

Building capacity in primary health care to respond to the needs of asylum seekers and refugees in Melbourne, Australia: the ‘GP Engagement’ initiative

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Abstract. Asylum seekers and refugees experience poorer health than the broader Australian population. Universal primary healthcare services play an integral role in supporting and optimising the health and wellbeing of these communities. However, clinical-level issues frequently compromise the quality of care provided to these groups. The ‘GP Engagement’ initiative, implemented in the south-eastern region of Melbourne, aimed to build capacity within universal primary health care to respond to the needs of asylum seekers and refugees. This involved engaging general practice clinics, resourcing them with tools and frameworks, and undertaking collaborative problem-solving on refugee issues. Evaluation methods included: rigorous record keeping; pre- and post-practice assessments guided by a self-reported ‘12-Point Checklist’; and participant feedback. Findings from 57 participating health professionals indicated changes in the way that GPs work with asylum seekers and refugees. ‘GP Engagement’ suggests that it is possible to build primary healthcare responsiveness to asylum seekers and refugees through a strategic regional approach that is firmly grounded in evidence-based practice and considerate of the requirements and constraints of GPs.

Received 5 December 2018, accepted 19 September 2019, published online 3 February 2020

Introduction

Between 2017 and 2018, the Australian Government granted 16 250 visas under their Humanitarian Program (Australian Government, Department of Home Affairs 2018). It is widely acknowledged that asylum seekers and refugees experience heightened vulnerabilities, including complex physical, psychological and social health needs (Harris and Zwar 2005; Edberg *et al.* 2011). This includes an excessive burden of communicable diseases, chronic diseases, nutritional deficiencies, skin lesions, reproductive health complications, untreated injuries and mental health issues – predominantly anxiety, depression and post-traumatic stress disorder (Burnett and Peel 2001; Silove 2002; Steel *et al.* 2006; Tiong *et al.* 2006; Murray *et al.* 2009; Coffey *et al.* 2010). The extent and nature of these health issues often contrast the wellbeing needs of Australian-born people.

In direct response to asylum seeker and refugee health needs, refugee-specific services have been established in many high-settlement regions throughout Australia (Milosevic *et al.* 2012; Joshi *et al.* 2013; McBride *et al.* 2017). These services generally provide intensive, short-term care to asylum seekers and refugees who are either newly arrived or highly vulnerable, before transitioning them into mainstream primary health care for ongoing health maintenance. Therefore, universal primary healthcare services are integral to supporting and optimising the health and wellbeing of asylum seekers and refugees in the longer-term (Spike *et al.* 2011; Joshi *et al.* 2013).

However, asylum seekers and refugees face a range of barriers to accessing timely and appropriate primary health care, both within Australia and other resource-rich settings (Lamb and Smith 2002; Sheikh-Mohammed *et al.* 2006; Spike *et al.* 2011). Individual barriers found to hinder service access include: limited English proficiency; financial constraints; low health literacy; varying cultural and health beliefs; and competing settlement priorities (Eckstein 2011; Clark *et al.* 2014; Mahimbo *et al.* 2017; Mishori *et al.* 2017). Clinical- and system-level issues also compromise primary health care for asylum seekers and refugees, including: time and resource constraints of health practitioners; insufficient use of interpreters; limited familiarity with prevalent refugee health issues; and complexity within the health system (Eckstein 2011; Cheng *et al.* 2015; Mishori *et al.* 2017; Robertshaw *et al.* 2017).

There is a need to improve the accessibility and competency of universal primary health care for asylum seekers and refugees. Specifically, literature describes the importance of primary health care that overcomes communication challenges through the use of considered language, interpreters and bilingual staff (Joshi *et al.* 2013). The unique physical, emotional and social wellbeing needs of asylum seekers and refugees should also be considered within optimal health care delivery (Eckstein 2011; Mishori *et al.* 2017). Interpersonal skills, such as cultural sensitivity, and the ability to establish trust and rapport with patients are further attributes of competent care for this population group

What is known about the topic?

- Primary health care plays an integral role in optimising the health and wellbeing of asylum seekers and refugees. However, clinical-level issues frequently compromise the quality of care provided to these groups.

What does this paper add?

- This paper describes an initiative aiming to build capacity in primary health care to better meet asylum seekers and refugee health needs. The evaluation findings highlight the efficacy of this approach.

(Joshi *et al.* 2013). Despite recommendations for GPs to receive training and support to more effectively meet the diverse health and social needs of these communities (Harris 2018; Johnson *et al.* 2008; Mahimbo *et al.* 2017), there are limited examples of strategies that have been implemented in response to this issue. This article addresses this paucity of literature by describing 'GP Engagement'; an initiative implemented in the south-eastern region of Melbourne, Australia, that aimed to build capacity within universal primary health care to respond to the needs of asylum seekers and refugees. This article will also present and discuss the evaluation findings of this strategy.

Methods

Setting

The City of Greater Dandenong and the neighbouring City of Casey, located in the south-eastern region of Melbourne, are home to the largest settlement of asylum seekers and refugees within the state of Victoria, Australia (Australian Bureau of Statistics 2018). Monash Health Refugee Health and Wellbeing is an integrated generalist and specialist refugee health service located in the centre of Dandenong. The service provides comprehensive care to asylum seekers and refugees, before supporting their transition into universal primary health care when initial health needs are contained (McBride *et al.* 2017). The 'GP Engagement' initiative evolved in response to an organisational priority to build capacity within the region to ensure universal services were better-placed to respond to the needs of asylum seekers and refugees.

The 'GP Engagement' initiative

This activity was undertaken as part of the Refugee Health Fellow Program, funded by the Department of Health and Human Services in Victoria, Australia. This initiative involved the employment of refugee fellows across the State, with the overarching aim of improving asylum seeker and refugee health care by addressing issues of care coordination, and providing education to health professionals based on identified need.

The Refugee Health Fellow appointed to the south-eastern region of Melbourne was co-located within Monash Health Refugee Health and Wellbeing, Dandenong (McBride *et al.* 2017), where they already provided clinical GP services 0.3 FTE (full-time equivalent). An additional 0.2 FTE was funded as part of the Refugee Health Fellow Program, to dedicate towards improving asylum seeker and refugee health care within the

region. Being co-located within a refugee-specific health service ensured that a broad network of expertise was available to provide support this initiative as required.

The 'GP Engagement' initiative evolved through a thorough planning process, which included canvassing the literature, considering patients' service experiences and consulting with GPs and key informants. The 'GP Engagement' concept and evaluation framework was refined throughout this course, with a pilot period undertaken before implementation. Further detail on the planning and piloting of the initiative is beyond the scope of this paper. Rather, this article will focus on describing the 'GP Engagement' initiative, and presenting and discussing the evaluation findings.

The implementation of 'GP Engagement' involved four key phases:

- (i) **Identifying and contacting general practice clinics within the region.** General practice clinics with a high refugee caseload, or identified as requiring support with refugee patients, were mapped. The Refugee Health Fellow made contact with each clinic by phone to provide an initial overview of the initiative, and scope their interest in participating. For interested clinics, the Refugee Health Fellow would also undertake informal probing around current needs, and schedule a time to attend the clinic for a meeting; strongly encouraging as many staff to attend as possible.
- (ii) **First clinic visit.** At the first clinic visit, the Refugee Health Fellow further introduced the initiative, and described what involvement entailed. Then, the Refugee Health Fellow worked through the 'GP Visit Pack'; a uniform set of tools and templates that provided a structure to share useful refugee health resources and frameworks, and explore current practice issues. The individual challenges and issues identified through this process were then the focus of collaborative problem-solving and education. Sessions were intentionally informal and interactive to nurture engagement and participant-led discussion that was tailored and relevant to the needs and experiences of each participant. A follow-up visit was arranged before session close.
- (iii) **Second clinic visit.** The Refugee Health Fellow made a second visit to each general practice clinic to provide additional education based on their specific needs, and further engage in collaborative problem-solving around issues encountered since the first visit. Particular consideration was given to areas of practice that staff had found difficult to implement change.
- (iv) **Ongoing follow up and support.** The Refugee Health Fellow provided general practice clinics with ongoing support on refugee health issues, as required. This included further clinic visits, secondary consultation and tailored education, as needed. The relationship established between the Refugee Health Fellow and the general practice clinics between the first two visits intended to set a solid foundation to provide this ongoing assistance.

Evaluation methods

A mixed-methods approach was used to evaluate the 'GP Engagement' initiative. The evaluation aimed to:

- explore key issues experienced by general practice clinic staff when working with asylum seekers and refugees;

- compare participants' treatment approach when working with asylum seekers and refugees pre- and post-intervention; and
- determine participants' perceived acceptability of the 'GP Engagement' initiative.

Practical considerations, in particular, time constraints that were common among GPs, strongly influenced the evaluation methods selected. Therefore, it was important that the evaluation processes were efficient, recognisably purposeful to participants and embedded into the project design. Where possible, evaluation instruments were developed to function with a dual purpose; that is, to provide a springboard for discussion throughout general practice visits, while also collecting meaningful data to capture the process and outcomes associated with the initiative.

Thorough record keeping was used to establish the number of general practice clinics that participated in the initiative, the number of staff members that participated and the professional roles of all participating staff. In addition, each clinic visit was guided by a 'Visit Record Sheet', which included the session agenda, and provided space for the Refugee Health Fellow to document the 'challenges experienced when treating refugees' reported by participants. During analysis, thematic categories were derived from these notes, and 'challenges' were grouped accordingly. These were counted to determine the number of times that issues were reported.

The '12-Point Checklist' ([Appendix 1](#)) is a self-reported survey completed by participants at each visit. This instrument was developed internally specifically for this initiative, and was a key tool in the evaluation. Each item on the '12-Point Checklist' was based on best-practice refugee healthcare principles, which were informed by the literature and key informant consultations. Items covered included: interpreter use ([Eckstein 2011](#); [Joshi *et al.* 2013](#); [Mishori *et al.* 2017](#); [Robertshaw *et al.* 2017](#)); identifying patients of asylum seeker and refugee background ([Foundation House 2018](#)); use of refugee-specific assessment templates ([Foundation House 2018](#)); appropriate blood screening ([Eckstein 2011](#); [Mishori *et al.* 2017](#)); immunisation ([Eckstein 2011](#); [Mishori *et al.* 2017](#)); appropriate referral to dental and optometry ([Mishori *et al.* 2017](#)); appropriate referral to specialised refugee mental health services ([Mishori *et al.* 2017](#)); provision of extended appointment times as necessary ([Joshi *et al.* 2013](#)); engagement with health literacy and communication models ([Foundation House 2018](#)); promoting social connection ([Eckstein 2011](#)); use of online resources; and referral to public specialists in consideration of patients' ability to pay ([Joshi *et al.* 2013](#)). A four-point ordinal response scale was used to elicit the frequency of compliance with each best-practice principle (1 = Never; 2 = Sometimes; 3 = Usually; 4 = Always). When drafting the '12-Point Checklist', care was taken to phrase each item simply and clearly, and the working group provided input on the wording and structure of the initial draft. Then, throughout the pilot period, participants were asked to read each item, and articulate any thoughts or queries related to clarity or meaning. They were also asked to paraphrase the item to determine if their interpretation aligned with the intended meaning. No major issues were uncovered throughout this process, and therefore only minor tweaks were required to finalise the tool.

The '12-Point Checklist' data were used in three ways. First, all participants' scores for each of the 12 items were totalled and

averaged. The 12 items were then ranked according to their average score to establish a baseline indication of each refugee health practice pre-intervention. Second, participants' total '12-Point Checklist' scores for first and second visits were calculated separately, averaged across all participants, and compared pre- and post-intervention. The '12-Point Checklist' could get a maximum score of 48. Third, the four response options were merged into two categories; 'Never' and 'Sometimes' were grouped together under the heading 'Rarely', and 'Usually' and 'Always' were grouped together under the heading 'Frequently'. This simplified the results and made them more accessible. The percentage of participants who moved from 'Rarely' at the first assessment to 'Frequently' at the second assessment was then determined to establish changes in refugee health practice pre- and post-intervention. Statistical software IBM SPSS version 22 (IBM Corp, Armonk, NY, USA) was used to store and analyse data.

For the final component of the evaluation, each participant completed a feedback form at the end of the second practice visit. This captured their perspectives on the initiative's content, relevance, engagement and provision of resources, using a four-point response scale ranging from 'Poor' to 'Excellent'. Participants were also asked to rate their overall experience with the initiative out of 10. This paper will only report the results from participants who completed more than one visit and, therefore, contributed complete data.

Results

Between June 2015 and June 2018, 57 staff from 25 general practice clinics participated in all four phases of 'GP Engagement'; that is, they took part in a minimum of two clinic visits, and subsequently completed the '12-Point Checklist' at baseline and follow up, and the participant feedback form.

Over 40% ($n = 25$) of these participants worked within Dandenong, with the remaining staff working in 10 different suburbs spanning the south-eastern region of Melbourne. Most of the participants (95%, $n = 54$) were GPs and the remaining 5% were practice nurses.

Participants described encountering a broad range of challenges when working with asylum seekers and refugees, which were recorded on the 'Visit Record Sheet'. These were thematically allocated into the following categories: Patient billing/payment issues; Time of treatments; Costs of treatments; Patient health literacy; Medical history; Immunisations; Infectious disease screening and management; Refugee health knowledge; Refugee health assessments; Referrals; Interpreters; and Resources. Participants raised a total of 216 challenges across all categories. The most common issues reported by participants related to making timely referrals, particularly to specialists, allied health and support services such as mental health and drug and alcohol. Almost one-quarter of concerns raised by participants pertained to this issue. Other commonly reported issues related to: a lack of refugee health knowledge; infectious disease screening and management, specifically around diseases that are less common among Australian-born residents; and patient health literacy.

Participants' rating scores (which ranged from 1 = Never to 4 = Always) for each item on the '12-Point Checklist' were tallied and averaged to give an overall indication of refugee

Table 1. Changes in GP practice pre- and post-intervention
Hep B, hepatitis B; TB, tuberculosis

12-Point Checklist questions			Rarely (%)	Frequently (%)	Percentage of improvement between visits
1	Use of interpreters	Visit 1	46.9	53.2	28.1
		Visit 2	18.8	81.3	
2	Identify patients from refugee or asylum seeker background	Visit 1	68.8	31.2	34.5
		Visit 2	34.4	65.7	
3	Refugee Health Assessment	Visit 1	56.3	43.8	25.0
		Visit 2	31.3	68.8	
4	Blood screen include Hep B, TB Quantiferon/Mantoux	Visit 1	46.9	53.1	31.3
		Visit 2	15.7	84.4	
5	Referral to other health services	Visit 1	62.5	37.5	31.3
		Visit 2	31.2	68.8	
6	Referral to mental health services	Visit 1	78.2	21.9	43.7
		Visit 2	34.4	65.6	
7	Catch-up immunisations	Visit 1	15.7	84.4	15.7
		Visit 2	00.0	100	
8	Engagement with health literacy	Visit 1	43.7	56.3	31.2
		Visit 2	12.5	87.5	
9	Use of refugee online resources	Visit 1	84.4	15.6	31.3
		Visit 2	53.1	46.9	
10	Referral to public specialists	Visit 1	88.0	68.8	24.9
		Visit 2	06.3	93.7	
11	Referral to social connection activities	Visit 1	68.8	31.3	21.9
		Visit 2	46.9	53.2	
12	Longer appointment times or regular visits	Visit 1	25.0	75.0	06.3
		Visit 2	18.8	81.3	

healthcare practices pre-intervention. Each item, or refugee health practice, was then ranked accordingly, with findings as follows: immunisation (average score of 2.9/4); referral to public specialists in consideration of patients' ability to pay (average score of 2.7/4); provision of extended appointment times as necessary (average score of 2.7/4); interpreter use (average score of 2.5/4); engagement with health literacy and communication models (average score of 2.5/4); appropriate blood screening (average score of 2.3/4); appropriate referral into dental and optometry (average score of 2.1/4); identifying patients of asylum seeker and refugee background (average score of 1.9/4); use of refugee-specific assessment templates (average score of 1.9/4); appropriate referral to specialised refugee mental health services (average score of 1.8/4); promoting social connection (average score of 1.8/4); and use of online resources (average score of 1.2/4).

Participants consistently reported increases in the frequency of practices across all 12 domains between the first and second practice visit, captured through the '12-Point Checklist'. Overall, the average score for participants increased from 26.3/48 (54.8% of the possible total score) at the first visit, to 37.3/48 (77.7% of the possible total score) at the second visit. Areas where participants' practice showed greatest increase, moving upward from 'Rarely' (the grouping of 'Never' and 'Sometimes') to 'Frequently' (the grouping of 'Usually' and 'Always'), included: referral to specialised refugee mental health services (increased from 22% at the first visit to 66% at the second visit); identifying patients of asylum seeker and refugee background (increased from 31% at the first visit to 66% at the second visit); and undertaking appropriate blood

screening that includes hepatitis B, tuberculosis and Quantiferon/Mantoux (increased from 53% at the first visit to 84% at the second visit). The complete list of findings from the '12-Point Checklist' is presented in [Table 1](#).

Finally, participants were overwhelmingly satisfied with their involvement in the 'GP Engagement' initiative, stating that they found the education delivered to be relevant and appropriately tailored to their needs, and the resources provided to be useful to implement within their daily practice. Participants also indicated that they appreciated opportunities to ask questions, work collaboratively with the Refugee Health Fellow on a range of issues, and identify areas for further education. Participants gave 'GP Engagement' an average rating of 9/10.

Discussion

The evaluation findings suggest that the 'GP Engagement' initiative has influenced the way that GPs work with asylum seekers and refugees. Through this initiative, 25 primary healthcare practice clinics located throughout the south-eastern region of Melbourne are resourced with at least one GP who has received training and support around refugee health issues.

Participating staff reported that they encountered a range of challenges when working with asylum seekers and refugees. Many of these concerns, such as a lack of refugee health knowledge, patient health literacy, challenges working with interpreters and referral issues, have been raised within prior studies ([Eckstein 2011](#); [Cheng et al. 2015](#); [Mahimbo et al. 2017](#); [Mishori et al. 2017](#); [Harris 2018](#)). However, this evaluation has illuminated several clinically based issues, which are not as frequently described within the literature. These include billing

and payment issues; difficulties associated with treating patients with limited access to their prior medical history; the challenges of managing patient expectations; and the need for greater access to practical refugee health resources within mainstream primary health care. Future research into these challenges would provide valuable evidence to inform future capacity-building initiatives.

At the baseline assessment, referral into refugee health mental health services, promoting social connection and use of online resources were the 'practices' reported by participants as having the lowest frequency of compliance. This finding suggests that participating staff were far more responsive to the physical health needs of asylum seekers and refugees, than their psychological and social health needs. Given the body of evidence emphasising the complex, interrelated and compounded health needs of asylum seekers and refugees (Harris and Zwar 2005; Edberg *et al.* 2011), it is important that progressive notions of holistic health and well-being continue to be promoted within primary health care. This is an essential step towards comprehensively and sustainably improving the health of asylum seeker and refugee communities, and high-needs population groups more broadly. In addition, the low rate of interpreter use for non-English-speaking patients at initial assessment, in which only 53% of participants reported frequent use, is worth drawing specific attention to. Interpreter use is consistently related to improved clinical care (Karliner *et al.* 2007); therefore, the low level of interpreter use within primary health care, as found in this study, is concerning due to the risks that this presents for patients' care, and the additional medico-legal implications this may have for health providers. This priority issue requires further attention to improve the quality of primary health care for linguistically diverse communities.

The 'GP Engagement' initiative activity targeted clinical barriers to optimal refugee health care, and worked with GPs to move their treatment approaches into much closer alignment with best-practice refugee healthcare principles. Substantial increases documented across all domains, coupled with high participant satisfaction ratings, suggest that this is an effective and acceptable strategy. This outcome is notable, as while the need for GP support and training has been identified (Johnson *et al.* 2008; Mahimbo *et al.* 2017; Harris 2018), there is a lack of evidence defining effective strategies to address this need. Therefore, this initiative provides valuable learnings for primary healthcare capacity building in other high settlement regions.

Over a 3-year period, the 'GP Engagement' initiative was led by a Refugee Health Fellow, who was dedicated and suitably experienced to drive the project. This role was allocated specifically to planning, coordinating and undertaking all actions. This also meant that there was one, consistent person building and maintaining relationships with GPs throughout their participation in this initiative. The repute and rapport established between the Refugee Health Fellow and the participants during the project term is recognised as contributing towards the positive outcomes achieved. In addition, the co-location of the Refugee Health Fellow at Monash Health Refugee Health and Wellbeing enabled access to a range of expertise and resources that further strengthened this initiative, and facilitated opportunities to improve the flow of referrals between services within the region.

These factors highlight the value of relationship building, service coordination and knowledge sharing to most effectively and efficiently utilise health resources, and improve regional health care delivery for asylum seekers and refugees.

Strengths and limitations

'GP Engagement' has demonstrated that it is possible to build primary healthcare responsiveness to asylum seekers and refugees through a strategic regional approach that is firmly grounded in evidence-based practice, and considerate of the requirements and constraints of GPs. This initiative included a suite of field-tested resources to support implementation, and an agile evaluation framework to ensure that program impact was captured. These are key strengths of this project.

Further, 'GP Engagement' was accredited by The Royal Australian College of General Practitioners' (RACGP) Quality Improvement and Continuing Professional Development (CPD) Program. This acknowledged that 'GP Engagement' made a valuable contribution towards the ongoing advancement of contemporary general practice within Australia.

However, the sample size, which included 57 participants, and the lack of comparison group are recognised as limitations of this study. In addition, most of the participants were GPs, with only minimal representation from practice nurses and other relevant staff. Exploration into why this occurred, and the possible implications, was beyond the scope of this evaluation. However, such areas should be considered for future work. Finally, a large proportion of the findings were drawn from the '12-Point Checklist'. This pre- and post-intervention relies on accurate self-reporting from participants. In an attempt to mitigate the risk of social desirability bias, items on the tool were worded carefully and neutrally. However, it is still possible that participants over reported 'desirable' practices, particularly in the post-intervention assessment. Furthermore, the '12-Point Checklist' was used within the sessions as a springboard for discussion, as well as for evaluation purposes. The instrument serving a dual function was an intentional, practical decision made in consideration of GPs' time constraints, and in an attempt to foster a collegial environment, rather than appear to approach participants as an external organisation assessing their practice. This methodology also ensured that the focus of sessions could be immediately tailored to areas of practice that were lacking. However, it is important to note that participants' ratings after the intervention may have been influenced by discussion surrounding the '12-Point Checklist' at the initial visit, and that bias may have been introduced within this approach.

Finally, within this evaluation, the frequency of clinical tasks undertaken was used as the primary indicator of increased capacity. Establishing consistent, evidence-informed practices are indeed a notable outcome, and an important step towards ensuring more competent care for asylum seekers and refugees. However, other important aspects of capacity to work with asylum seekers and refugees, such as the interpersonal skills required to demonstrate cultural understanding and build trust and rapport with patients, were not captured within this evaluation. Future studies should consider exploring these aspects of capacity within the primary healthcare setting.

Conclusion

Universal primary health care is integral to maintaining population health. However, groups characterised by diversity often have unique requirements that must be considered to ensure primary health care is accessible, appropriate and patient-centred. ‘GP Engagement’ recognised this, and established an effective strategy to provide education, distribute resources and influence GPs’ approach to care for asylum seekers and refugees. These factors strongly lend to increased capacity within the region to work with this priority population group. ‘GP Engagement’ efficiently utilised refugee health expertise to share knowledge and resources, thereby ensuring wide-reaching benefits. ‘GP Engagement’ complemented Monash Health Refugee Health and Wellbeing’s clinical service, allowing focus to remain on the most vulnerable and complex patients; further promoting appropriate resource utilisation. These factors intend to contribute towards a more sustainable health system, and longer-term health gains for this priority community.

Conflicts of interest

The authors declare no conflicts of interest.

Acknowledgements

This research did not receive any specific funding.

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Appendix 1. GP Engagement 12-Point Checklist

Please indicate how frequently you follow each of these practices or actions when working with asylum seeker and refugee patients		Never	Sometimes	Usually	Always
1	Does your practice use trained interpreters for non-English-speaking patients?	1	2	3	4
2	Do you identify patients from a refugee background (distinguish between asylum seekers and refugees)?	1	2	3	4
3	Do you use the Refugee Health Assessment for screening new patients?	1	2	3	4
4	Does your blood screen include full hepatitis B serology, tuberculosis QuantiFERON/Mantoux?	1	2	3	4
5	Do you refer all your new refugee and asylum seeker patients to dental/optometry?	1	2	3	4
6	To address mental health issues, do you refer to specialised refugee mental health services like Foundation House?	1	2	3	4
7	Do you provide longer appointment times or more regular visits to complete the Refugee Health Assessment?	1	2	3	4
8	Do you provide catch-up immunisations?	1	2	3	4
9	Do you engage with appropriate health literacy and communication models (e.g. explain repeat scripts or use TeachBack)?	1	2	3	4
10	Do you utilise online refugee resources, such as the Victorian Refugee Health Network?	1	2	3	4
11	Do you refer to free social activities as part of improving social connection?	1	2	3	4
12	Do you refer to public specialists as part of considering ability to pay?	1	2	3	4