



victorian refugee  
health network

## **Asylum Seeker Health Orientation and Triage Model for Northern and Western Metropolitan Melbourne Evaluation Report**

**November 2013**

*A partnership between the Western Region Health Centre, Doutta Galla Community Health Service, ISIS primary care, Dianella and Darebin Community Health Service, the Australian Red Cross, AMES and the Victorian Refugee Health Network.*

*Funding was provided by the Inner North West Melbourne and Northern Melbourne Medicare Locals to provide coordination for the project.*

*Valuable support was given by the GP Refugee Health Program Coordinator, funded through the Macedon Ranges and North Western Melbourne Medicare Local, the Refugee Health Fellow, Royal Melbourne Hospital and the Royal Children's Hospital.*

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## List of Acronyms

ARC	Australian Red Cross
AMES	Adult Multicultural Education Services
ASAS	Asylum Seeker Assistance Scheme
BVE	Bridging Visa E
CAS-TS	Community Assistance Scheme – Transition Support program
DIAC	Department of Immigration and Citizenship
DIBP	Department of Immigration and Border Protection
GP	General Practitioner
IHMS	International Health and Medical Services
INWMML	Inner North West Melbourne Medicare Local
MCH	Maternal and Child Health
NMML	Northern Melbourne Medicare Local
PAG	Project Advisory Group
RCH	Royal Children’s Hospital Melbourne
RHN	Refugee Health Nurse
SEMML	South Eastern Melbourne Medicare Local
WRHC	Western Region Health Centre

## Executive summary

This report presents the evaluation findings and lessons learned from the *Asylum Seeker Health Orientation and Triage Model for Northern and Western Melbourne (HOTAS)* project. The evaluation concerns both the implementation of the project, together with an evaluation of the triage approach, as this evolved throughout the course of implementation.

This project was established by the State-wide Refugee Health Nurse Facilitator and developed as a partnership across four community health centres; the Western Region Health Centre, Doutta Galla Community Health Service, ISIS primary care, Dianella and Darebin Community Health Service, in collaboration with the Australian Red Cross, AMES and the Victorian Refugee Health Network.

Funding was provided by the Inner North West Melbourne and Northern Melbourne Medicare Locals to provide coordination for the project for the period May to November 2013. Following an Expression of Interest process, this role was undertaken by the Western Region Health Centre.

The community health centres provided Refugee Health Nurses to staff the triages, with funding support provided by an additional allocation of \$670,000 (in March 2013) provided by the Victorian Government for refugee healthcare across the state to support the surge in numbers of asylum seekers arriving in Victoria. Funding of \$22m over four years for refugee health services was subsequently announced in the 2013-14 Victorian state budget.

Valuable support was given by the GP Refugee Health Program Coordinator, funded through the Macedon Ranges and North Western Melbourne Medicare Local, the Refugee Health Fellow, Victorian Infectious Diseases Service, Royal Melbourne Hospital and the team from Immigrant Health, Royal Children's Hospital.

### **Project Aims**

The HOTAS project approach was developed in response to the rapid, unplanned and unpredictable release of large numbers of asylum seekers from detention facilities in Australia. Specifically, the pilot project planned to deliver the following aims:

- To pilot an approach to providing high quality health orientation, triage and GP referral for vulnerable populations from refugee backgrounds.
- To pilot an approach to efficiently manage health services provision for the significant influx of new arrivals from refugee backgrounds.
- To provide program participants with health education, health services orientation, an initial health screen triage and timely referral to primary care services in order to prevent deterioration of health concerns and potentially more costly interventions at a later date.
- To provide referral to specialist and emergency care where required.
- To scope and investigate possible resources and existing infrastructure that may be used to make the program sustainable at the conclusion of the pilot period.

### **Results and Outcomes**

In the period December 2012 – September 2013, a total of 818 people attended 17 triage sessions, with 777 receiving health orientation. Two per cent of those triaged required immediate transfer to an Emergency Department and twenty two per cent required

appointments in the next 1 – 3 days, which were made on the day of the triage. If the triage sessions had not taken place, it is highly likely these people requiring immediate appointments would not have seen a medical professional for a much longer period of time, with potential serious health repercussions as a result. The provision of health orientation delivered key messages to new arrivals with regard to accessing health services and navigating the health system.

This project developed the knowledge and capacity of all those directly involved in the provision and receipt of the health orientation and triage sessions. It also raised the awareness of the complex needs of this client group. It established links between clients, case workers and health service providers, delivering more integrated referral pathways. Partnerships of real value and importance have been built by this project and it is essential that this network of relationships is maintained into the future.

In addition to the group health orientation and triage sessions, other activity instigated as a result of needs identified through this program included:

- Development of standard content for health orientation sessions;
- Development of training materials for case workers regarding health issues and services;
- Delivery of 12 training sessions and 150 case workers from ARC and AMES;
- Identification across the state of need for robust system of health alerts for those with significant health concerns that is now being progressed with the Department of Immigration and the detention health service;
- Identification of additional General Practices with an interest in refugee health and the commencement of work to develop a statewide/national approach to General Practice Liaison and Support.

### ***Challenges***

The evaluation identified a number of challenges encountered during project implementation. One of the most significant challenges was the changing demographics of the asylum seekers released from men on their own to families with children, which introduced additional complex health needs and required a revision of the triage model.

Asylum seekers are particularly vulnerable and typically have low levels of health literacy. Another key challenge was the limited availability of general practices engaged in refugee health, able to respond to this unprecedented demand. Finally, the capacity of case workers with regard to their understanding of health concerns and their importance, together with an understanding of the specialist services available for asylum seekers and refugees was an area in need of development.

A number of these challenges are outside the control of this project, but the flexibility and innovation of the implementation successfully addressed those challenges within the scope of its timeframe and influence

### ***Sustainability***

It has been agreed by the Project Advisory Group that whilst the current fund for project coordination has concluded, the health orientation and triage model could still be sustained within certain constraints. The current refugee health nurses and ARC and AMES case workers could provide a single session a month for up to 50 people.

## **Lessons**

The 3 key lessons are:

1. The importance of the triage health screen and referral as a rapid response, particularly for large groups of new arrivals
2. The importance of the health orientation sessions, and the need for further development in this area.
3. The importance of developing and maintaining knowledge and capacity of the case workers and general practices in refugee healthcare.

For large numbers of people, the health orientation and triage model is very effective in prioritising those with urgent health needs, rapidly link them in with the appropriate health service and provide timely health services information to support people to access the services they need independently.

This project successfully picked up the diverse health needs of clients early and delivered a timely intervention to issues that could have been missed altogether, or treated after a period of time detrimental to the individuals concerned.

This project successfully developed the knowledge and capacity of a number of groups. It provided asylum seekers with basic information around certain health issues and support to navigate the health system. It developed the capacity of case workers around the complexity of diverse health issues and appropriate referral pathways. It enabled a more thorough follow-up for the health issues of individual clients.

The objectives of this project, with regard to developing the approach and model to provide quality health orientation and triage, and efficiently manage health services provision, remain relevant to respond to any future influx of refugees and asylum seekers.

## **Recommendations**

A number of recommendations are made with a broader application to health sector development to respond to the complex health needs of refugees and asylum seekers. These include the need for investment in the development of health literacy programs for new arrivals; state-wide provision of support to general practices to support their care of refugees and asylum seekers; and more structured capacity development for case workers around health issues and the health system.

There are also recommendations specific to the future implementation of the group health orientation and triage model. These include tailoring the triage process to respond to the demographics of those participating, such as separate triages for women and children; the revision of the delivery and content of the health orientation; and modifications to the data collection. Evaluation would be enhanced with follow-up at a later date with a sample of clients who received the orientation and triage.

### **Triage program**

#### ***Operational issues for future triage programs***

1. Consideration be given to ways of following up with clients to measure impact of the program including usefulness of health orientation sessions, and sustainable links made into health services.
2. Consideration be given to replicate dual approach – group health orientation and triage and nurse led outreach model to suitable accommodation facilities.

3. Tailor the triage process to respond to the demographics of those participating e.g. separate triages for families, or for women and children, ensuring referral pathways are in place for pregnant women and children under 5 years of age.
4. Allow more time for health orientation to provide the opportunity for a more conversational style with questions, the introduction of other relevant health issues and for health promotion messages (e.g. maternal and child health, sexual and reproductive health, oral health, nutrition etc.).
5. Develop a systematic follow-up to record information about appointments made by case workers according to the timeframe recommended at triage and overall attendance at appointments.
6. Consider the amount and purpose of the data collected, to ensure a balance between information and data needs, with the time taken to collect and analyse data.

#### *Transfer of information and health information*

7. The Department of Immigration consider ways to improve the timeliness and accuracy of information about the number of people to be released from detention, including demographics, to allow more efficient preparations for arrival by the asylum seeker agencies and health services.
8. Triage program to introduce a system to measure and monitor the consistency, detail and accuracy of the health discharge summaries provided to people on release from detention facilities, and provide regular feedback to the Department of Immigration of any concerns.

#### Broader Sector development

#### *Transfer of information and health information*

1. The Victorian Refugee Health Network continue to work with the Department of Immigration, Detention health services providers and the Victorian Department of Health to introduce a health alert system or similar for those with significant health concerns including latent TB, mental health, HIV, requiring timely medical follow-up.

#### *Health information and health services information for new arrivals*

2. The Victorian Refugee Health Network, Community Health Services, Water Well and Medicare Locals, work to develop sustainable approaches to providing timely health information and health services information to new arrivals across a variety of settings, eg one to one consults, group information, community advisory approaches.

#### *General Practice Support*

The number of General Practices able to work with new arrival refugee background populations is insufficient to meet demand, particularly in the outer metropolitan regions.

3. Medicare Locals to work with Refugee Health Nurses and Case work services to maintain an accurate record of General Practices offering refugee health services and develop a process for effective dissemination of this information.<sup>1</sup>
4. Consideration be given to duplicating the current NW Melbourne and Macedon Ranges and SW Melbourne ML GP Refugee Health Program Coordinator in the North (Northern Melbourne and Inner North West) and expanding the program to include broader practice support.

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<sup>1</sup> See for example, list prepared by the GP Refugee Health Program Coordinator for community health centres and general practices in the West (see Annex 11).



5. The Victorian Refugee Health Network, in consultation with Community Health Services, Medicare Locals, hospital and specialist services continue to explore potential formal shared care/GP liaison/co-ordinated care models for this population, to enhance referral pathways, provide opportunities for secondary consult support, professional and organisational development and other supports identified by General Practice to sustain their practice in this area.

*Case workers*

6. Australian Red Cross (ARC) and AMES, supported by the Refugee Health Nurse program ensure all case workers have in-depth orientations around health issues and presentations, together with the structure and functions of the Victorian health system for case workers.
7. ARC and AMES consider dedicated Health Liaison roles, within their staff teams to act as a point of contact with health services and build in-house expertise in health issues.

*Health orientation and triage model*

8. Based on the findings and conclusions from this project, further refine this model for use in other contexts applicable beyond releases from detention.

## Introduction

This report presents the evaluation findings and lessons learned from the *Asylum Seeker Health Orientation and Triage Model for Northern and Western Melbourne (HOTAS)*<sup>2</sup> project.

This report provides an overview of the project and also presents some analysis of the de-identified data that was collected during the triage sessions. The evaluation concerns both the implementation of the project, together with an evaluation of the triage approach, as this evolved throughout the course of implementation.

Health Orientation and Triage sessions were trialled in a pre-pilot phase starting in December 2012 and running until May 2013. During this period, the need for a more formalised partnership model was identified and put into place in May, 2013 when the 6 month pilot period commenced after funding for coordination was secured.

This project was established by the State-wide Refugee Health Nurse Facilitator and developed as a partnership across four community health centres; the Western Region Health Centre, Doutta Galla Community Health Service, ISIS primary care, Dianella and Darebin Community Health Service, in collaboration with the Australian Red Cross and AMES. The project workers from the Victorian Refugee Health Network also supported the establishment and implementation of the project.

The coordination of the pilot project was funded by the Northern Melbourne Medicare Local (NMML) and Inner North West Melbourne Medicare Local (INWMML). Following an Expression of Interest process, this role was undertaken by the Western Region Health Centre.

The community health centres provided Refugee Health Nurses to staff the triages, with funding support provided by an additional allocation of \$670,000 (in March 2013) provided by the Victorian Government for refugee healthcare across the state to support the surge in numbers of asylum seekers arriving in Victoria. Funding of \$22m over four years for refugee health services was subsequently announced in the 2013-14 Victorian state budget.

In the pre-pilot phase, Doutta Galla provided administrative support as well as a GP at a triage session. Further GP support during the pre-pilot phase came from the Refugee Health Fellow and the provision of time given pro-bono. Valuable support was given by the GP Refugee Health Program Coordinator, funded through the Macedon Ranges and North Western Melbourne Medicare Local. The role of GP Refugee Health Program Coordinator is to engage and support GP practices to work effectively with refugee and asylum seeker clients, so this program was able to identify a number of practices for referral purposes.

This evaluation covers both the pre-pilot period, December 2012 - April 2013, and then the pilot period from May 2013 - November 2013, recognising that the pre-pilot data is valuable and informs the information gathered throughout the pilot period.

The recommendations and lessons of this report aim to inform future health and community level responses to rapid and unpredictable increases in the number of asylum seeker and humanitarian arrivals. It also serves to inform broader health sector development for

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<sup>2</sup> The full name of this project according to the resourcing proposal is the Asylum Seeker Health Orientation and Triage Model for Northern and Western Melbourne. During implementation it came to be referred to as the Health Orientation and Triage project for Asylum Seekers, or HOTAS, which is how it will be referred to throughout this report.

refugees and asylum seekers, since this project has identified learning and recommendations applicable beyond the health needs of people being released from detention.

## Context

In 2012-13, boat arrivals of people seeking asylum in Australia increased significantly, in comparison to previous years.

**Table 1: Boat arrivals from 2011 – 13.**

Calendar Year	Number of Boats	Number of Crew	Number of People (exc. Crew)
2011	69	168	4,565
2012	278	392	17,202
2013 (to 30 June)	196	407	13,108

**Source:** Customs and Border Protection advice provided to the Parliamentary Library on 1 July 2013, quoted in *Boat Arrivals in Australia since 1976*, Parliament of Australia Research Papers 2013-14.

The Commonwealth Department of Immigration and Citizenship (DIAC)<sup>3</sup> announced on 30 June 2012 that it would begin to release men and women asylum seekers, without children, into the community on a Bridging Visa E. This visa provides eligibility for Medicare, but all those who arrived by boat on or after 13<sup>th</sup> August 2013 are prohibited from working.

The Health Orientation and Triage project for asylum seekers was implemented in response to the Commonwealth Government announcement that 2,000 asylum seekers per month would be released from Australian immigration detention centres to live in the community while finalising their immigration matters, or waiting for an immigration decision.<sup>4</sup> It is recognised that living in the Australian community has far greater positive health and wellbeing outcomes for individuals than being in detention.

The Victorian refugee health sector noted that in order to ensure adequate and appropriate health information and care on release, a rapid, region-based response was needed. An orientation and triage model had already been established in the South East. The *Asylum seeker integrated healthcare pathway* was piloted by South Eastern Melbourne Medicare Local (SEMML) and Monash Health between September and December 2012<sup>5</sup>. The *Asylum seeker health orientation and triage northern and western Melbourne* built on this model in the South East, adapting it to suit the specific context in the North and West and to respond to the significantly increased numbers. Two thirds of the ARC's clients receiving health orientation were being released from detention to the North West of Melbourne.

In the South East project, health staff were drawn from a large metropolitan hospital and its associated community health centre. In the North West, nurses from 4 community health centres, all with different and competing demands, were engaged for the project. In addition, the role of the single Medicare Local in the South East was significantly different to that played by the multiple Medicare Locals that funded this project in the North West. In

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<sup>3</sup> Renamed Department of Immigration and Border Protection in September 2013. This report will refer to the Department as DIAC when referring to the Department during the period before it is renamed.

<sup>4</sup> Australian Government. Irregular Maritime Arrivals on Bridging Visa E [Internet] 30 June 2012 Canberra (AUS): Department of Immigration & Citizenship, 2012. June 30 [cited 2013 July 15]. Available from: <http://www.immi.gov.au/media/statistics/pdf/bve-statistical-report-30june-2012.pdf>

<sup>5</sup> *Asylum Seekers Integrated Healthcare Pathway, Health Orientation Session Pilot: September – December 2012*, Report Summary, South Eastern Melbourne Medicare Local – [www.semml.com.au](http://www.semml.com.au)

the North West, there were a large number of general practices located across fourteen local government areas.

The arrangements in place to support asylum seekers on release consisted of the Community Assistance Scheme – Transition Support program (CAS-TS), delivered primarily by the Australian Red Cross (ARC) and AMES. The CAS-TS program provides temporary support for 6 weeks, which includes temporary housing, basic financial assistance and support from a case worker to get to know the local community, help to open a bank account and apply for Medicare and assistance with finding ongoing accommodation, minimal English classes and employment, if eligible to work. After this period most clients are eligible for the Asylum Seeker Assistance Scheme (ASAS). Those considered highly vulnerable may be eligible for CAS on an ongoing basis.

The CAS-TS and ASAS support includes referral for general counselling, medical support and torture and trauma counselling. These referrals are organised by the case workers, who are generally social workers, who have minimal health training.

Asylum seekers are a highly vulnerable population group and may not seek health services, or struggle to access them, due to limited health service literacy, language and cultural barriers to access, and socioeconomic disadvantage.<sup>6</sup> These health inequalities may be compounded by past experiences of torture, sexual assault and other forms of trauma (war, violence, persecution etc.) that impact on mental health.<sup>7</sup> The impact of sometimes extended periods in detention and/or extended periods of uncertainty in relation to asylum claims, for those who have sought protection on-shore in Australia, also may affect their health after release from detention and negatively impact their settlement into local communities.<sup>8</sup>

The health issues reported amongst asylum seekers released from detention prior to commencing this project included a high prevalence of mental health issues, infectious diseases, chronic illness, nutritional deficiency and vaccination gaps.<sup>9</sup> Many people have multiple health concerns, and require referral to multiple services (such as dental, optometry and physiotherapy). Many asylum seekers need support to gain access to Medicare and services that can assist with management of chronic diseases and to ensure access to preventative medicine such as health check-ups, screenings, vaccination and health information.

During the project, a series of policy changes resulted in a change of demographics of the people being released from detention from predominantly men on their own and a few women, as part of a couple, to families with children. Further policy changes also resulted in the last group of arrivals not having their asylum claims processed. Many asylum seekers are highly transient, living in short-term emergency accommodation provided through the CAS-TS program for the first 6 weeks, low cost private rental, or staying with community links, due to low income and uncertain circumstances.

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<sup>6</sup> Foundation House (2012), 'Chapter 1: Why focus on refugee health?' in *Promoting Refugee Health: a guide for doctors, nurses and other health care providers caring for people from refugee backgrounds*, pp.15-30.

<sup>7</sup> Foundation House (1998), 'Chapter 2: The psychosocial impact of torture and trauma', in *Rebuilding Shattered Lives*, pp. 29-69.

<sup>8</sup> Coffey, Kaplan, Sampson, Tucci (2010), 'The meaning and mental health consequences of long-term immigration detention for people seeking asylum', *Social Sciences and Medicine*, vol.70, pp. 2070-2079

<sup>9</sup> *Asylum Seekers Integrated Healthcare Pathway, Health Orientation Session Pilot: September – December 2012*, Report Summary, South Eastern Melbourne Medicare Local – [www.semml.com.au](http://www.semml.com.au)

The on-arrival health orientation and triage sessions provided a unique opportunity to link this vulnerable population in with health services in a timely manner and provide basic health messages.

Asylum seekers released from detention typically have a minimal understanding of the Australian health system and are highly vulnerable, so it is critical that they have access to an initial health screen conducted by health professionals. This occurs in the triage and they are also provided with a basic health orientation presentation about how the Australian health system works. The triage model provides an opportunity for people to be effectively linked with the appropriate healthcare services on arrival into the community.

Failure to do this would likely result in immediate health concerns not being addressed, individuals running out of essential medicines, an increased public health risk with infectious diseases and unnecessary presentations at emergency departments. This would result in the need for more costly interventions, with the development of multiple and complex health issues placing a high demand on secondary and tertiary health services, without additional resources to meet the needs. Asylum seekers are at risk of significant health inequalities and have little to no understanding of the Australian healthcare system and how to access medical care.

## **Project background**

The project was managed by the Project Coordinator, and supported by the Project Administrator, funded by the Northern Melbourne and Inner North West Medicare Locals, and based at Western Region Health Centre. The Australian Red Cross (ARC) Community Assistance Scheme – Temporary Support (CAS-TS) program team has been an invaluable and innovative partner in this process. The ARC provides support to approximately one third of the CAS caseload in Victoria, with AMES providing support to the remaining two thirds. The triage sessions from December 2012 occurred in partnership with the ARC and supporting their client caseload. The Project Co-ordinator undertook significant relationship building and project scoping work in order to develop an equivalent approach to working with clients supported by AMES, to fit within AMES procedures and systems, which culminated in an initial triage session with AMES in September 2013. No further group releases from detention have occurred since September 2013.

This project aimed to provide high quality health orientation, healthcare triage and appropriate referral for asylum seekers on Bridging Visa E being released into the Victorian community from detention facilities.

Specifically, the pilot project planned to deliver the following aims stated in the resourcing proposal:

- To pilot an approach to providing high quality health orientation, triage and GP referral for vulnerable populations from refugee backgrounds.
- To pilot an approach to efficiently manage health services provision for the significant influx of new arrivals from refugee backgrounds.
- To provide program participants with health education, health services orientation, an initial health screen triage and timely referral to primary care services in order to prevent deterioration of health concerns and potentially more costly interventions at a later date.
- To provide referral to specialist and emergency care where required.
- To scope and investigate possible resources and existing infrastructure that may be used to make the program sustainable at the conclusion of the pilot period.

The 6 month pilot phase focused on working with asylum seekers released from detention on a BVE, who were supported primarily by the Australian Red Cross in the region, in order to trial the orientation and triage approach, gather data on the model's efficacy and on prevalent health concerns, and evaluate the cost-effectiveness of the approach.

The project was initially designed to respond to the healthcare needs of men on their own, who with a small number of women, were being released from detention on Bridging Visa E. In May 2013, this changed significantly, and the project evolved to adapt to the needs of families, and greater numbers of women on their own and couples, when these groups started being released with a Bridging Visa E, previously all families were released from held to community detention.

This resulted in refocusing the project to not only pilot an intervention to respond to a high number of diverse asylum seekers, but also to build organisational and sector responsiveness to a rapid and unpredictable change to asylum seeker demographics, entitlements and living arrangements. The lack of predictability of asylum seeker releases, demographics and entitlements has been a constant in recent Australian history and is likely to continue to be unpredictable into the future.

The release of significant numbers of asylum seekers from detention into the community necessitated the need for an immediate response. As a result, the health orientation and triage model was adapted throughout the course of the implementation of this project to respond to needs as they arose (such as the change from single men to families) and to improve its efficiency on an ongoing basis, as lessons were identified. Two key foundations for the successful delivery of the project were the flexibility of the model and the innovation of the services and staff involved in implementation.

Fifteen health orientation and triage sessions were held at the Multicultural Hub in central Melbourne and two sessions at the Australian African Community Centre in Footscray. The project team coordinated the supply of free fruit to those attending, as part of the triage process, from an organisation called Second Bite.

#### **The original health orientation and triage model**

The ARC and AMES were, at the time of this project, contracted by the DIAC, to provide casework support to asylum seekers in the first six weeks after release from detention. Part of this care package is the provision of an orientation day that focuses on living in the community, seeking legal assistance, living and employment services and assistance to sign up for Medicare. A large volume of information is therefore disseminated during an intensive day, which runs the risk of key health orientation messages being diluted or lost.

It was originally anticipated that the health orientation and triage session would be run as part of this orientation day. However, due to the volume of people needing to be triaged, a separate triaging day was introduced and included a presentation from DIAC, which ensured all clients would attend.

This evaluation captures data from both the pre-pilot (December 2012 – April 2013) and pilot periods (May – November 2013). The pre-pilot sessions provided evidence of significant needs and proved to be an effective approach for engagement and referral. The 6 month pilot provided the opportunity to trial and evaluate this approach in more detail. Changes were made early in the pre-pilot to provide a more effective service during the pilot period. The model described below is the original model that was refined throughout the course of implementation. Changes made to the model are described within the narrative around the evaluation framework.

The adapted model included the following components:

#### Health orientation

- A health talk provided by one of the Refugee Health Nurses to all those attending (approximately 50 clients) with interpreters provided by the Red Cross (may be as many as 4 interpreters of different languages). This talk provides a basic overview of health services provision in Victoria (i.e. Medicare, role of GPs, community pharmacy, community health services and Refugee Health Nurses, torture and trauma counselling, hospital and emergency services). It explains the need for the GP to be the first point of contact for medical issues, outside of an emergency.

#### Triage<sup>10</sup>

- Clients are invited to see a Refugee Health Nurse to discuss health concerns, according to the following four steps:
  - a. The welcome desk where informed consent and basic demographic data is recorded.
  - b. The triage desks: Refugee Health Nurses (between 4-7) and a GP, if required. The screen is designed to triage individuals into one of 4 categories (see Annex 10 for more detail about the medical issues included in the individual categories):
    - (1) Referral to an Emergency Department, for clients who are seriously unwell (i.e. chest pain), actively self-harming, or showing signs of severe agitation and/or psychosis. Referral to a dental hospital emergency department if there is facial swelling or new mouth/teeth trauma;
    - (2) Referral to a GP in 1 - 2 weeks for clients with health needs that require follow-up by a GP (in private practice or Community Health) with presentations that may include asthmatic/chronic respiratory problems, terminally ill, diabetes, chronic liver or renal disease, suffers severe allergic reactions, repeat prescription medication;  
(Note the revision to Category 2 once families started to be triaged, described below.)
    - (3) Requires GP or community health review in the next 2 - 4 weeks for clients with non-urgent health needs including immunisation, dental referrals, repeat prescriptions and stable chronic health conditions (e.g. low Vitamin D, non-specific joint pain, mild anxiety etc.);
    - (4) May require GP review in next 4 -6 weeks for the same conditions as Category 3.
  - c. Referral to on-site GP for prescriptions and/or further medical opinion if required.
  - d. Appointment desk: Appointments are made with local services for those requiring appointments within 1 – 2 weeks. When family groups came into be triaged, the categorisation changed, so appointments were only made for those requiring them in 1 – 3 days. However, there was some flexibility, with appointments made on the day for clients in Category 3 who lived in areas where appointments were difficult to get and had a long waiting time, or for those to be included in appointments for Category 2 family members. Participants are given a card on the day that tells them the details of their appointment, treating doctor and a map and address of clinic which, as far as possible, is on a direct public transport route or within walking distance of their

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<sup>10</sup> See Annexes 6-11 for the tools used information about the categories allocated to clients.

accommodation. Australian Red Cross staff provide follow-up support (e.g. a reminder phone call) to attend their appointments.

It is important to note that the triage approach is an initial health screen to prioritise treatment needs to inform referrals to the correct health service provider. It does not include a comprehensive health assessment and the commencement of any treatment.



# Health Orientation and Triage

## 1. Registration








Registration tasks:

1. Give triage form to the client and direct them to the triage desk (with interpreter)

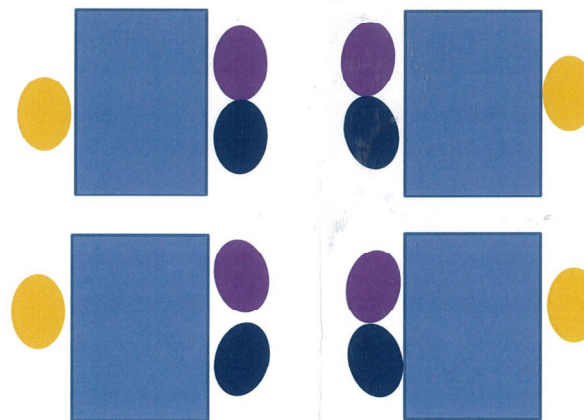


GP private consultation room  
(for onsite referral to GP)

### Key

	Client		GP
	Interpreter		Nurse
	Admin, project or case work staff		

## 2. Nurse/GP Triage



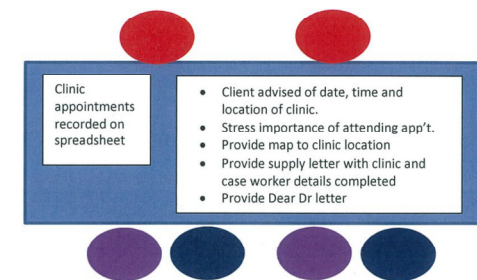
### Nurse/GP Triage tasks:

1. Perform triage, by looking at IHMS data, screen using tool, recommend follow up and care and explain to client.
2. Complete section 2 of the triage form; date, country of birth and section 3 on data slip.
3. Record work using statistics sheet (including the reference number, presenting concerns and triage category).
4. Explain what to take to doctor (triage form and IHMS information).
5. If Category 2A direct client to appointment desk with triage form.
6. For all other categories please retain triage form and data slip for collection, copying and return to client by ARC case workers.

### Traffic director:

1. Directs Category 1 & 2A clients to appointment desk.
2. Assists with the flow of queues and locating interpreters.
3. Collects all triage forms and data slips.

## 3. Appointment Desk



### Appointment desk tasks:

1. Ask client for triage form.
2. Make an appointment based on triage category 1 or 2A near the client's location.
3. Fill out appointment sheet for medical clinic and complete green slip and retain with triage form.
4. Give client appointment details and attach to map of how to get there.
5. Explain if health situation changes what to do

### Who takes what home:

#### Project staff to take:

- Triage forms with attached data slips
- Statistics forms

#### After triage:

##### Project staff will:

- copy triage forms and ensure that important information about appointments is included.
- Compile a spreadsheet showing all triage categories, note where appointments have been made and timelines for appointments all other categories.
- Return copies and originals of triage forms to Red Cross by noon the following day to enable case workers to follow up appointments and understand urgency.

# Evaluation

## Methodology

A Project Advisory Group<sup>11</sup> was established, in accordance with the resourcing proposal, including all the key stakeholders involved in the project's funding and implementation. This group agreed the evaluation framework and key indicators that were developed, which is included as Annex 2. The monitoring and evaluation of this project was conducted by a Project Worker of the Victorian Refugee Health Network, supported by the Project Administrator and in collaboration with the Project's Advisory Group.

The purpose of the evaluation is to review and assess the approach and model for the provision of effective health orientation and triage services to asylum seekers recently released from detention into the Victorian community. The evaluation also considers the cost effectiveness and sustainability of the model.

A range of qualitative and quantitative data was collected in order to improve the process over time, and evaluate the project's impact against its stated objectives. The evaluation has utilised the data collected at each triage to review the variety and complexity of health issues that people presented and the necessary action taken,<sup>12</sup> thus demonstrating the critical need for such an approach and development of the model. The evaluation is further informed by qualitative information collected through six detailed interviews<sup>13</sup> with 7 key stakeholders<sup>14</sup> involved in the implementation of the project.

It is important to acknowledge that this is a point-in-time evaluation, which focuses more on the effectiveness of the model to inform future action, than an evaluation of the quality of the project implementation itself. Due to the evolutionary nature of the project and responsiveness of the implementation, the quality of the data collection improved throughout the project period, although some gaps remain. However, particularly during the pre-pilot period, the data collection was inconsistent. Asylum seekers recently released from detention are a particularly fluid population with a very high probability of relocating. This makes it very challenging for health workers to keep track of all those who passed through the one off triage and health orientation sessions.

A decision was taken not to involve clients directly in this evaluation, primarily motivated by expediency and the difficulties of getting ethics approved within such a short timeframe. The evaluation of the impact of this project would have been strengthened if it was possible to follow-up with a number of clients after a set period of time to see whether the orientation had been useful and advantageous. It also would have been beneficial if there was follow-up with a sample of case workers to assess whether appointments had been made within the timeframe stipulated according to the category from the triage.

Some underlying principles for the evaluation were agreed to by the Project Advisory Group. These are the protection of confidentiality, ensuring a client-centred approach and investigating all avenues and infrastructure for sustainability.

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<sup>11</sup> PAG members: Western Region Health Centre, Northern Melbourne Medicare Local, Inner North West Melbourne Medicare Local, Macedon Ranges and North Melbourne Medicare Local, South West Melbourne Medicare Local, Doutta Galla Community Health Service, ISIS primary care, Dianella and Darebin Community Health Service, Joslin Clinic, North Yarra Community Health, ARC, AMES, Victorian Foundation for Survivors of Torture and the Victorian Refugee Health Network.

<sup>12</sup> See Annex 3 for the data analysis.

<sup>13</sup> See Annex 12 for the interview questions

<sup>14</sup> 2 ARC staff in 1 interview.

## **Results and findings<sup>15</sup>**

A total of 17 triage sessions were conducted over both the pre-pilot and pilot phases, with health orientation delivered at 16 of these sessions, since there was no health orientation at the very first session. A total of 6 health orientation and triages were run with Australian Red Cross clients in the pre-pilot period from 11 December 2012 - 30 April 2013. Eleven sessions were run in the pilot phase (May 2013 - September 2013), with 10 run with Australian Red Cross and 1 session was run with AMES clients in September.

### *Demographics*

Iran was the most common country of birth for asylum seekers attending the orientation and triage sessions, with 40% of participants in the project, followed by Afghanistan (22%), Pakistan (10%) and Sri Lanka (9%).<sup>16</sup> This compares with the South-East triage model, where Afghanistan was the most common country of birth (43%), followed by Sri Lanka (22%), with Iran comprising only 16% of the population. Further information is outlined in table 2 below.

**Table 2: Number of Asylum Seekers per Country of Birth**

Country of Birth	Number of Asylum Seekers	Percentage of Total
Iran	319	40
Afghanistan	177	22
Pakistan	84	10
Sri Lanka	75	9
Burma	43	5
Stateless	33	4
Iraq	28	3
Sudan	20	2.5
Bangladesh	15	2
Other Asian	5	0.6
Lebanon	4	0.5
Syria	2	0.2
Indonesia	1	0.1
Malaysia	1	0.1

Seventy per cent of those engaged with the project in the North West were aged between 19-45 years (refer to table 3 for more details).

**Table 3: Age Groups of Asylum Seekers**

Age range (years)	Number of Asylum Seekers	Percentage of Total
0-5	34	4.5
6-10	33	4
11-15	19	2.5
16-18	50	7
19-25	211	28
26-35	258	34

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<sup>15</sup> A more detailed presentation of the data collected through the triage sessions is presented in Annex 3.

<sup>16</sup> All of the below data presentation and analysis comes from work completed by Rebecca Pallot.

<b>36-45</b>	<b>99</b>	<b>13</b>
<b>46-65</b>	<b>47</b>	<b>6</b>
<b>66+</b>	<b>2</b>	<b>0.3</b>

In comparison to the Asylum Seeker Integrated Healthcare Pathway project in the South East, more females (21%) were screened in the North West compared to the 2% for females screened in the South East. The North West service saw increasing trends of families arriving together during the May - September 2013 period.

### *Health presentations and referrals*

A total of 818 people attended the triage sessions, with 777 receiving health orientation. The largest group seen by the triage team was a group of 74 people who participated in the health orientation and triage on 28<sup>th</sup> August 2013. The average group size was between 45-50 people. In total, 14 people were referred to an emergency department. One hundred and seventy six appointments were made on the day to private GPs and community health clinics, according to data received from the ARC, meaning 22 per cent of all the people triaged required an immediate appointment to be made. It should be noted that a small number of people within this percentage would not have been in Category 2, but still had appointments made on the day for the reasons outlined above.

According to data collected by the project, a further 34 per cent of those passing through triage required an appointment in the next 1 – 4 weeks, according to their categorisation. At triage, 94 referrals were made to private GPs and 87 to community health clinics, for appointments to be made for clients to be seen over the next 1 – 6 weeks. Sixty six people were recommended to seek support at both community health clinics and private GPs.

Overall the top health concerns<sup>17</sup> for asylum seekers in this project (regardless of nationality and age) were:

1. Catch-up immunisations (56%)
2. Dental (31%)
3. Optical (10%,)
4. Musculoskeletal (9%) and
5. Mental health (8%)

It is important to note that this was a triage and not a complete mental health assessment, so limited questions were asked around sadness, anxiety and initially about ease of sleep, as the indicators for mental health considerations.<sup>18</sup> Further considerations must be taken into account, as the sessions were carried out in a large room, with up to seven triage desks for nurses and clients, so was not private. Other potential reasons why reporting was low at triage for mental health issues include the cultural stigmatisation of mental health considerations in many cultures and the fear disclosure might affect their visa consideration. When this is combined with the fact that many asylum seekers were quite euphoric during their first days after release, it is likely that levels of mental health issues would be understated through this process. The triage purpose was designed to conduct a basic health screen, but to refer on for a comprehensive health assessment, including a mental health screen.

South East health data findings were similar in comparison, with immunisations required in 60% of cases, dental 24%, mental health 15%, musculoskeletal 13% and 9% optometry.

<sup>17</sup> See Annex 3 for a more detailed presentation by age group and country of birth.

<sup>18</sup> See Annex 9.

It is important that children are linked in with health services as soon as possible after their arrival into the community.

The top 5 health presentations for children at triage were very similar to the overall top 5, with a higher prevalence of mental health concerns:

1. Immunisation
2. Dental
3. Optical
4. Mental health
5. Musculo-Skeletal

Given the top health concerns are complex and often a-symptomatic (i.e. the need for catch-up immunisation), the triage is a very useful way to ensure that health concerns are followed up within the necessary timeframe. The triage offers the opportunity to identify and discuss medication needs, mental health referral, dental referral and timeframes for ensuring immunisations are completed with the clients.

Asylum seekers have low rates of immunisation on arrival, are unlikely to have immunisation consistent with the National Immunisation Schedule and very rarely carry any history, or bring immunisation records with them. This creates significant barriers to catch-up, so the triage process was critical to ensure children and adults could overcome these barriers.

Two per cent of those triaged required immediate transfer to an Emergency Department and twenty two per cent required appointments in the next 1 – 3 days, which were made on the day of the triage. If the triage sessions had not taken place, it is highly likely these people requiring immediate appointments would not have seen a medical professional for a much longer period of time, with likely serious health repercussions as a result.

It is therefore fair to conclude that the triage process served its purpose in identifying those with priority needs and arranging the necessary appointments. In addition, further complex cases, for example mental health concerns, understanding and following treatment regimens and pregnancy, were identified and adequately referred for follow-up.

#### *Project design and innovative responses to an evolving context*

Under changing circumstances and an evolving context, the project successfully provided a rapid response to the increased numbers of asylum seekers released from detention and settling in Victoria.

Organising the response to the rapid increase in asylum seekers released into the community in North and Western Melbourne was made more complex by both the changing demographics of the population released, together with the short notification timeframe provided to the ARC and AMES by DIAC and final confirmation of the numbers to expect. Quite often, numbers were not confirmed until the Friday before people arrived the following Monday, with the triages then held on the Tuesday or Wednesday.

The refinement of the model and the innovation introduced throughout the implementation reflects the ongoing assessment of delivery and the shared commitment by all those involved to offer the best service available to a vulnerable population, with the added complexity of multiple partnerships. It also demonstrates that the response provided by this project to asylum seekers was both rapid and exceeded adequate.

Examples of refinements to the model include:

- 1) Automating the registration of clients at the triage to avoid repetition with information collected and inputted, as well as to reduce the amount of handwritten input required from the administration staff and nurses. A system was developed to auto populate the triage forms with information from the data spreadsheets provided by the ARC.
- 2) Health orientation presentations were initially provided by the refugee health nurses, but it was decided that their time would best be spent in the triage process. It was recognised that case workers would be better placed to provide the health presentations, as this would develop their own capacity with regard to understanding the importance and diversity of health needs, developing an improved understanding of the Victorian health system, as well as improve the follow-up asylum seekers received from case workers around health. It was appreciated that the level of detail provided during the orientation had to focus on the absolute essentials, due to the high amount of information provided to asylum seekers as part of their overall orientation around life within the community. One particular innovation was the development of a pictorial tool (see Appendix 5) provided to all participants at the health orientation, with pictures of a Medicare card, bulk billing clinic, prescription, ambulance and other key points. This allowed participants to write notes and reminders against these points in their own languages.
- 3) The dissemination of health information continued throughout the triage process, with nurses reinforcing messages around immunisation, taking medication, emergency presentations and necessary follow-up. It was recognised that clients better absorbed the information received in the triage, since it was a more individual discussion.
- 4) Case workers realised that they needed a deeper understanding of the variety of health concerns for asylum seekers and a better understanding of the intricacies of the Victorian health system. As a result, a number of case workers asked to sit in with their clients during their triage (dependent on gaining client consent), as this would enable them to more efficiently follow-up on medical needs.
- 5) At the beginning, appointments were made on the day for all those in Category 2. The majority of clients fell into this category, which caused a bottleneck in the triage process, with long queues at the appointment desk. It was also very resource intensive, which resulted in Refugee Health Nurses assisting to make appointments, which was not the optimal use of their time.

In addition, when making appointments a variety of issues had to be considered including:

- a. the client's current address
- b. their planned length of stay at this address
- c. the provision of a map showing public transport routes between the place of residence and the clinic
- d. the capacity of local practices to respond to the client group
- e. the clinic preparedness to use interpreters
- f. the capacity to undertake a thorough health assessment



- g. the willingness to accept a supply letter from the Red Cross prior to the allocation of a temporary Medicare card.

This process required some understanding of the requirements and locations of clients and clinics, meaning the nurses were not always best placed to make the appointments. As a result, the sub-division of Category 2 enabled nurses to prioritise and project staff to make the most urgent appointments. Case workers took on the responsibility for all other appointment making. This reduced the time clients had to wait at the appointment desk and improved levels of follow-up by the case workers, as well as increasing their understanding about the health system.

- 6) A GP was present at all triages. Initially the GP attended the full triage, however the time was reduced to an hour towards the end of the pilot project. The GP was available to write prescriptions on the spot if clients had insufficient medication for conditions, such as Type 2 Diabetes. The RHNs would refer clients to the GP if they had triaged a client and required further medical opinion, as demonstrated by the earlier case study. Approximately 8 per cent of those triaged saw the on-site GP. The cost for the GPs' time was initially covered by Doutha Galla, the Refugee Health Fellow and a GP offering time pro-bono in the pre-pilot phase. It was later covered throughout the pilot by the ARC supply letters.
- 7) It was identified through the orientation and triage process that case workers required up skilling with regard to health service access and health service supports for people from refugee and asylum seeker background. Twelve training sessions were provided to AMES and ARC case workers over the pilot period by the project staff. Ongoing health training sessions for case workers are to be implemented in 2014.

This project was originally designed to respond to single men being released from detention, with a few women who were part of a couple. However, the demographics of those being released changed from the outset of the pilot phase in May 2013, with significant numbers of family groups also being released from detention, to the extent that they were in the majority for 6 out of the 11 pilot triage sessions, with 4 of those sessions being only family groups.

The medical needs of both families and men on their own are complex. Men on their own are often isolated and lack proximity to family support. As a result they are less likely to self-present and are more likely to miss their appointments, which has significant health implications across all areas, particularly mental health. They also have a high level of need for catch-up immunisation. Families add a level of complexity that required some trialling and refinement of the original, established model. Family groups have a broader variety of health concerns, including women's health, pregnancy and paediatric health. Children under the age of 5 years can become unwell very quickly, making it all the more important for parents and carers to know how to access health services. The logistics of making multiple appointments is also more complicated for family groups.

A de-identified case study follows that demonstrates the complexity of responding to families:

#### **Case study 1**

*Trinka is a single mother with three children (Joe 7 years, Amal 5 years and Muthi 3 years) is part of a large group of asylum seekers who arrived three days ago in Melbourne. Trinka and her children are the only Tamil speakers in the group and are living in emergency accommodation in Werribee with plans to move to Springvale as soon as they can. Trinka is clearly pregnant and has not seen a doctor about her pregnancy as she feels well, but has*

*had difficult deliveries with her other births. Muthi appears unwell, is flushed and seems quite red in the face. Towards the end of the interview Muthi vomits and Trinkka tells you that she has had diarrhoea for two days and doesn't seem hungry.*

*This presentation requires follow up on a number of issues of varying urgency. Firstly Muthi's fever must be addressed through the administration of Panadol or similar, then she must see a GP as soon as possible to address the vomiting, appetite loss and diarrhoea. Trinkka requires referral for antenatal support at a local hospital, but it is likely that her care will need to be transferred to a hospital closer to Springvale for the birth and post natal care before being linked into Maternal and Child Health.*

*In this instance the triage team will firstly refer Muthi to the on-site GP for assessment and if necessary escalation to the emergency department at the local hospital. The GP can contact the Paediatric Fellow for further advice re the care of Muthi. An urgent appointment for Muthi at a GP clinic close to her home in Werribee was made at the appointment desk, with a referral to a Refugee Health Nurse at Isis Primary Care for antenatal support and referral to the local maternity hospital.*

The policy change of releasing more families in the middle of the project's implementation required an immediate response by all those involved, in particular the refugee health nurses at the triage and the case workers supporting the families. The nurses did not want to overload local GP practices and community health clinics by simply block booking multiple appointments for all family members, so targeted support was provided to families.

At the first triage where families were expected, the Paediatrician and Paediatric Refugee Fellow from the Royal Children's Hospital (RCH) attended. On reflection, the role of the specialist paediatricians did not fit with triage process – to identify the most pressing health issue for that family or family member – when their usual practice is to undertake a detailed health assessment and treatment, much more thorough than a triage allows. There were also a number of organisational aspects constraining their activities, such as no sterile facilities or easy access to hand washing. In addition, due to the constraints of available space, the 2 RCH staff were operating in one room, with interpreters required for rare languages only available by telephone. Mobile phones were used, as no landlines were available but this is not an optimal method for communication.

As a result, it was decided that the RCH paediatricians and RMH Refugee Health Fellows would best be utilised as a secondary consultation for triage nurses or the GP, whereby they are telephoned on the day if there are any queries with regard to the children they are seeing. According to the Refugee Health Fellow, on average one call a session was received, mainly asking about TB screening and management of latent TB, or questions around the referral process. Referrals can be made as needed for specialist assessment at the RCH refugee and immigrant health clinic, although this will more likely be referral from GP following a more thorough health assessment.

At this stage in the project, Category 2 within the triage categorisation became more defined and sub-divided into Category 2A and 2B. Pregnant women and families with children were now included within Category 2 health needs.<sup>19</sup> Whilst the conditions defined in Category 2 were not changed, a measure of urgency was introduced to determine whether or not the client was categorised as 2A or 2B. All those who required an appointment within 1 - 3 days were categorised as Category 2A and the appointments were made at the triage appointment desk. Case workers had the responsibility to make the appointments for those in Category 2B and Category 3.

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<sup>19</sup> See Annex 10.



## **Impact**

The overall impact of this project cannot be determined solely on the quantitative basis of the number of asylum seekers that were reached. The impact of this project and its true value is measured through a more qualitative assessment, which is explored in more detail in this section.

This project was coordinated by the Western Region Health Centre (WRHC) and involved a partnership between the Australian Red Cross, AMES, Inner North West Melbourne Medicare Local, Northern Melbourne Medicare Local, ISIS Primary Care, Doutta Galla Community Health Centre, Dianella Community Health Centre, Darebin Community Health Centre, Joslin Clinic, North Yarra Community Health, Foundation House and the Victorian Refugee Health Network.

The extensive, collaborative and positive partnerships developed through the implementation of this project have been very beneficial and all those involved have committed to ensure these networks are sustained into the future.

### *Health orientation*

Seven hundred and seventy seven people received health orientation, 95 per cent of those triaged. It is difficult to evaluate whether the orientation was adequate without the follow up, at a later date, of a sample of those who received the orientation to see whether the orientation has helped with the access to health services and the navigation of the health system. Anecdotally, it did emerge through the stakeholder interviews that there was less reporting at emergency departments for non-emergency presentations by those who had received health orientation through the triage sessions, in comparison to those who had not gone through the triage, but there is no data to support this assertion.

The health orientation was provided as part of the overall orientation on life in the community, delivered to asylum seekers on their release. This orientation was refined throughout the project, taking the context of the delivery into account and recognising the enormous volume of information provided to people through the complete orientation process. As a result, only the most critical messages were delivered in their simplest form, including what to do in an emergency, Medicare cards, the importance of consulting GPs and bulk billing. Community healthcare was removed from the orientation presentation because it was too complicated, with each community health clinic offering different services and having a different referral system. Oral health messages were also removed from the health orientation because of the vast amount of information provided and the very busy schedule for asylum seekers post release.

The critical difference delivered by this project was that this orientation was either delivered by a health professional, the refugee health nurse, or it was delivered by case workers who had received specific support from the project to provide this orientation. Outside of this project, the case workers provided the health orientation, but without a clear understanding of the critical messages to highlight and with a sometimes limited understanding of how the health system works.

The evaluation has revealed mixed reviews as to the appropriateness of the health orientation, mainly with respect to the method of delivery, with a suggestion that there needs to be more time for question and answer, and a more interactive, conversational style of delivery, instead of a presentation to a large group. There are also views about expanding the content beyond the critical messages to include issues such as maternal and child, sexual and reproductive, and oral health. Whilst this indeed would be beneficial, the project had to strike a balance with the volume of information presented.

Ideally, there would be far greater benefit if more time was available for the delivery of the health orientation, with sufficient time for questions. Those involved in the delivery of the orientation, stated when interviewed, that they perceived the simple messages, such as what to do in an emergency were better understood than rather more complicated information around the role of the GP and the need for a referral to access specialist services. However, taking the context into consideration, the quality of the health orientation was significantly improved by this project. Anecdotally it was reported that those receiving the orientation did find it useful to help them navigate the health service system. It also points to the need for a greater focus on community-based health sessions.

Key messages from the health orientation were further reinforced during the actual triage process and this would likely have had a significant impact on the amount of information absorbed by individuals. The triage assessment also provided an opportunity to ask important questions. The face-to-face contact with a refugee health nurse was much more empowering for people, as it further increased their understanding of the health system and how it works.

One aspect that is not covered within the evaluation framework, but needs to be highlighted is the importance of the individual face-to-face contact between the asylum seekers and the refugee health nurses. After a period spent in detention, it is not possible to quantify the value of the contact with the refugee health nurses, showing care and concern for all those they encountered on an individual basis, providing the opportunity for people to raise their health concerns, answering questions and making the appropriate referrals so people had these concerns addressed within the right timeframe. The RHN could also explain the information contained on the IHMS summary, as some clients were still not fully aware of medical issues identified by IHMS whilst in detention.

#### *Refugee Health Nurse Outreach*

Health orientation, triaging and referrals were also provided by the refugee health nurses at both Western Regional Health Centre and ISIS Primary Care through an outreach service at the short term accommodation provided by AMES in Maidstone and ARC in Werribee. This was an offshoot of the project, designed to reach more people with health orientation, in advance of AMES undergoing triage sessions. These outreach sessions increased the numbers reached and also managed to address some health and wellbeing, and health and safety issues that were compounded by the conditions in the accommodation.

To give an indication of the complexity of the services provided at the facility based drop in clinic a snapshot of a 3 week period is valuable.

#### **Case Study 2**

*During this period, 8 pregnant women were assisted to make and attend GP appointments; maternity care transferred when they changed accommodation, ultrasounds arranged and dental appointments made. Over half of these women were first seen at the Maidstone Outreach Clinic and required more assistance, so became WRHC and Joslin Clinic clients. A number of the others were not seen in person for a variety reasons but have had their health care coordinated through this model. During the same time, 15 children under 5 years of age were seen at Maidstone including 2 babies less than 6 months of age. Links with the Enhanced Maternal Child Health program in the Maribyrnong local council area was established and 1 newborn child was visited at the Maidstone facility by a Maternal and Child Health nurse and linked into the MCH service. The other 6-month old baby was in contact with TB on their boat journey to Australia 3 months prior and had been commenced*

*on TB treatment in detention. The baby required review at the TB clinic at The Royal Children's hospital and was seen for this review.*

The next case study also highlights the importance of this outreach program and illustrates the context of the operating environment.

### **Case Study 3**

*A Tamil family, including 2 female children aged 12 months and 5 years, had arrived by boat from India into Cocos Islands in March 2013. They were in Australian immigration detention in Cocos Islands, Christmas Island and Broadmeadows in Melbourne. They had contact with a Tuberculosis (TB) positive case on the boat journey and both children were placed on Isoniazid treatment for 6 months and the treatment was started in detention. A catch up immunisation was started and a chest x-ray taken that was reported as normal. The family was released into the community on bridging visas in July 2013, with 4 weeks of TB treatment. A brief management plan after release from detention was developed on the IHMS summary with the note as below.*

<b>8. Is Follow Up Care Required?</b>	Yes
If Yes, what follow up care is recommended?	GP required for prescription medications

*A refugee health nurse met the family in late July 2013 during her weekly outreach visit to a temporary accommodation facility used by the settlement agency providing them with casework support. She met the family only because a friend of the family also staying at the same accommodation, who knew of their situation, alerted her to their need for ongoing medication and medical review. The refugee health nurse then booked for review with a local GP, ongoing medication ordered and referred for review at the Royal Children's Hospital to determine ongoing treatment. They have since attended the Royal Children's Hospital, had Mantoux testing and ceased treatment. The refugee health nurse informed the family's caseworker of the medical care arranged with the family's consent.*

*There were some gaps in the transition of care for these children from the detention setting to the community:*

- 1. The lack of communication between DIAC and the settlement agency. The caseworker was not aware of the importance of the continuation of the prophylactic treatment and need for review of the TB treatment with a GP and/or a specialist medical team.*
- 2. Despite the family's compliance with the treatment, there was a lack of understanding of how to access ongoing medical care and treatment in the community. It is unclear if the need for ongoing TB treatment for 6 months and medical review was explained to the family while in detention using an interpreter and if they understood.*

### *Development of service responses and integrated pathways*

The purpose of the triage is to prioritise primary healthcare issues and this objective was achieved. A triage will not (and should not) venture into the more complex parts of the health system beyond primary healthcare. The overall content of the health orientation did not really change, other than the identification of the top priority health messages for the general population delivered in its simplest terms. The triage process did change to respond

to the evolving needs through the changing demographic, as more families with children were released. Pregnant women and children were therefore referred to the appropriate maternal and child health services. During the triage process, the refugee health nurses were aware of the health services on offer in the locality of those being assessed. They were also conscious of the need not to overwhelm individual practices and clinics. As a result, there were a number of recommendations for individuals to be referred to both a community health clinic and to a private GP, to ensure they received the quality of care required to address the complexity of their health presentations.

Regional systems and approaches have been established, such as the Northern and Western refugee health planning/working groups. ISIS has developed a new service referral database and system, which is an excellent outcome of this project.

#### *Capacity development*

##### *a. Clients*

It is difficult to evaluate whether capacity was transferred to those who received the health orientation without a follow-up at a later date to ask clients if the health orientation has made any specific difference in their access and utilisation of health services. The ARC did suggest that there was a lot of demand for Medicare cards, with ongoing follow-up by clients until receipt of their cards, so this might anecdotally demonstrate that one of the key messages from the health orientation was being promptly acted upon. However, ARC was not in a position to state whether this was an increase in demand in comparison with those who had not gone through the triage process. This highlights the need for community-based approaches at multiple points to enable people to get all the information they need.

##### *b. Case workers*

A key issue identified through the HOTAS project was the need to improve the knowledge and understanding of case workers in the suite of health services available to asylum seekers and the variety of referral pathways.

Twelve training sessions were provided to at least 150 AMES and ARC case workers over the pilot period on the following topics: Christmas Island and the journey to Australia; orientation to the health system in Victoria; and communicable diseases. Ongoing health training sessions for case workers are to be implemented in 2014. There is consensus that the capacity and knowledge of case workers was increased around health issues and their priority, together with a much better understanding of how the health system in Victoria works. The evaluations following the case worker training sessions indicated a much higher level of understanding of the health systems and the importance of health concerns in the arrival process.

The ARC reported that the involvement of the case workers in this project addressed any misconceptions or misunderstandings they had around health issues, resulting in those who might have been misinformed now prioritising their follow-up to clients with health concerns and being much more comfortable in their response to clients with health needs. A number of case workers took the initiative and requested to sit-in and observe the triage sessions, dependent on client consent. This then helped their understanding of a variety of health issues and enabled them to provide more efficient follow-up support. The awareness of the case workers was increased with regard to the specific health needs for asylum seekers coming out of detention.

A beneficial result of this increased awareness was an improved information flow between case workers, when clients moved to a new program with new case workers (e.g. from CAS-TS to ASAS). The health needs requiring follow-up and the links already made to specific health services were identified and conveyed to the new case workers. However, the

project evaluation did not include any scope to assess whether the case workers had indeed made all the required appointments identified during the triage process and had provided the necessary follow-up to individual health needs as the weeks progressed.

Case workers also improved their understanding of the various services on offer to refugees and asylum seekers, such as the refugee health nurses. Before the project, many case workers were not aware what services were provided by the refugee health nurses and were not accessing their expertise, which often resulted in a duplication of efforts and a lack of coordination when it came to making appointments and accessing services. As the project progressed, the refugee health nurses reported that the case workers were now contacting them regularly to utilise their expertise.

One of the conclusions made during project implementation was that it would be better to develop the capacity of case workers to deliver the health orientation, as this was originally part of their role and it would improve the quality and sustainability of the provision of health orientation in the longer term. This also enabled the nurses to devote their time to the triage assessments. A script was prepared by the project staff for delivery by the case workers, taking into consideration the learning throughout the project of the need to prioritise only the essential information in its simplest form.<sup>20</sup> The health orientation was then delivered by case workers in the final three triage sessions, although there is no qualitative assessment on these orientations. One concern raised was that nurses would be better able to answer health specific questions, but it could be argued that people would still have the opportunity to ask questions during triage.

The level of follow-up by case workers was significantly improved by their exposure to the health orientation and through the specific capacity development support they received to deliver the health orientation. This ensured that when complex cases were referred after the triage session, the case workers had the necessary knowledge and information to provide adequate follow-up. In addition, the ARC introduced Key Performance Indicators for its staff relevant to the implementation of this project and AMES recruited two additional staff, senior case managers with health portfolios (general health and mental health) to provide a stronger focus on and capacity for health that had not been present in the agency prior to these appointments.

### c. Refugee Health Nurses

The refugee health nurses benefited from their exposure to case workers, increasing their understanding of the myriad of issues case workers are responsible for. The Project Coordinator provided ad hoc updates to the refugee health nurses to keep them updated on the current context and to provide tips and reminders on the basis of lessons identified throughout implementation.

### d. General practices

Increasing the capacity of GP practices to respond to the needs of asylum seekers was not a specific objective of this project. However, this was identified as a significant issue to be addressed during the project implementation. The project's purpose focused more on the efficient management of health service provision. Specific information has not been gathered about the number of new private GP practices that have started to engage with asylum seekers as a direct result of this project. However, the ARC did comment that one of the positive impacts of the project was an increase in the number of working relationships developed with GP practices and community health centres and new relationships established.

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<sup>20</sup> See Annex 4.

According to the latest list developed by the GP Refugee Health Program Coordinator in November 2013, there were 120 GPs across 46 practices and clinics in the Western region engaged in refugee health services.<sup>21</sup> It must be noted that this list does not reflect the level of expertise in refugee health, nor preparedness to undertake comprehensive refugee health assessments.

This project has highlighted the importance of the GP Refugee Health Program Coordinator in the North and West, both in terms of identifying GP practices and health centres offering refugee health assessments, and in offering support to these service providers and encouraging uptake by others. The Health Orientation and Triage project did not provide direct capacity support to GP practices, although the GP Refugee Health Program Coordinator did conduct 2 workshops for practice staff to raise their awareness of the asylum seeker context and offer some guidance on working with this population group. There is a need for a state-wide provision of support to GP practices, encompassing a whole-of-practice approach and utilising a shared care model, to increase the capacity and the willingness of GP practices to work with refugees and asylum seekers.

The primary measurement of the impact of this project is based on the numbers who passed through the orientation and triage and who had appointments made for them on the day of the triage, since this supported by the data. According to the data from ARC, 176 appointments were made for private GPs and community health centres on the day of triage. According to data collected by the project, an additional 94 referrals were made to private GP practices and 87 to community health centres, with 66 referrals suggested for clients needing to see both a GP and a community health centre, due to the diversity of their medical needs.

Data is not available to confirm the follow-up by the case workers after the triage, so there is no information to confirm that the appointments were made for those categorised from 2B to 4. Since people in these categories make up 60 per cent of the total of people categorised, it is hard to provide an overall conclusion about broader impact.

### **Challenges**

The project was implemented at a time of revised policy decisions and changing circumstances, which resulted in a number of challenges that had to be addressed throughout the duration of the project.

#### **No time to dedicate to design**

This project responded to an immediate need within a very short timeframe, as large numbers of people were released from detention into the community. There was a model developed in the South East to draw upon, but there was no time to redesign and evaluate an optimal model. This model was also designed to serve a different context and environment to that in the North West. As a result, ongoing flexibility was built into the project, with learning from the implementation experience and ongoing refinement of the model a constant process throughout this project.

#### **DIAC notification**

A key challenge was the timeliness and accuracy of the information provided by DIAC to the ARC and AMES with regard to the numbers and demographics of those to be released from detention. The usual scenario was that a working figure would be provided at the start of the week before the asylum seekers were released, which would only be confirmed by the end of that week. This made it very difficult to organise the triage sessions, when it was not

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<sup>21</sup> See Annex 13.



known exactly how many nurses, case workers and administration support staff would be needed and which languages interpreters would need to speak. It should be noted that the quality of the information, although not the timeliness, did improve over time.

#### Variance in health service provision in detention

The asylum seekers involved in this project were released from a range of detention centres, including Christmas Island and mainland Australia. There was some inconsistency in the health discharge summary documentation accompanying the asylum seekers on their release. As the numbers due for release increased and also when people were in detention for a shorter period of time, the level of healthcare apparently reduced, with fewer courses of immunisation being commenced and incomplete medical histories and pathology results being recorded.

#### IHMS health discharge summaries

Clients would be provided with their discharge summaries from International Health and Medical Services (IHMS) on their release from detention. As the number of asylum seekers released increased rapidly and their time in detention reduced, the quality and amount of health information included in the discharge summaries decreased, which made the triage and referral/appointment process much more difficult. In addition, many people did not understand the relevance of this document, so quite often it could be lost in the transition from the place of detention to living in the community. Clients may have received some medication, but were not necessarily clear on when or how it should be taken, or even that they had been given it.

#### **Case study 4**

*Younus was a 21 year old Hazara man from Afghanistan who had spent 6 months on Christmas Island before being transferred to Darwin for four weeks and then released and flown to Melbourne to live in the community. Younus had arrived in Melbourne 2 days before the triage and was living with community links.*

*During the triage, the refugee health nurse asked to see his IHMS summary, which he provided in a sealed envelope. Upon opening the IHMS summary, some medication fell out and Younus was not aware that it was included in his documentation. Younus has not been taking the medication and further enquiries indicate that he had some mental health issues identified whilst in detention and he was seeing a mental health counsellor on Christmas Island. The counselling did not continue in Darwin.*

*Younus was a little agitated at the beginning of the triage assessment, evidenced by his constant shifting in his seat and fidgeting. He became more agitated when talking about his experiences on Christmas Island. He was clearly distraught and his behaviour became more erratic as time passed. He was assessed by the GP present at the triage and an urgent GP appointment was organised that afternoon. His case worker was informed of the urgency and accompanied Younus to the appointment.*

Quite often people would start treatment for latent TB and would be given a course of medication, but had very few tablets left on arrival in Melbourne. Often they did not understand that this course of medication must continue for months and required specialist medical follow-up and that they would need a prescription to get the full course of treatment required. Messages about completing the course of medication despite feeling better were not always understood or complied with.

### Changing demographics

The changing demographics of the people being released from detention midway through the project implementation, with a move from men on their own to families, introduced an extra level of complexity with regard to additional health issues and the logistics of organising multiple appointments at General Practices.

### Increased demand & GP availability

One outcome of the project was an increased demand for health service provision in areas including GP consultation, pathology, catch-up immunisation and Mantoux testing and TB follow-up.

It has been challenging to find GP practices willing to provide the appropriate services in localities close to where the asylum seekers are initially living. Whilst there appears to be quite a high number of GPs already engaged, according to the list of general practices engaged in refugee health in the West, it is important to note that demand still outstrips supply in a number of areas. Engagement in refugee health also does not necessarily mean that services are delivered with cultural competence, or that a comprehensive refugee health assessment is undertaken. It is hard to find a sufficient number of bulk billing practices willing to take on more patients and practices willing and able to use and access interpreters.

It is difficult to maintain a positive relationship with the health clinics and practices that are known to provide a good service and strike the right balance to ensure they do not drop out because they are overloaded. It is also difficult, within the resources available, to provide support to other practices to increase their level of expertise to be able to work with refugees and asylum seekers.

### Project staff knowledge, continuity and turnover

None of the case workers have a health background and most have had little personal contact with the health system, as a result of their age and health status. Some of the case workers were overseas trained and had very little experience of the Australian health systems, or knowledge of the specialist refugee and asylum seeker health services available in Victoria.

With the large numbers being released from detention, there was a significant increase in the number of people allocated to individual case workers to support, together with a diverse number of competing priorities including health, accommodation and income support. With a limited understanding of health issues and the urgency of follow-up for some specific health concerns, it was easy for health concerns to not receive the priority they needed. In addition, since case workers were allocated to people on a programmatic basis, according to the budgets available, it meant that people would have different case workers when they progressed from the CAS to ASAS programs. The increased capacity of the case workers around health issues and the necessary follow-up did mean that vital information was included in the handover between case workers, but it did also increase the opportunity for information to be missed.

As the numbers of people released from detention increased, the ARC recruited more staff, meaning new staff had to be trained on an ongoing basis throughout the project's implementation.

The ARC used 4 different team leaders for 14 triage sessions, which sometimes affected the continuity of the support provided. However, this was acknowledged by the ARC and resolved with the appointment of a single Triage Team Leader for the final 4 triage sessions.



This demonstrates the ongoing opportunities and partnership development between the health services and the ARC.

#### Appointment making and follow-up

Appointment making was quickly identified as a bottleneck in the triage process and was also very resource intensive. It caused long delays for people waiting to have appointments made for them on the day and diverted refugee health nurses away from focusing on the triage assessments. This bottleneck was addressed by sub-dividing Category 2, as explained previously, and passing more responsibility for appointment making to case workers and administration staff. From the perspective of the refugee health nurses, this was the preferred solution, so long as they were confident that the case workers would make the necessary appointments within the timeframe identified through their triage categorisation. From the case worker perspective, whilst this did increase their workload, it was easier to follow-up when they made the appointments themselves and talked to the service provider. Case workers could make appointments for clients being mindful of the range of issues, context of their lives and living arrangements.

#### Client relocation and appointment attendance

Asylum seekers released from detention most often were settled in temporary accommodation immediately after their release, to then move at a later date. One of the main reasons for missed appointments was the relocation of the person to a different area. The importance of cancelling appointments was emphasised during the health orientation, but this could often fall through the cracks when relocation occurred. Relocations are a challenge, as it requires new links to be made with health services in the new area and it breaks the continuity of the treatment and the relationship with the health service providers. When people are moved and as groups become dispersed, the chances of issues not being tracked and followed-up increase. Efforts were made during the triage process to find out how long a person was likely to stay in their current accommodation and to find out where they could be moving to, but people did not always know the answers to these questions and could move to a new location at quite short notice.

#### Data collection

The model of care offered through the health orientation and triage evolved throughout the implementation of the project. This affected the data that was collected, both the quality and the quantity. The quality of data improved throughout implementation, helped significantly by the recruitment of a Project Administrator through project funds in May 2013, who was responsible for data analysis. It is also important to balance the demand for time spent on the health screen at the triage with the time consuming demand for data collection, involving nurses filling in forms rather than spending time with people. It is acknowledged that the available data has some gaps, resulting from the context of its collection. For example, the priority of people at the appointments desk was to book appointments and ensure people knew where and when it was, together with how to get there. In the midst of a crowded appointment desk, it cannot be guaranteed that every appointment made was methodically recorded. The evaluation could have benefitted from some additional data, but this statement is made acknowledging the competing demands on time and recognising the priority to effectively triage the clients first and foremost.

Many of the challenges described above are outside the control or influence of the project and require improvements in upstream planning and processes.

A limited number of complaints were received throughout the project duration. The main complaint came from GPs when appointments were missed. Data from the ARC shows that 25 appointments were missed, which is approximately 14 per cent of the total. However, it

is difficult to equate an exact percentage, since the number of appointments made was recorded according to individuals, whereas the number of appointments attended, or not attended was recorded according to family, rather than individuals. The data is also incomplete for all triage sessions, with no record of attendance/non-attendance for 30 appointments. The reasons for non-attendance included relocation, lack of Medicare cards and late arrival. The health orientation always emphasised the need for clients to cancel appointments, with the assistance of their case workers, if they were unable to attend.

The project responded to challenges as they evolved, refining the health orientation and triage model. Prime examples include the adaptation to the changing demographics, with the move from single men to families and the sub-division of Category 2 to reduce the pressure for appointment making on the actual day of the triage. The capacity development of the case workers was ongoing, with support provided for case workers to deliver the orientation, through formal training sessions and also with the preparation of a script, accompanied by a presentation to deliver. In addition, the transfer of responsibility for case workers to make more appointments for their clients, enabled case workers to follow-up and ensure health concerns were being addressed. The automation of the registration process, whilst quite straight forward, resulted in more time at the session for the actual triage, rather than a scrum of asylum seekers and ARC administration staff seeking to manually register all those attending the triage. The automation also meant a more orderly flow of clients through the triage, with consideration for language, and availability of interpreters as guides to smooth traffic flow.

The availability of GPs willing to see asylum seekers, accept supply letters and offer bulk billing remains a challenge outside of the scope of this project to address.

### **Efficiency**

The consideration of the costs is based primarily on costing information provided by the ARC, since AMES was only involved in a single triage. Costs would be dependent on the number of people expected and the variety of demographics. For example, a large group would require a large venue, for a longer period of time to process everyone and potentially more interpreters, if there were a number of different languages. The ARC costs are based on a session for 50 – 60 people. This was the average number attending the triage, but there were sessions with larger numbers, which would have increased the costs.

The costs for the implementation of the health orientation and triage sessions include the following components:

Component	Cost (AUD\$)
Venue hire	\$252 (\$42/hour usually booked for 6 hours)
Catering	\$50
Interpreters	\$1,750 (\$350 approximately per session per interpreter, with an average number of 5 interpreters per session)
Case workers and support staff	\$1,131 for an average of 6 staff
Team Leader	\$485 – including preparation, delivery and follow-up
Transportation from accommodation	\$116
Refugee Health Nurses	\$950 (\$38/hour with 5 nurses on average for 5 hours)
Project coordination and administration support	\$350 (\$70/hour for 2 staff for 5 hours)
GP	Paid according to supply letters received for each consultation
<b>Approximate total</b>	<b>\$5,084</b>

Using these approximate costs<sup>22</sup>, 818 people were triaged in 17 different sessions at an estimated total cost of \$86,428. This provides an approximate (and crude) delivery cost of **\$105.66** per individual for their health orientation and triage.

When considering cost implications it is important to remember the potential costs that were saved through this project. The fact that the triage delivered referrals in the most appropriate timeframe ensured that those requiring medical attention within days were seen and treated. If these people had not been seen in this timeframe, a potential scenario is their condition could have deteriorated and required longer-term and more expensive treatment in the longer term.

### **Sustainability of the project**

This project coordination function has now finished and there is currently no funding available for a continuation of this support. The main resources that currently exist should the project need to restart are the refugee health nurses and the ARC and AMES project staff and case workers.

The Project Advisory Group was of the view that it would be possible to continue providing health orientation and triage so long as there was only one session a month, for between 50 – 60 people. The State-wide Refugee Health Nurse Facilitator could coordinate the Refugee Health Nurses, with ARC and AMES sharing the responsibility for the supply and coordination of case workers and project staff. Therefore, this would be undertaken without a specific project coordinator or a data collector/analyst and it assumes that there would be continuity of the refugee health nurses and case workers involved in the project. No data for the purposes of evaluation could be collected in this iteration.

The experience of this project, combined with the specific capacity development support, has enriched the individuals involved. Systems have also been well established for the triage process itself. There is always a risk of staff turnover resulting in a diminishment of knowledge and experience, but this has been mitigated to the extent possible through the documentation of findings and lessons. Further consideration is necessary as to how to make this repository easily accessible by people coming in without prior experience of the project. The broader dissemination of the findings, lessons and this evaluation will help further embed knowledge into the relevant organisations.

### **Lessons**

This project was implemented to respond to an immediate need; it did not have the luxury of time to design, evaluate and redesign before full implementation commenced. The achievements of this project are testament to the flexibility allowed within the design and the responsiveness and innovation of all those involved in implementation. It provides a strong argument for response and evolution as complementary components.

There are a number of lessons illustrated below, but the 2 key lessons concern the importance of the triage health screen and the delivery and content of the health orientation.

#### ***Importance of the triage health screen***

A significant number of asylum seekers require an appointment with a GP for urgent medical issues within their first few days after release. For large numbers of people, the triage process is the most effective way to prioritise those with urgent health needs and rapidly link them in with the appropriate health service. Refugee health nurses are best placed to

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<sup>22</sup> Costs varied according to the number of clients seen for triage. Maximum cost used in calculations, as 5 hours calculated for venue hire and staff, when often 4 hours needed.

provide this initial health screen and then refer to the proper service provider to address the needs identified. The triage session opened up effective referral pathways for the asylum seekers, providing guidance on these pathways. People knew who they needed to see and in what timeframe. In the absence of the triage, asylum seekers would receive a level of health orientation, but would then have to fend for themselves and likely present at emergency departments for all health concerns.

The triage offered face-to-face contact with a sympathetic health professional. The value to asylum seekers of this more personal contact and its help with the transition from detention to life in an unfamiliar new community is very difficult to measure, but it should not be underestimated.

#### **Case study 4**

*Ahmed was a 40 year old man who presented at the Health Orientation and Triage system with his newly pregnant wife and 10 year old child. He had fled Iran and had been living in Indonesia prior to taking a boat to Christmas Island with his wife and child. He was in detention approximately 3 months prior to arriving in Melbourne and was being managed by the AMES, Community Assistance Scheme.*

*The Refugee Health Nurse triaged the wife and child and organised a follow-up ante natal appointment for the wife and a follow-up appointment for the child for catch-up immunisation. Ahmed disclosed in his interview with the RHN that he had a history of chest pain and numbness in his arms. He stated that he did not have the chest pain at the time, but had been experiencing it whilst in detention and had been booked in for investigations in Iran, but they had never been completed. He had not had any treatment for this chest pain in detention, although he had complained of feeling unwell. The RHN asked about any current medication and Ahmed was sure he had been on medication prior to leaving Iran, but was not taking anything at the moment.*

*The RHN then spoke with the GP who was on site at the triage and referred Ahmed to her for a more thorough examination, due to the risk and the medical history he had discussed. Ahmed presented as slightly underweight, but generally a good colour and not in pain of any sort. The GP took a thorough family history and it became clear that Ahmed's father had died from a heart condition when he was in his early 50s. After an examination, the GP contacted a cardiac consultant and discussed this gentleman. The cardiac consultant recommended that he be booked for an appointment with a GP close to where he was living the next day to get a thorough medical including ECGs and cardiac enzymes. The cardiac consultant did not think it was necessary for Ahmed to attend emergency.*

*Admin staff booked a GP appointment in his area the next day with a GP who spoke Farsi. The case worker was informed of the urgency of the appointment. Ahmed attended the GP appointment and is having ongoing treatment for his condition.*

The triage identified and prioritised the health issues presented by those at the triage. A large number of these, including mental health, catch-up immunisations and maternal and child health, require longer-term support and follow-up, which need well established relationships between the clients, the case workers and the relevant parts of the health system.

The project has shown that without the triage and orientation there was a high chance that critical medical concerns would likely not be identified in a timely way, so people would not receive necessary attention and treatment. Over 20 per cent of the people passing through

the triage required appointments in a matter of days, with 2 per cent requiring instant referral to the emergency department. These people would not have been supported in this tight timeframe in the absence of this project.

### *Health orientation*

The health orientation provides vital information to people about how to navigate the health system and who to see dependent on the urgency of the medical issue. It provides important information with regard to Medicare cards, bulk billing and what to do in an emergency. Opinion is somewhat divided on who should deliver the orientation and when it should be given. This project started with nurses providing the orientation, but ended with case workers doing it from a script and presentation prepared by the nurses. No qualitative assessment has taken place to compare the orientations given by nurses or case workers. The advantages of health orientation by the case workers are that it allows the nurses to focus solely on the triage assessments and reinforce the key messages of the health orientation; and it develops the capacity and understanding of the case workers with regard to health issues and the health system. However, with the available information, it is not possible to conclude whether orientation by the case workers is best for the people who participated.

The health orientation was also given on the same day as all the orientation information provided to asylum seekers in a large forum, including life in the community, advice for accommodation and an outline of the determination process. It is doubtful that all of the information provided in this forum is absorbed by the audience, so suggestions have been made to separate the health orientation and triage from the rest of the information provision to concentrate purely on health. This would allow a more detailed health orientation to allow more time for questions and to include additional relevant areas, such as pregnancy and maternal and child health. It is possible to conclude that the orientation provided the key messages and the triage provided a further opportunity to reinforce the absorption of the orientation, as well as provide an opportunity to ask questions. People are more likely to have taken on board the information received during the face-to-face triage, more than that which was delivered through the large forum. However, there are logistical issues around bringing people together for 2 different information sessions and concerns that numbers could dwindle as a result.

All new arrivals require health orientation to help them navigate the health system and ensure valuable time and resources are not taken up at a later stage if people present in the wrong place. People attending triage did not have all the information about the medication they needed, or were taking, including the necessary course of treatment and where to get more supplies if required.

### *Coordination*

This project has identified coordination as a key issue that was improved through this project, but which needs to remain at the forefront in the consideration of future activities. There is a need for better coordination and communication between the Department of Immigration and the agencies providing support with Commonwealth funds to asylum seekers. This would allow more time for the agencies to organise support as soon as people arrive into the community. An earlier application for Medicare, perhaps prior to release, would enable people to have immediate access to healthcare on arrival in the community.

There needs to be better coordination between the agencies and the health system, including the utilisation of the expertise of the Refugee Health Nurses and better links and follow-up between case workers and the community health clinics and GP practices. These

system issues should be addressed regardless of the number of people being released from detention, as this would benefit those currently in the community on BVEs and those currently in community detention.

#### *Project reach*

It took quite some time for project staff and AMES to agree a process for running a triage, which is reflective of the pressure of a larger caseload than the ARC (AMES was responsible for two thirds of those released from detention and the ARC one third). There was a single triage conducted with AMES in September 2013. However, this means that a large number of asylum seekers released from detention during this time and supported by AMES, were not reached by the project.

#### *Importance of capacity support*

This project successfully developed the knowledge and capacity of a number of groups. It provided asylum seekers with basic information around certain health issues and support to navigate the health system. It developed the capacity of case workers around the complexity of diverse health issues and enabled a more thorough follow-up for the health issues of individual clients. More broadly, it raised the awareness of the specific needs faced by asylum seekers released into the community and the services available to support some of these needs. It was not within the scope of the project to upwardly develop capacity – e.g. with the Commonwealth – or more laterally in the longer-term – e.g. with community health clinics and private GP practices. The project has identified these needs, but a comprehensive, state-wide approach is required. Looking to the future, there is a clear need for more capacity development support for general practices to deliver the appropriate health services to respond to the complex needs of asylum seekers and refugees. There is also a clear need for the further development of service pathways and links between general practices and community health services.

#### *Partnerships developed*

This project successfully established and developed a number of key partnerships between organisations and agencies working with asylum seekers. These partnerships improved coordination, communication and information flow, and successfully identified solutions to issues as they arose. These partnerships and networks will be valuable beyond the life of this project and will benefit from continued investment from all engaged.

#### *Victorian Refugee Health Network project staff support*

The support provided by the Victorian Refugee Health Network project staff, in partnership with the State-Wide Refugee Nurse facilitator, was vital to get the project up and running and maintain its effectiveness throughout implementation. In a resource constrained environment, the project would have suffered without the allocation of significant time from the project worker to establish systems and procedures, and provide the initial start-up support to the project. This project benefited more generally from the members of the Victorian Refugee Health Network, as it a good example of successful collaboration between Network members to deliver tangible outcomes and results.

#### *Efficiently managing health service provision*

One of the purposes of the project was to pilot an approach to efficiently manage health service provision for the significant influx of new arrivals from refugee backgrounds. The triage screen enabled the refugee health nurses to identify and prioritise health concerns and to utilise the correct referral pathway to ensure clients were seen by the right provider within the necessary timeframe. The project's establishment, utilisation and dissemination of referral pathways served this purpose. However, there is no data to follow-up whether



case workers made appointments within the timeframe according to the different categorisations on individuals, so it is not possible to provide an overall conclusion as to whether this purpose was wholly achieved. The referral put the individual on the right path in the short-term, but the available information makes it hard to judge whether health service provision has been effectively managed throughout.

#### *Utilisation and applicability of the model*

A key value from the implementation of this project is it trialled a model and an approach for responding to the diverse needs of a large population group. The learning from this project means this model could now be adapted and tailored to be utilised in other contexts. It could both be scaled up for a more state-wide approach, as well as used in a more localised environment. The importance of the provision of specific health orientation and triage in a timely way, the support provided to access appointments and the capacity development support to case workers in particular cuts across a wider variety of circumstance and is not specific solely to the context of asylum seekers released from detention.

## **Conclusion and Recommendations**

This project has highlighted the need for a comprehensive health triage and orientation process for asylum seekers being released from detention. The fact that 24 per cent of all those triaged either required immediate attention at the Emergency Department (2%) or to be seen by a GP within 1-3 days (22%), demonstrates that a significant proportion of new arrivals need to access health services in a matter of days.

The release of large groups of asylum seekers from detention stopped in September 2013 immediately after the federal election. The change in federal government has brought a changed policy environment and has created a level of uncertainty about future releases. There are still some 22,000 people nationally in the community in the CAS-TS and ASAS programs, in community detention, or in held detention. As a result, this group will continue to be a priority group, despite the unpredictable changes to the international situation and domestic policy changes. At the time of writing this evaluation, the federal Government is facing opposition to its plan to reintroduce Temporary Protection Visas.

The objectives of this project, with regard to developing the approach and model to provide quality health orientation and triage, and efficiently manage health services provision, remain relevant to respond to any future large group arrivals of refugees and asylum seekers to Victoria. The result of the triage, which addressed immediate health concerns and provided the correct referrals, was entirely appropriate, as it ensured clients did not overload health service providers and were seen by medical staff in the necessary timeframe.

There was a general consensus from the key stakeholders interviewed that this project successfully picked up the diverse health needs of clients early and delivered a timely intervention to issues that could have been missed altogether, or treated after a period of time detrimental to the individuals concerned. Through the health orientation, people were empowered to access the health system and overcome the barriers faced by many refugees and asylum seekers. Through the triage process, people had a personalised plan to address their individual health needs and were clearer on the importance of timeframes for immunisations or for a treatment regimen.

This project developed the knowledge and capacity of all those directly involved in the provision and receipt of the health orientation and triage sessions. It also raised the awareness of the complex needs of this client group. It established links between clients, case workers and health service providers, delivering a more integrated referral pathway.

Partnerships of real value and importance have been built by this project and it is essential that this network of relationships is maintained into the future.

The lessons and learning from this project provide the foundation to what could now become an ongoing solution to the provision of health orientation and triage for large groups from refugee backgrounds. The main finding is that the triage successfully identified and prioritised key health concerns and referred to treatment in a matter of days for the most urgent needs. This would not have been achieved through any other process. As a result, this should be considered the best approach and model for a more permanent solution.

On the basis of this evaluation, a number of recommendations are made. There are recommendations specific to the future implementation of the health orientation and triage model. There are also recommendations with a broader application to health sector development to respond to the complex health needs of refugees and asylum seekers.

The group approach to triage health needs of large groups of people being released from detention has been evaluated as effective; however medium to long term, impact was unable to be specifically evaluated due to various constraints.

Recommendations are made below regarding further modifications to the model with any further roll-out, in response to significant group arrivals from refugee backgrounds.

In addition, a number of broader sector and community strengthening recommendations are made in response to needs identified by this project.

### *Triage program*

#### *Operational issues for future triage programs*

1. Consideration be given to ways of following up with clients to measure impact of the program including usefulness of health orientation sessions, and sustainable links made into health services;
2. Consideration be given to replicate dual approach – group health orientation and triage and nurse led outreach model to suitable accommodation facilities.
3. Tailor the triage process to respond to the demographics of those participating e.g. separate triages for families, or for women and children, ensuring referral pathways are in place for pregnant women and children under 5 years of age.
4. Allow more time for health orientation to provide the opportunity for a more conversational style with questions, the introduction of other relevant health issues and for health promotion messages (e.g. maternal and child health, sexual and reproductive health, oral health, nutrition etc.).
5. Develop a systematic follow-up to record information about appointments made by case workers according to the timeframe recommended at triage and overall attendance at appointments.
6. Consider the amount and purpose of the data collected, to ensure a balance between information and data needs, with the time taken to collect and analyse data.

#### *Transfer of information and health information*

7. The Department of Immigration consider ways to improve the timeliness and accuracy of information about the number of people to be released from detention, including demographics, to allow more efficient preparations for arrival by the asylum seeker agencies and health services.



8. Triage program to introduce a system to measure and monitor the consistency, detail and accuracy of the health discharge summaries provided to people on release from detention facilities, and provide regular feedback to the Department of Immigration of any concerns.

#### Broader Sector development

##### *Transfer of information and health information*

1. The Victorian Refugee Health Network continue to work with the Department of Immigration, Detention health services providers and the Victorian Department of Health to introduce a health alert system or similar for those with significant health concerns including latent TB, mental health, HIV, requiring timely medical follow-up.

##### *Health information and health services information for new arrivals*

2. The Victorian Refugee Health Network, Community Health Services, Water Well and Medicare Locals, work to develop sustainable approaches to providing timely health information and health services information to new arrivals across a variety of settings, eg one to one consults, group information, community advisory approaches.

##### *General Practice Support*

The number of General Practices able to work with new arrival refugee background populations is insufficient to meet demand, particularly in the outer metropolitan regions.

3. Medicare Locals to work with Refugee Health Nurses and Case work services to maintain an accurate record of General Practices offering refugee health services and develop a process for effective dissemination of this information.<sup>23</sup>
4. Consideration be given to duplicating the current NW Melbourne and Macedon Ranges and SW Melbourne ML GP Refugee Health Program Coordinator in the North (Northern Melbourne and Inner North West) and expanding the program to include broader practice support.
5. The Victorian Refugee Health Network, in consultation with Community Health Services, Medicare Locals, hospital and specialist services continue to explore potential formal shared care/GP liaison/co-ordinated care models for this population, to enhance referral pathways, provide opportunities for secondary consult support, professional and organisational development and other supports identified by General Practice to sustain their practice in this area.

##### *Case workers*

6. Australian Red Cross (ARC) and AMES, supported by the Refugee Health Nurse program ensure all case workers have in-depth orientations around health issues and presentations, together with the structure and functions of the Victorian health system for case workers.
7. ARC and AMES consider dedicated Health Liaison roles, within their staff teams to act as a point of contact with health services and build in-house expertise in health issues.

##### *Health orientation and triage model*

8. Based on the findings and conclusions from this project, further refine this model for use in other contexts applicable beyond releases from detention.

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<sup>23</sup> See for example, list prepared by the GP Refugee Health Program Coordinator for community health centres and general practices in the West (see Annex 11).

## **List of Annexes**

The following annexes are included as separate documents to accompany this report:

1. Asylum Seeker Triage Service Agreement
2. Evaluation Framework
3. HOTAS Evaluation Data Analysis
4. Health Orientation Presentation Script
5. Pictorial Health Orientation Material
6. Triage Roles and Responsibilities
7. Triage Staff Functions
8. Triage Procedural Flowchart
9. Triage Tool
10. Triage Categories
11. Triage 'Greenslip' for Medical Staff and Appointments Desk
12. HOTAS Evaluation Interview Questions
13. GPs in the West providing refugee health services