Equity: from clinical to research and back again; the case of refugee children

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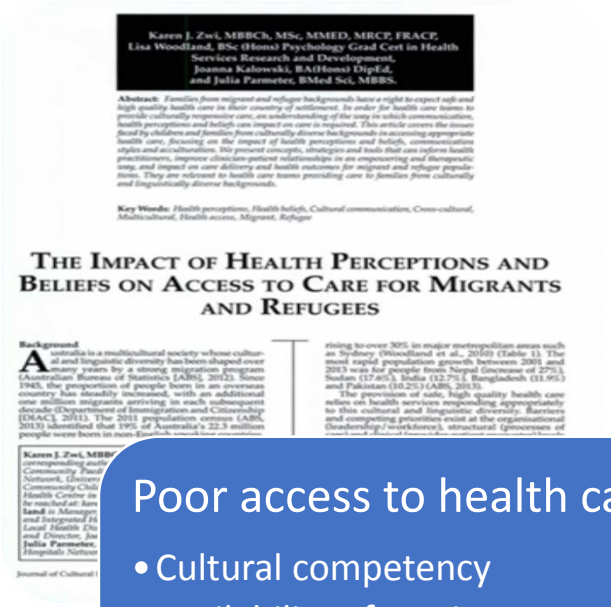
2007: what we know about refugee children

- **Highly vulnerable** yet **resilient** group
- **Models of care to enhance access 'known' but access not measured**
- **Routine screening is highly effective** for physical health
- **Development and social-emotional wellbeing is not well documented**
- **Trajectories over time in resettlement country not known**
- **Predictors of wellbeing over long term not known**

Moving from knowledge to implementation



Karen J. Zwi, MBBCh, MSc, MMED, MRCP, FRACP,
Lisa Woodland, BSc (Hons) Psychology Grad Cert in Health Services Research and Development,
Joanna Kalowski, BA(Hons) DipEd,
and Julia Parmeter, BMed Sci, MBBS.

THE IMPACT OF HEALTH PERCEPTIONS AND BELIEFS ON ACCESS TO CARE FOR MIGRANTS AND REFUGEES

Journal of Paediatrics and Child Health

VIEWPOINT

Health service delivery for newly arrived refugee children: A framework for good practice

Lisa Woodland,[1] David Burgner,[2] Georgia Paxton[3] and Karen Zwi[4]

Poor access to health care

- Cultural competency
- Availability of services
- Barriers for GPs
- Language and knowledge barriers
- Practical barriers

Journal of Tropical Pediatrics Advance Access published September

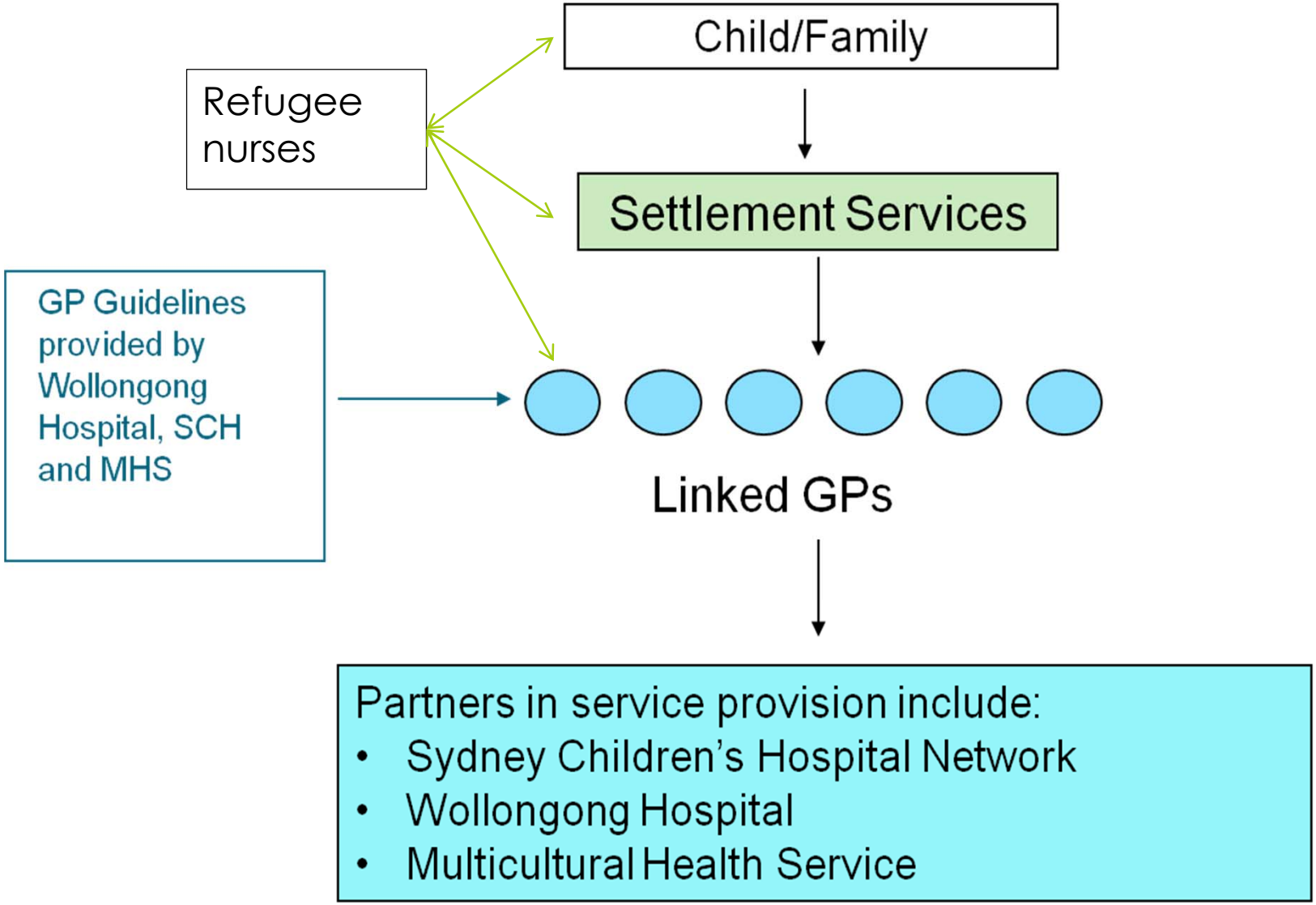
Screening and Primary Care Access for N
Arrived Paediatric Refugees in Region
Australia: A 5 year Cross-sectional Anal
(2007–12)

by Karen Zwi,[1,2] Nikola Morton,[1] Lisa Woodland,[3] Kylie-Ann Mallitt,[2] and Pamela Palasanthiran[1,2]

Framework for good practice

- **Routine screening linked to ongoing care**
- Care co-ordination
- Consumer engagement
- Accessible
- Data collection & evaluation
- Sustainability
- Advocacy

Model of care: regional NSW



Key finding: access can be enhanced

- 97% of newly arrived refugee children accessed screening
- 88% screened within one month and 96% within 6 months of arrival
- 72% had all the recommended screening tests performed
- Innovative models of care can
  - provide timely and accessible health screening
  - build capacity in the primary care sector

Knowledge gaps: health over time, development and social-emotional wellbeing

Longitudinal study

1. To assess over time
- **Physical health**
- **Development** (6 mths-5yrs)
- **Social-emotional wellbeing** (4-15 yrs)

On arrival → year 2 post arrival → Year 3 post arrival

2. Identify risk and protective factors that contribute to health outcomes **in order to provide early intervention for optimal outcomes**

BMJ Open

Methods for a longitudinal cohort of refugee children in a regional community in Australia

Karen Zwi,[1] Santuri Rungan,[1] Susan Woolfenden,[1] Katrina Williams,[2] Lisa Woodland[3]

Study design to address equity in participation

Easy to answer
85%

N=61 (40% of eligible enrolled)
100% follow up at 13 months
85% follow up at 31 months

Respectful
100%

Journal of Paediatrics and Child Health

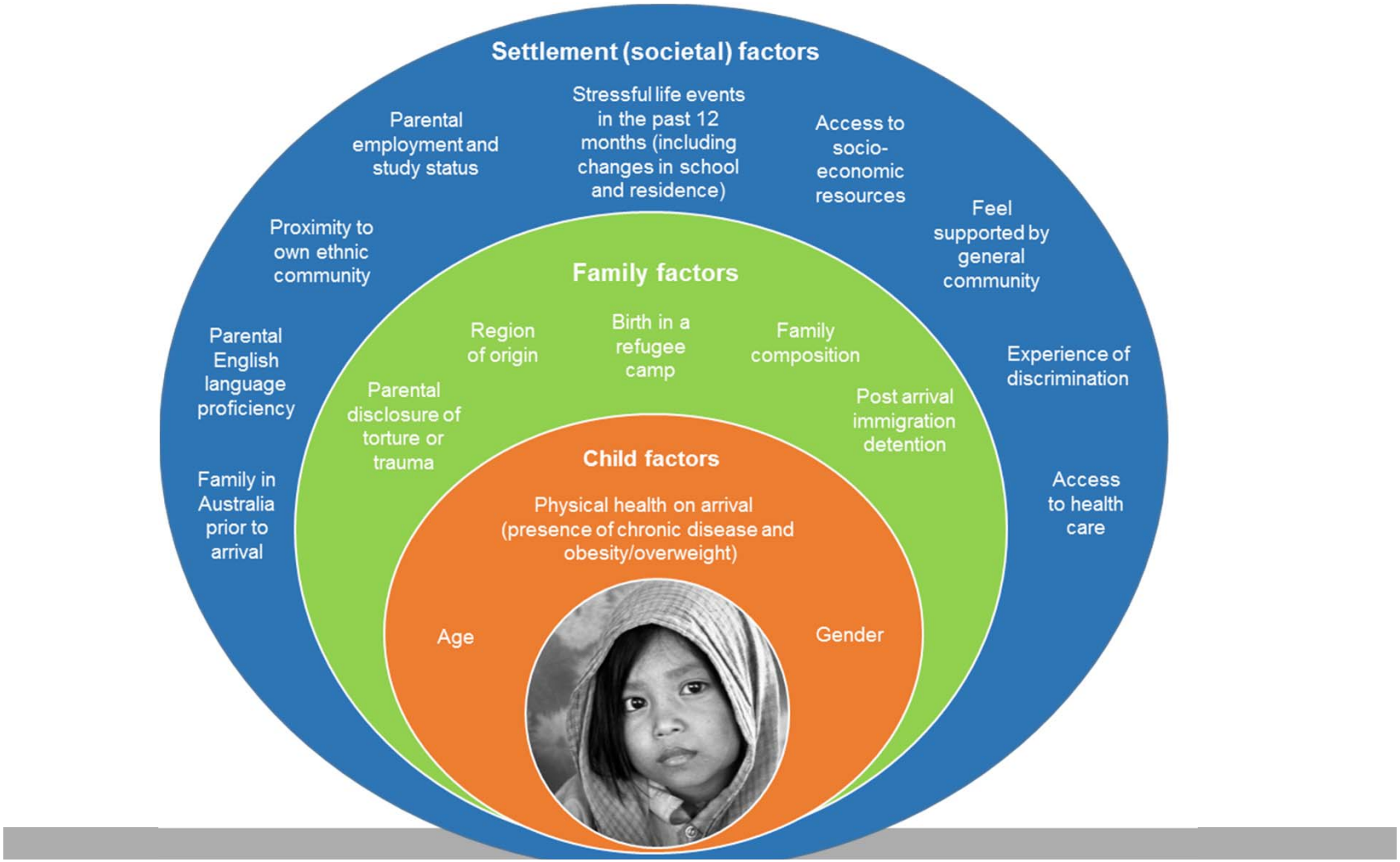
Refugee children and their health, development and well-being over the first year of settlement: A longitudinal study

Karen Zwi,[1,2] Santuri Rungan,[2] Susan Woolfenden,[2] Lisa Woodland,[3] Pamela Palasanthiran[1,2] and Katrina Williams[4]

Health outcome measurement at 3 follow up:

- Physical health - 15% chronic disease 13% overweight
- Developmental health - 27% mild developmental problems in year 2; all resolved by year 3
- Social-emotional wellbeing (SDQ) - abnormal scores reduced from 13% to 6% over time

How do we identify the small number at increased risk of poor social emotional wellbeing?

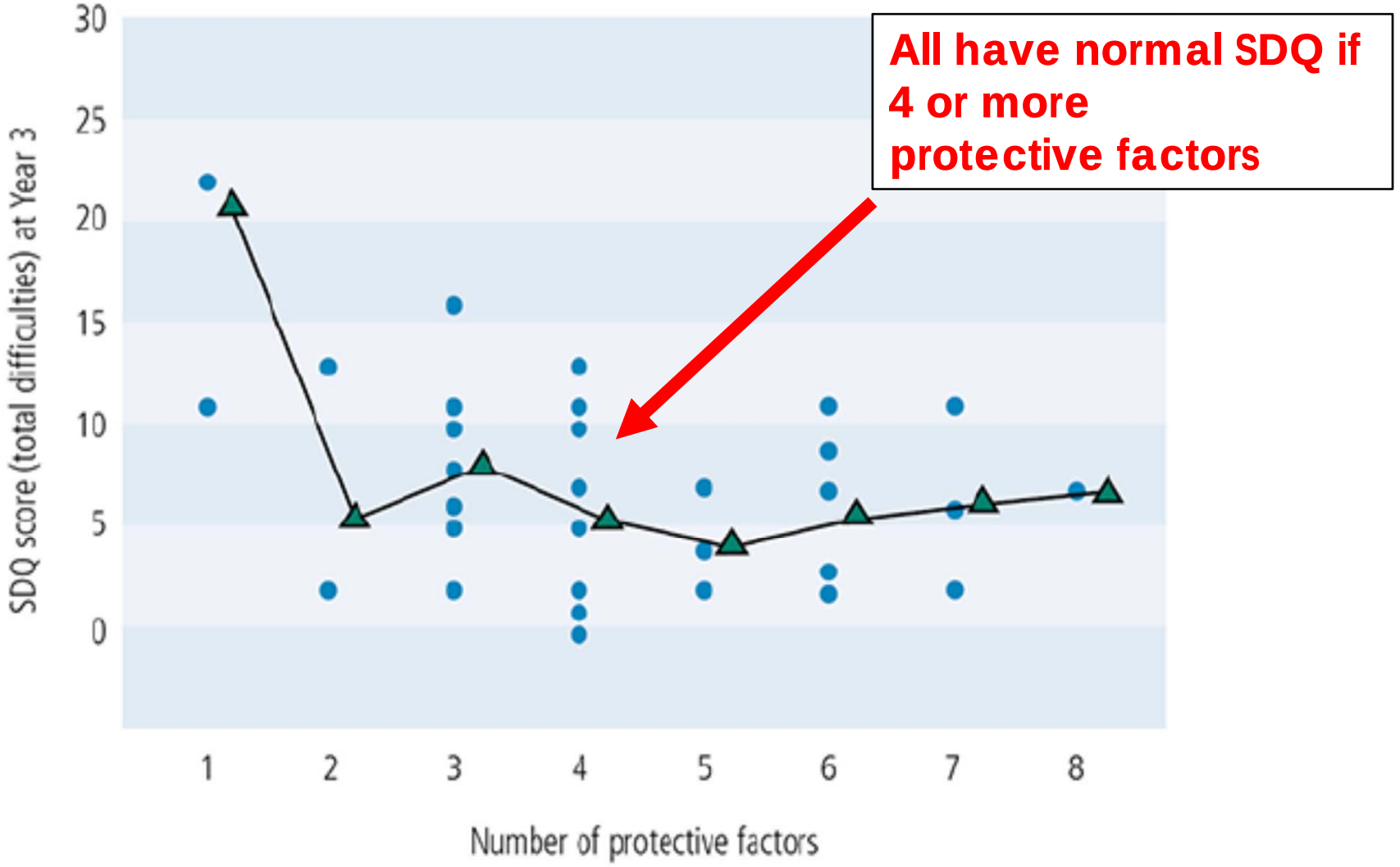


Protective factors for social-emotional well-being of refugee children in the first three years of settlement in Australia

Karen Zwi,[1] Lisa Woodland,[2] Katrina Williams,[3] Pamela Palasanthiran,[1] Santuri Rungan,[4] Adam Jaffe,[1] Susan Woolfenden[4]

Child factors	Younger age Gender Chronic disease BMI
Family factors	**Region of origin - Africa** **Family composition – father present** No parental disclosure of torture or trauma Birth in a refugee camp
Settlement factors	**Fewer stressful life events in the past year** Family in Australia prior to arrival Proximity to one's own community External community support Stability in child's school and residence Financial stability Marital stability Parental employment Parental education and study status English language proficiency Access to health care

Cumulative protective factors predict social-emotional wellbeing

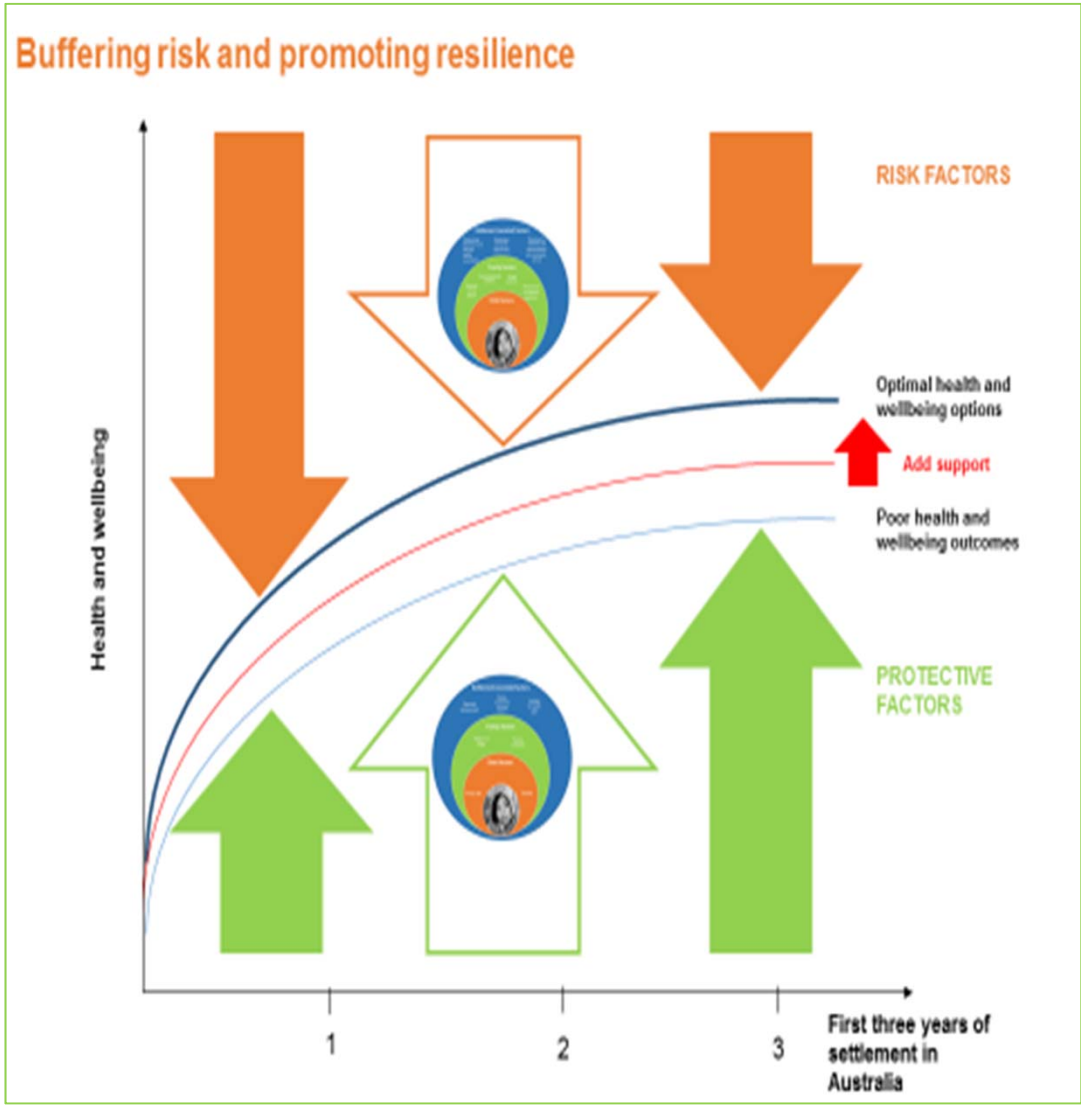


What these studies add to our knowledge

Participation in research and access to care can be enhanced

Most refugee children do well over the first 3 years

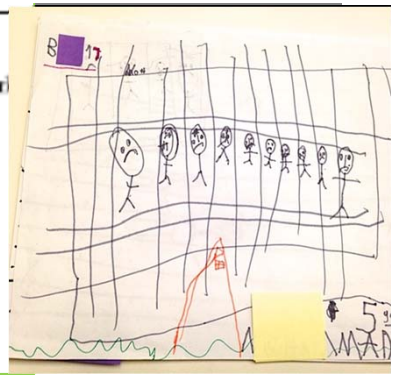
Identification of early protective factors enables proactive f-up if <4 protective factors



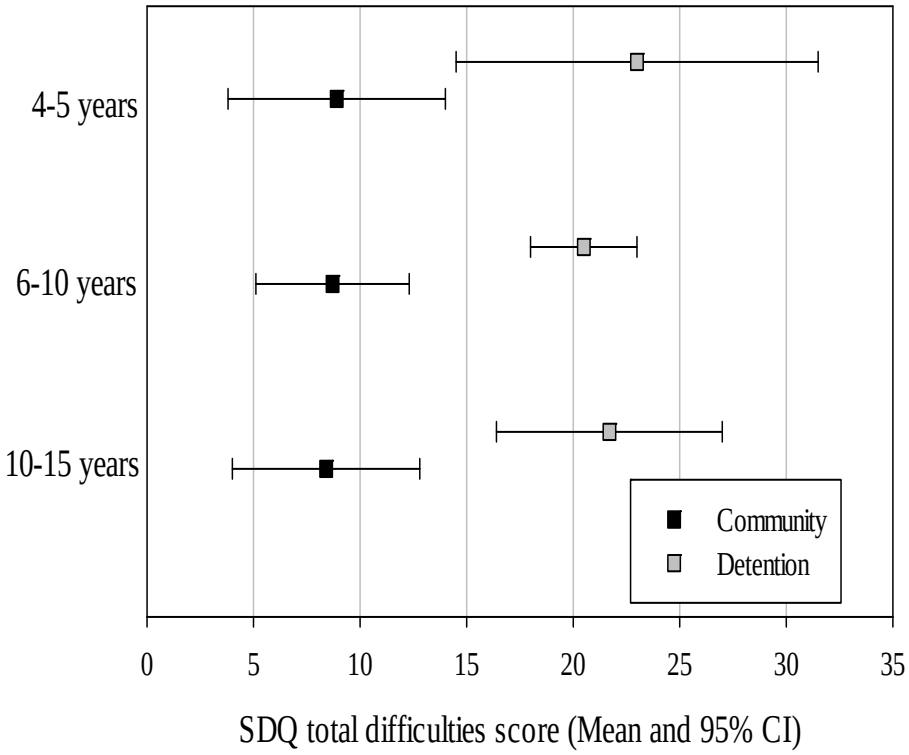
ORIGINAL CONTRIBUTION

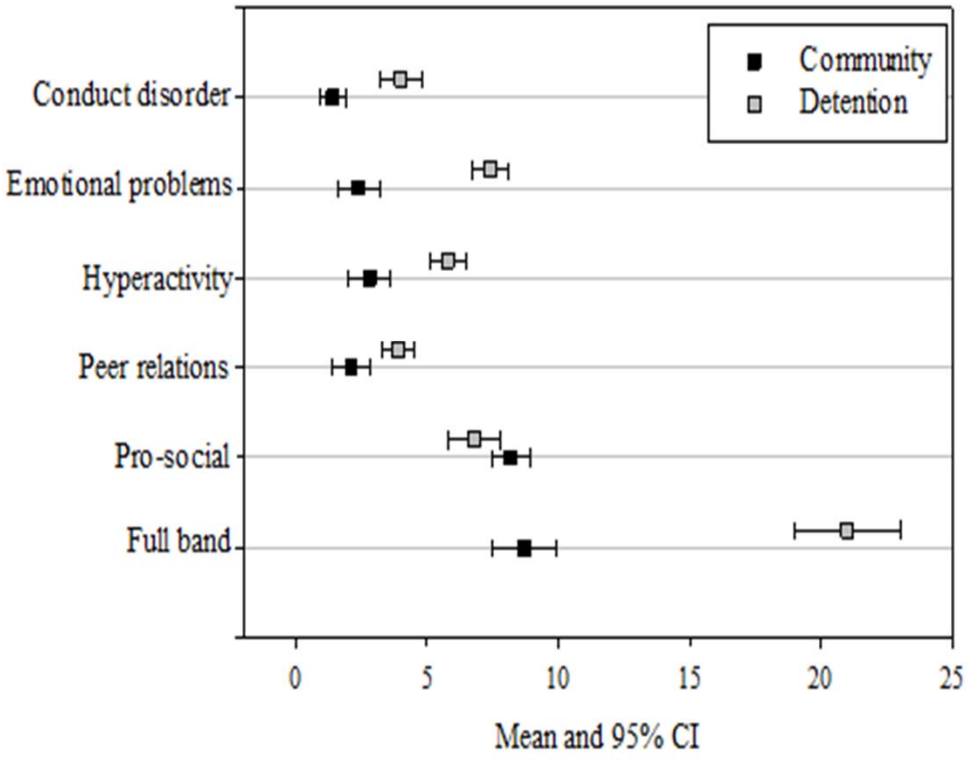
The impact of detention on the social–emotional wellbeing of children seeking asylum: a comparison with community-based children

Karen Zwi[1,2] · Sarah Mares[3,4] · Dania Nathanson[2] · Alvin Kuowei Tay[3,5] · Derrick Silove[3,6]



What about the impact of detention?





Implications for policy and practice

Likely to optimise outcomes in accompanied refugee children settling in high-income settings :

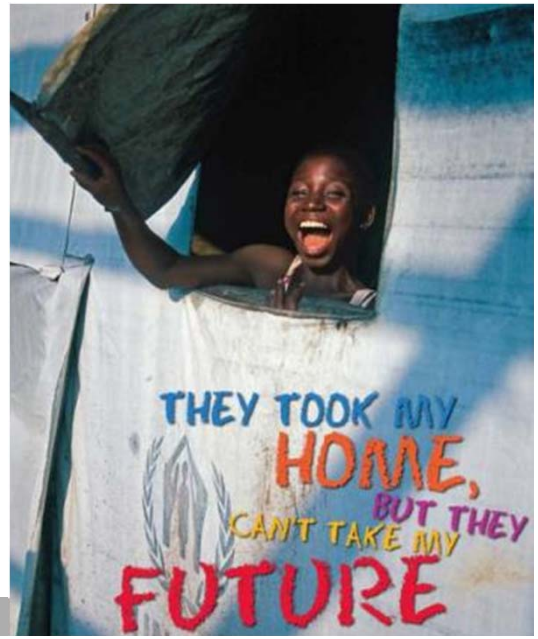
- child and family level:
  - reduce postmigration exposure to detention and discrimination
  - promote stability and belonging in school and residence
  - provide support for families to remain intact

Helping refugee children thrive: what we know and where to next

Karen Zwi,[1,2] Lisa Woodland,[3] Sarah Mares,[4] Santuri Rungan,[2] Pamela Palasanthiran,[1,2] Katrina Williams,[5] Susan Woolfenden,[2] Adam Jaffe[1,2]

Implications for policy and practice

- community and societal level:
  - promote welcoming environment in the host country
  - settle families in close proximity to their own ethnic community
  - provide access to social & economic resources
  - facilitate employment opportunities



Equity: from clinical to research and back again
Thank you and questions

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Thank you to the families and children who generously shared their time

Extra slides not for talk

Thank you and questions

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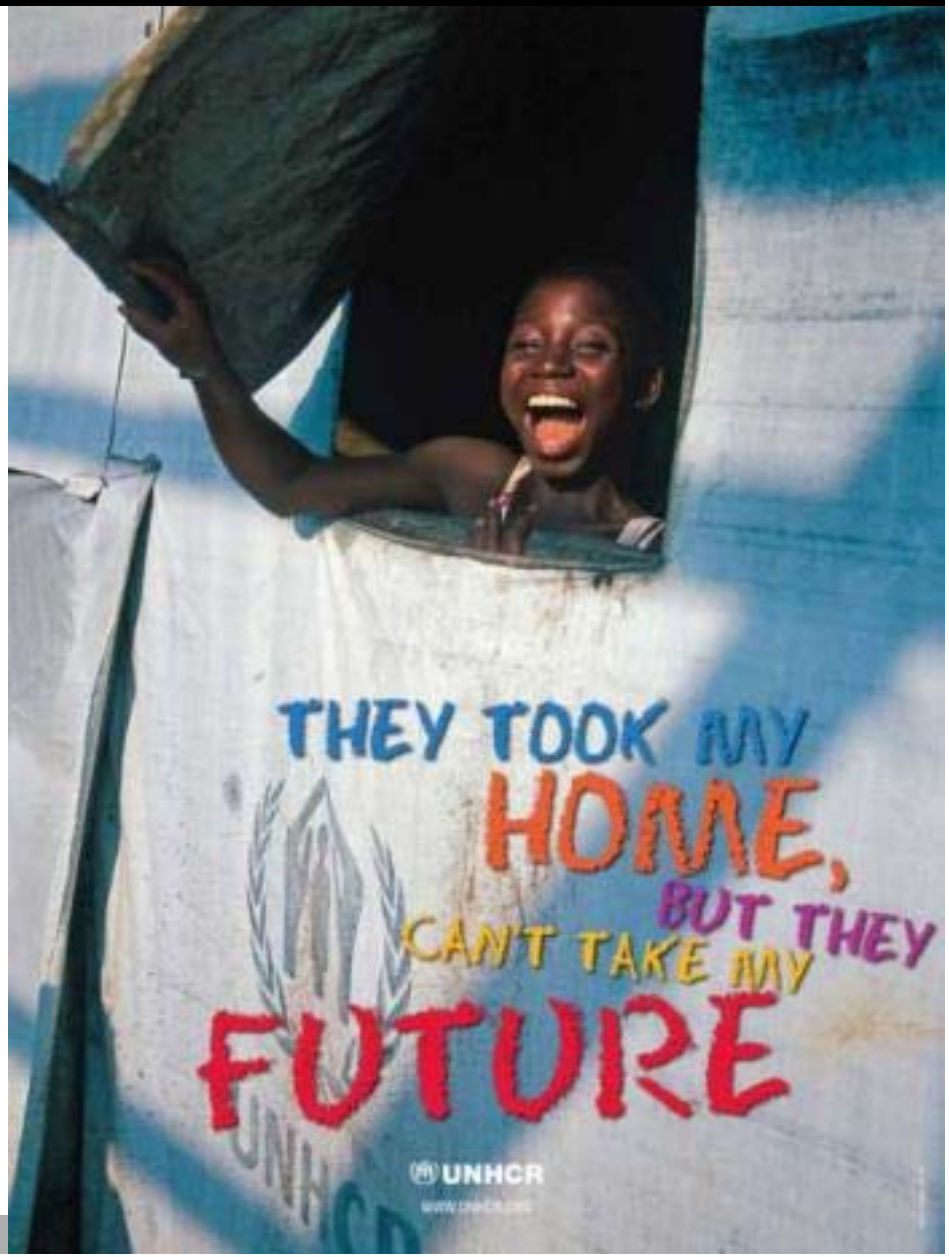


Next steps in clinical practice and research

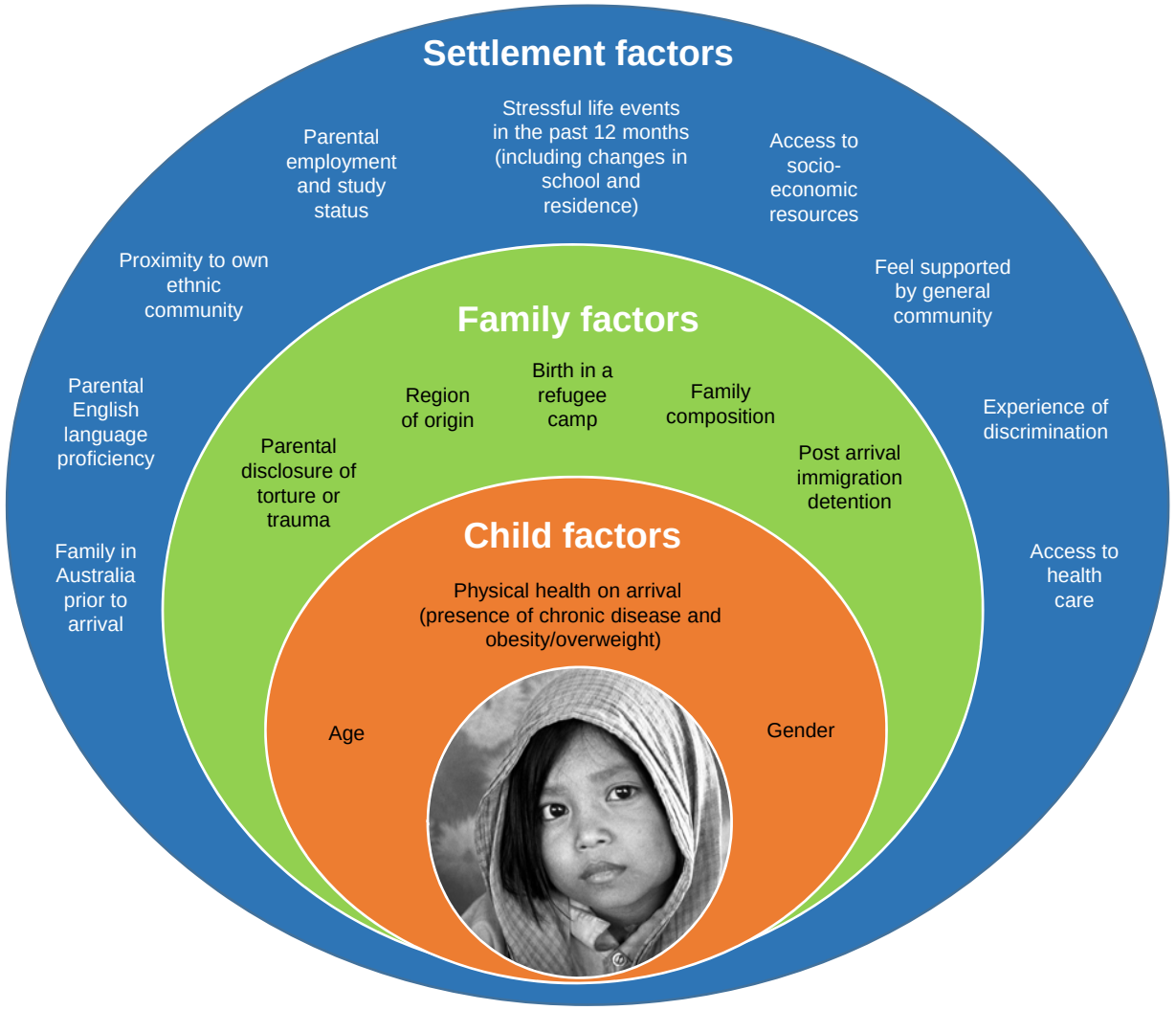
Trial predictive tool and early identification

Trial interventions likely to be effective in producing better outcomes

How do we promote

- employment?
- social inclusion?
- education…?

Predictors: Risk and Protective factors

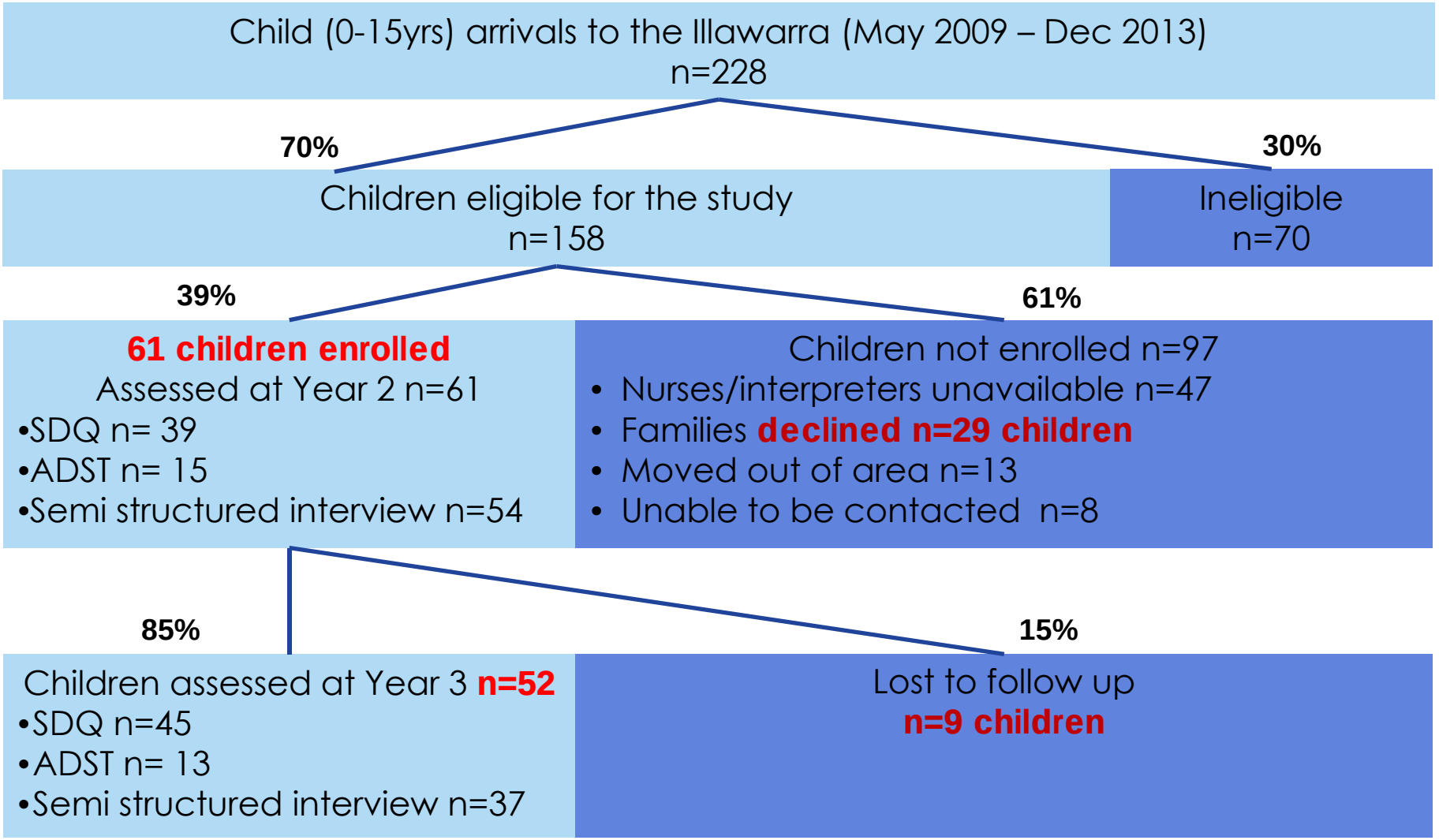


Bioecological model: Bronfenbrenner

Social-emotional wellbeing improved over time

SDQ	No. children requiring further assessment	
	13 months	31 months
Overall score	5/39 **(13%)**	2/36(6%)
Emotional symptoms (headaches, worries, feeling unhappy or fearful)	9/39 **(23%)**	3/36 (8%)
Conduct problems	5/39 **(13%)**	1/36 (3%)
Hyperactivity & inattention	3/39 (8%)	3/36 (8%)
Peer relations (preferring to play alone, not having friends, being bullied)	8/39 **(21%)**	2/36 (6%)
Pro-social behaviour	0/39 (0%)	1/36 (3%)

Study sample and follow up to 3 years



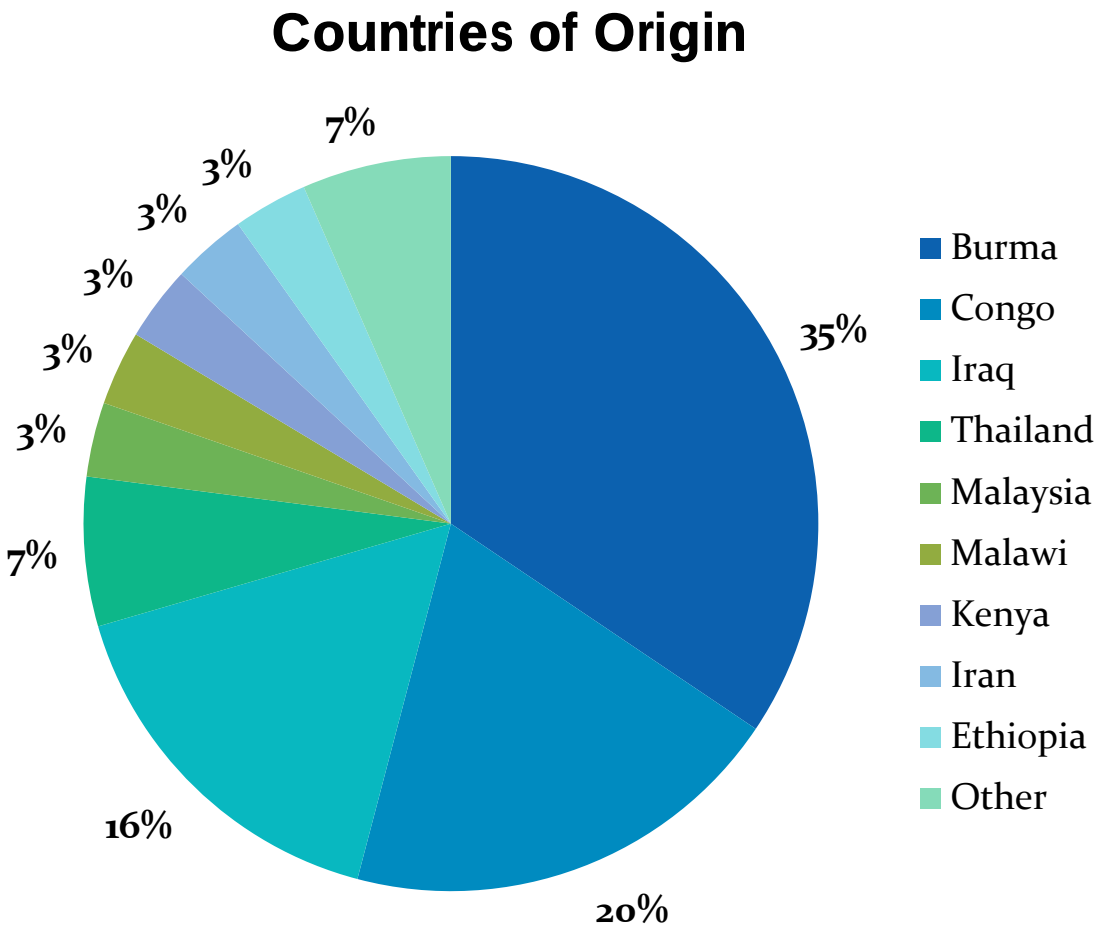
Study sample = national sample

♀ n = 32 (52%)

♂ n = 29 (48%)

Mean age: 6 years; Range : 6 months -15 years

- 40% of parents had low levels of education
- 30% of fathers were absent on arrival
- 13% of children were born in refugee camps, and
- 11% of parents self-disclosed previous trauma



Risk and protective factors over time

- increased parental employment (p=0.001)
- improved English proficiency for partners (p=0.02)
- reduced stressful life events in the last 12 months (p=0.003)

Stable - Parents were:

- studying English (96% at year 2 - 76% at year 3)
- accessing government financial support (96%;100%)
- feeling supported by their own community (78%;73%)
- feeling supported by the general community (69%;63%)

Access to health care longer term

Access to health care (Parent report)	Year 2 post arrival	Year 3 post arrival
Visited GP (every 1-3 months) Good access to GP	38/51 (75%) 50/51 (98%)	22/54 (41%) 45/52 (87%)
Presented to ED (last 12 months)	6/51 (12%)	4/51 (7%)
Visited Early childhood services (last 12 months)	5/22 (23%)	1/26 (4%)
Visited Dentist (last 12 months)	26/51 (51%)	33/52 (63%)
Fully Immunised	42/51 (82%)	48/51 (94%)