

MR WAKERMAN: It gives me great pleasure to welcome Geraldine Duncan, who we last saw at the 9th National Rural Health Conference in Albury. Geraldine was a joint winner of the prestigious Louis Ariotti Award and she's an academic and GP from Wagga.

(Applause)

**Case studies in providing health and counselling services to refugees in rural areas
(continued)**

*Dr Geraldine Duncan
General Practitioner, Wagga Wagga*

DR DUNCAN: Could I just start off by acknowledging the University of New South Wales paid for my hire car to come today, so I had to say that I'm from the University of New South Wales. Could I also ask everybody to keep their eyes out for a pair of glasses with red frames with a yellow stripe? I seem to have lost my distance glasses since I've arrived here.

Okay. We've already seen that statement today. What do I do to move them on? Do I click this on or that one? This one. Okay. So I'll just quickly whiz past those because we've already seen those in the first presentation. What I'm going to try and do today is give a highlight of the work that we're doing in Wagga Wagga as we meet the challenges of refugee resettlement. I want to reinforce, as Mitchell has said earlier, the importance of timely review and a health needs assessment. I want to emphasise the importance of teamwork in resettlement and I will mention some of the barriers on the way through to achieving the above that I have found.

This is an acknowledgement again to one of Mitchell's diagrams. I reorganized one of your diagrams, Mitchell, to sort of show the pathway of events, but I will whiz past that as well, to some of the important things for refugees coming through. There's about 13,000 per annum, the Australian quota. The pre-settlement medical is taken. When you come down to the Australian destination in the middle column you are met by the IHSS settlement worker whose job it is to link you in with Medicare and the health services and to link you in with health providers and link you in where more urgent psychological health assessment might be needed.

That's a picture of the Multicultural Council of Wagga Wagga front door, which is up the top end of the street over the road from Il Corso, which is one of the restaurants in Wagga.

Our local background. The Multicultural Council of Wagga has evolved from the ethnic communities councils and it seeks to deliver services under both IHSS and CSSS. It's part of a consortium with St Vincent de Paul, the Riverina Resettlement Consortium and Centacare. Another important service provider that's vitally important but not actually part

of the original consortium is TAFE. Volunteer support is vital and the social support, friendship and assistance provided by volunteers is crucial in settling refugees into Australia.

I won't talk about the two programmes because you've already had those described to you this afternoon.

There are regional concerns however. While rural and regional settlements has brought welcome benefits for both refugee communities and regional areas in which people have settled, there are some problems associated with service delivery and the coordination of services. That does impact significantly on individuals and families. We're very reliant on caseworkers. I became involved in looking after refugees several years ago, I think in the mid 1990s to the early 1990s, where some members from Companion House came out and emotionally blackmailed me into looking after refugees. I was at that time working in my own practice, which I've since had to sell for various reasons which I won't go into in this forum, in 2003, and I'm now a full time academic and my general practice is "part time" because I actually work four or five hours on a Tuesday and 12 hours on a Friday and every second Saturday most of the day sort of trying to fit in all the various needs.

Now, clearly that's not sustainable for the future, but at the moment it's actually what's happening to push things along till we get something happening. I have found the caseworkers at the Multicultural Council vital in helping me provide that service, because I'm a little bit obsessive. If I provide a service I like it to be a good service and I'm petrified that people will fall between the cracks and that things will not be followed up, and I rely very much on the caseworkers to help me follow those things up.

The United States Department of Health and Human Services - a very nice statement there about the vital importance of caseworkers to managing refugee resettlement. In Wagga Wagga they do accept that healthcare coordination is part of their role. There's been a bit of a tension in the consortium where some of the members of the consortium feel it's not part of the role, but the person that I work with says that "holistic help for people is what I'm on about and health is part of the whole."

So our caseworkers will pass on need for test, reasons for test or treatment, help remind when dosing times are due. For example, if I'm giving some Flagyl for some Giardia, in some cases they'll ring up and say, "Remember to take the tablet now." They'll chase up follow-up tests if needed, organise appointments and, as Mitchell said, transport to appointments, meet and greet on arrival, help organise the Medicare paperwork - which is important that when they get to the front desk of the clinic I can work. There's actually now a system in place where that's all done before hand - organise accommodation from temporary through to permanent, and liaise with the volunteers with respect to bits and pieces needed to settle an individual and a family into their home.

These figures are the same figures that I presented in February and so they're a little bit out of date now, it now being August. I did ask for an update, but everybody's busy and I haven't had my update. We've had a few more Sudanese families arise with nine and ten members since then and we've also had some extra Burmese families arrive as well. But as you can see, in the community of Wagga we actually now have reasonable numbers of refugees. This doesn't account for the secondary migration, the numbers of which are uncertain.

Secondary migration occurs for a variety of reasons, family connections, but one of the big drawcards in Wagga Wagga is Cargill's Meats, which is an abattoir and Cargill's themselves are beginning to actively recruit people from refugee organisations to work in the meatworks. I have an ethical problem with that, but these are the things that are happening. Beginning to see young men now who have worked in Cargill's for many years with, you know, sore backs, sore arms, because it's very heavy work. It interferes with getting an education and moving forward too. So there are issues there.

The Multicultural Council knows that I'm the identified person so if they actually have a problem during the course of any time or day they will actually ring them about them. If there's somebody who comes in who needs medical attention or a review within 24 hours, they'll ring me to see where I can organise that as well. In some situations before my surgery was reorganised, I actually had a little office at home and Saturday morning consultations did occur. However, volunteers will often take people to their own practices when situations arise, which is great and well and good, but there can be problems if I don't know about this in cross-communication and making sure unnecessary tests and things are not redone.

The TAFE teachers are important for English language acquisition and I work with one of the TAFE teachers in the university, but they are also a source for offloading psycho-social and health problems as well. So those teachers often need support as to how we manage these things. Coordination and teamwork is very important and we are at the beginning of the journey to work out how we do that. There is a meeting planned in Wagga later on this month or early next month to try and get more of the key players together to see how we take that forward.

So, as said, our families are met at the airport, but increasingly secondary migration, people might just turn up at Multicultural Council and say, "Here we are." Motels are used for temporary accommodation until permanent accommodation becomes available. Now that the health manifest is actually more well organised I actually get an inkling as to when there's going to be a family or two arriving, so I've actually got a little bit more time to plan and try to fit that into my lifestyle, but previously it would happen, "Here we are Geraldine. When can you help us? When can you fit people in?" Knowledge of what happens on the pre-departure medical screen has been a good help as well, and getting information on who and who not has had the albendazole or the anti-malarial treatment or the MMR.

One of the things I try to do is a full health assessment, more to know actually what it is that this person has, we can help them move forward into full settlement into Australia. I try to organise a full gamut of tests which looks at, you know, bloods and malaria and hepatitis urology, parasite screening for the bowels, vitamin D levels, and there are a lot of people with low level vitamin D, iron, haemoglobin EPGs, trying to work out what's the best thing to do. Difficulties are that results come back in dribs and drabs and trying to get a consistence system - I've got all the tests done, I'll bring the people back now and we'll go through all the results - isn't easy.

Time availability of the doctor is a problem. Appointment times that I might have might clash with TAFE classes, which are of prime importance, hence the Saturday mornings coming up increasingly. Families and people being used to our system, which is a system of review. "I'm not happy with this test. I'm not sure what it means, but I need to repeat it." You know, that sense of "Why are you doing all these tests?" and that does create a big effort on my part to try and explain that and be patient. People may have moved and might not be close, so getting here is a difficulty.

Just a couple of quick little case examples, we have the sorts of things we might be looking at. Here's a lady who arrived just before Christmas last year with a history of her son having been made to disappear because of his involvement in the political movement and she herself was assaulted. So she comes with two other ladies with whom she's got no social or family connection and presents with speaking, which is not always an easy language to get on the telephone translating and interpreting service, but we managed to get it, and she's got problems with teeth because of dental problems, and dental services in Wagga Wagga have been appalling.

Quite fortuitously, our building, the University of New South Wales building provides very nice rooms for the Area Health Service when they meet, so much so that they now think it's their building and they can wonder in and have meetings whenever. But the dental organisation had organised a meeting in our building and I happened to be standing there when they came through the front door and introduced themselves so I very rapidly told them to factor in refugee dental health in their dental planning. Actually I've had some phone calls back and there's been some movement on that.

But headaches, neck aches and no English, and how we sort through those when a lot of this musculoskeletal problem is probably from the direct result of physical trauma, but also the psychological effect of all of that trauma and how do I make that better for this person? You know, there was no response to proton pump inhibitors. Do we use low dose tricyclics? How do we explain the dosages to use? Is it wise to give non-steroidals when there may have been abdominal surgery? How do I organise a gastroscopy and how do I explain that you go onto the public waiting list and that might take six to 12 months? You know, do we think

about other things like coeliac disease, a lactose intolerance? How do I bring in alternative therapies and how do I use them?

But we're gradually working our way through them and the last headache diary I saw seemed to have the headache level of pain down from 4 out of 5 to 2 or 3 out of 5 and maybe some days even 1 out of 5, so I thought I was actually getting somewhere.

This other lady had significant evidence of depression but she did not want any medication. She eventually disclosed that she had problems with disclosure about relationships and whether she'd get into trouble and whether she wouldn't be able to come and what would happen if she stayed and what would happen if she went back, but she was significantly depressed about the strength of her relationship, but she also was eventually felt comfortable at telling me, "Look, I don't want anymore counselling. I don't want to have to go to Centacare anymore," and I hope relieved when I said, "Look, the ball's in your court. We are here if you need us." It took us time to work out the depth of her problems.

Davidson said that:

A comprehensive health assessment -

going back to the children -

can assist in identifying children at risk of poor health and ... provide them with timely and effective care -

and the AMA also has a policy written in 2005 for refugees. I've cut a slide out of this, but the RACGP had one as well. Some of the issues that I've demonstrated locally are Giardia Lambia, which is very common, other bacterial parasites, Guinea worm in one man who actually went on to another practice, so I didn't have the problem of treating that, malarial parasites, significant dental caries, and there was an HIV in one child a few years ago, but it actually turned out probably to be a related virus that we didn't know much about, because it all got better and we were very relieved about that. Several anaemias, thalassaemiatraits and abnormal haemoglobin EPGs. What do we do about that? Do I do it? Do I worry about it? What's the significance for the future when people marry and when we have compounding genetic problems with haemoglobinopathy.

Abdominal pain. What's the cause of this? How I sort out what it is? Following up positive helicobacter. Epilepsy in a child where the family said he'd never had epilepsy before. Nothing like this had ever happened to him before. Happened after about two days arrival into Wagga and the CT shows whiteout of almost one side of the brain, which is possibly a perinatal effect. But getting that young person stabilised we managed to do through the paediatricians the paediatric fellow. Pregnancies, mental disturbances, folate deficiency, iron deficiency, hypospadias, a male's undescended testes. The other big thing is the significantly raised inflammatory markers, raised GSR, raised CRP, no faeces that actually helps you say, "A-ha, it's this and I can treat it," and how do we manage it? How do we follow it up? What do we do about it? And physical symptoms of indeterminate cause.

So the increase in arrivals to a town such as Wagga has not actually been met with an increase in resources in dealing with these. The number of arrivals have to be balanced with the capacity of the team to deal with the people that come and make sure that they themselves are happily settled so we're not sort of like a swing door, you're swinging around and then you're coming back for another go. There's a lack of specific policies for articulating with existing health services and there is a lack of some health services, particularly in rural areas. Plus the tyranny of time that we all work with anyway.

Available workforce opportunities are a problem for people and moving forward in tertiary education and using skills is also an issue where our families need support. In Wagga we're finding suitable accommodation increasingly difficult to find and our volunteers lack specific training and that's something I've put a bit of thought to. Oddveig Nygard from Norway says that one must guard against the tension between:

humanity and the resource limitations of the bureaucracy

which I thought was a nice sentence. That's all I have to say. Thank you.

(Applause)