Case studies in providing health and counselling services to refugees in rural areas

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DR SMITH: Thanks again, John.

My normal job is running a small State wide service based in Sydney funded by NSW Health. I've got 10 staff , and it's one example of what happens at a State level. I'll indicate where we do attempt to provide support in rural and regional areas from a perspective of a service that's obviously based in a large city. Then I'll give an example of something that happens in our regions in the northern part of the State - you're going to hear about the southern part of the State from Geraldine and Penny in a moment.

So our State run refugee health service is, as I said, very small. We have three part time GPs who do clinics once a week in various parts of western Sydney, which is where 90 per cent of refugees in New South Wales settle. We have some bilingual workers from a range of different communities who provided information directly to refugee groups about the health system, how to dial triple-0 and that sort of thing. At the moment we have a nutrition project in one part of Sydney that is focussing on children under five and their families and their access to foods and healthy diets. So that's the work we do directly with refugees and, as I said, most of that is focussed in the greater west of Sydney for numerical reasons.

The other work we do is broad based and does extend beyond the city. We have projects that relate to immunisation, nutrition and other aspects of refugee health - I'll show you an example of one in a moment. We do a lot of education to Area Health staff in New South Wales, to general practitioners within GP Division programs, and to students at the various universities here: medical, nursing, sometimes social work, other students. That is part of an important role in upskilling people who are going to be seeing refugees as part of their day to day work.

We give input to policy relevant to refugees, including the one you just heard about, and to planning. We sometimes assist Area Health Services, for example, in the planning of what they might be wanting to do for refugees settling in their Area.

We advocate at different levels. So from the clinical perspective we advocate for individual refugees and people like asylum seekers who don't have Medicare - so our nurses sit on the phone and ring up and say, "I want you to see this person." So we advocate at that level. We advocate at local health service level for increased services - for example, improved access for refugees to oral health care, a big issue. Then we advocate at the State and national levels in terms of policies and government interventions that might happen. Daniel mentioned a working group on refugee health that meets in Canberra and I help represent NSW Health on that forum. Part of their discussions is in fact about refugees settling in rural and regional areas - so if there are issues that come up today, there are opportunities to take the up at the federal level with the Departments of Health and Immigration and others, because they are certainly aware of the special needs for health services in rural and regional areas.

Other things we do as a city based service is provide advice to people working in rural and remote areas. There may be individuals who contact us for advice, or it might be people who are setting up their own service and we help support that by sending information, templates, feedback on various issues. Again the education role, which happens through the development of resources as well. That's our website which

practitioners can go to and find published articles and other information; it also flags the existence of other resources, like the College of General Practitioners' website, which is excellent in terms of refugee health.
Various booklets and reports are produced – e.g. about older refugees, working with refugee young people, working with refugee children and families. We're recently produced a DVD which is actually targeting refugees themselves, not health practitioners. I'm going to show three minutes of it shortly to entertain and as a break. As well as the resources we also provide seminars - my staff and I have travelled to Coffs Harbour, Lismore, Newcastle, Wagga Wagga etc around the State as part of the GP education training programs and student programs, lecturing about refugee health, trying to raise awareness and highlighting different issues. We're also just about to complete a six month series of educational seminars by telemedicine or telehealth, i.e. beamed by television where you have people sitting in a room and you have an expert in a room in Sydney or elsewhere who speaks to a camera. Those of you from regional areas will be very familiar with telemedicine. It's the first time it's been used for population health type programs - it's usually more clinically orientated material. It's also useful for networking, e.g. getting nurses together who are working remotely, they can talk with staff who are working in similar fields and swap stories and information.
I'm now going to show three minutes of this DVD "Health Check". A brief background - it recently won a multicultural communication award. It's targeting people from newly arrived communities of African background. It's available in six or seven different languages. You'll be seeing the English one, thankfully for most of you. Although the Pidgin English is fun to watch, I must say. I've left out the bit about bulk billing because most GPs in rural and regional areas can't bulk-bill, but it kicks on in giving people advice, a little bit about general practitioners and how they work, and then there's an interaction with a patient, a girl who is going to be immunised.
[DVD PLAYED]
DR SMITH: So I think something like that can facilitate the interaction of a newly arrived refugee with the health service wherever that health service is, rural and regional included, as well as raise awareness about issues such as immunisation. Other aspects covered are personal hygiene, hand washing, how to dial triple-0 and when you should use an ambulance service, when you should use an emergency department as opposed to a GP or medical centre. It's fifteen minutes in all and they're for sale after this talk.
Coffs Harbour is one example of where a regional health service has created its own refugee health service, if you like. I think 1999 or perhaps 2000 was the first Sudanese family who were sponsored and settled in Coffs Harbour. The trickle continued for several years, and interested community members and staff from the local health services (chest clinic etc) literally drove them around to their medical appointments. This is the sort of thing that happens, as you people will be well aware.
In fact, it was the local Aboriginal health service that ended up seeing the majority of the Sudanese, because the capacity of the local general practitioners to deal with these new and complex patients was limited for reasons you're well aware of. That worked well for a while, but as numbers increased it outstripped the welcome of the Aboriginal health service - again totally understandable as they have their own clientele they need to cater for. So those working in Coffs Harbour with refugees felt that it was time to set about doing it differently.

In early 2005 there were some meetings held with the Area Health Service, including the GP Divisions (who were very much involved), local health staff, and the services funded by Immigration who work in the Coffs Harbour area and who were meeting and greeting the refugees and helping them to settle in. It took 12 months, and it was smell of an oily rag stuff, but in February 2006, just over a year ago, a monthly clinic was commenced. They were able to get hospital premises allocated. You can see the nature of it as a partnership. There are a lot of agencies putting in, but nevertheless it's somewhat ad hoc. The nurse who had been involved from the chest clinic perspective became the coordinator of the effort, and apart from still driving people around to medical appointments, she essentially oversees the whole process, performs the initial questioning and screening, refers people to the dental clinic, etc before they're even seen by a GP. The GPs come in on a retainer. Our African patients tend to work by African time as those of you who are from Africa will know, and no-shows can be a frequent occurrence. That is partly because of the other demands that they have on their lives as new arrivals, so the GPs have to be on a retainer, otherwise it's just not fair to have them there. They are able to bulk-bill and that money goes to supporting the clinic in other ways, for example buying medications, some of which aren't on the Pharmaceutical Benefits Scheme.

The hospital does pathology. The Public Health Unit is involved in terms of advice and some funding. They use interpreters either on the phone from Newcastle Healthcare Interpreters or from TIS that you've heard about. It was supported again with education sessions for the GPs and others who were going to be directly involved in the clinic or who would be seeing the refugee arrivals.

Counsellors were engaged locally by STARTTS, the torture and trauma service based in Sydney. So essentially the clinic is something that has arisen out of nothing with a small amount of money, and they're trying to sustain it now, including with Medicare funds. It is a great example of a partnership which is working well and shows the dedication of the local staff. An anecdote that I always recall is going to Lismore to talk to GPs at a restaurant and sitting next to an anaesthetist who told me how, in his spare time, he was teaching Sudanese young men how to drive - which I thought was a fantastic thing. So there's a lot of good will and commitment there and it has to be admired.

Thank you.

(Applause)