Refugee resettlement in regional Australia

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Abstract

Aim
To analyse the current approach in resettling refugees in Wagga Wagga, as a potential model for Regional Australia.

Background
The Wagga Multicultural Centre has the responsibility for providing support to relocate families from countries as diverse as Africa, Afghanistan, former Yugoslavia and the Middle East, from backgrounds of disruption and trauma and different cultural needs. These challenges escalated during 2005 and 2006 with the arrival of several families from many countries in Africa. Arranging a system for appropriate review and relevant follow up has been difficult but in Wagga we have been able to establish the beginnings of a team approach to co-ordinating care.

Medical review
Immediate challenges to medical review relate to timely overall assessment, evidenced based ordering of relevant investigations, time delay between writing requests, the test being performed and return of some of the results. Stress is placed on the time availability of workers from the multicultural centre team to always accompany their clients to medical appointments; volunteers, often from supporting church groups accompany clients instead. Hence there is variability in further co-ordination of health care actions for the client.

Social integration
A further challenge for the Multicultural Council is to influence rural communities, which have been of predominantly Anglo-Celtic background to embrace peoples vastly different both ethnically and culturally. Employment opportunities, acquisition of English language skills, smooth integration into schooling and ability to adapt to different food, water and cooking practices all test the ingenuity, resourcefulness and flexibility of the Multicultural Council team. For peoples used to living in cities or crowded refugee camps, the relocation to rural areas of Australia can be quite confronting.

Recommendations
The resettlement of refugees to rural Australia needs structured planning. Facilitated discussion across Australia should occur to examine approaches to helping our new settlers so as to develop co-ordinated systems of integrating health and social care needs. Appropriate, available and adequate funding of centres such as this should be offered as it underpins their ability to help the new, rural, disadvantaged community members. These process should remain under review.

Introduction

Australia has a long and proud tradition of humanitarian resettlement and offers a range of settlement services to refugees that are amongst the most comprehensive in the world. In 2004, Australia was second only to the US, in numbers of refugees resettled.¹

The United Nations 1951 Convention and 1967 Protocol on the Status of Refugees defines refugees as people who are outside their country of nationality or their usual country of residence; and

- are unable or unwilling to return or to seek the protection of that country due to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, and
• are not war criminals or people who have committed serious non-political crimes.²

What does this mean in real terms at the local level?

The Multicultural Council Wagga Wagga (MCWW) provides support to refugee families from many diverse countries aiming to set up a comprehensive range of services for peoples with backgrounds of disruption, torture and trauma.

Hurryiet Babacan ³ describes settlement as a “dynamic process” with “what services are available, what attitudes exist towards the newly arrived and what government policies are in place” having a “lasting impact” ³. Since Wagga Wagga has been involved in settlement for humanitarian entrants the MCWW has found it challenging encourage rural communities (predominantly of Anglo-Celtic background) to embrace peoples vastly different both ethnically and culturally.

During 2006 between 150 and 200 African people were resettled into Wagga Wagga and for many of them, used to living in cities or crowded camps, the relocation to rural areas of Australia has been confronting, requiring dedication and effort by those involved in the resettlement process. Timely physical and psycho-social review and targeted intervention can help minimise interruptions to settlement and is part of the holistic care organised and facilitated by MCWW.

**Settlement system**

While Australia has a prominent place internationally in accepting humanitarian entrants, the process is a complicated one. The Department of Immigration and Multicultural and Indigenous Affairs (DIMIA) works within the recommendations and co-ordination of the United Nations High Commissioner for Refugees (UNHCR) to accept persons under its humanitarian programs. Dr Mitchell Smith director of NSW Refugee Health Service ⁴ depicts the process for NSW in the attached diagram “Pathways and Health Processes for Humanitarian Program Entrants to NSW” (Figure 1) demonstrating the complexity of the system. As well a DIMIA booklet Refugees and Humanitarian Issues: Australia’s Response 2005 ⁵ further describes the “onshore” and “offshore” programs which exist for refugees.

Under the Integrated Humanitarian Settlement Strategy (IHSS), intensive settlement support is provided for humanitarian entrants for six months after arrival; guiding them towards self sufficiency. Funding supports a case management approach, where needs are identified and addressed utilising mainstream services.⁶,⁷ Subsequently federal support is delivered through the Community Settlement Services Scheme (CSSS) (recently integrated with the Migrant Resource Centre to become the Settlements Grants Program; from July 2006⁷). Hence a complex system persists.

The Refugee Council of Australia however, has voiced concern regarding the effectiveness of current systems in Australia for refugee resettlement.

Adrienne Millbank’s Parliamentary Library (Commonwealth of Australia) E-brief also highlights concern:

> While rural and regional settlement has brought some welcome benefits for both refugee communities and the regional areas in which people have settled, there is a range of problems associated with service delivery and coordination of services that impact significantly on individuals and families.⁵

> Despite the extra attention … Australia has not been adequately prepared to cope with the special needs of African refugees arriving with poor education, poor health, poor language skills and a history of brutalisation and trauma from years of civil wars and refugee camp experiences.⁷
The Multicultural Council Wagga Wagga

History

The Multicultural Council of Wagga Wagga (MCWW) has evolved over several years to deliver services under the IHSS and the CSSS. MCWW now participates in a consortium with St Vincent de Paul, the Riverina Resettlement Consortium and Centacare. There is a management committee with representation from church sponsoring groups, the Wagga Wagga Community College and community members. Currently there are no guidelines as to the range of expertise required for the management committee composition. Federal funding to MCWW is per numbers of families supported and the support of volunteers is crucial.

In their submission to the NSW government on the settling of African Humanitarian entrants, Pittaway, et al. emphasise the important role volunteers play; especially for regional and rural Australia:

The social support, friendship and assistance provided by these volunteers is crucial in assisting refugees to settle in Australia.

Barriers

Wagga Wagga faces similar problems in that volunteers receive minimal training and may be unfamiliar with the special and intensive settlement needs of the refugee families they are trying to support. Pittaway, Bartolomei and Eckert note that community groups frequently mention that the current DIMIA funded training does not meet their needs.

They also state that the volunteer role must not be confused with that of their paid counterparts and that appropriate funding should be available to support capacity building in this regard.

Projections

Locally, the MCWW would benefit from sufficient funding for a paid manager with project funding skills to co-ordinate the multiple jobs and responsibilities of the caseworkers (and volunteers) allowing them more time for client work and training. Review of the expertise needed on the management committee would allow a global perspective in planning and developing the infrastructure needed to cater to the needs of refugees.

In California a Refugee Health Assessment Program provides funding to allow for comprehensive health assessments for refugees, allowing for trained, culturally sensitive interpreters to guide families through the health assessment process, orienting families to the health care system, providing outreach and education and making referrals for other health conditions identified.

Challenges

During 2005 and 2006 the arrival of several families from many different countries in Africa challenged the resourcefulness of the MCWW team. Indeed between December and October 2006 eleven families arrived as primary migration and 15 as secondary migration. At least four more families were expected between October and the end of December. See Table 1. Various responsibilities that caseworkers with MCWW have undertaken include: managing employment opportunities, finding housing, guiding acquisition of English language skills through liaison with TAFE, enhancing smooth integration into schooling and guiding adaptation to different food, water and cooking practices as well as education about medication (eg reminding when to take). To manage these effectively requires a significant time resource in liaising with other services to create openings and adapt programs. The difficulty with this is starkly highlighted by Oddveig Nygard as a tension between the humanity of the caseworker and the resource limitations of the bureaucracy.

As an IHSS service provider the MCWW attempts to tailor service delivery to the specific needs of different caseloads and entrant groups and is performing an admirable job. It should also be noted that MCWW has responsibility not only for Wagga Wagga but also for surrounding rural regions such as Young and Griffith, creating the extra demands of travel. The capacity to tailor service delivery is noted to be important by the Refugee Council of Australia and they emphasise the need for adequate resourcing in this regard.
Table 1  Numbers of refugees currently residing in Wagga Wagga as at Feb 2007

<table>
<thead>
<tr>
<th>Country of origin</th>
<th>Total number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sudan</td>
<td>170</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>30</td>
</tr>
<tr>
<td>Liberia</td>
<td>16</td>
</tr>
<tr>
<td>Burundi and Congo</td>
<td>20</td>
</tr>
<tr>
<td>Afghanistan</td>
<td>4</td>
</tr>
<tr>
<td>Iran</td>
<td>4</td>
</tr>
<tr>
<td>Iraq</td>
<td>15</td>
</tr>
<tr>
<td>Burma</td>
<td>20</td>
</tr>
</tbody>
</table>

Health care

Davidson et al 2004 highlight the importance of timely medical assessment for children stating that “a comprehensive health assessment can assist in identifying children at risk of poor health and .. provide them with timely and effective care, advocacy and appropriate referral.”

Equally, the Australian Medical Association (AMA) in its position statement “Health Care of Asylum Seekers and Refugees” 2005 recommends that “all asylum seekers and refugees should undergo comprehensive and timely health assessments in a culturally appropriate manner by suitably trained medical practitioners...”

Australia has a complex policy for the entitlements of refugees to health care.

For the purposes of this article the complexities of access are not discussed here. The majority of refugees we have hosted are accepted on a permanent status. The discussion below describes our approach.

Medical review

In Wagga Wagga, the MCWW identified at the outset a doctor for assessments. Consequently a system of communication and follow up has evolved but with the recent numbers this will have to be revised. When a new family arrival is expected the doctor is emailed the “health manifest ” from DIMIA which details family members, ages, gender as well as history of torture or trauma. Information may be included regarding immunisations and any antiparasitic or antimalarial medications given prior to travel to Australia (see Mitchell Smith’s flow chart Figure 1). An assessment is organised within the first few weeks of arrival. For some clients more immediate review is suggested by DIMIA and MCWW contacts the doctor to review within a day or two of arrival. More immediate review is requested for a variety of reasons such as undiagnosed fever, physical symptoms occurring en route such as headache or pain, review of recent malarial treatment, post natal review for women delivering on their way to Australia and even warfarin stabilisation for pulmonary embolus.

Considering the potential medical and psychosocial problems of peoples from refugee backgrounds one cannot underestimate the importance of effective networks between health-workers and volunteer organisations. Dedicated health service organisations to cater holistically for emergent problems are few in number and non-existent in rural areas. There are currently few leaders within the migrant communities to push agendas for social and health needs.

A Health Needs Analysis of the refugee population in South Eastern Sydney in May 2001 highlighted that health services lacked specific policies or protocols for articulating their relationship with other health services. This problem exists as well in rural and regional Australia and together with the lack of some necessary services poses dilemmas for health care workers and the refugees they support.
No formal protocol exists for interaction between the Greater Southern Area Health Service and the MCWW similar to that cited for SESAHS; although DIMIA does pass on a “health undertaking” regarding potential problems with pre-immigration Chest X-Rays to the Centre for Public Health.

Use of translating services

The Translating and Interpreter Service (TIS) is funded and co-ordinated through the DIMIA and is vital when medical reviews are performed. There are no face-to-face interpreter services in rural or regional areas. Once connected to TIS and access codes are gained this works reasonably well but it does take time to work with patients in this way. Some of the African dialects are not available however, and only partial translation is possible. A hands-free telephone system is important but may not always be available. At the outset the doctor should make appropriate introductions explain to patients that all information is confidential and in no way will be passed on to government agencies. Using TIS where necessary, a full medical and social history is attempted including family history. Gentle questioning of the patient’s experiences of torture and trauma is important. This takes time and needs to be sensitively carried out. It is of course not always possible to achieve a full history due to limitations on consulting time, ability to find interpreters with appropriate dialects for the patient and areas of increased sensitivity. It is always a challenge to know how to pitch questioning so as to “at first, do no harm”. The completeness of the history gained may also be affected by the gender of the interpreter and any other family members present. Certainly application of “the medical model” and its approach to formal history taking may not be relevant and history appropriate to the needs of an individual may in fact take several contacts.

Weinstein et. al. remind us that refugees as survivors of torture may have multiple symptoms and signs as a consequence leaving both physical and emotional scars. They highlight the importance of good history taking to reflect the trauma experience so as to provide good medical care.

General medical overview involves assessment of cardiac, respiratory and abdominal systems as well as ENT (hearing) and visual acuity. Problems in these areas may of course affect job opportunities and advancement in schooling. Where appropriate, discussion of the “well woman” gynaecological check might occur on the first visit but more commonly is followed up later. Sensitivity in this is paramount as a woman might have been a victim of sexual assault or suffered female genital mutilation in the past.

Our experience in Wagga Wagga is consistent with reports such as that of the Multi-jurisdictional Refugee & Humanitarian Working Group (NSW) that the shift in refugee profile to patients with more complex health needs and often exotic and unusual health conditions. This has implications for upskilling of health professionals.

Team approach

Caseworkers/Case managers:

Caseworkers within the system are paramount in helping organise attendance at investigations. Valuing, training and supporting these workers is highlighted by Pittaway, Bartolomei and Eckert as mentioned above. The US Department of Health and Human Services, Office of Refugee Resettlement notes that “the use of case managers by refugee services programs” to “track the progress of each case and refer refugees to the services they need, when they need them… has been a strong factor in increased self-sufficiency.”

In Wagga Wagga our caseworkers have accepted health care co-ordination as part of their responsibility and liaise with the volunteer groups to ensure each individual refugee’s needs are met. Unfortunately the increase in arrivals has not been matched by an increase in resources.

Volunteers

Again reference is made to Pittaway et al where the nurturing of volunteers in refugee work is affirmed. Stress placed on the time availability of caseworkers has been increased when several families arrive within a short timeframe. Volunteers, often from supporting church groups, accompany clients to medical appointments. Volunteers may or may not have expertise in dealing with the medical system so at to be of maximum benefit to the client that they are supporting. They may or may not
recognise the importance of follow up and the need to encourage prompt carrying out of medical tests. The risk of volunteer burnout and the need for ongoing training, support and upskilling is present in our regional community as well.

In summary, Wagga Wagga demonstrates the capacity of regional areas to support refugees well because of closer ties between community and health care networks as stated by Pittaway, Bartolomei and Eckert;

   despite their limited resources, regional providers are often able to provide a level of personalised support and assistance that would not be possible in a metropolitan setting.8

However the number of arrivals has to be balanced with the capacity of the team to cater to individual needs matched with appropriate incremental resource allocation.

**Current approaches to management in Wagga Wagga**

**Weekly meetings**

In Wagga Wagga in an attempt to manage these potential difficulties we commenced a weekly face-to-face discussion between the doctor and the MCWW IHSS caseworkers. Care plans are co-ordinated including:

- tests ordered, results received, follow up needed
- specialist referrals
- family planning
- population/public health screening
- interventions such as Hep B vaccination, immunisation catch up
- organisation of well women’s checks
- mental health issues
- oral health care.

These discussions have proven very fruitful and branched into more general psychosocial areas:

- for seeking employment
- concepts around the importance of song with the African Community
- approaches to education around nutrition and even concepts around establishing a community garden.

**Future planning**

A greater sense of organisation has developed and volunteer organisations are now more aware of the complexity of issues in health care. In 2007 Wagga Wagga meetings are planned with the involved general practitioner to discuss roles and responsibilities in the health care arena. The general practitioner is currently involving a larger team of GPs and looking at the possibility of an independent clinic for assessment with involvement of the Riverina Division of General Practice and Primary Health Care.

A system of comprehensive record keeping needs to be in place to ensure health care providers both medical and allied health have access to appropriate information enabling comprehensive care. Issues of privacy versus need to know are of paramount importance. These are concerns for us to address during 2007 as our refugee numbers have increased.
**Dental**

The lack of services for provision of oral health care must also be mentioned as a significant problem in our community as in other areas. “Oral health needs are currently unmet in the public health system” as stated by Marshall and Spencer is also reflected locally. In Wagga Wagga dental clinic appointments are made but chronic underfunding, limited public facilities and scarcity of dentists in rural areas causes delays in service provision. This is concerning given that by 2010 Australia is predicted to be short of 1500 dental care providers, largely dentists aggravating the urban and rural maldistribution.

**General practice nurses**

Provision of adequate health care is best through a team approach and it would be relevant to mention the role of general practice nursing specifically in the care of refugees. It is important to have a system of follow-up for refugee patients with respect to our national Population Health measures such as immunisation. In this regard the role of the general practice nurse is vital and we have been fortunate in Wagga Wagga to establish a system that ensures follow up through the general practice where the co-ordinating doctor works. However this will not be able to be sustained as numbers increase. It will be vital to review partnership roles of the MCCWW to examine this, for example through discussion with the Riverina Division of General Practice or through IHSS funding to support a co-ordinating nurse to overview immunisation catch-up requirements.

**Social integration**

The responsibilities of guiding and ensuring all aspects of social integration test the ingenuity, resourcefulness and flexibility of the Multicultural Council team and they have risen to the challenge. Two areas must be highlighted.

**Employment**

Of the families arriving in Wagga Wagga in 2005 and 2006, several people have entered the work market with a varying success rate. Work has been gained at places such at Cargill’s Meats (abattoirs) and house cleaning. An important role is played by Wagga TAFE to improve English language skills prior to new arrivals entering the work market and the local teachers are keenly interested in their role and their students. Of note is work done by Colic-Peisker and Tilbury where political strategies to resettle more migrants into regional areas are highlighted. They refer to literature criticising Australia’s lack of cultural diversity and the development of “Rural Australians for Refugees” which led to the involvement of more rural and regional areas for resettlement. Colic-Peisker and Tilbury however, comment that despite jobs being “guaranteed” as part of this initiative they in fact are “low-status, low paid and often unhealthy”.

This situation is reflected in Wagga Wagga. Many of our refugees have been pastors working in camps, human rights activists, accountants and nurses for example and now they face the stark reality of jobs which carry no respect or satisfaction. Some young people have left almost completed university degrees with no “transcript” of their progress.

Colic-Peisker question whether we are insightful enough to recognise and utilise the skills base of our recent refugee arrivals. However we must be mindful that regional problems with employment, education pathways and services may impact on our refugees.

**Financial concerns**

Financial concerns and difficulties have been evident in several families. Learning our systems of Centrelink payments, banking, paying rent and stretching monies for food, clothing, medicines and other health care costs causes further mental stress. Planning, time and energy is needed to adequately explain and support these new immigrants to help understand our systems and ease the burdens or resettlement. These issues are also reflected in the literature and highlight the further risk of depression for refugees coping with financial stress.
Mental health

The potential effect on mental health is of concern. One must be mindful of the lack of mental health services in rural areas. Wagga Wagga, for example, has no resident psychiatrist and relies on a fly-in service. Rapid access to psychiatric assessment is not always easy to arrange. In our region Centacare has provided counselling for those identified with torture and trauma issues. We are in the process of working together to enhance care planning of our mutual patients/clients.

Recommendations

Settling refugees into our community continues to be a learning curve for all involved. Professionals have generally improved in anticipating and smoothing concerns in multiple areas. This paper has raised several issues concerning refugee resettlement. It has arisen out of needs perceived in trying to cater for new communities being established in Wagga Wagga. There is much written in the literature yet more needs to be written regarding issues for rural and regional Australia both highlighting success stories as well as noting areas for improvement. Recent events in Tamworth in NSW Australia highlight the need for community education. The ethical question arises as to what our community responsibility should be to support these new members of society and facilitate pathways for further education and workforce development.

The resettlement of refugees to rural Australia should not be taken lightly. Wagga Wagga as a regional area of NSW demonstrates the difficulties of this process. Areas to be addressed include:

- appropriate and insightful resourcing of DIMIA funded settlement services
- services to evaluate roles and responsibilities to target appropriate funding avenues
- sharing of regional stories and successes
- development of community leaders and integration with existing services
- targeted upskilling for medical and allied health care provision.
- upskilling volunteer support organisations and case managers/caseworkers of the DIMIA funded settlement services. (Appropriate training and support of employed caseworkers and volunteer personnel should be a reasonable expectation of tender applications from organisations such as the Multicultural Council of Wagga Wagga).

In summary, facilitated discussion across Australia should occur to examine various approaches to helping our new settlers and develop co-ordinated systems of integrating health and social care needs. Along with this, review of commonwealth and state funding arrangements should be ongoing as Australia responds to its humanitarian responsibilities.

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- Bernadette Kelly: Senior Lecturer Charles Sturt University — Discussion on the history of the Multicultural Council Wagga Wagga
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- Margaret Reardon: Social Worker — Initial and long time sole health professional for the Multicultural Council Wagga Wagga
- Professor Louis Pilotto: Director UNSW Rural Clinical School — Review and comments on the paper
- Dr Mitchell Smith: Director NSW Refugee Health Service — Flow chart of Pathway and Health Processes

Presenter

Geraldine Duncan is a Senior Lecturer of the UNSW Rural Clinical School and is the Campus Co-ordinator of the Wagga Wagga Campus. She has a background in general practice and has, until the end of 2005, also been the Senior Medical Educator for CoastCityCountry Training one of the 21 regional training providers for general practice training. Dr Duncan has a keen interest in holistic medicine which is why she chose general practice as her medical craft although she has also undertaken obstetric study and still provides GP obstetric support to the Wagga Wagga Base Hospital. Her patient base crosses from infancy to the elderly. She also has a strong commitment to Aboriginal and Torres Strait Islander and refugee health. Her interest in medical education has been to encourage a holistic and patient-centred approach with both medical students and GP registrars. The opportunity to help mould an essentially metropolitan curriculum for medical undergraduate education through involvement with the Rural Clinical School has been exciting and fulfilling and continues as the new UNSW curriculum is rolled out.