be undertaken to meet the aims of the Program:

- Establishment of administrative and collaborative arrangements and a program identity.
- Development of a network of general practitioners with a particular interest in refugee health care.

- Development and piloting of clinical guidelines for the assessment of recent arrivals from refugee backgrounds.
- Development of professional development programs targeted to GPs with differing levels of interest in and contact with refugee health care.
- Promotion of the Program and dissemination of specific products.
- Conduct of an evaluation of the Program.

This report documents and evaluates activities undertaken in each of these areas.

## 2 Program administrative and collaborative arrangements and identity

### 2.1 Contractual arrangements

The contract between the VFST and the WMDGP was finalised on January 6, 2000.

A Program Manager was appointed for an 18 months period (March 2000 to September 2001) at 24 hours per week. In September 2000, recognising the work load demands associated with the Program, the WMDGP allocated further funds from the program budget, enabling the Program Manager's hours to be extended from 24 to 32 hours per week.

The Program Manager was integrated into the agency infrastructure of the VFST, being part of the Program Development Team and working closely with VFST counsellor-advocates. Office accommodation was established for the Program Manager (including computer, office furniture, filing systems etc). She had access to the agency's professional expertise and administrative support.

Regular meetings between the WMDGP contracts manager and the manager, along with informal e-mail and telephone contact were held to monitor the contract and ensure that appropriate support was offered to the VFST.

### 2.2 Program management

In the original submission it was proposed that two separate bodies be established to provide advice and direction to the Program - a Steering Committee (comprising representatives of participating Divisions) and a Reference Group (comprising other expert collaborators).

However at the commencement of the Program, it was agreed that in the interests of

administrative efficiency and optimising communication and coordination, one body would be established representing both Divisions and expert collaborators (referred to as the Steering Committee).

The first meeting of the Steering Committee was held on the 5 April, 2000. It met at three months intervals throughout the Program with a total of six meetings being held. The committee was responsible for the overall direction and implementation of the Program (see Appendix 4, Terms of Reference).

Membership of the Steering Committee is outlined on page 5 and included representatives from:

- Participating Divisions of General Practice (both Program Officers and GPs)
- The Victorian Transcultural Psychiatry Unit (VTPU)
- The General Practice and Infectious Diseases Units, Department of Human Services
- The Asylum Seekers Assistance Scheme, Australian Red Cross
- The Infectious Diseases Unit, Royal Melbourne Hospital and Melbourne University
- VicHealth
- General Practice Divisions Victoria
- Refugee communities (two representatives)
- The Victorian Foundation for Survivors of Torture (VFST).

The Steering Committee was chaired by Paris Aristotle, Director VFST and resourced by the Program Manager and provided with minutes of meetings, regular progress reports and discussion or issue papers.

Advice and consultation was sought from committee members throughout the Program and many were actively engaged in various program activities (eg the briefing sessions for GPs participating in the pilot of guidelines; trialing the checklist for the pilots study).

### 2.3 Program identity

A program logo and letterhead were designed with the aim of establishing a clear program identity. The identity promotes the Program as a collaborative venture and acknowledges the input of all formal contributors. The logo was subsequently used for any promotional activities.

### 2.4 Program database

A database of GPs with an interest in refugee health care and other relevant stakeholders was established for the purposes of facilitating communication.

The database was continually expanded throughout the Program and will be maintained by the VFST. At the time of writing, it has 249 entries, 168 of whom are GPs.

One hundred and fourteen of these GPs were recommended by allied health agencies as having a particular interest in refugee health and are corresponding members of the GP Network (see below).

The database was used in the course of the Program to distribute information relevant to GPs in their care of refugee patients, for example the findings of the African Health Study, described below, or the new emergency contact number established by the Telephone Interpreter Services (TIS) for GPs.

### 2.5 Program promotion

Since its commencement the Program has been promoted widely through a number of media including divisional newsletters, mail-out, journal articles, and on the worldwide web.

Specific initiatives included:

- E-mails to all Victorian Divisions including summary description of the Program and promotion of the GP Network for inclusion into divisional newsletters.
- Mail-outs to GPs on the database including a complimentary copy of *Caring for Refugee Patients in General Practice: A Desk-top Guide* (see Section 6).
- Promotion of the Network of General Practitioners and its various activities through dissemination of minutes and promotional fliers for forthcoming information sessions.
- Promotion of the pilot of the clinical guidelines and recruitment of GPs for participation.
- Publication of companion articles in the *VGD Quarterly Newsletter* (Number 3/2000) on inter agency cooperation in providing care to people from refugee backgrounds. The first article, providing the divisional perspective, was written by Dr Vladimir Vizec (then Chair at WMDGP). The second, providing the perspective of an allied health agency working with GPs, was prepared by Paris Aristotle and Kim Webster (VFST). The articles describe the development of the collaboration between the WMDGP the VFST and highlight the benefits arising from these links for both the agencies and client group alike (Appendix 2).

- *The Current Therapeutics* (December 1999/January 2000 Issue) published an article highlighting the role of Australian GPs in refugee health care. This article was a collaboration of Dr John Stanton, Manager, General Practice Unit, Department of Human Services, Dr Ida Kaplan, Coordinator of Clinical Services VFST and Ms Kim Webster, Coordinator Program Development Team VFST (Appendix 3).

This and other articles have been used widely for promotion and induction of interested GPs.

- Establishing a page providing a description of the Program and relevant contact details on the web-site of the VFST.

## 2.6 Planning data

With the assistance of the Department of Immigration and Multicultural Affairs Population Planning Unit, a profile of refugee settlement across Victoria and within Victorian Divisional catchments was developed.

As well as being used for planning and evaluating specific Program activities, this data was made available to Divisions to assist them in better understanding the size and characteristics of refugee populations within their catchments.

## 2.7 Evaluation mechanisms

At the end of the Program, an evaluation questionnaire was sent to all committee members to:

- Assess the extent to which members of the Steering Committee believed that the aims and objectives of the overall GP Program were met.

- Assess the extent to which members of the Steering Committee believed that the administrative functions of the Program were fulfilled satisfactorily (eg its effectiveness as a point of contact, distribution of relevant information and resourcing of the Committee).
- Assess the extent to which members of the Steering Committee were satisfied with the individual program components.

A total of seven completed evaluation sheets were returned. The relatively low number of responses may be due to the fact that the evaluation corresponded with the busy pre-festive and holiday season with members apologising for not having the time to respond due to other demands placed on them.

Committee minutes and other program documentation was also reviewed.

Feedback was sought from four Divisions of General Practice not directly involved in the Steering Committee to assess the extent to which these divisions were aware of the Program. Brief telephone interviews were held with the executive officers or program officers from the Melbourne, Inner Eastern, Mornington Peninsula and North East Valley Divisions of General Practice.

## 2.8 Evaluation findings

### 2.8.1 Strengths

- Overall committee members were highly satisfied with the facilitation and resourcing of the Program.
- The Program base has developed a strong identity and a distinct role as a centre for inquiries, information exchange, cooperation, networking and the cross-fertilisation of ideas on refugee health.

- A range of expertise and resources are required to develop and coordinate strategies to support GPs in caring for refugee patients. For the first time in Victoria, the Program has brought together GPs, key infectious diseases and mental health agencies and relevant government policy and planning personnel concerned with refugee health care.
- The Program's location at the VFST:
  - Promoted links between individual GPs and VFST counselling personnel, thus promoting coordinated care of refugee patients.
  - Provided a link between GPs and the Program, since VFST counsellor-advocates were able to promote the Program in the course of their contact with GPs.
  - Allowed the Program to draw on the expertise and infrastructure of the VFST.
  - Allowed the Program to consolidate its identity relatively quickly (with the VFST having an established reputation as a provider of counselling and health assessment programs to refugee communities).
- The Steering Committee has served as an important vehicle for ensuring that refugee health care initiatives (undertaken both as part of and in addition to the Program) are appropriately coordinated and actively involve GPs.
- The inter-divisional structure and involvement of GPs in program management meant that the Program was able to engage a large number of GPs in its activities.
- The involvement of the General Practice and Infectious Diseases Units of the Victorian Department of Human Services have enabled policy issues raised in the course of the Program to be brought to the attention of government.

For example, in the course of the Program the Department of Human Services requested a meeting with key members of the Steering Committee to discuss strategies for enhancing the role of hospitals and community health centres in post arrival health care. The Department has subsequently drafted a proposal for a formalised health assessment program which, at the time of writing, is being considered by the Victorian Government.

- The clear program identity has allowed collaborators to feel a sense of ownership of, and investment in the Program.
- Members of the Steering Committee have contributed their expertise in a range of activities and made themselves available as consultants throughout the life of the GP Program. They also enabled access to the infrastructure, resources and networks of their respective organisations. For example, General Practice Divisions Victoria convened a meeting of relevant state and commonwealth government policy officers for a presentation on the key findings of the Program.
- The Steering Committee included divisions in four of the five major metropolitan Divisions of General Practice in whose catchments people from refugee backgrounds settle
- As a result of the Program, there is now a database of GPs with interest and expertise in refugee health, for ongoing use by allied health care workers and others working with refugee patients. The Program is frequently approached by agencies for 'refugee friendly' GPs for the purposes of liaison and referral.

### **2.8.2 Weaknesses**

- There was a general consensus that the Program would have been enhanced if more intensive effort had been placed into promotion and creating linkages between it and GPs and GP Divisions. However it was acknowledged that this would have been difficult given the time and resource demands associated with other program activities.
- Those Divisions who were not directly involved in the Program reported that their contact with it and awareness of it was relatively limited. These Divisions, however were actively involved in distributing the Desk-top Guide and appreciated this resource.
- While the Program involved four of the five Divisions with a large proportion of refugees in their catchments, there are small numbers of refugees in other metropolitan catchments. Further there are two regional Divisions, Geelong and Goulbourn Valley, with significant refugee populations. If the Program were to be extended, consideration would need to be given to ways of engaging other metropolitan and rural Divisions. It is of note that the GP Association of Geelong and the Melbourne and Goulbourn Divisions of General Practice have expressed interest in participating in an extended program.

### **2.8.3 Key learnings**

- One of the purposes of having representation of the GP Divisions on the Steering Committee was for them to act as a link between the Divisions and the Program (eg by including program material in divisional newsletters, promoting activities to GPs). While some divisional representatives played this role well, for other Divisions, links were not well maintained. In part this was due to changes in staff and GP representation in the course of the Program. Divisions of General Practice have a range of competing demands on their time and resources. The experience of this program was that maintaining divisional engagement required a significant investment of Program Coordinator time.



## 3 The Refugee Health and General Practitioner Network

### 3.1 Rationale for strategy used

An important component of the Program was the establishment of a network of general practitioners with a particular interest in refugee health care to serve as a focus for professional development, information exchange and peer support.

It was also intended that the Network would provide a forum for communication between GPs directly involved in caring for refugee patients and the program particularly for developing strategies for peer support, debriefing and professional consultation.

It was intended that the Network, once established would be self-sustaining. The contract specified that three meetings of the Network be held.

The process of establishing the Network, and lessons learned, were documented so that they could be incorporated into the professional development resource manual *Building Capacity in Refugee Health: A Training Resource Manual for GPs, Allied Health Workers and Providers of Professional Development* to serve as a resource for organisations interested in establishing similar initiatives (see Section 6).

### 3.2 Promotion

The Network and its meetings were widely advertised, with material being regularly sent to relevant Divisions of General Practice for inclusion in their Newsletters. Promotional letters were sent to all those GPs on the newly established mail list. Once the meetings had commenced minutes and materials produced as a result of the meetings were mailed to all Network participants and corresponding members.

### 3.3 Process and content development

The formative meetings of the Network were held in May and June 2000. A role statement and terms of reference were developed by participating GPs (see Appendix 4).

On the request of those GPs participating in the formative meeting of the Network, the meetings were structured to comprise two parts – the first an expert presentation and a case study provided by one of the participating GPs and the second a discussion of identified agenda items relevant to the Network.

Three sessions were developed in consultation with participating GPs and addressed broader contextual and settlement issues of concern to people from refugee backgrounds eg pre-migration experiences, entitlements, psychological issues (see table below).

All but the formative network meetings were approved by RACGP as a Continued Medical Education (CME) activity and were awarded two CME points per hour.

To enhance the accessibility of the Network to GPs, the venues for the meetings were rotated between Parkville (close to the central business district) and the Monash Division of General Practice in Melbourne's south eastern suburbs. Rural and other outer metropolitan GPs were offered participation via tele-conferencing. However, no GPs availed themselves of this resource.

The Network has some 12 core GP members and around 114 corresponding members.

Meeting	No GP participants	Title / Content	Expert presenters
1	8	Formative	Ms Annerose Reiner Program Manager  Ms Kim Webster Coordinator Program Development Team
2	7	Formative	Ms Annerose Reiner Program Manager  Ms Kim Webster Coordinator Program Development Team
3	12	Coming to Australia as a refugee - It's not that easy.  National and international policy contexts of the refugee and humanitarian visa categories and processing of protection visas.	Mr Gleb Webster Senior Migrations Officer
4	10	Helping patients from a refugee background through the maze. Refugees and asylum seekers and service entitlements: Placing refugee patients into context of early settlement.	Ms Sue Gail Refugee Settlement Worker
5	14	Taking the war experience to the new country. War related trauma: the psychological impact of the refugee experience and practical strategies for GPs	Dr Ida Kaplan Clinical Services Coordinator VFST

### 3.4 Evaluation mechanism

All Network meetings were evaluated by administering evaluation sheets to participating GPs, with a total of 30 evaluation sheets being completed (see Appendix 5 for a sample evaluation form). The findings represent the mean value of all GP Network sessions. This evaluation served both to meet the accreditation criteria for RACGP and for evaluating of the GP Network. As well as being asked to rate certain aspects of the Program on a scale from good to fair through to poor, input was sought on

- the good aspects of the sessions.
- how the sessions could be improved
- other topics GPs would like to see covered
- the three most important aspects of the meetings for GPs' personal learnings and
- whether the meetings were relevant enough to impact on practice management.

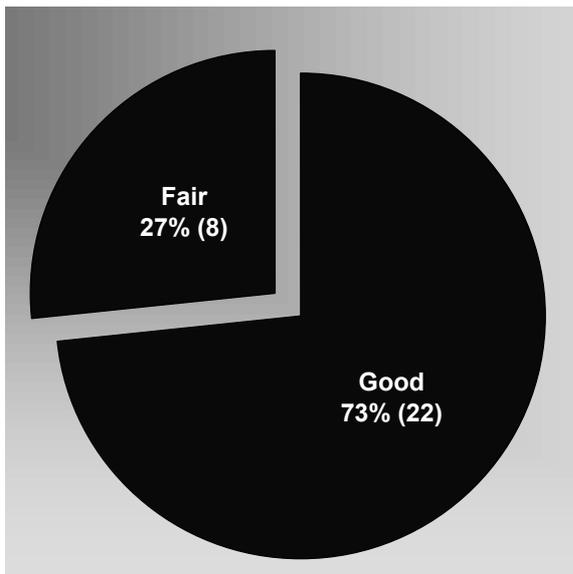
The Network for GPs was also evaluated as part of a focus group conducted for evaluating this and other program components (see below).

## 3.5 Evaluation findings

### 3.5.1 Sessions aims

As can be seen most GPs were of the view that the sessions met their aims well.

**Figure 3.1: How well did the presentation meet the aims specified for the sessions (n=30)**



When asked what they had learned from the sessions, GPs responses indicated that they had acquired:

- A good overview of refugee categories, assessment and processing of migration applications locally and globally.
- Improved information about services available to refugees and asylum seekers and the difference between refugees and migrants.
- Knowledge about the Asylum Seekers Assistance Scheme.
- A good overview of visa sub-categories and how they may relate to symptoms and recovery.

When asked what GPs believed were the three most important things they had learned, common responses included:

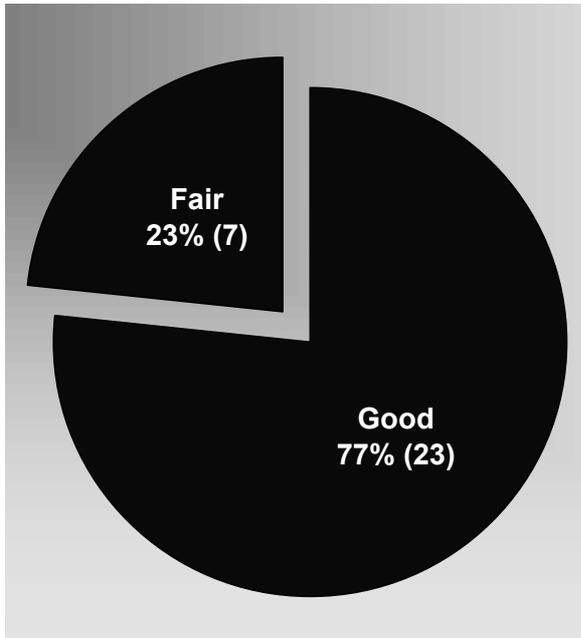
- The complexity of the refugee and asylum seeker situation, the stress and uncertainty associated with the processing of visa applications; and the impact of negative press reports on refugee issues on the health of refugees and asylum seekers in Australia.
- Different migration categories and how these determine service entitlements (in particular access to Medicare).
- The importance of the GP being aware of patient's visa status and country of origin so that they are able to better accommodate their needs in the consultation.
- The systemic nature of torture and its impact on the psychosocial wellbeing of the refugee.
- The importance of looking beyond presenting symptoms; to allocate adequate time for consultation and to express genuine interest in the patient's refugee experience and cultural background.
- The importance of coordination between agencies and health care providers.
- The value of displaying multilingual literature in GP practices.

Overall the responses were consistent with the learning objectives identified for the sessions. It was also apparent that the meetings were successful in meeting their peer exchange and support objectives. A strong theme emerging in the evaluation was that GPs found the sessions valuable in validating their existing skills, experience and knowledge in refugee health care. It was suggested that the program explore ways of pooling and documenting this.

### 3.5.2 Quality of learning experience

The majority of participating GPs reported that the sessions met their needs as a learning experience.

**Figure 3.2: How well did presentations meet GPs needs as a learning experience?(n=30)**



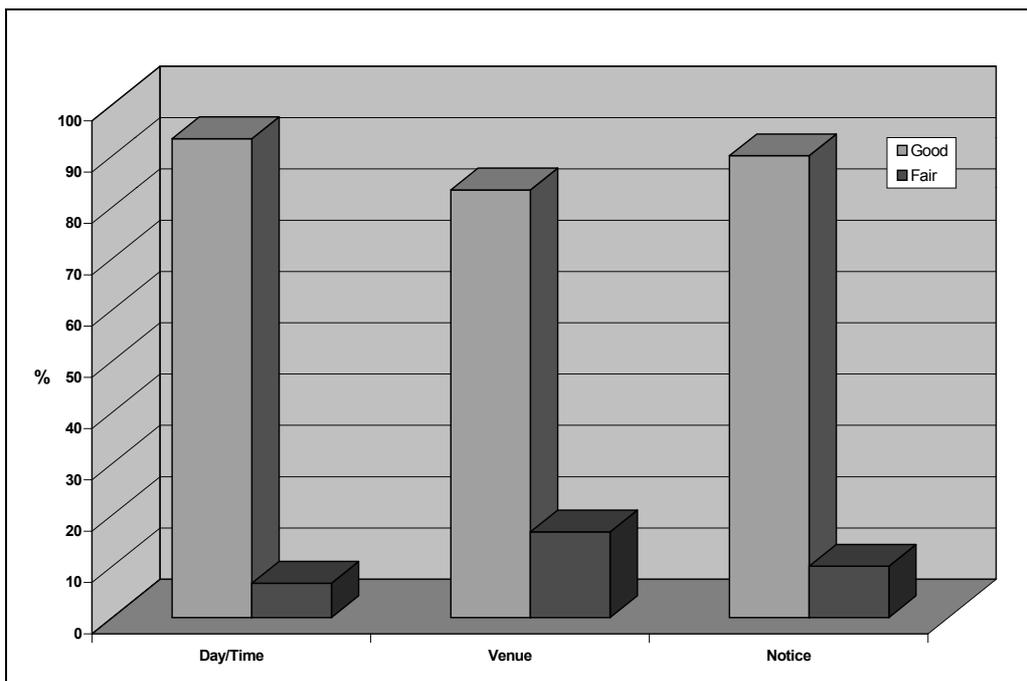
They reported that the information sessions were well facilitated with interesting and precise presentation. They appreciated the knowledgeable speakers and that all their questions were answered. GPs particularly valued the interactive discussion and case presentation. They also commented positively on the recommended reading.

When asked how the sessions might have been improved GPs noted that they would have appreciated more time for discussion, particularly of specific management issues and wider use of interactive learning approaches such as case discussions, case presentations and role plays.

### 3.5.3 Quality of overall planning

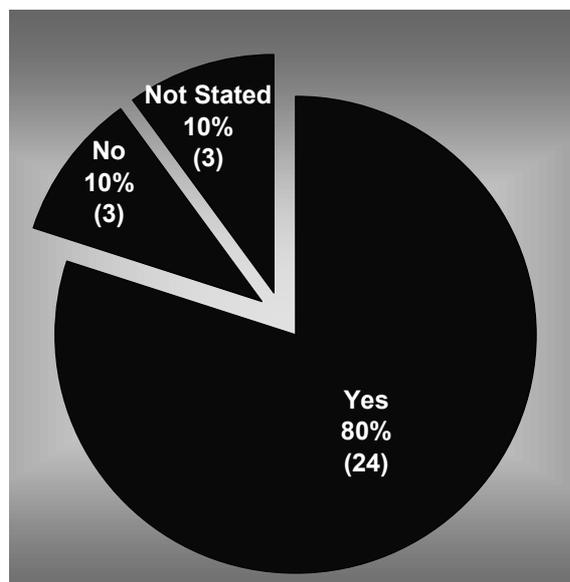
Most GPs were very satisfied with practical arrangements for the meetings. The number of GPs reporting that the location was fair is likely to reflect the difficulties in promoting geographic accessibility to a state-wide GP population.

**Figure 3.3: How well did the administrative and planning components carried out? (n=30)**



### 3.5.4 Relevance to and impact on Practice

**Figure 3.4: Was the session relevant enough to make a difference to practice? (n=30)**



Most GPs reported that the sessions did have an impact on their practice management.

They identified the following impact in particular:

- An increased awareness of the issues facing refugee and asylum seekers and the importance of taking account of the impact of torture and trauma in their practice.
- An increased awareness of the need to be more tolerant and less judgemental of patients from refugee backgrounds
- An increased ability to identify where to start working with refugee patients. This was thought to be important since many reported feeling overwhelmed by the complexity of the issues with which refugee patients often present.

One of the GPs reporting that the sessions would have minimal impact on practice believed that this was because the information provided was not sufficiently

detailed. Another noted that the potential for impact was limited by the fact that as an experienced 'refugee health' practitioner, she was aware of many of the issues raised in the sessions and was already implementing many of the strategies proposed.

The GP Network was organised in an open group setting that allowed GPs to attend one or all sessions. Although the majority of GPs participated on a regular basis other GPs attended selectively. Whilst this flexible structure was developed to attract GPs to the Network, responses to the evaluation questionnaires suggest those attending all sessions were more likely to report a positive impact on their practice than those attending selectively.

### 3.5.5 Future Needs

When asked what topics and skill areas they would like covered in future meetings GPs identified the following:

- The psychological impact of the refugee determination process for those seeking asylum in Australia and for those granted Temporary Protection Visas.
- More detailed discussion on the psychological manifestations of trauma, in particular Post Traumatic Stress Disorder (PTSD).
- The role of medication in the management of refugee related psychological sequelae.
- Social issues impacting on client health.
- Improved counselling skills.
- Specialist referral sources, options and systems and ways of improving referral processes.
- Issues relating to the Health Undertaking.
- Information about the ethnic groups settling in their area of practice to enable them to target their services effectively.

Following the first session GPs identified the need to better understand terminology, programs and acronyms used when describing refugee selection and settlement processes. A handout was subsequently developed by the Program Manager and distributed to GPs on the database with resource materials for that session.

### **3.5.6 The Role and Future of the Network**

As part of the evaluation, GPs asked if they wanted the Network to continue and, if so, what form they believed it should take; what role it should play and whether they could continue to meet independently or would require further support.

GPs overwhelmingly agreed that they wanted the GP Network meetings to continue.

They believed that it had an important future role in

- Ongoing education and research, particularly given the diverse and changing nature of refugee health issues.
- Providing updated information to GPs on available resources and refugee and health policy issues.
- Offering multi-disciplinary case conferences.
- Providing a forum for supervision and peer discussion (eg a role as a Balint Group).
- Documenting and writing about practice issues to share with each other and colleagues.
- Serving as a doctors' human rights group.
- Creating linkages between GPs via e-mail and the world wide web.
- Enhancing cooperation and referral between the VFST and GPs.

However, GPs noted that if the Network was to continue there would be a need for some administrative support, of the kind hitherto provided in the context of the *Refugee Health and General Practice Development Program*. This was particularly the case given that most members are in private practice and have limited time and resources to engage in activities not directly related to client care.

### **3.5.7 Strengths**

- The contractual arrangement stated that a total of three GP Network meetings be held during the life of the GP Program. The Program has exceeded this aim, conducting a total of five meetings.
- The Network has, for the first time in Victoria, formally brought doctors with an interest in refugee health care together and has offered them resources to further develop and consolidate their skills.

### **Value for GPs**

GPs response indicated their high level of appreciation for the Network as a forum to meet colleagues with a common interest in refugee health care, to raise practice issues, learn from each other's experience and to validate own experiences in working with refugee patients.

- Network members formed a core group who developed their knowledge on refugee issues (pre-and post migration) in a coherent manner. This was particularly the case for those GPs who attended all meetings and who had been part for the formative meetings during which the topics of the presentations were identified.
- A significant factor contributing to the success of the Network has been the fact that the information sessions were awarded points under RACGPs CME professional development activities program. This helped to engage some GPs who might not otherwise have

participated by providing a focus for discussion and providing an immediate and tangible benefit (in the form of CME points).

- After completion of the formal Network meetings an e-mail network was established for those GPs who have this facility. GPs were supplied regularly with selected information on lectures, conferences and talks relevant to refugee health. Positive feedback from GPs indicates that this service is highly valued.

#### **Value for the GP Program**

- The existence of the Network was important to the Program overall, with members contributing their views and experiences to planning of other program components. Network GPs contributed to the planning of the professional development strategy and participated in the pilots of clinical guidelines (see Section 5). Their input has been critical in ensuring that the Program remained responsive to the needs of GPs.

#### **Value for refugee patients**

- While this evaluation did not formally seek to assess the impact of program activities on practice and patient satisfaction, a number of the VFST counsellor advocates participating in the evaluation reported that they had received positive feedback from clients of GP Network members. They also reported that access to and cooperation with GPs who were Network members was enhanced.

#### **Value for Co-operation between GPs and other health care providers**

- The GP Network, and in particular the data base, has contributed to enhanced linkages between GPs and allied health care workers. With their permission details of individual GPs will be forwarded to the special immigrant

health clinics being established at the Royal Melbourne and Royal Children's Hospitals for the purpose of linking clinic clients with a 'refugee responsive' community based GP. Similarly GPs prepared to provide free services for Medicare ineligible asylum seekers were linked with the Asylum Seekers Assistance Scheme (ASAS). The Network has also provided an important source of referral for counsellor-advocates at the VFST.

#### **3.5.8 Weaknesses**

- The contractual agreement stated that the Network would be state-wide and include urban and rural GPs. Although tele-conferencing was offered to enable rural GPs to participate this option has not been taken up. While a small number of rural GPs attended Network meetings and registered on the database, the overwhelming majority of participants are from practices located in metropolitan Melbourne. Consultations with rural GPs indicate that local interventions would be critical to engage rural GPs.
- The intention was that the Network would be self-sustaining after the life of the Program. While the Program was successful in establishing a cohesive group of doctors, its members have identified the need for ongoing administrative support if they are to continue to meet as a group.

#### **3.5.9 Key learnings**

- Through the process of establishing the Network, the Program developed a more sophisticated understanding of the needs of GPs and ways of facilitating their involvement.
- In developing a Network of this nature a practice orientated focus (in this case the CME points) is critical, particularly in the early phases. This provides an important incentive for GPs to attend

and a focus for meeting less tangible objectives which might have less immediate appeal to GPs (eg peer support).

- Consultation with GPs is vital in the planning phase and to ensure responsiveness to their needs and interests are met.
- The information gathered in the context of establishing and facilitating the GP Network is valuable and once documented will provide guidance for those agencies that intend to establish a similar initiative.
- To attract GPs to the GP Network and to retain their interest it was critical that the presentations were of high quality. This is particularly the case since GPs face many competing demands on the limited time available to them to participate in professional development and other non-practice activities. GPs require up-skilling on a range of practice issues and other training providers offer competitive incentives for participation.

### **3.5.10 Future directions**

As indicated above, GPs have a strong interest in the Network continuing, further funding or administrative support will be critical if the momentum gained in the Program to date is to be built upon (see Section 8).

## 4 Professional development

### 4.1 Rationale for strategy used

The purpose of the professional development programs was to promote a comprehensive and holistic approach to refugee health care developed in the handbook *Refugee Health and General Practice* and summarised in the guidelines *Caring for Refugee Patients in General Practice: A Desk-top Guide* (see Section 5 and 6).

In summary this approach encourages GPs to

- Offer people from refugee backgrounds who have recently arrived in Australia an overall health assessment structured over several consultations (ie to go beyond the presenting health concern).
- Give particular attention to patient care issues (eg using interpreters, orientating to Australian general practice).
- Attend to psychosocial and settlement support issues through assessment and referral.

In order to apply this approach GPs require knowledge and skills in

- Identifying patients with a refugee background.
- Understanding the nature of the refugee experience and its impact on health and health care.
- Assessing the physical and psychological sequelae of torture and trauma.
- Identifying local support agencies and facilitating referrals to and working cooperatively with them.
- Engaging professional interpreters to facilitate patient consultations.
- Specialist referral and prescribing practices that contain the costs of care for refugee patients, in particular Medicare ineligible asylum seekers.

### 4.1.1 Professional development strategy

A professional development strategy was developed in November 2000 in consultation with both GPs participating in the Refugee Health and General Practitioner Network and direct services staff at VFST.

The Program took a strategic approach to professional development taking into account that GPs will have different levels of interest in refugee health care. It was agreed that this would comprise two components:

- The *Advanced Level Professional Development for GPs Working With Survivors of War Related Trauma*. This program, focussing on psychological assessment and management was targeted to those GPs with a particular interest in refugee health care.
- The *Educational Practice Visits Program*. This program was targeted to GPs who see a large number of refugee patients, but who have not identified a high level of interest in professional development in this area. It was intended that the Program, taking an approach akin to academic detailing, would address both physical and psychological health issues as well as those concerned with patient care. Recognising the important role other practice staff play in care (eg through booking interpreters, making appointments), it was agreed that the program would take a 'whole of practice' approach.

### 4.1.2 Resource development

All components of the Program were pre-tested and evaluated. Evaluation findings contributed to the refinement of the professional development programs, which were subsequently documented and developed into a training resource manual

*(Building Capacity in Refugee Health: A Training Resource Manual for GPs, Allied Health Workers and Providers of Professional Development).*

It was intended that this training resource manual would serve as a resource for the programs to be offered to a wider range of GPs by the VFST, other support agencies and general practice divisions in both Victoria and other Australian states and territories.

It was also envisaged that material in the manual may be incorporated into other professional development processes nationally and possibly internationally (eg; formal undergraduate and postgraduate medical courses; CME practice audits, general practice trainee ships).

#### **4.1.3 Accreditation**

Accreditation of all professional development activities was awarded by RACGP at two CME points per hour.

## **4.2 Advanced Level Professional Development**

A course outline was developed by the VFST's Coordinator of Clinical Services and principle trainer for this program and the Program Manager, based on the earlier consultation with GPs.

This outline was presented to the GP Network for appraisal and to ensure that their needs and expectations were accurately captured and reflected in the training outline (see below).

Given the intensity of the training it was proposed that the course be structured into three sessions of four hours length (4pm to 8pm) each to be conducted over a period of three months. This was determined in close consultation with GPs and attempted to balance practice demands with the need for intensive training time.

The program was offered in a closed group format and GPs were asked to enrol in all three sessions. Given the highly interactive nature of the program the group size was limited to 12 participants allowing GPs to be actively involved in discussion and case presentations. The advantage of this approach is supported by findings into the effectiveness of professional development for GPs which indicate that interactive strategies are more effective for reinforcing learning. This involves a combination of strategies, for example workshops with case discussions and rehearsal, chart reviews or examples by opinion leaders (General Practice 1998:202, Davis & Thomson 1998:133).

The monthly intervals between sessions allowed GPs to practice the new skills between sessions and to discuss their experience and emerging questions in the subsequent session.

#### **4.2.1 Content**

The Advanced Level Professional Development introduced the following content:

- *Psychological assessment and responding to patients with prior exposure to torture and trauma.*
- *Assessing psychological functioning:* This component including psychological functioning of patients with torture and trauma experiences and assessment of psychological functioning, including Post Traumatic Stress Disorder (PTSD).
- *The role of medication in alleviating psychological symptoms* including the role of medication in alleviating psychological symptoms in survivors of torture and trauma, the effectiveness of various medications and compliance issues and ways to address compliance and correct usage of medication.

- *Management of survivors of torture and trauma* included appropriate ways of offering psychological support, setting suitable goals for intervention, use of stress reducing techniques, dealing with distressed patients, therapeutic qualities of the doctor patient relationship and indicators for referral to other psychological or psychiatric services.
- *Support for GPs working with survivors of torture and trauma* including developing appropriate support systems, exploring ways for GPs to achieve a balance between empathy and professional distance.
- *The GP as a health and human rights advocate for survivors of torture and trauma* including principles and the role of GPs in human rights advocacy.
- *Report writing for asylum seekers* including understanding of the refugee determination process, the role of the GP in the assessment.

#### 4.2.2 Promotion

The Advanced Level Professional Development Program was offered to members of the GP Network and those GPs who participated in the pilot of guidelines (see Section 5) who had substantial knowledge and/or exposure to refugee health issues.

A brochure was developed and used to promote the program to interested GPs and some Divisions of General Practice. Because the demand for the program exceeded the number of places available no additional promotional activity was required.

#### 4.2.3 Evaluation mechanism

At the end of each session evaluation sheets were given to all participants. The final session was concluded with a reflective discussion about the training. This discussion was structured around specific evaluation questions prepared in advance.

The purpose of the evaluation was to:

- assess the value GPs assigned to the training
- assess to which extent the training met the needs and interests of GPs
- identify potential long-term impact GPs may anticipate as a result of the training
- identify other topic areas GPs might be interested in for further training
- identify ongoing support GPs may expect from VFST.

#### 4.2.4 Evaluation findings

The sessions were conducted in February, March and May 2001. Session one was attended by 16 GPs, session two by 13 and session three 10 GPs. Although fewer GPs attended the third session, this reflects the topic area, with the session being exclusively concerned with preparing reports for asylum seeker refugee determination processes. Indeed, given this, attendance at this session was somewhat higher than anticipated.

The sessions were divided into two parts including a presentation / lecture (with GPs being encouraged to ask questions throughout) and a case study. Time was also allocated for GPs to debrief and share their experience in applying their learning from previous sessions in their practice.

Prior to each training session participants received selected professional articles to familiarise themselves with the subject matter. They were also provided with copies of overheads used in the course of the training and further relevant literature was made available for review in the session.

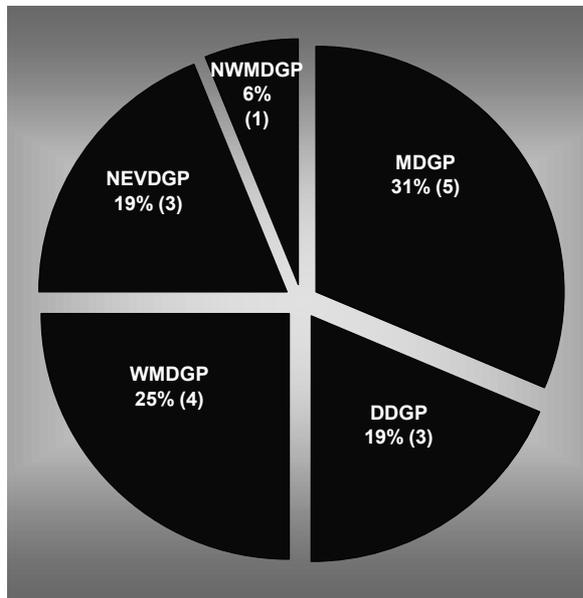
Overall 16 individual GPs participated with a total of 38 evaluation sheets being completed (see Appendix 5). A number of evaluation questions were included which asked GPs to rate the sessions on a scale from good to fair through to poor.

Findings represent the mean value of all three training sessions held.

#### 4.2.4.1 Characteristics of participating GPs

There was a larger number of female than male GPs. While there were equal numbers of GPs from private practices and community health centres, community health centre GPs were clearly over represented proportionate to their numbers in the GP workforce. Participating GPs came from the Melbourne (MDGP), Dandenong (DDGP), Western Melbourne (WMDGP), North Eastern Valley (NEVDGP) and North Western Melbourne (NWMDGP) Divisions of General Practice.

**Figure 4.1: Practice location participating GPs (n=16)**



#### 4.2.4.2 Session aims

As can be seen most participants reported that the sessions were successful in meeting their aims.

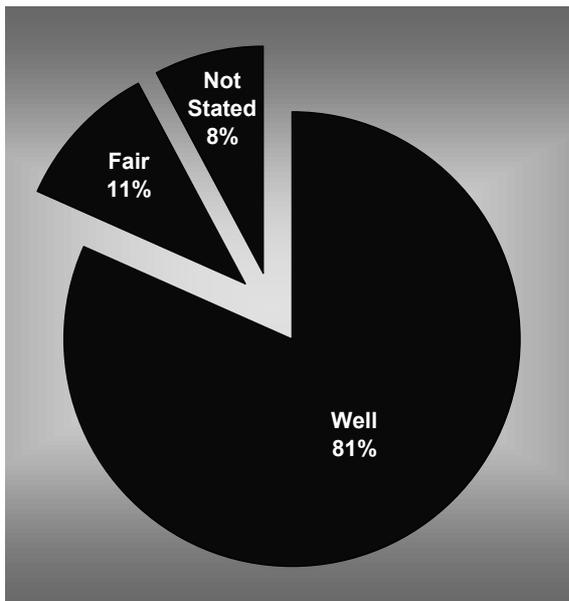
GPs were asked what were the most important things they had learned from the sessions. Consistent with the session aims, GPs indicated that they had learned about:

- The differences between various categories of refugees depending on their migration status eg temporary protection visa holders released from

detention centres and on-shore asylum seekers.

- The importance of country background information.
- The level of information that can be drawn from knowing the country of origin and visa category of the refugee patient.
- Links between health and human rights and the role of GPs in advocacy.
- Report writing for the refugee determination process.
- Defining and maintaining professional boundaries, including acknowledging the limitations of the role of the GP.
- The complexity of psychosocial symptoms in refugee patients and the high prevalence of Post Traumatic Stress Disorder.
- The importance of establishing rapport with patient and being non-intrusive and not having to resolve all problems in one consultation.
- The therapeutic nature of the medical consultation.
- The multifaceted nature of Post Traumatic Stress Disorder and underlying factors.
- Brief assessment tools for Post Traumatic Stress Disorder screening and diagnosis knowledge of typical reactions.
- Psychological therapies.
- Models of management.
- Approaches to discuss and explore symptoms with patients.
- The importance of acknowledging and accommodating cultural issues in counselling.
- Use of medication and specific medication regimens for the management of war-related trauma and associated psychological sequelae.

**Figure 4.2: How well did the presentation meet the aims specified for training (n=38)**



When asked what content areas they found particularly valuable, participants identified the following:

- The nexus between human rights and health.
- Conceptualising the role of GP in the context of refugees and asylum seekers.
- The provision of a frame work for management of PTSD.
- Approaches to psychological assessment including assessment tools that allow for a brief and GP oriented assessment of psychological functioning in survivors of torture and trauma.
- The therapeutic benefits of sensitive consultation.
- The role of medication.

Participants noted that much of what they had learned in the sessions would also be transferable to other client groups.

#### **4.2.4.3 Quality of learning experience**

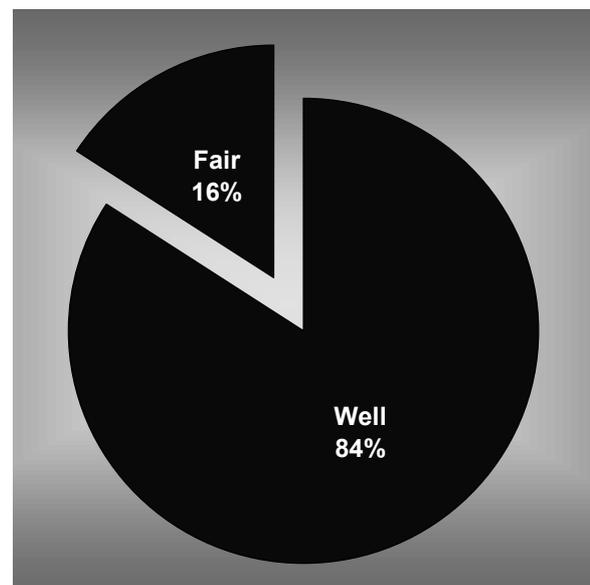
The majority of participants rated the learning experience offered in the sessions as good. GPs commented that the trainer demonstrated a high level of understanding

of GPs and how they work and that the training content was very much in line with the way GPs work. They reported that the needs and interests of GPs were well met.

Other positive aspects of the sessions noted by participants included:

- That the sessions were comprehensive and well structured.
- That the speakers were well informed and competent.
- That both speakers and participants had a diversity of experience to share.
- The quality of the written resource provided to participants.
- That the training reflected principles of good general practice and how they could be applied in more unusual and extreme cases.

**Figure 4.3: How well did presentations meet GPs needs as a learning experience (n=38)**



Particularly positive comments were made about the interactive nature of the sessions and their role in engaging participants in peer support and exchange, including:

- The value of open discussion with other GPs.
- Interactive group discussion.

- The opportunity to ‘compare notes’ with fellow GPs.

While overall, participants appreciated the exploratory and participatory nature of the sessions, a small number of participants asked for more factual information.

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*‘This training was very stimulating. I am now more willing to accept refugee patients; before I considered them as very time consuming and therefore not as rewarding. In the past I had difficulties in believing the stories I heard and the reasons for that. It was so beyond normal experiences. This has changed.’*

*‘This training has helped to be more trusting. I will work on a one-to-one and policy level. There is lots of hostility in the media about refugees coming to Australia. The professional support in this group is very valuable (little pockets of good energy).’*

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When asked how the sessions might be improved, GPs suggested the following:

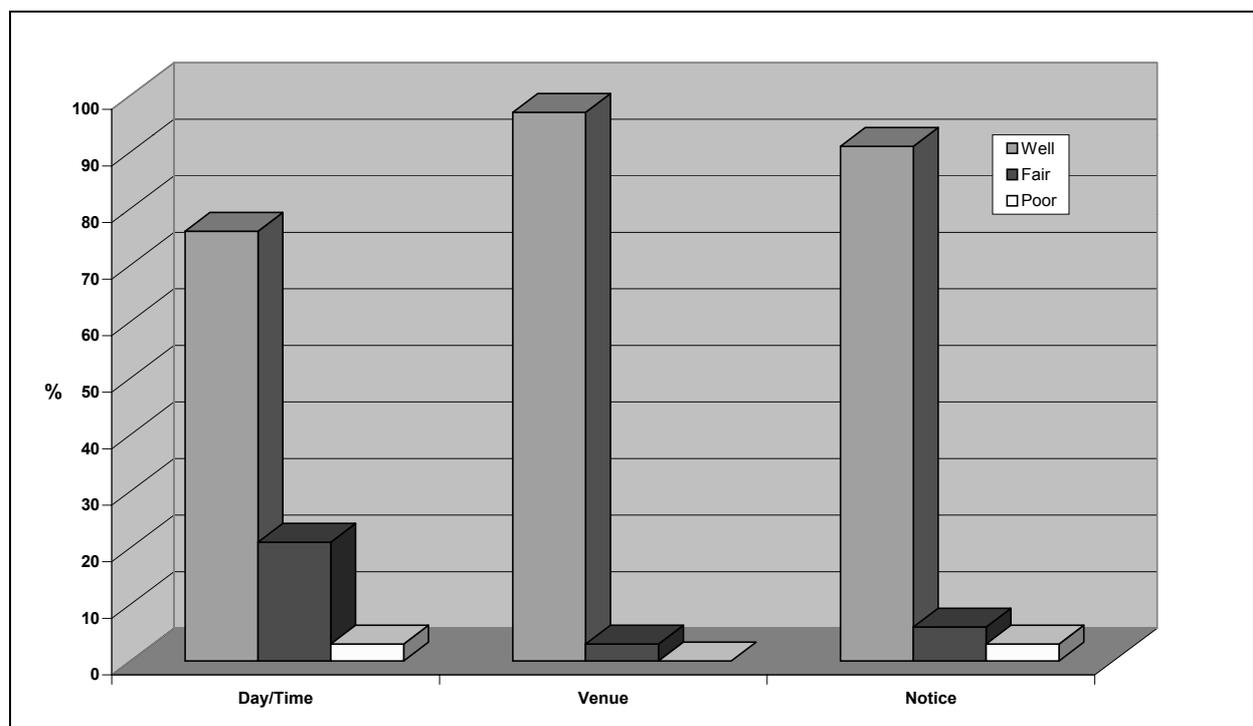
- More time for general and reflective discussion.
- Wider use of case studies and management examples (particularly for PTSD).
- Opportunities for debriefing with colleagues around the personal implications of caring for a highly traumatised patient group.

Participants identified an interest in receiving copies of over-heads and handouts on pharmacotherapy. These were subsequently forwarded to all participants.

#### 4.2.4.3 Quality of overall planning

While participants rated the overall planning as good, a significant proportion reported the time of the sessions as being only fair or poor. While the time of the sessions was determined on the basis of the preferences of a majority of participating GPs, the diverse practice structures and individual commitments of participants meant that it was not possible to accommodate the preferences of all GPs.

**Figure 4.4: How well was the administrative and planning component carried out (n=38)**



#### 4.2.4.4 Relevance to and impact on practice

As can be seen from Figure 4.5, most participants reported that the information was sufficiently relevant as to influence their practice. There was also overwhelming agreement among GPs that the sessions had had an impact on their practice.

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*'One of the benefits for me has been realising that listening and understanding is a therapeutic process in itself; the GP is therapeutic to survivors of trauma and torture.'*

*I am very aware of my limitations, increasingly. My curiosity has gotten a different quality now. I have become more interested in the bigger policy context and not only in the individual sitting in front of me'.*

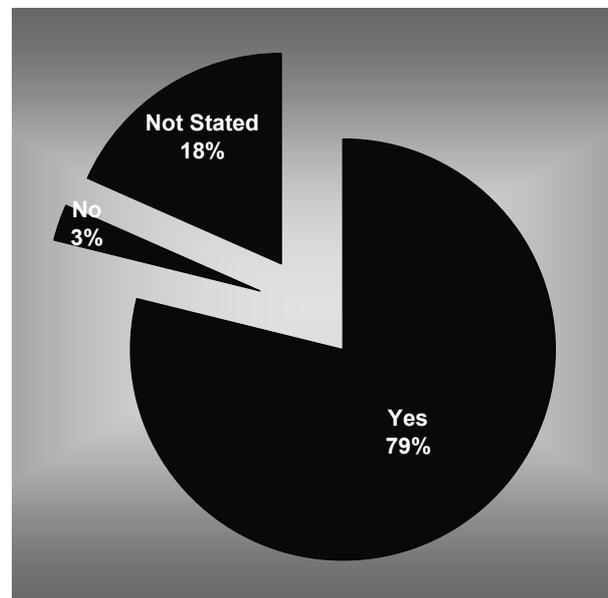
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In particular GPs noted that they:

- Had an enhanced understanding of refugee issues.
- Had increased confidence and competence in working with refugees.
- Had an enhanced appreciation that refugees have gone through extraordinary experiences and need special care.
- Adopted a more systematic advocacy role.
- Were more patient, tolerant and non-judgemental.
- Felt more effective in their work with refugee patients
- Recognised the importance of validating the refugee experience.
- Better appreciated the value of relationship between GP and patient and its therapeutic potential.
- Had an increased awareness of Post Traumatic Stress Disorder.

- Had a framework for better understanding their role in exploring psychological issues.
- Appreciated the value of sitting with patients, thus being relieved of the pressure of having to provide a 'quick fix'.
- Felt more competent when writing asylum seeker reports and more aware of the complexities involved, including those associated with the refugee determination process.

**Figure 4.5 Was the session relevant enough to make a difference to your practice? (n=38)**



#### 4.2.4.5 Future needs

We asked what information GPs would like to see addressed if further training of this nature was offered. They expressed interest in the following areas:

- Long term recovery process from torture and trauma experiences.
- Legacy of war trauma for subsequent generations dealing with child survivors of trauma eg Vietnamese children.
- Issues facing survivors in the longer term, especially those from WWII.
- Refugee health screening.

- Counselling and psychotherapy such as the physical surrounding conducive for counselling, the difference and similarities between survival strategies and psychopathology, family and group therapy approaches.

#### 4.2.4.5 Strengths

- The program was well accepted by GPs, evidenced by the high rate of participation across all three sessions and positive evaluation.
- The course and associated materials have been carefully documented. Their publication and distribution will allow the course to be replicated in Victoria and other Australian States and territories.
- The program was successful in building a group of GPs with a high level of skill in refugee health care. As well as enhancing care to refugee patients this group might also have a role in serving as mentors or trainers for other GPs.
- Relationships developed between program participants will enhance opportunities for peer support and information exchange.
- The interactive format of the course promoted the development of a cohesive group of GPs which has the potential to play a future role in advocacy and in providing advice to government and other policy bodies on refugee health issues.
- The program has resulted in strengthened relationships between GPs and the VFST.
- The course is accredited by the RACGP and its design meets new criteria set out by College for providers of Continuing Professional Development (CPD) scheme for the triennium 2002-2004.

### 4.3 Educational Practice Visits

This component of the professional development strategy was offered to GPs and practice staff. It was targeted to those practices/community health centres who see large numbers of refugee patients by virtue of the geographic location of their practices, but which had hitherto had no or minimal contact with the VFST or the *Refugee Health and General Practice Development Program*. These practices had varying levels of interest in refugee health. One of the purposes of this strategic targeting was to widen the pool of 'refugee responsive practices'.

This component takes a 'whole-of-practice' approach recognising that nursing and reception staff can also play a significant role in supporting GPs to care for refugee patients. Specific practices were identified by VFST Counsellor Advocates based on their work with recent arrivals from refugee backgrounds.

The objectives of this training approach were:

- To enhance the skill of GPs in their contact with refugee patients.
- To enhance cooperation and referral between participating GPs, VFST staff and other allied health and settlement services.
- To promote a whole-of-practice approach to refugee health care in private practice and community health by exploring changes that can be made at the practice level to enhance access for refugee patients.

This practice-based training was conducted by VFST Counsellor Advocates and monitored by the Program Manager. A train-the-trainer session was conducted for Counsellor Advocates prior to the commencement of the Educational Practice Visits including an introduction to the training (see below) and discussion of practical strategies when approaching GPs for participation.

#### **4.3.1 Content development**

A training manual was developed based on *Caring for Refugee Patients in General Practice: A Desk-top Guide* (see Section 5) and complimented by information or resource materials relevant to GPs and practice staff.

The training content covered eight topic areas, developed into fact sheets to be used as overheads and handouts. They cover the following subjects:

- The refugee patient
- Practice improvements
- Engaging a professional interpreter
- Consultation and management
- Physical and psychological sequelae of torture and trauma
- Cooperation and referral with allied health and settlement services
- Asylum seekers
- Refugee children and youth

A total of 30 fact sheets were developed for the pilot phase.

Training manuals containing fact sheets (overheads), instructions for the trainer, evaluation sheets and selected resource materials for distribution were compiled and made available to the Counsellor Advocates for use at the session and for distribution to participants. Counsellor Advocates had access to portable overhead projectors to facilitate the training.

A highly flexible approach for training delivery was used to enhance interest in the training and to minimise barriers to practice participation. It was anticipated that training sessions could be as short as 20 minutes or up to 1½ hours length. They were conducted at a time convenient to the training recipients. Training content was negotiated with the contact person (GP or practice manager) prior to delivery based on the interests and needs of participating practices.

It was intended that the approach would be piloted in 12 practices/CHCs across metropolitan Melbourne.

#### **4.3.2 Promotion**

The pilot of the Educational Practice Visits Program was promoted by VFST counsellor advocates and all those GPs who participated in one or several program components. Counsellor Advocates identified and specifically approached those GPs/practices with whom they share a client cohort. Counsellor Advocates did this in the context of their work when accompanying clients to their GPs. Some of the GPs who had contact with the Program promoted the training to their colleagues and staff and subsequently booked a training session.

#### **4.3.3 Evaluation mechanism**

The educational practice visits were evaluated with a range of methods involving both the Counsellor Advocates and training participants. These included the following:

- Counsellor Advocates completed a record for each training session documenting the contact person, time needed to get practice engaged in the training, barriers encountered, number and composition of participants, length of the training session, topic areas chosen, whether training session was interrupted and whether Counsellor Advocates anticipated that request for further training would be lodged.

- After completion of the pilot period the Counsellor Advocates participated in a focus group facilitated by the Program Manager.
- Evaluation sheets were administered after each session with all GP practice participants.
- A small-scale impact evaluation was conducted four to six weeks after the training session with selected GPs and practice staff in the form of brief telephone interviews. These were carried out by a research assistant. GPs participating in the impact interviews were remunerated for their participation.

The purpose of evaluation was

- To assess the usefulness and effectiveness of the whole-of-practice approach from the perspective of Counsellor Advocates, GPs and practice staff.
- To identify strategies that assist in improving the approach (quality of training materials, range of topic areas, strategies to engage practices / CHCs).
- To assess the extent to which the training yielded positive results for the daily practice of Counsellor Advocates and GPs in terms of improved cooperation, referral practices and so on.
- To identify barriers to engaging practices and CHCs into the training and to identify strategies for overcoming these.
- To refine the approach and associated resources for documentation in a resource so that it could be replicated with other groups of GPs by Divisions of General Practice, the VFST and other support agencies working with people from refugee backgrounds in Australia.

A total of nine interviews were successfully conducted; another three interviews could not be carried out due to lack of availability of the interviewees. The interviews were conducted with four GPs and five practice staff.

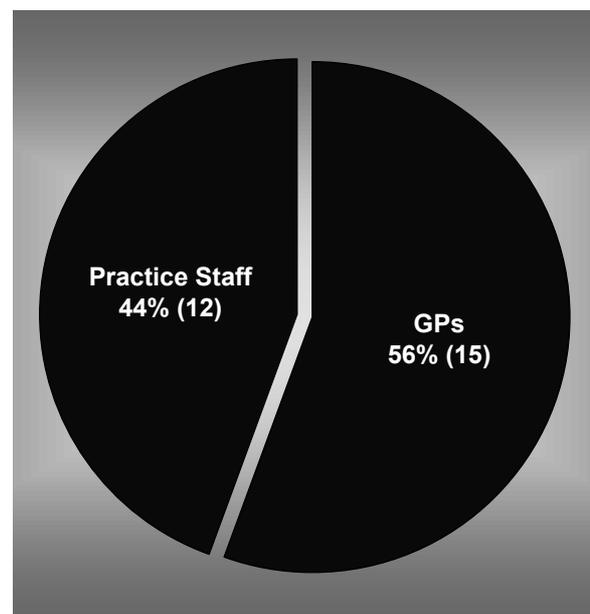
#### 4.3.4 Evaluation findings

The approach was piloted during May and June 2001.

A total of seven training sessions were successfully conducted. 27 individuals participated in the training. Of these 15 were GPs and 12 were practice staff (four nurses, four receptionists, three practice managers and one other).

The findings represent the mean value of all the training sessions and include the responses from the impact evaluation.

**Figure 4.6: Participating GPs and practice staff (N=27)**



Sessions could not be negotiated with the remaining five practices. This was due to a decision by the VFST counsellor-advocate to discontinue recruitment because of a lack of a positive response from the practice itself (two practices); practices positively declining to participate (two practices) and

participant’s failure to attend the agreed training session (one solo GP practice).

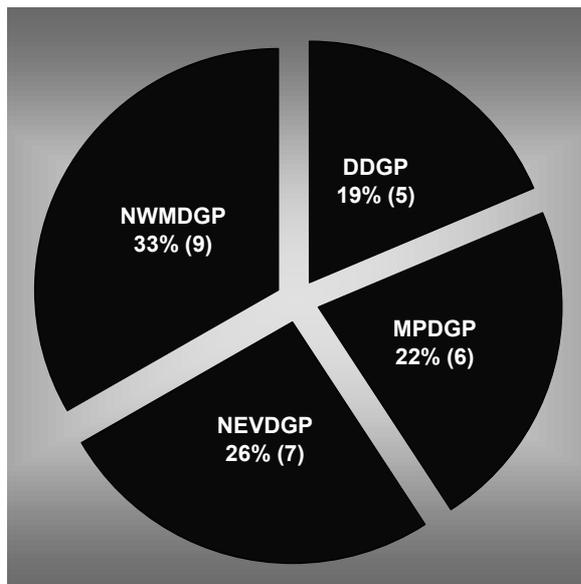
Two GPs who attended the Advanced Level Professional Development and recognised the value of a coordinated whole-of-practice approach promoted the training to their peers and practice staff and were successful in organising training to be conducted at their practices.

A total of 27 evaluation sheets were completed by GPs and practice staff (see Appendix 5 for sample evaluation form).

A number of questions were included which asked GPs to rate the sessions on a scale from good to fair through to poor.

#### 4.3.4.1 The characteristics of participating practices

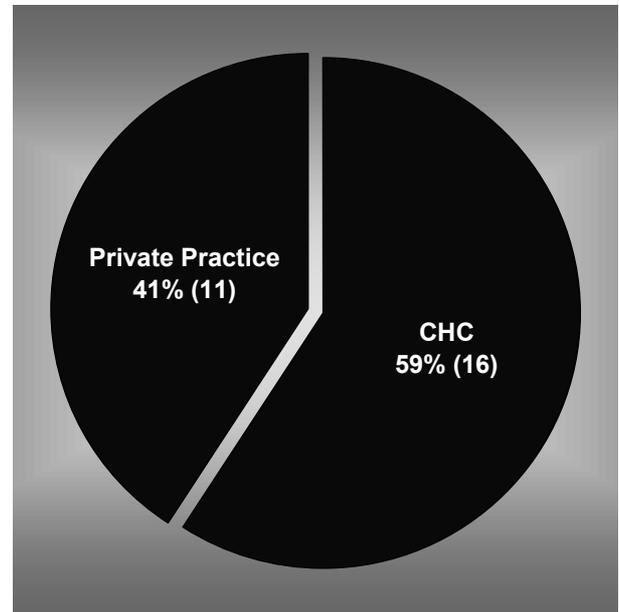
Figure 4.7: Practice location by participant (N=27)



Participating practices were from the Melbourne, Peninsular, Dandenong, North East Valley and North East Melbourne Divisions of General Practice.

Two sessions were held in community health centres and the remainder in private practices.

Figure 4.8: Practice setting of participants (N=27)

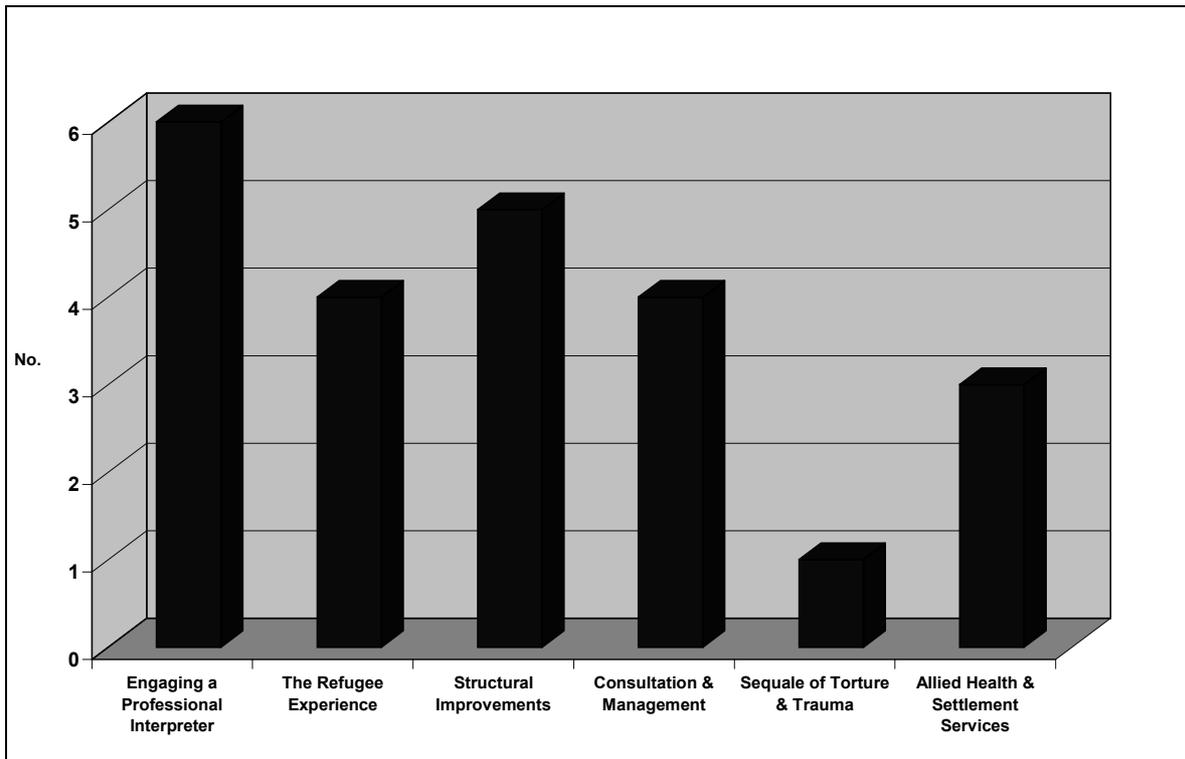


#### 4.3.4.2 The sessions

Training was delivered ‘on-site’ with a view to making it more accessible and acceptable to practices. In the majority of practices, schedules were re-arranged to ensure that the training could proceed without interruption. In two cases, however, some staff were required to continue with other practice duties and were unable to attend the training.

As can be seen from Figure 4.9 below, priority areas selected by GPs and practice staff for the training included the use of professional interpreters, structural improvements at the practice level, information on the refugee experience, issues related to consultation and management and improved cooperation with allied health and settlement services.

**Figure 4.9: Topic areas selected for training**

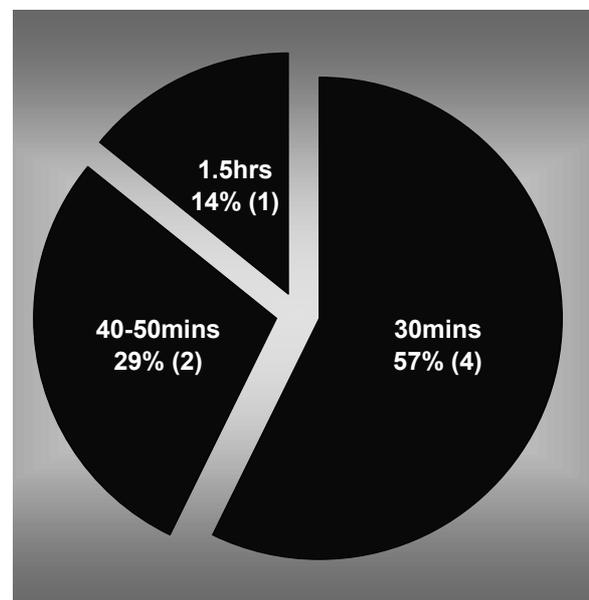


This selection of topic areas correlated with the assessment by Counsellor Advocates of the professional development priorities of participating practices/CHCs.

The low uptake rate of the other topic areas may reflect that all training sessions conducted were first sessions. Training on other topic areas may occur in a subsequent session if this was to be requested.

The average length of training session was 44 minutes with four sessions lasting 30 minutes, two sessions lasting between 40 to 50 minutes, and one session of 1.5 hours length (a CHC with seven participants).

**Figure 4.10: Duration of training (N=7)**



#### 4.3.4.3 Planning and administration

Counsellor Advocates reported that in three cases practices were engaged with relative ease. In a further two instances practices were slow to agree to participate in a visit and did so with reluctance. In two instances, while it took some time to establish rapport, practices were highly cooperative once their interest had been secured.

Counsellor Advocates stressed the importance of having a contact person - a GP or practice staff member - to provide an inroad into the practice for the purposes of organising the session. In those practices where Counsellor Advocates could not readily identify such a person, negotiations were frustrating and, as indicated above, in some instances ultimately unsuccessful.

Counsellor Advocates reported that a significant factor in some GPs resisting or declining to participate was a fear that they would become overburdened with refugee patients once identified as 'refugee friendly'.

In one case this was based on the experience of GP colleagues. Others reported that they were already very busy and had limited capacity for new patients.

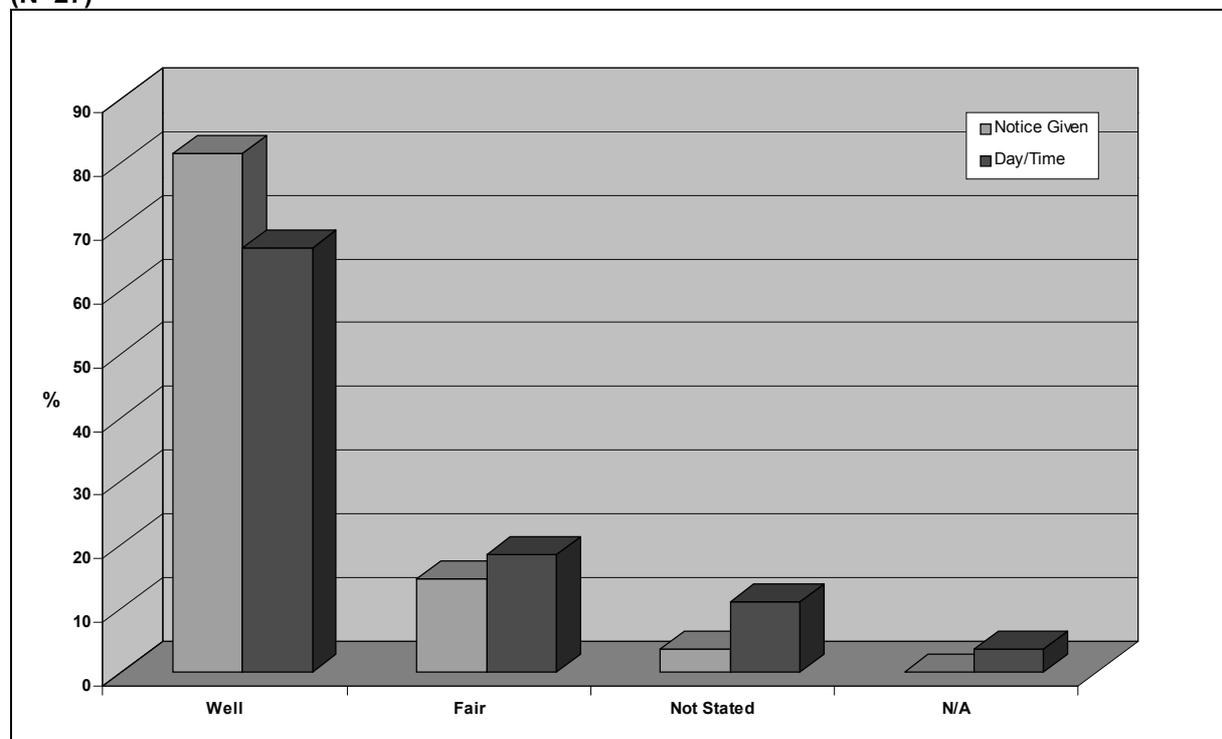
Counsellor advocates stressed the importance of engaging practice staff in the sessions, noting that reception staff had a significant influence on the ease with which refugee patients are able to access a practice.

Counsellor Advocates reported that there were a number of practices in which practice staff had expressed an interest in attending, but were ultimately unable to do so because of other job related demands. This was particularly the case in small practices.

Counsellor Advocates reported that they were initially hesitant to use overheads and a projector, but in practice found this method of presentation worked well.

Several GPs noted that they would like future training sessions offered by a GP experienced in working with refugees.

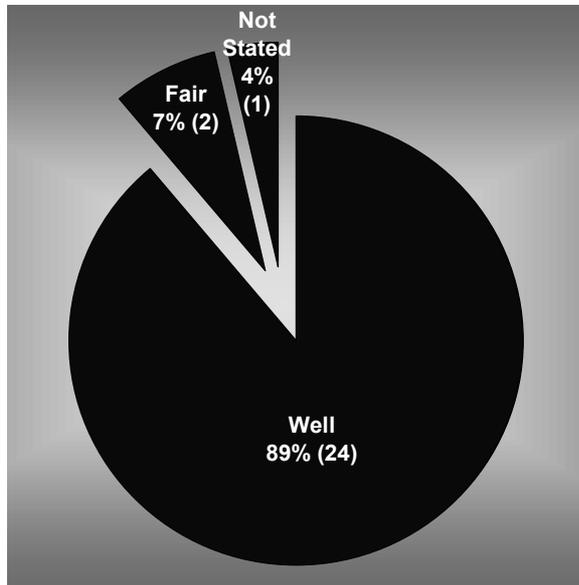
**Figure 4.14: How well was the administrative and planning component carried out (N=27)**



#### 4.3.4.4 Aims

Overall, participants reported that the sessions met the aims well.

**Figure 4.11: How well did the presentation met the stated aims of the training (N=27)**



When asked what the three most important things they learned from the sessions were, participants identified the following areas, most of which was consistent with the session aims:

#### GPs

- Refugee source countries.
- That pre-arrival screening is not a substitute for health assessment by a GP.
- Psychosocial issues in care of refugees.
- Supports and benefits available to refugee patients depending on their visa category.
- Working with asylum seekers.
- The complexity of settlement issues.

- The availability of interpreters and how booking systems can be streamlined.
- The use of case-conferences with refugee patients.
- Services available including psychological support provided by VFST.
- Approaches to referral.
- Management issues in refugee health.
- Importance of engaging reception staff.
- That refugee patients may move frequently in the early settlement period and the importance of taking this into account in management.

#### Practice staff

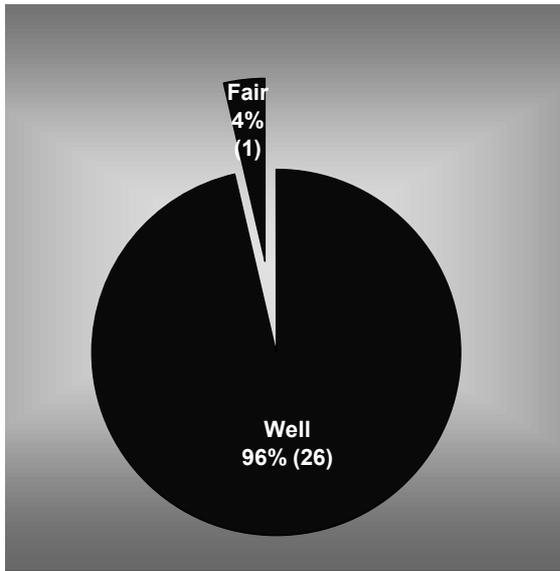
- Other services assisting refugee patients including the VFST.
- Awareness of refugees' medical needs.
- Importance of, and how to book interpreters.
- Refugee source countries.
- Importance of communication between GPs and practice staff.

#### 4.3.4.5 Quality of learning experience

GPs and practice staff commented on the clear, concise and informative presentation and how well it was aimed at their particular needs. They valued the handouts provided.

Both GPs and practice staff noted that the training would have been better had there been more time available, particularly for discussion. GPs in particular noted that they would have preferred a more interactive approach. Practice staff noted that they would have appreciated more case studies.

**Figure 4.12: How well did presentations meet participants' needs as a learning experience (N=27)**



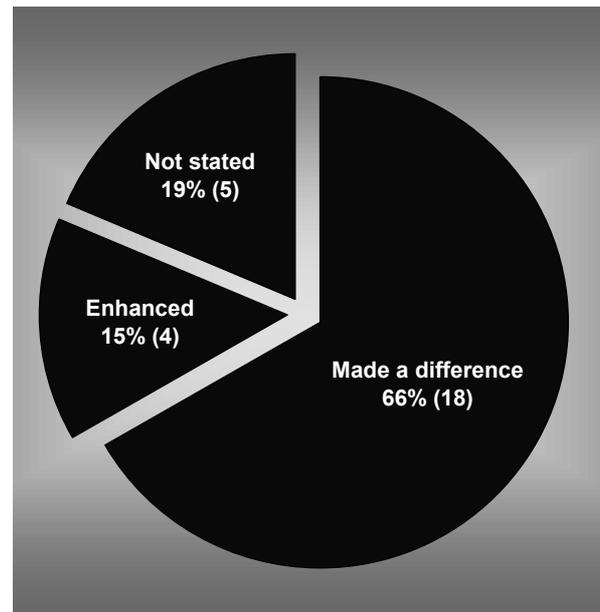
#### 4.3.4.6 Relevance and impact on practice

Overall GPs felt that the training was very relevant to their practice, particularly given its role in improving their understanding of the complexity of refugee health issues and services available to assist refugee patients. They noted their intention to adopt a more coordinated approach with practice staff and allied health agencies. However, a number voiced their concern that long waiting lists for counselling services made it difficult for them to achieve this in practice. Two GPs felt that the presentation was a repetition of information they knew already.

Practice staff reported that they had gained an increased understanding of refugee patients and the importance of all staff being aware of refugees' needs. Some practice staff found that the training was more orientated to the needs of GPs.

When asked what would have made the sessions better, GPs identified the need for more discussion and more detail on the refugee context, in particular specific migration categories.

**Figure 4.13: Was the presentation / info session relevant enough to make a difference to your practice? (N=27)**



The following were identified as the good aspects of the sessions:

#### GPs

- Overview of refugee health issues.
- Strategies on how to engage with disadvantaged patients.
- Information on the needs of refugees.
- Awareness raising regarding the refugee and resettlement experiences of refugee patients.

#### Practice staff

- Awareness raising about the needs of a patient group practice staff had previously known little about.
- Information about the availability of interpreters and how to book them.

As noted above, a small sample of participating GPs and practice staff was contacted four weeks after the training session. When asked if they or their peers had made any changes to their practice as a result of their participation, the following were identified. They

- were more likely to ask about refugee status
- were more confident in talking about refugee experiences with their clients
- more aware of the cultural backgrounds of their clients
- more likely to refer clients to support agencies
- used interpreter services more often
- made longer appointments for refugee patients.

One practice noted that it had more frequent and better quality contact with the VFST as a result of their participation.

One GP indicated that she had not noted any changes in her practice with refugee patients and another GP had not yet discussed the training with peers to establish any changes in their attitude.

While three practice staff interviewed identified no changes as a result of the sessions, others noted the following:

- Enhanced awareness of traumatic experiences of their refugee clients.
- A greater use of professional interpreters by doctors who had previously used family members or friends.
- The introduction of systems at the practice to streamline interpreter bookings.

Two practice staff observed that colleagues were more aware of the pre-migration experience of refugee patients, their specific health needs and health problems.

Two practices reported that they had used the handouts provided during the training as a basis for developing a resource folder on refugee health issues or an agency refugee policy.

Counsellor advocates were asked whether they had observed improved cooperation between them and the participating practices since the training sessions. While most noted that it was too early to assess this, the following impacts were identified:

- One participating CHC reported that it intended to change its structure significantly to accommodate refugee patients. This centre has since approached the VFST for substantial input into the development of a refugee health policy.
- Counsellor Advocates reported increased rapport with practice staff as a result of this contact with them which they anticipated would have benefits for future cooperation.
- Several Counsellor Advocates had received positive feedback from clients attending participating practices.

Counsellor Advocates noted that if the training were successful, it would promote a shared understanding of refugee health issues between Counsellor Advocates, GPs and practice staff. This would reduce the level of advocacy required with participating practices on behalf of individual clients and the tension that may sometimes be associated with this.

Counsellor Advocates were asked if they would use the 'practice visit' session approach again. Overall they agreed that it was a good means of establishing and consolidating cooperation with practices and community health centres and of expanding the group of GPs knowledgeable in refugee health issues. They reported that they did intend to continue conducting the training and hoped to contact and reach more practices with this approach.

Counsellor Advocates noted that their ability to offer professional development had a positive impact on their relationship with GPs, assisting them to develop rapport. It also introduced a measure of reciprocity in the Counsellor Advocate/GP relationship. Counsellor Advocates noted that while in their direct practice work they are usually in the position of asking GPs for assistance, the professional development package placed them in a position of being able to offer GPs some practical support and information. Some saw it as an opportunity to thank GPs who had accepted referrals of a large number of their patients.

Counsellor advocates reported that one of the significant advantages of the sessions was their role in promoting a 'whole-of-practice' approach. Involving reception staff, nurses and practice managers was important as many have the discretion to introduce systems (eg for interpreter bookings) to enhance practice accessibility to refugee patients. They felt that the sessions were useful in bringing both GP and practice staff together to discuss and develop a coherent response to refugee patients across the practice.

They also reported that bringing staff together and providing opportunities for them to discuss issues with their peers and to express opinions could in itself lead to positive attitudinal changes.

#### **4.3.4.7 Quality and value of training material**

GPs were very satisfied with the training material and valued that the training had been clear and concise and direct to the point. They valued the good summary provided of the refugee background and factual information such as visa categories, Post Traumatic Stress Disorder and the role of VFST, and different community resources.

Practice staff also confirmed that the information provided was relevant, appreciated the range of topics covered, particularly country of origin information,

and information on problems that force people to leave their countries. Some staff would have appreciated more information about the particular refugee group they see in their practice.

There was unanimous agreement among counsellor-advocates that the training materials were of a high quality and flowed well. They noted that the training kit was practical, practice-oriented and easy to use.

This was seen as particularly critical for the success of the training given that GPs have little time to reflect and translate concepts into practical strategies, and tend to prefer information that can be immediately implemented.

Some practices used the materials provided as the basis for developing a resource file for refugee health issues and for the development for a refugee health policy.

As indicated above, practices were able to select the topics for their training session from those included in the resource manual. Counsellor advocates reported that irrespective of the topic areas chosen for the training two core topics should be included in each session – 'the refugee experience' and 'using professional interpreters'. It was noted that the former was important as it provided a basis for dealing with the other topic areas and ensured that participant's different levels of knowledge and awareness of refugee health issues was accommodated.

The counsellor advocates commented on the value of the training resource manual being a critical tool for training provision. They highlighted the following aspects:

- The training manual provided them guidance on priority topics for training.
- The availability of a standardised training approach professionalised Counsellor Advocate's practice.
- Having the new resources enhanced 'Counsellor Advocates' confidence in approaching new GPs, Counsellor Advocates felt that they had more strength for negotiation, because they

can provide GPs with strategies to overcome barriers in their care for refugees.

- Training with a resource manual was much more efficient. Previously Counsellor Advocates prepared their training materials individually which was time consuming and did not follow a standardised approach to training. Counsellor Advocates now feel confident to conduct more training with minimal effort.

Counsellor Advocates felt well equipped for the training and appreciated the training kit and projector and the ability to provide complimentary copies of the Desk-top Guide, overheads and other resource material to the training participants.

The following refinements to the training materials were proposed by counsellor advocate (which were subsequently incorporated):

- A clearer presentation of New Enhanced Primary Care items and how these compliment cooperation with allied health services.
- Inclusion of material on strategies of self-care for GPs. This was thought to be important to acknowledge the difficult work GPs undertake when working with refugee patients and the impact this can have on the most experienced GP.
- More detailed information on pre-migration screening and the health undertaking. Experience in the course of this component of the Program confirmed that many GPs assume that pre-migration health screening is comprehensive and are unaware that some patients may be on a Health Undertaking.
- More information on the different conditions applying to CHCs and private practices for booking interpreters; a greater emphasis on the need for prior booking; and information

about the availability of the booking requirement waiver on medical grounds.

- The value of medical care on the psychological wellbeing of refugee patients.

#### **4.3.4.8 Demand for further training**

One of the objectives of the visits was to provide initial training in the hope that practices would identify the need for more detailed follow-up. Two of the practices reported that they did want more training; four reported that they might be interested in further material and one declined the offer of follow-up.

When asked what topics they would like to see addressed in future sessions, participants identified the following:

#### **GPs**

- Specific training in refugee health assessment.
- Working with allied health care providers.
- Working with asylum seekers.
- Working TPV holders
- Government policy relating to refugee patients.
- More detailed information on the role of the VFST.
- Disease patterns in people from refugee backgrounds.

#### **Practice staff**

- Psychological impact of torture;
- Particular health problems of refugees.

While practice staff noted that they valued the training and were interested in further sessions, they identified few specific areas instead indicating that they saw themselves as part of the team and as such would agree to training content proposed by GPs.

#### **4.3.4.9 Strengths**

Overall GPs reported that they valued the sessions and the ‘whole-of practice approach’ promoted. Like the Counsellor Advocates they noted that a shared understanding between GPs and practice staff is critical and beneficial for refugee clients.

One of the training participants, who was a new graduate, noted that she appreciated the fact that the training sessions provided the opportunity for her to have contact with other experienced staff in dealing with refugee health issues.

#### **4.3.4.10 Key learnings**

- Counsellor Advocates reported on the importance of establishing rapport with key people in a given practice before negotiating professional development. Having one committed staff/GP within the practice is very valuable for promoting the training to other GPs/staff and for organising the training session.
- Practices tend to continue to operate during training, which may cause a certain degree of disruption. Counsellor Advocates/trainers must take this aspect into account when planning for the training.
- It is useful to achieve an agreement with participating GPs not to book any new clients prior to the training session to minimise disruption caused by a backlog of patients.
- A high level of flexibility is needed on the part of the Counsellor Advocate/trainer to accommodate the specific situations of individual practices eg time allocation for training.
- Counsellor Advocates who conducted the training experienced an increased appreciation of their specific area of expertise by participants to the training which makes them becoming more equal and respected partners in the professional contact.
- Feedback from training participants and members of the Steering Committee suggested that the training approach has a lot of scope to be developed into an important approach to improve quality of care if carried out in partnership with Divisions of General Practice. It allows those practices who are identified as not providing optimal care to refugee patients to be specifically targeted.



## 5 Pilot of guidelines in refugee health care

### 5.1 Rationale for strategy used

A major component of this program involved the development and piloting of clinical guidelines for conducting early health assessment for people from refugee backgrounds (referred to as the pilots).

This report documents the process of conducting the pilots and evaluates their value as a program methodology. The Guidelines and a separate report of the findings of the pilots are currently being finalised and will be two of the specific publications arising out of the Program (see Section 1.6).

The approach to care promoted in the context of this program is outlined in Section 2. However, as indicated there may be a number of barriers to delivering this care in the context of community based general practice.

The purpose of the pilots was to engage GPs in a practical study to:

- Assess the extent to which it is possible to apply the approach to refugee health assessment and care outlined above.
- Identify and demonstrate practical strategies for implementing the approach.
- Identify constraints to implementing the approach.

It was anticipated that the outcomes of the pilots and the African Health Study (see below) would be used as a basis:

- For demonstrating practical strategies for providing optimal care to people from refugee backgrounds for use in both future resource and professional development activity.

- To refine and supplement existing guidelines, particularly in the area of infectious disease screening.
- To assist in planning future activities of the *Refugee Health and General Practice Program*, particularly in the area of professional development.
- For liaison with government to demonstrate and seek to address structural constraints to achieving optimal care of recently arrived refugees.

### 5.2 Establishing the pilots

While it is recognised that GPs preparedness to implement the approach; the extent to which they adhere to it over time; quality of care, overall patient outcomes and patient satisfaction are of importance, these were not the specific subjects of the pilots.

Guidelines for the provision of health care to refugee patients were developed collaboratively by the WMDGP, the VFST and the Royal Melbourne Hospital Infectious Diseases Service and the University of Melbourne and documented in the form of *Caring for Refugee Patients in General Practice: A Desk-top Guide*. These guidelines were used as a basis for the pilots. A health assessment ‘checklist’, based on the Guidelines, was developed to serve the dual purpose of both practice prompt and data collection.

A proposal for piloting the clinical guidelines was drafted and approved by the Steering Committee. It was subsequently submitted to, and appraised and endorsed by the VFST Research and Ethics Sub-committees.

GPs participating in the pilots were asked to apply the approach to care documented in the Desk-top Guide in their care of all patients aged 18 years and over from refugee

backgrounds presenting to their practices who had been in Australia for two years or less and to:

- Maintain a record of each patient in his or her care and the time involved in its delivery by completing a checklist.
- Participate in a semi-structured interview, seeking their feedback on the Desk-top Guide, information on strategies adopted to implement the approach outlined and any barriers encountered.
- Participate in a focus group. The purpose of the focus group was to bring participating GPs together to use a peer discussion process to validate, discuss and refine the findings.

Patients from refugee backgrounds were identified by their country-of-origin.

In the contract with General Practice Divisions Ltd, it was specified that a minimum of two clinics were to be contracted to participate in the pilots. However, members of the Steering Committee were concerned that a small sample would be insufficient to provide generalisable results. Accordingly, it was agreed that the number of participating GPs be increased and that a target of 60 completed records would be set.

The pilot was overseen by a sub-committee comprising representatives from the Victorian Infectious Diseases Service, the Western Melbourne Division of General Practice, representatives from VFST and the Program Manager.

Prior to the commencement of the pilots all participating GPs attended a briefing session covering the objectives of the pilots, the methodology, use of clinical guidelines in providing care for patients from a refugee background, time-lines and ethical considerations. This session was approved by the RACGP as a professional development activity and two CME points per hour were awarded.

Although the study involved GPs recording and reflecting on their own practice, rather than specific interventions, it was agreed that it was important that refugee patients were aware that details of their care was being recorded. Accordingly, patient information about the study was translated into those community languages spoken by recent arrivals.

Clearly, the increase in the number of participating GPs had significant implications for both the program budget and coordination and management time, with the pilots commencing some two months later than anticipated. The larger volume of GP participants also added to the time and resources involved in implementing each component of the pilots.

In the beginning of the pilots the number of recently arrived refugee clients presenting to practices was somewhat slower than anticipated. This was due in large part to the temporary freeze on processing of humanitarian visa applicants by the Department of Immigration and Multicultural Affairs (DIMA) following the 'boat arrivals' crisis late in 1999. The delay in the commencement of the study meant that it coincided with the Christmas period and Ramadan (the Muslim month of fasting) contributing further to a slower than anticipated rate of suitable patients presenting at the practices of participating GPs.

To ensure the pilot target was met, the period for completing records of care was extended by a month. In this period, the records of some 72 patients were recorded.

### **5.3 The African Health Study**

In the original submission for the *Refugee Health and General Practice Development Program* it was anticipated that the pilots would also incorporate a disease surveillance component with the aim of documenting disease patterns in particular refugee communities. This information was to be

included in the Guidelines to assist doctors to tailor the communicable diseases aspects of refugee health assessment to the needs of particular refugee groups (thereby reducing the risks of both under and over investigation). This was thought to be important given the dearth of evidence based information, particularly relating to disease patterns in emerging refugee communities.

In planning the pilots, however, it was agreed that it would be difficult to incorporate the disease surveillance component into the pilots given the difficulties in achieving a high enough throughput in the program period and the costs associated with this activity (eg pathology tests, statistical expertise).

The Royal Melbourne Hospital one of the program collaborators agreed that it would conduct a separate disease surveillance study drawing on its own resources, with the *Refugee Health and General Practice Development Program* making a small contribution toward the costs or recruiting participants and the Program Manager participating on its Steering Committee. The focus of the study was on new arrivals from East Africa. This community was selected on the grounds that it is an emerging community about which very little is known. Further, anecdotal evidence suggests that this community experience relatively poor health status.

In addition to documenting the prevalence of particular diseases and conditions (including immunity from vaccine preventable diseases) the study also sought information on participant's views and experiences of general practitioner services.

With the assistance of African community workers 126 adult participants were included in the study, which was conducted between 19 June 2000 and 29 July 2000.

A separate report of this study is attached as Appendix 6. This study provided important baseline data on disease prevalence in the African community.

Detailed guidelines for the detection and management of communicable disease, nutritional deficiency and other significant physical health problems were developed on the basis of the outcomes of the research and have been made available to GPs on the web-sites of both the Royal Children and Royal Melbourne Hospitals.

The outcomes of the study were also disseminated through the *Refugee Health and General Practice Development Program* to GPs and other relevant stakeholders and have been incorporated into the revised edition of *Caring for Refugee Patients in General Practice: A Desk-top Guide*.

Following the completion of the study the Royal Melbourne and Royal Children's Hospitals agreed to establish Immigrant Health Clinics. These clinics were promoted extensively through the Program as source of advice and referral for GPs.

## 5.4 GP profile

Following extensive promotional activity, 20 GPs were successfully recruited to the pilot. Two GPs discontinued their participation shortly after commencement due to competing work and overseas travel commitments. The remaining 18 GPs participated until the official closure of the pilot in May 2001. An equal number of male (9) and female (9) GPs participated in the pilots. Five were in private clinics, 11 in community health centres (CHCs) and three in a community medical clinic attached to a hospital.

All GPs working in community health centres or community medical clinic were in a salaried employment. From those working in private practice one was in salaried position and the remainder were self-employed.

All practices and CHCs of participating GPs were located in urban Melbourne: 11 GPs were from Melbourne Division, three GPs from Western Melbourne, two GPs from North West Melbourne, one GP from Inner Eastern and one GP from the Dandenong Division of General Practice.

## 5.5 Implementation

Data was collated by three means.

### 5.5.1 The checklists

A checklist was developed on the basis of the Desk-top Guide, coded and provided to GPs (see above).

GP were asked to keep the checklist at a safe place and separate to patient files to ensure confidentiality of patients' personal details. The checklists were completed in the course of each consultation with a maximum of five consultations being recorded for each patient. It sought to measure implementation of key aspects of the approach including how care is managed over time and the time taken.

Checklists were collated and analysed, and final results were fed back to GPs individually along with a composite of the results of all participating GPs.

From the 18 GPs only 13 GPs were able to record patient consultations due to a lack of patients meeting the study criteria. Together 72 episodes of care were recorded with a total of 250 consultations.

All checklists were viewed by the Program Manager to ensure consistency in the responses. All handwritten comments were transcribed for inclusion into the qualitative evaluation. The data was subsequently analysed using the Statistical Package for the Social Sciences (SPSS) format and queries were formulated to elicit the information relevant to the study objectives.

### 5.5.2 The semi-structured interviews

At the end of the study period all GPs who had recorded patient consultations were asked to participate in a semi-structured interview conducted by the Program Manager. The questions were developed based on the findings of the checklist. During the interview GPs were asked to reflect on their practice with refugee patients in general and the pilot patients in particular and to:

- Explore the extent to which elements of the approach could or could not be followed.
- Give their views on the adequacy and appropriateness of the Guidelines for care proposed in the Desk-top Guide.
- Identify any barriers to offering optimal care.
- Identify any strategies they found useful to facilitate optimal care of people from refugee backgrounds.

The interviews were recorded and analysed by the Program Manager with key themes and issues documented.

### 5.5.3 The focus group

After analysis of the interviews all GPs were invited to attend the focus group.

The purpose of the focus group was to

- validate the findings of the pilots
- discuss any issues / dilemmas arising in the research
- utilise the group process to generate further ideas/strategies.

To guide the discussion a set of evaluation questions were developed based on issues emerging from the analysis of the checklist and the interviews.

The focus group, attended by six GPs, was conducted at VFST, chaired by the Program Manager, and facilitated by the Program Development Team Coordinator. GPs were advised to adhere to issues of confidentiality should they intend to discuss individual cases. The preliminary findings of the checklist analysis were presented to the GPs in form of summary overheads. GPs confirmed that the presentation reflected their ideas and practice and identified with the findings.

## 5.6 Patient profile

While the study did not seek to achieve a representative patient sample, a diversity of patient characteristics was represented.

The age of the patients whose assessments were recorded for the study ranged from 18 to 79 years old with two thirds being between 25 and 54 years old. Of the 72 patients 33 were male and 39 were female.

Consistent with the aims of the study most patients had been in Australia for two years or less. 47 patients had been resident in Australia less than six months, 11 for 6 months to 1 year, seven for 1 year to 18 months and only four patients recorded by the doctors fell outside the study criteria.

Patients originated from 20 different countries and spoke the following languages: Albanian, Arabic, Bosnian, Ceylonese, Croatian, Dari, Ethiopian, Hakka, Kurdish, Mandarin, Nigerian Languages, Oromo, Persian, Serbian, Somali, Spanish, Tamil, Turkish and Vietnamese.

The vast majority (61 patients) reported that they had been forced to leave their country.

## 5.7 Evaluation findings

The study has produced a wealth of quantitative and qualitative data presented in detail in a separate report (see above). In particular the pilot report will assess and discuss the following:

- The feasibility of the approach
- The appropriateness of the approach for refugee patients
- The feasibility of including psychological and social support in assessment and management of refugee patients
- Issues related to engaging a professional interpreter
- Consultation and management
- GPs role in introducing patients to Australian health care system
- GPs awareness of cultural and religious practices
- Cooperation with and referral to health allied health and settlement agencies
- The extent of work undertaken by GPs between consultations
- Use of the New Enhanced Primary Care items
- Medical history and examination
- Strategies for enhancing medication instruction
- Usefulness of Guide and suggestions to improve it
- Impact of working with refugee patients on GP and importance of self-care and support structures for GPs
- Summary of barriers in providing care to refugee patients
- Summary of innovative strategies to overcome these barriers
- Vision of 'best practice' service for post-arrival health care for refugees
- Relevance of findings for policy development and for changes which can be implemented at practice level.

### 5.7.1 Strengths

- The Program was able to contract and retain a large number of GPs who participated in the study over a period of seven months.
- The analysis of the patient profile confirms that the study was able to contact the target group the study had aimed for.
- GPs produced a substantial number of records of patient care. The magnitude of the qualitative and quantitative data obtained will provide substantial input into policy formulation, practice-level changes and advocacy on refugee health issues.
- The pilots has effectively documented care provided to refugee patients in contemporary general practice and have gone some way toward producing an experiential and evidence base for clinical guidelines in refugee health.
- The study has produced a group of GPs who have developed a thorough understanding of refugee health issues and have incorporated some of the key aspects of the holistic approach to health into their practice.

### 5.7.2 Weaknesses

Whilst GPs persevered and participated in the study for seven months until the aim of minimum 60 patient records had been reached, the length and intensity of the study involved a considerable contribution of their time.

GPs commented that the completion of the checklist for each consultation was time consuming and repetitive whilst acknowledging that this was a critical part of the study.

The magnitude of the study was welcomed by all key stake holders. Clearly the much larger than originally planned for study required substantial resources for monitoring and facilitation of the pilots and, subsequently substantial time for data processing and analysis.

## 6 Development and dissemination of program resources and findings

As indicated earlier in this report, a number of resources are currently being finalised as part of the Program including:

- a report of the pilot study
- a training resource manual *Building Capacity in Refugee Health: A Training Resource Manual for GPs, Allied Health Workers and Providers of Professional Development*.
- the revised *Caring for Refugee Patients in General Practice: A Desk-top Guide*.

While it was anticipated that these would be completed and disseminated within the program period, delays in program commencement and the larger than anticipated workload associated with the pilots (involving a far greater number of GPs than intended in the earlier submission) has meant that this has not been possible. These resources are currently in draft form and will be complete by March 2002.

### 6.1 The Training Resource Manual

One of the aims of the professional and network development components of the Program was to develop an approach and accompanying resource materials which would allow these aspects of the program to be replicated on an ongoing basis by Divisions of General Practice, the VFST and other counselling and support agencies working with people from refugee backgrounds.

These aspects of the program were carefully documented and evaluated to this end and are currently being finalised in the form of a self contained manual *Building Capacity in Refugee Health: A Training Resource Manual for GPs, Allied Health Workers and Providers of Professional Development*, containing both background and

instructional information as well as handouts, overheads, references and other materials required to plan, promote and deliver the programs (eg evaluation sheets, sample promotional pamphlets).

The manual also incorporates relevant information and experience from the pilots, in particular ideas contributed by participating GPs on practical strategies for conducting refugee health assessment in general practice. The manual includes:

- Background material on the *Refugee Health and General Practice Development Program*.
- Information on how to use the manual.
- The Advanced Level Professional Development for GPs Working with Survivors of War-related Trauma.
- The Educational Practice Visits - Promoting a Whole-of-Practice Approach to Refugee Health.
- Instructional material on how to promote, establish and facilitate a network of GPs interested in refugee health.

It is being produced in both digital and print formats.

### 6.2 Revised Guidelines

As indicated in Section 5, one of the significant activities of the Program was the development and piloting of *Caring for Refugee Patients in General Practice: A Desk-top Guide* to assist general practitioners offering early health assessment to people from refugee backgrounds.

The Guide has been refined to incorporate materials from the pilots, including feedback from participating GPs and counsellor advocates and is currently being produced.

The Guidelines are in a A5 spiro bound format and address the following areas:

- Caring for the refugee patient
- Engaging a professional interpreter
- Consultation and management;
- Medical history and examination
- Infectious diseases, immunisation
- Psychological sequelae, settlement support
- Referral, further information.

They also include the forms required by GPs to establish an interpreter booking system.

800 copies are being produced for distribution to GPs in Victoria. A further 1000 copies are being produced on behalf of the NSW Refugee Health Service. These versions will include state specific information supplied by that service.

Findings from the Program, in particular the pilots, were also included in a publication being prepared by the VFST as part of a second program - the Health Access Pathways Program. This program involved the development of a handbook for primary health care professionals working with refugee patients and multilingual brochures for new arrivals to assist them in accessing and making the best use of health services, in particular general practitioner services.

In the course of the GP Program, the Royal Melbourne and Royal Children's Hospitals (both program collaborators) established immigrant health clinics. These clinics have developed detailed clinical guidelines on the basis of the African Health Study and prior research and practice experience and have placed them on their web-sites. Both organisations are committed to up-dating these guidelines.

While these Guidelines have an emphasis on the physical aspects of health assessment, both hospitals have agreed to place the Desk-top Guide (which has a holistic and patient care orientation) on their web-sites. The VFST has been invited to participate on the

reference groups of both clinics to contribute its expertise in the patient care and psychosocial aspects of refugee health care.

Further funding, however, would be required if the Desk-top Guide itself were to be regularly up-dated.

The RCH and RMH guidelines have been promoted through the Program resource and other activities.

### **6.3 The report of the pilots**

As indicated above much of the information and findings from the pilots has been incorporated into the Guidelines and resource manual.

A separate report has also been prepared providing detailed information on the methodology used and specific findings. This report includes a section outlining the implications of the findings for key players (eg GPs, Divisions of General Practice, Government, counselling and support agencies).

This report will be used a resource for both awareness raising and advocacy, particularly around those issues requiring the attention of government.

### **6.4 Dissemination strategy**

Dissemination of program resources has been ongoing throughout the Program and has included the following:

- Complementary copies of the Desk-top Guide were provided to all those GPs who participated in program activities.
- On the request of services for Survivors of Trauma and Torture in other Australian states and territories copies of the Desk-top Guide were published. These were amended to include the contact details of health, allied health and settlement agencies for referral and cooperation of the relevant state.

- Agreement was reached with the Royal Australian College of General Practice (RACGP) to publish the *Caring for Refugee Patients in General Practice: A Desk-top Guide* on its web-site including those issues that were prepared for other states (see above). The Desk-top Guide can be downloaded from the website in pdf format.
- Dissemination of the Desk-top Guide through DGPs to divisional GPs.
- A presentation on the pilots findings to senior policy officers from General Practice Division Victoria, Department of Health and Aged Care, Centre for Ethnicity and Health and from Community Health convened by the General Practice Divisions Victoria.
- Dissemination of information produced in the context of the GP Network and professional development (eg overheads, specific information developed for training participants eg glossary on terminology related to refugee issues) have been disseminated to all those GPs on the Program database electronically or in hard copy.
- A visual display was produced on request of the WMDGP on the findings of the GP Program initiatives for display at the National Divisions of General Practice Forum 2001 22-25 November 2001 in Sydney - *Caring for Patients from Refugee Backgrounds - Difficult but not Impossible*. The display will be used for promotional activities on refugee health.

The following plan has been developed to disseminate the final program resources:

<b>Program Resource</b>	<b>Target Audience</b>	<b>Dissemination Mechanisms</b>
Report of the pilots	<p>Policy officers in relevant state and commonwealth government departments.</p> <p>GPs with a particular interest in refugee health.</p> <p>GP divisions in key settlement areas.</p> <p>State and territory trauma and torture services.</p>	<p>Program launch/policy forum (see below).</p> <p>Distribution to key GP organisations.</p> <p>Distribution to relevant state and commonwealth government officers Divisions of General Practice.</p> <p>Distribution to key community health centres.</p> <p>Articles in Divisional newsletters and GP publications.</p> <p>Distribution to state and territory trauma and torture services.</p>

Program Resource	Target Audience	Dissemination Mechanisms
<p>Training resource manual <i>Building Capacity in Refugee Health: A Training Resource Manual for GPs, Allied Health Workers and Providers of Professional Development</i></p>	<p>Divisions of General Practice.</p> <p>Allied health and support workers working with people from refugee backgrounds.</p>	<p>Program launch policy forum (see below).</p> <p>Train-the trainer workshop to promote the manual and enhance skills in using it.</p> <p>Promotion on VFST web-site.</p> <p>Promotion through divisional and allied health professional newsletters.</p> <p>Distribution to state and territory trauma and torture services.</p>
<p>Guidelines</p>	<p><b>Primary:</b> GPs</p> <p><b>Secondary:</b> Allied health care workers working with GPs</p>	<p>Program launch/policy forum (see below).</p> <p>RACGP website (agreement secured).</p> <p>Websites of the Royal Melbourne and Royal Children's Hospital's Immigrant health clinics (agreement secured).</p> <p>Individual GPs in settlement areas via participating general practice divisions.</p> <p>Distribution by VFST counsellor-advocates in the course of their day-to-day contact with GPs.</p> <p>Information about guidelines on VFST website.</p> <p>Promotion in key general practice publications (eg divisional newsletters, Doctor Weekly).</p>

A brochure has been specifically developed to support the promotion of the resource materials.

A launch has been planned for the resource upon their completion. As well as promoting the resources and acknowledging the contributions of those involved, the launch will serve as a forum for identifying and discussing key policy and service development issues arising out of the Program requiring the attention of government, GP and allied health agencies. Individual GPs, relevant state and commonwealth government officers,

Divisions of General Practice, GP organisations and allied health workers will be invited to participate in the Launch.

While humanitarian entrants settle across Victoria, the dissemination strategy will be geographically targeted to those areas in which a significant number of entrants settle, specifically Melbourne's Northern, South Eastern and Western suburbs, Geelong and Goulbourn Valley/Shepparton. These areas have been selected on the basis of planning data collated in the establishment phases of the Program (see p16).

## 7 Evaluation of overall GP Program

As well as being asked to assess the individual program components, feedback was sought from the following key players on the program overall:

- Counsellor Advocates at the VFST, through group interviews held in the course of regular team meetings.
- GPs through focus groups and professional development programs.
- The Steering Committee, through a questionnaire distributed to all members. Seven completed questionnaires were received.
- Divisions of General Practice who were not actively involved on the Program Steering Committee. Individual interviews were conducted with program or executive officers at the Melbourne, Inner Eastern Melbourne, Mornington Peninsula and North East Valley Divisions of General Practice.

### 7.1 Input received from VFST counsellor advocates

Overall counsellor advocates commented positively on the Program. The following were particularly highlighted as useful to their practice:

- The data base of GPs for the purposes of referral.
- GPs enhanced knowledge about the VFST and its roles.
- The specific resources (the Desk-top Guide and training resource manual) which provided counsellor advocates with something tangible on which to base their initial contact with GPs. They noted that the 'self contained' nature of the training resource manual was particularly useful, since it allowed them to offer GP training without

having to undertake extensive preparation. This was seen as particularly important given the time constraints faced by counsellor advocates.

When asked whether they felt that the Program had resulted in improved care to refugee patients, counsellor advocates felt that it had done so by:

- Improving communication between Counsellor Advocates and GPs and contributing to the development of a more collegial relationship.
- Enhancing the sensitivity of both GPs and practice staff to the needs of refugee patients. For instance Counsellor Advocates working in the south eastern suburbs noted that two practices that had participated in the Program had streamlined systems so that waiting times for refugee patients were kept to a minimum and interpreters were booked routinely. Counsellor-advocates noted that refugees patients were now able to access these practices independently, thereby containing the time Counsellor Advocates would otherwise have had to have spent making and attending appointments with clients
- Increasing GPs preparedness to consult with Counsellor Advocates by telephone about complex issues.
- Increasing GPs awareness of the need and preparedness to bulk bill refugee clients and to arrange referrals to bulk billing specialists.
- Promoting a more collaborative approach between GPs and Counsellor Advocates by bridging the divide between the medical and psychosocial domain. It was felt that refugee patients benefited from this because their care

was informed by a broader knowledge and skill base.

- Enhancing GPs appreciation of the knowledge base contributed by Counsellor Advocates.
- Increasing GPs awareness of the needs of refugee patients and their preparedness to advocate these to both their colleagues and government. For example a counsellor advocate noted that one of the GPs she had contact with was writing articles on refugee health and GPs role as a health and human rights advocate with the aim of sharing her knowledge and educating her peers. Another two GPs had presented at conferences on refugee health issues.

Counsellor advocates were concerned, however, that while the Program had been successful in increasing GPs preparedness to refer clients requiring psycho-social support, long waiting lists at the VFST, private psychiatry practices and other allied health agencies, meant that referral was often a difficult and protracted process.

## 7.2 Input received from GPs

Overall GPs actively involved in one or more program activities were highly satisfied with the Program and highlighted the following aspects as useful to their professional development.

### 7.2.1 Strengths

- GPs stressed the value of having the opportunity to meeting like-minded colleagues for the purpose of professional exchange and peer support. This was perceived as particularly important to validate own practice experience as well as removing the sense of isolation many GPs felt.
- The ability to combine GPs interest in refugee health with professional development that is accredited by RACGP was highly valued as this

allowed them to prioritise their professional development interests with need to accrue CME points for re-registration.

- GPs commented on the high quality of resources that were provided in the course of various program components and the value of these for their practice.
- The content of the various program activities was highly relevant to the needs of GPs and reflected a good understanding of the principles of general practice.
- Much of the content learnt can be applied to other patient groups such as the importance of holistic care and assessment and counselling skills.
- The understanding of the local and global policy contexts governing the Refugee and Humanitarian Program was perceived as critical to the improved understanding of refugee health issues and the importance of adopting a holistic approach to refugee health. The enhanced understanding of the policy contexts contributed substantially to a shift in perception of and attitude towards refugee patients in a number of GPs who previously had perceived this patient group as being difficult to work with.
- As a result of participating in program activities GPs reported that they became more sensitive to the needs of refugee patients, reflected on their own practice with this patient group and introduced a range of practice-level changes to enhancing their care for refugee patients.
- GPs felt they became sensitised to the concept of holistic care and the importance to applying the approach for the benefit of the patients.

## 7.2.2 Weaknesses

GPs in particular commented on systemic limitations to apply the principles of holistic care due to a limited capacity of allied health services to respond to referrals. This was in particular felt by those GPs who had attended the advanced level professional development and increasingly identified patients with trauma related issues that require more intensive care and who wished to refer clients accordingly but are left with caring for these patients to bridge extended waiting periods for allied health and settlement services.

## 7.3 Input received from the Steering Committee

Overall the members of the Steering Committee valued the Program and its activities highly. The summary of their feedback included the following.

### 7.3.1 Strengths

- The Program brought together a number of individuals and organisations interested in refugee health across a range of disciplines.
- Committee members agreed that program components chosen and implemented in the course of the GP Program were relevant to meet the Program's overall aims and objectives. Members also commented on the high quality of resources developed by the Program.
- The Program reached and involved a substantial number of GPs with its initiatives.
- The Program contributed to improved linkages between GPs and other agencies involved in the care of refugee patients.

It was noted that reaching a large group of GPs and changing their behaviour might be a task very difficult to achieve.

## 7.3.2 Weaknesses

- Whilst the Program reached a substantial group of GPs most of these were from inner metropolitan Melbourne. Reasons for limited reach in rural and outer suburban areas were identified as being due to high demands placed on GPs and their time constraints to attend refugee health activities, the location of the Program base in Parkville which was difficult to access for GPs operating in suburban or rural areas. It was felt that DGPs needed to adopt a more pro-active role in promotion and coordination of refugee health activities.
- Promotional activities could have been more extensive and continuous. It was acknowledged, however, that the magnitude of program and resource development impacted on the time available for promotional activities.

## 7.4 Input received from Divisions of General Practice

The feedback received established the following:

- Three of the Divisions had actively promoted various program activities through their newsletters, in particular the GP Network and disseminated the Desk-top Guide to GPs in their catchment area.
- Out of the four Divisions contacted only one representative was aware that GPs from their divisional catchment area had participated in GP Program activities, despite the relatively high levels of involvement of their members. However, this lack of information was not perceived as unusual due to varying degrees of involvement of some GPs in divisional activities.
- All Divisions were aware of products on refugee health including the *Refugee*

*Health and General Practice* (GP Handbook) and commented on the high quality of these products and their value for GPs.

- DGPs reported that support for GPs to care for refugees was critical in particular to those with a large refugee patient cohort.
- DGPs expressed interest in being kept informed about new refugee health initiatives.
- One Division was interested in becoming a collaborator should funding be secured for program extension.

## **7.4 Reflection on overall GP Program**

A total of approximately 55 GPs participated actively in one or more program initiatives with some 114 GPs being linked to the Program as corresponding members.

The Program has exceeded its contractual obligations in a number of areas - the number of Network meetings conducted, and the number of practices engaged in the pilots.

The Program has developed a group of GPs highly skilled in refugee health some of whom could play a critical role in

- Professional development or peer support for other GPs.
- Assisting in an advisory or clinical capacity in the event of a future initiative such as 'operation Safe Havens' undertaken by the Government in 1999.
- Providing advice to government and others on refugee health issues.

The Program has greatly benefited from its host agency the Victorian Foundation for Survivors of Torture by being able to draw and build on existing practice experience, skills and resources within the organisation

as well as benefiting from agency infrastructure and networks.

All professional development programs developed in the course of the GP Program were accredited by RACGP under its CME Scheme. The accreditation acted as a key incentive to GPs participation.

GPs have expressed their interest in an ongoing special interest group on refugee health. In the submission it was proposed that a mechanism be developed that ensures the sustainability of the GP Network. However, current participants have indicated that the Network would need to be resourced by a designated worker and funding would need to be made available.

### **7.4.1 Unexpected benefits, potential for further development**

A range of unexpected benefits and/or potential for further development emerged from the Program. These include:

- Training on New Enhanced Primary Care Items was offered and conducted for VFST direct client services staff by a GP Network member. The training aimed to provide Counsellor Advocates with the skill to initiate case consultations and care plans with GPs. It is anticipated that the ability to facilitate these processes will further strengthen the cooperation between allied health services and GPs.
- Two GPs presented at a local conference on refugee health issues.
- Some CHCs approached the Program Manager to provide professional development sessions for their nurses and allied health workers. GPs who participated in program activities and who work in these centres prompted this interest in professional development on refugee health.

- VFST was approached by a new provider of professional development for GPs and is presently conducting training for GPs as part of their post graduate degree.
- TeleQuace a provider of on-line vocational training for GPs based at Melbourne University, Faculty of Medicine and Dentistry, Department of General Practice is interested in collaborating with the VFST to producing professional development provided on-line consisting of one to three modules. This medium would extend reach and would make these professional development activities accessible to GPs in rural and remote locations on a state level but also a national level (see below).
- The Educational Practice Visits have a great potential for further development, particularly if offered collaboratively with DGPs and through their infrastructures. The WMDGP has expressed interest in offering this training to their GPs.
- Interest in refugee health generated in rural Divisions of General Practice namely The Goulbourn Valley Division of General Practice and GP Association of Geelong. Negotiations with these DGPs were held to provide professional development locally and to train selected GPs to become trainers in refugee health to their peers. Further funding would be required for this and both Divisions have expressed an interest in participating in an ongoing collaboration.
- Two other Divisions ,namely the North East Valley and the Northern Melbourne Divisions of General Practice, have also expressed interest in collaboration should the GP Program receive further funding.
- In the course of the Program Immigrant Health Clinics were established at the Royal Children's Hospital and the Royal Melbourne Hospital (program collaborators). These clinics are of great value for GPs for cooperation and referral. The VFST has been invited to participate in the reference groups of both clinics.



## 8 Conclusions and future directions

The *Refugee Health and General Practice Development Program* is the first of its kind nationally to actively engage general practitioners, allied health professionals and relevant experts to support GPs to provide high quality and sensitive care to people from refugee backgrounds.

Program evaluation suggests that it has been successful in:

- Providing for the first time in Victoria a mechanism for coordinating activities to support GPs caring for refugee patients.
- Linking GPs with relevant infectious disease, mental health and allied support services.
- Building networks and supportive peer relationships between GPs caring for refugee patients.
- Enhancing GPs capacity to identify refugee patients and to provide high quality assessment and follow-up care.
- Developing and disseminating information and resources for GPs to assist them on caring for refugee patients.
- Engaging GPs in the development of resources and programs.

Evaluation suggests that the Program is valued by participating general practice divisions and individual GPs. Many of the developmental activities undertaken in the context of the Program (in particular the General Practitioner Network and the Program database) – have begun to take effect. However, further funding would be required to ensure their sustainability in the long term.

The Program has been successful in developing a strong body of practice wisdom and resources for the delivery of professional development in refugee health care to general practitioners. As indicated in this report, there are a number of opportunities for building on this base so that professional development activities can be extended to a wider range of general practitioners through a range of communications media.

While the Program reached a large number of GPs practicing in metropolitan Melbourne, there were low rates of participation by GPs practicing in two rural areas with significant refugee communities (Goulbourn Valley and Geelong). Consultation with these Divisions suggests the need to develop an outreach approach.

While the collaborating partners are committed to maintaining and extending the Program, their capacity to do so would be limited without further funding.

In May 2001 the Program Steering Committee developed a submission to extend program funding. This submission attracted the support of a further four Divisions of General Practice including the two rural divisions of Goulburn Valley and Geelong. This submission, is attached as Appendix 1 and outlines possible future directions for the Program.

In summary the submission outlines the need for further funding for an integrated program to:

1. Consolidate a base for the continued development and coordination of activities to support GPs in their care of refugee patients through the Refugee Health and Health and General Practice Program.
2. Conduct a feasibility study of options for addressing broader systemic constraints faced by GPs in caring for refugee patients (eg overall monitoring and coordination, interpreter access).
3. Support and further develop the Refugee Health and General Practitioner Network.
4. Pilot a professional consultation and debriefing program for GPs caring for refugee patients.
5. Develop a computer-based assessment sheet derived from the Guidelines developed in the first phase of the Program.
6. Engage rural GPs in the Program through targeted outreach approaches.
7. Build on the professional development initiatives undertaken in the first phase of the Program to:
  - Develop a practice audit in refugee health linked to allocation of Continuing Professional Development (CPD) points.
  - Establish General Practice traineeships in the area of refugee health.
  - Establish an on-line professional development program.
  - Develop a program involving both GPs and nursing staff in community health centres aimed at supporting coordinated care.

## 9 References

- Davis D A and Thomson, M A (1998), 'Continuing medical education as a means of lifelong learning' in Silagy C. and Haines A *Evidence Based Practice in Primary Care*, BMJ Books.
- General Practice - Changing the future through partnerships*, Report of the General Practice Strategy Review Group, Commonwealth Department of Health and Family Services, Commonwealth of Australia 1998, Publication Production Unit, Canberra.
- Lehn A (1997) 'Recent Immigrant's Health and Their Utilisation of Medical Services: Results from the Longitudinal Survey Of Immigrants to Australia' in Department of Immigration and Multicultural Affairs' *Population Flows: Immigration Aspects*, Department of Immigration and Multicultural Affairs.
- National Health and Medical Research Council (NHMRC) (1994) *Survivors of Trauma and Torture in Australia*, NHMRC Canberra.
- NSW Health (1999) *Strategic Directions in Refugee Health Care in NSW*, NSW Health Department.
- Reid J and Strong T (1987) *Trauma and Torture: The Health Care Needs of Refugee Victims in New South Wales*, Cumberland College of Health Sciences, Sydney.
- The Victorian Foundation for Survivors of Torture (1998) *Building a Foundation: The 10<sup>th</sup> Anniversary Edition of the Annual Report of the Victorian Foundation for Survivors of Torture 1997-8*, VFST.



## **10 Appendices**

### **Appendix 1:**

**Submission for extension of GP Program**

### **Appendix 2:**

**Articles - *VGD Quarterly Newsletter* (Number 3/2000)  
Integrating care for refugees; 'Tall oaks from little acorns  
grow'**

### **Appendix 3:**

**Article - *The Current Therapeutics* (December 1999/January  
2000 Issue) Role of Australian Doctors in Refugee Health  
Care**

### **Appendix 4:**

**GP Network Role Statement**

### **Appendix 5:**

**Evaluation tools**

### **Appendix 6:**

**African Health Study (findings)**



# Appendix 1: Submission for Extension of GP Program

Submission overview from  
Refugee Health and General Practice Development Program  
Submission for Program Extension  
27<sup>th</sup> April 2001

Prepared by The Victorian Foundation For Survivors of Torture Inc. on behalf of the Steering Committee to the Refugee Health and General Practice Development Program.



## Submission Overview

This is a submission for funds to extend the *Refugee Health and General Practice Development Program* for a further two-year period. Funds are sought to build on and consolidate the developmental work undertaken within the program to date, extend program initiatives to a broader range of GPs, including those in rural areas, and to pursue further strategies arising out of the program.

In 1999 the Commonwealth Department of Health and Aged Care allocated \$151,000 for the *Refugee Health and General Practice Development Program* through the General Practice Innovations Pool. The Program became operational in March 2000, with the appointment of a program manager, and is due for completion in August 2001.

Its aims are:

- To support Victorian GPs to provide comprehensive and coordinated care to Humanitarian program entrants and other patients from refugee-like situations.
- To enhance the capacity of Victorian GPs to contribute to the early identification and management of physical and psychological health problems in recent arrivals and other patients from refugee like backgrounds.

People from refugee backgrounds have a relatively high rate of long term physical and mental health problems and may experience a number of barriers to accessing general practitioner services in Australia. The *Refugee Health and General Practice Development Program* is the first of its kind nationally to actively engage general practitioners, allied health professionals and relevant experts to support GPs to provide high quality and sensitive care to this patient group.

The Program is a state-wide, inter-divisional initiative being undertaken by the Western Melbourne, Monash, North West, Dandenong and Greater South Eastern Divisions of General Practice in collaboration with the Victorian Foundation for Survivors of Torture (VFST), the Royal Melbourne Hospital Infectious Diseases Service, the Victorian Transcultural Psychiatry Unit (VTPU), the Australian Red Cross, General Practice Divisions Victoria and the Victorian Department of Human Services, General Practice and Infectious Diseases Units.

The Western Melbourne Division is the lead agency for the Program with the VFST being contracted to undertake significant components and to serve as a program base.

The indications to date are that the Program has been highly successful in:

- Providing, for the first time in Victoria, a mechanism for coordinating activities to support GPs caring for refugee patients.
- Linking GPs with relevant infectious disease, mental health and allied support services.

- Building networks and supportive peer relationships between GPs caring for refugee patients.
- Enhancing GPs capacity to identify refugee patients and to provide high quality, evidence based assessment and follow-up care.
- Developing and disseminating information and resources for GPs to assist them in caring for refugee patients.
- Engaging GPs in the development of resources and programs.

The Program has supported the establishment of the *Refugee Health and General Practitioner Network*, comprising doctors with a particular interest in refugee health and has developed, evaluated and is currently documenting a comprehensive professional development program for GPs in refugee health care. Guidelines for the care of refugee patients have been developed and are currently being piloted by 19 GPs in 12 general practice settings.

Evidence to date indicates that the program has been highly successful and that it is valued by participating General Practice Divisions and individual GPs.

The collaborators have developed this submission for the following reasons:

- While many of the developmental initiatives undertaken in the context of the Program are beginning to take effect, further funding is required to ensure their sustainability in the long term.
- Further funding would allow program initiatives to be extended to a broader range of GPs and to be integrated through a wider range of systems and structures. As well as extending program impact, this will ensure that the best possible use is made of the investment in the program to date.
- In the course of the Program, a number of structural impediments have been identified to GPs providing high quality, sensitive care to refugee patients. Further work is required to determine options for addressing these issues.

Funding is being sought in this submission for an integrated program to:

1. Consolidate a base for the continued development and coordination of activities to support GPs in their care of refugee patients through the *Refugee Health and Health and General Practice Program*.
2. Conduct a feasibility study of options for addressing broader systemic constraints faced by GPs in caring for refugee patients (eg overall monitoring and coordination, interpreter access).
3. Support and further develop the Refugee Health and General Practitioner Network.
4. Pilot a professional consultation and debriefing program for GPs caring for refugee patients.

5. Develop a computer-based assessment sheet derived from the guidelines developed in the first phase of the Program
6. Engage rural GPs in the Program through targeted, outreach approaches.
7. Build on the professional development initiatives undertaken in the first phase of the Program to:
  - Develop a practice audit in refugee health linked to allocation of Continuing Medical Education (CME) points;
  - Establish General Practice trainee-ships in the area of refugee health
  - Establish an on-line professional development program;
  - Develop a program involving both GPs and nursing staff in community health centres aimed at supporting coordinated care.

This submission is being lodged by all of the collaborating partners under the auspice of the *Refugee Health and General Practice Development Program*. The Victorian Foundation for Survivors of Torture is the lead agency. The submission has the support of the original collaborating Divisions and a further four Divisions of General Practice being the North East Valley, Northern Melbourne, Geelong and Goulburn Valley (see attached letters of support).

A total of \$ 247,043 is sought. However, each of the above components has been separately costed to enable decisions to be made in the context of government funding priorities.



**Appendix 2: Articles VGD Quarterly Newsletter  
(Number 3/2000)**



**Appendix 3: Article The Current Therapeutics  
(December 1999/January 200 Issue)**



## **Appendix 4: GP Network Role Statement**



# Refugee Health and General Practice Development Program

## Refugee Health General Practitioner Network

### Role Statement and Terms of Reference

The Refugee Health General Practitioner Network has been established to bring together GPs with a particular interest in refugee health care. It operates under the auspices of the Refugee Health and General Practice Development Program, an initiative of five Divisions of General Practice, the Victorian Foundation for Survivors of Torture and infectious disease and mental health agencies.

#### **Aim**

The overall aim of the Network is to support GPs to provide high quality, holistic care to people from refugee backgrounds which is sensitive to their particular needs.

#### **Role**

- The roles of the Network are to:
- Provide a forum for debriefing, peer support and information exchange and for discussing practice issues relating to the care of refugee patients.
- Increase awareness of the needs of GPs (including rural GPs) who work with refugee patients among other GPs, service providers and government.
- Enhance awareness of health issues of concern to refugee patients among GPs and their professional bodies, service providers and government
- Identify constraints experienced by GPs working with refugee patients and to determine innovative approaches to addressing these
- Provide advice to the Refugee Health and General Practice Development Program.
- Promote the coverage of refugee health issues in Continuing Medical Education and relevant medical education courses at undergraduate and post graduate levels.
- Contribute knowledge and expertise in refugee health care in the development of professional development and education programs for GPs
- Serve as a link and liaison agent between Divisions, GPs, regional services and newly arrived as well as established communities.

#### **Membership**

Membership of the Network is open to Victorian general practitioners with an interest in refugee health care and who support the Network's aim.

#### **Base and administrative support**

The Network is provided administrative support by the Refugee Health and General Practice Development Program based at the Victorian Foundation for Survivors of Torture.

**Structure**

The Network is currently in its formative stages and as yet has no formal decision making structures and processes.

It is proposed that any public representation made on behalf of the Network be approved in advance by both heads of the key agencies of the Refugee Health and General Practice Project, namely Dr. Vladimir Vizec (EO Western Division of General Practice) and Mr Paris Aristotle (Director, Victorian Foundation for Survivors of Torture).

Endorsed by members of GP Network on 22 June, 2000.

## **Appendix 5: Evaluation Tools**

- 1. CME Evaluation Form (sample)**
- 2. Evaluation of Steering Committee**
- 3. Evaluation of Divisions of General Practice**
- 4. Evaluation of Advanced Level Professional Development**
- 5. Educational Practice Visits Evaluation Counsellor Advocates (focus groups)**
- 6. Educational Practice Visits Evaluation GPs and practice staff**



**REFUGEE HEALTH CARE AND GENERAL PRACTICE  
ADVANCED PSYCHOLOGICAL TRAINING FOR GENERAL PRACTITIONERS WORKING WITH REFUGEE  
SURVIVORS OF TORTURE AND TRAUMA**

**Seminar ##: Title**

**Date / time**

**Speaker/s:**

**GP Facilitator:**

**The aim of this presentation was:**

- #####
- 
- 

**1. How well did the sessions generally achieve these aims?**

well  fair  poorly

**2. How would you rate the presentations as meeting these aims?**

good  fair  poor

**3. How well did the presentation meet your own needs as a learning experience?**

good  fair  poor

**4. How would you rate the following aspects of the session's admin and planning?**

- |               |                               |                               |                               |
|---------------|-------------------------------|-------------------------------|-------------------------------|
| a) Notice     | <input type="checkbox"/> good | <input type="checkbox"/> fair | <input type="checkbox"/> poor |
| b) Venue      | <input type="checkbox"/> good | <input type="checkbox"/> fair | <input type="checkbox"/> poor |
| c) Catering   | <input type="checkbox"/> good | <input type="checkbox"/> fair | <input type="checkbox"/> poor |
| d) Day & Time | <input type="checkbox"/> good | <input type="checkbox"/> fair | <input type="checkbox"/> poor |

**5. What were the good aspects of the session?**

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**6. What would have made the sessions better?**

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**7. Is there a topic you would like covered at future meetings?**

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**8. What were the three most important things you learnt from this seminar?**

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**9. Was this meeting relevant enough to make any difference to your practice management?**

**If yes**

**If no**

Thank you very much for your participation and contribution to the success of the seminar.

## Refugee Health and General Practice Development Program

### Overall Program Evaluation with members of the Steering Committee to the GP Program

December 2001

#### **Purpose of evaluation:**

- To assess the extent to which members to the Steering Committee believed that the aims and objectives of the overall GP Program were met.
- To assess the extent to which members to the Steering Committee believed that the administrative functions of the Program were fulfilled satisfactorily (point of contact, distribution of relevant information and resourcing of the committee).
- To assess the extent to which members to the Steering Committee were satisfied with the individual program components.

#### **Evaluation questions:**

1. Do you think that facilitation and resourcing of the GP Program was satisfactory? If not, what do you think are the reasons?
2. Do you think that the components chosen and implemented in the course of the GP Program were relevant to meet the Program aims and objectives (Network, professional development, pilot of Guidelines)? If not, why not?
3. Do you think that the GP Program reached the GPs it was meant to reach? If not, what do you think are the reasons?
4. What do you think were the strengths and weaknesses of the GP Program?
5. Do you think that members to the GP Program Steering Committee and Reference Group represented a balanced selection of relevant disciplines and GP and divisional representatives? If not, why not?
6. Do you think that the GP Program activities contributed to improved relationships between GPs and allied health services? If not, what do you think are the reasons?

Thank you for your cooperation.

## Refugee Health and General Practice Development Program

### Overall Program Evaluation with representatives of Divisions of General Practice

July 2001

#### **Rationale for selecting DGPs for inclusion in the evaluation:**

- Contact those DGPs (Program Officers) from which GPs participated in one or more GP Program components. These DGPs include the Melbourne DGP, Inner East Melbourne DGP, Mornington Peninsular DGP and NorthEast Valley DGP.
- Program Officers are sent a GP Program Summary prior to the evaluation (phone).
- The other DGPs (WMDGP, NWMDGP, DDGP, Monash DGP and VDGP) are covered through the evaluation of the Steering Committee and Reference Group to the GP Program.

#### **Purpose of evaluation:**

- To assess the extent to which DGPs and associated GPs were aware of the GP Program and its components.
- To assess the extent to which DGPs believe that the GP Program and its components met the needs of GPs for professional development, networking and debriefing on refugee health issues.
- To assess the extent to which the GP Program contributed to a heightened awareness of DGPs / GPs on refugee health issues.

#### **Evaluation questions:**

1. Are you / is your DGP, if at all, aware of the GP Program and its components (Network, Pilots, Professional development)? If yes, what is your level of knowledge / awareness?
2. Have you / your DGP contributed to promoting the GP Program or components of it. If yes, in what way (newsletter, mail-out, verbal)?
3. Are you aware of GPs in your division having participated in any of the GP Program components? What value did they assign to the initiatives?
4. Do you / your DGP think, if at all, that the GP Program and its components were relevant to GPs interests and needs regarding refugee health? If not, why not?
5. Do you / your DGP think, if at all, that refugee health is critical and should remain on the agenda? If not, why not? If yes, how would you want this to happen?

Refugee Health and General Practice Development Program  
Advanced Level Professional Development  
Reflective discussion with GPs at completion of all 3 training sessions

**Purpose of evaluation is to:**

- Assess the value GPs assign to the training.
- Assess to which extent the training met the needs and interests of GPs.
- Identify potential long-term impact GPs may anticipate as a result of the training.
- Identify other topic areas GPs might be interested in for further training.
- Identify ongoing support GPs may expect from VFST.

**Evaluation questions:**

1. Did you notice any changes to your practice as a result of attending this training?
2. What do you anticipate will be the impact on your practice as a result of having participated in this training?
3. What other topics would you have liked to be covered that would further enhance your work?
4. What do you think is the role of GPs in addressing psychosocial issues in their refugee patients?
5. What level of ongoing information / support would you like to have from VFST?

**Refugee Health and General Practitioner Network and future directions:**

Because many of the participating GPs were members of the GP Network some additional evaluation questions were asked.

6. How important is it to you that the GP network is sustained?
7. If the funding submission for the GP Program is successful and the GP Network could continue what would you expect the GP Network should provide? What would you like to be the Network's future role?
8. If the funding application is not successful – have you any suggestions for how the GP Network might be sustained?

Thank you for your participation.

## Refugee Health and General Practice Development Program

Educational Practice Visits: Whole-of-practice approach (May and June 2001)

Focus group with Counsellor Advocates who conducted the training

### **Purpose of evaluation**

- To report on the findings of the evaluation of the practice visits including analysis of evaluation sheets and phone interviews with selected participants and to seek Counsellor Advocates feedback and comments.
- To assess the value Counsellor Advocates assign to this whole-of-practice approach (usefulness / effectiveness).
- To identify strategies that assist in improving the approach (quality of training materials, range of topic areas, strategies to engage practices / CHCs).
- To assess the extent to which the training yielded positive results for daily practice of Counsellor Advocates (improved cooperation / referral practices).
- To identify barriers to engaging practices / CHCs into the training.

### **Evaluation Questions**

1. The approach promotes a whole-of-practice approach to professional development. How feasible was this in your experience? What were the positive features? What were the barriers encountered?
2. Did you find the training material provided (quality and coverage) sufficient? What were the good aspects? What areas could be improved?
3. Did you experience / observe improved cooperation with practices / CHCs as a result of the training?
4. Did you receive feedback from clients that indicate improved practice with refugee patients as a result of this training?
5. Will you use this approach / resource again?

## Refugee Health and General Practice Development Program

### Educational Practice Visits: Whole of Practice Approach

Impact evaluation with selected GPs / practice / centre staff conducted approximately four to six weeks after training

#### **Purpose of evaluation:**

- To assess the extent to which GPs and/or practice / centre staff believed they changed their practice with refugee patients as a result of the training.
- To assess the extent to which structural changes were introduced in this practice / centre as a result of the training.
- To assess the value that was assigned to the training (usefulness / effectiveness of whole-of-practice approach, relevance of training content).

#### **Evaluation Questions**

1. Did you notice any changes in your practice / work with refugee patients as a result of attending this training? (attitude) If yes, what were these?
2. Did you notice any changes in your colleagues in their work with refugee patients as a result of attending this training? (attitude) If yes, what were these?
3. Were there any structural changes introduced in your practice / centre as a result of the training? If yes, what were these? If no, why not?
4. Do you think it is useful that GPs and practice staff work in a coordinated way when working with refugee patients? If yes, what do you think are the benefits? If no, why not?
5. Did you find the quality of the training material sufficient? If yes, what were the good aspects? If no, what could have been improved?
6. Did the topics covered in the training meet your expectation? If no, what are the reasons?
7. Did you find the depth of the training content sufficient?
8. Are you interested in further training? If yes, what topics would you like to be covered?

## **Appendix 6: African Health Study (findings)**



# ASSESSMENT OF THE HEALTH AND VACCINATION STATUS OF RECENTLY ARRIVED IMMIGRANTS IN AUSTRALIA.

## AFRICAN COMMUNITY HEALTH PROJECT

SUE SKULL, BEV BIGGS, JOANNE NGEOW.

VICTORIAN INFECTIOUS DISEASE SERVICE, ROYAL MELBOURNE HOSPITAL &  
DEPARTMENT OF MEDICINE, UNIVERSITY OF MELBOURNE

### Feedback to Medical Practitioners

#### Overview:

The project was conducted between 19 June 00 and 29 July 00 at the Western Region Health Centre and the Banyule Community Health Service. Participants on the whole gave very positive feedback about the services the project was able to provide to the community, and indicated that it would be desirable to make a similar service available for their children.

Many previously undetected conditions were found during the project, resulting in referral to specialist clinics for hepatitis, TB and general infectious diseases. The information gathered during the course of the project has provided a useful addition to the limited Australian data available on the patterns of health status and health services utilisation among immigrants and refugees living in Australia. It represents the only data available on the health conditions affecting refugees and migrants from the Horn of Africa. Information of this type is essential to facilitate a holistic approach to the health care of immigrants on arrival in Australia.

#### Summary of results:

##### *Demographics*

126 participants were seen (80 female, 46 male) between the ages of 16 and 75 years (mean 34 years). The majority were from Somalia and had been resident in Australia for less than 2 years.

##### *Utilisation of health services*

General practitioners (GP) were reported as the main health care providers. Participants who reported having a regular GP were also less likely to have health concerns that they had not sought advice for. Participants found the lack of interpreters and their own poor command of English to be the biggest obstacles to accessing health care services in Victoria.

##### *Vaccination Status*

Almost all participants could not recall their vaccination status. The Australian Immunisation Handbook recommends that all persons with uncertain vaccination status should commence their vaccination schedule as though no vaccines had previously been given. Serological testing showed that three quarters of all participants had inadequate immunity against at least one of tetanus (67%), diphtheria (34%) or measles (3%). This was despite a median of 5 visits to all types of vaccine providers. Participants with regular GPs were more likely to have received one or more vaccines, however, many still had an incomplete vaccination status. All persons found to have an incomplete vaccination status were referred to their nominated GP to update their vaccinations.

### *Hepatitis B*

Chronic carriage of hepatitis B surface antigen was found in 6% of participants who were otherwise asymptomatic. These persons were considered at potential risk of complications of hepatitis B and were referred to a specialist Hepatitis clinic for ongoing management. Evidence of previous exposure to hepatitis B was found in 47%. This outcome increased with increasing age. Only a fifth of those not previously exposed showed serological evidence of hepatitis B immunisation.

### *Intestinal parasites*

15% of participants had parasitic infections detected on faecal microscopy. Parasites isolated included *Giardia lamblia*, *Trichuris trichiura* and *Entamoeba histolytica*. More than 10% of participants had positive/ equivocal serology to strongyloides and schistosomiasis indicating possible undetected infection. All persons found to have evidence of schistosomiasis or strongyloides were referred to an infectious diseases clinic with access to appropriate treatment, while persons with other parasites were referred to their nominated GP for further management.

### *Mantoux Testing*

Almost a fifth of participants (20/117; 17%) had a positive Mantoux result and 18/20 were seen at the Royal Melbourne Hospital for further investigations. One case of active tuberculosis was detected. This person continues to receive treatment via RMH.

### *Vitamin D status*

There is a high level of vitamin D deficiency in this population with 53% (61/116) having levels which were suboptimal. This was especially the case for women, Muslims and those with reduced sun exposure as a result of cultural practices. Importantly, 20% of adult males were also Vitamin D deficient. Participants who were resident in Australia for a longer period of time were also more likely to be lacking in vitamin D. As a result of these findings, our policy will now be to test all dark-skinned individuals for Vitamin D deficiency.

## **Conclusions:**

While routine screening programs such as those established in the 1970s are no longer appropriate, our project showed that it is important that relevant health checks in asymptomatic persons are undertaken at the primary health care level to detect chronic diseases that may have adverse outcomes. Certain communicable diseases were found to be much more common in East African immigrants than the general community. In particular, participants were at risk of vitamin D deficiency and having inadequate immunity to vaccine-preventable diseases. Specifically we would encourage clinicians to consider Mantoux testing, faecal microscopy and serology looking for intestinal parasites, hepatitis B serology testing, testing for Vitamin D levels in all dark-skinned individuals as well a careful history of current immunization status for any newly-arrived East African immigrant.

## **Acknowledgments**

We would like to thank the doctors and staff of the Western Region Health Centre and the Banyule Community Health Service for their support.