

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

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DR SMITH: Right. Thanks again, John. Okay. Time to switch hats. So my normal job is running a very small State wide service based in Sydney funded by [NSW Health](#). I've got about 10 staff and I'll show you what I do. So in terms of a it's a little bit about 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 big 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 I'll focus more on the north and let you know what's happening there.

So our State run refugee health service is, as I said, very small. 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, at least 85 to 90 per cent. We have some bilingual workers from a range of different communities who provided information directly to refugee groups about the health system and, you know, how to dial triple-O and all 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 about access to foods and health diets. So that's the sort of direct stuff we do 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, thankfully. So we have projects and they might relate to immunisation or again nutrition or 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 for divisional programs, and to students at the various universities here; medical, nursing, sometimes social work, other students. That is used as an important role in up skilling people who are going to be seeing refugees as part of their day to day work.

We give input to policy, including the one you just heard about, but other policies relevant to refugees, and planning. So 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 we just heard about, asylum seekers who don't have Medicare, so our nurses sit there on the phone and ring up and say, you know, "I want you to see this person." So we advocate at that level. We advocate at local health service level for 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 that meets in Canberra every now and then and I actually help represent NSW Health on that working group, looking at the health of refugees. Part of their discussions are 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 Department of Health and Immigration and others, because they are certainly acutely aware of the special needs, if you like, and the special demands for health services in rural and regional areas.

So the sort of things we do do, as I said, as a city based service is provide that advice to people working out in rural and remote areas. That may be individuals who might ring us up for advice, or it might be people who are setting up their own service and we help support set up of that service by sending them information templates, advice, feedback on various things that they might be thinking of doing. Again that education role, which happens both through the development of resources. That's our [website](#) there which practitioners can go to and find our published articles. We also advertise the existence of other resources, like the [College of General Practitioners' website](#), which is excellent in terms of refugee health.

Various booklets and reports. There's some on the desks outside, so at the afternoon tea break you might want to grab some of those. I didn't bring many, but if you want some just speak to me and I can get you stuff. There's stuff there about older refugees, working with refugee young people, working with refugee children and families, you know, a couple of published papers. So do see me if you want any of that stuff.

We're recently produce a DVD which is actually targeting refugees themselves and not health practitioners. I'm going to show three minutes of it shortly just to entertain and as a break. As well as the resources we also provide seminars in two ways, both on site. So my staff and I have travelled to places like Coffs Harbour, Newcastle, Lismore, Wagga Wagga et cetera around the State as part of the GP education training programs and student programs, et cetera, lecturing about refugee health, just trying to raise awareness and pointing out different things. We're also just about to complete a six month series of educational seminars by telemedicine or telehealth, i.e. that's beamed by television where you have people sitting in a room; you get an expert in a room in Sydney who speaks to a camera, essentially. Those of you in regional areas will be well familiar with telemedicine. It's the first time it's actually been used for population health type programs. It's usually more clinically orientated stuff. So we've been using it for refugee health education over the past six months. It's also good for networking, so getting nurses together who are working remotely. They can get together and talk with staff who are working in similar fields and swap stories and swap information.

So for your entertainment, DVD person, I'm now going to que just three minutes of this DVD. A brief background; it recently won a multicultural communication award, I might say. So 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 think it kicks in - I've left out the bit about bulk billing because most GPs in rural and regional areas can't bulk-bill, but it kicks 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. Cue.

DVD PLAYED

DR SMITH: Okay. 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 immunisation. Other aspects covered are things like personal hygiene, hand washing, how to dial triple-O or 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. If you wish to know about them there's a couple of [order forms](#) out the front.

So just to mention an example of something that's happened in Coffs Harbour, it's 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 sort of trickle continued for several years and really interested community members and interested health staff from the local health service, chest clinic, 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 somewhat complex patients was limited for reasons that you're well aware of. That worked well for a while, but as numbers increased it also essentially outstripped the welcome of the aboriginal health service and again that was totally understandable because they've got their own clientele that they need to cater for. So those working there felt that it was time to set about doing it differently.

So 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 who were meeting and greeting the refugees and helping them to settle in. It took 12 months and that's the time that these things can take. 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's 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 sort

of coordinator, if you like, of the effort and apart from still driving the people around to medical appointments, she essentially oversees the whole process, performs the initial questioning and screening, refers people to the dental clinic, et cetera, before they're even seen by a GP.

The GPs come in on a retainer. Our dear 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 actually 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's involved in terms of advice and some funding. They use interpreters either on the phone from Newcastle Healthcare Interpreters or sometimes from TIS that you've heard about. It was supported again by education sessions for the GPs and others who were going to be involved in the clinic and other health staff who would be seeing the refugee arrivals.

Then counsellors were engaged locally by [STARTTS](#), they are now paid by STARTTS, which are the torture and trauma service based in Sydney. So essentially it's something that has arisen out of nothing, a small amount of money that sort of ran out rapidly and they're trying to fund it now I guess themselves through the Medicare bulk-billing aspect. It is a great example of a partnership. It's working well and it shows, I think, the dedication of some of the local staff.

An anecdote about that I always recall is going to Lismore to talk to GPs at a restaurant and sitting next to an anaesthetist at the dinner who told me how in his spare time he was teaching Sudanese young men how to drive around Lismore, which I thought was a fantastic sort of thing. So there's a lot of good will and commitment and it has to be admired.

Thank you.

(Applause)