
# Rural and Regional Health Services Survey Report

*October 2011*

# Contents

The Victorian Refugee Health Network will also be referred to as the Network throughout this document.

# Introduction

Rural and regional Victoria has received 10% of people arriving in Victorian via the humanitarian settlement program over the past five years, 2,128 people (extracted from the DAIC Settlement database 5/9/2011). Many rural and regional practitioners and services are active participants in Victorian Refugee Health Network working groups, forums and other activities. Over the last few years there have been two rural & regional refugee health roundtables and in 2009 the forum exploring Access to Specialist Services was well attended by rural and regional health services.

Rural and regional settlement of people from refugee backgrounds and asylum seekers awaiting the outcome of their applications continues to be a significant trend, encompassing both direct settlement and secondary movement from metropolitan and other areas. A core part of the work of the Victorian Refugee Health Network is to continue to support rural and regional health service providers.

The Victorian Refugee Health Network in reviewing how to best support rural and regional service providers conducted an online survey from June 2nd to July 11th, 2011. The survey was promoted via the Network E-Bulletin and targeted emails were sent to the coordinators of regional Refugee Health working groups or similar. Respondents were provided the option to complete the survey together as a working group or as individuals.

In October 2011 key stakeholders Suzanne Cooper (Diversitat Geelong), Hamish Fletcher (Primary Care Connect Shepparton), Cheryl Sobczyk (Bendigo Community Health Service), Sue Casey (Health Sector Development Manager, Foundation House), Therese Meehan (Rural Coordinator, Foundation House) and Philippa Duell-Piening (Victorian Refugee Health Network) to discuss the findings of the survey.

This report aims to display the de-identified responses in an accessible format, draw out common themes, and begin to shape recommendations about the Network's future work to support rural and regional practitioners and services.

## Geographical location of survey respondents

| | | **Existing Refugee Health Working Group** |
|---|---|---|
| ***Loddon Mallee*** | | |
| Midura | 3 | Yes |
| Swan Hill | 1 | No |
| Bendigo | 4 | Yes |
| Castlemaine | 1 | No |
| ***Grampians*** | | |
| Ballarat | 1 | No |
| Ararat | 1 | No |
| ***Barwon South Western*** | | |
| Geelong/ Corio | 2 | Yes |
| Colac | 1 | No |
| ***Hume*** | | |
| Wodonga | 1 | No |
| Shepparton | 2 | Yes |
| Total | 17 | |

## Types of services represented

| | |
|---|---|
| Community Health/Primary Health Care | 4 |
| Counselling teams/Mental Health Services | 2 |
| Specialist Services - ID/Maternity | 4 |
| Settlement Services | 2 |
| Centrelink | 1 |
| School Nurse/Welfare | 3 |
| Transport Connections Project | 1 |

# Client characteristics and demographics

## Ethnic backgrounds/country of origin of clients

*This table demonstrates the number of respondents that reported seeing refugee clients from these ethnic backgrounds or country or origin.*

| | |
|---|---|
| Togolese | 1 |
| Congolese | 3 |
| Sudanese (Dinka, Nuer) | 13 |
| Afghan | 10 |
| Indian | 1 |
| Pakistan | 2 |
| Karen | 6 |
| Bhutanese | 1 |
| Iran | 2 |
| Iraq | 3 |
| Turkey | 1 |
| Kurdish | 1 |
| Timorese | 1 |
| Sri Lanka | 2 |
| Kenya | 1 |
| Liberian | 1 |
| Ethiopian | 1 |
| No refugees accessing service | 1 |

## Age range of clients

10-50 years, 0-55 years, Babies to elderly, “a lot of children”.

## English language proficiency of clients

Respondents to the survey reported overwhelmingly that their clients from refugee backgrounds had low English language proficiency; women were reported to be more disadvantaged in this area. A number of respondents reported that their clients commonly had low literacy levels in their first language as well.

## Services accessed by clients from refugee backgrounds

*This table demonstrates the number of respondents that reported clients from refugee backgrounds access specific services.*

| | |
|---|---|
| Refugee Health Nurse | 3 |
| Settlement Service | 4 |
| Diabetes Educator | 2 |
| Exercise Physiologist | 1 |
| Dietician | 1 |
| Dental Services | 3 |
| Physiotherapy | 1 |
| Counselling/Mental Health Services | 5 |
| Paediatric Vit D clinic | 1 |
| Drink Driving Education Program | 1 |
| Drug and Alcohol counselling - directed by the court | 1 |
| Women's Health/ Sexual and Reproductive Health for women | 2 |
| Antenatal/Maternity | 2 |
| Maternal and Child Health | 1 |
| Emergency department | 2 |
| ID clinic | 2 |
| GPs | 2 |
| Disability | 1 |
| Pathology Services | 1 |
| Carers Respite | 1 |
| Centrelink | 2 |
| School nurse program | 2 |
| Bi-lingual health workers | 1 |
| Supported play groups | 1 |
| Transport connections | 1 |
| Housing services | 1 |
| Material aid | 1 |

## Are refugees accessing services at the same rate as the wider community?

*There appeared to be some confusion with this question, therefore the response rate was quite low.*

| | |
|---|---|
| Yes | 5 |
| Probably | 2 |
| No | 2 |
| No-because of the targeted nature of the service | 1 |
| Refugees over represented and resource intensive | 1 |

A respondent commented that there was a need for more counselling services in their region. Another respondent commented that secondary movement communities do not appear to be accessing their service.

## Approaches to working with people from refugee backgrounds

*Respondents varied in their conceptualisation of this question, some responded in regards to their individual interaction with people from refugee backgrounds, others responded at a service/community intervention level.*

### Individual direct service approaches

Respondents reported that their approach to working with people from refugee backgrounds was "open and inclusive", utilising an empowerment approach and that they "did not assume anything about (a client's) background". Remembering names of families, learning some words in a client's language and teaching them some words in English were also methods utilised to build rapport with clients. Supporting clients accessing services and advocating on their behalf if required was another theme, including referral to social work and counselling services if previous trauma appears to be impacting on daily functioning. Respondents commented that they utilised interpreters, were mindful of culturally sensitive interactions and provide language appropriate information where available. Bi cultural workers were utilised in engaging and working with people from refugee backgrounds including community guides. Identification of a client's goals and needs as articulated by them and working on these while integrating the services needs and goals was also described.

### Service capacity building and structural approaches

Some respondents described service development to meet specific needs of people from refugee backgrounds such as the development of policies around interpreter use, cultural awareness plans and the employment of bi-lingual workers. Through monitoring changes in demographic data one respondent reported this enabled them to better tailor their service to the needs of people from refugee backgrounds. A respondent spoke of structural factors such as priority access for people from refugee backgrounds. Service capacity building was also described by a respondent, outlining skill development around using interpreters and in identifying mental and physical health needs in people from refugee backgrounds. Another respondent spoke about capacity building and advocacy with services that they are referring into.

### Community development approaches

Community development approaches were also outlined such as partnerships with ethnic community councils, community organisations, community elders and leaders. Being part of community events was also described as a way to engage with communities.

### "Egalitarian" perspective

A number of respondents stated that they treat people from refugee backgrounds as any other community member. It was unclear if they did not view people from refugee backgrounds as having specific needs or that their needs competed with so many other vulnerable groups and were addressed in the same way.

### Variation to approaches in rural and regional areas compared to metropolitan

Some respondents felt that service delivery was similar in their rural and regional area as it would be in metropolitan Melbourne while others felt that it was vastly different. Some respondents spoke about the strengths of rural and regional services including more time per client, working with predominantly one ethnic group and others spoke about the difficulties outlined on page 7.

## Perceived barriers for rural and regional services

### Difficulty accessing resources and services

#### *Interpreters*

Many respondents spoke about difficulties and frustrations in accessing interpreters. Accessing onsite interpreters posed a greater difficulty than phone interpreters however phone interpreters were still not always available. Respondents reported that interpreters can sometimes be difficult to arrange and in rural and regional areas they specify minimum times which may not always be required and can be costly to the service. For instance a respondent described that they had no local access to interpreters and their service had to pay for the cost of travel for the interpreter. One respondent reported that over the previous two months funding for interpreters was used up in the first week of the month.

Quality of interpreters was also an issue, one respondent stating that "access to accredited interpreters is even more difficult". Some respondents spoke about the limited availability of onsite interpreters may affect the quality of the consultation. Confidentiality or perceived confidentiality was reported as another issue in a small community as the patient may know the interpreter and not feel safe even if the interpreter is professional and follows guidelines around privacy. It was felt that metropolitan services would have more access to interpreters.

#### *Other services*

Respondents viewed accessing services to be another barrier, some rural and regional areas did not have specialist refugee health services (or refugee heath nurses). Furthermore some respondents reported that they did not have access to or enough torture and trauma counselling.

### Experience/ expertise of the service providers

One respondent reported that it felt "as though (they were) very new to working with people from refugee backgrounds", another commented that they have poor access to further education options. It was felt that metropolitan areas would have more exposure to working with CALD communities therefore feel less daunted about working with people from CALD backgrounds. A general theme was that staff were not as skilled in working with people from refugee backgrounds and do not possess an understanding of the refugee experience. Practitioners and services with little experience and expertise was a common theme in the responses. Problems with recruitment and retention of staff were seen to compound this issue.

> *"The small numbers of arrivals that are seen in some regional and rural areas mean that sometimes skills are developed and then forgotten as there are long gaps between arrivals."*

### Distance and transport

Distance and transport was raised as an issue for rural and regional service providers. Public transport options where described as "still being established" and another respondent stated that people from refugee backgrounds that do not drive are "reliant on volunteers to take them to specialist services". Clients without drivers' licences face much greater isolation and difficulty in accessing services in rural and regional areas.

## Collaborative work

*Respondents varied in the level of collaboration with other service providers and communities. For some respondent collaboration was used to describe the development of joint programs, at the other end of the spectrum for some respondents collaboration was used in terms of referral into services.*

### Collaborating with local service providers

Respondents described collaborating with a broad range of services to increase quality of care to people from refugee backgrounds. These services included settlement services, Department of Justice, employment agencies, Centrelink, schools, AMEP (Adult Migrant English Program) providers, local councils, welfare agencies and GPs. Collaborations had various aims such as the development of group programs, resources, funding applications and complex case discussion. Some of the tangible outcomes included parenting group, play groups, bilingual resources and funding to employ a bilingual worker for 6 months.

### Collaborating with communities

Some respondents described collaborating with communities to better understand their needs. A respondent reported asking a member of the Bhutanese community to speak at their maternity ward. Partnerships with the Ethnic council were also common however this was generally to target more established migrant groups such as Turkish, Croatian, Greek and Italian. Respondents also spoke about attending community cultural days. Holding information days for newly arrived people from refugee communities to learn about services was also described.

### Membership of Refugee Health working groups or alike

A number of respondents described meeting together with other professionals with the view to capacity building their services and the broader sector.

# Challenges

## Interpreters and translated health information

*The following themes were identified:*

### *Access to interpreters and lack of translated information*

As outlined on page 7 access to interpreters is an ongoing challenge in rural areas identified by five respondents. One respondent commented that GPs that work at community health services are not eligible to access TIS interpreters for free. Another respondent commented that lack of translated health information is an issue.

### *Encouraging staff to use interpreters*

When a service is able to gain access to an interpreter a respondent stated that it can be challenging changing staff behaviour to encourage them to use interpreters. Similarly another respondent commented that ensuring that all staff are aware of the interpreter policies and how to access interpreters is a challenge.

## Working cross culturally

A respondent commented that it is challenging working with different health beliefs in a system that is designed for service delivery that is a biopsychosocial western model. Another respondent commented that it is difficult building a work force that has the skills in negotiating health beliefs cross culturally.

## Access to services

Further to the discussion on page 7 respondents spoke about the difficulty in accessing appropriate services, the consequence being at times serious health issues. Specifically access to torture and trauma counselling services and settlement service was mentioned once by respondents. Lack of specialist clinics and long distances to specialist services was also reported. Other access issues were more global such as accessibility to health services, housing, training and jobs, family support, access to public transports. However these issues may be more acute in various geographical areas.

## Engagement and assessment

Some respondents spoke about the difficulties of engaging people from refugee backgrounds. Considering the competing priorities such as family, work and school commitments can mean that it is difficult for a client to attend appointments. This is compounded by transport challenges (discussed on page 7). Furthermore a respondent wrote that it can be challenging gathering accurate demographic information around sex, age, language literacy (in first and second language).

## Clinical complexity

Respondents described challenges relating to the clinical complexity of presentation one respondent stating; “People from refugee background at times have complex physical and psychological health and well being needs. This is further complicated by the diversity of presentations.”

## Support that practitioners are receiving

*Some respondents took this question to mean individual self care support while other respondents appeared to interpret this question to mean program support.*

### Self care

Support arrangements varied enormously. Some services received support from Foundation House and the local settlement service. Some organisations providing counselling and debriefing for staff in house.

### Program support

Some health networks had CALD liaison workers and bi-lingual workers which provided support. One respondent recommended that a “Bilingual Worker should be put in place at the same time a Refugee Health Nurse is employed in a rural area to help access the community who otherwise won't/don't access the service”.

Some people spoke about an organisational culture which enabled a "business as usual" approach to working with people from refugee background. Senior management support was also seen as important.

### In-services and professional development

In-services and professional development appeared to be another valued form of support with one respondent stating that more professional development should be run in regional and rural areas. Foundation House was provided with positive feedback about the quality of their training in rural and regional areas.

### No support or very little

Some people appeared to feel very alone in the work with no support. One respondent commented that "generally there is a lack of resources and a lack of money".

## Support ideas

### Workforce

Workforce development to create positions such as CALD officers, further Refugee Health Nurse positions and bilingual workers was suggested by respondents. It was also felt that the employment of more social workers or advocates to help with practical support needs and family support matters would also be useful.

### Professional development

Many respondents suggested further professional development programs to develop more capacity in working with new arrivals and skill in working cross culturally. Specifically one respondent asked for more training for schools and school nurses.

### Resources

Resources that respondents felt would be useful included more multilingual material (written and digitally), and interpreting service (both onsite and telephone) including overnight access for emergency departments. Better resources for complex case management were also suggested. Some respondents asked for accurate demographic data to assist with designing of programs.

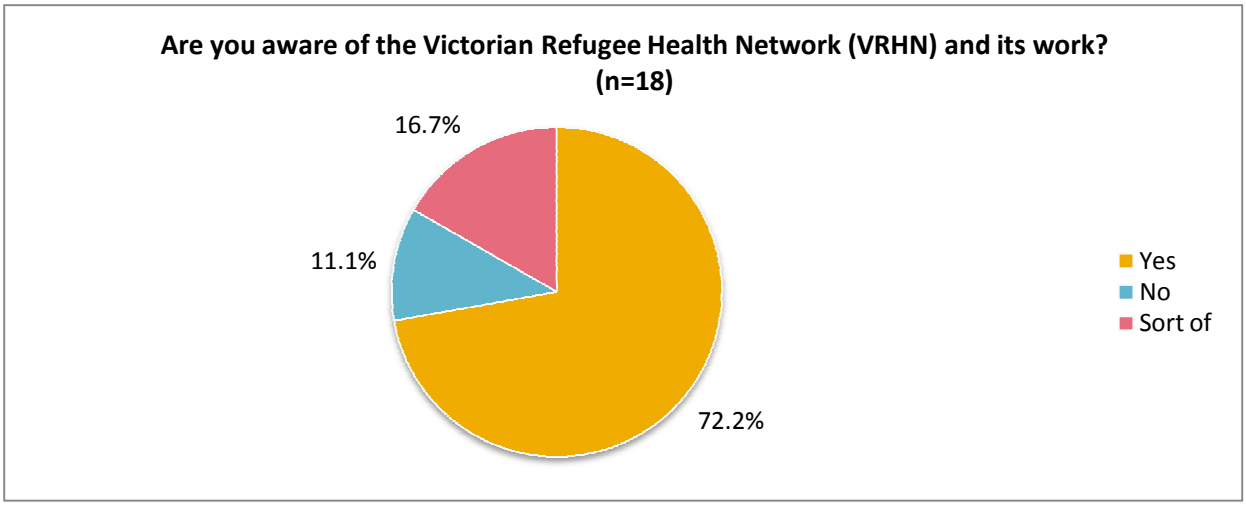
### Service coordination

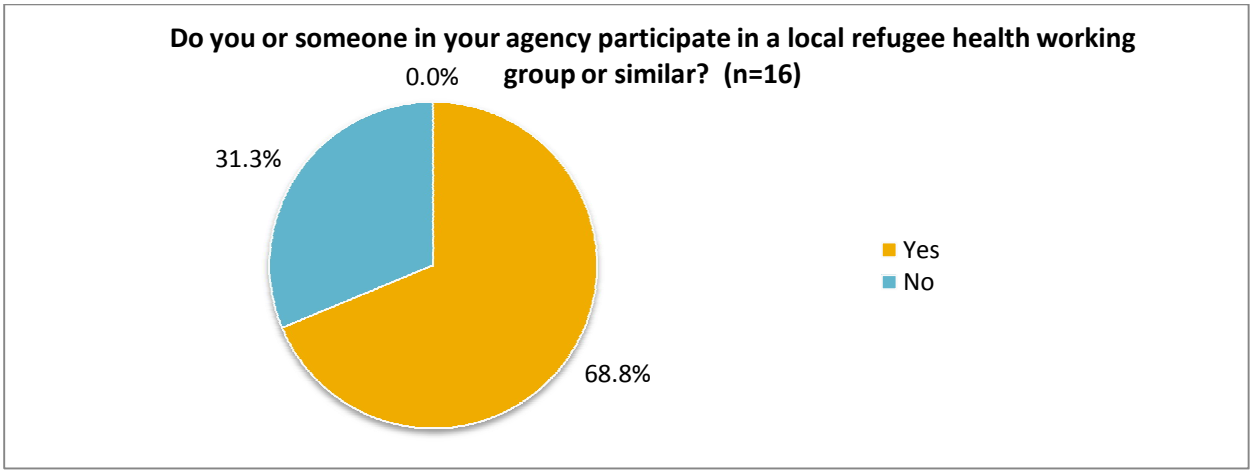
Respondents also felt that better coordination of services in the bigger regional areas would be useful, including better networks and collaborations. Some respondents called for a local approach that is specific to the location and the socio-economic profile of the area. One respondent suggested the development of local specialist clinics

### Enough support

Some respondents felt that they were in a better position in rural and regional areas due to sense of community and close knit networks, they viewed that local contacts could be used more effectively in a smaller community. However they described that the flip side of this is tensions can escalate if an issue exists.

## Victorian Refugee Health Network



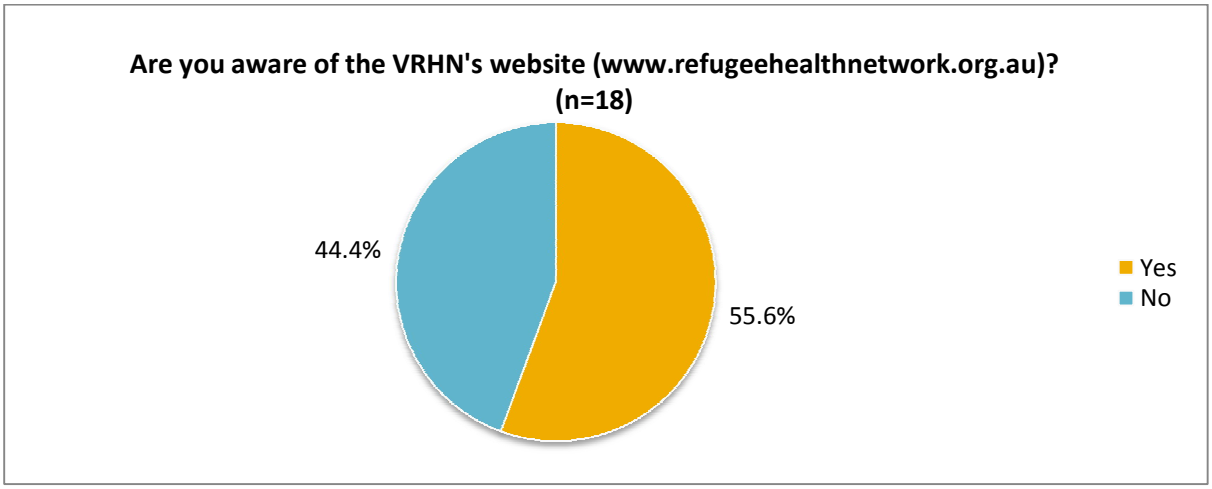



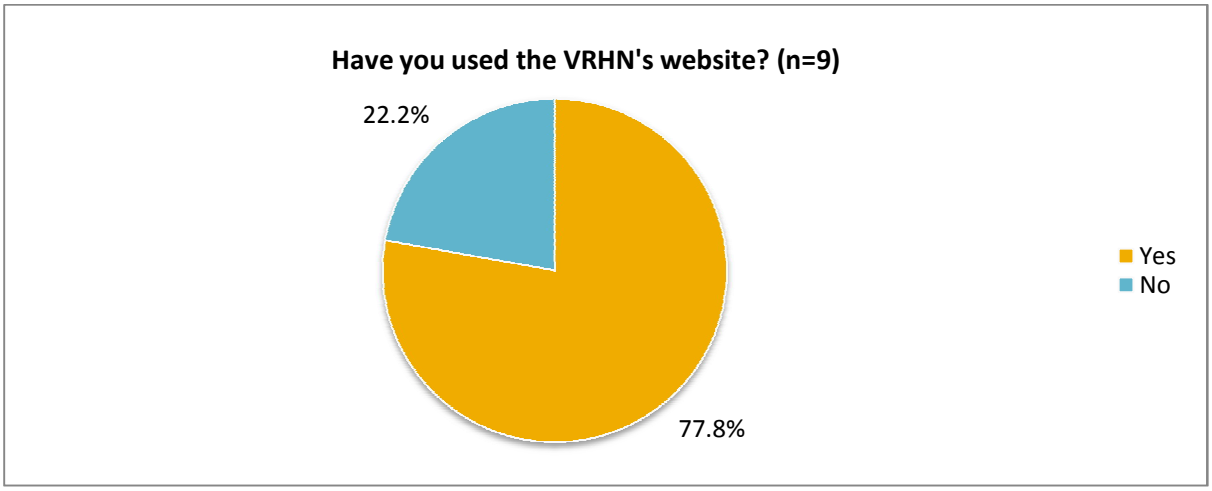

### Role of the regional Refugee Health Working Groups

Many respondents were unclear about the role of the Refugee Health Working Group in their area. One group was in the process of adjusting its terms of reference. Some respondents reported that they used this forum for networking, providing program updates, discussing referral pathways and service mapping. Some working groups focused on building capacity of health professionals in their area.

### VRHN support for local Refugee Health Working Groups

There was a very low response rate to this question, perhaps because the role and work of VRHN was not clear. Of the three responses, two suggested that VRHN have representation on the local working groups, one respondent suggested more education in rural areas supported by VRHN and another respondent suggested online access to other working groups run by VRHN.



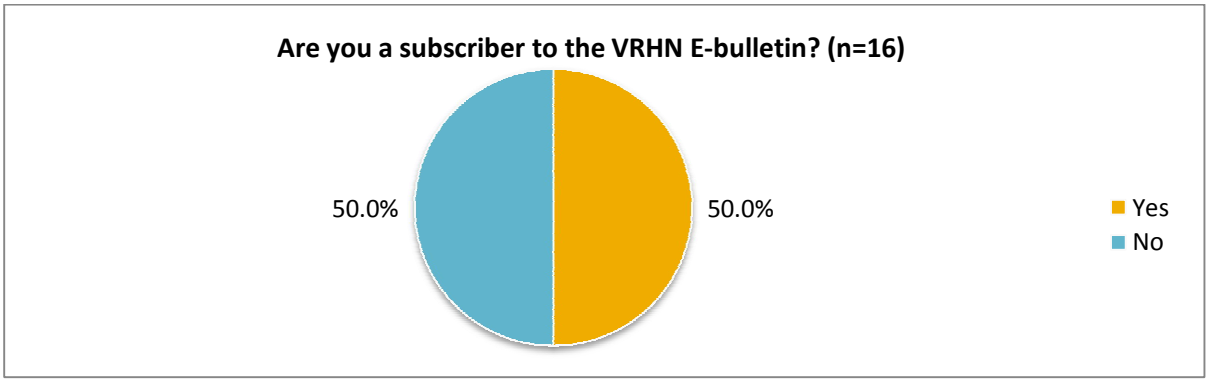

## How respondents are using the VRHN website

*Refugee health working groups do not exist in all rural and regional areas, areas that have working groups are marked on page 3.*

One respondent stated that they accessed the website "Too many times to mention", others used the website to see “what initiatives were out there”. Some respondents accessed information on specific clinical issues such as TB and Hep B. One respondent commented that they used the website to track down local resources. A respondent reported that they referred other service providers to the website when they were seeking information on how to work with clients from refugee backgrounds.

## Information that would be useful on the VRHN website

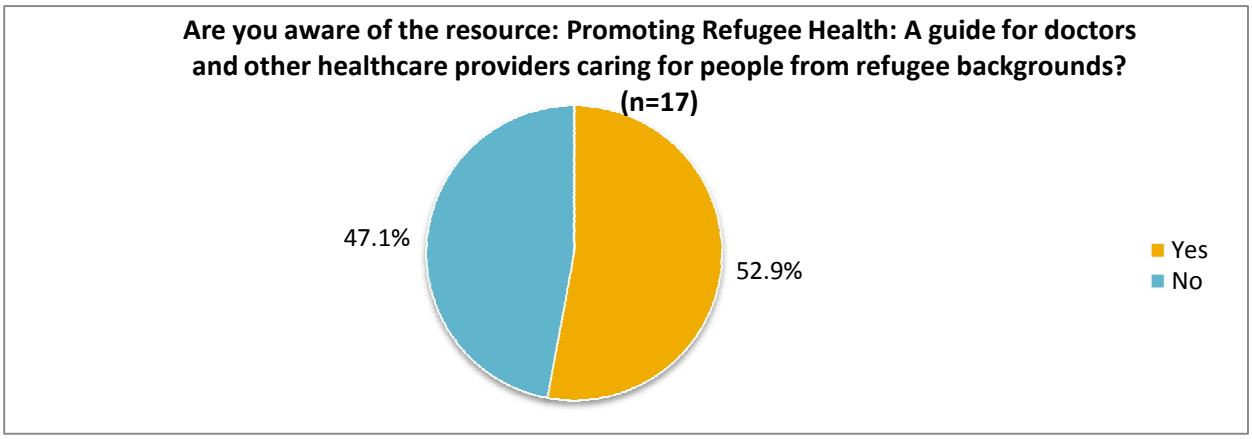
There was a general theme of wanting to use the website to share resources such as translated materials, research, PowerPoint presentations, documents, programs (templates, program designs, evaluations etc) and website links. One respondent asked for an online translator - however this could be problematic given that it may translate literally and not pick up nuances in the language as well as cultural meanings places on various works and concepts. Updates on what is happening and what services are available was also requested by one respondent.




*Four people provided their email address to newly subscribe to the E-Bulletin.*

## Information that would be useful in the E-Bulletin

Respondents said that they would like to have information about best practice models that have been successful and commented they liked the inclusion of recent literature relating to refugee health. Also, information about what other services were doing was seen as useful. One respondent recommended having more introductory information for those new to working in the area. Regarding the format of the E-Bulletin a respondent felt that it was too long and should be shortened to headings that could link to more information.




## Feedback about the GP guide

One respondent commented that it was difficult to get doctors and other health providers to read the guide and follow the recommendations. Other respondents provided positive feedback about the content of the guide, however they were interested in obtaining culturally specific information to complement the guide's non-ethnic specific approach to working with people from refugee backgrounds.

# Preliminary Recommendations (to be further developed at the Rural and Regional services meeting Oct 7)

## Recommendations in line with wider work of VRHN

1. **Advocacy for the development of multilingual material and the sharing of quality multilingual material.** VRHN is currently conducting a project looking at the most effective medium for delivering health information to people from refugee backgrounds. VRHN are also engaging with the coordinators of the Health Translation Directory to discuss further development of this resource. VRHN website is also utilised to share some locally developed multilingual resources.
2. **Better communication - not duplicating efforts.** VRHN is currently reviewing the way information is presented on its website and continues to distribute a monthly e-bulletin. The needs of rural and regional providers should be considered in the development of the website (eg. a place to showcase work occurring in rural and regional area). Furthermore VRHN could forward the minutes of the reference group to the regional chair for the refugee health and wellbeing group.
3. **Access to Specialist Services working group** is mapping specialist services capacity including in rural and regional areas.
4. **Language services review.** Foundation House currently have a project worker reviewing language services in the health sector, this include consideration to the situation in rural and regional areas. This report will be used to inform advice to government about future funding and service planning.

## Recommendations specific to the needs of rural and regional providers

5. **Language services issues specific to rural and regional areas.** Continue to explore the capacity for technology to be used in interpreting in regional and rural areas - ?links with current telemedicine initiative.
6. **More promotion of the website in rural and regional areas**, perhaps this can be the planned around the re-launch of the website early next year. Utalise the primary health care E-Bulletin.
7. **Provide advice to DIAC to place newly arrived humanitarian entrants and resources associated into a sustainable number of geographical areas to build a skill base and services system that are able to support new arrivals.** Specific areas have been established and consolidated over the past 5 years. This approach also allows state government to allocate suitable resource to areas an example of this is the refugee health nurse program.
8. **Ongoing workforce development through Learning and Development opportunities and supervisions for staff working with people from refugee backgrounds.**