Exploring the fit between the perceived mental health needs of resettling refugees and current health service responses

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Abstract

Introduction
A small but growing field of research has expanded the focus on trauma and associated interventions historically evident in refugee mental health research. Proponents emphasise the need to contextualise refugee mental health with respect to resettlement and culture. Furthermore, they argue for a re-assessment of how health services and systems respond. However, health service research has tended to focus on small sections of the health system. Studies have included those concentrating on a singular group of practitioners, a particular service, or on a particular type of service. This narrow scope of investigation may not be useful in informing overall health systems development.

Aims
This thesis explores the fit between the perceived mental health needs of resettling refugees and current health service responses from a broad health system perspective. Furthermore, it considers how a better alignment of responses and needs can be facilitated, and how health service and system capacity can be increased.

Methods
A qualitative study focussing on health service and system responses to Sudanese refugees in South Australia – a group that has figured prominently in Australian humanitarian intakes over the last decade – was undertaken in order to explore the responsiveness of the health system to the mental health needs of refugees. A qualitative approach was used in order to gather information-rich data from a range of perspectives. In-depth interviews were conducted with a diverse array of key informants. Sudanese community leaders, Sudanese health workers, primary and mental health care practitioners, health service managers and policy makers were among the twenty key informants interviewed. Interviews were analysed using the Framework approach to thematic analysis.

Results
This study reiterated the need to address issues relating to the social and cultural context of resettlement. These needs were viewed as most immediate and pressing. However, there was variation in the capacity of services within the health system to respond to such issues. Services with higher degrees of refugee specificity were generally better equipped than those with less specificity. General Practitioners working in private practices were considered to face particular challenges. Several factors were found to influence the capacity of services to provide responses that are holistic, accessible, and of sufficient quality. The structures and philosophies in operation within services and the system, and the level of integration between services and sectors were important among these.

Conclusion
This thesis argues that there is a need to build health system capacity to address the needs of resettling refugees holistically. It outlines several health service and system level strategies that could be adopted to do so. In so doing this thesis constitutes a resource that health service managers, policy makers and decision makers can draw on to further service and health system development.
Declaration

This work contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text.

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Michael Savic (Candidate)

Date: ______________________
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Abbreviations and Acronyms

ABS – Australian Bureau of Statistics
ACIS – Acute Crisis and Intervention Service
AIHW – Australian Institute of Health and Welfare
AMEP – Adult Migrant English Program
CALD – Culturally and Linguistically Diverse
CCS – Complex Case Support
CHW – Community Health Worker
DIAC – Department of Immigration and Citizenship
DIMIA – Department of Immigration, Multicultural and Indigenous Affairs
DIMIA – Department of Immigration and Multicultural Affairs
ECT – Electroconvulsive Therapy
GP – General Practitioner
HiaP – Health in all Policies
ICTs – Information Communication Technologies
IHSS – Integrated Humanitarian Settlement Strategy
MRCSA – Migrant Resource Centre of South Australia
NGOs – Non-Government Organisations
NHHRC – National Health and Hospitals Reform Commission
NHMRC – National Health and Medical Research Council
PTSD – Post-Traumatic Stress Disorder
RCOA – Refugee Council of Australia
SA – South Australia
SDB – Settlement Database
SGP – Settlement Grants Program
TIS – Translating and Interpreting Service
UNHCR – United Nations High Commissioner for Refugees
WHO – World Health Organization
Chapter 1

Introduction

1.1 Introduction

The potentially adverse effects of forced migration on mental health have been well documented in the literature on refugees. The majority of this literature has been concerned with western defined psychopathology rather than with wellbeing or needs. Consistent with this preoccupation with disease, much of the health care literature focuses on treatments and interventions aimed at alleviating individual psychopathology rather than addressing needs. However there is growing scepticism amongst some researchers, practitioners and refugee communities as to the appropriateness and usefulness of such an approach for health service and systems development. There have been very few studies to inform the responses of health services and systems to the mental health needs of refugees. In the context of this gap, this research aimed to explore the fit between the perceived material, social and mental health needs of resettling refugees and current health service provision responses in order to improve the appropriateness and relevance of services and systems.

In order to do this, a qualitative study focussing on the needs of and service provision to Sudanese refugees in South Australia was conducted. A growing Sudanese community has emerged in Australia since the year 2000, increasingly bringing health and social welfare services into contact with Sudanese refugees. Whilst there are likely to be common elements that underpin the health needs of all resettling refugees related to the experience of forced migration, the historical, cultural, and forced-migration context that Sudanese have experienced also render them unique. Health services and systems have typically experienced challenges in dealing with diversity, and thus attempts to cater to the needs of Sudanese provided an excellent case study of health system responsiveness.

This thesis argues that health services and systems need to reorient their responses such that they can provide support and assistance to resettling refugees with the task of rebuilding social worlds. Furthermore, it is argued that this can occur by altering the structures and philosophies of services, increasing the integration of services, and improving the quality and accessibility of services. A number of specific ‘bottom-up’ and ‘top-down’ policy and practice options are derived to guide health service and systems development.
In this chapter the context of the research problem and this study will be introduced through a summary of key concepts. The researcher’s interest in the topic will be illuminated, culminating in the articulation of research aims and questions.

1.2 Refugees

Article 1 of the 1951 United Nations Refugee convention (UNHCR 2006), of which Australia is a signatory, defines a refugee as:

“A person who is outside his/her country of nationality or habitual residence; has a well-founded fear of persecution because of his/her race, religion, nationality, membership in a particular social group or political opinion; and is unable or unwilling to avail himself/herself of the protection of that country, or to return there, for fear of persecution” (pg 6).

The official United Nations High Commissioner for Refugees (UNHCR) definition notably excludes people who are not outside their country of origin, internally displaced people, and fails to adequately capture the multi-faceted nature of identity, often creating the homogenous ‘refugee’. Halilovich (2006) warns against overlooking the diversity within refugee populations, arguing that it amounts to:

“...reducing the identity of diverse groups of people to only one of their life episodes – that of fleeing persecution and leaving their homelands” (pg 60).

This is particularly poignant in the context of research on the needs of refugees, as it highlights the importance of acknowledging the potential complexity and diversity of needs that exist within refugee groups.

Despite its shortcomings the UNHCR definition is utilised by governments and agencies. It attempts to distinguish refugees from economic migrants; the major point of difference being the element of choice in the decision to migrate. Refugee migration is often considered to be forced because the persistent threat of persecution leaves refugees little choice of staying in or returning to their country of origin. Economic migrants however have a greater degree of choice in whether they leave or return to their country of origin and many leave seeking better opportunities.
1.3 Resettling refugees

It has been estimated that at the end of 2008 there were 15.2 million refugees worldwide and yet another 26 million internally displaced people (UNHCR 2009). The vast majority of refugees are hosted in developing countries (UNHCR 2009). Only the “lucky few”, as Coker (2004 pg 16) calls them, are resettled in western nations (UNHCR 2009).

The UNHCR is the international organisation responsible for administering the protection of refugees. It advocates three durable solutions to refugee situations (UNHCR 2004). *Voluntary repatriation* of refugees from refugee camps and/or neighbouring countries back to their homeland is the UNHCR’s most preferred solution. However, it is one that it is dependent on peace and security in homelands. Where voluntary repatriation is not viable, *local integration* into the societies to which refugees have fled is the next preferred durable solution. *Resettlement in a third country* – mostly western developed ones – is the least preferred solution. It is estimated that less than 1% of the world’s refugees are offered resettlement in a third country (RCOA 2009). In some cases, none of these options are available to refugees, resulting in ‘warehoused populations’. This is where people languish in refugee camps for several years with little prospect of any of the three solutions eventuating.

This thesis is primarily concerned with the needs of and provision of health services to refugees who are undergoing *resettlement in a third country*. Whilst some of the findings from this thesis may be relevant to other refugee populations, the majority will not due to vastly different health systems and socioeconomic contexts.

The term ‘resettling refugee’ is thus used to refer to refugees who are in the process of resettlement in third countries of resettlement. In addition to traditional host countries for resettlement, such as Australia, New Zealand, Canada, the US, the UK, Netherlands, Germany and the Scandinavian countries, new countries like Chile, Brazil, Ireland, Italy, Burkina Faso, and Benin are emerging as resettlement destinations (Hinsliff 2007). This means that health services research on resettling refugees has the potential not only to impact on health systems with some experience in addressing the needs of refugees but also on those of emerging resettlement destinations, which are likely to have comparatively less experience. The term ‘resettling’ is preferred and used throughout this thesis in contrast to the sometimes used ‘resettled’ refugee, which suggests that refugees have reached a conclusive endpoint and are thus ‘resettled’. The term ‘resettling’ conveys the continuity of the resettlement and adjustment process without making assumptions about when someone is resettled.
1.4 Resettling refugees in Australia
Australia has a long tradition of refugee resettlement. Since World War II Australia has resettled around 600,000 people conforming to the UNHCR definition of a refugee, with the current humanitarian intake capped at approximately 13,000 people per year (Hugo 2001). The source countries of refugees under the humanitarian programme in Australia have differed over time in line with the occurrence of global events and national priorities. Each year the approximate regional composition of the humanitarian intake is reviewed and determined by Immigration Department officials and the Immigration Minister. Prior to 2000 Australia’s humanitarian intake was predominantly shaped by conflicts in Asia, in the former-Yugoslavia, and to a lesser extent, Middle East (Jupp 2007). Since the late 1990s there has been a trend for an increasing number of refugees from Africa (DIMIA 2005), which represented the most statistically prominent region for successive humanitarian intakes up until 2007-2008 (DIAC 2009a). In the 2008-2009 intake approximately one-third of refugees were from Africa, a third from the Middle East, and a third from Asia (DIAC 2009a). Thus African refugees remain prominent. The shift in humanitarian intake has prompted questions about how services, with little previous experiences of African refugees, respond.

1.5 The extent and context of Sudanese refugee resettlement in Australia
Sudanese migration to Australia exemplifies the current trend of African migration. In the period between 1996 and 2006 over 20,000 Sudanese refugees resettled in Australia, making the Sudanese community one of the fastest growing in Australia (DIAC 2007a). This trend is also evident in South Australia. Between 2002 and 2006 1,580 Sudanese humanitarian entrants resettled in South Australia, which constitutes the greatest number of humanitarian entrants in the state from any particular country over this period (DIMA 2006).

The reasons for high levels of Sudanese refugee migration to Australia and other resettlement countries are bound up in conflicts in Sudan. Since 1956, when it gained its independence from Britain, Sudan has been in an almost constant state of civil war (Schweitzer et al. 2006). Conflict erupted as a result of the postcolonial power vacuum and has centred upon the distribution of power and resources between the largely Arabic north of Sudan and the African south (Johnson 2003). From the late 1980s to the present day, where the latest episode has taken place in the Darfur region of western Sudan, the conflict has escalated resulting in mass refugee movement from Sudan (Schweitzer et al. 2006). It has been estimated that 1.3 million Sudanese have died fleeing violence and that there are in excess of 500,000 Sudanese refugees globally; many of whom are not resettled in western nations but
who reside in countries neighbouring Sudan (US Committee for Refugees, 2000). Thus Sudanese community and family networks have been separated and dispersed throughout the globe forming a growing diaspora, or globally dispersed community. This is likely to be an influential factor affecting the resettlement experiences of Sudanese refugees in third countries of resettlement.

War has been accompanied by drought and famine, severely hindering development and infrastructure in Sudan (DIAC 2007a). A potential by-product of these factors is that Sudanese refugees may have had interrupted or limited education and work opportunities and may have had limited contact with formal health care systems in Sudan (DIAC 2007a). Furthermore, the health and opportunities of Sudanese refugees are also likely to be affected by the fact that prior to entry to Australia many Sudanese refugees have lived in refugee camps in neighbouring countries like Kenya, Ethiopia, Uganda, and Egypt (DIAC 2007a). Refugee camps are recognised as being spaces deleterious to health, and emotional wellbeing in particular (Orach 1999).

Data from the Australian Department of Immigration and Citizenship’s Settlement Database suggests that 79% of the Sudanese refugees settling in Australia between 2001-2006 have been described as possessing ‘nil’ or ‘poor’ English language proficiency (DIAC 2007a). This is likely not only to hinder employment opportunities and adjustment but also may pose difficulties for health providers attempting to deliver services to Sudanese refugees. For instance, it is thought that access and outcomes are compromised when a client and a health worker do not share a common language (Ahmad 2000).

The fact that the Sudanese population does not represent a homogenous group adds to the difficulties services and policy makers may face in developing appropriate responses. Sudanese refugees are composed of many different cultural, ethnic and religious groups (Schweitzer et al. 2006). The majority of Sudanese refugees in Australia are South Sudanese (Marlowe 2009). The meaning attached to the ‘South Sudanese’ marker of identity is multi-faceted according to Deng (1973). It can signify the geographic origin of a person and their family, and/or the political desire for an independent South Sudan. It can also be an affirmation of black African and Christian identity as opposed to the Arabic and Muslim markers of identity, which are often held by Northern Sudanese. However, overly simplistic North-South, Muslim-Christian, and Arabic-African dichotomies mask a greater and more complex cultural diversity amongst Sudanese. For example hundreds of different ethnic and
tribal groups are thought to exist in Sudan, whilst some of the larger groups include the Kababish, Ja’alin, Bagarra, the Dinka, Nuer, Shilluk, and Azande (DIAC 2007a).

A further manifestation of this heterogeneity is in relation to language, where, whilst Arabic is the most widely spoken language, it is thought that around 400 languages and dialects are spoken across Sudan. This is reflected in the Australian Department of Immigration and Citizenship’s Settlement Database (SDB), which suggest that the main languages spoken by Sudanese refugees in Australia are varied, including Arabic, Dinka, and many others, for which the SDB does not have language codes (DIAC 2007a).

The heterogeneity of the Sudanese refugee population is also likely to manifest in varying cultural attitudes and beliefs. These are likely to affect beliefs about mental health, help-seeking and the role of health services. Schweitzer et al. (2006) allude to the collectivist orientation of Sudanese cultures suggesting that group and family cohesion is considered to be of paramount importance. Therefore Sudanese families may be large as children are highly valued (Lainof & Elsea 2004). Schweitzer et al. (2006) also comment on the patriarchal nature of Sudanese society in general, noting that there are clearly prescribed gender roles in which men occupy the head of the family. The observation of the patriarchal nature of society has also been made with respect to specific Sudanese ethnic groups such as the Dinka (Deng 1972) and the Nuer (Lainof & Elsea 2004), who like the Dinka represent a significant proportion of Sudanese refugees in Australia (DIAC 2007a). Forced migration and acculturation are likely to influence cultures and beliefs. Shandy (2007), in her ethnographic work on the Nuer in America for instance, highlighted the role of transnational networks and remittances in producing and altering Sudanese cultures. Thus, the degree to which past seminal observations about Sudanese cultures in Sudan (i.e. Evans-Pritchard 1940, 1951, 1956; Deng 1972) remain valid for individual Sudanese refugees in Australia is likely to vary.

This brief introduction to the Sudanese in Australia highlights the potential role context is likely to play in shaping mental health needs and the challenges services are likely to face in addressing these.

1.6 Material, social and mental health needs
As a consequence of forced migration and resettlement, refugees are thought to have specific material, social and mental health needs, which will be discussed fully in the following chapter. There is a well noted tendency for health-related research with refugees to focus
solely on pathology-model of mental health (Ryan et al. 2008). The World Health Organization (WHO) defines *mental health* as:

“A state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (WHO 2007a).

Whilst the WHO definition clearly sets out that mental health is not merely the absence of disease, many studies have conflated *mental health* with *mental disorder* ignoring the social context that has been shown to be influential in the wellbeing of refugees (Porter & Haslam 2005). In recognition of the important role played by the social context, researchers are increasingly utilising alternative terms, such as ‘psychosocial wellbeing’, which are also seen as less stigmatising (Tempany 2009).

This study explicitly set out with a broad and malleable notion of ‘mental health’, underscoring the material and social context that is alluded to in the WHO definition. Thus the term ‘material, social and mental health needs’ is utilised throughout this thesis. Sometimes terms like ‘needs’ or ‘mental health’ needs are used as shorthand for ‘material, social and mental health needs’ throughout this thesis. The imposition of pre-conceived notions of what constitutes mental health was avoided during interviews however, in acknowledgement of cultural and individual differences in mental health beliefs.

1.7 Need

The concept of *need* requires further clarification at this point. Bradshaw’s (1972) pioneering theoretical taxonomy of needs highlighted that what constitutes need depends upon who is doing the defining. For instance he differentiated between needs identified by professionals, *normative* needs, and those *felt* by individuals. Altschuld and Witken (2000) extend this conceptualisation with respect to services suggesting that there are three types of need; those defined by community members or service users, those defined by service providers, and those defined by policy makers, administrators and managers. The perspectives and concerns of each of these groups are likely to differ. Community members may be concerned with desires, service providers with the service level, and policy makers and managers with resource and system level issues. Billings and Cowley (1995) argue that an array of perspectives are thus required, and are important in undertaking needs assessments in relation to services. Lee et al. (2007) similarly note that understanding differences in stakeholders’
perceptions contributes to a more in-depth picture of needs. This view was influential in informing the study design and thus the perspective taken within this thesis.

1.8 Australia’s refugee resettlement programme and services

The context of service provision to resettling refugees in South Australia is influenced by Australia’s refugee resettlement policy and the subsequent organisation of resettlement services.

A number of non-government, private and public services exist to assist migrants and refugees to settle into Australia. Such resettlement services are not only important in terms of meeting refugees’ needs but also in terms of facilitating access to the health system.

By the late 1970s the Federal Immigration Department was directly and heavily involved in migrant settlement service provision. It provided on-arrival accommodation in migrant hostels, assisted in teaching migrants English through adult and child migrant education programmes, conducted consultations with ethnic organisations, provided face-to-face and telephone interpreter services, employed social workers and subsidised a number of charitable organisations to assist with this work (Jupp 2007). However since the late 1980s and consistent with broader governance movements towards economic rationalism, there has been a rising trend towards cost-recovery and competitive tendering of services (Jupp 2007). This has meant two things. Firstly it has meant that services directly provided by the Immigration Department previously have been outsourced to non-government organisations. Secondly, there has been a mainstreaming of services such that the Immigration Department does not fund or has scaled back funding of services where it considers migrants to have similar needs to the general population (Hinsliff 2007). For example, employment and housing services for migrants are, for the most part, considered outside the realm of Immigration Department responsibility (Hinsliff 2007). In practice this has resulted in a focus on on-arrival resettlement needs considered specific to migrants and refugees such as English education and interpreting services. In Government discourse this is couched as a:

“…specific and limited investment in supporting new arrivals in their early years of settlement” (DIMIA 2003 pg 32).

This is evident in current refugee settlement policy in Australia. Most humanitarian entrants to Australia are entitled to resettlement services provided under the Federal Government’s
Integrated Humanitarian Settlement Strategy (IHSS) for a period of up to six months after arrival. Included in this suite of services is:

- On arrival reception and assistance
- Case coordination, information and referrals
- Accommodation and housing support
- and short-term trauma and torture counselling (DIAC 2009b).

The day-to-day delivery of IHSS services is administered by contracted IHSS providers in each state and territory. As is the case in the state of South Australia, often consortiums of multiple services develop in order to carry out the service provision obligations set out in competitively tendered IHSS contracts. In South Australia the IHSS service provider consortium is led by a migrant resource centre and consists of two NGOs, a vocational education provider, a university, and two ethnic community bodies (MRCSA 2008).

After the six month period, when the eligibility of newly arrived refugees for IHSS services has elapsed, resettling refugees may access services provided under the Federal Government’s Settlement Grants Programme (SGP). Under this programme resettlement, other non-government services, and community organisations may apply for federally funded grants to provide ongoing resettlement support to refugees. Examples of funded SGP programmes in South Australia between 2009-2010 include those focussed on facilitating access to mainstream services, ongoing case management, information and referral services, housing support and homelessness prevention activities, youth programmes, women’s programmes, mentoring programmes, subsidised driving lessons, education and health promotion activities, and a small number of community development and capacity building activities (DIAC 2009c).

Resettling refugees who are considered to be vulnerable or thought to be experiencing considerable difficulties with resettlement may be referred to federally funded Complex Case Support (CCS) services, which take an intensive case management approach. CCS services are provided for a period of up to five years after arrival, and are provided by 38 organisations nationally (DIAC 2009d).

Additionally, resettling refugees over the age of 18 are eligible for 510 hours of free English language tuition under the federally funded Adult Migrant English Programme (AMEP) (Hinsliff 2007). In South Australia, AMEP is provided in a number of locations by the
vocational training organisation that is a part of the IHSS consortium in South Australia. Instead of AMEP services, school age children learn English language and other educational skills at New Arrivals Programme Schools, where they may be for up to two years prior to being ‘transitioned’ into mainstream schools.

Australia’s system of refugee resettlement is highly regarded internationally but nevertheless a number of issues have been raised (RCOA 2009). These include resourcing, and the degree of integration between settlement systems and other systems, such as health (RCOA 2009).

1.9 The Australian health system
Although there may be some similarities, health systems vary internationally. It is thus important to establish the health system context of this research. The Australian health system is complex, involving a number of different public and private providers and funding arrangements. Some of the key features of the Australian health system will be briefly summarised.

Primary care is the most utilised site of care by Australians (Swerissen & Duckett 1997). Primary care services take a number of forms in Australia. These include general practice services, allied health care services, dental services, alternative medicine practices, and community health services. Despite the increasingly recognised role of nurse practitioners and other primary care providers, General Practitioners (GPs) continue to be the major primary care providers in Australia (Swerissen & Duckett 1997). GP care is predominantly funded by the Federal Government’s universal health insurance scheme called Medicare. Medicare provides users with free or subsidised treatment at the point of care. Exceptions include some GPs working in community health services, which are funded by the State governments, and which often employ salaried practitioners. The addition of a number of allied health and nurse practitioner items to the Medicare Benefits Schedule – the list of services and treatments that the Federal Government will subsidise via Medicare – has seen an increase in their use over recent years (AIHW 2008).

Other services funded or partially funded through Medicare include specialist services – services targeted at specific medical conditions – such as mental health services, irrespective of whether they are private psychological or psychiatric services, public community mental health services, or psychiatric hospital care. Where services are partially funded through
Medicare, whether it is GP services or specialist services, the remaining cost of care is paid by service users.

Public hospital services are primarily the responsibility of State governments however hospitals also receive funding from the Federal government, and some revenue through private patients (AIHW 2008). Private hospitals are predominantly funded by service users – those with private health insurance – but also receive some funding from the Federal government (AIHW 2008). The routes to hospital care may include via, a GP or other specialist referral, self-admission, or ambulance and emergency-department admission.

A similar Federal government scheme to that of Medicare, called the Pharmaceutical Benefits Scheme, subsidises a number of ‘essential’ medications. Citizens pay the remaining cost of subsidised medications and the full cost of non-subsidised medications.

The responsibility for public health and health promotion services, programmes and campaigns is distributed amongst NGOs, the State Government, and the Federal Government.

Generally speaking, the Federal government is responsible for collecting revenue and distributing it to State Governments who in turn are responsible for funding and overseeing service provision. Having said this, in March 2010 the Federal Government announced a proposal to play a greater role in direct funding of hospitals and service provision (Maiden 2010). Any major changes in responsibility such as a Federal take-over of the health system requires the agreement of the States and/or constitutional amendment, which can only be achieved by public mandate. This is because the split in responsibilities for the health system in Australia between State governments and the Federal governments is enshrined in legislation.

The split in responsibilities means that there are a number of government health department bureaucracies around Australia responsible for oversight of aspects of the health system. Whilst there are ongoing debates around the efficacy and efficiency of such a split-responsibility system, proponents of the status quo argue that the present system enables state authorities to plan services and programmes to cater to the needs of their populations. As such there is variation in the way in which health systems are organised within each of the states in Australia. Elements of this will be elaborated upon further in the context of the South Australian health system and particularly in relation to refugees.
1.10 South Australian health system and resettling refugees

The orientation of the South Australian health system in relation to refugees consists of a mix of service delivery. Amongst this mix are public services, community health services, private sector primary health care and specialist services, and non-government organisations. Whilst the South Australian health system may be viewed as generally engendering a mainstream approach there are elements of refugee specificity within the system.

A major review of the South Australian health system, the Generational Health Review, called for health system reform. As a consequence, the South Australian public health system underwent reform in 2004 (SA Department of Health and Ageing 2004). This reform divided metropolitan Adelaide into two regions. Each region is serviced by an overarching health service with its own board; the Central Northern Adelaide Health Service and the Southern Adelaide Health Service (SA Department of Health and Ageing 2004). Furthermore a third state-wide service called Children, Youth and Women’s Health Service was established amalgamating the Women’s and Children’s Hospital and Child and Youth Health (SA Department of Health and Ageing 2004). Public hospitals and a range of community health and mental health services are under the jurisdictions of each of the regional health services.

Many of the services provided within the public sector are mainstream in their orientation. However, elements of refugee specificity are evident in mechanisms such as the provision of interpreters, and bilingual liaison workers that have been implemented within this sector.

There is one refugee specific primary health care community health service in South Australia. It is a primary health care service with a holistic focus that especially caters to the needs of refugees and asylum seekers. Furthermore the refugee specific primary health care service aims to promote the self efficacy of newly arrived refugees in such a way to assist access to mainstream services. Consistent with this aim it usually offers services up until about two years after migration if necessary.

Like the refugee specific primary health care service, other community health services in South Australia may have greater capacity to respond to the needs of refugees in their local community more flexibly than mainstream services. Often such community health services operate under salaried practitioner models as compared to fee-for-service models operating in private service provision contexts. Furthermore, community health services in South Australia
tend to be located in areas characterised by low-socio economic status. These are also the areas in which resettling refugees tend to settle.

Although there are a small number of GPs who work in state-funded community health services in South Australia, the majority work in private practice settings. Research suggests that GP provided primary care is the most utilised type of health service amongst refugees (Sheik-Mohammed et al. 2006). In addition to reflecting broader service utilisation trends in the community, the Federal Government also encourages the utilisation of private GP services by resettling refugees through a specific Medicare item; item 714. Item 714 enables GPs in private practices to be reimbursed for providing an initial comprehensive health assessment, including psychosocial wellbeing, to newly arrived refugees. As, Johnson et al. (2008) point out, in South Australia, this has had the effect of encouraging referral from the IHSS provider directly to GPs in private practices. At the same time it has discouraged referral to community health services, who may be well equipped to provide care to newly arrived refugees (Johnson et al. 2008).

As noted earlier with respect to resettlement, a variety of non-government organisations (NGOs) deliver a range of health and welfare services to refugees. Some NGOs like the refugee specific community mental health service are specifically tailored to addressing the mental health issues of refugees in addition to addressing resettlement issues.

Refugee health may not receive adequate attention at a policy level in South Australia. For example South Australia is not described by Minas et al. (2007 pg 4) as one of the “active states” (i.e. Victoria, New South Wales, Western Australia and Queensland) in relation to refugee and migrant mental health. Unlike the “active states” (pg 4) South Australia does not have a specialist transcultural mental health policy nor does it have an active involvement with Multicultural Mental Health Australia (previously known as the Transcultural Mental Health Network). Whilst the explanation for this may be in part historical, as South Australia has not been a major destination for refugees in the past, this has changed somewhat and in fact South Australia is now the fourth most popular settlement destination for refugees in Australia (DIAC 2007b).

1.11 My interest in the topic

This research developed in the aforementioned context of health system level ‘inactivity’ in South Australia and was driven by a strong personal interest in the topic.
My Honours work on approaches to community health work with Culturally and Linguistically Diverse (CALD) people found that organisations, even well intentioned holistic-care focussed ones, can find providing care to CALD communities difficult (Savic 2006). Within my honours research, refugees were one group within the CALD community that stood out as having particular needs, and thus requiring particular service responses (Savic 2006).

At the same time I noticed a growing number of Sudanese refugees settling in areas near where I lived. I also became increasingly aware of unfavourable media reports and public discussion about the Sudanese. As well as the future viability of Sudanese refugee migration in Australia, it seemed that many commentators had an opinion about what ‘they’ needed, from up-scaled counselling and trauma services to better resourced settlement services. It seemed that the voices of Sudanese themselves, and those that provided care to them in health and social services were overshadowed by opinionated commentators. This became my motivation to try and understand what the needs of Sudanese refugees actually are and what services could do to best respond.

1.12 Aims and research questions
Driven by gaps in the literature that will be identified in the following chapter, and with the intention of being a policy and practice relevant piece of research, this study had two aims. Firstly it sought to explore the perceived fit between the mental health needs of resettling refugees and current service responses. Secondly it aimed to explore how a better alignment of responses and needs can be facilitated, and how health service and system capacity can be increased.

Specifically it set out to answer three questions:
1. What are the material, social and mental health needs of resettling Sudanese refugees as understood by key informants?
2. How are the material, social and mental health needs of resettling Sudanese refugees currently being addressed and what, if any, are the gaps in service provision?
3. What are the factors that impact on the ability of services to address the material, social and mental health needs of resettling refugees?
1.13 Organisation of the thesis
This thesis contains eight chapters.

Building on the contextual introduction developed in this chapter, in Chapter Two, three strains of literature are reviewed:

1. The material, social and mental health needs of refugees.
2. Health related research with Sudanese refugees
3. Health service provision to resettling refugees.

In Chapter Three the methods used to explore the research problem are described and reflected upon.

Results of analysis are presented in Chapters Four, Five, and Six, with each chapter focussing on one of the research questions posed. Chapter Four establishes what the material, social and mental health needs of Sudanese refugees are according to key informants. Chapter Five highlights how services and communities are attempting to address these needs currently. Chapter Six focuses on the factors that affect the ability of services and the health system to address the needs of resettling refugees.

In Chapter Seven, the results are contextualised within the broader literature such that practical strategies for improving health service appropriateness and relevance are developed, and conclusions are made.

1.14 Conclusion
Beginning with a global outlook around definitions of refugees, this chapter outlined the local and specific context of the research problem. Key terms and concepts relevant to the research problem – the needs and service provision responses to resettling refugees, such as those from Sudan – were introduced and defined. Furthermore, the position taken throughout this thesis on commonly used terms, such as ‘resettling refugees’ and ‘needs’ was clarified. Through this process the rationale for this research, research questions and aims were elucidated. In the following chapter the literature is reviewed, adding a scholarly dimension to the context building undertaken in this chapter.
Chapter 2

Refugee mental health and health service provision responses reviewed: major currents and gaps

2.1 Introduction
In this chapter three strands of literature are reviewed in order to highlight what is already known and identify gaps in the knowledge base around refugee mental health and service provision responses. Firstly factors affecting the material, social and mental health of resettling refugees will be discussed in order to identify what is known about needs. Attention will then be turned specifically to health and health services research on resettling Sudanese refugees. Finally, the literature on health service provision to resettling refugees will be reviewed. This review is not intended to be exhaustive but does provide an overview of major currents and gaps in research on the needs of and responses to resettling refugees. Additional research studies are critically interpreted in the discussion of results in Chapter Seven.

2.2 Forced migration and mental health
Forced migration and the events that prompt it are thought to constitute threats to health, and mental health in particular. Palinkas et al. (2003) suggest that there are three major threats to the health of refugees including: exposure to infectious disease risk factors in their country of origin preceding migration; post-migration exposure to chronic disease factors in their host country; and the prevalence of mental illness as a result of pre-migration and post-migration experiences. Whilst these threats might not necessarily apply to all resettling refugees with respect to age, gender, and experiences, a small Australian study describing the health issues in newly arrived African refugees reflects this (Tiong et al. 2006). For example Tiong et al. (2006) found that inadequate vaccinations, nutritional deficiencies, dental disease and infectious diseases were the most common health problems identified amongst African refugees, whilst psychological and social problems were also common. Given the long-term nature of chronic diseases the fact that Tiong et al. (2006) did not identify any chronic diseases may reflect the composition of the sample (i.e. newly arrived refugees). Furthermore, high levels of western defined mental illness amongst refugees including post-traumatic stress, anxiety, and depression have also been documented (Silove 1999).

In conceptualising the mental health of resettling refugees many point to the effect of pre-
migration experiences of trauma and post-migration experiences, including health service access and equity issues (Schweitzer et al. 2006).

2.2.1 Pre-migration experiences

According to a common school of thought, pre-migration experiences of trauma are thought to render refugees vulnerable to mental illness and psychosocial distress. Ingleby (2005) notes that there has been an exponential increase in studies focussed on trauma in refugee populations since the 1980s. He illustrates that this focus on trauma has come to dominate research on the mental health of refugees.

Few would question the fact that many refugees have been exposed to traumatic experiences such as violence, rape, torture, and lack of food, water and shelter prior to migration. Using the Harvard Trauma Questionnaire as part of an Australian study on the pre-migration and post-migration experiences of Sudanese refugees, Schweitzer et al. (2006) found that all the participants reported having experienced at least one category of trauma. Furthermore Schweitzer et al. (2006) found that 54% of the 63 Sudanese refugees who participated in the study reported experiencing five or more different categories of trauma. Furthermore the literature suggests that the trauma experiences of refugees are cumulative rather than isolated events (Silove 1999), having the effect of challenging an individual’s self-concept, and sense of control (Schweitzer et al. 2006). Testimony to this is the fact that in attempting to escape initial sources of trauma, many refugees find themselves in refugee camps characterised by destitute circumstances, where they may experience yet more trauma (Kim et al. 2007).

The likelihood that resettling refugees have had terrible experiences that might be considered traumatic is thus not contentious. However what is contentious is the framing of psychosocial distress experienced by resettling refugees as Post Traumatic Stress Disorder (PTSD).

The view of trauma posited in research and opinion emanating from such fields as psychiatry, psychology and psychiatric epidemiology is that it is implicit in the experience of forced migration, and that trauma has enduring negative consequences (i.e. PTSD) that need to be prevented or treated using western techniques. However, insights from perspectives as diverse as anthropology, public health, and community development studies have brought the dominant biomedically informed refugee trauma paradigm into question. Marlowe (2009) argues that the critique of the refugee trauma paradigm has been levelled on three fronts. Firstly, he views one element of this critique as being the tendency of the trauma paradigm to
localise distress within the individual psyche and to subsequently pathologise it. According to Marlowe (2009) this gives rise to the second part of the critique, which is the inability of the trauma paradigm to contextualise suffering and distress within external factors and particularly those relating to resettlement. Marlowe (2009) suggests that the final element of the critique relates to the inability of the trauma paradigm not only to contextualise hardship within broader external factors but also its inability to adequately recognise healing and coping mechanisms that exist within cultures and refugee communities. Inherent within the developing critique of the trauma paradigm is the idea that whilst many resettling refugees have experienced very distressing events, the priority to deal with any distress caused by such events may be overshadowed by pressing and immediate concerns related to resettlement. Proponents of this school of thought thus warn against conflating psychiatric epidemiology with the mental health needs of resettling refugees.

2.2.2 Post-migration experiences

Whilst the dominant trauma paradigm views pre-migration trauma as potentially affecting and rendering refugees vulnerable, post-migration difficulties have been found to be stressors in their own right. In fact a small but growing field of research highlights the role of such post-migration experiences arguing that refugee ‘recovery’ is primarily a social process rather than a biomedical one (Westoby 2008, Summerfield 1999). Sinnerbrink et al. (1997) take a middle position regarding pre and post-migration experiences in mental health. As cited in Schweitzer et al. (2006), they suggest that:

“…living in a post-exile community may compound rather than alleviate mental health problems associated with migration and the refugee experience” (pg 185).

The literature highlights four conglomerations of post-migration factors that impact on wellbeing in a resettlement context. These include adjustment to a new socio-cultural context, host-country reception, other practical resettlement related factors, and access to support.

Adjustment

Victor Turner (1967) as cited by Coker (2004) describes refugees as “transitional beings” (pg16) referring to their precarious position of being caught between cultures, societies and statuses. The inability to reassert or recreate one’s sense of identity and life upon relocation to another place, with its own socio-cultural context is thought to negatively affect emotional wellbeing.
Adjustment to a new socio-cultural context and the forging of a ‘new’ identity is likely to be affected by the degree and style of acculturation, and the length of time an individual has lived in their new country (Nwadiora & McAdoo 1996). Acculturation refers to the cultural changes that occur when sustained contact between two cultures transpires. This inevitably affects the beliefs, values and identities of migrants and minority group members as they adjust to living in a different socio-cultural context (Foss 1996). Although there have been many models developed to conceptualise acculturation Berry’s (1997) two-dimensional model of minority individual’s styles of acculturation is commonly cited. It involves both the degree of assimilation into the dominant culture and the degree of retention or maintenance of an individual’s culture or ethnicity of origin resulting in four acculturation styles; integration, separation, assimilation, and marginalisation (Abu-Rayya 2006). Integration refers to those that identify strongly both with the dominant culture and their own cultural heritage whilst separation identifies those individuals that identify strongly with their own cultural heritage and not so much with the dominant culture. Assimilation describes those individuals who strongly identify with the dominant culture and who have lower levels of maintenance of their cultural heritage whilst marginalisation distinguishes those who have low identification with both the dominant culture and their own cultural heritage.

Berry et al. (1987) found that marginalisation was associated with high acculturative stress whereas integration was associated with low acculturative stress. Acculturative stress refers to the psychosocial manifestation of difficulties individuals or groups may have in adjusting to living in a new culture. In articulating the effects of acculturation and acculturative stress on mental health Nwadiora and McAdoo (1996) suggest that it can “virtually destroy a person’s sense of identity, integrity, and ability to cope” (pg 481). Coker (2004) argues that the contact that exists between refugees and the host culture is the most traumatic form of transcultural contact because it is forced upon refugees who are “physically and socially defenceless” (pg 33) in the face of the dominant host culture. In explaining the “socially defenceless” position of refugees Coker (2004) refers to the inadequacy of refugees’ past culturally defined experiences, schemas, and historical scripts in navigating transcultural contact with dominant host culture/s. In characterising refugees as “socially defenceless” or as passive actors one must also be wary of underestimating the resilience and coping ability of refugees, many of whom have adapted to various trying circumstances without the aid of help from health professionals (Steel et al. 2002). In line with this, neither should the ability of refugees to contribute to host societies be underestimated.
According to Nwadiora and McAdoo (1996) one important determinant of the level and intensity of acculturative stress is the relative difference between the cultures involved in the acculturation process; the host culture, and the culture of the individual undergoing acculturation. Thus individuals from non-western societies, for example, may find adjustment to life in a western society difficult and have higher levels of acculturative stress than, say, individuals coming from one western society to another. Schweitzer et al. (2006) found that Sudanese refugees commonly cited difficulties adjusting to cultural life in Australia, reiterating the role that conflicting cultural beliefs and values may have on the psychosocial wellbeing of refugees. Whilst adjustment difficulties may be experienced by migrants and refugees alike, according to Berry et al. (1987) refugees, regardless of their cultural background, may have greater adjustment difficulties than economic migrants. This is because refugees have less choice in their decision to migrate than economic migrants and they may also have less positive initial attitudes towards change and contact with a new culture (Berry et al. 1987).

**Host country reception**

Adjustment to life in a new country is not only likely to be affected by refugees’ own experiences and expectations but also the way in which they are perceived and accepted by the wider society (Nwadiora & McAdoo 1996). Kelaher and Manderson (2000) describe the social construction of immigration as draining resources and the notion that migrants and refugees compete for jobs as becoming an increasingly populist attitude in Australia. Furthermore as with the arrival of many new migrant and refugee groups historically an air of uncertainty and even xenophobia in some elements of the Australian community has accompanied the settlement of Sudanese refugees. Racism is thought to be a major factor in exacerbating health and socioeconomic inequalities (Harris et al. 2006). Associations between perceived racial discrimination and mental health outcomes (Williams & Williams-Morris 2000), and self-reported general poor health (Karlsen & Nazroo 2002) have been found. Henry and Tator (2000) note that intolerance and racism in Canada are particularly directed towards those who have been socially constructed as ‘visible minorities’ due to the colour of their skin, region of origin and perhaps also cultural and religious customs surrounding dress. In Canada, for instance, it is thought that European migrants are placed high on what has been described as a hierarchy of ‘social distance’, whilst Jews, Africans, Asians and other ‘people of colour’ are located low on the preference scale (Berry & Kalin 2000, Richmond 2001).

Intolerance due to visible minority status may be additionally implicated in the post-migration
experiences of Sudanese refugees in Australia, who Overington (2007), in an article in *The Australian* newspaper, described as:

“…the tallest, leanest, blackest and therefore most noticeable group of people taken under the federal Government’s refugee and humanitarian programme” (pg 13).

Overington’s (2007) description is indicative of the “otherness” that is often portrayed and promulgated in the media where a negative construction of African and particularly Sudanese refugees as being lawless, involved in gang violence, disease ridden and unable to integrate has been prevalent (Black 2007, Castello 2007, Overington 2007, Saeed 2007, Wright and Castello 2007). The view that Sudanese refugees are unable to integrate into Australian society has also been perpetuated by politicians like the Immigration and Citizenship Minister Kevin Andrews who on August 18 2007 announced that the intake of refugees from Africa would be reduced by 30% (Andrews 2007). McManus (2007) asserts cost as a reason for the Minister’s decision reporting in the *Herald Sun* newspaper online that:

“…integrating African refugees, particularly from war-ravaged Sudan, has been very expensive”.

This lack of political commitment may impact negatively on the funding of health and welfare service delivery to Sudanese refugees and thus their overall health, adjustment and resettlement.

*Resettlement related factors*

Adjustment issues can be exacerbated by a whole range of other resettlement related factors analogous to the social determinants of health. Social determinants of health, as defined by Labonte and Schrecker (2007), are:

“The conditions in which people live and work that affect their opportunities to lead healthy lives” (pg 2).

Many of the post-migration difficulties faced by refugees act in ways that restrict opportunities for health and adjustment.

Unemployment and underemployment are thought to be common amongst refugees (Saunders
many of whom may have had interrupted educations in their country of origin, whilst the qualifications of some go unrecognised. Furthermore such difficulties are likely to result in refugees accepting hazardous and low paid jobs (Gwyther & Jenkins 1998).

Communication difficulties for refugees, stemming from limited English language skills, may be a factor that persists throughout the early resettlement period and beyond and may also be implicated in decreased employment opportunities for refugees, which may hinder adjustment (Danso, 2001). Bottomely and DeLaprevanche (1990) make the connection between English language proficiency and socioeconomic status arguing that opportunities for upward social mobility are decreased for migrants with limited English language skills. Thus decreased employment opportunities and poor English language proficiency, among other things, may culminate in some refugees being categorised as being of low socioeconomic status (Mitchell et al. 1998). A well-documented association between socioeconomic status and a variety of health indicators and specific diseases exists (Najman & Davey-Smith 2000) such that those lower in the social hierarchy tend to experience worse health than those higher in the hierarchy (Adler et al. 1994). Therefore the health of refugees, like other population groups, is likely to be affected by their socioeconomic status.

Furthermore, often due to the nature of forced migration many refugees are dislocated from family and friends and thus may have an inadequate social support network (Schweitzer et al. 2007). This may be particularly the case for refugees from cultural backgrounds that are not highly represented in the Australian population. Stuchbery et al. (1998) conceptualise social support as “involving the exchange of social resources between individuals” (pg 484) whilst Albers and Williams (2002) highlight the importance of social support in the promotion of mental health suggesting that it can help an individual to cope with key life events and that information and reassurance increase self-efficacy (i.e. personal control). Thus it seems that social support could aid refugees in navigating the key life event of migration, but as Schweitzer et al. (2006) point out, a lack or loss of social support networks may be detrimental representing an ongoing source of trauma for refugees. Sudanese refugees in Schweitzer et al.’s (2007) study reported the disintegration of their social support networks upon arrival in Australia which prompted many to rebuild and diversify their social support networks to include, in addition to family and friends, other members of the Sudanese community. Thus social support was found to increase the ability of refugees to cope with and adjust to their unfamiliar situation (Schweitzer et al. 2007).
However, depleted social support networks may be accompanied by worries about family and friends who have been unable to migrate but may still be in insecure circumstances. One of the most common post-migration difficulties cited by refugees participating in Schweitzer et al.’s (2006) study was concerns about family not living in Australia. Similarly, on the basis of a case study of the effects of the Balkan conflicts of the late 1990’s upon Serbian Australians, Procter (2000) also concluded that global events and happenings continue to have an effect at the local level for immigrants and refugees. Using the concept of glocalization or the local-global nexus, Procter (2000) explains that the mental health of immigrants and refugees is affected by events in, and worries about their homeland such as the fate of other relatives and friends.

Access to services

Despite the potentially high material, social and mental health needs articulated to this point, there is a body of literature that suggests refugees experience many barriers to accessing health care services. The implications of access issues on equity are articulated by DeSouza (2005) in relation to western health care systems, who argues that a “universal system that provides for everyone fails to cater to the individual needs of minority cultures” (pg 99) resulting in further disadvantage. Thus it is important that research has the ability to inform services of the individual needs of minority groups, such as Sudanese refugees in order to promote access and equity.

Costs associated with health care have been found to be a major deterrent for refugees wishing to access services, even in situations where urgent medical treatment is required (RCOA 1992). Thus services not covered by Medicare may be underutilised by refugees given their likely financial constraints (Lamb & Smith 2002). Financial constraints may also result in transport difficulties for refugees who may not have a car, and thus hinder access (Lamb & Smith 2002).

Unfamiliarity with the Australian health system is thought to hamper the ability of refugees to negotiate and advocate for themselves therefore exacerbating existing power differentials (Portes et al. 1992). This may be especially exacerbated when refugees come from countries where the health system may be different, such as countries with no or minimal primary health care systems. For instance, as in many parts of the world, the services of traditional healers are thought to be widely utilised in addressing health issues in Sudan (Ahmed et al. 1999), the likes of which may not be available in western contexts. Burnett and Peel (2001)
describe the situation in which refugees, who may be used to grossly different health systems, may attend a hospital in the expectation of receiving care for matters that in countries like Britain or Australia are addressed in primary care. Such a situation stemming from unfamiliarity with western health systems may result in disappointment for refugees and irritation for health workers, as postulated by Burnett and Peel (2001). Inadequate information about health services is thought to maintain this sense of unfamiliarity and thus entrench existing access difficulties (Davidson et al. 2004).

The health service–client nexus was described as the meeting place between two cultures by Wiklund et al. (2000) but also the stage in which conflicting cultural values, traditions, and expectations may manifest. Coker (2004), for instance, found that Sudanese refugees in Cairo viewed their illnesses as resulting from social, emotional and cultural breakdown manifesting in the body. This corresponds to the idea of somatisation, which is the idea that psychological issues may manifest as physical issues (Kugelmann 1997). Good (1977), as cited by Coker (2004), similarly explains that illness and the meaning attributed to them become “warped by trauma and flight” (pg 20). Thus this speaks to the importance of providers contextualising illness and exercising caution, when generalising health beliefs beyond the context which produced them.

Refugees from diverse cultures may have different expectations about the role of healers and how issues are addressed. Consistent with the collectivist nature of society, Deng (1972) explains that, amongst the Dinka of Sudan, illness is not only the domain of the individual but a cause for community concern and as such family, relatives, friends and elders are all involved in the treatment/care of sick individuals. For example, Lainof and Elsea (2004) describe that in Sudan, disagreements between married couples are often resolved with the aid of community elders. Additionally, Sudanese conceptions of time and obligation lead to health services in Sudan having what (Holtzman 2000) describe as a ‘walk-in policy’. This contrasts rigid western notions of time requiring appointments and sometimes resulting in cancellations.

Asymmetrical meetings between health services and refugees in terms of explanatory models of illness and expectations about how issues are addressed may be viewed as a disincentive for further health service access (Handelman & Yeo 1996). Thus health services and health providers have been called upon to engender cultural sensitivity in their interactions with refugees. Different cultural approaches to communication and language barriers may also be
particularly implicated in refugees’ access to services as English language proficiency is not a
determinant of humanitarian programme selection (Lamb & Smith 2002). Thus the use of
interpreters has been viewed as means to overcome language barriers in the service provision
to refugees (Hatton & Webb 1993) but the use of interpreters is thought to comprise its own
set of difficulties such as misdiagnosis and confidentiality issues (Davidson et al. 2004).

Distrust of government services and health providers may occur for some refugees and
particularly for those who have suffered previously at the hands of governments and those
working within government services (Sharpe 1996). As well as affecting access, distrust of
health providers may contribute to non-attendance or non-disclosure (Kang et al. 1998).
Disclosure of sensitive information may also be affected by stigma surrounding illness in
many cultures (McKelvey et al. 2002). For instance, Lainof and Elsea (2004) assert that
acknowledging mental illness amongst Sudanese is not culturally acceptable.

Thus it seems that an array of pre and post-migration experiences including health service
access and equity barriers for refugees may affect emotional wellbeing. However the question
of priorities in terms of need remains contentious. Some emphasise the need to deal with
trauma related issues whilst others stress the need to address the resettlement and adjustment
factors related to the social context.

2.3 Health research on Sudanese refugees
International health research on Sudanese refugees has focused on infectious diseases
(Tompkins et al. 2006, Berman 2005, Holt et al. 2003), trauma and mental health (Simich et
al. 2006, Neuner et al. 2004, Lustig et al. 2004), or refugee camp experiences (Kim et al.
2007, Orach 1999). Less prevalent are studies of health service provision responses in third
countries of resettlement. Two Australian studies have been cited earlier and are studies of the
mental health of Sudanese refugees; one of which relied on a number of translated
questionnaire instruments to identify levels of pre-migration trauma and post-migration
difficulties (Schweitzer et al. 2006) whilst the other presented a qualitative narrative account
of the resilience and coping mechanisms used by Sudanese refugees (Schweitzer et al. 2007).

The literature points to groups within the Sudanese community that may have unique needs.
Refugee children and adolescents have been considered to be a particularly marginalised
group who experience considerable access and equity issues and subsequently may be at risk
of sub-optimal health (Davidson et al. 2004). Considering that 62% of Sudanese refugees
settling in Australia from 2001-2006 were 24 years old or younger, with many under the age of 18, the health and adjustment of Sudanese refugee children and adolescents is likely to be an issue of concern (DIAC 2007a). Many unaccompanied Sudanese refugee youth, often referred to as the ‘Lost Boys’ due to the fact that they were separated from their families during childhood as a result of civil war, were forced to flee and encounter a number of traumatic events in the absence of their parents and thus are thought to be particularly susceptible to psychological distress and adjustment difficulties (Bates et al. 2005).

Tempany (2009) conducted a literature review of mental health research with Sudanese refugees internationally. She found that differences in research findings reflected the methodologies employed. For instance, she notes that quantitative studies highlight high rates of western defined psycho-pathology amongst Sudanese refugees. On the other hand she found that mixed-methods and qualitative research with Sudanese refugees stress the resilience of Sudanese refugees, who were found to report “more concern with current stressors such as family problems than with past trauma” (pg 300). Furthermore Tempany (2000) concluded that there are few studies available regarding appropriate interventions and service responses.

In terms of health services research in Australia, two studies have addressed the issues of health service access amongst refugees from the Horn of Africa (Neale et al. 2007) and newly arrived sub-Saharan refugees (Sheikh-Mohammed et al. 2006). Sudanese refugees were part of the composite categories used in both studies, however only 6 of the 126 participants in Neale et al.’s (2007) study were Sudanese. In Sheikh-Mohammed et al.’s (2006) study involving parents from 34 families, Sudanese refugees were one of the main groups represented in the sample.

Utilising a quantitative descriptive approach Neale et al. (2007) found that GPs were important in delivering primary health care to refugees from the Horn of Africa but also that communication issues including, the lack of interpreter availability, were the main barriers to access. However Neale et al. (2007) also found that 17% of participants in their study had not seen a GP since their arrival, 68% of whom had been in Australia for less than six months. The fact that such a proportion of newly arrived refugees had not utilised a GP is problematic in terms of the ability to access health services and also because non-access negates the ability of primary health care providers to undertake initial comprehensive health assessments. Neale et al. (2007) suggest that such non-access of GPs by newly arrived refugees may represent a
failure on the behalf of humanitarian resettlement providers to provide an initial orientation to the Australian health system and local primary health care providers. These early experiences of the health system or absence of are likely to impact negatively on ongoing utilisation. For instance, Neale et al. (2007) also found that 26% of the refugees in their sample had reported having a health problem/issue but had not sought advice about the health problem suggesting that help-seeking behaviour may be influenced by access barriers and not having a regular doctor.

In their exploration of the health care access barriers for sub-Saharan refugees in Australia, Sheik-Mohammed et al. (2006) used a descriptive epidemiological approach. Like Neale et al. (2007), Sheik-Mohammed et al. (2006) found that GPs were the most utilised type of health service. Despite high levels of satisfaction with Australian health care services Sheik-Mohammed et al. (2006) likewise found that language barriers and an uncertainty about where to seek help were major health care access barriers for the sub-Saharan refugees in their sample. Additional major access barriers that were identified by Sheik-Mohammed et al (2006) included financial difficulties, lack of health information, and a sub-optimal understanding of how to access health services, which points to the importance of a comprehensive orientation to the Australian health system soon after arrival.

The Australian and international literature does not go far in answering the question of the needs of resettling Sudanese refugees. It is particularly limited in providing guidance as to how such needs can be addressed appropriately by health systems.

2.4 Health service responses to resettling refugees
The question of how health services and the health system at large responds to the needs of those that may be most marginalised in society is central to an understanding of the plight of Sudanese refugees. A strong health equity argument can be made as to why the health system should respond to the particular needs of resettling refugees and other minority groups. Health has long been recognized as a human right. This is evident in the first WHO constitution, which stated that:

“The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition” (WHO 1946 pg 2).
The concept that “every human being”, including refugees, should be able to reach their full health potential regardless of their social circumstances is central to current ideas about health equity (Whitehead & Dahlgren 2006). The health system is one of the institutions in society that can contribute to people reaching their full health potential. It thus follows that the activities of the health system should be accessible and appropriate for all members of society including refugees. Thus Whitehead and Dahlgren (2006) consider equity in health care as being about:

“…fair arrangements that allow equal geographic, economic, and cultural access to available services for all in equal need of care” (pg 11).

The ultimate goal of equity in health care according to Whitehead and Dahlgren (2006) is that services are matched to the level of need within the populations they serve. But how well matched are current health service and system responses to the needs of resettling refugee groups, such as the Sudanese in Australia?

This is a particularly poignant question given that Sudanese refugees represent a ‘new and emerging community’ in Australia (DIAC 2007a) and thus information regarding the needs of Sudanese refugees may be limited. The question of health service delivery responses to refugees can be addressed both from a macro or ‘whole-of-health–system’ perspective and also at the micro-level of individual health services and health service providers. Whilst they may be presented as two distinct entities the macro-level of health system structures and policy and the micro-level of health service delivery at the individual health service and provider level are not mutually exclusive but are interconnected and consequently affect each other.

2.4.1 Macro-level

Whilst studies concerned with the micro-level of health service provision to refugees tend to predominate, there is some work illustrating broader health service and system thinking in relation to refugees.

In general, debate around the provision of health services to migrants and refugees has often centred upon two discourses; that of mainstreaming and ethnospecificity. Ethnospecific services or programmes are usually aimed at meeting the needs of individuals from a particular cultural/migrant group whereas mainstream services do not specifically tailor
services to the needs of migrants or refugees. However, as Kelaher and Manderson (2000) indicate, service delivery models for migrants and refugees have historically been influenced by government policy and perceptions of immigration in wider society (Kelaher & Manderson 2000). Prior to the 1970s and in line with the policy of assimilation (Jupp 2007) there were few ethno-specific services and, as such, service provision to migrants was firmly rooted in the mainstream sphere (Kelaher & Manderson 2000). Partly influenced by greater diversity in the migration programme, the 1980s heralded another shift in policy to that of multiculturalism, in which differences were embraced (Kelaher & Manderson 2000). The policy of multiculturalism, which still exists, resulted in a greater emphasis on the health of migrants and refugees and service delivery to them. Thus ethnospecific workers, and ethnospecific stand-alone programmes and services, became a typical response to meeting the needs of immigrants and refugees in this period, somewhat displacing the mainstream paradigm (Kelaher & Manderson 2000). However some would argue that the culmination of vocal minorities and the construction of migration as a social and economic burden (Kelaher and Manderson 2000) in addition to the rhetoric of ‘Australian values’ and Australia’s policy of mandatory detention has subsequently weakened the discourse of multiculturalism and actually represents a shift away from it (Jupp 2007). This shift, in some ways, parallels the Australian Government’s policies towards health service delivery to Indigenous Australians, which has increasingly been towards mainstreaming (Anderson 2004).

The current shift away from multiculturalism has been coupled with a change in theoretical thinking, suggesting that culture has been overemphasised in the health of migrants and refugees at the expense of other social determinants of health (Ahmad 1996). This has been driven by the realisation that an emphasis on culture or cultural stereotypes, as have been equated under a cultural sensitivity orientation, tends to result in culture being blamed for health disparities (Ahmad 1996). Furthermore, this theoretical shift has also been driven by an acknowledgement that intra-cultural differences may be greater than inter-cultural differences (Kelaher & Manderson 2000), thus casting doubt on the efficacy of existing mainstream and ethnospecific health service delivery models. Kelaher and Manderson (2000) suggest that both models may be inadequate in the delivery of services to migrants and refugees arguing that:

“…while mainstream services typically do not recognise differences between populations, ethno-specific services often fail to acknowledge differences within populations” (pg 2).
Thus Kelaher and Manderson (2000) argue that appropriate service delivery to migrants and refugees is that which matches interventions and programmes to population characteristics. In other words, Kelaher and Manderson (2000) advocate for services that acknowledge both the heterogeneity of need between and within groups of migrants and refugees. For example, they suggest that there may be differences between the needs of migrants who are highly educated and proficient in English and thus may be confident to access and be satisfied with mainstream services, whilst others who are more isolated and marginalised may benefit from an ethnospecific service delivery model.

The diversity of needs that refugees may have and the ability of the health services and the health system as a whole to cater to these needs is not only affected by the service delivery orientation, whether mainstream or ethnospecific. It is also influenced by the assumptions made regarding the needs of refugees and, subsequently, the way in which the health system is structured around these assumptions. Narrowly defined and medically influenced notions of care in the health system that distinguish between health care and social care may not be conducive to meeting the entirety of refugees’ needs, which may include social, economic, as well as health issues (Watters 2001). Watters (2001) suggests that a medicalised approach involving the treatment of Post-Traumatic Stress Disorder, for example, may be unhelpful and inappropriate when immediate concerns such as food, shelter, and safety may remain unaddressed. However, the highly structured nature of western health care systems, which tends to compartmentalise specific health areas/issues, and result in strict service mandates (Lawrence & Kearns 2005), may act against the responsiveness of services to address the needs of refugees (Watters 2001). Due to their potentially unique needs, refugees may not fit “neatly into pre-defined categories” as created in western health care systems and thus refugees may be:

“…shunted from one social services team to another, without anyone accepting responsibility for assessing or providing services to individuals” (Henderson 1999, pg 61).

The tendency of western health care systems to categorise is also reflected in the distinction between mental health and physical health services, based upon a Cartesian mind-body dualism (Watters 2001). This mind-body dualism asserts that health problems can either be categorised as related to the body or the mind despite that in many cultures the mind and body are viewed as intertwined rather than existing as distinct entities. However Watters (2001) describes that in some cultures, physical health issues may be attributed to social, personal,
and interpersonal distress, and thus a biomedical response that only addresses the physical 
health problem may only be treating the symptom rather than the underlying causes. 
Therefore Watters (2001) suggests that a holistic approach to health service delivery that 
refrains from imposing its own biomedical taxonomies and distinctions but rather is flexible 
ought enough to meet the array of needs as articulated by refugees may be a more appropriate model 
of service delivery to refugees. This may involve an expanded definition of health care to 
incorporate social, mental and physical health care.

Feldman’s (2006) tripartite framework for primary health care to refugees acknowledges the 
need for three types of necessary primary health care services with different yet 
complementary objectives: gateway services that aim to facilitate access, core services that 
provide comprehensive primary care and ancillary services that aim to provide essential 
support in order to meet any additional health needs. Such a framework moves beyond a 
constricted notion of care to a more integrated systems approach recognizing the integral 
role played by resettlement and welfare services that have the potential to facilitate access and 
meet resettlement needs and also by specialist mental health services such as those for 
 survivors of torture and trauma.

Integration

Acknowledgment of the link between socio-cultural determinants and psychological and 
physical wellbeing has resulted in health service delivery models that aim to address the 
 entirety and complexity of factors impinging upon an individual’s health. No more so is this 
relevant than to the health and wellbeing of refugees. The philosophy of holism, which is 
closely allied to the person-centred approach, is increasingly being used at a whole of health 
service and individual health provider level. It refers to a conceptualisation of care that takes 
into account and seeks to address all of an individual’s needs including the physical, 
psychological, and social (Strandberg et al. 2007). Several examples of health service delivery 
models based upon a holistic care philosophy highlight the opportunities for the application of 
such service delivery models in the realm of refugee health service provision. The idea of 
integrated care and integrated services has been used in many human service delivery settings 
and has been advocated as potentially improving access, quality of care, patient and provider 
satisfaction and cost-effectiveness (Leichsenring 2004). Integrated care is a means of 
delivering health and social care services by coordinating the efforts of services that otherwise 
act as single units (Leichsenring 2004). Broadly speaking, there are two types of integration 
that are often referred to as horizontal and vertical integration. Horizontal integration aims to
link parts within a single level of care or care context such as in the creation of multi-disciplinary professional teams (Leichsenring 2004). In contrast vertical integration attempts to coordinate the responses of different levels of care (i.e. primary, secondary and tertiary) (Leichsenring 2004). The approach of vertical integration has been applied into practice in a variety of forms in the service delivery to elderly people, for example, who may be subject to chronic illness, co-morbidity, social isolation, and may require a range of services to meet their needs (Kodner & Kyriacou 2000).

Case or care management represents one approach under the umbrella of integrated care that has been used in relation to elderly patients (Leichsenring 2004) but also with respect to mental health care, and maternity care; particularly for women considered ‘at risk’ (Curry et al. 2006). Case management involves the matching of need and demand to supply in the form of a network of services and providers via an intermediary such as a case manager (Leichsenring 2004). In relation to maternity case management of women considered ‘at risk’, for example, this may incorporate antenatal medical and psychosocial screening, ongoing contact with case managers throughout the perinatal period, referrals to partner services and providers (i.e. social workers, psychologists, counsellors, nurse educators, groups etc.) as needed, and may involve home-visiting throughout and beyond the perinatal period to facilitate transition to parenting role at home (Curry et al. 2006).

Leichsenring (2004) explains that there are many different approaches to integrated care depending on different academic, political and national perspectives but all rely on some degree of collaboration and partnership. Concordant with the literature presented here, Kodner (2003) highlights the opportunity for “clients whose complex problems cut across multiple systems and providers” (pg 93) to benefit from an integrated care model. As outlined earlier, refugees are likely to represent a group whose needs include addressing resettlement and social issues, mental health and physical health issues and thus holistic and integrated service delivery models may be appropriate and perhaps highly effective ways of delivering services to refugees.

2.4.2 Micro-level

Much of the literature on service provision to refugees has focussed on specific micro-environments within the health system. These include research or commentary focussing on the individual health provider-client interaction (Bhatia & Wallace 2007) and articles focussing upon specific types of health providers, such as GPs (Johnson et al. 2008) and
psychologists (Gorman 2001). Other research has focussed on the specific micro-environment of an individual health service (Lawrence & Kearns 2005, Fowler 1998) or a single type of health service (Zane et al. 1994).

At the micro-level of the health system, health care providers are directly involved in health service delivery and thus may have an understanding of the needs of refugees in general and Sudanese refugees in particular. However there is a body of literature which suggests that, just as refugees may face access and equity issues in utilising health services, health care providers experience an array of challenges when working with refugees. Refugees are sometimes perceived by health providers as having many and complex needs, and thus consultations with refugees are considered, by health providers, to be demanding and time-intensive (Burnett & Peel 2001). Thus due to macro and micro-level structural influences health providers may not have adequate time to respond to the needs of refugees. Further documented perceptions include communication difficulties (Mitchell et al. 1998), the need to go beyond the ‘normal’ realm of service provision (Mitchell et al. 1998, Fuller 1995), and cultural challenges stemming from different cultural understandings and explanatory models regarding health, health care and treatment (Omeri & Malcolm 2004, Lawrence and Kearns 2005). Furthermore, macro-level influences such as the highly structured nature of the western health care systems or organisational level issues such as strict service mandates or the necessity to adhere to bureaucratic processes may affect the ability of health service providers to address the challenges of health service delivery to refugees (Lawrence and Kearns 2005).

The health provider–client nexus was described as the meeting place between two cultures by Wiklund et al. (2000) but also the arena in which conflicting cultural values, traditions, and expectations may manifest. It is thought that in the same way that refugees’ past experiences, schemas and historical scripts may leave them unprepared for transcultural contact with a dominant majority group, health providers, as members of a majority group, may be similarly uncertain of appropriate ways to behave and act in such transcultural contexts (Wiklund et al. 2000). Bauman (1993) labels the unavailability of schema to inform ways of behaving for majority group members, such as health providers, a reflexive crisis. Kleinman (1980) viewed different explanatory models held by patients and health providers as influential in the difficulties of cross-cultural health provider-client interactions. Explanatory models are an individual's beliefs, experiences and understandings about the causes, consequences and the appropriate methods of treatment for a particular health issue (Kleinman 1980, Watters 2001).
However, often explanatory models differ between patients and health providers, particularly when patient and provider do not share the same cultural background. Health providers’ explanatory models may be largely influenced by the culture of bio-medicine whilst patients’ explanatory models may be influenced by their own cultural ways of knowing.

Contrasting explanatory models may be apparent in the understandings about mental health of refugees from culturally diverse backgrounds and western trained and influenced health providers. It may be that refugees do not view mental health issues, for example, in terms of a biomedical framing of sickness but rather as manifestations of adverse social, economic, personal, and interpersonal circumstances (Watters 2001). In a qualitative study, that compared ‘lay’ accounts of depression between Anglo-Australians and East African refugees in Australia, Kokanovic et al. (2008) found that many of the Anglo-Australians in their sample spoke of depression in terms of an individualised experience whereas East African refugees spoke of depression within a collective framework. However the so called objectivity and scientific basis of the production of biomedical knowledge often results in providers’ explanatory models being privileged above patients, assuming the status of ‘facts’ whilst patients’ explanatory models are relegated to the status of opinion (Watters 2001, DeSouza 2005). These kinds of asymmetrical meetings between health service providers and refugees in terms of explanatory models may result in less than optimal outcomes and may be viewed as a disincentive for further health service access (Handelman & Yeo 1996). Thus successful interactions between health providers and refugees may require an understanding of the explanatory models of individual refugee patients such that addressing the health concerns of refugees can ensue in an appropriate and meaningful way.

Cultural sensitivity has been advocated as a way for services and health providers to overcome barriers associated with cross-cultural interactions in a responsive and meaningful fashion. Terms such as cultural appropriateness and cultural competency have also been used to describe approaches services and providers can take in order to be responsive to cultural diversity. Although they are often used interchangeably, each of the terms differs slightly on the basis of whether approaches advocated involve changing providers’ behaviours, attitudes, or imparting knowledge (Wear 2003). For instance cultural sensitivity and appropriateness focus on changing attitudes, whilst cultural competency emphasises imparting knowledge (Wear 2003). The definition used in the National Health and Medical Research Council’s guidelines (2006) for cultural competency health attempts to draw all these elements together. It states that cultural competence is:
“a set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations…” (pg 7).

Methods that services and providers have undertaken to incorporate cultural sensitivity into their responses have included cultural awareness training, policies, making interpreters available and the employment of bilingual health providers or bi-cultural workers (Watters 2001). However, a persistent criticism directed at the discourse of cultural sensitivity and related concepts have been their tendency to represent culture as a static and representative entity. This often results in the reduction of the diversity of refugee experiences, beliefs and understandings to stereotypes resulting in prescribed modes of action based on assumptions that are not likely to hold for all members of a particular cultural group (Eastmond 1998). Thus as Watters (2001) suggests, components of service delivery aimed at improving cultural sensitivity may instead entrench dominant paradigms and moreover may even be counterproductive. For example Watters (2001) explains that bi-cultural workers can become agents used by services as mechanisms to translate or fit clients’ understandings into the dominant medical paradigm. This is consistent with Watters (2001) observation that:

“The voice of the refugees is only heard within predefined and compartmentalised contexts that conform to and reinforce institutional structures within the health and social care field” (pg 1710).

Given this, there is a need for research to better understand the needs of resettling refugees and how the “health and social care field” as a whole can best address these needs. In order to do this there is a need to explore the perspectives of a diverse array of stakeholders including refugees and people working within the “health and social care field”, including health service providers, managers and policy makers.

2.5 Conclusion
This review of the literature highlights three important gaps, which have influenced the aims of this study. It established the potential array of factors that affect the wellbeing of resettling refugees. However, the review illustrated that the degree to which such factors constitute priorities in terms of need is contentious. Secondly it found that there is little research on appropriate service provision responses to Sudanese refugees in third countries of resettlement. Finally it identified a need for broader health system level focussed research to
complement that of research focussed on micro-environments within the health system. Such research would assist decision makers in strengthening health systems development in relation resettling refugees. With these gaps in mind, this thesis seeks to understand the need-service provision gap in relation to resettling refugees from a broad health system perspective.
Chapter 3
Methods

3.1 Introduction
This chapter describes the methods that will be used in this thesis to explore perceptions about the mental health needs of Sudanese refugees and the ensuing health service provision responses. The theoretical framework that underpins the qualitative research design is discussed from the outset. This is followed by a detailed discussion of the methods employed including explanations of ethical considerations, the sampling strategies used, the participants, data collection, and data analysis. The chapter concludes with discussions on rigour, trustworthiness and reflexivity as they apply in the context of this research.

3.2 Theoretical framework
The research objectives, questions posed, and design all influence the theoretical paradigm employed in research and vice versa.

A qualitative methodology was considered appropriate to capture the complexity and diversity of understandings that are likely to exist around the question of the needs of Sudanese refugees and how needs can best be met. Qualitative methods are particularly suitable when little is known about a topic, making it suitable in the context of this research given its exploratory nature. Furthermore, a qualitative methodology was also considered desirable in that it allowed the space for these understandings to emerge iteratively. Specifically, this research may be considered a piece of applied qualitative research in the sense that the findings derived from the study may have the potential to inform action, policy and practice, as well as theory, in the realm of refugee health service provision (Ritchie & Spencer 1994).

The focus of this research on understandings, opinions and perceptions of needs and how these can best be addressed has influenced the theoretical underpinning of this research. The positivist and post-positivist paradigms assume a reality or a truth (or in this case about needs and solutions) that is independent of human perception. This assumption is untenable in the context of research dealing with needs and service provision responses. It leads to a view that there are undisputable needs and appropriate service provision responses (that would hold
true for all people who identify as Sudanese refugees in Australia) that can be uncovered regardless of individual experience. However, as has been established in Chapter One, what constitutes needs depends upon who is defining them.

Thus, the perspective taken here is that there are a diversity of understandings of needs and appropriate service provision responses that constitute multiple legitimate realities and truths based upon people’s constructions of those realities. This is consistent with the constructivist paradigm (Guba & Lincoln 1994), which has partly informed the approach taken in this study. For instance the study was not interested in uncovering whether this or that need is ‘actually’ a need (i.e. by quantifying a need) but to explore what meaning is attributed to that need and what experiences inform people’s understanding of needs and appropriate service provision responses. Thus all key informants’ perspectives, whether concordant with others or not, were considered important in the sense that each represented constructions of reality that could help in developing a nuanced picture of the mental health needs and service provision responses in relation to refugees. The use of and valuing of multiple stakeholders perspectives in identifying and interpreting needs is advocated by Lee et al. (2007). But the theoretical framework was not only informed by the research questions and research objectives but also by ethical considerations around conducting research with refugees, which will be elaborated upon in the next section of this chapter.

3.3 Ethical considerations

The research topic necessitated an understanding of the considerations involved in conducting research with refugees and refugee communities, as well as with health service providers and policy makers. To facilitate this understanding, the researcher attended an Ethics of Refugee Research Workshop early in the research process as well as consulting community members and the literature. The knowledge developed about the ethics of research with refugees not only informed the practical aspects of undertaking the research, the research methods, but also the research design.

Jacobsen and Landau (2003) suggest that social researchers have a dual imperative in conducting research; firstly to maintaining a professional commitment to the craft of research by ensuring standards of methodological soundness, and secondly to possessing an ethical commitment to improving the plight of those with whom we conduct our research. Few researchers would take issue with such suggestions. However, arguments about the means of satisfying this dual imperative are more contentious. Jacobsen and Landau (2003) believe that
in relation to refugee research, this dual imperative can only be met if researchers preserve the objectivity of a ‘true scientist’, urging researchers to aim to produce large scale quantitative studies with ‘representative’ samples rather than the small-scale qualitative studies that they view as dominating the field of research with refugees. Rodgers (2004), in contrast, is critical of approaches that attempt to treat the social world as a laboratory that can be studied objectively. He believes that through the critical distance between researcher and the researched they foster the power differentials that are inherent in ‘us’ and ‘them’ dichotomies, ultimately de-humanising refugees and downplaying the role of the social and political contexts in which refugees live. Furthermore, Rodgers (2004) re-asserts the benefits of small-scale qualitative studies, in which data are generated through in-depth interpersonal interactions with refugees, suggesting that such studies allow for the voices of refugees to emerge in all their complexity and diversity “without claiming to definitively represent them” (pg 41).

Such was the ethical and methodological appeal of a small-scale qualitative design in the context of this research project, which includes refugees as key informants. However, where Rodgers (2004) constricts his argument to refugees (and justifiably so), the benefits of the qualitative paradigm that he describes can also apply to other participants more widely. In the case of this research project the ability to encourage the voices of health service key informants, as well as those that identify with the experience of forced migration, in all their complexity and diversity, is desirable both from an ethical standpoint and in terms of developing nuanced understandings of issues around health service provision to refugees.

In addition to the ethical issues associated with particular methodological designs the literature on the ethics of research with refugees stresses the potential vulnerability of refugees and their decreased potential to offer informed consent (Mackenzie et al. 2007). Care was thus taken to offer adequate explanations of the project, a realistic summary of the potential benefits of the research, and the space for questions and comments about the project. This care was exercised by the researcher in obtaining the informed consent of all key informants regardless of whether they had undergone the experience of forced migration or not.

As part of the procedure of gaining informed consent, written and oral explanations of the purpose of the study, the expected applications of the research findings, and the nature of the participant’s involvement were given. The written explanation took the form of an
Information Sheet (see Appendix A) and was distributed to participants prior to seeking written consent. Potential key informants were also given the opportunity to ask questions or discuss the research project over the phone and in person prior to interviews taking place. The right to withdraw from the research project and/or refuse to answer any questions was made clear to key informants during the informed consent process. Furthermore, permission to use a tape recorder during the interview and permission to be recontacted if necessary was also sought by the researcher.

Given that many refugees have experienced terrible things as a consequence of forced migration a very sensitive approach was required. The possibility that key informants might re-experience negative events during interviews was taken seriously. This research project was not specifically interested in eliciting traumatic individual experiences but rather was concerned with the perceptions of needs and service provision responses. Questions asked during interviews reflected this interest and thus attempted to safeguard against any re-experiencing of negative experiences. However where key informants voluntarily talked about negative pre-migration experiences, for example, the researcher did not reprimand nor deny key informants the opportunity to do so. In addition to the element of paternalism inherent in denying people the opportunity to talk about such experiences, the interpretation here was that if they did discuss negative experiences, people must have felt it important to do so. Thus, although the researcher tried to avoid discussing potentially negative experiences he also avoided denying people the opportunity to talk about them if key informants voluntarily began to discuss such experiences.

The issue of confidentiality was of particular importance in the conduct of this research. Due to the fact that the ‘refugee health sector’ in South Australia is relatively small, identification of key informants or significant cases that they might have described was a salient problem. Similarly, due to the fact that some of the key informants were prominent members of the Sudanese community in South Australia, this also made them potentially easily to identify. Of particular concern were those key informants who were both members of the Sudanese community and health workers, as the pool of Sudanese health workers in South Australia is quite small, again making identification potentially easy. Several steps were taken to prevent the possibility of key informants being identified including de-identifying transcripts including any references to names or information about other people. Due to the potential for breaching confidentiality, care has been taken when describing key informants or where illustrative quotes are used in this thesis. For instance, where illustrative quotes are used,
Sudanese key informants are referred to as ‘Sudanese man’ or ‘Sudanese woman’. The author recognises that such descriptors do not adequately describe identity and associated roles. The occupations of such key informants are notably missing from descriptors. However, given the size of the Sudanese community this was thought to be a necessary measure in preserving anonymity and confidentiality.

3.3.1 Ethical clearance
The University of Adelaide Human Research Ethics Committee approved the study on 1 November 2007 for the period of one year. It was given the approval number H-136-2007 (see Appendix B) and was subsequently renewed on November 1 2008 for the following year.

3.3.2 Consultative process
A persistent and vital feature of the continual development of this research has been the consultative process. This process has had a dual purpose: injecting health provider and community described need to help inform the research focus; and also to inform the ethical considerations of this research. In order to inform the objectives of the research and ethical issues, consultations with Sudanese and refugee community leaders and health workers, health care providers who work in the area of refugee health, and researchers who have previously carried out research in this area were undertaken from the outset.

Whilst the research questions were not changed by consultations, the process did reinforce the need and appropriateness of focussing on health system responses to Sudanese refugees. Likewise it reinforced the appropriateness of the aims of the research. Consultations also shaped the research design. For instance, consulted individuals stressed the need to ensure that a diversity of perspectives be sought in order to get a broad understanding. This was considered to be more valuable in terms of policy and practice relevance than say a piece of research focussed on the responses of only one health service. This influenced the sampling process such that key informants from a number of services, organizations, and community avenues were invited to participate.

Mechanisms for further participation were built into the research design, including asking key informants whether they would agree to be recontacted to discuss interpretations on the data or simply to discuss how the research process was proceeding.
3.4 Sampling
Key informants were identified and invited to participate using purposive sampling techniques. Purposive sampling involves the selection of a sample which may best facilitate understanding of the questions under investigation (Marshall 1996b). Utilising purposive sampling, which by definition is a non-probability sampling technique, participants or key informants are consciously selected on the basis of their capacity to contribute to an understanding of the area of interest (Higginbottom 2004, Marshall 1996a). As Higginbottom (2004) explains, purposive sampling is a particularly appropriate and pragmatic means of generating information-rich data in circumstances where it is not feasible to conduct in-depth interviews with every member of a particular group of interest, which was the case for this research project. As the research was interested in uncovering understandings, as well as experiences, purposive sampling allowed a great degree of flexibility in terms of following up on emergent themes. It was particularly helpful in ascertaining a diversity of perspectives, which is considered important in facilitating a broad understanding of particular issues (Lee et al. 2007, Billings & Cowley 1995).

From the outset it was thought that purposive sampling might ensue primarily through the use of ‘gatekeepers’. In the context of this research, potential gatekeepers were defined as prominent people within health services that refugees might access, such as health service managers. These people were envisaged to distribute letters of invitation to key individuals working in the individual health services where they worked. However this proved to be a largely unfruitful pathway to identify and inviting key informants to participate, with only six of the 20 resultant participants being sampled through gatekeepers. With the exception of one health service manager who acted as a gatekeeper for participants from a particular health service, other health service managers were found to be extremely busy and sometimes unhelpful. Four possible gatekeepers were identified at four services that were considered as having experience in providing services for refugees. These possible gatekeepers were contacted and their help in recruitment was requested but only one, after a period of time, agreed to help with the request. In the case of the gatekeeper that agreed to aid in recruitment, six letters of invitation and information sheets were passed on to him, and he then distributed them to people in the health service where he worked who he thought matched the selection criteria that the researcher described to him at a meeting prior to the distribution. The gatekeeper asked each person to whom he distributed information sheets if they would give him permission to pass on their contact details to the researcher and for those that agreed, their work contact details were passed on to the researcher. If each of the potential key
informants did not contact the researcher within three days, the researcher then contacted them and asked them about their thoughts on participating. If they agreed then a convenient time and place was organised for the interview to take place.

The necessary process of attempting to share the research project idea and request the help of key individuals at relevant services was time consuming and involved numerous meetings, attendance at staff meetings, phone calls and emails, and the sending out of research proposals for little result. This cannot be attributed to a lack of interest and in fact in some cases, it was quite the opposite, with potential gatekeepers wanting to influence the design and research questions of the research project to a point that was considered undesirable. That is, to a point whereby suggestions, if acted upon, would have taken the research in directions that contradicted the general thrust of what emerged from the consultative process begun early on in the project. Some potential gatekeepers had remarked that they had been requested to help in the sampling for other refugee health related research projects and so this request may have been yet another for them to deal with, indicating that there may have been an element of ‘gatekeeper fatigue’. In the instance of one service where sampling of any key informants through a gatekeeper or otherwise did not eventuate, the fact that the research was interested in a systems perspective and not only individual providers was a source of unease. The involvement of individuals from a number of different services with some link to refugee health in Adelaide’s small and sometimes political ‘refugee health sector’ was perceived by some as threatening. This was because some people suspected a potential for perspectives that would potentially indict their service.

The initial experience of using gatekeepers to recruit key informants in the only health service that agreed to recruitment from their service to proceed in this way was generally positive. However, there was at least one interview where the participant, whilst helpful, may not necessarily have been the best key informant in terms of providing information on the research questions that the study set out to answer. Such early experiences of recruitment via gatekeepers alerted the researcher to the potential danger of recruiting too many participants without properly screening for their ability to enlighten the topic of interest as a consequence of ‘handballing’ the responsibility for recruitment to other people. The relatively unsuccessful attempt to recruit participants through gatekeepers at health services highlighted the need to explore and use other possible purposive sampling techniques.

Snowball sampling proved to be a successful purposive sampling strategy for this research
During the development of the research design snowball sampling, whereby key informants recommend further potential key informants (Marshall 1996b), was envisaged as a useful strategy to supplement the recruitment of key informants through gatekeepers. However, in practice snowball sampling accounted for the majority of key informants. Out of 15 potential key informants who were recommended by others, 14 agreed to participate (i.e. 14 of the 20 key informants). After each interview had ended the key informant was asked whether they knew of anyone that might have some insights that would be valuable in terms of the research project. Alternatively, sometimes during the course of an interview a key informant would say something like “you should talk to…. they can tell you more about this than me”, in which case the researcher would prompt key informants about this further at the end of the interview. If key informants could identify someone that might be interested in participating in the research project, they were then asked to contact that person and pass the researcher’s details on so that the nominee could contact the researcher directly.

Furthermore, interviewed key informants were asked to ascertain, upon contacting the recommended key informant, whether the recommended key informant would give their permission for their contact details to be divulged to the researcher where details were not otherwise publicly available. There were very few instances where recommended key informants contacted the researcher directly, which meant that the latter scenario predominated. That is to say, if permission was granted, potential key informants were contacted directly by telephone or by email. During this initial contact the researcher provided some information about the project and asked the potential key informant if they would be happy to receive an official letter of invitation and an Information Sheet, which provided more detail about the project and the interview process. The letter of invitation and Information Sheet used as part of the recruitment process is attached in Appendix C. If potential key informants agreed to receive a letter of invitation and Information Sheet these were either sent by mail or email depending on the potential key informant’s preference. The researcher then waited to hear from the potential key informants and if key informants did not contact the researcher within a period of a week, the researcher then re-contacted them. This was done in order to ascertain whether they had any questions about the project and whether they would like to participate in the project. If participants agreed to participate then a time and location for the interview that was convenient for key informants was organised. Snowball sampling allowed for the recruitment of participants in mainstream health services, as well as refugee specific health services, but was also extremely useful in contacting key informants.
informants from the Sudanese community who did not work inside the health system.

3.5 Participants
A diverse sample of key informants participated in this research. The following sections will detail a number of important issues related to key informants.

3.5.1 Selection criteria
Selection criteria for participation in in-depth interviews included that all participants be over eighteen years of age, be able to communicate in English, and due to familiarity with issues around refugee health, and/or the Sudanese community, be able to shed light on the topic of interest.

The criterion that participants are able to speak in English was employed pragmatically to negate the need for interpreters, for which there were no funds. Essentially this precluded the possibility of members of the Sudanese community who did not speak English well from participating in the research, and thus their views are not necessarily ‘representative’ of other members of the community. In fact key informants who identified as being Sudanese had high levels of education, all of which included tertiary education, and most had jobs in the fields in which they were trained. All were respected members of the Sudanese community in South Australia, holding positions of leadership within the community. However the aim of sampling in qualitative research in most cases is not to ascertain a representative sample but to ensure a richness of viewpoints sufficient to answer the research question posed by the study (Miles & Huberman 1994). Thus it is important to understand who participants were and what experiences might inform their perspectives. Such understandings enable readers to critically interpret data and make judgements about the applicability of the research findings to contexts other than that in which the data and findings were generated. Thus the fact that key informants who identified as being Sudanese may not have been ‘representative’ of other members of the Sudanese communities in Australia was not considered problematic. The suggestion that such key informants may not have been ‘representative’ of other members of Sudanese communities in Australia, does not discount their ability to comment on or hold an informative and valuable viewpoint about the experiences of other members of Sudanese communities. The use of ‘refugee representatives’ in other research with refugee communities affirms this point (Lawrence & Kearns 2005, Van der Oest et al. 2005). The researcher’s experience of data collection confirmed that such key informants were able to comment not only on their own individual experiences, but due to their proximity to the community, on those of other members of the community. It was in this ability to reflect on both individual
and community experiences that the ‘voice’ of Sudanese refugees was heard loudly and articulately through the voices of Sudanese key informants. This is pivotal because hearing the voices of refugees is an important ethical imperative in research with refugees (Mackenzie et al. 2007). It is also important in the sense that it potentially enhances the applicability of the research findings in other contexts.

The final selection criterion, that key informants be able to shed light on the research questions, was also important but, in some cases, difficult to ascertain prospectively. This criterion was applied primarily to ensure that the data generated were rich and would enable answering of the research questions. It was also a preventative measure to ensure that the time of the potential participant and the researcher were not wasted. Due to the predominant use of snowball sampling, key informants themselves were useful in establishing the potential suitability of participants that they had recommended. For example, often when an interview had ended and participants were asked if they knew of any other people they might recommend to be interviewed, frequently their recommendations were accompanied by a description of the role of the nominee, where they worked and in what particular areas they might have some in-depth understandings. Thus decisions about whether to seek the participation of a recommended potential participant would then proceed partly on the basis of information gleaned from such conversations and also depending upon the ideas that were being generated in the interviews. For example, in order to gain a diverse range of perspectives on ideas generated in the interviews it was necessary to select key informants from a diverse range of services and who carried out a range of roles and so sometimes this dictated whether a potential participant was invited to serve as a key informant. It was much more difficult to determine whether participants who had been sampled through the use of gatekeepers satisfied selection criterion as a result of a degree of distance between the researcher and the participant. As mentioned earlier, there was one case early on in the data collection process where a key informant was sampled through the gatekeeper route who turned out to be not necessarily the best key informant in terms of the research questions that were being posed. It was through this early experience that the need to maintain a greater involvement in the sampling process was recognised.

3.5.2 Refusals to participate

As the issues associated with gatekeeper sampling have already been discussed, the reflection here is concerned with refusals to participate related to snowball sampling.
Only one potential key informant who was recommended by another interviewed key informant and was subsequently contacted by the researcher refused to participate directly. His refusal to participate was not so much a disagreement with the objectives of the research project itself but was more to do with him being busy and not having enough time to conduct an interview. The man was Sudanese and was involved in a number of health service and community activities. Perhaps a further explanation that relates to this case and one that had not been considered until brought up in some interviews was the concept of community ‘burn out’. This was the idea that community pressure was placed upon members of the Sudanese community who were considered to have been or be on the way to being successful (however defined) to help others in the community, take on leadership roles within the community, speak at functions and events, and to interact with services and mainstream society on behalf of the community. Such pressure was constructed as leaving ‘successful’ members of the Sudanese community in the precarious situation of needing to try to strike a balance between helping in the community and pursuing one’s own dreams and aspirations. One might speculate that the man who was unable to participate in the research project may have also found himself in this situation and that the research project may have represented one too many engagements amidst an already busy schedule of helping out in the community.

At least two potential key informants refused to participate indirectly. In other words, they were contacted but subsequent attempts to recontact them via email or telephone were unsuccessful. One of these potential key informants was a health service manager and the other was a psychologist who worked in at least two health service settings, both of whom expressed a willingness to participate when initially contacted. Thus one might speculate that the demands of their busy lives were too great to consider taking on yet another task.

3.5.3 Description of key informants
A diverse sample of a total of 20 key informants participated in the in-depth interviews. Fourteen of the key informants were women and six were men. Many participants had multiple roles and responsibilities from which they could share experiences.

Of the 20 key informants six were born in Sudan and five arrived in Australia as refugees within the last 20 years (the other Sudanese key informant arrived in Australia within five to 10 years but not as a refugee). Most Sudanese key informants had been in Australia between five and 10 years with none having been in Australia for less than five years. The Sudanese key informants identified with various ethnic identities such as Dinka or Nuer but all
identified themselves with the broader level of identification as South Sudanese. As has been noted in Chapter One, the majority of the Sudanese in Australia are South Sudanese. All of the Sudanese key informants worked in the health and resettlement system, with the exception of one, who worked in education. Specifically Sudanese key informants were medical practitioners, social workers, and bi-cultural community health workers, some of whom worked in mainstream health services and others in services with a greater degree of refugee specificity. Some of the Sudanese key informants were prominent members in Sudanese community associations and/or other community organisations. Others were not formally involved in any such community representative bodies but were considered to be role models or to possess wisdom and life experiences making them elders or community leaders.

According to Sudanese key informants who participated in the research project the distinction between community leader and elder is one based upon age and experience. Whilst all elders are considered community leaders not all community leaders are considered elders. Furthermore the term ‘elder’ entails/describes a specific role within the Sudanese community including mediating in any family disputes, providing counsel and comfort to the bereaved, giving advice and advocating on behalf of the Sudanese community.

As mentioned earlier key informants laid claim to multiple roles and responsibilities from which they enlightened the topic of interest. Primary health care providers (n=5) including GPs and nurses and mental health care providers (n=6) including psychiatrists, mental health nurses, and mental health social workers made up a significant proportion of key informants. However, the distinction between primary health care providers and mental health care providers was not so clear cut. Some of the interviewed GPs, for example, were also trained in mental health care and had a significant interest and experience in providing mental health care within primary health care settings. Two key informants worked as social workers in a resettlement service context. Four key informants had management positions within their health service, or organisation. Two key informants were actively involved in refugee health policy making at a Government level.

The health service environments key informants worked in are also likely to inform, or partly inform, perspectives. Five key informants worked in community primary health care services and five worked in community mental health services whilst two worked in hospital or secondary mental health settings. Three had direct experience of private general practice settings either through the provision of clinical care or being involved in the administration
and management of General Practice. Other key informants were from Government departments, other hospital settings, and refugee resettlement services. Again, some key informants had experience of working in a number of types of health services throughout their employment history, and at the time of the interviews some key informants worked at more than one health service.

Another influential element of the health service environments key informants are exposed to is the degree to which their service caters specifically to the needs of refugees. This degree of refugee specificity is likely to affect their perspectives on the mental health needs and service provision responses to refugees. An almost even balance was evident between those that worked in refugee specific and mainstream services, with slightly more key informants working in health services refugee specific services.

3.5.4 Distinguishing between multiple voices
Due to the fact that key informants often had several platforms from which they could enlighten the topic of interest, it was necessary to ascertain exactly what role or experience was shaping their perspectives during interviews. A few strategies were employed to ascertain this. Usually at the beginning of each interview key informants were invited to introduce themselves and elaborate upon the roles that were likely to inform their accounts. This provided the opportunity for key informants to self-nominate the role from which they would like to speak or to allow for multiple roles to come through the interview. Rather than speaking from a single role, often during the course of interviews key informants would phase in and out of speaking from particular roles. Most of the time key informants themselves explicitly stated from what role they were speaking. For example key informants said things like “What I’ve gleaned from working at…”, “In my role as… I’ve noticed…”, which provided clarification as to the role from which a participant was speaking. Where this was still unclear the researcher would specifically prompt for clarification. Another technique employed in certain circumstances was to ask questions in such a way that directed the key informant to respond through the lens of a particular role that they had experienced.

For the most part the fact that key informants had multiple angles from which they could enlighten the research questions was not a hindrance but on the contrary contributed to the diversity within and the richness of the data.
3.6 Data collection
A total of 25 interviews were conducted with the 20 key informants between February 2008 and February 2009. In line with qualitative data collection techniques the number of interviews conducted was dependent upon the point at which saturation had been reached, or in other words where no new themes had emerged (Glaser & Strauss 1967). An audit trail was kept throughout the research process. One of the purposes of this was to aid the researcher in making an informed judgement about the point at which data saturation was reached. After each interview initial reflections upon the emergence of themes were jotted down in a written research journal. This was later transformed into an electronic format. The deliberate attempt to space interviews over a twelve month period allowed sufficient time for in-depth reflection upon emergent themes. These reflections in turn informed an ever-evolving interview schedule for subsequent interviews. The strategy of comparing data generated in previous interviews with that of subsequent interviews is synonymous with the process of constant comparison, which not only facilitates analytical thinking but also signals when the point of saturation has been reached (Pope et al. 2000). By the 15th interview, audit trail entries illustrated that the list of new themes began to decline until there were no new themes to emerge from the 25th interview, which was thus deemed the last interview. It is impossible to preclude the possibility that had subsequent interviews been conducted, new themes or insights might have arisen. Thus, whilst the interviews with key informants provided a range and richness of data on the topic of interest, there are likely to be other perspectives that exist, which would extend the range of views that have been gathered in this research. However, the researcher is satisfied that many rich and diverse perspectives have been accessed throughout the data collected, and that data were collected as per accepted conventions in qualitative research.

Five key informants were interviewed twice. Two key informants were interviewed twice because an interview had to be cut short due to time constraints. Three key informants were interviewed twice because the researcher felt there was a need to conduct another interview in light of new information emerging from subsequent interviews.

3.6.1 Time and place
Interviews were conducted at times and locations that were chosen by, and convenient for, key informants. The vast majority of interviews took place in offices at the workplaces of key informants. Only one interview took place in an office at the university. In this instance the key informant was a Sudanese man who was in between jobs and thus did not have an office
space of his own. He informed the researcher that he would like to be interviewed at the university. The benefits of interviewing key informants in their own or preferred/familiar environments are well documented. These include contributing to a level of comfortableness for the participant, facilitating a more egalitarian relationship between researcher and participant, and facilitating conversation and rapport (Elwood & Martin 2000). This resonated with the researcher’s experience in conducting interviews in this research project. The researcher also felt a sense of rapport and partnership was developed at the very outset in the process of simply asking participants where and when they would like to have an interview conducted with them. In the asking of this question the researcher is essentially saying that he is willing to step out into an unfamiliar environment in a similar way to the participant who may be undertaking an unfamiliar role as a participant. Through this unfamiliarity both the key informants and the researcher alike immediately had something in common; something upon which to build rapport and a relationship.

3.6.2 Interviews in practice

Interviews were semi-structured and in-depth ranging in length from 45 minutes to three hours. All interviews were conducted by the researcher. In-depth interviews were considered an appropriate way of generating information rich data (Cohen & Crabtree 2006). The semi-structured nature of the interviews allowed key informants the space to shape the course of the interview with the researcher, who within that space was also able to clarify, probe deeper, and ask pre-determined questions.

Prior to the commencement of interviews the researcher reiterated the objectives of the research, reassured potential key informants of confidentiality, and their right not to answer questions that they felt uncomfortable in answering and/or to withdraw from the project at any stage. Permission to tape record interviews was also sought and all key informants gave their permission to do so. Then space was given to key informants to ask any questions. After answering any questions the researcher then went through the Consent Form (see Appendix D) and again extended the invitation for any questions during this period. If key informants did not have any question or were satisfied with answers to any questions, and expressed their willingness to participate, they were then asked to sign two copies of the Consent Form. Each key informant was given one copy to keep for their record. The researcher kept the other copy.

After informed consent had been obtained (including permission to tape-record interviews),
the researcher then turned on the tape recorder and proceeded to give a brief overview of the broad areas that might be covered in the interview. The following passage typifies the way in which interviews were started, although such introductions differed slightly according to the specific key informant interviewed:

“I’m really interested to hear your stories/experiences/opinions about planning or providing care to Sudanese refugees. There are a few broad areas that I’d like to cover in this interview including:

- the mental health needs of Sudanese refugees,
- how the mental health needs of Sudanese refugees are met and by whom,
- any issues associated with service provision,
- and how well the health system addresses the needs of refugees in general.”

3.6.3 Note taking
As all key informants gave their permission for interviews to be tape recorded, the need for note taking during the interview was minimal. It was restricted to making short notes about areas to prompt or follow up on during the course of the interview. This enabled the researcher to devote full attention to key informants’ responses, constructing relevant follow up prompts, whilst focussing on the course of the interview.

3.6.4 Interview schedule
The course of the interview was partly determined by an interview schedule and partly by key informants’ responses to questions. An interview schedule was developed and piloted in two practice interviews between December 2007 and February 2008. The first of these practice interviews was conducted with the researcher’s supervisors and the second was conducted with a colleague who also happened to deliver clinical services to refugees. Not only did such practice interviews provide an opportunity to further develop the interview schedule but also to gain feedback on interview technique. A ‘post-mortem’ of a practice interview (see Appendix E) illustrates this. One major point to arise from practice interviews was that the interview schedule should more closely relate to the research questions. Thus, subsequently developed interview schedules included potential questions organised around each research question.

The interview schedule evolved iteratively over the course of data collection as new themes emerged. It was essentially modified after each interview and prior to the next interview in
order for the role/s of the key informant to be taken into account. For instance whilst the question “What strategies are employed by the health service where you work to address the needs of Sudanese refugees?” was a legitimate question for many of the key informants interviewed, it would make little sense to ask this question to a Sudanese man who was not employed by a health service. Appendix F illustrates how the interview schedule evolved and was modified with reference to new themes and for different key informants. It shows the interview schedules used for a Sudanese key informant, a health service provider, and a policy maker. Of course, due to the semi-structured nature of the interviews interview schedules only acted as guides. Audit trail entries show that as the researcher conducted more interviews and felt more comfortable with the process there was less reliance on interview schedules. Often the richest data came through in interviews where they were not so structured, as is conveyed in the audit trail entry in Appendix G.

Audit trail entries also highlight that whilst the researcher intended to use open ended questions during the interviews so as not to overly influence or direct the key informant’s responses, there were some closed ended questions that crept into interviews from time to time. However, the audit trail acted as a quality control mechanism alerting the researcher to areas in which interview technique could be improved.

3.6.5 Other materials used in interviews
The researcher developed three diagrams that illustrated referral pathways for refugees throughout the health system in South Australia, as the researcher understood them, based upon information gleaned from interviews and other grey literature. These were used as tools for further discussion in some interviews. These are not included in appendices in order to ensure anonymity of the services, from which key informants were drawn.

3.6.6 After the interview
In addition to being asked whether they could recommend any potential participants, at the conclusion of each interview key informants were also asked if they would like a copy of the transcript of the interview. This was done so that key informants could check whether they had conveyed everything they wished to convey and to provide any further comment. Only one key informant requested a copy of the transcript and this was sent to the key informant, who then responded with a short email saying that she did not have anything to add.

Immediately after each interview some initial reflections on the themes that emerged in the
interview, the interview technique, reflexive thoughts, and any other comments were written down as part of the audit trail. Such audit trail entries had many purposes including facilitating concurrent analysis, acting as a tool to aid in the modification of the interview schedule and guiding what emergent themes to prompt in subsequent interviews. It was also used to document reflexive thoughts and acted as a quality control mechanism, alerting the researcher to areas where interview technique could be improved.

Tape recorded interviews were transcribed verbatim by the researcher. This was useful in terms of familiarising the researcher with the data and in assisting in the identification of preliminary themes. To prevent any confidentiality issues from arising, all identifying information was excluded from transcripts.

3.7 Data analysis
Thematic analysis was conducted using the Framework approach, which will be explained below.

3.7.1 Framework analysis in theory
The Framework approach (Ritchie & Spencer 1994) was developed for use in the context of applied or policy relevant qualitative research. Thus it was deemed to fit well with the objectives of this research. It is differentiated from other qualitative data analysis techniques in that as well as encouraging themes to emerge inductively it often starts deductively from the pre-determined aims and objectives of the research (Pope et al. 2006). This was deemed a desirable feature of the Framework approach in the context of this research, enabling the researcher to maintain a focus on the research questions that had been developed through a literature review and consultations at the outset of the study as well as any emergent issues that arose.

Partly due to its ability to integrate both inductive and deductive thinking as well as its explicitly articulated process, Framework has been used broadly by qualitative researchers in the realms of health services research, and population health. Examples of qualitative research utilising the Framework approach have been published in the *British Medical Journal* (Hussey et al. 2004, Griffiths et al. 2001), the *Journal of Health Services Research and Policy* (Maisey et al. 2008, Taylor-Robinson et al. 2008), *BMC Health Services Research* (Gask et al. 2008, Glenton et al. 2006), *BMC Public Health* (Weaver et al. 2008, Vogt et al. 2006) as well as in journals that have an established history of publishing high quality qualitative work,
such as *Social Science and Medicine* (Jones et al. 2008, Koffman et al. 2008, Rhodes et al. 2007).

Criticisms of the quality of qualitative research in the public health arena often stem from the perceived lack of transparency about how findings are generated (Green et al. 2007). As a result of its explicit and well-defined five-stage process however, Framework has been viewed as a systematic and transparent approach to qualitative data analysis, which allows others to see how findings and interpretations are derived (Pope et al. 2006). The five stages involved in the Framework approach based on Ritchie and Spencer’s (1994) articulation of the procedure are briefly summarised in Table 3.1, which is a distilled version of a table developed by Pope et al. (2000).

*Table 3.1: Summary of Framework Analysis (Pope et al. 2000 pg 116)*

<table>
<thead>
<tr>
<th>Stage Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Familiarisation</strong></td>
</tr>
<tr>
<td>Immersion in the raw data by reading transcripts, taking notes and maintaining an audit trail.</td>
</tr>
<tr>
<td><strong>Thematic framework identification</strong></td>
</tr>
<tr>
<td>Identifying all key themes based upon pre-determined considerations and emergent issues to devise a thematic framework (an index) that can be systematically applied to all the data.</td>
</tr>
<tr>
<td><strong>Indexing</strong></td>
</tr>
<tr>
<td>Systematic application of the index to all the transcripts.</td>
</tr>
<tr>
<td><strong>Charting</strong></td>
</tr>
<tr>
<td>Collating all the indexed data under appropriate theme headings. Creating distilled summaries of the range of experiences and understandings for each theme (charts).</td>
</tr>
<tr>
<td><strong>Mapping and interpretation</strong></td>
</tr>
<tr>
<td>Developing higher order findings and explanations such as:</td>
</tr>
<tr>
<td>- Defining concepts</td>
</tr>
<tr>
<td>- Mapping the range and nature of phenomena</td>
</tr>
<tr>
<td>- Creating typologies</td>
</tr>
<tr>
<td>- Finding associations between and within themes</td>
</tr>
<tr>
<td>- Providing explanations</td>
</tr>
<tr>
<td>- Developing strategies</td>
</tr>
</tbody>
</table>

Each of the stages described in Table 3.1 are deliberately not numbered to safeguard against the impression that Framework is a mechanical approach with each stage followed by the next. This is an impression which the creators of the approach seek to avoid, suggesting that despite its well defined approach, deriving meaning from the data is reliant on the creative
and conceptual ability of the analyst (Ritchie & Spencer 1994). This means that in practice, stages may occur simultaneously or in an order that complements the analytical ways of working of the individual analyst. In this sense the Framework approach may be put into practice in different ways depending upon the interpretations of it and ways of working of the researcher. This will be illustrated in the following section, which describes how Framework analysis was utilised in practice in this research.

3.7.2 Framework analysis in practice

For the purposes of analysis each research question was treated as a separate study and thus the five stages of Framework analysis were repeated for each research question. Approaching analysis in this way enabled the researcher to maintain a focus on each research question separately rather than shifting focus between research questions, which upon initial attempts proved to be difficult and time consuming.

The process of familiarisation and immersion in the raw data began immediately when data collection commenced through such pursuits as keeping an audit trail, listening to and transcribing interviews, and writing rough notes on the interview data. The process was continuous and never really had a finite end point. When freshly conducted interviews were transcribed and reflected upon and even after all the interviews had been conducted, there was a need to re-familiarise with earlier data, each reading prompting new insights.

During the process of familiarisation, ideas about possible themes and a thematic framework began to develop for each research question. A closer inspection of a sample of transcripts, which were coded in the qualitative data analysis programme called QSR NVivo 8 (QSR 2007), provided an opportunity to refine the thematic framework further. Each line, sentence and paragraph of the sample of transcripts were carefully considered and coded as a potential theme. Themes were then categorised into major themes or variations on the major themes, sub-themes. In relation to the first research question this initial attempt to develop a thematic framework returned a large number of themes. After reading other transcripts and audit trail entries on other interviews the thematic frameworks were refined further. This period of refinement also included a number of oral presentations of theme overviews to supervisors, comments from which proved helpful in the development of each thematic framework. It was particularly helpful in steering considerations toward a focus on original research questions. The process of developing and refining thematic frameworks was an ongoing one that took place concurrently with the familiarisation stage and also with the indexing stage, throughout
which ideas about themes were sometimes reinforced or alternatively sometimes were abandoned.

Indexing, or the process of applying each of the thematic frameworks to all of the data, can be done in a number of ways. Indexing can be done by writing theme headings as they apply to corresponding pieces of text in a column on the side of a hard copy of each of the transcripts. Another approach is to use Excel in a similar vein with electronic versions of transcripts. In this instance, however, NVivo was used to apply theme headings to corresponding text, and was found to be a useful and time saving method of indexing. For example, NVivo allows users to apply more than one theme heading to a corresponding piece of text, which was particularly helpful as often a piece of text was interpreted as evidence of a number of themes. Appendix H provides an example of an excerpt of an indexed transcript in relation to Research Question One. The headings and stripes on the right hand side illustrate the themes that correspond with segments of text in the transcript on the left hand side.

Up until the charting stage the integrity of the transcripts, in this instance, was maintained. However, charting involves the movement of indexed data under corresponding theme headings such that distilled summaries and interpretations of the data can develop. NVivo allows the researcher to collate data under theme headings with relative ease and organises data by key informant. Once the data on each theme were all in the one place short notes were made beside each chunk of data. Some of these had already been written down elsewhere in audit trail entries or on scraps of paper. However, it soon became clear that creating distilled summaries of excerpts of data was going to be an extremely time consuming and relatively ineffective process considering that for Research Question One alone there were some 1576 individual segments of data coded under theme headings. Instead of the repetitive and arguably passive approach of creating distilled summaries of the data, short notes of a more interpretative nature were adopted as a way of facilitating more analytical thinking. With these short notes organised by participant, it was possible to reflect more deeply upon the range and diversity of experiences within each theme or sub-theme. Appendix I which is an excerpt of a chart created for the sub theme in relation to Research Question One illustrates the approach to charting taken in this research. The annotations at the bottom of the chart represent short interpretative notes relating to each piece of coded data.

The process of mapping and interpretation was not the final stage in a mechanical process as even from the very earliest exposure to the data (i.e. during the course of interviews) one is
always trying to interpret and make sense of what is being said. However, throughout the data analysis process there was an increasing emphasis upon attempting to understand the intersections and divergences between and within themes.

3.8 Rigour

There is much discussion about what constitutes quality and rigour in qualitative research. Often views of rigour are shaped by the epistemological assumptions that underlie particular research paradigms (Cohen & Crabtree 2006). Thus, what is considered important in terms of ensuring rigour in an ethnographic study will differ from what is considered important in a study utilising grounded theory. It is partly due to this reason that numerous sets of quality criteria for qualitative research have proliferated; each pertaining to a particular methodology (Cohen & Crabtree 2006). The development of such sets of criteria might also be seen as a reaction to the perception of qualitative research as being unsystematic and lacking in rigour in the eyes of researchers from positivist traditions. Whilst the terminology used in each may be different there is a significant degree of overlap/agreement between different sets posited suggesting that there might be some core elements that contribute to rigorous qualitative research.

Mays and Pope’s (2000) articulation of quality criteria for qualitative research takes a pragmatic perspective, arguing that validity and relevance – criteria for assessing quantitative research – can be used in a modified form when considering the quality of qualitative research. This pragmatic perspective is appealing to those qualitative researchers, particularly in health services research, whose work is of an applied nature. As the Framework approach used in this research stems from an applied qualitative research perspective, Mays and Pope’s (2000) set of quality criteria seems most relevant to this research. Whilst Mays and Pope (2000) articulate a number of strategies for improving the rigour and quality of qualitative research they also suggest that these should be used with discretion depending on the particular study design and methodology. Table 3.2 illustrates some of the key strategies advocated by Mays and Pope (2000) for improving the validity and relevance of qualitative research and summarises which of these strategies have been employed in this research, and how so.
Table 3.2: Rigour enhancing strategies as articulated by Mays and Pope (2000) and the use of in this research

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Summary</th>
<th>Used</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Triangulation</td>
<td>Consideration of multiple sources of data or viewpoints such that points of convergence or difference can be reflected upon.</td>
<td>Yes</td>
<td>Two triangulation techniques were used. A technique called triangulation of sources was used whereby data collected from people with different viewpoints (i.e. health service managers, health workers, refugee leaders etc.) was compared to enhance the richness of the data. A modified form of analyst triangulation was also used whereby interpretations of the data and possible findings were presented to the researcher’s supervisors in order to prompt new ways of interpreting the data and also to check that they could understand how findings were arrived upon.</td>
</tr>
<tr>
<td>Respondent validation</td>
<td>Asking participants to provide feedback upon the researcher’s interpretations of the data in order to establish concordance.</td>
<td>Partially</td>
<td>Respondent validation was sought in terms of transcript checking. However due to the diverse nature of the sample and the diversity of viewpoints contained within, it was not considered useful for key informants to validate themes. This research was interested in developing themes based upon multiple and various viewpoints – all equally important and valid – rather than uncovering a fixed ‘superior truth’ that holds for all participants (Angen 2000). Respondent validation of themes was therefore at odds with the aims of this research.</td>
</tr>
<tr>
<td>Clear exposition of methods of data collection and analysis</td>
<td>Development of a clear account of the research process such that a reader can ascertain how the researcher reached their findings.</td>
<td>Yes</td>
<td>An audit trail was kept to document all stages of the research process from its development, through to data collection and analysis. This would potentially enable someone not familiar with the study to understand how themes and findings were arrived upon.</td>
</tr>
<tr>
<td>Reflexivity</td>
<td>Critical reflection upon how the research process and the researcher, through their personal opinions and past experiences, age, gender, cultural background etc. influenced the findings generated.</td>
<td>Yes</td>
<td>The audit trail also contained reflections and feelings about how the researcher influenced (through past experiences, considerations of age, power, gender and cultural background etc.) and was influenced by the research process.</td>
</tr>
<tr>
<td>Attention to negative cases</td>
<td>Consideration of alternate explanations and voices throughout the data that may contradict or differ from the general consensus.</td>
<td>Yes</td>
<td>Negative or contradictory cases were considered through the process of mapping the range of understandings/experiences posited during the stage of Framework analysis called ‘Charting’.</td>
</tr>
<tr>
<td>Fair dealing</td>
<td>Explicit incorporation of a diverse array of perspectives so as to safeguard against a one-dimensional understanding developing in relation to the research question.</td>
<td>Yes</td>
<td>A sample containing a diverse array of viewpoints was intentionally sought in order to add to the richness of the data.</td>
</tr>
</tbody>
</table>
3.9 Reflexivity
Despite the diversity of opinions that exist regarding strategies for enhancing rigour in qualitative research there is a general consensus that reflexivity is important. Underlying the need to be reflexive is the idea that the context and the researcher, in particular, affect the research process and the knowledge produced. As Malterud (2001) articulates:

“A researcher's background and position will affect what they choose to investigate, the angle of investigation, the methods judged most adequate for this purpose, the findings considered most appropriate, and the framing and communication of conclusions” (Malterud, 2001 pg 483-484).

Many would argue that the need to acknowledge how the researcher’s perspective, preconceptions, and position affect the research process applies equally to all research regardless of its paradigm. Qualitative researchers consider the systematic reflection and articulation of the impact of the context on knowledge construction important in allowing readers to critically interpret their findings (Cohen & Crabtree 2006). Thus the purpose of the following section is to illuminate some of the forces and factors that have impacted upon the researcher and subsequently the generation and interpretation of data. Such reflexive thought has been documented throughout the research process in a personal research journal as part of the audit trail.

3.9.1 Insiders and outsiders
From the very outset of the research process a seed of doubt and uncertainty was sown about my perceived position as an ‘outsider’ in relation to the key informant groups that were the focus of my research. I am not a member of the Sudanese community, nor am I someone who has undergone forced migration, nor am I someone from within the refugee health sector. This perception of being an ‘outsider’ was almost constantly in the forefront of my consciousness throughout the study and early on almost overwhelmingly so. Such feelings of ‘outsiderness’ were particularly exacerbated whilst attending refugee health conferences and seminars where it seemed that, unlike me, everyone was either a member of a refugee community group or a health worker involved in addressing refugee health issues. I came away from such events questioning the validity of my interest in the topic, asking myself what right I, as an ‘outsider’, had to study the needs of and health service provision to Sudanese refugees. The idea that only ‘insiders’ can properly understand and represent the experiences of their own communities as Bridges (2001) comments on, seemed quite compelling to me initially.
Perhaps this is because in the realm of research with or related to refugees, the ethical dimension of this idea – what is ‘proper’ – is particularly emphasized. Of this Collet (2008) says:

“Refugees, by virtue of their migration experiences and their frequently diminished levels of power within host societies, constitute a population particularly vulnerable to the exploits of academic researchers. Here overcoming obstacles presented by the insider-outsider distinction is not merely a methodological and academic concern, it is also one with an important moral dimension” (pg 82).

A conversation with my supervisors alerted me to the flawed logic that underpinned my feeling that the issues of ‘insiders’ are best researched by ‘insiders’. Following such logic women would only be able to conduct research with women, men with men, the depressed with the depressed, Sudanese with Sudanese, GPs with GPs and so on. In such a world there would be few conversations between ‘outsiders’ and ‘insiders’. Merriam et al. (2001) establish that an ‘insider’ perspective will be different to that of an ‘outsider’ perspective. However, they argue that both are equally valid and important if phenomena are to be understood in their complexity, of which multiple perspectives are desirable (Merriam et al. 2001). Furthermore, as Collet (2008) acknowledges, it is not a researcher’s group membership but the researcher’s conduct and the research design that makes research ethical and rigorous. Similarly, I had come to my own personal realisation that a researcher does not necessarily have to have had experienced what their participants had, nor do they have to be of the same creed, cultural background, sexuality, or gender but that they need to be open to listening and hearing.

As I started conducting interviews I realised that perhaps this dichotomy between insiders and outsiders was more one that I had manufactured and reinforced through worrying about it. Many researchers have likewise rendered the ‘insider-outsider’ dichotomy problematic. For instance Merriam et al. (2001) ask: “what is it that an insider is an insider of?” (pg 411). Cultures are not homogenous entities, and as Aguilar (1981) points out, “all cultures (including subcultures) are characterized by internal variation” (pg 25). Similarly and as is evident in my sample, diversity is likely to be present amongst those working inside the health system (or a sub-sector of it). Given this there has been a movement away from objective categorisations of ‘insiders’ and ‘outsiders’ to the more relative notion of positionality in scholarly circles. Expanding on this notion, Aguilar (1981), argues that:
“...a more realistic model of the situation would view the local ethnographer as relatively inside (or outside) with respect to a multiplicity of social and cultural characteristics of a heterogeneous population” (pg 25).

For example, Merriam et al. (2001) discuss the experience of two researchers who initially considered themselves ‘insiders’ because they were going to interview people from the same cultural background. However, during the process of interviewing, differences between themselves and their participants with respect to age, gender, and socio-economic status had made them feel less insider-like (Merriam et al. 2001). Thus Merriam et al. (2001) argue that throughout the course of a study researchers will experience moments where the feel relatively more or less like an ‘insider’ (or ‘outsider’) in relation to identifying with the social and cultural characteristics of the participants in their research. Reflecting upon my experiences as I conducted more and more interviews, I also found this to be true. I generally felt more of an ‘insider’ when interviewing younger key informants, those who were more acculturated to ‘western’ concepts and ways, and those who I perceived to be of similar power status. However, even where difference was present in relation to these or other characteristics I found that in the act of the sharing of experience through interviews there was an element of identification with one another as co-creators or co-authors of a narrative rather than as ‘outsiders’ and ‘insiders’.

Upon reflection however, I believe that my relative outsider status in certain circumstances was actually advantageous in terms of generating information rich data. It allowed me to ask questions that might otherwise be considered taken-for-granted knowledge by an insider. It also shielded me from the politics within. Because I was not perceived as having a stake in the politics associated with the refugee service sector, key informants were perhaps more able to speak openly without fear of judgement, or fear that the information would be used to further any particular political agenda. My experience is consistent with what others have said about the potential benefits of relative ‘outsider’ status. For instance Merriam et al. (2001) suggest that:

“The outsider’s advantage lies in curiosity with the unfamiliar, the ability to ask taboo questions, and being seen as non-aligned with subgroups thus often getting more information” (pg 411).
3.9.2 Ethical preoccupation
I resolved to undertake the study with great attention to ethical considerations as a further way of convincing myself that what I was doing and how I was doing it was valid and justified. As I delved deeper into the literature on the ethics of conducting research with refugees, attended ethics workshops, and consulted community members, this pre-occupation with ethical considerations almost became debilitating. It encouraged a mind set of “everything is unethical until proven ethical” and so even apparently insignificant details like the act of calling potential key informants on the phone were subjected to intense deliberations invoking this or that ethical argument. Even the assurances of ethical soundness on behalf of my supervisors, who were listed as key investigators on the application for ethical approval, did little to quell my ethical hypochondria. I convinced myself that their assurances meant little, as it would be me alone who would have to answer questions about the actions taken during the research process to a conference, seminar or community audience. I do not think I really ever resolved this pre-occupation with ethical considerations, but I did learn how to contain my deliberations on ethical issues such that they did not totally forestall the progress of the project.

3.9.3 Perspective
In addition to key life experiences my acculturation to the language and principles of public health have inevitably shaped the way I view the world and thus the way the data have been collected and my interpretations of those data. This process of acculturation to a public health worldview has been ongoing, stemming from my undergraduate days and then intensifying during Honours and over the course of this research. There is of course a great diversity of views within public health and part of the challenge of the public health academy has been to integrate all of these. The views and ideas stemming from or adopted by public health that have been influential in shaping my consciousness include those around equity and the social determinants of health, and the primary health care approach which integrates both equity and holism into its philosophy of care. My Honours thesis, which was entitled “Reaching out to culturally and linguistically diverse women: factors facilitating community health work” dealt with many of these themes (Savic 2006). Undoubtedly this lens has influenced my interpretation of the data in this research. Likewise the influence of public health and health services research is evident in the broad health systems focus of this research, which contrasts with a narrow clinical focus.
3.9.4 Interdisciplinary perspectives
However public health draws upon ideas from a range of disciplines and so to have I. Ideas from medical anthropology, community development studies, psychology and sociology have all informed my interpretative lens generally and specifically in relation to this research. One of my supervisors is a psychologist who works in the Discipline of Psychiatry, and her input also facilitated a broad perspective.

3.9.5 Power
Among the key informants that I interviewed were health service managers, senior policy figures and government officials, and Sudanese community leaders; all of whom I perceived to be important and powerful figures in the microcosm of the world that I was studying. Depending upon the personality of such key informants, I generally felt uncomfortable and nervous in interviewing, whom, I perceived to be high status figures. The feeling of being judged via my questions and demeanour as to my competency to undertake research in the area of refugee health were consistently articulated in audit trail entries. In these instances such imposed pressure, self or otherwise, contributed to a reliance on the interview schedule and the comfort and safety this brought. This hindered my ability to follow up emergent ideas in the way that I had done in other interviews, making interviews with high status key informants quite structured.

3.9.6 Age
The issue of perceptions of power imbalances was also bound up in the issue of age disconcordance, and perceptions of experience. All of the key informants, with the exception of one, were older than I am and had what I perceived to be much more life experience than me. In fact like my parents, many key informants were of the ‘baby boomer’ generation whilst I am a member of, so called ‘Generation Y’. Whilst this did affect my level of comfort in some early interviews and subsequently the data collected, I increasingly found that my youth and relative lack of life-experience was to my advantage rather than a detriment. It reinforced the position of the key informants as experts, which encouraged them to speak openly without any fear that their responses would be judged as not being useful or articulate. In the same vein, it also allowed me to ask questions or construct prompts that might otherwise have been considered assumed knowledge or ‘silly’ questions. In the responses to such questions valuable information was generated. In addition to being an ‘outsider’ in relation to the refugee health sector, my youth may have also contributed to an impression of harmlessness. This enabled them to speak, for the most part, openly about sometimes
sensitive or political issues within the context of the ‘refugee service sector’ in South Australia.

3.9.7 Gender
The majority of the key informants in my research were women. William’s and Heikes (1993) suggest that “men who study women using qualitative interviews may confront more formidable obstacles to rapport” (pg 289) than women interviewing men. However as a young man, I did not feel that gender disconcordance during interviews affected the information generated negatively. In fact I generally felt more comfortable and felt that some of richest information generated came in interviews with key informants who were women. Perhaps the idea or stereotype of women as being more nurturing, caring and expressive than men played out in some small way in the interviews with women in my research. Conversely in some of the interviews with key informants who were men I encountered situations where I felt less comfortable and felt that generally less information rich data was generated.

3.10 Conclusion
In this chapter the methods used to generate and analyse data have been discussed through a critical lens. In articulating the methods used along with the accompanying trials and tribulations in their application, this chapter provides an understanding of the context of knowledge production.

The factors that have influenced the theoretical framework taken by this research including ethical considerations were discussed. This was followed by descriptions of the theoretical and practical issues that have affected the generation of data for this small scale qualitative study. The way in which generated data was treated and interpreted using Framework analysis was then illuminated in a discussion of the data analysis techniques employed. A discussion of rigour in qualitative research and how it applies to this research preceded an articulation, in the spirit of reflexivity, of how the research process was affected by the researcher.

Chapters’ One and Two illustrate how the research questions were developed in light of the relevant literature. This chapter described and reflected upon the strategies that have been used to attempt to explore these questions. This chapter, along with those that have preceded it, provide the context for understanding the findings in relation to the posed questions in the chapters to follow. The ensuing chapters represent descriptions and interpretations of the generated data and it is to these that attention will now turn.
Chapter 4
Exploring the material, social and mental health needs of resettling Sudanese refugees

4.1 Introduction
In this chapter attention is turned to the question of the perceptions of the material, social and mental health needs of resettling Sudanese refugees. Key informants posited an array of views that illuminated the complexity and multi-faceted nature of the material, social and mental health needs of refugees. These perceptions converged around two overarching themes; what has been interpreted as the need to rebuild social worlds, and the need to address mental health issues. Over the course of this chapter these themes will be deconstructed with attention to variation, and the interconnectedness of themes. This chapter thus provides the basis for engaging with subsequent chapters related to health service and system responses to meeting the needs of resettling Sudanese refugees articulated here.

4.2 Thematic framework
The results presented in this chapter were generated via Framework analysis, and specifically relate to Research Question One:

What are the material, social and mental health needs of Sudanese refugees in Australia as understood by key informants?

In accordance with the Framework approach a thematic framework was developed based upon the main themes to emerge throughout the data in relation to the first research question. As described in the previous chapter, the process of developing and refining the thematic framework was a continual one. This involved consulting the data, maintaining an audit trail, and presenting preliminary versions of the thematic framework to supervisors. The thematic framework illustrated in Figure 4.1 provides the structure upon which, generated findings were organised. The framework contains two overarching themes and five major themes that stem from these overarching themes. Furthermore, as is shown in the diagram, each of the five major themes contains a number of sub-themes.
Over the course of this chapter each of the elements of the thematic framework will be unpacked and discussed. Particular emphasis is placed upon illuminating the interrelationships between themes in addition to the variation within themes. In contrast to the appearance of discrete and linear themes given by the diagram, needs were interconnected.

Where illustrative quotes are used in this and the following results chapters, these are accompanied by a brief two or three word description of the key informant to whom the quote belongs. Given the small refugee health sector in South Australia, these descriptions are necessarily limited by the need to ensure key informants’ anonymity.

**4.3. Overarching theme: The need to rebuild social worlds**

What has been coined the need to rebuild social worlds was found to consist of three major interconnecting elements as illustrated in Figure 4.2: the practicalities of rebuilding social worlds, adjusting to life in a new social world, and balancing living in old and new social worlds simultaneously.
As Figure 4.2 suggests, wellbeing was thought to be largely contingent upon the ability of refugees to deal with the highlighted elements and the questions that each provokes. Each of these elements will be discussed throughout the course of this chapter with attention given to their potential impact on wellbeing. In the following chapter it will become evident that, as the agency affirming metaphor implies, refugees are active participants in ‘rebuilding’ their social worlds.

4.4 Practicalities of rebuilding social worlds
Dealing with the practical issues associated with resettlement, such as those shaded in Figure 4.3, was viewed as intrinsically intertwined with mental health and wellbeing. They were perceived to be the foundation in the process of rebuilding social worlds. Where the foundations were viewed as being shaky key informants suggested that so too was the world which was being built. Subsequently the state of wellbeing of individual refugees and their families was also thought to be affected.
Practical resettlement issues were viewed as being the most immediate and pressing of needs that newly arrived refugees faced after arrival in Australia. As one key informant suggested a realisation of the need to address such practical issues can herald the end of what other key informants described as the “honeymoon period”:

“First of all it started with the house, the kind of house you are given; you look at it and you’ve never had this before, nice house with lights on, with a TV, with telephone, and your bed - you just live like a king - so that’s really high. And then you are told ‘now get out there and start doing something for yourself’ and you want to get out there and then you find the language is difficult and then you find finding the job you want is difficult and then you find getting into the course you want is difficult and then you find getting into the course you want is difficult and then you find people back home are harassing you for this and that and you need to be doing something for them and then you find that’s not easy either. And so your life just sort of, from big smile, slowly, slowly, slowly, slowly...Yes it’s all very bright and very beautiful but as months pass you get depressed because you don’t get, you don’t understand anything and things are not happening as you want them and you just. Sometimes you don’t know that you are really becoming very unhappy, you just think ‘oh still very happy, still enjoying this beautiful country’ but slowly, slowly it is becoming worse then, than even in refugee camp; yeah that’s how it gets for some.” (Key informant 3 – Sudanese man)
As is borne out in the quote, the barriers between desires and the realisation of those desires for refugees can be difficult to deal with. This is especially the case because resettling refugees are likely to have an awareness of what a “bright” and “beautiful country” like Australia can potentially offer. In the disappointment and frustration that comes with experiencing barriers to the realisation of desires one can begin to understand that for some refugees, life can feel worse in resettlement countries than in the refugee camps; places that some key informants have characterised as environments pervaded by fear and uncertainty. Unlike in resettlement countries like Australia, expectations of life in refugee camps are likely to be constrained by the need to survive on a day to day basis. Thus there is likely to be little opportunity for the disappointment associated with unmet expectations.

### 4.4.1 Expectations

Contrary to popular belief, key informants in this study highlighted that the desires and expectations of refugees’ lives in resettlement contexts are likely to extend beyond safety. Many commented on the desire of refugees to actively participate in the societies to which they now belong. Expectations canvassed included the desire to gain employment, to further one’s education, and to be financially secure. This was expressed in terms of being able to financially support family networks in Australia and abroad and also with respect to assist with the migration of other family members.

However, some key informants felt that the expectations of Sudanese refugees in relation to resettlement were too high and/or based upon misleading information:

“So I mentioned earlier that people are coming; some of them got a high expectation. You are going somewhere and you got an expectation and then they probably get frustrated or disappointed, that’s the main problem.” (Key informant 6 – Sudanese man)

“The expectation people have because they see the images of the magazine of the western world is totally different; everything is rosy, you don’t have to look for houses for long time and you don’t have to struggle with certain things. You know we have this expectation if you’re living in the West you must live a better life; you’ll have lots of money and when you come here actually that’s not the case.” (Key informant 8 - Sudanese woman)

Together with a lack of adequate information about life in Australia, some key informants implicated the disordered and chaotic nature of forced migration itself. They felt that this
provided Sudanese refugees with little time for preparation for living in a new society and to adjust their expectations accordingly. The following quote from a health service key informant illustrates this:

“You know, people clearly arrive with nothing but the bags they are carrying; there’s no sense of orderly preparation to migrating to a new country as, you know, migrants have the opportunity to do. Sometimes people know very little about where they are going and what to be prepared for.” (Key informant 10 – Health service manager)

Success or failure in terms of resettlement was measured against pre-migration expectations but also via comparison to other friends and relatives who had resettled in Australia or abroad. For example, one key informant compared his resettlement experiences to those who migrated to the United States, pointing to the existence of and participation of resettling Sudanese refugees in transnational communication networks. Consequentially, and as will be illustrated further in this chapter, Sudanese in the diaspora and Sudanese in Sudan are able to communicate and impact upon each other’s lives.

Perceived failure to meet expectations was viewed as contributing negatively to emotional wellbeing. Such failure was felt to be compounded in some circumstances by the fact that, in the case of sending money home for instance, expectations were not just of an individual nature but were shared. That is, there were consequences for family members, who had a vested interest in the success of relatives abroad. Sudanese key informants considered the inability to meet shared expectations particularly difficult to cope with, sometimes leading to feelings of despair, guilt and despondency.

The ability to realise expectations is likely to be integral to emotional wellbeing. It is these expectations and aspirations that are likely to motivate and shape the rebuilding of social worlds. However as, will be illustrated in the following sections of this chapter, the realisation of expectations is often hindered by the many potential barriers and difficulties that resettling refugees are likely to face in the rebuilding of social worlds.

### 4.4.2 Housing

One of the major practical aspects of rebuilding social worlds as described by the key informants was the issue of housing. In many ways housing was the epicentre around which social worlds were reconstructed. It represented stability, safety, stillness amidst a history of
movement. It provided a chance to build social networks, a chance to participate in a geographical community and to make use of the resources that exist in communities. Aspects of this are evident in the following quote:

“So housing becomes a symbol of real, sort of, trauma and you know, it’s sort of got this duality about it because it symbolizes, you know, the stability and promise for the future but it’s also this thing that’s shifting and if housing ends up being out at Salisbury North or in the far south, where there’s no one there, then it becomes a symbol of just social isolation because people end up in these just terribly far flung places like Parafield Gardens and places like that.” ¹ (Key informant 10 – Health service manager)

However, key informants expressed many barriers and difficulties faced in the pursuit of long-term and appropriate housing. Some of these difficulties were thought to apply, not only to resettling refugees, but more broadly. For instance key informants noted the difficulties for resettling refugees to obtain public rental housing, or as one Sudanese key informant commented:

“You go to Housing Trust²; they’ll tell you there are millions of people on the waiting list and you’re one of them; you have to be on the waiting list you know.” (Key informant 7 – Sudanese woman)

As the quote suggests, difficulties in obtaining public rental housing were not thought to be unique to resettling refugees. Key informants attributed the difficulties in obtaining public rental housing to supply issues such as the ever decreasing numbers of public housing stock despite the potential demand. Limited supply and high demand was also thought to be partly implicated in the difficulties for resettling refugees in renting or purchasing housing in the private housing market. Despite consistent and increasing demand, housing shortages were thought not only to restrict opportunities to enter the private housing market and increase competition for the supply but, as one key informant suggested, were also thought to contribute to the high cost of rent.

Employment and financial difficulties were thought to exacerbate issues of housing

¹ Salisbury and Parafield Gardens are suburbs that are approximately 20 and 15 kilometres from the Adelaide CBD respectively. They are considered low in socioeconomic status (SES).
² The Housing Trust is the Government authority responsible for public housing in South Australia.
affordability for some resettling refugees. Many key informants highlighted that as a result, resettling Sudanese refugees were likely to be forced to seek cheaper housing options in areas characterised by socioeconomic deprivation such as those suburbs on the outskirts of the city. According to key informants, safety issues, minimal job opportunities, and social isolation were thought to possibly result from living in these low SES and underserviced areas. Furthermore, the difficulties in obtaining housing were thought to lead to resettling refugees accepting cheaper rental houses that were in poor physical condition and that may not have been suitable for larger families.

In addition to the high cost of rent, other factors were thought to negatively impact upon the chances of resettling Sudanese refugees of obtaining rental housing. Key informants suggested that landlords considered resettling Sudanese refugees with large families or those where women headed families to be undesirable tenants. This may be due to the landlord’s perception that there may be a risk that such potential tenants may be less likely to afford to consistently pay rent. Some key informants also hinted that there may be the possibility of deliberate discrimination in the case of African refugees like those from Sudan.

Not only was obtaining housing considered to be an issue for resettling Sudanese refugees but so too was long-term housing security. Key informants suggested that the likelihood that resettling refugees would have to move after having obtained housing was high. Factors such as the short-term nature of leases, of which many were thought to be less than twelve months, and the uncertainty of landlords’ future intentions for their properties, were cited as being implicated in housing insecurity, and subsequently residential mobility.

Having to move house often and having housing applications rejected, were thought to be quite demoralising for some resettling refugees as one key informant illustrated:

“...that process of constantly being rejected and not being good enough is quite demoralising and I think reignites a lot of sense of not having a home.” (Key informant 4 – Social worker)

Access to resources and services in local communities were thought to be constrained by residential mobility, or as one key informant suggested:
“Housing may be unpredictable or uncertain so if you know that you’re not going to be staying in a place very long or in a community, you don’t start to find out about the resources in that community so housing may be an issue.” (Key informant 5 - Psychiatrist)

Specifically, residential mobility was considered to have implications for continuity of relationships with health service providers:

“Well yeah they’ve got subsidised housing for about six months, most of them, and in that time there are housing case workers who work with them to help them into the private rental market. The private rental market has been quite tight and very expensive compared to income and so it’s been quite difficult but they do. Most actually move within the first year and so that usually means having to find another GP…if they actually move to another suburb they wouldn’t tend to think about health really until they needed it; until somebody got sick or the parent had to decide to send the child to school or not and then what were they going to do about that.” (Key informant 18 – Health service manager)

Residential mobility is not necessarily a negative experience. What, however, is likely to be most influential is the degree of control that people have over decisions to move. In the case of resettling refugees, the degree of control over residential movement was thought to be small. Rather it was considered to be bound up in the decisions of other individuals like landlords or bureaucrats or intertwined with broader structural factors like the availability of affordable housing, public housing stock, and financial issues.

Key informants suggested that one consequence of the difficulties in obtaining housing may be that resettling Sudanese refugees are forced to take any opportunity for housing that arises, even if this meant moving to an area where there were few Sudanese people. Thus the geographic dispersal of Sudanese refugees was also considered to undermine the ability of ‘the Sudanese community’ itself to operate as a community. This was thought to constrain opportunities for members of ‘the Sudanese community’ to avail themselves of the support and resources that the community was thought to offer. As one key informant suggests:

“And where they are used to living in big refugee camps, or communities, or villages and the whole kind of social structure is built around community, to end up in a house in Salisbury is just terrible. So housing is really; that’s a PhD all on its own because it’s so fundamental and
yet it’s so riddled with, you know different things.” (Key informant 10 – Health service manager)

Another key informant expressed a similar concern at the geographically fragmented nature of the Sudanese community in South Australia, pointing to the negative effects that such fragmentation has had, in her eyes, on the role of elders within the community:

“Because our community we not living very very close to each others; you know housing like I’ve said was a big problem. So some of the elders actually are isolated; someone might be living in Modbury, or Salisbury, or in Elizabeth. A person that could easily come to someone with any mental health issue in the evening, just to come and talk to them, because they will come to you at a time when you are not doing anything; they’ll just come to you and chat, chat, chat for a while and then, you know, slowly they’ll go through what they want to talk about but now because people live far, far, far away elder’s role is not very effective, yeah. Although few elders who get the opportunity, you know, or when they are informed that there is a person with problems and you need help, they will ring and talking on the phone, but it isn’t effective when they talking to you looking to you in the eye.” (Key informant 7 – Sudanese woman)

4.4.3 Education

Due to the disruption to lives that forced migration and the events that prompted it caused, the education needs of Sudanese refugees were generally considered to be high. This is not to say that there are not Sudanese in Australia who are educated but that there may be some difficulties associated with gaining education. Furthermore, education was viewed as being a part of the process of rebuilding social worlds, as an investment in the future, as enabling people to gain employment, and as a means of taking back what forced migration had stolen. Broadly speaking there were two groups identified within the theme of education; young people and adult learners.

Key informants described the education pathway for newly arrived young refugees as initially involving placement into new arrival English language schools before being transitioned into mainstream schools. Education provision for resettling refugees in new arrival English

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3 Modbury is a suburb that is about 14 kilometres from the CBD, whilst Elizabeth is about 25 kilometres from the CBD. The distance between Modbury and Elizabeth is approximately 16 kilometres. Like Salisbury, these suburbs are considered low in SES.
language schools was officially described as being for a period of up to two years. However, key informants commented that in many cases young people were transitioning to mainstream schools much earlier and in some cases only after six months. This was not necessarily thought to be negative if in fact young resettling refugees were academically, linguistically, and socially ready to move to mainstream schools. However, it was thought that sometimes young resettling refugees were placed into mainstream school before they were ready, as the following key informant suggested:

“...they’re getting dropped into high school or they might spend two years at Adelaide Secondary School of English where they are trying to basically catch up on seven years of, or eight years of educational experience and then get dropped into mainstream high school, where they are, you know, extremely aware that they’re not meeting the same expectations as their peers.” (Key informant 2 – Mental health nurse)

The idea that some resettling refugee young people were aware that they were not meeting the same standards as their peers in mainstream schools was thought to be exacerbated by the practice of placing young people into classes on the basis of their age rather than their ability. As one key informant suggested:

“Unfortunately you get sent to school, as well as the different system that you have to get used to you, you get put into a class according to your age rather than your academic level. So for a lot of young people that’s a very difficult thing to do...” (Key informant 19 – Sudanese man)

However, the alternative whereby young resettling refugees are placed into classes on the basis of their achievement rather than their age was also recognised as potentially problematic. Some key informants commented that this would mean being in a class with younger peers, which may lead to perceptions of failure and despondency.

Interviews also revealed that schools and teachers themselves may have unrealistic expectations or may not be sufficiently aware of young resettling refugees’ past and current circumstances, which may affect their ability to meet expectations. This understanding was exemplified by the following statement from a Sudanese key informant:

“It’s like the schools. Some of the teachers in the schools have a lot of expectations with
refugees. They say ‘refugee kids are not adjusting’ but these kids for God sake they have been coming from a very hard situation; they don’t have a concept of schooling, their parents don’t speak English, their parents can’t help them with homework but still they are saying ‘oh these kids aren’t settling in the schools.’” (Key informant 11 – Sudanese woman)

Given the greater perceived opportunities for education in western countries like Australia in comparison to Sudan or in refugee camps, interviews revealed that parents of resettling refugee young people may also have high expectations of their children. As the following quote suggest, this may also put added pressure on refugee young people:

“...their parents are really, they have high expectations for their kids, you know, and they’re acutely aware that these kids are not meeting those.” (Key informant 2 – Mental health nurse)

Parental expectation was also thought to manifest in pressure for young people to go to university after finishing school rather than going to vocationally focused training centres such as, what in Australia are called, Technical and Further Education (TAFE) colleges:

“I think it’s an immense pressure for the young people; they’ve already got a lot of pressure as it is but to succeed to the extent of university when they’ve missed out on a lot of education, that’s quite a lot of pressure. I think some Sudanese people view success as going to university and a lot of students don’t think TAFE’s anywhere near good enough for what they should be doing. And I think that goes back to the fact that they have the opportunity here in this country to go to uni and go to school so they think ‘why not?’” (Key informant 20 – Youth worker)

Whilst key informants commented on the relatively high number of resettling Sudanese young people undertaking university study, the pressure to do so may have negative impacts on those that may not want to, or may not be able to, gain admission to university education.

The effects of not meeting expectations and difficulties at school for refugee young people were thought to possibly include frustration, guilt, a sense of failure, not attending school, and in some cases dropping out of high school. Adolescent boys were thought to be particularly prone to dropping out of high school, as is evident in the following quote:
“And there’s certainly a group of young people have, sort of, dropped out of the system and have engaged in, you know, with their peers in order to try and find some sort of peer group, but they’ve engaged in activities that are, you know, that are not very helpful to them; anti-social activities are not very helpful...” (Key informant 2 – Mental health nurse)

As some key informants commented in relation to some Sudanese young people dropping out of school, this may contribute to marginalisation within both the Sudanese community and the broader community.

Some key informants also commented on post-school education pathways and the perceived inadequacies of the information available to assist resettling refugees to make informed choices about their continuing education. Even where information was provided the ability to critically evaluate such information may be constrained by unfamiliarity with Australian systems and institutions. This was the case for one Sudanese key informant who reflected on his own decisions about further education saying:

“Like looking at it, I think I could have done a few things differently but at the time. Yes I was told, but I didn’t have the ability to decide because I didn’t know which one was good for me.” (Key informant 3 – Sudanese man)

The impacts of unmet education needs for both young people and adults alike, were thought to be felt in terms of difficulty in gaining employment, financial security, and sending money home; cumulatively impacting upon emotional wellbeing.

4.4.4 Employment and financial security

Gaining employment, and the associated financial security that it was thought to bring, was mentioned as an important pre-migration expectation about life in Australia. Employment, along with housing, education and learning to speak English, was considered a very high priority. One key informant expressed this view in terms of such factors being the foundations or “pillars of normal life” (Key informant 10 – Health service manager).  

One of the major reasons that employment was considered so important was its connection with financial stability and certainty. Housing, sponsoring other family members to migrate to Australia, sending money home, paying bride-wealth (dowries), as well as the meeting of
every day requirements such as a food and bills were, all thought to be bound up in the financial security that employment afforded.

Sending money home and sponsoring other family members to migrate to Australia highlight that there is much vested in the employment status and financial standing of Sudanese refugees in Australia. Not only is their ability to rebuild their own lives in a local context affected by their employment status but the course of the lives and wellbeing of significant others around the globe are also affected. This was thought to place additional pressure on resettling Sudanese refugees, which may impact upon the decisions that they make in relation to employment in order to satisfy the urgent need for income.

However, the ability of resettling refugees to gain adequate employment was thought to be constrained by a number of factors. English language ability was a major factor that was considered to affect employment opportunities. Even workplace environments employing relatively unskilled labour, such as factories, were thought to require a degree of English language ability so as to understand workplace and safety instructions.

Not having qualifications recognised within Australia was thought to have a negative impact upon resettling Sudanese refugees gaining employment in the area in which they were qualified. Consequentially some resettling Sudanese refugees were thought to either retrain in their particular area or apply for jobs for which they were overqualified.

A few key informants also felt that some resettling Sudanese refugees may experience explicit discrimination when applying for jobs. Whilst interviews revealed little about the sources and causes of this discrimination one might speculate that negative perceptions about Africans and Sudanese might be implicated.

However, even if employed, key informants suggested that employment may be considered sub-optimal for some resettling Sudanese refugees. For instance, as one key informant’s account exemplifies, it was thought that some resettling Sudanese refugees were employed in poorly paying jobs due to a number of the factors already discussed:

“...without education and qualifications, then people are, you know, limited to low, really low income, sort of, factory work and that kind of stuff.” (Key informant 10 – Health service manager)
If such employment is transitional this may not be problematic but if such jobs persist into the longer term it may work against the securing of jobs commensurate with skills. The confluence of such factors mentioned above and poorly paid employment was also thought to result in some resettling Sudanese refugees working in poor or relatively unsafe working conditions. In addition to factory work the example of resettling Sudanese refugees undertaking taxi work was given by one key informant who said:

“...often Sudanese become taxi drivers for example and there’s a significant amount of crime that goes on out there against taxi drivers…” (Key informant 13 – GP)

Whilst key informants highlighted a number of barriers and difficulties to gaining employment many also emphasised the perseverance of Sudanese refugees in their attempts to secure employment. Some of the Sudanese key informants themselves had undertaken volunteer work in order to gain experience that would enhance their job prospects. Reflecting upon their own experiences, Sudanese key informants also mentioned undertaking further training and courses in order to enhance employability. To this end many of the Sudanese key informants at the time of interviews were studying for university degrees.

Some Sudanese key informants made the difficult decision to retrain again in their professional area such that they could have their qualifications recognised, and subsequently work in Australia. Some Sudanese key informants did this part-time or at nights whilst they worked in order to support themselves and/or their families. One key informant highlighted the resilience that is associated with undertaking the challenge of retraining all over again saying:

“I mean we just heard so many different stories of people who have had really high ranking position in Sudan particularly, before the war and, you know, they, may have lived in exile for x number of years in other second countries before coming here and then they come here and they may speak English but they have to sort of retrain in their professions, and it’s a very brave and resilient person who will take that level of challenge on.” (Key informant 10 – Health service manager)

This was particularly the case for Sudanese key informants who worked in health professions.

Through volunteering, taking jobs for which they were overqualified, undertaking training
and retraining, the perceptions posited in this research emphasise the perseverance and resilience of Sudanese refugees in attempting to gain suitable employment. The taking of such steps indicates people who wish to rebuild their social worlds, and who take the initiative in doing so.

Whilst many of the Sudanese key informants were employed at the time of the interviews they also reflected upon the effects of unemployment and financial insecurity on the mental health of resettling Sudanese refugees in the community. Unemployment was thought to contribute negatively to emotional wellbeing and health more broadly as is illustrated in the following quote:

“...when you don’t have a work; you stay at home, you become depressed, you drinking, smoking – it’s natural.” (Key informant 6 – Sudanese man)

Where refugees were unable to gain employment in the area in which they were trained, the understanding that this was associated with a loss of status and self-worth was posited by a number of key informants. For resettling refugees whose identities are likely to be thrown in to question as a result of forced migration, the continuity of and stability of identity that is afforded by gaining employment in an area in which one was trained is likely to become extremely important. The inability to achieve this may thus be seen as part of a larger crisis of identity affecting resettling refugees.

Key informants alluded to the intersections between gender, identity and employment. Some key informants thought that given traditional gender roles that endorse the male as the breadwinner, unemployment was thought to have a particularly negative emotional impact upon men:

“And particularly men sort of slump into this sort of, you know, sense of failure and, you know, depression and that sort of thing.” (Key informant 10 – Health service manager)

This was thought to be exacerbated when accompanied by a female partner or wife who may have been able to gain employment. The ability of women to gain employment whilst men could not was thought to play a role in changing gender and role dynamics, which was sometimes a source of conflict within families. This will be discussed in greater detail later in this chapter.
4.4.5 Need for information
The need for information to aid in the process of rebuilding social worlds cut across all sub-themes and was particularly evident in the accounts of Sudanese key informants. Information to assist refugees in navigating unfamiliar health and social systems, in addition to information about life in Australia, cultural norms, education opportunities, career paths and health issues was considered to be important in the process of rebuilding social worlds. This is reflected in the following quote from a health service key informant:

“They need stability and, you know, assistance with everyday things like, you know, learning how the health system works, how buses work, how the education system; you know just practical information.” (Key informant 10 – Health service manager)

Furthermore there was a desire for information to be reinforced rather than a once-off event, which was thought to be at risk of being lost amidst the range of other considerations that refugees were likely to have. The role and provision of information will be discussed further in the following chapter.

4.4.6 English language abilities
The need to learn English was thought to be a high priority that in many ways underpinned the success or failure of Sudanese refugees in other areas of rebuilding social worlds. As already mentioned, the ability to gain employment, for instance, was thought to be connected with the ability of refugees to learn English.

English language ability was also considered to affect the ability of Sudanese refugees to navigate everyday practical issues in their new social worlds such as filling out forms, paying bills, negotiating loans and contracts, shopping, and catching public transport. A sense of this is evident in the following quote:

“And in terms of getting the basic, their rights to, you know, in terms of signing contracts and having things interpreted, and understanding loans that they might be taking out is very, very impaired; A because of language but B because this is just a whole new world to negotiate.” (Key informant 4 – Social worker)

Where Sudanese refugees required assistance from services in meeting their needs, the ability to be availed of the assistance required was thought to hinge on English language abilities. In
many instances the inability to communicate needs was thought to be a major barrier to accessing services, as the quote below suggests:

“I mean again the biggest problem is language I think. If you’re not proficient in English language you can’t really call out for help in a way that would immediately get some help. Just knowing what’s out there, just knowing what services are available; we find that in the mainstream community, the English speaking community, let alone the non-English speaking community who don’t know about what help’s available.” (Key informant 5 – Psychiatrist)

As one Sudanese man suggested, learning the language of the society in which one finds oneself is also likely to facilitate understanding about and adjustment to living in that society:

“For me the problem was that when I came to Australia, I would not say, I know limited English, but it’s very hard to be integrated into the community in terms of the language, the culture.” (Key informant 6 – Sudanese man)

Here the ability to participate in the community is linked to language ability. Other key informants drew the connection between the inability to learn English and learning a new culture, and poor self-esteem and stress:

“They feel embarrassed because they are not progressing well with the English; you know these things, this sort of sense of self-esteem coming low because, you know, they don’t feel that they are quite grasping what’s going on or being able to communicate, to communicate their needs so all. Language, you know the stress of dealing with a new language and the new culture is quite significant.” (Key informant 12 – GP)

Thus the ability to learn English is likely to affect resettling refugees’ ability to adjust to life in a new social world. The theme of adjustment emerged strongly throughout key informants’ accounts and it is to this aspect of rebuilding social worlds that attention is now turned.

4.5 Adjustment to living in a new social world

Dealing with the practical issues associated with resettlement was one aspect of rebuilding social worlds that was thought to constitute an important need. A related theme important in the endeavour of rebuilding social worlds was that of dealing with adjustment. Adjustment refers to the question of how one can live in the new and often quite different society and
culture, in which social worlds are being rebuilt. Some aspects of the need to deal with adjustment that emerged as important sub-themes in the data are illustrated in Figure 4.4. The perceptions of the key informants in this research illuminate that the way in which resettling Sudanese refugees respond to this issue can have a significant impact upon their mental health. But as interviews suggest the style of adjustment adopted is likely to differ according to a number of factors, including age, and gender.

Figure 4.4: Adjustment to living in a new social world – theme overview

Where the practical tasks associated with rebuilding social worlds were thought to be the most immediate issues facing newly arrived refugees, issues of adjustment were thought to emerge with time:

“But I think issues change over time too. You know, in the early years, you know, the first few years, the settlement issues; you know finding a house, learning English, trying to work out how to get an income, you know just really basic issues are predominant. They are the biggest pressures for families. As time goes on I think that, particularly when you have a situation where the kids learn English much more quickly than the parents and it’s through the kids that the parents are negotiating the school system and perhaps other systems as well, sporting systems, that I think that, I suppose the parents and the children have different rates of adjusting, really, to a new environment.” (Key informant 2 – Mental health nurse)
However key informants posited a nuanced understanding of adjustment suggesting that the process of adjustment begins right from the very outset of displacement and forced migration. Key informants thus highlighted that the processes of adjustment and forced migration can be seen as interwoven. Through living in cities or refugee camps in different societies the understanding was that Sudanese refugees have been forced to adapt in order to survive. The numerous languages spoken by Sudanese refugees for instance were alluded to as evidence of this history of adjustment.

This history of constant rebuilding and adjustment was thought to be not inconsequential to the experience of rebuilding and living in a new social world in Australia. The country of asylum before arriving in Australia for Sudanese refugee youth – many of whom were born in settings outside of Sudan – for instance, may form an important part of their identity. As one Sudanese man suggested, sometimes the peer groups of Sudanese youth are formed around identifications with the experiences and the language spoken in countries of asylum.

Furthermore, key informants suggested that traditional Sudanese cultural practices have undergone permutations as a result of this constant process of adjustment and this was sometimes perceived as weakening them. Thus a static view of adjustment from living in a native social world (i.e. Sudan) to a foreign one (i.e. Australia) is likely to be an overly simplistic one. In light of this, adjustment and the process of rebuilding social worlds might best be seen as part of a continuum rather than one that begins upon arrival in a country of resettlement.

### 4.5.1 Changing gender roles and family dynamics

Many key informants highlighted the need to cope with different cultural understandings about gender. These changing gender dynamics were thought to have a significant impact at the family level, shifting family dynamics. As a result of resettling in Australia key informants suggested that the traditional Sudanese family unit headed by the male breadwinner had changed and in some cases people felt that it has been weakened.

One of the major factors key informants viewed as contributing to changing gender roles was the perception of more social and financial freedom for women in Australia in particular. It was thought that Sudanese women were likely to adopt and respond positively to greater social and financial freedom, as the following health service key informants suggest:
“...it can be very conflicting coming into a society where there’s seen to be much more gender equity or much more fluidity in gender roles and for many couples that creates quite a bit of conflict. I think more so for the men than the women because the women see this as an advantage in adopting this state of more gender, you know equality.” (Key informant 5 – Psychiatrist)

Greater financial freedom for women was thought to stem from the fact that Sudanese women in Australia were able to have their own bank accounts, gain employment, and/or receive social security payments on behalf of their children or families. However, this was thought to challenge the traditional male breadwinner role and was considered to be a potential source of conflict within the family:

“And the same goes for the husband and usually it’s around, you know, how the house should be run; maybe he should be having hold of the money and the wife says ‘no I have the right now to have my own account and my finance’ and this is a big conflict between the family because their husband think he has lost his manhood and it’s gone now to the women and the children. So it becomes sort of like sometimes you hear there is a lot of domestic violence or some man has turned to drink.” (Key informant 8 – Sudanese woman)

Greater social freedom for women was thought to centre around employment primarily. Situations where women were able to gain employment whilst their husbands or male partners were not were perceived to present as a potential source of conflict within families. It was thought that Sudanese men may feel a sense of failure or resentment at the perceived loss of their traditional breadwinner role and that this may contribute to alcoholism, domestic violence, family conflict and break up.

Key informants also highlighted the role of circumstance in changing gender roles and family dynamics as well as the norms, values and beliefs in Australian society. For example, women who migrated with their children were thought to be forced to assume aspects of the role and responsibilities of the men that war had taken from them or forced migration had separated them from. Partly as a consequence, and due to the potential for social isolation, many key informants felt that women who headed households were a group within the Sudanese community that had particularly high needs. At the same time it seems that some women who headed households may have been able to adjust to their new role despite the difficulties. In fact, key informants also emphasised the resilience of such women in providing for and
protecting their children, working, playing significant roles in the Sudanese community, managing households, learning English, and studying. Successful family reunification, in which husbands or male partners were able to re-join their wives or female partners and children in Australia, was generally viewed positively. However, some suggested that it could also introduce an element of tension when the male partner finds the family and gender roles that governed the family in pre-war Sudan significantly altered.

The disruption of families and extended families due to the separation and dispersal of family members around the world was also thought to be influential in altering gender and family dynamics in other ways. Key informants commented on the traditional structure of Sudanese families and the significant role played by extended family members within families. For example the responsibilities of rearing and looking after children were thought to be distributed throughout significant women relations in Sudanese families. However, in Australia, extended family networks were not always accessible. This relative lack of social support accompanied by the need to work often meant that pressure was placed on men to adopt responsibilities traditionally held by women. For some men however, key informants explained that adopting such responsibilities might be viewed as demeaning or threatening traditional notions of masculinity. This again was thought to constitute a potential threat to relationships where men were unwilling to adjust their roles accordingly.

Likewise, as a consequence of circumstance, and as a result of their command of the English language and new society, young people may also be forced to take on adult roles and responsibilities, which they might not have otherwise done if families had remained intact. Examples canvassed included young people caring for children, undertaking the majority of household responsibilities whilst parents worked, accompanying parents to appointments, and translating for parents. Some of these are evident in the account of one key informant:

“And I also think for girls in particular, socially they are restricted because they take on a lot of adult mother responsibilities so they might babysit their younger siblings or go home from school and have to cook for everyone in the family. I mean cooking for females in Sudanese cultures is the norm but I guess they’re not able to go out as much or they’ve got commitments at home to help out their family. And I think they kind of just miss out on their childhood and growing up because they have to take on adult responsibilities at a young age and even some girls as young as ten are doing that role as well so they learn from quite a young age.” (Key informant 20 – Youth worker)
In being compelled to undertake these responsibilities, key informants felt that significant pressure was placed upon young people and as a result, opportunities for participation in Australian society and to engage in a ‘normal’ social life were diminished.

Key informants consistently listed family conflict and separation, domestic violence, and alcoholism as potential consequences of an inability to negotiate cultural differences in terms of gender roles and changing family dynamics. The impact of such issues was viewed as contributing negatively to mental health. However some key informants understood these issues as being manifestations of mental health issues in and of themselves. As one key informant indicated:

“So it’s very common that emotional health issues will start to manifest and culturally there may not be a way of recognizing all of that, so it may come out in very, sort of, difficult ways. So commonly depressive illness might manifest in other forms of behaviours like family violence issues, you know men kind of drinking too much...” (Key informant 10 – Health service manager)

This sentiment was also conveyed in the reflections of a Sudanese key informant on another Sudanese woman in the community:

“She has issues with her husband and she separated from him and she ended up drinking just out of frustration, which is also mental health issues. So she became very, very frustrated and started drinking alcohol; she wasn’t able to take care of her kids.” (Key informant 11 – Sudanese woman)

Here it is evident that issues of family conflict and breakdown not only affect husbands and wives but also their children.

4.5.2 Divergent adjustment pathways

Key informants’ perceptions revealed that as much as the course of adults’ adjustment had an impact upon children at the family level so too did the trajectory of childrens’ adjustment affect family dynamics and the emotional wellbeing of other family members. Key informants consistently commented on the differential rates of adjustment or the sometimes divergent adjustment pathways taken by children and parents. Due to their greater exposure to Australian society through school, their relative speed in learning English, and subsequently
their greater consumption of western culture, it was thought that young Sudanese people were more likely to adopt western attitudes, and beliefs than their parents. Several manifestations of young people’s adjustment that were thought to contradict traditional Sudanese norms are illustrated in the following quote:

“What’s contributing to that is that the parents have been brought up in a specific way and they are oriented to their culture but when kids come to Australia, they don’t want to abide to that culture, they want to adopt the western culture like they want to do whatever they want to do – parents, don’t have to ask them. But in my culture, if you are not married you are still under the obligations of the family, you are still under, you have to stay at home, you have to ask permission going out, you are not allowed to go around, you know, night clubs and things like that. Drinking, smoking is something that cannot be discussed in the family. Having a relationship with boys, you know, like what white people do here is something that is not easy. Talking about sex is a taboo. So things like that have had a lot of impact on the settlement of people in Australia.” (Key informant 11 – Sudanese woman)

This was also thought to be linked to identity, with some key informants stressing the importance of peer group belonging in relation to Sudanese young people:

“...you see a lot of the stress occurring in families when children and particularly teenagers as I said adapt very readily and want to, particularly for young people coming here say as teenagers, want to very quickly feel an affinity with their own age group and adopt those customs of dress, or musical taste, or behaviour or language so that they can survive in their social group really but that being at odds with their parental expectations; you know particularly say for boys say drinking, curfews, who they mix with, manners, etiquette all of those sorts of things.” (Key informant 5 – Psychiatrist)

Whilst young people’s adjustment trajectories might be characterised by an openness to change, continuity of identity, family structures and gender roles were considered to be important for parents and men in particular, as one key informant explained:

“So when you migrate as a refugee family it’s terribly important for parents to hold onto that; so to retain the practices that they had that, you know, made their family what it was when they were at home.” (Key informant 10 – Health service manager)
Thus it may be important for parents to maintain and “hold onto” the family and cultural structures that they are used to so as not to lose these on top of other losses they had accrued as a result of war and forced migration.

Where adjustment trajectories were thought to clash, key informants commented that there can be significant effects on family and community members. It was thought to be a source of stress for adults and parents, as the following quote suggests:

“Like you know, naturally young children they also want to identify themselves with yeah so our children have been, they’ve been going through different cultures from Sudan to Kenya, some in Uganda and Egypt, so they keep on adapting themselves to those cultures and those cultures they conflict with our traditional cultures, you know. So that is causing a lot of trauma to adults when they see their children they feel that our generation is getting lost; this is how I want my children to behave, I want them to do things the way like this but the kids of course they are in a different environment – they want to live they way young people here live – and that is a shock to adults in our community, so that is causing another stress.” (Key informant 7 – Sudanese woman)

Not only was the perceived losses of traditional Sudanese values and beliefs considered stressful for parents and adults but as key informants revealed, the adoption of a western individualistic rights based framework by young people was also considered a source of stress and potential area of conflict:

“I think it’s very painful and you know the parents talk about just really being lost in terms of feeling like they have no authority anymore over their children; that their children come here, they quickly get the idea that you can do anything you want in Australia and it’s all rights and no responsibility. And the traditional parenting methods or the way they might of dealt with rebellion or non-compliance are completely unacceptable here and that leaves their parents feeling completely disempowered and very, very frightened because they don’t know where it’s all going to lead to.” (Key informant 4 – Social worker)

4.5.3 Cultural differences

As above, the need to negotiate cultural differences was considered pivotal to the adjustment and mental health of Sudanese refugees. As well as being an ever present feature of everyday life, key informants highlighted major areas in which cultural differences impacted upon
resettling Sudanese individuals and families, including differences around parenting and the perceived collective nature of traditional Sudanese societies versus the perceived individualistic nature of Australian society.

The weakening of parental authority over children was linked to young people’s immersion in an individualistic rights based cultural framework as opposed to the emphasis on responsibility in Sudanese cultures. However it was also connected with the perception that aspects of Sudanese parenting methods were considered unacceptable in Australia. One Sudanese key informant described how this might play out in families:

“And you know if you say you know ‘do this’. ‘No, no, no the school say don’t do this and if you argue I’ll call the police or the social worker’ so the parents actually find it that their hands are very tied; they can’t do much with their children.” (Key informant 8 – Sudanese woman)

The adoption of western values and beliefs at the expense of Sudanese ones was viewed as influential in some examples described by key informants of young people leaving home at a young age – something which is not the norm in Sudanese cultures nor in ‘Australian’ society but that may be more common in Australian households – and the subsequent impacts on parents and families:

“One time there was one lady in our community, her daughter decided to leave the house by the time she was, I think fifteen. The mum was as if she was mourning, as if someone died. The women were coming to visit her and she was crying and everybody was; like the house was full of women, supporting her – it’s like as if someone had died. It’s not easy losing a child going out of the house; for them it’s very, very difficult.” (Key informant 11 – Sudanese woman)

“You know, if a young person is not an honest person then obviously it’s a recipe for conflict in the home environment. Some cases they move out or they manipulate the system. As I said sometimes young people have moved out of home and then wreaked havoc wherever they winded up and then come back home again but the damage is already done. Some parents are tearing their heads off and want to go back to Africa; can’t cope, things like that.” (Key informant 19 – Sudanese man)
As the above quotes illustrate, adjusting to living in a new social world may be so difficult to cope with that people may contemplate returning to Africa. This was commented upon by other key informants and is also likely to be an expression of the desire for the familiarity of social worlds once lived in. Contemplating returning to Africa often manifested in the lament of the perceived loss of extended family networks, community, and a collective consciousness, which was set in contrast to the isolating individually orientated nature of western society. Such sentiments are exemplified by one Sudanese key informant:

“And I think also here what make it more hard because people are isolated; you go to school if you are going to English classes, go home, cook for your kids, go to sleep, next thing tomorrow where in our culture we all sort of, what do you call it, we all together – like I don’t isolate myself. If I’m going somewhere I just leave my kids; I don’t even say to my neighbour ‘look I’m going to the shop, the kids are there’ but the neighbours know I’m not in, they’ll look after the kids. And if I have kids my family or my husband’s family will send somebody; two young girls or whatever to come and stay with me and give me a hand so that release the pressure for me, where here they isolation – you do everything yourself, you stay yourself, you just eat with your kids. I think for most Sudanese it’s very, very difficult because we not used to that kind of life. And I think that’s the other problem that makes people feel a bit depressed because you don’t have anybody to share your feeling with.” (Key informant 8 – Sudanese woman)

Key informants had different views about what constituted ‘healthy’ adjustment, suggesting that the answer is likely to be dependent on individuals and their circumstances. However, the need to negotiate an adjustment trajectory that allows resettling refugees to operate and thrive in their new social worlds was considered important. When taken in light of other potential difficulties the effects of an inability to do so are likely to be detrimental to emotional wellbeing.

Key informants’ accounts also highlighted that the task of adjustment for resettling refugees is likely not only to be a matter of adaptation to living in a new social world but also to living in new and old social worlds simultaneously.

4.6 Coping with living in old and new social worlds simultaneously
The need to cope with living in new and old social worlds at the same time was interpreted as another element of the broader theme of rebuilding social worlds. Key informants consistently
highlighted the continued impact of people and events abroad on the local context in which Sudanese refugees lived, and upon their emotional wellbeing. Prominent ways in which this was thought to occur are highlighted in Figure 4.5 and will be discussed in this section. Key informants drew attention to the interdependence of new and old social worlds and the need to engage in this complex aspect of the experience of resettling refugees.

Figure 4.5: Coping with living in old and new social worlds simultaneously – theme overview

The interplay between old and new social worlds is expressed in the following reflection upon the factors contributing to mental health issues amongst resettling refugees:

“Because of those financial stresses in Australia, because of separation of families left home, because of stress; being stress about people, supporting people financially, people who are left home; about the issue of Sudan; having a problem – coming from war for two decades. People wanting peace so much here that they are staying in Australia but they are still thinking of the people back home in terms of security, in terms of peace keeping, in terms of peace and sustainability in Sudan. These are all affecting the people who are staying here; affecting their mental health. So I think these are important issues that need to be addressed.”

(Key informant 11 – Sudanese woman)
4.6.1 Separation and its impact

The need to cope with the impact of old as well as new social worlds was for the most part thought to stem from the separation and dispersal of family members around the globe as a result of war and forced migration. Key informants commented on the chaos of flight, which Sudanese key informants, in particular, explained as contributing to the separation and dispersal of families around the world. In so doing some highlighted the nature of their own dispersed families:

“Yeah I think from my own experience because when we were in Sudan during the war, the only thing you wish is to get out of that situation; you wanted safety and security, OK. So when we got out of the country you had no that choice to say ‘I want to take all of my family’; it depends on what comes up and you just go. Today I live in Australia, I’ve got sister in Canada, I’ve got sister in America, I’ve got sister in you know, Ireland; the whole family is separated.” (Key informant 7 – Sudanese woman)

Separation was viewed as a major barrier to the happiness of resettling refugees as the following quote suggests:

“There are so many people here, someone came and left their children because they didn’t know where their kids were before they came here so even though you are in Australia, life is good, but you lost your children, you can’t be happy, you know. Children are here, they want to sponsor their parents, their parents are rejected, they can’t be happy.” (Key informant 7 – Sudanese woman)

One consequence of the separation of family members was a constant worry about the wellbeing and safety of significant others back home and around the globe. Many key informants highlighted the possibility that significant others were still in precarious situations in refugee camps, or in the poor urban areas in countries neighbouring Sudan, or in Sudan itself. Even though the hostilities have ended in South Sudan it was thought to still bear the scars of war, poverty, lack of infrastructure, and difficulties associated with repatriation. The worry for resettled refugees was thought to be made worse by an awareness of the plight of significant others in such situations, given the likelihood of having similar experiences.
themselves:

“But I think, you know when people are preoccupied with either their past experiences or knowing that other people, significant other people, are still going through them, they’re not safe either. And I think exposure of the media of, certainly in Iraq; you know there’s a lot of media about what’s happening there and that has an ongoing impact on people who are here, some of whom are almost obsessively watching the news. Now when there was an issue in Kakuma refugee camp a couple of the Sudanese men were texting me, giving me updates; they were obviously glued to the outside media and I think, you know, it’s very hard. I think that’s a major barrier to people being able to settle when they are really still not safe.” (Key informant 4 – Social worker)

Like the key informant above, many key informants emphasised that the safety and wellbeing of resettling refugees in Australia is often bound up in the safety of significant others. In this way one can begin to understand that the global can significantly impact not only upon the emotional wellbeing of resettling refugees but also their ability to resettle.

Also evident in the accounts of key informants is the limited degree of control that resettling refugees have over situations globally that can potentially impact upon the wellbeing of significant others, and thus themselves. Technology, in some ways was viewed as being positive in terms of maintaining connections and receiving news. However, considering that news was more likely to be bad than good, it was thought to exacerbate the sense of worry and the powerlessness of resettling refugees to act on any information they received. It also was thought to contribute to the consistency and immediacy of worrying information about relatives or situations globally that could potentially affect them.

As well as worry, key informants’ accounts also highlighted the potential for feelings of guilt associated with having been able to escape the situations that significant others may still be experiencing. This was thought to have a tangible impact on the emotional wellbeing of resettling Sudanese refugees in Australia, as the following reflection indicates:

“...you eat, when you eating the picture of your family come to your face, what are they eating now? Here I am eating bread and butter what do they have because you know exactly what you have to have, most of the time nothing. So when you eat and you feel that my nieces are really screaming for something to eat there, your tummy will just close and you lose
appetite, you don’t eat. And this is, many people are going through that here.” (Key informant 7 – Sudanese woman)

This particular key informant’s experience also points to the possibility of embodied pain amongst resettling refugees; an indication that situations and experiences affecting old social worlds may be lived on an immediate level rather than simply occurring thousands of miles away.

Not only did key informants feel that separation was a major source of stress and worry about the safety and wellbeing of significant others around the globe, the effects of separation were also canvassed in the language of loss and grief. The loss of the intact family was often considered the focus of this grief:

“All my family is cut in half and when I think about it I say ‘this is another war, this is the separation forever, I will never see my nieces, I’ll never see my nephews, they are American, they are Canadian, I am Australian, where is our family’ and that grieving affected me a lot, it’s affecting my children a lot. So really you just wonder, you know. (Key informant 7 – Sudanese woman)

But given the non-nuclear nature of the traditional Sudanese family unit as portrayed by key informants, separation was thought by some to also signal the loss of the collective nature of life that governed the old social worlds of Sudanese refugees. This has been commented upon earlier in the unpacking of the adjustment sub-theme but the following quote of a Sudanese woman further exemplifies the grief associated with this perceived loss:

“And our system, we are kinship; in our relationships we stay together. So that togetherness is support, is caring; everything is done in a collective way, you know – that thing is lacking now.” (Key informant 7 – Sudanese woman)

Despite the associated difficulties, the need to maintain contact with family members was considered important by key informants in bridging the distance that separation created and as a way of maintaining old social worlds. However, for some the difficulties associated with, or the pain of, separation may be so great that maintaining contact may not be enough to allow resettling refugees to function adequately in their new social worlds. This was particularly thought to be the case for women who headed households, in which case separation was
viewed as exacerbating social isolation. Thus the need for family reunification was also stressed as being important.

One GP key informant recalled the improvement in a Sudanese woman’s emotional wellbeing after having heard of her husband’s successful attempt at securing a humanitarian visa to Australia, saying:

“So I supported a woman for a long time a woman who was wanting her fiancée to join her and she was highly depressed, incredibly depressed, and it was really for several years that I continued to keep her hopes high and say you know ‘we are here to support you, will take a long time’ to reassure her ‘but we will get there, we will support you’...Yes, yes, he arrived and they got married. And then you know but even when she knew that things were moving along she started to shift and be more involved with the community; more positive. So that is a very important element; you know this sort of emotional isolation.” (Key informant 12 – GP)

This along with other perceptions reiterates the importance of the social world in contributing to and addressing mental health issues in resettling refugees.

Despite the need for family reunification in some cases, several barriers to family reunification were uncovered throughout key informants’ accounts. These included perceptions of complicated Visa application processes and slow processing times of Visa applications, and the cost burden that is associated with sponsoring family members under the Special Humanitarian Programme (SHP).5

4.6.2 Sending money home
The need to send money home was yet another important example of the potential impact of old social worlds on new social worlds, and vice versa, for resettling Sudanese refugees. Many key informants emphasised the potentially high need for resettling Sudanese refugees to send money to relatives in Sudan or elsewhere in the world and the subsequent pressure that this placed on them, particularly when considered in light of the other concerns that they may have.

5 Under the SHP sponsors are required to assume responsibility for and cover the majority of the cost of the flight to Australia and subsequent resettlement arrangements. Given that approximately half of Australia’s offshore refugee intake consists of SHP entrants the cost burden placed upon sponsors is a significant issue (Refugee Council of Australia 2008).
Interviews highlighted that the priority of sending money home was generally very high amongst resettling Sudanese refugees, often superseding local concerns. However the priority of sending money home is likely to vary according to a number of factors including the size, location, and intactness of family and social networks.

A psychiatrist key informant’s perception was that sending money home is “a constant pre-occupation” and “a constant source of stress” for the Sudanese refugees that she had seen in a clinical setting (Key informant 5 – Psychiatrist). A Sudanese key informant illustrated this through his own personal experiences in describing that he would often send money to relatives first before paying bills:

“I would line up people for the money that I’m yet to earn; ‘in 14 days I will earn this much, please when I do that, I’ll give you this much’. But then in 14 days, I don’t know, the bill will be here and this and the rent will be due and the money will not be enough and I will need to do some shopping... sometimes I used to say ‘ah I will pay the bill later and I help this person first’...” (Key informant 3 – Sudanese man)

Resettled refugees in countries like Australia are likely to be acutely aware of the plight of people back home, having experienced similar hardships, having ‘been there’ themselves. When the suffering of loved ones in Africa can be alleviated by sending money to them it is understandable that doing so might be a high priority.

For the senders, sending money home may also be a way of maintaining ‘Sudanese’ identity or in-group status, or a way of participating in the family, community and society which, key informants suggest, is so important. This was illustrated in a discussion with a Sudanese key informant:

“And some people say ‘ah nah just ignore them’ but it’s too hard for someone that’s really in that situation because you fear being ostracised... no one wants to be seen as now out of the community; you want to prove to people that you’re still one of them, you want to prove that I’m still who you know, I’m not changed, I’m not bad or if anything I’m better now because I’m in a good position to help you and I’m in a good position to look after myself”” (Key informant 3 – Sudanese man).
Thus, sending money home may be an expectation of those receiving the money and an important priority and an obligation for the senders. However, the need to send money home is likely to impact upon the ability of resettling Sudanese refugees to ‘get on’ with their lives in a local context; to ‘get on’ with the task of rebuilding social worlds. As is evident in the following quote, at times life in Australia may give way to more pressing concerns abroad, even if this may come at some personal cost to the resettling refugee and their family:

“…we get the money… and we send some home and then we end up with we can’t pay our bills, we can’t feed our kids properly, can’t dress them properly.” (Key informant 8 – Sudanese woman)

It is thus evident that the pressure to send money home interacts with the pressures that Sudanese refugees may be facing as a result of resettlement in Australia. This also raises the question of what effect unemployment, rent increases, or rising food prices (all things related to the local context), for example, might have on the ability of resettled refugees to send money home and subsequently on their own wellbeing.

The pressure to send money home was thought to be exerted in a number of ways. One of the elements that permeated the discourse of key informants was the role of communications technology. Whilst in many respects this was thought to exert a positive influence in terms of maintaining connections and identity and bridging the distance that separation from family members had created, it was also thought to be a mechanism through which constant pressure can be exerted upon resettling refugees to send money home.

The intensification of social relationships around the globe may also be partly implicated in another way in which the pressure to send money home is exerted, as is illustrated in the understanding of one Sudanese key informant:

“Your village in Sudan they will be aware; they will say ‘oh their son went to USA now he’s doing that and he buy the cattle, he buy a car or he buy for the family’ because I don’t have work, where can I get the money, I depend on social security... I’m doing nothing for my parents or my family, what do you think will happen? And then your people would say well ‘what are you doing there?’ and it will reflect on you... So that’s one way to get pressure to the people.” (Key informant 6 – Sudanese man)
This kind of comparison illustrates how other refugees’ stories of rebuilding social worlds, even in other parts of the globe, are likely to impact upon the way in which the resettling Sudanese refugees in Australia view themselves as successful or unsuccessful in their own attempts to rebuild social worlds.

In addition to the resettlement trajectories that resettling Sudanese refugees may take, interviews revealed that the inability to send money home can impact upon emotional wellbeing. Many of the key informants talked about feeling guilty or the potential to feel guilt as a consequence of not being able to send money home:

“*And you have this guilt, if you don’t send money and something happen, you’ll feel guilty for the rest of your life... It’s got a lot of effect on them because they feeling guilty of; if you are here now where you thought you’ll be rich to support them and now you can’t support them...*”  (Key informant 8 – Sudanese woman)

A perceived sense of failure in not being able to send money and fulfil family expectations or obligations is implicit in the above understandings, but was explicitly mentioned in others. In referring to the impact of the pressure to send money home on young Sudanese people, one Sudanese key informant said:

“...*sometimes they (Sudanese young people) just say ‘no it’s not worth it, living here (in Australia) because I can’t support my family (back home), they think I’m just a loser’ and they (Sudanese young people) tend to use drink.*”  (Key informant 8 – Sudanese woman)

This sense of failure may be likely to challenge an individual’s self-esteem particularly when the collectivist nature of Sudanese society and the importance of the family is taken into account. The understanding that some resettling Sudanese refugees, and young people in particular, who may be unable to cope with the weight of family expectation and obligation may use alcohol as a consequence – something which, according to Sudanese key informants, may be culturally inappropriate in some Sudanese cultures – further highlights the potentially negative consequences in terms of wellbeing.

As has been illustrated in a number of ways in this section, whilst resettling refugees’ bodies may be in new social worlds, their minds may be very much concerned with their old social worlds, as one Sudanese key informant evocatively articulated:
“...we kind of staying here but we are detached like all our soul is back home, you know. And we kind of like someone who has a split personality; one here and one at the other end...” (Key informant 11 – Sudanese woman)

Such understandings highlight the difficulty of moving forward, and/or recovering when body and mind are detached from one another pointing to the need to re-unify or at least find a middle ground between ‘old’ and ‘new’ worlds so as to enable resettling refugees to adequately function in both.

4.7 Overarching theme: Addressing mental health issues
Key informants predominantly viewed the mental health needs of Sudanese refugees in terms of rebuilding social worlds. The need to specifically address possible mental health issues was thus only thought to apply to a small proportion of Sudanese. However, the possible need to deal with trauma related and/or other mental health issues for some resettling Sudanese refugees was viewed as constituting one facet of the array of needs that refugees may have.

4.8 The need to deal with trauma
In the context of other needs, key informants highlighted the possible need to deal with trauma related issues. However, the need to address trauma related issues was viewed as contingent on the ability of resettling refugees to address rebuilding social worlds and on personal resilience. This theme will be deconstructed further in this section focussing on the sub-themes highlighted in Figure 4.6.
If trauma related and other mental health issues emerged they were generally though to do so in the longer term. This was when the flurry of activity associated with the practicalities of resettlement and living in a new society were thought to subside:

“So you know, there’s that long-term stuff where, you know, underlying issues start to come out. So that’s when, you know, PTSD type stuff comes in; when things quieten down, when all the flurry of activity - when all that stops then the body lets the mind kind of start processing all this stuff and then that’s commonly when people do start to experience post-traumatic stress disorder – like, you know, a year after they’ve arrived when they suddenly have all this time to start processing.” (Key informant 10 – Health service manager)

4.8.1 The role of trauma in the experience of forced migration

Key informants expressed a range of views in relation to the role of trauma in resettling Sudanese refugees’ experiences of forced migration. The views of health service key informants, in particular, reveal a tendency to consider trauma as implicit to the ‘refugee experience’ and thus the Sudanese experience of forced migration. This is exemplified in the following quotes:
“Very often the traumas, the family executions, all that sort of imprisonment torture stuff is pretty universal in the client base here.” (Key informant 13 – GP)

“…anybody that comes from a refugee background has been exposed to trauma.” (Key informant 4 – Social worker)

According to key informants, such as the ones above, resettling Sudanese refugees are likely to have experienced a number of possibly traumatic events. Many of these events such as rape, direct or indirect exposure to violence, separation from family members, the unnatural death of a loved one, torture and extreme deprivation were thought to have been experienced prior to migration to Australia, during flight or whilst in refugee camps.

As many key informants commented however, the continuation of hostilities in Sudan and the precarious safety situation in Sudan and in neighbouring countries meant that such events were thought to be potentially experienced in a post-migration context. In relation to the impact of separation for example, the assumption that the distance from homelands and warzones affords resettling refugees protection and safety is problematic in light of key informants’ accounts. Furthermore the description of post-migration stressors such as practical issues associated with resettlement and adjustment issues, as traumatic by some key informants is important. This suggests that perhaps traumatic events cannot be assumed to be solely located in experiences in the faraway places of the past histories of resettling refugees but may be ongoing, or in some cases may even be unique to post-migration contexts. Such understandings may prompt a re-assessment of conventional understandings about trauma, and how it may be addressed in resettling refugee populations.

Some key informants perceived that a negative emotional impact of having experienced traumatic events was inevitable. Such key informants were likely to medicalise the negative effects of traumatic events, interpreting them through the lens of post-traumatic stress disorder (PTSD) or other psychological labels. Whether western cultural constructs such as PTSD have meaning outside of the context in which they were produced is questionable. The perceptions of Sudanese key informants in relation to trauma were diverse. These are likely to have been influenced by their exposure and possible acculturation to western medical paradigms given that most Sudanese key informants were currently or had been working within the health system. Some Sudanese key informants questioned the applicability of the trauma concept:
“Trauma, I don’t know if they would understand it as trauma. They can say ‘yes the person had a bad experience’, and sometimes yes they have reflection of what had happened but they wouldn’t have a particular name, saying a ‘trauma’ or anything like that.” (Key informant 8 – Sudanese woman)

Other Sudanese key informant’s views were more consistent with western views of trauma but nevertheless fell short of the explicit labelling of the problem as PTSD:

“Well the effect of the war is on people who have been witnessing the atrocities that’s happening; people being killed, people being tortured, women being like you know, violence against women – all sorts of violence, physical, mental and all sorts of violence, even sexual violence against women – these are all issues that affect refugees and stay inside them. Like it’s very traumatic experience to them… Some people have the bad memories from things they have seen during the war, which always influence them; sometimes they think about it and it’s just blocking their mind.” (Key informant 11 – Sudanese woman)

One Sudanese key informant and health professional, however, explicitly medicalised traumatic experiences, and saw them as contributing to mental health problems like PTSD:

“But my belief is that because most of them; if you go on the statistically it’s hard, it’s extremely to get a person who’s maybe been to a war zone and got no mental problem. But those who’ve been in the war or been wounded they’ve been a lot of people who’ve got a mental problem at the moment. And to back up my observation is that if you look into also to people who, especially Australian who’ve gone to the Vietnam, most of them got a PTSD.” (Key informant 6 – Sudanese man)

As will be elaborated upon further in this chapter, mental health beliefs are likely to influence perceptions of what constitutes a mental health need, and perceptions of how best to address that need.

4.8.2 Impacts of trauma

Whilst such accounts illustrate something of the meanings attached to the trauma label amongst resettling Sudanese refugees, they reveal relatively little about the need to address or cope with trauma in the context of other needs resettling refugees may have. Consistent with the following views, most key informants emphasised the point that, despite the likelihood of
having experienced traumatic events, the need to address trauma may not necessarily be a high priority when viewed in the context of other needs:

“So we certainly do offer Sudanese people the opportunity for counselling but it’s rarely taken up or if it is the workers often talk about just getting bogged down around practical advocacy rather than, perhaps, a more structured approach to dealing with post-traumatic stress symptoms, yeah; learning relaxation methods, yeah, or even using the massage service it’s not – I wouldn’t say it’s not used but it doesn’t have the same uptake that other cultural groups seem to have.” (Key informant 4 – Social worker)

“So there doesn’t seem to be enough focus on the link between these social problems that they actually experience as a result of migration or resettlement. So to give them that opportunity to air or to express their experience of trauma is therapeutic of course but more helpful than anything is that support in all those aspects; the social aspects of their lives.” (Key informant 12 – GP)

Like those quoted above, some key informants posited a multi-tonal understanding revealing that the effects of traumatic events are likely to be affected by the ability of resettling refugees to rebuild their social worlds and also by the resilience of individual refugees. A health service key informant exemplified this viewpoint saying:

“So I think the African thing because of the – you know this is not scientific or anything – the degree of suffering, I guess, that individuals have had to endure, perhaps even over generations, contributes, I think, to a, sort of, sense of resilience and personal strength amongst Africans, and particularly Sudanese that enables them to resettle reasonably well and get over experiences of trauma...Anyway I don’t know that anybody has done any research on this but the African experience is one of just sort of, pick yourself up and keep moving and, you know, again it depends on the individual, and it depends on their pre-migration experiences, and entirely upon what sort of post-migration support and what experience they have. (Key informant 10 – Health service manager)

The articulated possible impacts of trauma for those refugees who may be affected by it, however, also point to the interconnectedness of needs. Nightmares, flashbacks and an inability to sleep were all mentioned as possible trauma related symptoms impacting upon wellbeing and everyday functioning. Furthermore according to health service key informants
trauma was thought to impact upon the ability of resettling refugees to rebuild their social worlds in a number of ways including:

- Impaired ability to concentrate and learn at school or in English language classes
- Impaired ability to undertake practical activities associated with resettlement and everyday life
- Emotional inaccessibility to significant others
- Impaired ability to function in a family environment and so forth.

The ability of refugees to meet needs associated with rebuilding social worlds was thought to also affect their ability and/or readiness to deal with trauma. It was common for health service key informants who provided clinical services to resettling refugees to remark that trauma issues could only be dealt with once needs associated with rebuilding social worlds had been met. This understanding of the inter-relatedness of trauma and other needs is exemplified in the comments of a psychiatrist key informant:

“And sometimes it’s only when some kind of reasonable stability is established can we start really dealing with the trauma itself; sometimes these things take priority, these things need to be sorted out, before the trauma can be but sometimes it’s a vicious cycle and it’s interrelated. Say a person who is traumatised can’t deal with the housing or the English, or going to English class or dealing with social security so you know, you have to deal with all these things at the same time. (Key informant 14 – Psychiatrist)

4.9 The need to address other mental health issues

Some key informants revealed that resettling Sudanese refugees may experience, and need to address, other mental health issues like depression. Furthermore, the need to address mental health issues involving psychosis amongst resettling Sudanese refugees was also canvassed as a possibility, as key informants drew attention to some extreme cases of which they were aware. However, key informants highlighted that resettling Sudanese refugees are likely to have their own mental health beliefs that amongst other things may influence how mental health needs are defined. Such understandings are important to keep in mind when interpreting perceptions of mental health needs in any community. However these have particular pertinence when exploring mental health needs in cross-cultural contexts. These themes, which are highlighted in Figure 4.7, will be elaborated upon in this section.
4.9.1 Mental health beliefs

At this juncture it is necessary to highlight that resettling Sudanese refugees are likely to have their own beliefs about mental health and illness that affect how one might interpret these findings, and the way in which needs might be met. Differences in perceptions about Sudanese mental health beliefs or explanatory models were evident in this research. There was a tendency for non-Sudanese key informants in particular to equate Sudanese mental health beliefs with African or non-Western mental health beliefs. Whilst there may be some common threads, the accounts of Sudanese key informants point to a greater diversity depending upon factors like ethnic group and sub-groups, exposure to western culture and medical ideas, and whether people had lived in rural or urban areas prior to forced migration. Table 4.1 summarises what were interpreted to be important perceptions about the mental health beliefs of resettling refugees.
### Table 4.1: Summary of important perceptions about the mental health beliefs of resettling Sudanese refugees to emerge from key informants’ accounts

<table>
<thead>
<tr>
<th>Perception</th>
<th>Illustrative Quote</th>
<th>Whose perception?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression may not be understood as abnormal</td>
<td>&quot;...even when I first came and then I started hearing something called ‘depression’ I thought ‘gosh that is white man’s sickness, we don’t have that’ because we don’t have a name for such a thing as depression, we don’t. In my mother tongue, we don’t. I think in most Sudanese mother tongue they don’t have anything called ‘depression’ because if I have problem or issue I talk to my aunt, my cousin, my grandma, my whatever, my neighbour and we talk about it and that’s it, it’s finished. So we don’t have to go and see a special person to solve this problem; it’s just talking to the members of your family whatever, your aunts, and then it’s finished.&quot; (Key informant 8 – Sudanese woman)</td>
<td>Mostly Sudanese key informants, with some exceptions, including key informants working in refugee specific and community health services. A philosophy of resistance towards the medicalisation of distress was found to permeate such services, and thus likely to influence the perceptions of staff.</td>
</tr>
<tr>
<td>Community connectedness may be an important measure of wellbeing or mental health</td>
<td>“They mostly say they’ve seen other people because they like, like now on Saturday or Sunday, they like to be stay together; if you are isolated yourself and you’re not going to them they put a question mark on you...So they would not say that you’ve got a depression because most of the people who got a mental isolated themselves then at the end they would say this person doesn’t want people; want to stay alone.” (Key informant 6 – Sudanese man)</td>
<td>Mostly Sudanese key informants.</td>
</tr>
<tr>
<td>May be supernatural explanations of mental health issues</td>
<td>“Well some of them say that it is a curse from God; they don’t believe that it is a maybe a chemical imbalance in the brain. And some of them don’t believe that there is a treatment.” (Key informant 6 – Sudanese man)</td>
<td>Some Sudanese and health provider key informants. However, the Sudanese key informants who commented on supernatural causes suggested that this is likely to be a more traditional explanation held by rural and/or less educated Sudanese.</td>
</tr>
<tr>
<td>Mental health issues may not be seen through the lens of a psychological explanation</td>
<td>“So very few of them really take up that offer that we have here of that psychological help, I wouldn’t say nobody but very few as compared with say Iraqis or the former Yugoslavia, or even Vietnamese are much more comfortable with psychological; the idea I guess of a psychological cause.” (Key informant 4 – Social worker)</td>
<td>Some Sudanese and health provider key informants.</td>
</tr>
<tr>
<td>Somatisation (physical manifestation of mental health issues), might be a culturally sanctioned way of expressing mental health issues</td>
<td>“So it’s quite different talking to Sudanese people about mental health and often they’ll only talk about the physical problems that depression brings with it. So you know we know as much as one can ever know, that if you are depressed there are physical things that go with what we call depression and if you’ve got no ability to talk about mood or anxiety or whatever, you’ll present a depression or anxiety with a physical problems. Now we call that somatising, as though that’s not proper talking about depression but for them it’s their presentation and I think we need to respect that as being a way of presenting with a problem that is a problem for the person.” (Key informant 1 – GP)</td>
<td>Mostly health provider key informants.</td>
</tr>
<tr>
<td>Mental health issues may manifest as alcohol abuse and domestic violence</td>
<td>“So commonly depressive illness might manifest in other forms of behaviours like family violence issues, you know men kind of drinking too much; there kind of things that happen as a result of depression but it’s really difficult for people from a very, kind of, entrenched cultural background to often articulate, you know, concepts about being depressed and emotional health stuff in the same way that we would because culturally it’s not common to do that.” (Key informant 10 – Health service manager)</td>
<td>Mostly health provider key informants and some Sudanese key informants.</td>
</tr>
</tbody>
</table>
Key informants also commented on the appropriateness of western therapies and the ways in which ‘mental health issues’ might be addressed within ‘the Sudanese community’. These issues will be discussed in the following chapter. Furthermore key informants suggested that, as in many cultures, there is likely to be stigma associated with mental health in Sudanese cultures. This will be explored more fully in Chapter Six in relation to access to care.

4.9.2 Depression
The need to address depression was thought to be contingent on the ability of resettling refugees to rebuild their social worlds, with ‘success’ being protective and ‘failure’ being detrimental. Furthermore, the link between social isolation and depression was prominent in key informants’ accounts, as is evident in the quote from a psychiatrist key informant, who was referring to depression in refugee women in particular:

“...a lot of their depression is contributed to by lack of social support and isolation.” (Key informant 5 – Psychiatrist)

Resettling Sudanese refugee women who headed households, and those who migrated to Australia alone, such as unaccompanied young men, were considered prone to social isolation. Additionally, those that by virtue of their education, English language ability, or location were unable to avail themselves of the support of community and other support networks were also considered susceptible to social isolation. Partly as a consequence, their ability to deal with grief or loss or other hardships was thought to be compromised in some cases.

4.9.3 Psychosis
Some key informants pointed to cases of severe mental health issues involving psychosis and/or schizophrenia amongst resettling Sudanese clients that they had seen or of which they were aware. In some extreme circumstances, they revealed, this led to mandatory detainment under the Mental Health Act (1993) in psychiatric wards of major public hospitals in South Australia. Although interpreted as affecting a small number of resettling Sudanese refugees it

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6 The Mental Health Act (1993) operates in Australia and provides powers to medical practitioners to order the immediate and mandatory detention of citizens with mental illnesses who are deemed to be a risk to themselves and/or to others in the community thus deemed to require immediate treatment (Mental Illness Fellowship Australia 2005). Under the Act, a three day detainment order can be administered by any medical practitioner whilst 21 day detainment orders can only be made by psychiatrists (Mental Illness Fellowship Australia 2005). Continuing detainment orders of up to 12 months can only be made by a Guardianship board which presides over and reviews applications for such orders (Mental Illness Fellowship Australia 2005).
was unclear exactly how common psychosis is amongst this group. This study was not equipped nor interested in quantifying issues so it is unhelpful to speculate. Nevertheless this finding points to the diversity of experiences and mental health needs within any given resettling refugee community. The issue of psychosis requiring hospitalisation and psychiatric care amongst resettling refugees, however, requires further study given a scarcity of published studies and data in this area.

4.10 Interconnectedness of needs
As was highlighted throughout the course of this chapter, key informants’ accounts revealed that the needs of resettling refugees like those from Sudan are likely to be interconnected. That is to say that each affects and is affected by another. For example, as was illustrated in the need to send money home, this was thought not only to affect resettling refugees emotional wellbeing but also their ability to deal with the practical issues associated with rebuilding social worlds like housing or financial issues. Likewise practical issues associated with resettlement like unemployment, for example, were thought to hinder the ability of resettling refugees to send money home, and subsequently affect their wellbeing.

Similarly the ability of refugees to address past trauma is likely to be contingent on their ability to rebuild their social worlds, which can be affected by the debilitating effects of trauma itself. Therefore in the unpacking of any one particular need one is likely to find other needs that affect or are affected by the ability of resettling refugees to meet any one particular need. Thus interviews directed attention to refugees needs in their entirety and complexity rather than focused on a single need or another. This is likely to have implications for the way in which the needs of resettling refugees are addressed. These implications will be discussed and deconstructed in the following chapter.

4.11 Conclusion
The exploration of the material, social and mental health needs of resettling Sudanese refugees discussed in this chapter highlights a diverse range of needs. Despite perceptions of variation in needs depending upon personal and family circumstances, the need to rebuild social worlds was viewed as being of primary importance according to key informants. The possible need to address trauma or other mental health issues such as depression was found to be contingent upon the ability of resettling Sudanese refugees to rebuild their social worlds and upon personal resilience. Key informants’ emphasis on the context of resettlement points to the need to reflect upon how such a multi-faceted array of needs is being addressed by
services and communities. Thus, the next chapter will address the question of how the material, social and mental health needs of resettling Sudanese refugees are being met whilst also highlighting gaps in these responses.
Chapter 5
Current responses to addressing the material, social and mental health needs of resettling Sudanese refugees

5.1 Introduction
In the previous chapter key informants’ perceptions of the major material, social and mental health needs of Sudanese refugees were presented. These congregated around the need to rebuild social worlds, which was viewed as pressing and immediate, and the possible need to address mental health issues. This chapter will explore whether these needs are being addressed and how so, providing a platform for comparison between needs and responses. Key informants’ accounts highlight that the needs of resettling Sudanese refugees are likely to be being addressed within the formal health system at a number of levels, but also outside of the formal health system in a number of possible ways. Through this exploration, gaps in health service provision responses relative to key informants’ perceptions of needs articulated in the previous chapter will be briefly highlighted.

5.2 Thematic framework
As in the previous chapter, the results presented in this chapter were derived from the Framework analysis process. In this chapter, results are presented in relation to the second research question posed by this study, which was:

*How are the material, social and mental health needs of resettling Sudanese refugees currently being addressed and what, if any, are the gaps in service provision?*

During the Framework analysis process, a thematic framework based upon emergent themes and a priori objectives materialised with respect to this research question. As the second research question is about how the needs of resettling Sudanese refugees are being met, a priori themes gleaned from results of the analysis of the first research question – what are the material, social and mental health needs of resettling Sudanese refugees? – were particularly drawn upon in developing the thematic framework. As depicted in Figure 5.1, this was a
multi-level framework consisting of two overarching themes, four major themes, and a number of sub-themes relating to each major theme.

**Figure 5.1: Thematic framework for Research Question Two**

Implicit in the generated thematic framework is the assumption that all elements described in this chapter are constituent parts of the health system. Given the multi-faceted and broad nature of the identified needs of resettling refugees, it is felt that this assumption is valid, and is further validated by the results presented in this chapter. The major distinction made in the interpretation of themes, however, is between services and activities that might be traditionally considered a part of the formal health system – services structurally oriented around and dominated by the “organized healing professions” as Kleinman (1980 pg 53) suggests – and those like resettlement services and the informal sector of care which may not conventionally be considered a part of the formal health system, and thus are outside of it.

**5.3 Overarching theme: Outside of the formal health system**

Consistent with conventional understandings, interviews reiterated the important role played by the informal sector of care and services that operate outside of the formal health system. Key informants’ perceptions, as discussed in the previous chapter, highlighted the important role of the social context in the mental health status of resettling refugees. Thus, it is of little surprise that needs associated with this context might be met in services and agencies that
specifically address issues associated with resettlement such as housing or employment. The role of the informal sector of care in meeting the mental health needs of resettling refugees is not necessarily a new postulation. However, it is often overlooked.

5.4 Informal sector

As the shaded portion of Figure 5.2 suggests, interviews highlighted a number of ways in which the mental health needs of resettling Sudanese refugees might be being met informally through individual, family and community actions. Several of these were clustered around the identified need to rebuild social worlds. These included the provision of social support and the development of community belonging, the provision of instrumental support, and strategies to bridge the gap that separation had created. Furthermore, the potential mechanisms that were thought to exist to address loss, grief, and mental health issues within the Sudanese community were also canvassed. This contrasts with the view of a lack of engagement with mental health issues amongst refugee or migrant communities. Such views can be seen to ultimately affirm/justify service-led responses in relation to addressing mental health issues. The exposition of this theme however points to the need to also support community development approaches given the perceived important role of the community in addressing social, material and mental health issues.

Figure 5.2: Informal sector – theme overview
5.4.1 Social support and community belonging

In the previous chapter, the way in which some key informants linked depression and social isolation was presented and discussed. Furthermore, issues of identity were alluded to in the discussion around the adjustment needs of resettling refugees. Key informants’ accounts underlined the important role of the informal provision of social support and Sudanese community events and gatherings. These were seen as redressing social isolation and also affirming a sense of connectedness and community belonging, which are likely to be important for identity maintenance. Aspects of this are evident in the comments of a Sudanese key informant about the importance of community gatherings within the Sudanese community in Adelaide:

“...almost every weekend something is happening. Yeah that people get together whether it is a funeral, or a wedding, or just a social gathering; yeah that is what is helping a lot of people, especially the elders who are isolated and women, who are doing things for themselves and they can’t get that chance of meeting with other people – that’s where they go and meet and hear other people’s experiences of what is happening in this life and how are people coping, and so those occasions, I think, are the best things that is happening to many people at the moment.” (Key informant 7 – Sudanese woman)

This was considered particularly important given the understanding of the collective nature of traditional Sudanese societies, in which interacting with the members of the group collectively appears to be very important. For example a Sudanese key informant said:

“And our system, we are kinship; in our relationships we stay together. So that togetherness is support, is caring; everything is done in a collective way, you know…” (Key informant 7 – Sudanese woman)

However despite the attempts of community members to “bring people in” (Key informant 11 – Sudanese woman) some key informants’ opinions suggested that there may be people within the Sudanese community who are isolated or who do not wish to engage with other members of the community. Therefore all the resources that exist within the community may not be accessible to all, pointing to the need for both formal and informal sources of support and service provision.
Key informants commented on the growing size of the Sudanese community in South Australia and the implications for the provision of support, and instilling a sense of community belonging. In comparison to other smaller new and emerging communities, some health service key informants felt that there were greater opportunities for newly arrived resettling refugees to be availed of the resources within the Sudanese community in Adelaide. Such a viewpoint was echoed by the following key informant:

“I mean you’re looking at the impact upon Sudanese. I think that’s an interesting choice because there’s large numbers here and there’s a degree of sophistication and capacity on the ground and growing in the community itself... So community capacity building is a big issue and the bigger the community the more opportunities for that. I think the smaller the community the more vulnerable some of the members are for kind of access and pathways in the smaller communities. They’re more dependent on case workers, paid case workers external to their communities, to kind of achieve access and equity in health services because they just don’t have information, they just don’t have access to the same information. So if you’re a Sudanese arriving now you are going to arrive into a Sudanese community. You are going to go to community events and women are going to sit down and one of them is going to say ‘look I’m pregnant, I’ve become pregnant here. How does one do babies here?’ And you’re going to get some information but if you’re not sitting at that community gathering because you’re not from that group, you don’t speak that language, your opportunities for that are going to be diminished.” (Key informant 18 – Health service manager)

However, some Sudanese key informants held contrasting views. Those who had been in Australia for quite a long time and thus had seen the community grow, lamented the growing fragmentation within the community. Such key informants described the emergence of sub-communities based upon ethnic, regional, or linguistic affiliation. They suggested that the small size of the Sudanese community in the past, in which most members knew each other, lent itself to cohesion, togetherness and the provision of social support.

The perceptions posited in this research suggest that due to the separation and dispersal of Sudanese around the globe, ideas of community and community belonging are unlikely to be bounded by a geographically confined ‘local community’. In the previous chapter, the need to send money home was discussed as being important for a number of potential reasons. Not least, it was seen as a way of maintaining identity and belonging in the family and community that was and is likely to be important in the lives of resettling refugees.
Another way in which resettling Sudanese refugees were thought to cement community belonging in a non-geographically bounded sense, was via the establishment and/or participation in organisations concerned with development activities in South Sudan. A number of Sudanese key informants themselves were involved in development activities in South Sudan through organisations that they themselves had created or in which they participated. Not only is this likely to facilitate a sense of community belonging but also a sense of purpose that comes with the participation in, and the changing of, society.

Keeping in touch with family members via information communications technologies (ICTs), such as telephones, mobile phones and emails was reportedly extremely common and important. ICTs were thought to be mediums through which family members could connect, and provide social and instrumental support. However, several limitations of such ICTs were identified. One of which was that they primarily encourage an individual interaction between two people at any one time rather than a communal interaction, which may be more in line with traditional Sudanese cultures. Other cited difficulties, associated with telephone communication in particular, included the cost of international telephone calls, poor communications infrastructure in Sudan, and dealing with time differences.

In light of such limitations younger Sudanese key informants, in particular, revealed that they and some of their friends and family used internet discussion boards, and email lists aimed at connecting South Sudanese in the diaspora with those at home.

These virtual spaces may not only facilitate a sense of community belonging and social support but also allow Sudanese in the diaspora to participate in the political, cultural, and economic life in South Sudan and contribute towards its rebuilding. For instance, one Sudanese key informant who was a member of a number of internet groups, including one for Sudanese health professionals, highlighted how this may work. She recounted a situation where, through this internet group, she was able to provide assistance to other members of the internet group who were seeking to establish a link with a hospital in Sudan:

“It makes it really easy; the internet and this communication make it very easy for people to communicate. Like a couple of days ago they were sending an email to me because they want contact numbers for someone in some part of Southern Sudan, in a hospital there; they want details to establish a link to that hospital. And I’ve been making phone calls yesterday trying
to track someone, and I’ve forwarded that email to them to be printed out and given someone who can help track someone.” (Key informant 11 – Sudanese woman)

The sense of purpose that such participation in virtual communities and networks may bring is likely to be beneficial for emotional wellbeing.

5.4.2 Instrumental support
Community events and informal visits were also thought to provide resettling Sudanese refugees with the opportunity for the sharing of information and facilitating other forms of instrumental support. Key informants viewed such instrumental support as being of a more practical nature than social support, which was viewed as being of an emotional nature. For example, instrumental support was seen as important in the context of meeting adjustment needs and the practical needs associated with rebuilding social worlds such as learning how to navigate health and social systems.

In addition to the opportunistic provision of instrumental and social support at community events, key informants’ accounts also highlighted a more deliberate approach to providing practical assistance occurring within the Sudanese community in South Australia. This approach involved more established resettling Sudanese refugees visiting newly arrived Sudanese or those who were in need of extra assistance. Whilst visiting, more established Sudanese would assist with translating and filling out forms, providing information and advice about Australian society and systems, and assisting with English language skills. This is evident in the experiences of one Sudanese key informant who was initially the recipient of assistance by members of the Sudanese community in Australia and then later became the provider of assistance for other newly arrived Sudanese refugees. It is important to note that he was not paid by an organisation to do this work.

Such experiences provide an insight into the development of migrant communities such that new entrants into that community are assisted and later assist other new entrants. Regardless of the motivations, the mobilisation of community resources in the form of social support, and instrumental assistance is likely to play an important role in the rebuilding of social worlds and in bolstering wellbeing.

As well as potentially benefitting the provider of assistance, the provision of assistance may however come at some cost to the individual. One key informant understood this in terms of
‘community burnout’. This was the idea that community pressure was placed upon some members of the Sudanese community who were considered to have been, or be on the way to being, successful (however defined) to take on responsibilities within the community. These were considered to include helping others in the community, taking on leadership roles within the community, speaking at functions and events, and interacting with services and mainstream society on behalf of the community. Such pressure was constructed as leaving ‘successful’ members of the Sudanese community in the precarious situation of needing to try to strike a balance between helping in the community and pursuing their own dreams and aspirations. Too much pressure to take on responsibilities within the community at the expense of advancing individual and family goals and aspirations was thought to result in ‘community burnout’. This was evident in the account of one key informant, who said:

“And I just had a conversation with someone I’ve known for a long time who moved his family right out to the northern suburbs where there’s not a single other refugee family out there... And he did that deliberately to get away from his own community because he said to me ‘I know I have to focus on my own family’ – he’s got six of his own children and they’re all young children – ‘and I need to be there for them; I can’t be solving everything for everybody else’ but it’s breaking his heart. And I think in the way that we understand Indigenous families, you know, you can’t just talk about the mum and dad and the kids, you know, it’s much more extended than that, so the responsibility just never ends really... it just goes on and on and on in terms of hearing bad news or knowing that somebody is having difficulty, who can sort it out; the capable ones are burning out in terms carrying the load... and I think that’s quite a common thing that I’m starting to see as there’s a core group now, some of whom are making it but the price for making it is often to have to kind of, to be quite non-traditional in terms of not helping other members of their family.” (Key informant 4 – Social worker)

Thus, interviews revealed a need to support such potential leaders to continue playing valuable roles in the community whilst simultaneously advancing their own dreams and goals.

Resettling Sudanese refugees who were not sponsored by, or did not have, family networks in Australia were considered by key informants to be in particular need of assistance. This was couched both in terms of social support and instrumental support. According to one key informant:
“I think what’s helping the new arrival Sudanese coping with the life is the family, especially if you get sponsored by a member of your family it’s much better than the person who comes here and doesn’t have any family because that member of your family will be there to support you, to guide you, give you information about how to live in this society, and if you are a person who listen you might take the information.” (Key informant 8 – Sudanese woman)

However, the quality of the instrumental assistance provided by family members is likely to be dependent on their knowledge of Australian systems and processes. This in turn is likely to be contingent on the quality of the information and assistance family members who arrived earlier received. Furthermore, it is also likely to be dependent upon the amount of time they have to provide such assistance, as one Sudanese key informant pointed out:

“...and those sponsors, actually at the moment they’re very busy; everybody is busy trying to work, trying to go to school, they don’t have time enough to support the family that they bring.” (Key informant 8 – Sudanese woman)

Hence there are likely to be unique issues associated with the social and instrumental support received by newly arrived resettling refugees who have family networks in Australia and those that do not. Regardless, these issues point to the importance of a diverse array of sources and means for providing instrumental assistance within the informal sector, and within the resettlement and health service sectors.

5.4.3 Bridging the separation gap
For the most part interviews suggested that resettling Sudanese refugees themselves were instrumental in bridging the separation gap between themselves and significant others elsewhere. Two major ways were highlighted as being used in order to bridge the separation gap. One way was through the use of information communication technologies (ICTs), which have already been discussed. The other was via family reunification attempts.

Key informants’ accounts suggest that for some resettling Sudanese refugees, keeping in touch through ICTs alone may not be enough to bridge the separation gap and counter its negative effects. In these cases family reunification was thought to be a commonly utilised mechanism for dealing with this gap. Interviews highlighted that it was often resettling refugees themselves who initiated or were involved in assisting others with family reunification attempts, which might also be considered another form of instrumental
assistance. This was the case of one Sudanese key informant who described her husband’s role in assisting others with family reunification attempts within the Sudanese community:

“And sponsoring their family, my husband always like helping with the forms...” (Key informant 8 – Sudanese woman)

However, sponsoring family members was thought to place an enormous cost and responsibility burden on resettling refugees. As is evident in the following quote some of the key informants’ own experiences suggest that resettling refugees may go into debt in order to facilitate family reunification attempts:

“Before, I sponsored my mother, brother, so many other cousins; I was in debt for a long, long time because I have to pay for medical check-ups and all this you know.” (Key informant 7 – Sudanese woman)

5.4.4 Dealing with loss, grief and mental health issues
Key informants also highlighted the mechanisms that exist and are being utilised within the Sudanese community for addressing what might be interpreted as mental health issues. Such understandings prompt reflection upon how the informal ‘health sector’ can be better supported to complement formal service orientated responses to the mental health needs of resettling refugees.

Many key informants underlined the potential cultural inappropriateness of counselling as a means of addressing any possible mental health issues amongst resettling Sudanese refugees. However, interviews also suggest that this is unlikely to be an outright rejection of the idea of counselling but of the western mode of/interpretation of counselling. Sudanese key informants in particular described what one key informant coined the “Sudanese way of counselling” (Key informant 7 – Sudanese woman). Given the diversity within the Sudanese community there are likely to be many Sudanese ways of counselling. From what can be ascertained from Sudanese key informants there seemed to be several key elements involved in the process of the “Sudanese way of counselling”. These included surveillance and information gathering, mobilisation of appropriate community resources, and the provision of collective support and advice.

According to Sudanese key informants, community members watch out for possible mental
health issues, family crises and other possibly stressful events experienced by members of the Sudanese community. In relation to mental health issues, social isolation or not engaging with the community was one factor that potentially identified someone as possibly requiring help. Potential exposure to a stressful event such as the death of a loved one, or a change in behaviour or personality, were also factors thought to potentially identify someone as in need of counselling and support:

“Like for example, if you have a bad news or you know if somebody is feeling down, they can say ‘that person is feeling down, we don’t know what’s wrong with them’ then people will start talking to them to find out what is wrong with them; this is to a point that like if I was a very outgoing person and suddenly I’m not anymore, I don’t talk to people, and then my family will be concerned and will try to investigate to see what’s wrong with me…” (Key informant 8 – Sudanese woman)

Once potential ‘cases’ were identified, Sudanese key informants suggested that members of the community would then observe them informally. This was done as part of a process of gathering information about what the problem could be and how members of the community might be able to help:

“The Sudanese ways of counselling. You don’t go and ask, say that ‘I need counselling services’ or ‘I have a problem, I need counselling’, you don’t; other people – it could be your aunty, your uncle, your friends – they will observe you and the changes that might be happening from your behaviours or from your dealing with things in life, from how you deal with your relationship or what. Then they will identify the change within you... If you identified me with that problem you will discover other people and say ‘this is how I observe her, there is something happening with her’. Then you will give other people also to watch me, to observe me; then if there is common, you know, feeling that that person has a problem...” (Key informant 7 – Sudanese woman)

The next step in the process is what might be inferred to be the mobilisation of appropriate community resources. Prior to the provision of support and counsel to the identified individual who may be having a problem, Sudanese key informants informed described a process in which there is a matching of community members’ expertise with the identified problem. This matching ensues on the basis of the surveillance and information gathered. From what can be gathered from Sudanese key informants’ accounts, this may include
ensuring gender concordance between the providers of support and the recipient of support. Additionally, it was thought that there is also a need to screen potential providers of support for the concordance of their life experiences with what the potential recipient of support was going through. This was thought to increase the validity of the counsel and advice proffered in the eyes of the potential receiver of support. Subsequently it was thought to ensure the success of the counselling effort. A younger person trying to provide support to an older relative was for example, viewed as being inevitably unsuccessful.

For this reason, elders within the community were most often likely to be involved in counselling efforts. Along with family mediation, this was considered an important part of the elders’ role within the community. However, elders’ ability to carry out their role, as indicated in the previous chapter, is negatively impacted by the geographically dispersed nature of the Sudanese community in Adelaide and in South Australia.

According to Sudanese key informants, appropriate community supports would then collectively approach the identified person and visit them in their home. The community supports would then present the information gathered and ask the person for their own version regarding what was happening to them. The community supports would then proceed to offer their support, advice and counsel. According to one Sudanese key informant, a ‘counselling session’ may proceed as follows:

“For example if you are grieving for lost; maybe someone died or someone, you don’t know whether they’re still alive or what, the only way to deal with it, other people, people with a similar problem will be identified, people who maybe are coping with their similar situation will come to you and say ‘look at me, this is my story’. They will tell you their story: ‘I have a son who was this age or a daughter and when they got lost this happen and I’ve never seen my child until today but I believe maybe he is alive or I believe he is dead’ something like that ‘so this is normal, it’s not only happening to me, it has happened to so many people and it will happen to other people. It’s not about you, you know, it is natural; things do happen. And if you think about it you will not solve it; thinking about it will not bring that person so the best thing is just to consider it has happened but open a new chapter in life because thinking will not bring that person, instead it will harm you and not bring a solution to your mind, especially if you’ve got other children or other things to do in life - you will raise your conscious mind that you’ve got other things to do – rather than focus on this. It’s time to look
up to this; how are you going to deal with this things in life, about yourself in life” so this is our ways.”’ (Key informant 8 – Sudanese woman)

The quote also highlights the possibility that, for some resettling Sudanese refugees, getting on with life rather than dwelling on or “thinking about problems” may be more helpful. This contrasts with some western psychotherapeutic approaches.

Whilst there may be similarities, another major difference between western and Sudanese approaches, as described by Sudanese key informants, is the notion of responsibility. In contrast to western approaches where individuals are largely considered responsible for seeking the help of a counsellor or service, the Sudanese approach stresses the community’s responsibility to seek out those in need of help and support them. This was perhaps best illustrated by a Sudanese key informant, who when talking about the “Sudanese way of counselling”, said:

“Then you’ll be called and be told ‘you have a problem and because you have a problem you need to deal with that problem and here we are to help you solve that problem. We might not know exactly what is your problem but it is up to you to tell us exactly what are you worried about or what are you concerned about or what might be going on in your mind, and we can’t let you live with that alone; it is our responsibility to help you deal with what is burning you.’” (Key informant 8 – Sudanese woman)

Thus, the persistence of individual suffering may reflect negatively on the collective, suggesting that the community has failed in its responsibility to seek out and assist one of its constituent parts. Given the stigma that may be associated with seeking help, the Sudanese approach protects individuals from the perceived shame of admitting they need help. Thus there may be major barriers to seeking help for a mental health issue at a formal health service given different notions of responsibility. As will be discussed in the next chapter, this was considered by key informants to be a major barrier to access.

In contrast to the individual approach to counselling within the western paradigm, the “Sudanese way of counselling” as described by Sudanese key informants in this research involves a collective approach. The group and its appropriate resources are drawn on within a ‘Sudanese counselling’ session. Thus the provider of help is unlikely to be a stranger as is the case initially, in a western counselling context. As one health service key informant indicated,
services can, however, integrate the notion of drawing on the resources of the collective into their responses via group programmes:

“Very often, particularly in the third world, it’s very difficult to see women talking one to one; you know this counselling or psychotherapy or whatever you have in the west, but in a group setting of people of their own background they feel much more trustful and comfortable... They sort of come together as a group, they meet every week or so and do things together and find help from each other. So if they talk to each other and share their problems sometimes what one person has undergone can be of help to another person and they explain how to deal with a particular service so that’s a very effective way of helping.” (Key informant 14 – Psychiatrist).

Given the diversity of mental health beliefs within the Sudanese community the “Sudanese way of counselling”, may not be appropriate or desirable for all resettling Sudanese refugees. As discussed in the previous chapter some resettling Sudanese refugees may have mental health beliefs that are more consistent with those that abound in western societies. Thus they might expect the way in which their mental health needs are met might be consistent with those beliefs. This highlights the need for the availability of a diversity of responses such that resettling Sudanese refugees may be afforded support in line with what they individually deem to be appropriate.

5.5 Resettlement and other services

Key informants’ views highlighted the role of resettlement services in meeting the mental health needs of resettling refugees and particularly in the area of rebuilding social worlds. Non-government organisations (NGOs), local councils and other housing, employment and family support services were also thought to possibly make a significant contribution to supporting resettling refugees with tasks associated with rebuilding social worlds. The shaded sections of Figure 5.3 provide an overview of how resettlement and other services are potentially contributing to meeting the needs of resettling refugees.
Three major strategies emerged throughout interviews as to the attempts of resettlement services to support refugees, particularly in the area of rebuilding social worlds. These included: case management, the provision of information, and group programmes. Furthermore, one resettlement service was considered to be involved in short-term clinical service provision in relation to dealing with any possible mental health issues.

5.5.1 Case management

In attempting to carry out their role in supporting the settlement of newly arrived refugees, resettlement services were thought to use a case management approach during the initial period after arrival. This was particularly the case of the Integrated Humanitarian Settlement Strategy (IHSS) provider. Case management was described as involving a worker assigned to a newly arrived refugee and/or their family, organising referrals and appointments to services and institutions like banks and social welfare providers, organising short-term housing and English language classes. These responses were geared towards addressing some of the immediate practical needs associated with rebuilding social worlds. Some examples of the possible assistance that newly arrived resettling refugees may receive through this case management approach were described through the personal experiences of Sudanese key informants, as in the following:
“Well when I came I was well received. I had a case worker looking after us; taking us to social security, to the bank but then after a few days we were able to do our own thing and we didn’t hassle her a lot.” (Key informant 11 – Sudanese woman)

The importance of resettling refugees making a positive start in terms of rebuilding their social worlds was reiterated by many key informants, particularly in facilitating access to services and organisations where their needs could best be met. Thus resettlement services were considered vital.

Of specific relevance to newly arrived refugees’ movement throughout the health system is the referral function of resettlement services to primary care providers for initial health assessment. As of May 2006 a Medicare item number 714 was introduced to reimburse GPs in private practice for the provision of an initial health assessment. The introduction of the item number 714 was generally welcomed by key informants as an incentive for GPs to engage in refugees’ initial health care. However, many also harboured concerns. These related to the mainstreaming of initial care and will be articulated in the following chapter.

The imperative to assist resettling refugees to obtain ‘self-sufficiency’ as soon as possible was thought to possibly culminate in a skewed assessment of the readiness of some resettling refugees to thrive without the support of services. Subsequently some key informants felt that this could result in the premature cessation of case management services under the IHSS or the Department of Immigration and Citizenship’s other case management programme, Complex Case Support (CCS). Of course the point at which individual resettling refugees are ready to exit initial case management services is likely to be dependent upon individual circumstances. Among the experiences of Sudanese key informants in this research there were examples of resettling refugees who exited case management services relatively early. This was because they were ready to become ‘self-sufficient’ and thus no longer needed them. However, key informants’ accounts suggest that this is not always likely to be the case. In circumstances where it is not, the consequences of cessation of initial case management services was considered detrimental to the task of rebuilding social worlds and for the mental health of resettling refugees. For example, one key informant elaborated on the possibility of problems for specific groups for whom this might be the case saying:

“The IHSS service provider does provide services but that’s short-term; for six months they will receive you from the airport, they’ll put you in temporary accommodation, they will enrol
your kids in school, they’ll show you how to go to the shop, but that’s short-term – after that period of time is finished it’s up to you how to survive and that’s when it becomes a problem for people who don’t know the language, for single mum who got many children, and illiterate, is not familiar with the western ways of living.” (Key informant 7 – Sudanese woman)

5.5.2 Information provision
As elucidated in the previous chapter, the need for information of both a practical, and health and health system nature, was considered to be important by key informants. Specifically, it was considered important in the rebuilding of social worlds but also in terms of accessing services. Interviews suggest that resettling refugees are given some information prior to arriving in Australia by the International Organization for Migration about what life in Australia might be like. However, it was thought that the potentially chaotic pre-migration context did not lend itself to the retainment of such information. Furthermore the quality and usefulness of such information was thought to vary. Thus further information was thought to be needed upon arrival to Australia.

The provision of information through the delivery of case management services or otherwise was thought to be another way in which resettlement services were attempting to assist resettling refugees. Key informants’ accounts suggest that within resettlement services this was likely to occur at an individual case or family level rather than at a group level. However, as will be discussed later in this chapter, the retainment of information and its usefulness in the chaotic initial period after arrival was considered to be an issue.

5.5.3 Group programmes
Group programmes were another way in which it was thought resettlement services were attempting to support refugees in the rebuilding of social worlds in particular. The programmes that key informants mentioned varied in scope and structure. These included those group programmes focussing on women’s and men’s adjustment and associated issues, and those focussing on youth adjustment, education and employment. Most of the group programmes mentioned were delivered by services other than the IHSS provider; some of which were funded by the Department of Immigration and Citizenship’s Settlement Grants Programme (SGP). Others were delivered in partnership with health services. One key informant also suggested that local councils were now offering group programme type activities and contributing to community capacity building activities through SGP funding:
“Interestingly and positively the Commonwealth has now given three year funding to both Council A and Council B and... they’ve both got a dedicated worker now for three years with the Commonwealth funding out of the SGP programme. And that’s great because they’ve got their networks of community houses and community centres and libraries and that sort of thing. So they can actually help with access and do community capacity building things. They can convene a meeting of community people and providers in a hall and get them together and get some food going and make the networking happen and get information to people who need it, so we’re going to one and do a session and people at the community health centre are going to do a session and the SGP worker from Council A is convening the whole thing. They’ve got fifteen or twenty women of African descent who are kind of come on their radar so they are going to be kind of their meeting people and getting in information and that sort of thing. So that’s one of the values of that programme.” (Key informant 18 – Health service manager)

A more detailed discussion about the use of group programmes and issues associated is presented later in this chapter.

5.5.4 Dealing with mental health issues
The IHSS provider was also described as being involved in addressing mental health issues in an individual one-on-one context. A short-term torture and trauma counselling team provided an initial assessment of and was thought to deal with, mental health issues directly. However none of the key informants in this research worked in this team and the team’s role is a little unclear from key informants’ accounts. Thus it would be inappropriate to speculate as to the role and strategies used within this context. However, taken with other understandings which highlight the great degree of service and policy emphasis on addressing needs related to the immediate post-arrival period, it raises questions about the ability of health and resettlement systems to deal with needs of resettling refugees in the longer term.

5.6 Overarching theme: Inside the formal health system
Whilst key informants reiterated the major role of activities and services outside of the formal health system in terms of addressing the mental health needs of resettling refugees, their views also highlighted the role of the formal health system in the service provision equation. Accounts of the ways in which the needs of resettling refugees were attempting to be met by formal health services were clustered around different levels of care. These included primary health care and community mental health services and secondary mental health services such
as hospital based psychiatric care. Variation in the ability or willingness of health services to address and engage with the social context of resettling refugees’ mental health needs was also highlighted and was thought to be dependent on a number of factors.

5.7 Primary care and community mental health services

Primary care and community mental health services were one level of care in which it was thought that addressing mental health issues was the major priority. However, key informants’ accounts also illuminated the strategies that are being employed in some health services to attempt to support refugees in the rebuilding of their social worlds. The ways in which primary care and community mental health services were thought to be attempting to respond are summarised in Figure 5.4. The orientation of particular services and the degree to which services were specifically targeted at meeting the needs of refugees were thought to be influential in shaping responses.

*Figure 5.4: Primary care and community mental health care services – theme overview*

Key informants suggested that if the material, social and mental health needs of resettling refugees were addressed at all within the formal health system they were most likely to be addressed within particular types of services. These included the refugee specific primary health care service, other community primary health care services, the refugee specific community mental health service, and/or other community mental health services, such as
those for children and adolescents. Key informants highlighted a number of integral factors that might account for this. These themes will be explored in Chapter Six, which is concerned with the factors affecting service provision to resettling refugees.

### 5.7.1 Dealing with mental health issues

In line with the traditional understanding of the health or ‘sickness’ system, key informants’ accounts revealed that many of the activities of primary care and community mental health services are likely to focus on addressing mental health issues in a strictly clinical sense. This was thought to be particularly the case in mainstream services. However, as discussed in the Chapter Four, key informants who deliver clinical services to resettling refugees illustrated that mental health issues could only be dealt with after issues associated with rebuilding social worlds were met. One key informant used the analogy of peeling back layers of an onion to describe this, with outer layers representing issues relating to the social context and inner layers relating to the mind:

“Yeah I think about it like kind of peeling the onion really. You know, you start on the surface and you work your way down and each layer is accompanied with some tears quite often and then you work through that one and you get to the next layer.” (Key informant 13 – GP)

But as also discussed in Chapter Four, the possibility of trauma and mental health issues was thought to affect and be effected by the ability of resettling refugees to rebuild their social worlds. In order to deal with this, some key informants, particularly GPs and psychiatrists, described that they would sometimes prescribe medication in their first consultation with a new resettling refugee client. As one key informant explained, this was thought to alleviate immediate symptoms that were considered to impact upon the ability of people to engage in the task of rebuilding social worlds, and subsequently to deal with any possible mental health issues:

“In order to even begin to work through those really simple things, you know the practicalities of daily living, I will often start them on some medication because that’s something that I can do and often will do right in the first session because it can give them some alleviation of their symptoms and some sleep hopefully, which then enables them to deal with everything else in daily life a bit more easily... So I think unless you can give them some help with their sleep it is very difficult for them to be constructive in their day.” (Key informant 13 – GP)
Medication was also used by some of those key informants able to prescribe it, for what they regarded to be clinically depressed clients.

**Individual approaches**

In addition to the possible use of medication, key informants described an array of individual counselling approaches that they understood to be utilised, or which they utilised themselves, in attempting to address any possible mental health issues of their resettling refugee clients. Counselling approaches mentioned by key informants included narrative or life story approaches, strengths-based approaches, and cognitive-behavioural therapy.⁷

However, many key informants questioned the applicability of western counselling approaches outside of ‘western contexts’ such as their use with resettling Sudanese refugees. Some pointed to the idea that Sudanese refugees are likely to have their own more collectively oriented approaches to dealing with mental health issues (as described earlier in this chapter). Other criticisms were that such individual approaches often failed to address the context in which distress manifested. Some key informants commented on the relatively low uptake of counselling services by resettling Sudanese refugees in comparison to other refugee groups:

“...a lot of Sudanese particularly, um they don’t really understand the concept of psychological support, particularly individual psychological support; traditional way would be a collective way of doing business. So often when we hear that they are having difficulty, and it can be quite profound difficulties, but when we approach them what they want is ‘can you get me a new house, can you get me this social security bill paid?’ and it’s often very focused on practical things; that’s how they measure whether they’ve been successful or not in getting an outcome... So we certainly do offer Sudanese people the opportunity for counselling but it’s rarely taken up or if it is the workers often talk about just getting bogged down around practical advocacy rather than, perhaps, a more structured approach to dealing with post-traumatic stress symptoms, yeah; learning relaxation methods, yeah, or even using the massage service it’s not – I wouldn’t say it’s not used but it doesn’t have the same uptake that other cultural groups seem to have.” (Key informant 4 – Social worker)

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⁷ Cognitive behavioural therapy focuses on changing dysfunctional emotions, thinking and behaviours in order to overcome any issues. Narrative therapy explores patient’s stories related to experiences, and problems, seeking to re-author stories by focusing on strengths. Likewise a strengths-based approach actively seeks out and attempts to magnify people’s strengths and coping abilities.
The perceived appropriateness and/or value of counselling approaches in the context of dealing with many other potential issues may thus be low.

When asked about approaches, one key informant said that counselling self-selects; that those who consider it appropriate and useful may utilise it and derive benefits from it whilst others who do not see it as appropriate will not use it. Again, this might be taken as reiterating the importance of the availability of choice such that resettling refugees who may find counselling useful are able to access it, whilst those who don’t find it appropriate are able to access alternatives that suit their needs.

Some mentioned alternatives offered by some services included massage for relaxation, family centred approaches, and group therapy approaches. According to key informants’ descriptions, community and refugee specific services were more likely to be offering such approaches for dealing with possible mental health needs.

**Family approaches**

Given the perceived importance of the family for Sudanese refugees, some key informants described utilising family centred approaches in dealing with mental health issues. One psychiatrist key informant described what this looked like in terms of the approach he sometimes takes, and the potential benefits of utilising the family as a resource:

“...It’s very different and it’s very difficult for a westerner to understand; idea of self - it’s not a bounded, you know something – the family is the unit. So I encourage them to bring their husband or wife or the children. They always tell them also and they come also; they are welcome to come and sit. Sometimes they come with the child; we leave the door open - the child runs out, comes in, plays. We just keep it open but there are big issues of confidentiality and things. In a western things it would be unheard of but I try to deal with the family as far as possible and very often another family member can be very helpful, say like in the medication, or doing massage, or they may give certain information, or they are able to carry out certain things in the home, or sometimes we can see what’s going on in the dynamics right in front of us; we can see them interacting and immediately see what's wrong or what’s happening so I always try to deal with the family... But it’s a resource also because I find that if the family relationships are reasonable and healthy, the members are going to recover; they are not going to need much treatment. So the trick maybe to get the family functioning properly or is to get the resources from some of the extended family; you know, what’s out
there. Some of them want to bring them here; maybe a brother or a sister so I encourage that – that’s helpful. So it’s an important resource also; it’s not only a source of problems.” (Key informant 14 – Psychiatrist)

Group approaches

Key informants described that some refugee specific and community services offered group therapy type programmes as another means of addressing possible mental health issues amongst resettling refugees. Many of the group programmes offered by such services focussed on aspects of rebuilding social worlds, which will be discussed later in this chapter. However, there were also some that explicitly focused on dealing with mental health issues. One example of such a programme described by some key informants was a group programme aimed at building resilience in women, and contextualised mental health issues with respect to the social context:

“So we developed a group therapy model which focussed on bringing women from shared experiences together and using the sort of group setting as a therapeutic environment providing useful information about how to live in a new country; so you know dealing with issues from, you know practical issues about negotiating the health system, and understanding about parenting issues, and women’s health issues, and emotional health issues but then doing it in a semi-structured way that gave women, gives women the opportunity to actually explore other deeper issues. And I actually have a lot of confidence in the group therapy model with women, well with refugees generally, because it mimics that family or community collective experience thing as well, particularly if you have people from, as I said, a really shared background; so really closely related in language and cultural groups and come from the same area so there is a lot of, you know, opportunity to share and learn from each other. And a lot of that’s basic stuff about group therapy but that would be one of my favourite ways of working with emotional health stuff because it also it doesn’t pathologise it into something that needs to be medicated and treated. It gives people the opportunity to explore their own personal resilience and ability to work through things because you are giving them some tools; you are giving them the information and space to talk about things.” (Key informant 10 – Health service manager)

As will be discussed later in this chapter, there were thought to be many benefits of a group approach including its consistency with collective ways of dealing with issues. These may be
perceived to be more appropriate than individual therapies for resettling refugees like those from Sudan.

Whilst the group programme described above may be an exception, one issue consistently highlighted by key informants was the lack of information about mental health issues within group programmes. As one Sudanese key informant suggested, in her opinion information should not be used to persuade or acculturate resettling Sudanese refugees to western ways of dealing with emotional distress but should be given anyway in order to:

“... give people the opportunity, you know, to reject the service completely or for someone to say ‘oh I wasn’t aware of this but now I know I can access the service.’” (Key informant 7 – Sudanese woman)

It must be noted that in discussions around how the mental health needs of Sudanese resettling refugees were being addressed, key informants who provided clinical services described using a number of different therapeutic strategies. For instance, rarely did a key informant suggest that they only used narrative therapy and no other approaches in an attempt to meet the needs of resettling refugees. This was even the case of those whose training had been heavily influenced by the biomedical model. However, again it is important to reiterate that the key informants interviewed in this research were health providers with an interest and experience in working with resettling refugee clients. This characteristic, among others such as training experiences, is likely to be influential in shaping key informants’ behaviours. Key informants’ accounts suggest that those who are not exposed nor have an interest in refugee mental health issues, and who perhaps work in more mainstream environments are likely to have less nuanced understandings. Thus they may have limited ability to deal with the mental health issues of resettling refugee clients in a flexible and culturally sensitive way.

**5.7.2 Supporting refugees to rebuild social worlds**

The focus on dealing with mental health issues in a clinical sense was thought to predominate particularly in mainstream services. However, key informants revealed a number of strategies that are being employed within health services to assist refugees in the rebuilding of social worlds.

Where health services did attempt to deal with the rebuilding social worlds four main strategies emerged. These included the delivery of group programmes, the provision of
information, advocacy, and referral. These were not limited to primary and community mental health services. However, they were thought to predominate in such services as compared to secondary mental health services.

**Group programmes**

Resettlement services, community primary health care services, and refugee specific primary and mental health services, in particular, offered group programmes for resettling refugees. Although different in their aims, content, and delivery many of these programmes explicitly or implicitly focussed on supporting resettling refugees with aspects of what has been interpreted as rebuilding social worlds. Examples of the types of group programmes aimed at resettling refugees mentioned included parenting programmes for women, resilience programmes for women, youth programmes, and men’s programmes.

Some of these programmes dealt with facilitating adjustment such as those aimed at young people, women or men. Others dealt with cultural differences and others focussed on redressing social isolation. In addition to their content, groups were also thought to vary in their structure. Some were thought to be structured and modular whereby there was a pre-set array of tasks, topics and information to be covered. Others on the other hand, were thought to be more semi-structured involving a social outing or an activity (i.e. a sewing group etc.) whereby information or assistance might be opportunistically delivered over the course of the activity.

The ability of services to offer group programmes was thought to be dependent upon funding, awareness of the needs of the client base, and management and personnel support. There was thought to be a general lack of coordination and planning of group programmes across the health and resettlement systems with group programme planning and provision thought to be generally, with a few exceptions, *ad-hoc*. The duplication of some group programmes was thought to result. There were few examples amidst key informants’ accounts of group programmes that had continued on an on-going basis. The sustainability of many was thought to be dependent on the drive of motivated individuals, like bi-cultural community health workers and on funding opportunities. The case of an innovative group programme that was started and delivered by a Sudanese bi-cultural community health worker and then ceased when the worker had to leave the service canvassed below illustrates this point:
“...they had two project workers from the Sudanese community and they ran a really successful cooking programme... So they did that and they also started African women’s dance classes... Well through the individual worker’s basically identifying what, you know, could happen and our organisation then resourcing them so that it did but then when that worker went off to take on another position we haven’t continued to try and do that.” (Key informant 4 – Social worker)

As one might expect there was little activity of this kind occurring in private general practice settings.

One of the perceived advantages of group programmes in the eyes of many key informants was that they were thought to be more consistent with the ways of dealing with issues in collectivist societies, such as those in Sudan. Apart from the benefit gained from the content of the group programme, key informants involved in the planning and/or delivery of such groups also highlighted the additional benefit in terms of addressing social isolation. This was thought to be the case for women and young people in particular.

Many of the group programmes, of which key informants were aware, were gender specific in the sense that they targeted either women or men. Whilst the choice for resettling refugees to access gender specific groups was considered to be positive, some key informants also commented that in some instances this could be problematic. For example, in the case of a parenting programme for resettling Sudanese women, feedback received from the participants in that programme highlighted the desire for partners and/or husbands to be included in the programme. One key informant commenting on the feedback from participants in the programme said:

“Yeah, they had really positive things to say about it. They wanted a group for the men and I’m not sure how we’re actually going to go about that but you know, it would be a really interesting exercise. (Key informant 2 – Mental health nurse)

When asked why women who participated in the group programme wanted a group for men, the key informant responded by saying:

“Because they were bringing these ideas home, and for most of them, they were having to use quite subtle strategies to get their men to actually listen to what was happening. We
translated the written information that comes in book form into Dinka and Sudanese Arabic on CDs so they would go home and play this, you know, when they were in bed at night and things like that, you know, so that they would get their partners to actually listen to some of the information. But I think the reason they’re asking for some sort of programme for the husbands is that they see them doing this alone in the family is not going too; there were huge changes but they needed to have consistency with their partners in parenting.” (Key informant 2 – Mental health nurse)

As some key informants commented, any skills or ideas gained from parenting programmes by a parent in attendance may not fit with the ideas of the other parent who could not attend the programme and who may be influenced by traditional cultural beliefs around parenting. Thus programmes that are gender specific may inadvertently be contributing to family level conflict through the selective giving of information to women, and not to men, for example.

Information provision

Another form of group level response that key informants commented on was group information sessions. The role of the informal sector, and resettlement and other services in providing information to resettling Sudanese refugees, has been documented in this chapter. In such contexts, the provision of information was primarily thought to occur at an individual level whereby case workers or community members may provide information to their ‘case’.

Interviews revealed that the refugee specific primary health care service was thought to be the only health service providing group information sessions to newly arrived resettling refugees. These sessions were conducted in partnership with an adult English language school. The content of these were described as including information on the health system and how it works, the importance of initial screening, diseases, promoting health, and practical information related to rebuilding social worlds. These information sessions were delivered to potentially any participant in English language classes and were not specific to particular groups of refugees. This was thought to be a less than ideal group composition for providing information as it meant that multiple interpreters or bi-cultural workers were needed to translate the information provided.

Services like the refugee specific primary health care service were also thought to be utilising other media to provide information. Flyers and radio were two ways specifically mentioned.
One of the major issues raised in association with the provision of information was the lack of reinforcement of information. For example, key informants commented that where information was provided, it was generally provided in the initial period after arrival. This was thought to be a period when resettling refugees have to deal with a number of issues simultaneously. Some described this a period when refugees were ‘bombarded with information’ and having to attend multiple appointments. Long-term retention of information amidst the context of potentially dealing with multiple issues was thought to be low:

“And you can’t say it’s the fault of the service provider but I think the way they structure the service delivery should be a bit different. The important thing is not just now; even the information that they provide to them when they arrive, probably 5% of it they kept, the rest, they are busy with their other life. So it should be a bit longer to provide all those information that are necessary to them as time goes; as they settling in and experiencing other things, that information has to be reinforced.” (Key informant 8 – Sudanese woman)

Thus like the key informant above, some key informants expressed the need to provide information not only immediately upon arrival but at various points in time thereafter.

Advocacy
Advocacy was another way in which some health providers were supporting resettling refugees to rebuild their social worlds. Amidst key informants’ accounts, examples of advocacy centred on trying to assist resettling refugees to gain housing, assisting in family reunification attempts, and with legal issues. Advocacy took the form of writing letters and making phone calls on resettling refugees’ behalf, agreeing to be referees, assisting with filling out forms, and in one case, appearing in court. Key informants who talked about using advocacy as a tool for assisting clients were concerned about and interested in refugee health issues. Many of these key informants worked in refugee specific or community health settings where there was a focus on holistic approaches to care. Evidence of the lengths to which key informants had gone to advocate on behalf of resettling refugee clients included the example of a health worker advocating on behalf of a woman whose baby had been removed, and the example of a health workers dealing with housing, below:

“So the baby was taken away and the baby was taken away to a white family 5 weeks ago; I’ve only just been able, and this is like intensive weekend work, phone calls at all hours of...
the day and night, only just been able to advocate for that baby being placed back with a family member.” (Key informant 4 – Social worker)

“Like you know accommodation; accommodation is invariably a very important issue and we at our service and myself as well, we do write a lot, we provide a lot of support in linking in with the housing trust and to explain and give an account of what has been that person’s needs in terms of accommodation...” (Key informant 12 – GP)

Referral

Another method used within health services to attempt to address the need of resettling refugees to rebuild social worlds was referral. The use of referral was not limited to dealing with the social context of mental health issues but was thought to be particularly important in dealing with such issues. Despite the attempts of health providers to be generalists or to take a holistic approach, interviews revealed that the time and skills needed to deal with specific issues might be greater than they could handle. In the case of some services the capacity to deal with issues in-house was high due to the existence of a multi-disciplinary team. The refugee specific primary health care service, for example, was organised into a number of clinics that enabled in-house collaboration. These included nurse clinics, a counselling team, a social workers’ team, GP clinics, a transition clinic, and women’s clinics. As such, referral, in this context, did not necessarily mean to another service, but to the clinics housed within the service.

Where the capability to deal with issues within the service was minimal there was a need, for primary health care providers and community mental health care providers, to refer to other services. Often referral was to resettlement services, group programmes run by other services, or to community groups. Such referral sources were thought to exist in addition to the spectrum of referrals to other specialist health services that one might expect from primary care services. However, as will be discussed in the following chapter, the success of referral as a service provision response to meeting the possible array of needs that resettling refugees might have was not straight forward. On the contrary, it was considered to be contingent upon the existence of positive relationships and partnerships between different service providers and sectors of care, which was not always thought to be the case.
5.7.3 Bi-cultural community health workers

Many of the service responses described were likely to be used regardless of whether refugee clients were Sudanese or not.

One of the major strategies described by key informants that some services had used in order to tailor their service delivery responses to the specific needs of the increasing number of resettling Sudanese refugees was the employment of bi-cultural community health workers (CHWs). Sudanese bi-cultural CHWs were thought to exist predominantly in resettlement services, the refugee specific primary health care service, the refugee specific community mental health service, and community primary health care services. According to key informants, these were members of the Sudanese community who were employed by health services to undertake a community health worker role, some of whom had qualifications and/or experience in social work, and refugee health. The sorts of activities in which bi-cultural CHWs were described as being engaged in included developing and running group programmes and information sessions, family and home visiting, and interpreting. Bi-cultural CHWs were also thought to be involved in liaising with other health workers within the health services in which they operated in order to assist with issues of cultural sensitivity.

Key informants who worked in services that employed bi-cultural CHWs considered their role to be important and helpful. According to those key informants, the benefits of having Sudanese bi-cultural CHWs included having increased access to cultural knowledge and advice, facilitating understanding about the needs of the Sudanese community and an increased ability for services to deal with any issues in a holistic manner.

Further testimony of their perceived benefit to other service providers and the Sudanese community was their motivation in initiating, developing and running group programmes. In fact, as discussed earlier in this chapter, one group programme aimed at Sudanese youth ceased when a bi-cultural CHW left the health service. This illustrates that the very existence and life course of group programmes, in some cases, is linked to the motivation of individuals like bi-cultural CHWs rather than the needs of a targeted client group. In this respect it is evident that bi-cultural CHWs can become agents of change within a health service in terms of improving its ability to meet the needs of resettling refugee groups. Whether change persists into the longer term, when perhaps bi-cultural CHWs have left organisations, is one that is questionable. This is a particularly pertinent question considering that in the health services that employed bi-cultural CHWs, the tenure of such workers was thought to be linked
to patterns in humanitarian arrivals, as well as funding. Thus they were not generally considered long-term appointments. As key informants suggested, this is likely to facilitate the responsiveness of the service to cater to the needs of new and emerging community groups. However, it also means that bi-cultural CHWs may come and go, consistent with the experience of one key informant:

“The service actually because it now working with like newly arrived refugee and asylum seekers so we sort of like; I used to work four days because there’s lots of African coming and now because the number of African are going down, so my days is now three days and there are going to be more Middle Eastern so we work according to the influx of refugees – that’s how we plan... and you can’t be permanent because the influx changes and the next thing we might have Asian, and we having Burmese, so we need to get somebody who speaks Burmese.” (Key informant 8 – Sudanese woman)

One of the downsides to such an approach in the context of addressing needs – some of which were thought to manifest after the initial resettlement period – may be that the priority to meet the needs of relatively more established refugee groups may be obscured by newer ones, for whom some services operating in a resource limited environment are likely to shift more time, energy and resources towards.

In some cases described by key informants who had experience of the bi-cultural CHW role it was considered difficult for bi-cultural CHWs to influence how mental health needs were met by services. These difficulties will be explored in the Chapter Six.

5.8 Secondary mental health services
Secondary mental health services such as hospital based psychiatric wards were thought to play a minor role in meeting the needs of resettling refugees. They were considered to primarily focus on addressing severe mental illness within a biomedical paradigm as is highlighted in Figure 5.5.
5.8.1 Dealing with severe mental health issues

Secondary mental health services were thought to be used by only a small number of resettling refugees like those from Sudan in crisis-type situations; some individuals were thought to have been mandatorily detained under the Mental Health Act (1993). One health service key informant who had considerable experience working with resettling refugees suggested that only rarely did he have to use mandatory detainment as a response to severe mental health issues:

“I think since I’ve been here at this service for twelve years I think I’ve probably certified one, or possibly two people against their will into a psych hospital when you could do that in the old days; I remember doing at least one, there may have been two.” (Key informant 13 – GP)

The perception that mandatory detainment was rare amongst resettling refugees, including those from Sudan, was consistent across most key informants. One Sudanese key informant however, suggested that the number of cases of resettling Sudanese being detained at the hospital where he worked had increased:
“...there is a lot of people, I wouldn’t say a lot, but a significant number who have got a mental health problem. Where I’m working at, this year alone there was about five or six Sudanese people being admitted or being detained in hospital because of mental problems.” (Key informant 6 – Sudanese man)

Further research is needed to quantify the number of acute mental health hospital admissions amongst resettling Sudanese refugees. However, circumstances where patients were thought to have been detained were generally considered to involve psychosis. Consequently individual psychiatric approaches were thought to be employed often involving medication. Whilst the issue of mandatory detainment was not discussed at great length by most key informants, one Sudanese key informant took particular issue with the process of detainment. He suggested that it is undesirable and may have specific meaning for resettling Sudanese refugees:

“I mean traditionally you can’t force anyone like you need to talk to him, explain to him why you are doing this; not just because you got a mental health we need to detain you because your risk and the risk of other, you have to explain ‘we need to help you, there is a help if you want to help, we will help you’ – that is the way. And I’ll go back to again to the language barriers is a difficult because someone who doesn’t understand English and you tell him ‘we are detaining you’, the word ‘detain’ has got a lot of meaning...Yeah maybe you detain, you put someone in the jail but if you detain someone for his safety is different...If you are coming from a country like Sudan, we got a police who see that the police always is the enemy of the person, is not a friend, unlike here. And then you go to the hospital and you see this guy, the security guy coming to you and hold you and shackle you and maybe you have that experience before with the police, what will go on in your mind?” (Key informant 6 – Sudanese man)

Similar understandings are not necessarily unique to resettling Sudanese refugees but are likely to resonate with broader fears and in some cases opposition to mandatory detainment in the wider community. Generally arguments against mandatory detainment in the wider community often stress perceived breaches of civil liberties or freedoms, and/or the power of professionals to make decisions about detainment. However, when considered in the context of cultural meanings, and of possible pre-migration experiences, detainment is likely to have particular connotations for resettling refugees.
Other routes through which resettling refugee clients were thought to possibly come into contact with secondary mental health care was through direct referral from primary care and community mental health services. Others were thought to self-present at public hospital emergency departments. However, as one key informant illustrated, emergency department and acute psychiatric presentations were thought to sometimes reflect unmet needs associated with rebuilding social worlds rather than being manifestations of severe mental health issues:

“You know, some mental health presentations, you know, are escalated because of the protracted, you know the length of time it’s taken them to access services or people not understanding them when they get there. Like when I was saying before about some of the presentations at hospital Y they’re often put down to mental health but then when they kind of get to the bottom of it they realise that somebody’s in an acutely anxious state over housing or they’re upset about somebody who’s at home. Now that person isn’t mentally ill but they need some sort of psychosocial support and if that’s given really early on then people know how and where to get the help, what to expect, what’s normal, what’s not normal then they are far less likely to escalate into these huge, sort of events, and then end up in the acute psychiatric ward of hospital Y when really, you know, they don’t need medication and ECT8, they need, you know, they’re socially isolated, and they’re lonely, and they’ve got PTSD symptoms, and they’re worried about their families at home because nobody knows where they are and you know so it’s big.” (Key informant 10 – Health service manager)

The view posited here is that failures at resettlement service and at a primary and community care level may be reflected in presentations at emergency departments or at acute psychiatric wards. This is consistent with the views of other key informants who pointed to the possibility of resettling refugees presenting at emergency departments for minor issues that could be routinely dealt with at a primary care or GP level:

“I mean what we heard in the community consultation is that some people just kind of give up and or they end up at the emergency department at the hospital. So they know, you know, they learn where the hospitals are and that - you know, if you’re really sick you just kind of go there. And often at night, you know, even if they had a GP it wasn’t open at night then they

8 Electroconvulsive therapy is a psychiatric treatment, which is sometimes used in the treatment of Major Depression and Mania. It involves the electrical induction of seizures in patients who have been anesthetised, to produce a therapeutic effect. Its use is controversial, with concerns raised about its effectiveness, possible adverse effects, and its humaneness.
would go there. We heard about that anecdotally for quite some time so I enquired with the emergency department at hospital Y and over the last three years more people are using emergency departments anyway for primary health care matters because GPs are a little thin in the suburbs, particularly the poorer suburbs. And so the rate of increase of presentations at emergency departments was about 6% a year but for people from refugee source countries like Sudan and Afghanistan – were the two biggest ones – their rate of increase was about triple that; about 18% per year whereas in the previous couple of years before that their rate of increase was still faster than the general population – more like twice rather than three times. So they are increasingly using emergency departments for their general medical business." (Key informant 18 – Health service manager)

The exact figures or the trend cannot be confirmed on the basis of this research. Accounts like the one above do however point to possible barriers in accessing quality help and support from resettlement services and in primary care and community mental health settings. In the following chapter, the issue of access will be dealt with in greater detail. A related issue that was flagged by some key informants and that will also be discussed in Chapter Six was that of pathways back into primary and community care for resettling refugees who had been seen in secondary mental health care settings.

5.9 Interconnectedness of themes
The levels of care presented as themes in this chapter were considered to be interdependent and examples of this have been interwoven throughout this chapter and will be developed further in the following chapter. Furthermore, key informants’ accounts illustrate that the degree of integration between and within levels of care are likely to have far reaching consequences. These were canvassed in terms of access to care and the ability of the system to respond holistically to the needs of resettling refugees. Throughout the course of this chapter some examples of partnerships in terms of service delivery responses across the levels of care were presented. However, significant issues in terms of partnerships and relationships between elements in the system were identified. In the following chapter the theme of partnerships between services and integration between each of the levels of care will be more fully explicated. In so doing, consequences for resettling refugees and barriers and facilitators to improving the integration of levels of care and partnerships between services will also be presented.
5.10 Gaps

Key informants’ accounts and interpretation highlight a number of gaps in health service provision responses relative to key informants’ perceptions of needs articulated in the previous chapter.

Foremost among these was the capacity – the ability and willingness – of services to assist resettling refugees in rebuilding social worlds. Of particular concern to key informants was the lack of longer term support through services for those that need it. The need to amplify and reinforce service and health and welfare system information refugees was also evident. Capacity was however generally thought to be higher in those services with higher degrees of refugee specificity. The reasons for this variation in capacity, and how such capacity can be improved will be discussed in the following chapters.

Given the articulated importance of the informal health sector in addressing needs, another gap relates to the need for community development activities to be supported, as is evident in the following quote:

“So community capacity building is a big issue... So there’s a big case for community capacity building that needs to be targeted around high priority needs, vulnerability – that sort of thing.” (Key informant 18 – Health service manager)

It will become clear in the following chapter that the quality and accessibility of service responses also constitutes a gap that will be further discussed in Chapter Seven, in which several strategies for addressing this gap are proposed.

5.11 Conclusion

The accounts of key informants in this research highlight that responses attempting to meet the mental, social and material health needs of resettling refugees are likely to emanate from a number of levels of care both outside and inside the formal health system. This research suggests that there is likely to be variation in the focus of each of the levels of care and variation within each level of care. This was evident in terms of the specific responses and capabilities of services, communities and individuals to address the material, social and mental health needs of resettling refugees. Questions were raised about the ability of services within the formal health system, and particularly mainstream services, to deal with the social and material context. This context was highlighted in the Chapter Four as potentially having a
significant impact upon the emotional wellbeing of resettling refugees. In contrast, many of the activities occurring outside of the formal health system were thought to specifically attempt to attend to the task of supporting resettling refugees in rebuilding social worlds. Thus key informants reiterated the importance of activities outside of the formal health system in possibly addressing mental health issues as well as the context in which they were thought to emanate. However, the results presented in this chapter also highlighted a number of gaps where responses were thought to be inadequate or non-existent, potentially resulting in unmet need amongst resettling refugees. By exploring the factors that impact upon service provision to resettling refugees the next chapter will enlighten as to the reasons why these gaps exist.
Chapter 6

Factors impacting upon the ability of services to address the material, social and mental health needs of resettling refugees

6.1 Introduction
In the previous chapter current attempts at addressing the material, social and mental health needs of resettling Sudanese refugees inside and outside the formal health system were documented. However, interviews revealed that the existence of a service alone does not necessarily equate to positive outcomes in terms of meeting needs. Thus, in this chapter attention will be turned to the factors that affect the ability of health services to address the material, social, and mental health needs of resettling refugees. Some of these factors were found to facilitate appropriate responses whilst others acted as barriers.

6.2 Thematic framework
The results presented in this chapter were derived from the Framework analysis process. A thematic framework was developed based on the data, and this specifically pertains to the third and final research question:

What are the factors that impact on the ability of services to address the material, social and mental health needs of resettling refugees?

In relation to this question a thematic framework, consisting of two overarching themes, eight major themes and a number of sub-themes, emerged. This is illustrated in Figure 6.1. Each of the interconnected elements of the thematic framework will be developed further throughout the course of this chapter.
The research question specifically pertains to health service provision in the context of material, social and mental health needs of resettling refugees. However, the data also revealed a number of issues that are likely to apply to health service provision to resettling refugees more generally. Where such issues were considered to impact upon, or have the potential to impact upon, the ability of refugees to have their social, material and mental health needs addressed, they were included within the thematic framework. Issues associated with primary health care were a prime example. As well as being potential providers of material, social and mental health support, primary health care providers are also the gatekeepers to the Australian health system. Thus it was considered necessary to include such issues here.

6.3 Overarching theme: Health service factors

Interviews revealed a number of individual health service level factors that influence the ability of services to meet the needs of resettling refugees. These included access to care, quality of care, the philosophies and structures in operation within individual services, and individual organisational factors. The theme of “Access to care” however, highlights that there is a considerable degree of overlap between what has been interpreted as “Health Service” factors and “Health System” factors.

6.4 Access to care

The issue of access to services and programmes for resettling Sudanese refugees emerged as a major theme throughout key informants’ accounts. It was considered fundamental to people being availed of the assistance that services could possibly provide. As Figure 6.2 illustrates,
both the current avenues for accessing services utilised and the potential barriers to access emerged as sub-themes.

Figure 6.2: Access to care – theme overview

6.4.1 Avenues utilised by resettling refugees in accessing services

Three major ways in which resettling refugees, like other members of the population, were thought to access services emerged. These included word of mouth, exposure to service information, and referral.

**Word of mouth**

The word of mouth route involved resettling refugees accessing services after hearing about them through friends or community networks. In the absence of consistent incoming referral routes, word of mouth was thought to be a major way in which new clients accessed services, such as the refugee specific primary health care service. For instance, a key informant from the refugee specific primary health care service said:

“So the kind of typical referral pathway up until a couple of years ago was that we had this, you know, really smooth referral pathway through the IHSS, or the Integrated Humanitarian Scheme, whereby new arrivals were seen and, you know, processed and then sort of brought to us for early health assessment. That not being the case now, our referrals come more indirectly so it’s...mainly through word of mouth so community members who have been
through the service before and have an experience of our service, you know...” (Key informant 10 – Health service manager)

**Exposure to information about services**

Another way in which resettling refugees were thought to access services was through exposure to information about services. Sometimes this was thought to be in the form of fliers and other information generated by services. Some services, such as the refugee specific primary health care service were also using media such as radio to inform refugees about their services.

**Referral**

Both word of mouth and exposure to service information are likely to be routes through which resettling refugees may access a service for the first time. These may be particularly useful in facilitating access for clients who may not be anchored to other support services, whether resettlement or health oriented. Referral, on the other hand, was a way in which resettling refugees utilised services after already having been in contact with a service. Interviews revealed that in the South Australian context the Integrated Humanitarian Settlement Strategy (IHSS) provider plays an influential role in referral routes. This is because the IHHS provider is responsible for making contact with resettling refugees at the airport or within a short period after arrival. Thus it is likely to be the first service with which newly arrived resettling refugees come into contact. Therefore the IHSS provider acts as a gatekeeper even before refugees reach GPs, who are often regarded as the gatekeeper to the Australian health system. As will be illustrated throughout the course of this chapter, this has implications for access, and underlines the need for strong relationships and integration between resettlement services and the formal health system.

**6.4.2 Barriers to accessing services**

Key informants’ accounts illustrate that there are likely to be many barriers to accessing health and other services for resettling refugees. Such barriers were interpreted as being cultural, practical and structural.

**Cultural barriers**

Culture was found to impact on mental health beliefs and help-seeking behaviour. In particular, stigma associated with mental illness was thought to deter help-seeking behaviour, and thus impact negatively on access to services.
Stigma

As in many cultures, key informants’ thought that there was significant stigma associated with mental health issues within traditional Sudanese cultures. For instance, Sudanese key informants in particular described that people considered to be affected by mental illness would traditionally be considered to be “mad”, “crazy”, and/or “lost causes”. The negative connotations associated with mental illness within traditional Sudanese cultures are evident in the following quote:

“‘Mental health’ or ‘depression’ is rarely used in Sudan or in refugee camp. We use very derogatory terms like, ‘he’s mad, he’s crazy’; that’s the word you hear. And so when someone is having a depression or is having mental health they would not admit it because they would be called ‘mad person’ or ‘crazy people’ and so they would rather keep to themselves or live in denial and they are not willing to seek any help because saying that you have it and you need help is an admission of weakness and you are opening up yourself to ridicule within the community so you’d better close up and brave the situation and hope it will go away.” (Key informant 3 – Sudanese man)

This quote, suggests that acknowledgement of a mental health issue may be considered an “admission of weakness”. Such perceptions are likely to hold currency in many cultures, including in western societies.

What is considered to constitute a mental health issue requiring support is also likely to affect access. Interviews suggest that for many Sudanese refugees, grief, sadness, worry and the experiencing of stressful events are more likely to be considered normal reactions to stressors rather than mental health issues. As discussed in the previous chapter, resettling Sudanese refugees have ways of dealing with such normalised reactions to stressors within the community including “the Sudanese way of counselling” (Key informant 8 – Sudanese woman). Thus there may be little or no need to seek help from a formal mental health service for such stressors; the exceptions being those with mental health beliefs more consistent with those in western societies.

For issues that are more likely to be considered mental health issues within the Sudanese community, such as “hearing voices” (Key Informant 6 – Sudanese man), or “saying things that don’t make sense” (Key informant 7 – Sudanese woman) people are equally as unlikely to seek help from a formal mental health service. This is due to the stigma associated.
Sudanese key informants suggested that, accompanying these mental health issues are derogatory labels such as “madness” or “craziness”. As key informants’ perceptions illustrate, these labels have significant social implications for the person perceived to have a mental illness. Having a mental illness was associated with a particularly low status in society, impacting negatively on the ability of such persons to contribute to the community, have their voice and opinions heard or taken seriously, and on their ability to marry.

Thus, in collectively oriented cultures especially the stigma associated with labels of “madness” or “craziness” may also have an impact upon the status and perceptions of families and kinship networks related to the individual labelled in such ways. This may also be a powerful reason not to seek help. For instance:

“...many people fear when they hear that there’s a mental health service they can access. They will say ‘oh but I’m not mad’ so there is a stigma to that. Because going crazy is someone who can’t handle problem and you will be told by someone ‘how can you let yourself be affected by the problem’ or maybe your family is a family that doesn’t care... So there is a stigma attached to it that people will be fearing to hear that when you go to a mental health service, you know, your mind is going not OK and there’s a fear for that.” (Key informant 7 – Sudanese woman)

Furthermore, given the sophisticated communication networks that are likely to be utilised by Sudanese across the globe and in a locally prescribed geographic community there may be a fear that once labelled as suffering from a mental health issue, everyone in the community will be aware. This is likely to impact negatively on the individual and the kinship networks to which the individual belongs.

Help seeking behaviour
Besides stigma, interviews highlighted that culturally influenced ways of seeking help may also mitigate against the use of services within the formal health system even if they were considered helpful. As described in the previous chapter, resettling Sudanese refugees may hold a view that stresses the community’s responsibility to seek out those in need of help rather than emphasising the individual’s responsibility to seek help. Perceptions of relatively low numbers of Sudanese utilising mental health services may, in part, reflect culturally sanctioned norms about help seeking behaviour within the Sudanese community:
"You don't go and ask, say that ‘I need counselling services’ or ‘I have a problem, I need counselling’; you don’t; other people – it could be your aunty, your uncle, your friends – they will observe you and the changes that might be happening from your behaviours or from your dealing with things in life, from how you deal with your relationship or what. Then they will identify the change within you. Then you'll be called and be told ‘you have a problem and because you have a problem you need to deal with that problem and here we are to help you solve that problem’... So you don’t ask yourself. People have to see it and tell you, but in the west you have to seek the service yourself...” (Key informant 7 – Sudanese woman)

Another issue that was flagged as potentially impacting upon resettling Sudanese refugees’ help-seeking behaviour and hence access to formal health services was the idea expressed by some key informants that Sudanese were likely to have a high tolerance of hardship. Many commented on the extreme nature of resettling refugees’ pre-migration experiences. Furthermore, many thought that whilst undergoing such pre-migration hardships it was unlikely that resettling refugees were able to get help for issues or alternatively were forced to endure them alone. Thus where, in western contexts, an issue might be deemed significant to seek help, for some resettling Sudanese refugees this may not be the case. As one key informant suggested:

“I think particularly people for whom their subsequent one or two generations have, you know, experienced nothing but war and difficulty, you know, calling it trauma; it’s just the way it is you know, it’s just life, you know. And they don’t see it, you know, as something that you deal with.” (Key informant 2 – Mental health nurse)

The logic may look like this: In having endured far worse circumstances or issues without help, why then would I seek help for an issue that I perceive to be relatively insignificant compared to previous experiences?

An interview with a Sudanese key informant encapsulates this idea of issues being “normal” and also suggests that there may be an element of stoicism in Sudanese cultures. This might also explain the tendency for resettling Sudanese refugees not to seek help. As he suggests:

“Within Sudanese community you’d think ‘that’s normal’ and you have to cope with it... and most of these diseases we just go around with them, so long as it is not immediately life
threatening, you just think it is normal and you can go around with it. Yeah so that’s how it is.” (Key informant 3 – Sudanese man)

Some health services had altered their ways of providing help in such a way that more closely reflects understandings about more collectivist notions of help-seeking behaviour. For instance, several key informants commented upon the development and existence of home visiting as an option offered to resettling refugees by some services. This contrasted with the predominant western notion of the service located in a specific geographic location to which individuals are expected to go if they require help. Home visiting was interpreted as the service attempting to mimic the role of the community by seeking out and assisting those in need of help in their own familiar environment. It was also thought to be one way of overcoming some of the other access barriers that will be discussed in this chapter.

The persistence of traditional Sudanese perceptions in western resettlement contexts are likely to inhibit help seeking for a severe mental health issue from a formal health service. However, as has been illustrated at previous points in previous chapters, Sudanese cultures are diverse, and so too are the individuals within them. Acculturation and education are likely to affect how individuals perceive mental health issues and their help-seeking behaviour.

Practical barriers

Key informants highlighted a number of what have been interpreted as potential practical barriers to accessing services. These included unfamiliarity with the health system and health services, the physical location of services and transport, and financial issues.

Unfamiliarity with the health system and health services

The ability to access services was, in part, thought to be dependent upon resettling refugees’ knowledge of what services are available, what services do, how they can possibly help, and how one utilises those services.

Key informants contrasted the sorts of health systems that resettling Sudanese refugees were used to prior to migrating to Australia, with the health system in Australia. For instance, many key informants suggested that the role of primary care, as understood in western contexts as involving GPs or community health workers, was minimal or virtually non-existent in pre-migration contexts. This was thought to contribute to unfamiliarity with primary care in Australia:
“Most of the health issues facing, problem facing the community, is the lack of understanding of the health system and some people; like I’m not used to the health system here. Like they are not even used to having their own GP. Some people find it very hard to have their own GP because it’s something new to them, it’s a new concept.” (Key informant 11 – Sudanese woman)

Similarly psychiatrists or mental health services were considered uncommon in the largely developing country health system contexts that resettling refugees were likely to have been familiar with.

In some cases unfamiliarity with the health system was thought to have implications upon the ways in which resettling Sudanese refugees accessed or did not access services in Australia. This was thought to be partly implicated in resettling refugees utilising hospital emergency departments rather than GPs in the community for issues that could be routinely dealt with by a GP. However, as has been suggested in the previous chapter and will be explored further in this chapter, utilisation of emergency departments by resettling refugees is also likely to be influenced by broader structural factors like the inadequacy of some referral pathways.

In addition to information about particular services, information about issues like Medicare, whether GPs bulk bill or not⁹, and the role of primary care and secondary care, were all thought to be important in enabling refugees to access services where their needs could best be met. However, as was illustrated in the previous chapter, the lack of information provided to resettling refugees was thought to constitute a gap.

**Physical Access**

The physical location of services may also act as a practical barrier to accessing services for resettling refugees, for whom transport may be an issue. Proximity to services, the size of families and whether there were children to care for, and the access to or use of a car were all factors viewed as impacting upon access to services. Public transport related factors were particularly stressed however; this included the availability of public transport, the availability and quality of information about the location of the service including bus routes and stops, the

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⁹ In Australia the majority of GP services and some other services are subsidised by the federal government through Australia’s form of universal health insurance called Medicare. In addition to the Medicare subsidy, a practitioner may also charge a further fee for their services, of which patients are expected to pay. This is termed ‘the gap’. Where a practitioner does not charge an additional fee, services are free at the point of care to patients. This practice is referred to as bulk billing.
familiarity and competence of resettling refugees in using public transport, and the perceived difficulties of taking young children or babies on public transport.

In terms of physical access it was thought that services in the city central business district (CBD) are generally easier to access as the CBD is an area that was comparatively better serviced by public transport than suburban areas. In reflecting upon the services where they worked, some key informants commented upon the obscure locations of their services. Some suggested that some potential clients would have to catch multiple buses if they were to access the service.

However, it was evident that a number of services were attempting to overcome transport related factors in order to facilitate access. One approach that emerged and has been documented earlier was the idea of home visiting or providing services in resettling refugees’ homes. Similarly some services were thought to provide programmes in non-threatening community settings that were familiar to the resettling Sudanese refugees at whom the programmes were aimed:

“I suppose the first thing to say is that they generally don’t come here, you know, we would generally go to them. And I mentioned to you before that we did run a group programme for Sudanese women last year and that was a really non-threatening place. I mean we thought fairly carefully about where we were going to hold it and you know we held it at a church where they run the African Women’s Day out that way and it’s a venue where they feel comfortable; there’s child care, it’s not a mental health service, it’s not a hospital, it’s not a school, you know. It’s not any of the places where they are constantly negotiating difference you know… I think the starting base is, you know, ‘where would you like us to come to?’”

(Key informant 2 – Mental health nurse)

In addition to decreasing transport related access barriers, such familiar spaces were thought to be conducive to the quality of service provision compared to clinic spaces. Clinic spaces were perceived to be formal, rigid, and in some cases privileging and promoting biomedical and professional knowledge over that of clients.

Another strategy mentioned by key informants from refugee specific and community services, as well as by resettlement services, was the provision of transport to resettling refugees to attend services and scheduled appointments. This was thought to be a useful approach when
refugees who may be particularly affected by transport-related access barriers needed to deal with mainstream services, for which home visiting was not offered. In some cases transporting clients was considered part of the role of bi-cultural community health workers (CHWs) employed at refugee specific services in particular. In fact, interviews suggest that as part of their role, some bi-cultural CHWs transport resettling refugees to services and appointments outside of the ones in which bi-cultural CHWs were employed.

**Financial issues**

In addition to the cost of transport, the cost involved in fee-for-service model services that did not bulk bill was thought to act as a disincentive to accessing such services for resettling refugees. Issues associated with gaining employment, financially supporting families in a local and global context, and housing were thought to place financial constraints upon resettling refugees. Thus additional potential costs of services were thought to represent another barrier to access.

**Structural barriers**

In addition to cultural and practical barriers to accessing help for mental health issues within the health system a third conglomeration of barriers emerged. These have been interpreted as structural barriers. Structural barriers were thought to be areas in which access hurdles for resettling refugees were organic to, or exacerbated by, the health system via institutional factors. Examples of structural barriers highlighted included referral pathway barriers, strict service mandates, quality as a disincentive to further access, and systematic discrimination.

**Referral pathway barriers**

The pathways to care taken by resettling refugees were thought to be greatly influenced by referral pathways within the health system. In many circumstances resettling Sudanese refugees were thought to have little control over the services they did or did not utilise. Instead, access was a function of the existence or not of established referral pathways. Where there were barriers in referral pathways these were thought to constitute barriers to accessing services best equipped to meet needs.

One example of a referral pathway barrier consistently highlighted throughout the research was the referral of resettling refugees from the Integrated Humanitarian Settlement Strategy (IHSS) resettlement services provider to primary care providers for initial health assessment and care; part of which is a psychosocial health assessment. As was described by key
informants the dominant initial care referral pathway in South Australia since the change in contracted IHSS provider in October 2005 has been one of direct referral to private general practice. The problem with this pathway, according to many key informants was, that it bypassed refugee specific and community primary health care services. These services were thought to be well equipped to provide comprehensive primary health care to newly arrived resettling refugees. Under the previous referral pathway the majority of newly arrived resettling refugees were referred to the refugee specific primary health care service and other community health services for initial assessment and care. According to key informants’ recollections of the previous arrangement, only those resettling refugees who were deemed to be ‘less vulnerable’ were seen in private general practice settings. Currently, the option of resettling refugees accessing the refugee specific primary health care service was thought to be severely constrained by the current referral pathway. This may be particularly detrimental in terms of those resettling refugees who may be considered ‘vulnerable’ or most likely to benefit from the comprehensive approach taken by the refugee specific primary care service.

Key informants suggested that the introduction of the Medicare item 714 to remunerate GPs for an initial health assessment for resettling refugees was a positive step but that it is an incentive rather than a capacity building measure. As such, questions were raised concerning the quality of care given to newly arrived resettling refugees within General Practice settings given that the Medicare item number did not require GPs to have undergone any further training. For instance, some key informants working in refugee specific and community health service settings provided examples of refugees who had come into contact with such services after having been initially seen by a GP, only to reveal that a full and proper assessment and care had not been provided:

“So we’re often seeing people afterwards and addressing the issues then. So for instance, I just saw a big family of eleven who’d been seen by a community GP, who didn’t screen for any of the usual illnesses.” (Key informant 1 – GP)

However, in terms of access, interviews revealed that after the ‘completion’ of initial health assessment by a private GP some resettling refugees did not continue to access private GPs for their subsequent care. There are likely to be many potential reasons for this, some of which were canvassed by key informants and will be discussed later in this chapter. Some resettling refugees were thought not to return to GPs, but had not found their way to the refugee specific primary health care service or other community health services. According to
key informants some of these people were thought to utilise hospital emergency departments for care:

“So there’s people falling through the gaps and there’s no way of measuring that. One of the ways of looking at it is to look at the, sort of, presentations in the emergency departments at the hospitals because both hospital X and hospital Y see a significant number of new arrivals. And we’ve been able at different times, to get hold of, you know, the stats on countries of origin and that sort of thing so, you know, anecdotally and statistically there’s, you know, reason to believe that a number of the people who, you know, stop here might end up just using hospitals as their GP services.” (Key informant 10 – Health service manager)

Others were thought to be accessing no health services at all as the following quote suggests:

“I mean what we heard in the community consultation is that some people just kind of give up (on health services)...” (Key informant 18 – Health service manager)

Key informants’ accounts, like the one above, illustrate that the consequences of referral pathway barriers are likely to be important in terms of continuing access and potentially unmet needs. A newly arrived resettling refugee is likely to have little or no say in which service they are referred to initially, and are likely to be given little or no information about the possible suitability of services for them. The interpretation of the views expressed by key informants here is that such decisions are already made for resettling refugees by the system through mechanisms like policy, contracting arrangements (IHSS), and the relationships, or absence of, between services.

The influence of systemic factors on resettling refugees’ access to services is evident in the following quote:

“And, you know, on the one hand we certainly want new arrivals to come here because we feel that new arrivals get a really good service but on the other hand there is a model that’s out there and the Department of Immigration is supporting it and we’ve agreed to honour that model so there’s nothing to be gained for us in trying to undermine that; it just causes friction so for new arrivals, it’s a little bit tricky.” (Key informant 10 – Health service manager)
Here there is a tension between encouraging new arrival refugees to access care and conforming to referral pathways entrenched within the system.

_Strict service mandates_
The adherence to strict service mandates that determine the time frame during which people can be seen within a particular service and types of issues that the service will and will not address can also affect access to services for resettling refugees.

It is of course unreasonable to expect, given funding and other constraints, that a service be able to provide a time-unlimited service that is able to deal with any issue or respond to any need that resettling refugees might raise. One would thus expect services to prioritise and set constraints that enable them to focus on particular issues or time periods such that they are able to provide a quality service. In general, refugee specific and community health services were more likely to be flexible in terms of constraints set. However, such constraints can also be viewed as affecting resettling refugees’ access to services. This was thought to be particularly the case where positive relationships and hence referral avenues did not exist between services. The issue of partnerships between services and levels of care was thought to have implications for the ability of the system to adequately address the needs of resettling refugees in their entirety. This will be discussed in greater detail later in this chapter.

_Quality as a disincentive to access services_
Perceptions about quality of care were also thought to affect access. As in the case of refugee specific services, perceptions of high quality care were thought to encourage further access. Assuming that resettling refugees were able to access a service in the first instance, three aspects emerged through key informants’ accounts with regard to what constitutes quality care. These included: the interpersonal relationship between patient and provider, the ability to have needs met, and culturally and linguistically appropriate care. These three aspects will be discussed fully throughout the course of this chapter. First it is important to highlight that communication was thought to underscore all three aspects of quality care. In situations where resettling refugees viewed the quality of care that they had received as poor or sub-optimal this was considered by key informants to constitute a disincentive for further access.

For those resettling Sudanese refugees who were not capable or comfortable with communicating in English, interpreters were considered essential. However, according to key informants, in certain service delivery contexts and in certain circumstances interpreters were
thought not to be used by health care providers even when a need for an interpreter was acknowledged. This was particularly considered to be the case in services operating under fee-for-service type arrangements such as in General Practice. The under-utilisation of interpreters in General Practice was considered to be the case even though GPs have access to free interpreters under the Translating and Interpreting Service (TIS) for medical practitioners and the Doctor’s Priority Line, enabling prioritised access to interpreters. As the following quote illustrates, the non-use of an interpreter in circumstances where one was considered necessary by resettling refugees appeared to negatively affect subsequent access of the service:

“They send you to the GP, the GP doesn’t speak your language and people are complaining that the Sudanese people don’t go to the GP; they don’t go simply because they will not understand the GP, the GP will not understand them unless there is someone accompanying them and GPs don’t use interpreters.” (Key informant 11 – Sudanese woman)

Other negative experiences such as non-empathic health care providers or misunderstandings with health care providers were also thought to act as disincentives to continued use of a service. One Sudanese key informant described how a negative experience with a GP had affected her subsequent access patterns saying:

“I found that most of the GPs either they are; they don’t like dealing with African or black people, I don’t know yeah. Like I remember when; sorry to say that but this is a fact, this is my experience. For example when I used to take my children to the clinic, you know that little table the doctor should make someone to lie down to examine; they would rather examine a child, a very sick child, standing up but they will never put the child on the bed. And one day I said ‘why don’t you let him lie on the table and just hold this properly so that you can hear properly?’ I became very angry. And he didn’t answer me and he just continuing doing this and I just told him ‘stop, you don’t want to see my child, it’s better just tell me I’m not ready to look at this child because I’m really not comfortable with; the child is sick, he need a doctor to attend to him. If you can’t see my child just tell me?’ He didn’t answer me so I just walk out. So I always have problem with the doctor; very few doctors really you know.” (Key informant 7 – Sudanese woman)

This example underscores the relationship between quality of care and access.
 Furthermore perceptions that needs were not being met by a particular service or that responses offered were not helpful or culturally relevant were also thought to affect access. The low uptake of counselling, and the preference for practical resettlement support, was given as an example by some key informants from the refugee specific mental health service. In some cases this was thought to result in resettling refugees seeking alternative care from other services.

The interpretation offered here is that the selective accessing of some services and not others based upon previous experiences of poor quality care is not necessarily negative. It is likely to prevent or minimise the chance of harm occurring in future health service experiences. However, this interpretation is only valid if resettling refugees are able to access alternative services to the one in which sub-optimal quality of care acted as a disincentive to further access. In some cases, however, negative experiences were thought to result in total disillusionment with not only the particular service where the negative experience occurred, but with the formal health system as a whole. In these cases some key informants, such as the one quoted below, perceived this disillusionment to result in complete disengagement from services:

“Some people would say ‘why should I be wasting my time going all the time to the doctor, I come back I have the same headache, but my tummy is still sore and I’ve been going to the doctor and nothing is improving, so why should I go, I think this thing is not going to go, I’ll just stay at home’... That is very dangerous if you’ve got a bit of headache and you just feel that it will go away because I don’t know how to talk to the doctor or when I go there the doctor won’t hear me or I’ve been going all the time and no improvements so why should I keep on going to the doctor – just rather sit at home and not to access the health services.” (Key informant 7 – Sudanese woman)

Systematic discrimination
At a macro or policy and service planning level the perceived inadequate consideration of refugees in policy making, and/or the total absence of policy and programmes, were thought to deny resettling refugees’ access to certain health services, even if they wanted to access such services. In this respect, examples given by key informants were interpreted as systematic discrimination.
One example consistently highlighted by key informants involved in primary and allied health care revolved around the Federal Government initiative called *Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule* (henceforth described as ‘Better Access’). As described by key informants the initiative was implemented in November 2006 and built on an earlier initiative called *Better Outcomes in Mental Health Care*. Better Access aimed to facilitate access to mental health care at a primary care level by creating a Medicare item which remunerates GPs for an initial mental health assessment, management plan and referral to an allied health provider. For the first time, under the programme allied health workers such as psychologists, mental health nurses, social workers, and occupational therapists could register with Medicare. Furthermore they could claim the introduced item number for the care that they had provided to the referred patient. In so doing, it was thought that the programme would encourage referrals from General Practice to allied health care providers for mental health issues. Subsequently this would allow more people to access allied health providers who otherwise may not have been able to seek such services given the high out-of-pocket costs associated with allied health consultations. Whilst this was generally considered to be an important initiative and was likely to increase access to mental health care in the general population, this was not thought to be the case for those from non-English speaking backgrounds, including many resettling refugees:

“So if someone is referred to an allied health provider, there can be five subsidised visits in a calendar year if they have a chronic disease under this enhanced primary care programme and if you speak English that’s fine but if you don’t speak English you can’t actually access it. I mean it’s systematic discrimination really.” (Key informant 16 – Program manager)

As key informants explained, GPs are able to gain access to free interpreting services through TIS because they are medical practitioners. However, at least initially, free TIS services were not available to allied health providers as they are not medical practitioners; this despite the fact that with the introduction of Better Access they were now able to register with and claim items for certain services through Medicare. According to key informants, this meant that allied health providers would be reluctant to use an interpreter where needed as payment would be needed for interpreter services. The cost of interpreter use would usually be passed onto the client. Thus whilst the cost barrier to accessing allied health care was thought to be decreased by the initiative for the English speaking population, it still existed for those that might need an interpreter. Therefore, Better Access might be interpreted as selective in terms of those on whom Better Access is conferred to. Key informants found it surprising that the
cultural and linguistic diversity within the Australian population was not taken into account in the planning of the initiative:

“Well I think wherever you’ve got Medicare items there should be capacity to have interpreters otherwise you are actually eliminating, you’re excluding particular members of the population who do not speak English from accessing those services because you cannot, you cannot; these are counselling, speaking type services on the whole under Better Mental Health stuff... Anywhere you’ve got a Medicare item; as soon as you do that it’s like public provision – what you make available for doctors you should make available for those service providers as well because it effectively, in my opinion excludes them from accessing that. However that’s a separate issue because that affects everyone who doesn’t speak English proficiently and that can be the elderly who have been here, settled here, for some years as well as new arrivals so it’s broader than refugee groups and humanitarian groups.” (Key informant 17 – Health service manager)

According to key informants, advocacy efforts have been launched and are underway in order to attempt to gain free interpreter access for allied health providers under TIS. Discussions are also being held at an interdepartmental level within government to try and rectify the situation:

“That’s been on or near the top of the agenda on the refugee health kind of advocacy for quite some time.” (Key informant 18 – Policy maker)

In one instance relayed by key informants, a metropolitan Division of General Practice had attempted to overcome the inadequacy of Government policy by securing funding for interpreters for allied health care providers with some success.

Better Access might be interpreted as an instituted programme that does not sufficiently consider the access needs of those individuals from non-English speaking backgrounds. However, key informants also highlighted examples where there was a total absence of programmes or policies, effectively denying resettling refugees’ access to care. The absence of remuneration for interpreter use within General Practice was a case in point. As was

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10 Divisions of General Practice are organisations that support GPs in local areas and are run by paid staff. Membership of a division is voluntary for GPs. In South Australia there are five urban Divisions of General Practice and nine in rural areas. They particularly assist GPs in the implementation of new policies and initiatives. They are also involved in GP policy development.
discussed by key informants, whilst GPs are able to get free interpreter access through TIS there is no Medicare item that can be claimed for consultations using an interpreter. This was considered problematic by key informants because consultations using interpreters were generally thought to be longer, more labour intensive, and requiring specific skills. Given that General Practice was thought to be a system built around incentives, key informants felt that there was no incentive for GPs to use an interpreter. Perceptions about the low utilisation of interpreters in General Practice, the quality of care in General Practice for resettling refugees, and the lack of motivation to deliver care to resettling refugees amongst some GPs were partly attributed to the lack of incentive to use interpreters. As has been presented in this chapter, such factors were thought to constitute disincentives for accessing care for resettling refugees.

6.5 Quality of care

As has been discussed, key informants’ accounts revealed that quality of care can potentially impact upon access to care. Furthermore issues of quality were thought to impact upon satisfaction with care. As mentioned earlier and as is reflected in the highlighted area of Figure 6.3, interviews suggested that quality of care comprised three main elements. These included cultural and linguistic sensitivity, the patient-provider relationship, and the ability of services to meet the needs of resettling refugees.

Figure 6.3: Quality of care – theme overview

The themes of cultural and linguistic sensitivity and the patient-provider relationship will be
discussed in this section. The ability of services to meet the needs of resettling refugees has been discussed in the Chapter Five and will be elaborated upon in the “Structure and philosophies” sub-theme section to follow.

6.5.1 Cultural and linguistic sensitivity
One might expect the patient-provider relationship and the ability of services to meet the needs of patients to be somewhat universal aspects of quality of care. In the context of providing care to groups with potentially different culturally and linguistically mediated understandings of health and wellbeing, the idea of culturally and linguistically sensitive services was found to be particularly important. Furthermore, it was found to underpin each of the other elements comprising quality care. Prior to illuminating the benefits of cultural and linguistic sensitivity, and the strategies employed by services in this respect, it is necessary to examine what key informants understood cultural and linguistic sensitivity to mean.

Meanings
An examination of key informants’ accounts revealed a variety of terms used to describe how services might respond to cultural and linguistic diversity. These included ‘cultural appropriateness’, ‘cultural competence’, ‘cultural sensitivity’, and ‘cultural safety’. The meanings attached to these terms stressed slightly different attributes.

‘Cultural appropriateness’ embodied a sense of there being an appropriate way of engaging with refugees that could be learnt. In the use of this term one could detect a tendency towards de-individualising or homogenising Sudanese refugees. For instance some key informants said that using a male interpreter with a female Sudanese client was ‘culturally inappropriate’. Here the assumption is that the use of a male interpreter to interpret for a Sudanese woman is always inappropriate for all Sudanese women. This view is likely to overlook individual preferences and differences. Furthermore, in extreme manifestations of this view, culture may be conceived as a static and unchanging concept to which all subscribe. Thus, according to meanings attached to the term ‘cultural appropriateness’ one can learn what is culturally appropriate and what is not, and act accordingly.

The use of the term ‘cultural competence’ advanced this notion further. The way it was used suggests that a health provider is not only able to learn what is appropriate or not for certain cultural groups but can also achieve a degree of mastery over it. Thus, often when the terms ‘cultural appropriateness’ or ‘cultural competence’ were used, practitioners talked about
cultural awareness training, education or reading about cultures as strategies that could be used to ‘become’ culturally appropriate or culturally competent.

On the other hand, an acknowledgement of not-knowing and the associated benefits were emphasised by key informants who talked about ‘cultural sensitivity’. For instance, in discussing cultural sensitivity one psychiatrist key informant said:

“I think, you know, one of the principal things is being able to take a not-knowing stance; not believing that you hold an expert body of knowledge, although you do in some ways, but in relation to that person you have to take a stance of not-knowing and be prepared to deal with uncertainty and not-knowing something rather than assuming something until you get the answer; that’s the principal I’d say, the rest is just icing on the cake. I mean things like using interpreters, bi-cultural workers, learning about the culture of the community that person comes from but I think it’s a particular therapeutic stance you have to take, or position you have to take.” (Key informant 5 – Psychiatrist)

Thus as the quote suggests, ‘cultural sensitivity’ was considered to be an attitude or an approach rather than a skill to be learnt. Inherent within the discussions of those key informants who used the term was an acknowledgement of the changing nature of culture and of the individual preferences of clients. Therefore, asking questions both of one’s own assumptions as a practitioner and of those of the client was considered a way of engraining cultural sensitivity within consultations.

A few key informants talked about ‘cultural safety’ as a way of dealing with cultural and linguistic diversity within a health service setting. The use of the term ‘cultural safety’ was bound up in the idea of risk, and specifically the risk that refugee clients could be harmed by interactions with health providers. This was evident in the following quote from a health provider key informant:

“So the patient’s need to be culturally safe because it doesn’t take much thinking to know that if we are only working within a western model and feeling that our culture, our model, is the right one, is the normal one and that other people from other cultures with other models of health and other models of other worldviews, you know they need to fit in with us; there’s likely to be trauma happening, there’s likely to be a lot of miscommunication, there’s likely to be a lot of conflict, that people are not going to understand what’s happening within a
consultation, they’re likely not to comply with the medication or the management regime that they’re given, you know, it’s not going to work.” (Key informant 1 – GP)

Here, the consequences of not managing the risk associated with a cross-cultural encounter were thought to include the potential for trauma, miscommunication, conflict, misunderstanding, and non-adherence with medication and treatments. A cultural safety perspective thus was concerned with preventing or managing risk.

Accordingly, ‘cultural safety’ or the sentiments espoused by it were often used by those involved in the administration, planning and management of health services. Such individuals not only referred to cultural safety as a tool to mitigate the risk of harm to the patient but also to the service. This is likely to be consistent with health service managers’ concerns about safety and quality more generally. However, in this context it also manifested in specific medico-legal concerns about informed consent, misunderstandings, malpractice and complaints.

Despite their differences in emphasis, all the understandings of the terms used had some commonalities that might be interpreted as representing what lies at the core of culturally and linguistically sensitive services and practice. Such common elements included:

- The need to ask questions about:
  - What patient’s understandings are.
  - What one’s own understandings are as a provider and how these might influence the diagnosis and the proposed solutions.
  - How one’s own position of relative power might affect the consultation and what solutions are privileged.
- The need to negotiate and the need for mutual respect.

This was evident in the following quote from a psychiatrist key informant, who said:

“You gotta ask them ‘well what does it mean to you? What do you call it? How do you think it happened? How do you think it came about? And what do you think the treatment is?’ So you know, I’m not an expert on it but that’s just generally how I would go about trying to understand what it is they are bringing to the interview or to the session.” (Key informant 5 – Psychiatrist)
Benefits

The benefits of cultural and linguistic sensitivity were evident in many key informants’ accounts. Cultural and linguistic sensitivity was thought to include facilitating the development of a positive patient-provider relationship, which was seen as vital within the context of addressing mental health issues. It was the development of this relationship that many health provider key informants viewed as being the most healing thing that they could do.

Through contextualising refugees’ descriptions of their needs or problems, cultural and linguistic sensitivity was also considered to increase health providers’ understandings of the needs of individuals. As many key informants acknowledged, this is likely to be particularly important given the potential for different and diverse mental health beliefs amongst Sudanese in Australia. It was thus considered vital in supporting refugees with appropriate ways of addressing problems or meeting needs.

Additional benefits of cultural and linguistic sensitivity included increased compliance with treatments, decreased potential for misunderstandings and what health service managers, in particular, talked about in terms of patient safety.

Interpreters

In relation to cultural and linguistic sensitivity most key informants also highlighted the importance of using interpreters for those who required them. This was particularly thought to be the case in relation to mental health. This was due to the perception that mental health consultations were particularly language rich and were thought to revolve around engaging in a dialogue. A health service manager also viewed the issue of interpreters from a medico-legal perspective. He suggested that communication and ensuring client understanding are essential not only to the safety of the client but also in protecting providers and services from litigation.

In some cases interpreters were not just seen as the passive vehicle through which patients and providers interacted but also as active participants and resources that providers could draw on in relation to cultural sensitivity and quality. In this respect one key informant said:

“And when you’re trying to negotiate, like as a worker, trying to be really clear about what are the western cultural concepts that I’m trying not to impose on them, I think an interpreter is really quite useful because when you develop a good relationship with the interpreters
they’ll often say ‘what’s that?’ or ‘you might want to rephrase that’. I mean, I know they’re not supposed to do that, but you know, for them to be able to provide a little bit of cultural context is really useful too.” (Key informant 2 – Mental health nurse)

Another health provider key informant stated that once she had asked an interpreter’s advice after a consultation. Thus some key informants highlighted the potential for interpreters to act a cultural resource and hence quality improvement tool. The same key informants however, also acknowledged that this was beyond the strictly defined understandings of the role of an interpreter. This strictly defined understanding centred upon the notion of interpreter as simply being the conduit through which communication could occur.

Whilst the importance of using interpreters was stressed, key informants also highlighted a number of difficulties associated with their use. These are likely to apply to any situation in which interpreters are required but may particularly be exacerbated when practitioners are dealing with mental health issues amongst refugee clients. Many key informants stressed the need to maintain confidentiality and emphasised the risks that involving interpreters might pose to this. This was particularly thought to be the case in relatively small communities, such as the Sudanese, where there is a possibility that interpreters may know or be related to clients from the same cultural background. For instance one health provider commented on this saying:

“It’s often very difficult for a new community because often the interpreter is part of their family, or their community or they might get to see them regularly and still often we have to have a discussion with the interpreter if I either pick up or the people say that they’re a bit anxious about talking about personal issues... And that’s very difficult in a new community, and certainly for the Sudanese, if they speak one of the more difficult languages like Nuer or Acholi or something like that; the communities are very small that speak those dialects. So, yeah, that’s a difficult thing and I don’t have any easy solution to it, except to say that you need to have that confidentiality discussion.” (Key informant 1 – GP)

One health service key informant relayed her negative experience of an occurrence where confidentiality was breached, commenting on the implications for the patient-provider interaction, saying:

“I think the issue that I’ve become clear about in terms of what we do that’s different to,
perhaps, other organisations; I think that we really understand about working with interpreters and I think most mainstream organisations don’t. An example of this was this young Sudanese woman that was detained, was detained at a major metropolitan hospital on a Friday night, and they got a Dinka interpreter; they didn’t check out with the young woman or the interpreter whether there was any conflict of interest and as it happened the interpreter was related to the father of this woman’s child and that’s been the source of much bad blood. So when she sat down to interpret what this young woman was saying she actually said “don’t make me say those things, you know, because it’s going to reflect badly on my family”.

(Key informant 4 – Social worker)

Whilst this may be an isolated example, it does however point to threats to confidentiality and positive patient-provider relationships in small communities. As a result of such threats, some key informants reported briefing interpreters before consultations to remind them of their role and responsibilities.

One health provider key informant preferred not to use interpreters at all suggesting that they tended to be counterproductive in terms of developing a relationship with the client.

Interviews revealed that the gender of interpreters was another important factor that needed to be taken into consideration. For some key informants, this meant that gender concordance between the provider of support, the interpreter, and client was necessary. It was particularly considered necessary in situations where sensitive issues were being discussed, such as mental health issues, family issues, and reproductive health.

The issue of face-to-face versus telephone interpreters was also raised by a number of health service key informants. Some suggested that telephone interpreters undermined the development of rapport, trust and positive patient-practitioner relationships. For instance one key informant said:

“I personally don’t like and almost will never work with phone interpreters because I just find that very unsatisfactory; it’s just a bit of a thing about me, I suppose I don’t particularly like telephones. I’d much prefer that face-to-face contact and see what’s going on. So quite often I will struggle along with somebody face-to-face with big language difficulties rather than use a telephone interpreter... It’s obviously much harder and the information you get is less and probably there’s much more misunderstanding but I still prefer to do that face-to-face than on
the phone because you have similar issues on the phone except you can’t see what’s going on so you don’t necessarily know that the misunderstanding is there in the same way. And you know I draw pictures and I do all sorts of things to get the ideas across if I’m struggling with language and I’ll write things down so that if there’s somebody else in the family who has a better understanding of English than me so they can deal with it as well so there’s ways you can kind of get around it a bit.” (Key informant 13 – GP)

Another health service key informant believed that telephone interpreters from interstate were preferable in certain situations, such as when working with refugees from small communities. The fear that a face-to-face interpreter may breach confidentiality commitments may be exacerbated when the client and interpreter are members of a small community. In the context of mental health issues, the fear may be exacerbated further by the perceived risk of stigmatisation within a community.

The type of interpreter used, who interprets, and their use was found to vary and thought to be contingent on a number of factors, such as the structures and philosophies in operation within services. Most refugee specific services and community health services employed interpreters. Otherwise such services, like other publicly funded services, organised for interpreters to be present where necessary at no cost to the provider or patient. GPs were also found to have access to free interpreting services but the time and effort required to organise interpreters were thought to reduce their use. One GP key informant exemplified this sentiment when asked about the logistics of using interpreters saying:

“You can’t coordinate it. You see like if someone rings up for an appointment in three or four days time, it has to be flagged through the system at the time so that an interpreter is booked to be present at that time on that day and if the booking is just taken; maybe somebody else phones up for an appointment not realizing that they need an interpreter and then the person rocks up and there’s no interpreter. And general practice just can’t cope with that because the appointment’s wasted and everybody’s that busy anyway so it just becomes very messy to deal with other than in more dedicated clinics like say the refugee specific primary health care service where they run a similar system to us here; the interpreters are booked at the same time as the patients every time we see them so the interpreter writes the diary at the same time we write the appointment in our diary.” (Key informant 13 – GP)
It was partly due to this that many key informants commented on the perceived low utilisation of interpreters within General Practice.

In some circumstances, health service provider key informants remarked that they had been aware, through their contact with refugees, that some health providers had used children or other family members to interpret. As the following quote suggests, this was thought to be due to the perceived time and effort required to organise interpreters:

“Very often what happens in this case is that the child interprets. The child gets into that role. A child going to school and his English is much better than the parents. It’s good that the child is getting involved in one sense. So very often they have to take the child to all the services; you know not only there but social security. The child is putting in a role; once or twice it’s OK but then in the long term there could be all kinds of other complications.” (Key informant 14 – Psychiatrist)

The use of children and other family members as interpreters was seen as problematic by a number of health provider key informants due to the potential for confidentiality issues to arise. Furthermore, some key informants viewed the use of children as interpreters as particularly problematic as it was thought to place extra pressure and responsibility on children, some of whom were thought to miss out on periods at school to attend appointments with parents. As mentioned previously the perception that some refugee children were required to take on adult responsibilities was thought to potentially affect children’s adjustment and family dynamics.

Strategies to achieve cultural and linguistic sensitivity

Given the perceived importance of cultural and linguistic sensitivity, key informants revealed a number of strategies and techniques that they had used or thought could be used in order to impart and engrain cultural and linguistic sensitivity in service provision.

In addition to the patient-provider level strategies already mentioned, key informants also illuminated a number of service level strategies. The employment of bi-cultural community health workers (CHWs) was one strategy. Bi-cultural CHWs were thought to be a ‘cultural’ resource that other providers could draw upon for advice about ‘cultural’ issues. Some services, and particularly refugee specific and community health services, were thought to encourage workers to undertake cultural sensitivity training. In some cases these services
delivered such training to new workers themselves. Such services were also likely to incorporate cultural and linguistic sensitivity within service policy, which meant that cultural and linguistic sensitivity was considered in all aspects of service planning and delivery.

6.5.2 The patient-provider relationship

Interviews revealed that the patient-provider relationship is a fundamental element of quality care that had particular importance in working with resettling refugees. This was due to the past experiences that resettling refugees may have faced as a result of forced migration. These included betrayal, abuse by those in power, and struggling against powerlessness in places like refugee camps. As a result some health provider key informants, in particular, flagged that some resettling refugees may be suspicious or distrusting of authority figures like health providers. This necessitated additional focus on cultivating a positive patient-provider relationship. Furthermore, where social isolation and marginalisation are a part of individual resettling refugee’s experiences in countries like Australia, then the development of a good relationship with a health provider was thought to be beneficial in decreasing that isolation. Thus, health provider key informants suggested that the patient-provider relationship may take on new dimensions when the patient is a resettling refugee. As alluded to in the following quote, this may mean that health providers might be a key person in refugees’ social support networks:

“And they do, I think they do appreciate that element of being able to share their feelings almost like someone to whom they can actually confide with because they don’t have their own family, their extended family... so I have found myself very often wearing the hat of also confidant; you know someone who say ‘you are the first person I met when I came’ almost. I mean of course they meet other people but in a therapeutic situation and they say you know ‘you are my friend’ in a sense so they very often come to me to ask my opinion, my advice and so that I think is a strong sign of trust I would say.” (Key informant 12 – GP)

Interviews revealed that a positive patient-provider relationship in the context of resettling refugees was thought to consist of a number of elements; all of which are likely to apply more broadly. These included confidentiality, sharing and openness, empathy and respect, and trust.

Confidentiality

Confidentiality was thought to be important given the relatively small size of many resettling refugee communities such as the Sudanese. It was also considered important because of the
possible emotional nature of the information being disclosed, particularly in relation to pre-migration experiences. The ability of health providers to assist those who needed assistance in dealing with such issues was dependent, for some health providers, on the disclosure of such information. Others advocated strengths-based approaches, and believed that disclosure of past trauma, for example, was unhelpful. Irrespective of their stance on the disclosure of past negative experiences, many health provider key informants stressed the need to reassure refugees and interpreters that whatever was being said in the context of a consultation would remain confidential. Some health provider key informants felt that this was a significant step in developing trust and providing a safe and supportive environment, in which resettling refugees could disclose information if they so desired.

Sharing and openness
Trust between patient and provider was also thought to be promoted by the sharing of experience and openness. For many health provider key informants this also meant answering questions about their own lives. In doing this, health provider key informants felt that they were encouraging resettling refugees to share their experiences if they found that helpful. Sharing and openness were also thought to promote an egalitarian relationship, which was considered important. This was considered particularly important because of the powerlessness that resettling refugees may have struggled against in the past or continued to struggle against. It was thought to differentiate health providers from other authority figures whom refugees may have experienced in the past as abusing their power.

Empathy and respect
In addition to sharing, many health provider and refugee key informants emphasised a need to be empathetic and respectful of the experiences and information being offered by resettling refugee clients. Unlike the objective and emotionally guarded white coat wearing health provider of the past, both Sudanese and health provider key informants expressed the need for a health provider who was an advocate and could sympathise with, or at least acknowledge, the difficulties faced by resettling refugees. This is echoed in the quote of a Sudanese key informant who said:

“Someone has to have a heart for people like this... So really if your profession is about helping people it shouldn’t matter what person because your aim is to help people so really colour should not be a problem, you know gender should not be a problem; you are just dealing with someone who need your help, your service... So if you value diversity and you
value people as people from your heart, that’s all you need, I think.” (Key informant 7 – Sudanese woman)

Trust

Elements discussed were thought to facilitate the development of trust. This was canvassed not only in terms of patients trusting that their information was going to be kept confidential, or that it would be respected by providers, but also that providers would act to address the expressed and individualised needs of the patient. The ability of services to meet the needs of resettling refugees was identified as one of the three components constituting quality care. Thus the element of trusting that providers act to address the personalised needs of those they serve may be particularly important. But, as the remaining sections of this chapter will illuminate, the ability of each provider to address the personalised needs of refugees is not simply a matter of the skills, abilities and good intentions of each individual provider. The ability of providers to meet refugees’ needs is also influenced by health service and systemic factors. These shape the way in which providers work and their ability to act.

6.6 Philosophy and structure of services

In the previous chapter, variation in the capacity of services to meet the material and social, as well as mental health needs of resettling refugees was established. The philosophy and structure of services were key factors identified throughout the interviews to account for this variation in capacity. The interconnected themes of philosophy and structures presented in Figure 6.4 were discussed throughout the interviews with respect to particular health service settings. Refugee specific services, community health services, and mainstream services were among service settings discussed.
6.6.1 Philosophy

Interviews revealed that the service provision philosophy espoused by individual services and those that work within them impact upon the willingness of services to address the mental health needs of resettling refugees in a holistic manner. Furthermore service provision philosophies were found to influence, and are influenced by, the structures and service delivery models in operation within services.

*Refugee specific services*

Accompanying an exclusive focus on refugees, refugee specific services were thought to engender a primary health care philosophy. That is to say, many key informants from refugee specific services described the values of such services as being consistent with those of the primary health care model. Such values were thought to include concerns about equity and social justice. These values were described as flavouring the clinical realm of service provision in terms of cultural sensitivity, and attempts to increase access. They were also present in the conceptualisation of refugee specific services as playing a larger role as an agent of change within the system. Examples of this agent of change role will be discussed in more depth later in this chapter.

The other aspect of primary health care philosophy that key informants from refugee specific services talked about was a commitment to expanding beyond narrow clinical service provision concerns. Key informants from refugee specific services were critical of narrow
biomedical notions such as those inherent in the focus on refugees and post-traumatic stress disorder, which is illustrated in the following quote:

“Sometimes they might present as mental health but they’re actually really things to do with resettlement like housing issues or family issues and they kind of manifest as acute mental health; people sort of spinning out and, you know, ending up in emergency departments when really if they were kind of anchored to a supportive community health environment where they were getting support and counselling then they wouldn’t, that kind of presentation wouldn’t be necessary.” (Key informant 10 – Health service manager)

As is evident in the above quote, there was an affirmation of the value and benefit of a broad social determinants of health focus within refugee specific services. Consequently refugee specific services were thought to be more likely to assist resettling refugees with the task of rebuilding social worlds, in addition to mental health issues. Furthermore such services were also thought to place emphasis on health promotion within the context of service provision and more specifically embedded in particular group programmes.

Community health services
Little distinction between refugee specific services and community health services was made by key informants. Many emphasised that the refugee specific services in South Australia are also community health services. Likewise, many revealed that community health services possessed a degree of refugee specificity. Thus community health services were similarly discussed as engendering a primary health care philosophy in service provision. Their equity agenda was generally thought to include resettling refugees but was thought to be broader, extending to other potentially ‘vulnerable’ groups in the community. Such groups included Indigenous Australians, migrants, and those of low socioeconomic status. Like refugee specific services, community health services were also thought to be characterised by a rejection of narrow biomedical notions of disease. They were similarly determined to contextualise an individual’s needs within a broader socioeconomic and cultural context. Consistent with the expansion in focus from disease to health, community health services were also more likely to view health promotion and prevention activities as important and time worthy.
Mainstream services

Within the context of services aimed at providing services to the population in general, there were also thought to be varying degrees of refugee specificity. For instance a key informant from a public mental health service discussed how the service had recently employed a Culturally and Linguistically Diverse (CALD) and Refugee programme coordinator to increase the service’s ability to respond to the needs of such groups appropriately. As a result, the service offered a number of targeted programmes specifically to resettling refugees. Interviews with key informants from General Practice revealed that some Divisions of General Practice had specific health promotion programme managers who incorporated a focus on refugee health within their work. Another manifestation of refugee specificity included the development and implementation of policy for working with refugee and CALD clients at a large metropolitan hospital. Thus a distinction between mainstream and refugee specific services may overlook the varying degrees to which services may target their responses to refugees.

Interviews revealed that there may be differences between mainstream and refugee specific services on the basis of the philosophies held and the degree to which services tailor their service delivery to the needs of resettling refugees. Generally, mainstream services were thought to be dominated by the philosophy of biomedicine and a narrow focus on disease. In part this was thought to promote superficial or ‘band-aid’ responses and an inability to engage with underlying or perpetuating factors most often located in the socioeconomic context. For instance one key informant said:

“From a GP point of view they think they can immediately sort out the problem without all these other; a person tells a headache or chest, and they think they can immediately give a treatment but that may not be the actual problem... so many times the whole depth of the problem can be missed.” (Key informant 14 – Psychiatrist)

Furthermore, in private service provision contexts such as in General Practice or consulting psychologists, service delivery philosophy was partly bound up with a small business or corporate philosophy, and its emphasis on profit. How this philosophy interacts with the structure of services will be discussed in the following section.
6.6.2 Structures

The values and philosophies of services are likely to be shaped by, and shape, the structure of services. A number of different models of service delivery were thought to be operating in relation to resettling refugees. These were thought to affect how services attempt to respond to the needs of resettling refugees.

Refugee specific services

The service delivery models of the two refugee specific health services were considered to be conducive to providing high quality care to resettling refugees. As discussed in relation to philosophy, refugee specific services were thought to take a holistic approach rather than a narrow biomedical one. This was considered beneficial in terms of the ability of such services to address issues associated with rebuilding social worlds, in addition to potential mental health issues. Such benefits were often highlighted through the comparison between community health services, and other mainstream models of care:

“And community health, I think, where there is a multi-disciplinary approach, where you’ve got you don’t have a business model of, you know, fee-for-service for everything that you do; where you’ve got a range of different services in the one place and you can case manage and holistically deal with the family, is I think is a more appropriate manner of dealing with a certain percentage of new arrival refugees and I would think a lot of the Sudanese who come from the sort of conditions that I talked about earlier; the big families, the people who have been in refugee camps, you know, women headed households, not speaking English – those people really, really struggle with General Practice and GPs often just, kind of, pull out their hair because they don’t know what to do with them.” (Key informant 10 – Health service manager)

The way in which refugee specific services were funded meant that they were free at the point of care. This is important considering that financial issues were flagged as an important issue in terms of the practicalities of rebuilding social worlds, and as such, cost of care may be a disincentive to access. Furthermore both refugee specific services employed salaried practitioners from diverse disciplinary and professional backgrounds. These included counsellors, psychologists, nurses, social workers, bi-cultural community health workers and in the case of the primary health care service, a salaried GP. According to key informants, the benefit of a salaried practitioner model, which was also present in other community health services, is that it allows service providers the time and flexibility to deal with social and
material health issues. It was also thought to be conducive to quality of care at the provider-patient level as it was thought to enable practitioners to undertake longer consultations. This might be particularly helpful considering the possibility of encountering with large families, using interpreters, and dealing with potentially complex issues. One of the drawbacks highlighted, however, was that salaried practitioners were thought to see fewer clients a day than their fee-for-service counterparts.

Given this and the pressure it places on waiting lists, the two refugee specific services complemented their salaried practitioner model with sessional therapists like GPs or psychiatrists. Due to their backgrounds in different structural environments, sessional therapists were able to see a higher number of clients a day. Although arrangements might vary between services, interviews revealed that sessional therapists worked in refugee specific services for a day or two a week. In the case of GP sessional therapists working in refugee specific services, arrangements had been made such that GPs continued to be reimbursed for their services through Medicare but would bulk bill. In some highlighted cases GPs and sessional psychiatrists were also paid a small fee directly from refugee specific services.

The existence of a multi-disciplinary workforce and the subsequent pooling of skills, within refugee specific services also enabled such services to engender a ‘one stop shop’ model, promoting comprehensiveness. Given the possible diversity of material, social and mental health needs that resettling refugees might have, this is likely to be beneficial.

The refugee specific primary health care service was organised into units or clinics with pathways in place to facilitate the movement through the service to clinics where refugees’ needs could best be met. Key informants from the refugee specific primary health care service explained that there was an intake clinic run by an intake nurse who would see new refugee clients on their first visit to the service. The intake nurse would then obtain a brief history and undertake an assessment of the needs of the client. From there key informants went on to explain that the intake worker would book the client into the relevant clinic/s and/or group programmes where their needs could best be met. Similarly, interviews revealed that the refugee specific community mental health service also employed an intake worker to perform an initial needs assessment. In addition this intake worker would also address any immediate practical resettlement health needs, before booking the client into one or more of the services offered within the service. The individual needs assessment mechanism, and the subsequent matching of care with need, was thought to be integral to providing tailored and holistic care.
Examples of the clinics within refugee specific services were mentioned in the previous chapter. Rather than each clinic operating in isolation from each other, key informants from the refugee specific primary health care service highlighted a number of mechanisms employed to integrate each of the clinics. These included informal information sharing about clients or families between workers in different clinics, meetings to discuss the needs of individual clients, the development and running of group programmes by staff from other areas, and staff meetings.

In terms of issues of quality and cultural and linguistic appropriateness, as has been discussed earlier in this chapter, both refugee specific community mental health services employed bi-cultural community health workers, and paid for interpreters to be present whenever they were needed. Thus such refugee specific services were considered to be sensitive not only to the context of forced migration, but also to that of language and culture.

**Community health services**

Community primary health care services and community mental health services were also thought to share similar structural environments to refugee specific services. That is to say, they were thought to employ salaried and sessional practitioners, and consist of multi-disciplinary teams conducive to addressing needs holistically. Thus, whilst their focus in terms of their target population was considered to include ‘vulnerable’ or ‘high need’ groups more generally, by virtue of the structural and philosophical environment under which they operate, community health services were also considered to possess the capacity to address the needs of resettling refugees.

**Mainstream services**

In contrast, mainstream health services were generally thought to operate under different structural, as well as philosophical, paradigms. Many of these were considered less conducive to meeting the material, social and mental health needs of resettling refugees. General Practice was one example within the mainstream health system that was repeatedly discussed in interviews.

Key informants reiterated that private General Practice settings were structurally shaped by the fee-for-service business models, and the system of incentives engrained within Medicare. The associated profit motive that accompanies GP service models was thought to promote shorter consultations, and encourage ‘thoroughfare’ through services. In some cases where
resetting refugees were not considered ‘complex’ clients, GP service models were considered to be acceptable. Those refugees with a high degree of English language proficiency and high educational attainment, and/or those whose initial on arrival needs had been met in refugee specific and/or community health services were not considered ‘complex’ clients. In the case of one Sudanese key informant, who reflected upon his own experience, GP service models were viewed as being preferable for ongoing post-initial arrival use, in relation to his own personal circumstances:

“Well the GP is easy; it’s always near your place and sometimes easier to make an appointment with them. The refugee specific primary health care service are always busy with new arrivals and they transfer you to another place anyway when you go there sometimes so you say “oh why go to them so that they now go and transfer me here, why don’t I just go direct to this place?” so that’s how it is.” (Key informant 3 – Sudanese man)

However, interviews revealed that the profit motive inherent within GP service delivery models can potentially compromise quality of care. Furthermore, it was also considered to compromise the ability of GPs to engage with the social and material health context associated with emotional wellbeing for many resettling refugees. One potential consequence commented upon by key informants, in addition to shorter consultation times, was the perception of the promotion of superficial or ‘band-aid’ responses to the material, social and mental health needs of resettling refugees. The prescription of medication was one example given. Subsequently the potential for unmet need in terms of rebuilding social worlds was thought to be high.

Furthermore the structure of general practice was considered to be built upon “carrots rather than sticks” (Key informant 18 – Health service manager) as one key informant put it. By this he meant that change within private GP models of practice is driven by incentives, in the form of claimable Medicare items, rather than policy. For instance, the absence of a Medicare item to remunerate GPs for consultations involving interpreters was viewed as contributing to the perceived low uptake of interpreters within General Practice. Similarly key informants also explained that the introduction of Medicare items, such as the 714 for initial health assessment for newly arrived refugees contributed to an increased propensity to deliver initial health assessments within general practice.

Many key informants working within refugee specific and community health settings saw a
structural environment dominated by incentives as problematic. In the case of the item number 714 there were no ongoing education or training requirements attached to the item. This means that GPs without any experience or training in refugee health or working cross-culturally, can claim the item despite the perception by some key informants that working with refugees and interpreters requires specialised skills and knowledge. Some key informants working in refugee specific and community primary health care settings attributed the fact that resettling refugees who had sub-optimal or incomplete assessments were surfacing at their services, partly to the lack of incentives for GPs being counterbalanced by appropriate training and up-skilling.

In its extreme manifestation, some key informants described instances of sub-optimal care provided to resettling refugees in corporate General Practices. These were described as practices owned by a corporation. Such corporations often owned a number of individual practices. Thus, the profit motive in corporate practices was thought to dominate, potentially compromising quality and patient safety. In relation to refugees, it was thought that large corporate practices were seeing many newly arrived refugees for initial assessment. According to some key informants, the attraction for the IHSS provider, who is largely responsible for referring newly arrived refugees for initial assessment, may be the fact that appointments are not required at such services. Furthermore due to a high throughput such services are able to see a large number of clients, including resettling refugees. However, according to key informants who happened to be seeing a number of resettling refugees who had accessed the service after having initially been seen in a corporate General Practice, the perceived non-use of interpreters, and the pressure to maintain high throughput was thought to result in incomplete initial health assessments.

The other problem identified by some key informants regarding the incentive driven structure of general practice in terms of resettling refugees regarded continuity of care. For instance, there was considered to be a distinct lack of incentive to address the needs of resettling refugees beyond the initial health assessment and into the longer term. There are no Medicare items that GPs can claim for the ongoing management of refugee health issues, or as has been mentioned, the use of interpreters. There was thus thought to be a gap in the transition between initial health care, and ongoing care, for which there are no incentives. Key informants perceived ‘mental health issues’ to be most likely to manifest in the longer term for resettling refugees. However, their access to ongoing primary care may be hindered by the structural environment under which General Practice was thought to operate.
Despite this, interviews revealed a number of positive examples of mainstream services and organisations attempting to alter structural environments in order to increase their capacity to address the needs of resettling refugees. Commenting on the service delivery models in operation within General Practice, one key informant said:

“General Practice is like opening a packet of liquorice allsorts; you know different sizes, shapes, structures but certainly the practices that can work well in teams, certainly there seems to be a good level of cooperation and not quite so much stress on the GPs that are trying to do it all.” (Key informant 16 – Program manager)

Private General Practices employing nurse-practitioners and/or practice nurses in addition to GPs were considered to have greater capacity than traditional solo GP practices. It was thought that nurse-practitioners and practice nurses were able to address issues relating to the context of resettlement and forced migration rather than a narrow clinical definition of mental health issues. Furthermore, nurse-practitioners and practice nurses were also thought to allow the sharing of responsibilities for patient care with GPs, enabling both parties more time to deal with issues with which they are best equipped to deal. According to one key informant, this may mean that nurse-practitioners and practice nurses may be involved in developing trust, taking histories, assessing needs, health promotion, and providing information, allowing GPs to focus on clinical care:

“I do see it very important and it’s often the way you can get into a practice through the practice nurse because obviously not as much of their time is going on to clinical care and so I think they often too have a holistic understanding about some of those other things like the settlement issues; they’ll need to get sorted if the person is going to enjoy better health anyway. So yeah I do see them as a really important link.” (Key informant 16 – Program manager)

Furthermore nurse-practitioners and practice nurses may also play a capacity building role within individual services in terms of refugee health and cultural and linguistic sensitivity. According to key informants involved in the administration of General Practice, nurse-

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11 Nurse practitioners are considered advanced registered nurses – generally with Masters level qualifications – who can work autonomously and collaboratively with a variety of professionals (Department of Health 2007). In comparison practice nurses may be registered or enrolled nurses who work in General Practices under the direction of GPs. Nurse-practitioners require a post-registration certification from the Nursing board of South Australia in order to practice in South Australia whereas practice nurses do not (Department of Health 2007).
practitioners and practice nurses were more likely than GPs to attend organised workshops on cultural sensitivity, and working with interpreters.

6.7 Individual organisational factors
Several organisational factors were also thought to have an influence on the ability and willingness of services to focus on resettling refugees, and the quality of care provided to resettling refugees. As illustrated in figure 6.5 these clustered around the motivation to include a focus on resettling refugees within service provision responses, and management support.

Figure 6.5: Individual organisational factors – theme overview

6.7.1 Motivation to focus on resettling refugees
A number of factors were thought to motivate certain services to respond to the needs of resettling refugees, such as those from Sudan. One persuasive factor was that of refugee settlement patterns. A service increasingly coming into contact with resettling refugees was thought to increase organisational focus by necessity. According to key informants, most of the resettling refugees in Adelaide have traditionally settled in the western and north-western suburbs and the sprawling northern suburbs. In parts of these areas cheaper accommodation can be found in comparison to some other areas. Services in such areas have thus had greater contact with refugees relative to other areas. However, the recent resettlement of refugees in the inner and outer southern suburbs of the city, for example – regions historically characterised by considerably less cultural diversity and refugee settlement – has brought
services in these regions into greater contact with resettling refugees. According to one key informant, this was partly implicated in the increasing focus on resettling refugees within the organisation where she worked:

“I guess a few years back when I learned that there were going to be quite a few refugees; there were predicted to be a couple of thousand refugees settled in the inner south. Now I don’t actually think that number was ever reached but I guess I saw it as a mandate for why we had to become better resourced and better equipped and support general practice better because whether they liked it or not, these new arrival refugees would be settled in the inner south so that was really a catalyst for saying yes this is legitimate work because or GPs, our members, are going to be seeing these people.” (Key informant 16 – Program manager)

Besides geography, settlement patterns in terms of source countries have also shaped the focus of services on particular groups of refugees. For instance, when African refugee migration to Australia started, increasing quite rapidly after 2000, both the refugee specific services employed bi-cultural community health workers (CHWs) from African backgrounds. Sudanese bi-cultural CHWs are represented among these. This was undertaken in an effort to increase the ability of such services to respond to the needs of the changing humanitarian intake. The use of bi-cultural CHWs will be discussed further during the course of this chapter.

However, if settlement patterns are likely to motivate services to react and respond to the needs of resettling refugees as key informants suggested, then there is likely to be a need for information and data about those settlement patterns. The IHSS provider is the primary recipient of prospective data on new arrivals from the Department of Immigration and Citizenship. Thus the IHHS provider represents a potential vehicle through which settlement data could be disseminated. Reflecting upon the responses of a consultation with community service workers, one key informant suggested that this was not occurring saying:

“But, you know, their feedback to the IHSS provider was ‘well we would really like to know who’s settling in our area. We’d like direct referrals. We’ve got all these programmes, we’ve got all these services but we don’t know who lives where. We use interpreters but nobody’s referred to us.’” (Key informant 10 – Health service manager)

In talking to this key informant and others, it seems that there is a distinct lack of
dissemination and information sharing in a number of areas within the system. Thus the ability of services to plan and proactively meet the needs of resettling refugees may be hindered.

Individual health providers motivated by an interest in social justice and refugee health issues were also found to be important in shifting organisational focus on refugees, and will be discussed under the “Agents of change” theme heading.

6.7.2 Management support
Organisational change was often contingent upon management support of an increased focus on resettling refugees. For instance, one key informant commented upon her desire to increase the capacity of the mainstream organisation where she worked to provide better services to resettling refugees. She then described the process of asking management whether she could incorporate this into her broader health promotion role, which she was able to do. She partly attributed her ability to act on ideas to improve health service provision to refugees to the management support she received.

Furthermore, management support was also seen as crucial in terms of ongoing professional development, such as cultural and linguistic sensitivity training, attending conferences, and up-skilling in terms of mental health. Such professional development activities were viewed by some as potentially improving the quality of service provision in the long-term. At the same time this was thought to come at some short-term cost to the organisation. The cost was talked about in terms of staff having to take time out of normal working hours to attend training and workshops, and organisations having to pay for staff to undergo training and/or attend conferences. Managers of refugee specific and community health services were particularly likely to support staff in ongoing professional development activities related to providing services to refugees. This is understandable as refugees are the core, or one of the core population groups, targeted by such services.

Decisions by managers of mainstream services to support refugee health related professional development activities were often complicated by the broader population focus of such services. In a fixed resource environment, professional development activities thought to be beneficial for service provision to one population sub-group or for one particular issue were weighed up against others. This was thought to be indicative of the broader question of in which areas, and for which population groups should mainstream services become more
specific. For instance, some key informants from mainstream services perceived a focus on refugees and migrants to be overshadowed or less important than the need to focus on Indigenous Australians. Additionally some key informants suggested that there was a perception within mainstream organisations that they do not need to focus on refugees because there are refugee specific services that already do that. In discussing the priorities and responsibilities of the community mental health service where she works, one key informant invoked the comparison between the service responses to refugees and the service’s responses to Indigenous Australians, saying:

“While I think that we, organisationally we prioritise, we give priority to these people amongst others but you know certainly people from refugee or CALD background are prioritised; I think there hasn’t been much emphasis organisationally on developing cultural competence or developing clinical skills that are useful. Having said that there’s people within the organisation who’ve worked a lot in that area but I’d say those numbers are pretty low, generally when you think there might be, I don’t know, 280 people in the organisation, you know we’re talking a couple of handfuls. I think that over quite a number of years now there’s been quite a lot of emphasis on providing appropriate services to Aboriginal people and employing Aboriginal people in the service and that sort of thing. I don’t think that there has been anywhere near that level of emphasis on CALD or refugee communities.” (Key informant 2 – Mental health nurse)

Whilst there are likely to be specific cultural issues that arise when providing services to different cultural groups, the concept of cultural sensitivity as articulated by key informants in this research suggests that it should apply to any client, regardless of culture or background.

6.8 Overarching theme: Health system factors
In addition to factors clustered around the individual health service level, a number of themes emerged at a health system level. These health system factors were seen as impacting on the ability of services to respond to the needs of resettling refugees at an individual health service level. However these were also perceived to be influential in shaping the ability of the health system as a whole, to meet the needs of resettling refugees. Such themes included integration and partnerships, workforce factors, agents of change and policy.
6.9 Integration and partnerships

In previous chapters, it was established that the social, material and mental health needs of resettling Sudanese refugees are likely to cut across different sectors and levels of care. Rather than each service and level of care existing as separate islands or silos and only addressing the needs upon which their service is focused, key informants pointed to the need for holistic service provision responses. For instance, as was discussed in the Chapter Five, referral was used as a strategy by providers to address needs that were considered to extend beyond the expertise of a particular service. However the ability of a service to refer to another service is likely to be affected by the existence of links, partnerships and relationships between services. This can be understood as pertaining to the integration of services. Key informants not only commented upon the benefits of integration but also the successes and failures in terms of integration and partnerships between services within a particular level of care and also between different levels of care. As Figure 6.6 illustrates, several areas of integration were specifically commented upon. These included between the informal and formal health sectors, between resettlement and primary and community care services, between refugee specific and mainstream services, and between primary and community care services and secondary mental health services.

Figure 6.6: Integration and partnerships – theme overview
6.9.1 Benefits of integration and partnerships

The benefits of integration and partnerships between services and between different levels of care were stressed throughout interviews. Integration and partnerships were thought to beneficial for both quality of care and access.

In terms of quality of care, integration and partnerships were thought to increase the probability that resettling refugees would be able to have their needs met. Considering key informants’ emphasis on the social context of resettlement it was thought that broader responses were needed in order to address such social determinants. However, as was alluded to by key informants, the biomedical approach often underpins health system responses, albeit to varying degrees in different services. This approach was viewed as primarily concerned with disease in individual parts of the body rather than with the individual and the social context in which they live. Thus, the need to overcome such constraints was particularly seen as important in terms of resettling refugees.

The development of partnerships between different services and the linking of different levels of care was seen as one important way of overcoming such constraints in order to facilitate holistic care. The interpretation of key informants’ accounts here is that integration means that no matter where in the health system a resettling refugee arrives they would ideally be able have their needs met. This would occur either at the service in which they arrive or by being connected with the most highly equipped service to meet their needs. For instance, a refugee might arrive at a primary care service and express a need for housing. Under an integrated system that person would not be turned away because the services’ primary focus is not housing. Instead the primary care provider might either:

1. Deal with the issue directly by advocating on behalf of the person if they felt equipped to do so or;
2. If they did not feel equipped to do so then they might seek the assistance from a housing service provider as to how best to proceed or;
3. They might refer the person to a housing services provider where their needs might be best met.

As key informants suggested, it is not realistic to expect that a service or provider would be equipped to deal with every possible issue, with which a person might present. Furthermore interviews revealed the need for providers to be aware of their own limitations such that they do not provide care for which they do not have adequate skills or resources. Thus options two
and three were considered to be important. Integration and partnerships were considered necessary in order to make options two and three available.

Partnerships were also thought to culminate in the pooling of resources, skills and abilities of individual services such that innovative, group programmes could eventuate.

6.9.2 Informal and formal health sectors
Key informants highlighted some examples whereby relationships between communities and the formal health system have resulted in programmes that were perceived to be beneficial. One example discussed by a key informant from the refugee specific primary health care service was a group information session. This session was co-facilitated by Sudanese community members and workers from the refugee specific primary health care service in response to the arrival of a large group of Sudanese refugees. As the key informant explained, this was considered beneficial for a number of reasons:

“I remember sometimes there was like twenty something Sudanese just came in one day and the refugee specific primary health care service with another organisation and some of the community members ran information session for them and we did it on health, finance, we explained it to them. Those families now don’t have that much trouble because we explained it to them ‘the money you get from social security, even though it says for you the women it doesn’t mean you spend it yourself, it’s all for the bills because you going to get a bill for this and that and that, and when the kids go to school they need this and that and that and that’ so it actually helped them to settle well... we the community thought it would be good... we thought it was very important to try and organise something so the community started and we asked the refugee specific primary health care service and I can’t remember which service and they agreed, so we did it.” (Key informant 8 – Sudanese woman)

However, interviews revealed that despite the benefits of relationships between refugee communities and services within the formal health system, there remains room for improvement. For instance one Sudanese man talked about the lack of utilisation of elders within the Sudanese community, despite their potential usefulness, saying:

“We need to involve a lot of Sudanese, especially Sudanese community elders to be involved or even to be orientate about how they can get help to their people if they having a problem.
Yeah if there’s a link between the health service and the community elders it would be good but it’s not happening.” (Key informant 6 – Sudanese man)

6.9.3 Resettlement and primary and community care services

Interviews revealed that integration and partnerships between resettlement services and primary and community mental health services were considered critical to the health system’s ability to address the needs of resettling refugees. Resettlement and other similar services were considered to play a crucial role in addressing issues relating to the social context, which was viewed as being influential in terms of mental health. Furthermore resettlement services were found to play a critical role in facilitating referral to other services. In South Australia, the Integrated Humanitarian Settlement Strategy (IHSS) provider in many instances is the first service of any kind to come in contact with resettling refugees. As has been established, the current mode of initial referral is from the IHSS provider directly to General Practice largely by-passing the state funded refugee specific primary health care service and the refugee specific community mental health service. This is occurring, despite the consistently reiterated benefits of refugee specific services in addressing complex issues, and the quality concerns relating to care provided to resettling refugees in general practice.

Thus in terms of initial care currently, key informant accounts suggest that there is only partial integration of the resettlement sector and the primary and community mental health care sectors; that being between the IHSS provider and General Practice. The relationship between the current IHSS provider and the two refugee specific health services were thought to be poor. As one key informant suggested:

“...all these other states have a really good relationship with their IHSS service providers; like they’re cooperative... You know, it makes sense to send clients to the Refugee Health Service... we don’t have that here; like it’s just, we’ve got the total opposite.” (Key informant 17 – Policy maker)

However, key informants distinguished between relationships between services and individuals. They suggested that there was no ill-feeling or animosity between individual service providers at these services, many of whom had worked with each other as colleagues in their careers in South Australia’s small refugee health and wellbeing sector.
A number of possible reasons were given to attempt to explain this lack of positive service relationship. One explanation related to the fact that the IHSS provider rarely referred to the refugee specific health services. In the eyes of some key informants this was seen as a deliberate ploy on the behalf of the IHSS provider to be:

“...seen to be the only person helping these people. You actually gain a kind of co-dependency relationship, create a co-dependency relationship. You are seen as the person who looks after African or other refugees...” (Key informant 17 – Policy maker)

Such a ploy was thought to enhance the prospects of subsequent or ongoing funding. Another explanation was the understanding that the two refugee specific health services were left out of the consortium that currently delivers IHSS services. The loss of the contract by the refugee specific mental health service, for instance, might be a source of resentment. Such explanations point to the politics within the refugee health and wellbeing sector in South Australia. The interpretation here is that such politics are not organic to individual services in South Australia. In contrast it appeared that such politics are encouraged by external factors such as competitive funding models that pit services, which ideally would be engaged in partnerships and collaboration, against each other for scarce funds. As some key informants suggested, the very existence of services in South Australia’s small refugee health and wellbeing sector are linked to their ability to secure funds. The competition for the IHSS contract resulted in services, and particularly smaller services and organisations, forming alliances and consortiums to strengthen their ability to secure funding. However, as with all alliances, they are significant in terms of who they exclude as much as whom they include. Furthermore, some key informants also suggested the possibility that services might be involved in the practice of “under-cutting”. As one key informant explained, this was the practice whereby a service would say that they required considerably less funds than other services to provide the same service. In any case economic rationalism on the behalf of funders inherent in competitive tendering models such as the purchaser-provider model, and the politics it produces, was seen as a major barrier to positive relationships and integration between resettlement services and primary and community refugee specific health services.

A number of positive examples of relationships between resettlement and primary and community mental health services were also highlighted. Some key informants described a parenting programme aimed at resettling Sudanese refugee mothers as being the culmination of a partnership between a resettlement service and a community mental health service. The
relationship involved workers from both services co-facilitating the programme. In previous chapters the group information programme borne out of the relationship between the refugee specific primary health care service and an English language service provider was discussed, and provides another positive example. Furthermore, some key informants even mentioned an example of the refugee specific primary health care service and the IHSS provider coming together to facilitate a consultation with service providers. This consultation was undertaken to find out what sorts of group programmes are being offered by services across Adelaide. Such examples further highlight the benefits of integration and serve as valuable points from which relationships can grow.

6.9.4 Refugee specific and mainstream services

Another level of integration that key informants discussed as being important was that of refugee specific and mainstream services within the formal health system. This was considered to particularly apply at the primary care and community mental health levels, where referral pathways in and out of services were thought to be affected. Key informants from the refugee specific community mental health service commented that only a small number of referrals to their service were from GPs in comparison to other sources. One explanation given was the perceived lack of awareness of GPs about the refugee specific mental health service.

As in many western nations, primary health care Australia it hinges on the capacity of GPs to act as gatekeepers to the rest of the health system. The interpretation of interview data suggests that GPs ability to do so when it comes to resettling refugees may be limited. The many perceived difficulties of addressing needs of refugees in General Practice heightens the need for the integration of mainstream providers and well equipped refugee specific health services.

The refugee specific primary health care service was thought to be reliant on relationships with GPs in order to facilitate outward bound referrals. Key informants from the refugee specific primary health care service explained that their focus was on providing holistic primary health care to resettling refugees for the first two years after arrival. The expectation is that resettling refugees will be ‘transitioned’ to a GP in their local area when they are ready and willing to do so. The exceptions are resettling refugees being seen by counsellors. Key informants from the refugee specific primary health care service also explained that a specific transition clinic and worker had been established to facilitate the transition to suitable GPs.
Suitable GPs in this context were defined as those who bulk billed, those who were willing to use interpreters if required, and those who operated in resettling refugees’ local areas. The role of the transition worker might be partly conceived as an ‘integration agent’; someone who specifically attempts to link and develop relationships between services such that clients can access quality care. Bi-cultural CHWs were also thought to play a major ‘integration agent’ role. In general, interviews revealed that such ‘integration agents’ were more likely to be present in refugee specific services. However, one example of an ‘integration agent’ working to locate and build bridges between refugee specific and mainstream services was also evident at a Division of General Practice. As part of their role, this worker attempted to find GPs who were willing to see resettling refugees such that the IHSS provider and the refugee specific primary health care service could refer clients to GPs within that particular Division.

6.9.5 Primary and community care services and secondary mental health

Whilst the need to access secondary mental health care was considered rare for resettling Sudanese refugee clients the importance of links between primary care and community mental health services, and secondary care was nevertheless stressed. Integration at this level was seen as important, not only to allow resettling refugees with ‘severe’ mental health issues to access psychiatric care but also in supporting primary and community health workers to address mental health issues.

Some key informants talked about the predominant referral pathway from primary care to secondary mental health care as involving the Acute Crisis Intervention Service (ACIS). There are ACIS teams covering the southern, northern, western and eastern metropolitan regions. In order for a patient to be admitted as an inpatient to a psychiatric ward in a major hospital, key informants reiterated that an assessment from ACIS was necessary. Some primary and community mental health care provider key informants were satisfied, and had relatively good relationships, with ACIS teams. They suggested that in the instances where they had to refer to ACIS the transition was smooth. Others, like the following GP, were less satisfied:

“Over the years that ACIS has become involved in care it’s more difficult because they’re not always able to respond as quickly and you can’t send people in directly to a psych hospital anymore; they have to go through an ACIS team... I don’t find them all that helpful to be honest.” (Key informant 13 – GP)
However, interviews revealed that some services were structurally equipped to foster relationships with secondary mental health care. In the refugee specific mental health service for instance, there was a specific worker employed to liaise with other services, as well as to assess the needs of incoming referrals. In addition to providing advice and information about working with refugee clients the specific worker was involved in developing, fostering and maintaining relationships with other services, including ACIS teams. A key informant involved in the administration of General Practice suggested that a worker took on a similar role in fostering relationships between General Practice and secondary mental health care. Such roles may be invaluable in terms of the integration of primary and community mental health services with secondary mental health care services because the need to refer to secondary mental health services, is relatively rare. Thus the time and effort required by individual providers to cultivate relationships with ACIS teams may be viewed as outweighed by the frequency of the need to refer to ACIS teams.

Some key informants working in secondary mental health care settings raised concerns about the pathways of clients, who have accessed secondary mental health care, back into primary care and community mental health care. This is exemplified by the following key informant when she said:

“The problem is that we are a time-limited service so what happens to that woman and their family after they leave hospital is the fraught part of the link; you know where do they go to after we’ve assessed them, we’ve started some treatment, or we have a management plan but they are not going to be coming back to the hospital for treatment, they need to be treated or managed in their community... It’s about trying to link them in with someone appropriate in the community. That’s a problem for all women here is finding a pathway to care for them, whether it’s their GP; GPs again are a very good source of primary health care. Everyone should have a GP and I make sure when I ask women that they have got a GP and if they haven’t try and get them to see one.” (Key informant 5 – Psychiatrist)

Such concerns are likely to apply to the general population as well as to resettling refugees who have utilised secondary mental health care. Nonetheless they highlight that integration or the development of links between two or more levels of care requires efforts at each of the levels in order to increase the likelihood of seamless care.
In addition to facilitating smooth referral pathways, some key informants also commented upon the role of integration in supporting the capacity of primary and community mental health care providers to address severe mental health issues. Some primary care providers highlighted the introduction of a Federal Government funded programme called *GP Psych Support*. This programme enables GPs to obtain patient management advice from Psychiatrists at no cost to GPs. One GP key informant found this to be helpful commenting upon situations where she sought advice in relation to resettling refugee clients:

“So, you know, what I’m saying is that it is very important that there is this linking in because I think the management of acute and quite major mental health problems requires this link between the primary care practitioner and the other mental health services, so this is one point. And I think it’s very good now having these GP; this psychiatric support for General Practitioners that is under the national scheme of Better Outcomes for Mental Health, I think it’s called. So you know, I can actually call a psychiatrist and within 24 hours I’m able to share with a psychiatrist to have an advice about management or treatment if I need to, so that’s very good.... Yes, it’s been very, very helpful.” (Key informant 12 – GP)

The employment of sessional therapists such as psychiatrists and GPs with mental health experience within refugee specific services was yet another strategy for integrating primary and secondary care. One perceived benefit of sessional therapist arrangements was that it increases resettling refugees’ access to care akin to that which might be provided in a secondary care setting within a more familiar primary and community care setting.

### 6.10 Workforce issues

Workforce issues within the health system were also found to have an impact on health service access and quality in relation to resettling refugees. Figure 6.7 illustrates that workforce issues clustered around two sub-themes: attracting and retaining health providers, and training and up-skilling health providers.
6.10.1 Attracting and retaining health providers

Interviews revealed the impact of general shortages of particular types of health providers on health service and system capacity to address the mental health needs of resettling refugees. General practice was one area in which workforce shortages were particularly thought to constrain health system capacity in relation to refugees. Key informants from the refugee specific primary health care service commented on the increasing difficulty in finding suitable local GPs for refugees exiting their service after initial needs were met. For some key informants, the perceived general shortage of GPs meant that the pool of GPs willing to bulk bill, use interpreters, and that were located in areas where refugees lived – often in areas of socioeconomic disadvantage – was subsequently decreased. Interview data suggested that the relative scarcity of GPs in areas of socioeconomic disadvantage meant that GPs operating within such areas were likely to be struggling to deal with the existing high demand.

Key informants involved in the administration of general practice echoed the sentiments of key informants from the refugee specific primary health care service suggesting that the number of GPs willing to see resettling refugees had decreased:

"...we have a GP shortage in this area and we also have a lot of practices who have closed their books to new patients. So when I ring up practices to see if they will take on new clients often refugees are people who have complex physical and mental health illnesses...but certainly I would say that the majority of our practices have closed their books to new..."
patients; they will continue to see family members of existing patients. But only recently I did some research just with a small number of our practices; I think I rang twelve and there were only three that had their books open.” (Key informant 16 – Program manager)

Key informants involved in the administration of General Practice emphasised several further reasons stemming from GPs own perceptions and preferences. Such key informants and others commented that there was a perception that refugee clients were difficult to manage. This was partly because of the perceived time and effort involved in organizing interpreters for refugee clients who needed them. Some key informants commented that in some cases resettling refugees were unable to keep appointments or were sometimes late, even though interpreters had been booked for specific times. The flexibility required to deal with such situations was not thought to be evident within GP structures. As one key informant suggested this was influential in affecting GPs willingness to see refugee patients, saying:

“And when GPs are so busy and have small appointment times and then there’s the extra dilemma of the patient not arriving, some have just said ‘no it’s all too hard and I’m not going to see refugees anymore’ and there’s no shortage of patients for them to see. So that’s some of the dilemmas. Also, even the size of the families can be a barrier for General Practice.” (Key informant 16 – Program manager)

Coupled with this, key informants involved in the administration of General Practice noted that many of the older GPs were retiring. Younger GPs were generally perceived not to work the longer hours of older counterparts. Instead they were thought to place greater emphasis on work-life balance, meaning they were less inclined to take on too many clients, and particularly those considered complex clients.

Despite the preferences of some GPs and the perceived difficulties of seeing refugee clients, some key informants however, suggested that there were some GPs who had a personal conviction and were committed to seeing refugee clients. A health service manager commented upon this saying:

“They’re a very labour intensive client group by comparison and so I guess to generalise, the incentives are not sufficient for doctors in private practice to acquire the skills and spend the time to provide a culturally appropriate service but I know there’s some out there who are prepared to see some refugee clients because of their own personal political convictions and
Mechanisms for ensuring the wellbeing of health providers working with refugee clients was also expressed as being important for their retention. Some health providers commented on the experience of dealing with potentially complex issues or disclosure of horrific experiences of some refugee clients. Those who did said that it was essential to their own wellbeing to have fellow colleagues and others to talk to as a means of dealing with potential stresses of working with some refugee clients. However, the opportunity to debrief was thought to be more readily available in community health or team environments as opposed to General Practice, or consulting specialist environments. One health provider key informant suggested that his way of coping with such stresses was to engage in other activities, like writing. Another reported the necessity to take time away from seeing refugee clients sporadically in order to maintain his own wellbeing and enthusiasm. The sessional therapy arrangement that this particular key informant worked under was thought to provide him with the flexibility to do so; a flexibility that may not be present in other employment arrangements. Interviews revealed that there is unlikely to be any one way of coping with the stressors of hearing and dealing with horrific experiences and circumstances. They also revealed a need to consider ways of supporting health providers to maintain wellbeing. In promoting work-life balance health service managers would also be promoting the continued willingness of health providers to see refugee clients.

6.10.2 Training and up-skilling health providers
Not only were the issues of attracting and retaining health providers viewed as affecting the provision of services to resettling refugees, so to was the quality and skills of service providers. Some health service key informants expressed the idea that mainstream health providers may not be frequently exposed to the needs of refugees in the course of their everyday service provision. Additionally key informants highlighted that the way in which services are provided may need to be different. Thus, according to a GP key informant, this required health providers to have specific skills. Important additional skills were thought to include techniques and approaches to working cross-culturally, cultural sensitivity, ways of working with and organizing interpreters, and skills in meeting the needs of resettling refugees holistically. However many key informants did not view such skills as additional to their ‘normal’ service provision but an integral part of it. As is evident in the following quote,
more important than skills was an ability to build a relationship and a passion and desire to assist refugees:

“I think the perception out there amongst the GPs in GP land is that this work is difficult and in some ways it is and in other ways it’s not that difficult because I think it’s in the relationship. So if you are compassionate and understanding and build trust, if you can do that then that’s probably being very, very helpful without having any particular knowledge or skill base at all and that’s one of the messages that I’ve been thinking about a bit more just in recent times that I’ll be trying to sort of push people to say that ‘you know anybody can do this, you don’t really need any special training. You just need to be a good GP and have an interest and this will work’. So I think one of the constraints out there is GPs concerns that it’s too difficult or that they don’t have the knowledge base or the experience to do it and I don’t think that that’s true; I think that’s a misconception.” (Key informant 13 – GP)

Another concern was that many interpreters in South Australia have not had any formal training or up-skilling in interpreting in mental health contexts. This was despite the understanding that interpreting in a mental health context was thought to place particular demands on interpreters. This was perceived to be due to the extensive use of language and discussion in mental health contexts. Furthermore, given the diversity of mental health beliefs within cultures like those in Sudan, some key informants suggested that there may not be words for particular western mental health concepts and/or different meanings attached to those words. Thus the potential for misunderstanding was thought to be high. One policy maker key informant pointed out that within interpreting accreditation and training courses in South Australia there is no specific module on interpreting in mental health contexts, pointing to a need to include such a module within existing courses.

Interviews revealed that refugee specific services, community health services and the voluntary refugee health advocacy network were highly involved in providing training and up-skilling spanning a range of training, education and up-skilling activities. Furthermore some Divisions of General Practice and resettlement services were also thought to be involved in up-skilling activities. Several key informants involved in such activities commented that the majority of people attending seminars, for instance, were allied health, resettlement and other sector professionals. Despite the incentive of continuing education and
professional development points\textsuperscript{12}, few GPs were thought to attend such seminars. Even fewer GPs who had minimal or no prior experience in delivering services to resettling refugees were thought to attend. This was often attributed to the busy schedules of GPs, and even though such seminars were often deliberately organised to be outside working hours, the low attendance of GPs might reflect a desire of GPs for better work-life balance. The low attendance of GPs at such seminars was concerning for some key informants involved in organising such seminars. This was because General Practice was broadly conceived as one sector where the need for skills in refugee health care was most needed. In the case of some services, this had led to a broadening of avenues for their up-skilling efforts including giving seminars and workshops at GP conferences, and providing training to individual GP and other services.

\textbf{6.11 Agents of change}

Interviews revealed some of the agents that were attempting to or had facilitated positive change to increase health system and health service capacity in relation to refugees. Figure 6.8 illustrates some of these identified agents of change. As will be discussed, the sub-theme of “Refugee participation” suggests that there are relatively few opportunities for refugees themselves to influence health system change directly.

\textsuperscript{12} Many health professional bodies require member-practitioners to participate in a minimum level of continuing education and professional development. Some do this by assigning continuing education and professional development points to particular professional development activities, and stipulating a minimum number of points that practitioners need to achieve over a period of time. Ongoing registration and accreditation of health practitioners within specialties is often partly contingent on attaining minimum levels of continuing education and professional development.
6.11.1 Refugee specific and community health services

In addition to the benefits in terms of holistically addressing the needs of resettling refugees, refugee specific and community health services were also considered to play an important role in terms of health system capacity building. Interviews revealed that many were engaged in efforts to improve the capacity of mainstream services and practitioners to address the needs of resettling refugees in a culturally and linguistically sensitive way. Key informants who worked in such services commented on activities, in which they were involved. These included involvement in refugee health related research, advocacy, and providing education and seminars at hospitals, emergency departments, within General Practices, and at conferences:

“And we do a fair bit of bridge building with different agencies and institutions like at the moment we’re doing a series of in-service talks to staff in the emergency departments at major metropolitan hospitals so that, you know, the staff there have a better picture of what the needs of refugees are and what to do, you know, when people present and different referral pathways and so on. You know, we do stuff through the Divisions and yeah so there’s a fair bit of that stuff that goes on all year, every year so it’s very important, it’s really important. (Key informant 10 – Health service manager)

A health service manager at a refugee specific service talked about how such capacity building efforts occurred. He indicated that sometimes mainstream services requested the help
of the refugee specific service directly. However he explained that often the service was proactive and strategic in its capacity building efforts. By this he meant that they were focussed along referral pathways, in which they were involved, and in areas where services were increasingly coming into contact with resettling refugees due to settlement patterns. Such strategic capacity building efforts were engaged in to ensure that the services the refugee specific primary health care service referred clients to were able to provide a quality service to their clients. In this sense the responsibility of the refugee specific primary health care service was not perceived to end when the resettling refugee left the service.

6.11.2 Advocacy groups
Similarly the refugee health advocacy network in operation in South Australia was also seen as an agent of change. This advocacy network consists of a number of committed volunteers, most of whom work within refugee specific and community health settings, and/or have an interest in refugee health. The work of the advocacy network was thought to revolve around providing education and information seminars to practitioners, organizing events, and advocating at individual service as well as policy levels in terms of improving capacity. It was seen as important in presenting a strong and unified voice with respect to refugee health, service provision, and policy.

6.11.3 Motivated individuals
Interviews revealed several examples where motivated individuals working within a variety of settings were attempting to facilitate change. As discussed in previous chapters, bi-cultural CHWs in refugee specific and community health service settings were often responsible for developing innovative group programmes for refugees. Having said this, such situations required bi-cultural CHWs to be supported by organisations with a degree of freedom, receptiveness, and flexibility. This support was not always thought to be forthcoming.

Some motivated individuals within mainstream organisations attempted to change the structural and organisational environment in order to be more ‘refugee friendly’. For instance a key informant involved in the administration of General Practice told of her attempts to increase capacity in terms of refugee health within the Division of General Practice, in which she worked and in General Practice more broadly. Such attempts were successful, with the Division increasing its focus on refugees as part of its focus on equity. Manifestations of such efforts included attempts to attract and support GPs to provide care to resettling refugees, and information and education sessions about the use of interpreters and the refugee health
Medicare item number. Additionally a number of clinical templates to assist GPs in undertaking initial health assessments were created. Furthermore, like the advocacy network, refugee health information and information about where resettling refugees could be referred and clinical templates were made available on the Division’s website.

6.11.4 Refugee participation

The efforts of agents of change on the behalf of refugees are likely to be particularly important considering that interviews uncovered relatively few opportunities for resettling refugees themselves to influence the way services and the system as a whole operate. Where resettling refugees were able to be heard it was often in a pre-defined context, with services controlling what questions were asked and what they wanted to hear about.

Exceptions to this included the two refugee specific health services which, interviews revealed, undertook regular consultations with their clients and refugee community representatives. According to key informants from such services, consultations were utilised as a service planning tool in order to better understand the needs of resettling refugees and how the service could adapt accordingly. They were also used for quality assurance and service evaluation, with clients being asked about their satisfaction with the care that they had received in such services. Another way in which consultations were used by refugee specific services was to find out about the experiences of refugees with the rest of the health system. In such a way consultations were also a means for refugee specific services to identify areas in which their capacity building efforts could be targeted and where their advocacy efforts should be focussed.

However, often services were thought to dominate consultation agendas. This was where a service asked specific questions that were primarily of importance to the service rather than community members. Further to this, consultations taking place in service premises, as seemed to be the norm from interviews, rather than in locations stipulated by community members reiterates the service control of consultation agendas.

Another issue to emerge from the interviews was that of who is consulted when consultations did occur. For instance, when asked about how the service decides who to invite to consultations, one key informant said:

“Whoever comes. You could invite fifty people and get ten. So the most recent ones, we did
one Middle Eastern session and one African session and we invite people who can represent their community well. So it might be community leaders and we ask them to bring along someone who has got a particular interest in health matters in the community and then you just get who you get.” (Key informant 18 – Health service manager)

It thus seems that participants in consultations are those that are able and motivated to “turn up”. Whether those that are perhaps the most disadvantaged are able to participate, or able to have their concerns raised by other attendees, is questionable. Furthermore, it also seems that in cases where consultation occurred, participants were clients of the service as well as community members. That is to say, consultations with members of refugee communities who were not clients of the service were unlikely to occur. It thus seems that services were primarily interested in the client perspective that resettling refugees could offer whilst the community member perspective may be of less importance to services.

Another avenue for refugee participation in individual health service planning and development that was mentioned in the case of the refugee specific mental health service was the inclusion of refugee representatives as board members. Given the array of organisational structures in place many services are unlikely to have boards involved in overseeing the direction of the organisation. However where they do exist, the inclusion of members of refugee communities on these boards was thought to enable resettling refugees to influence service directions, and inform the service of the needs of refugee communities like the Sudanese. Their degree of influence may or may not be high and was not clear from interviews. Furthermore, representation on boards is likely to be limited to those that are leaders within the community, and questions might arise as to their ability to convey the needs of those most marginalised within communities.

As has been discussed in the previous results chapter, bi-cultural CHWs themselves were also seen as mechanisms for refugees to convey the needs of particular refugee communities to individual health services. The idea was that through their interaction with clients and refugee community members, bi-cultural CHWs could convey the needs of the community to the service and the way the service works to the community. However their dual roles as working for the health service and the community was thought to potentially compromise their ability to advocate for the community. The role of working for the health service may override that of working for the community in some cases, as the ongoing employment of a particular bi-cultural CHW may be contingent upon this factor. In some cases illustrated in the interviews
bi-cultural CHWs felt a sense of frustration about the unwillingness of services to listen to their suggestions. Furthermore where they were listened to, there was an unwillingness of services to act on such input. This was the case for one key informant who said:

“I don’t know that there is any health service that is aware of what I’m telling you; you know the role of the elders or the needs of the people in terms of mental health – they’re not aware of it. They’re not aware because I remember when I used to work at the service I emphasised that, several times, that our people don’t understand the counselling system so the best way for them to understand; the service maybe needs to come out and teach people what is counselling in the western way, what does counselling mean? Until they understand your way they will not access the service. Unfortunately I was just shouting but no one consider that, so until I left nothing was done and the information I’m giving you, no health service is aware of that.” (Key informant 7 – Sudanese woman)

The difficulties faced by bi-cultural workers in facilitating change at an individual service level was symptomatic of a broader inability of ordinary resettling refugees to have direct input into the running of services. It seemed that their voices were only partially heard by proxy, through third-parties like bi-cultural CHWs, and community leaders, whom interviews revealed, may have trouble in making their own voices heard.

Influencing the health system as a whole might be conceived of as occurring either from below, such as by participating in changing individual health services, or from above by having a say in health systems policy directly. As in the case of participation from below, interviews revealed that there were few opportunities for resettling refugees to influence policy, and health system planning directly. Those key informants involved in policy in Government departments commented on a broader policy-practice disconnect. They suggested that they found it difficult to understand what was happening ‘on the ground’ at a health service level. Such key informants suggested that they were reliant on their contacts within refugee specific services and advocacy networks for information that could feed into policy. In terms of participation from above, resettling refugees’ voices were thus only thought to be heard by proxy, rather than directly.
6.12 Policy

Figure 6.9 illustrates the key policy related themes to emerge from the data. Many key informants stressed a need for and potential role of policy in the context of service provision to resettling refugees. In the absence of a State refugee health policy in South Australia, key informants commented upon what a refugee health policy might look like. They also highlighted some of the existing barriers in terms of developing refugee health policy.

Figure 6.9: Policy – theme overview

6.12.1 Need for and role of policy

Interviews revealed a number of potential benefits that could arise from policy in the context of service provision to resettling refugees in South Australia. Whilst according to many key informants, refugee specific and community health services could provide a quality service to resettling refugees, there were times when resettling refugee clients need to be referred out to other services. Thus many key informants expressed a desire for health system development to improve the ability of health services across the health system – not just in refugee specific services – to be able to better provide care to resettling refugees. Policy was seen as one instrument through which overall health system development could occur.

However, as has been illustrated earlier in this chapter, the ability of health services to meet the needs of resettling refugees was also thought to be affected by the degree of integration and partnerships between and within different levels and sectors of care. As already discussed for instance, the integration between resettlement services and primary care services was viewed as pivotal in facilitating access to quality and holistic care. Thus, many key informants
suggested that policy may also act as an integration tool. By this they meant that it could encourage partnerships between services and outline and facilitate referral pathways on the basis of the potential benefits for resettling refugees rather than competitive politics.

Similarly, given the array of activities and programmes occurring inside and outside of the formal health system, policy was also seen by some key informants as a means to coordinate those responses and consolidate them in the pursuit of a common direction. Coordination was also considered to reduce the duplication of services. However, other key informants highlighted the need for policy to remain flexible to local needs so as not to constrain the development of innovative initiatives.

Some key informants also suggested that a policy would increase accountability within the system and could be empirically evaluated. The lack of service accountability was a concern for health service manager and policy key informants. Such key informants suggested that services could claim to be providing culturally sensitive services, for instance, but there was no process to hold services to account. Having said this, only one health service manager key informant expressed a desire for benchmarks and measurable service standards in the realm of cultural sensitivity, for instance.

Policy maker key informants thought that a State policy would place refugee health in a better position to advocate for and attract government funds, particularly at a national level.

In the absence of a refugee health policy in South Australia, many key informants discussed the perceived benefits that refugee health policies had brought to other states with refugee health policies like Victoria and New South Wales. Others were unsure as to exactly what the benefits of policy might be, given a lack of evaluation of interstate policies.

6.12.2 Absence of a state refugee health policy and existing barriers
Key informants also commented upon the reasons they felt South Australia does not currently have a refugee health policy or a broader multicultural health policy. Some pointed to the fact that the numbers of resettling refugees settling in South Australia have traditionally been smaller than other states like Victoria and New South Wales. They suggested that this has contributed to a perception that there are too few resettling refugees to warrant a specific refugee health policy at a state level. However, a numbers based argument seemed to make little sense to many key informants who pointed out that population health policy should also
be driven by need and equity concerns rather than raw numbers. Apart from this others indicated that a multicultural health policy would have the potential to affect a greater number of people, given that it would include migrants, refugees, and even some Indigenous Australians. Thus some key informants took this to illustrate that there was something other than numbers or lack thereof could account for the lack of emphasis on refugees in State health policy.

One policy maker key informant suggested that whenever there were plans afoot to develop a multicultural health policy a new Minister with new priorities and a department restructure would occur. This suggests that timing given the short-term electoral cycle can conspire against policy makers. Similarly, many key informants suggested that refugee health was complex and not politically “sexy”, meaning an area about which the general public had little awareness and thus where few political points could be scored. Furthermore refugee health or multicultural health was thought to be obscured by disease based policy such as that dealing with chronic disease. Chronic disease, for instance, may be perceived to be of higher overall priority in the context of an ageing population and the overall disease burden.

Whilst South Australia does not have a specific refugee health or multicultural health policy, interviews revealed that there are personnel working within Government health departments whose role includes a responsibility for multicultural health policy and issues. Their role was understood as ensuring that the needs of a culturally diverse population were taken into account in general health programmes, funding and policies. So, for instance, in the realm of mental health this might include asking how a mental health policy might incorporate a focus on culturally and linguistically diverse individuals.

Another key role of such personnel was engaging in inter-sectoral discussions on refugee health. Participation in the Multi-Jurisdictional Working Group on Refugee and Humanitarian Health established at the end of 2005 was given as an example. This working group consisted of representatives from State and Federal health departments, and the Immigration Department. One of the perceived key successes of this group according to key informants was the introduction of the Medicare Item 714 for comprehensive initial refugee health assessment. This perceived success highlights the importance of inter-sectoral collaboration. In the realm of refugee health this is particularly important, given the perception that many of the needs of resettling refugees cut across social policy borders.
One of the expressed difficulties by policy maker key informants working in government departments related to the policy-practice nexus. That is to say, such key informants felt in some cases somewhat distant and removed from what was happening ‘on the ground’ at a service provision and community needs level. As one key informant expressed, knowledge of what was happening ‘on the ground’ was thought to be dependent upon whatever second hand information was passed on to them from practitioners and service managers. The quality of such information was thought to vary, with virtually no avenues for policy makers to verify it. Thus the ‘evidence’ on which policy was based was sometimes thought to be of questionable quality.

Bridging the policy-practice nexus and ‘evidence’ based policy are documented concerns in many realms of health and social policy making. This difficulty was thought to be particularly pertinent to the context of refugee health policy. One reason to account for this was the perceived general lack of evaluation, lack of quality data, and lack of research activity pertaining to refugees and refugee health service provision. For instance, one policy maker highlighted that resource constraints meant that state-wide surveys of population health and health services were always conducted in English, with no option for interpreter use. Thus data on resettling refugees from non-English speaking backgrounds was either not collected or extremely limited. In any case some key informants suggested that existing western developed scales used in state population health surveys like the Kessler Psychological Distress Scale were unhelpful. These measure biomedical formulations of mental illness and thus policy maker key informants warned that they should not therefore be taken as a marker for mental health needs amongst resettling refugees. Furthermore the non-sharing of data about prospective refugee settlement and patterns between the IHSS provider and health authorities was also considered to make it difficult for policy makers and health service managers to plan policy and services accordingly.

Key informants commented upon a general lack of research within a local context to illuminate the needs of and inform about appropriate health service provision responses. This was seen as particularly important given the unique health system and service context, as well as refugee settlement context, in each state. For instance, key informants commented upon the policies of other states suggesting that there may be some elements that could be applied in a South Australian context, but that there were also some that could not. For instance, one key informant commented on the hub and spoke model being adopted in a newly developed Queensland refugee health services policy. The plan under this policy is to have a major
metropolitan refugee health service hub with a number of smaller regional services or programmes representing spokes. The key informant suggested that this makes sense in Queensland where there is greater rural and regional settlement of refugees as compared to South Australia, where only a small number of refugees are resettled in rural and regional areas. Thus, according to this key informant, the adoption of the Queensland hub and spoke model to underpin refugee health policy in South Australia may be undesirable and ineffective. This is despite the possibility that future research in Queensland may suggest the model to be appropriate in that particular context.

6.13 Interconnectedness of themes
Throughout this chapter themes have been explored in a vertical direction throughout the thematic framework. However, the interconnectedness of themes has been implicit in the discussion thus far. Two pertinent examples of ideas that horizontally cut across a number of themes include GPs, and mainstream versus refugee specific services. Such themes will partially shape the discussion to follow in the next chapter.

6.14 Conclusion
The ability of services to provide care and respond to the material, social and mental health needs of resettling refugees is affected by a number of factors. These include individual health service level factors and broader health system level factors. Understanding how these factors impact on responses to meeting the material, social and mental health needs of resettling refugees is likely to be important for increasing health service and health system capacity. Variation in the themes presented in this chapter also illustrates areas in which improvement could occur, and through examples of services with high capacity, provides clues as to how improvement might occur. In the following chapter strategies for improving health service and system capacity will be discussed.
Chapter 7

Improving the relevance, quality and accessibility of health service and system responses to addressing the needs of resettling refugees

7.1 Introduction
The following discussion draws on the themes identified over the preceding chapters and in the literature to outline ways in which health services and systems could develop to become more responsive to the social, material and mental needs of resettling refugees. These needs will be briefly discussed with respect to the dominant trauma perspective in further developing the central argument; that services need to craft responses, which address the socioeconomic context of refugee resettlement. Having established this argument, attention will be turned to the role of health services in this pursuit, and the related question of what in fact is a ‘fair and decent’ health service in the context of providing care to refugees. It will be argued that relevance, quality and accessibility are essential elements constituting the ‘fair and decent’ service. Equipped with the notion of a ‘fair and decent’ health service, the remaining proportion of this chapter is devoted to what practical measures and strategies could be utilised by providers, services, and policy makers to increase the capacity of services to address the needs of resettling refugees appropriately. Finally, it will be argued that improving the capacity of the health system to address the needs of refugees should be viewed as a complementary, rather than a competing priority, of overall health system development.

7.2 Needs
This research reiterates and extends the growing emphasis within the literature on the impact of resettlement on emotional wellbeing for Sudanese refugees (Porter & Haslam 2005). The collective task of dealing with the practicalities of resettlement, adjusting to living in a new society and place, and coping with stressors that stem from situations and networks abroad has been interpreted here as the need to rebuild social worlds. Similarly, research with Sudanese and a multitude of other resettling refugee populations in western nations have also highlighted the role of resettlement factors in emotional wellbeing. Strong evidence of the role of resettlement factors in refugee mental health comes from a meta-analysis of 56 studies, totalling 67,294 participants, which found that the strongest moderator of mental health are
the social conditions refugees face after displacement (Porter & Haslam 2005). Such factors have been found to include employment and financial security (Simich et al. 2006, Danso 2001), the degree to which expectations about life in a resettlement context are met (Simich et al. 2006), housing and residential mobility (Warfa et al. 2006), family functioning and conflict (Boehnlein & Kinzie 1995), adjustment and acculturation (Papadopoulos et al. 2004, Nwadiora & McAdoo 1996), host country reception and discrimination (Danso 2001, Pernice & Brook 1996), the ability to deal with agencies and Immigration Departments (Papadopoulos et al. 2004), social isolation and social support (Stroll & Johnson 2007, Papadopoulos et al. 2004, Danso 2001), remittances (Stroll & Johnson 2007), coping with transnational family obligations (Simich et al. 2006) and events abroad (Procter 2000). In this research, the need to rebuild social worlds was found to be most immediate and pressing, and to be of higher priority than the need to address issues associated with pre-migration trauma. Likewise, a number of studies and commentators have also stressed that despite having experienced traumatic events in the past, the need to address these are often dwarfed by the need to cope with present-day stressors in resettlement contexts (Ryan et al. 2008, Miller et al. 2006, Baron 2002).

However research reinforcing the trauma paradigm with its emphasis on refugee pathology sustained in pre-migration contexts has become and remains a dominant voice in contemporary western societies (Ryan et al. 2008), and one of which key informants in this research were very aware. In a review of 183 studies published on the mental health of refugees, Hollifield et al. (2002) found that 80% of them relied on measures of psychopathology developed with western populations. Entire journals such as the *Journal of Traumatic Stress* are devoted to the study of trauma and trauma treatments – or ‘traumatology’ as this field of study has been coined – whilst trauma, refugee deficit, and PTSD are often invoked in the mainstream media in relation to refugees (Robins 2003). According to Marlowe (2009), the consequence of the dominant use of trauma and other deficiencies to describe and understand refugees in the media is that such a pathologised portrayal of the lives of refugees becomes engrained within the consciousness of the general public. In this research, key informants working in services with low degrees of refugee specificity were more likely to emphasise the role of trauma and PTSD as compared to key informants working in services with high degrees of refugee specificity. This difference might be partially explained by the greater reliance of key informants working in ‘mainstream’ settings on popular trauma understandings in the academic literature and in the media to inform perceptions, as opposed to the greater direct experience of working with refugees of
those within ‘refugee specific’ services. The tendency to view refugees’ needs through the lens of trauma may also be in part a consequence of wider societal trends such as medicalisation, individualism, and Furedi’s (2004) idea of ‘therapy culture’; the idea that western societies increasingly view adversity through the lens of disease and consider individuals as ‘vulnerable’ and unable to cope with stressors without the help of professionals. According to Marlowe (2009) such perceptions are potentially detrimental to refugees, and thus that:

“Acknowledging refugee lives beyond the camp and associated traumas with forced migration is an important step in recognising them as peers participating in rather than victims surviving within Australian society” (pg 144).

Such an “important step” requires alternative voices to be heard in order to highlight the individual experiences and effects of forced migration in their entirety and complexity. In academic circles however, there is a tendency for proponents of the trauma paradigm to assert the ascendancy of quantitative and diagnostic methods. For instance Turner et al. (2003) caution against “the tendency of some to reject the diagnostic paradigm in refugee populations” (pg 447) and thereby discount the offering of alternative explanations to that of the dominant trauma paradigm. This is despite the protestations of those like Summerfield (2003) who argues that “quantitative methodologies serving psychiatric categorisations risk a distorting pathologisation of refugee distress, with what is social and collective being reassigned as individual and biological” (pg 459) and who thus advocate for increasing use of qualitative methods.

A consequence of the pervasiveness of the trauma paradigm is its dominance not only over the clinical domain but also over health services planning and development, and health policy in relation to refugees. This is echoed in the comments of Pupovac (2006), who argues that “the closeness of the refugee burden, rather than the possibility of a refugee’s fate, has exercised policy-makers’ minds” (pg 7). Thinking about health service provision to resettling refugees has largely emerged from this “refugee burden” mindset. The role of the health service has thus been conceived as being to alleviate refugees of their individual burden – interpreted largely as the mental health sequelae of having undergone the past ‘traumatic’ experiences that made them refugees. According to Westoby and Ingamells (2009), whilst acknowledging the need to address resettlement needs, even the much hailed Victorian Foundation for Survivors of Trauma 1998 report Rebuilding Shattered Lives overemphasises
individual recovery from trauma. At a service level, and as this research found particularly in relation to services with low degrees of refugee specificity, this emphasis has manifested in the provision of mostly western developed interventions such as counselling, and various ‘talk’ therapies – each generally aimed at repairing individual psyches ruptured by events of the past divorced from the present socio-political context that refugees face in resettlement contexts. Alternatively, other approaches like behavioural therapies or medication attempt to allow refugees to live with past pain and trauma with minimal attempts to address the resettlement context. Both types of trauma-centric health service response share a pre-occupation with the past and an overemphasis on the individual dislocated from group, social, community, cultural and political processes.

One interpretation is that trauma-centric health service provision responses reinforce the status quo within mainstream services. That is to say, they require little effort and creativity to develop and implement. This is because, like the majority of mainstream health services, trauma-centric service delivery has its origins in the biomedical paradigm. Furthermore as Westoby and Ingamells (2009) point out, trauma-centric service delivery approaches are also likely to be appealing due to the demands of funders for evidence-based practice and programmes and the increasingly managerial focus of health services. According to Westoby and Ingamells (2009):

“This serves to justify modes of practice focused on individual needs, and has meant that diverse forms of engagement with families and communities to rebuild social and cultural life are less clearly articulated, less well theorised and less well positioned to attract funding and organisational support” (pg 3).

Not only does trauma–centric service delivery run the risk of decontextualising the experience and needs of resettling refugees and thus becoming irrelevant, but such service delivery also may be culturally irrelevant, overlooking the local idioms of distress and healing in refugee communities (Miller et al. 2006). The accounts of key informants in this research, for instance, illustrate that western beliefs about mental health and treatment are unlikely to have resonance with all or many refugees. Furthermore this research also highlights the existence of strategies for addressing mental health issues within refugee communities, such as the “Sudanese way of counselling”. It thus emphasises the need for services to explore how such strategies can be utilised and encouraged rather than invalidated by existing service responses.
Approaches to service delivery that not only attempt to address mental health issues but also material and social health issues are less common as Westoby and Ingamells (2009) point out. This is despite the potential for such holistic approaches to address the resettlement issues perceived by refugees themselves to be the most salient (Lawrence & Kearns 2005, Summerfield 1999). Thus, it is the contention of this research that it is the preoccupation with the past, and past trauma specifically, that does not match refugees’ needs in the present or hopes for the future.

7.3 Gap: Capacity to support resettling refugees in rebuilding social worlds
This mismatch between perceived needs and service responses was widely evident in this research. Not only was this mismatch apparent to Sudanese key informants but also to health service key informants. Thus this research, like others including Westoby and Ingamells (2009), found that the capacity of health services to support resettling refugees to rebuild social worlds constituted a major gap that needs to be rectified.

It is important to note however, that formal health services are only one avenue through which resettling refugees may gain assistance in the task of rebuilding social worlds. As found in this research the Sudanese community, broader social support networks, and resettlement services are likely to be major sources of resettlement support. Thus the calls of other researchers (Westoby 2008, Seebohm et al. 2006) to strengthen the existing efforts of refugee communities through community development are further endorsed here. This research highlights the potential for a variety of activities to be supported. These could include the resourcing of community events, gatherings, groups, and programmes to support both emerging leaders within the community and also those who are most disadvantaged. This research found that information communication technologies (ICTs) were important in managing living in ‘old as well as ‘new’ social worlds. There may be the potential for community development activities to assist refugees to participate in geographically unbounded forms of community via information communication technologies.

Likewise, the importance of ensuring that Australia’s resettlement regime is adequately resourced to continue to support refugees is also highlighted by this research. In particular, findings stress a need for longer term resettlement support to be available to refugees who require it. The current policy and service emphasis on the first six months after arrival was seen as important in terms of addressing resettlement issues as quickly as possible but does not sufficiently acknowledge the dynamic nature of resettlement needs and of individual
differences in need, which may require longer-term support for some refugees. Therefore resettlement policy makers may wish to consider developing new programmes and/or scaling up existing programmes aimed at addressing resettlement needs in the longer term.

The findings of this research lead to a conceptualisation of efforts to support refugees in rebuilding social worlds in terms of a network of different sources of assistance. In the centre of this network are refugees themselves, who as a number of others have also found, possess resilience and personal coping abilities (Khawaja et al. 2008, Schweitzer et al. 2007, Rosseau & Measham 2007, Muecke 1992), and who are active in rebuilding their own social worlds (Westoby 2008, Williams 2006). This is a point that contrasts with the dominant trauma paradigm which as Pupovac (2006) notes, tends to produce a narrow medicalised construction of refugees as sick victims in need of professional help. As Silove (1999) argues, most research studies have found that the majority of survivors of conflict situations do not suffer from long-term mental health issues. The resilience of refugees has been one factor that has been proposed to explain this, but as Marlowe (2009) comments, is “relatively unexplored terrain” in terms of research (pg 133). The argument however is that refugees are likely to draw upon personal, spiritual, and cultural resources to cope with and overcome the stressful experiences of forced migration. Muecke (1992) argues that:

“...refugees present perhaps the maximum example of the human capacity to survive despite the greatest losses and assaults on human identity and dignity” (pg 520).

Some have gone further suggesting that surviving such stressful or traumatic experiences can even act as a source of growth and transformation (Rosseau & Measham 2007). A number of key informants in this research affirmed the benefits of utilising strengths based approaches, which draw on refugees’ resilience, coping mechanisms and social support networks in their service provision. If not explicitly using such approaches in their service provision to refugees, services and providers should aim to affirm human agency rather than creating relationships of dependence. This is not to say that refugees should not be afforded the support they require – whether this is at one month or two years after arrival – but that in the act of providing support human agency should not be eroded.

7.4 The role of health services
The existence of a number of different possible sources of assistance with respect to rebuilding social worlds, raises the question of the role of health services in this network. A
possible argument is that it is the responsibility of resettlement services to assist refugees in rebuilding social worlds and not the role of health services. On the basis of this research, such an argument is sub-optimal for a number of reasons.

Firstly it overlooks the ‘reality’ – as constructed by key informants in this research – that refugees are presenting at health services with ‘resettlement issues’. Whether this is linked to the relative lack of emphasis in Australia’s resettlement regime on support and assistance beyond the initial six months after arrival requires further investigation. Regardless of the reason it is the contention of this thesis that refugees with ‘resettlement issues’ shouldn’t be turned away because health services would rather not address ‘resettlement issues’.

Secondly, it fails to acknowledge the ‘messiness of reality’. The idea that one can neatly sort issues into two domains – resettlement, and mental health issues – and then address only the domain with which one is most comfortable is problematic. To summarise what health practitioner key informants in this research have stated, refugees often present with a web of interconnected social, material, and mental health needs and issues. Thus when faced with this ‘reality’ services should attempt address the entirety of the needs of resettling refugees as best they can.

Of course, in pragmatic terms, health services are not panaceas and are constrained by budgets, funding requirements, skills, aims, values, and infrastructure. Thus it is necessary for services to impose some limits on what they do, who they see, and for how long they see anyone. The limits set are likely to be different for different types of services. General Practice services, for example, would ideally pose fewer limits than other types of services. Recognising this however, a growing body of literature has stressed the importance of engaging with the social determinants of health (Baum & Harris 2006) and affirmed the benefits of person-centeredness in terms of the relevance and quality of health care delivery (Mead & Bower 2000). Marmot (1999) argues that health services need to pay heed to the socio-cultural context and that in order to achieve health outcomes, health services need to address the determinants of health and not only treat disease. The intersections between the social determinants of health and person-centeredness are evident in the Stewart et al. (1995) articulation of one of the central tenants of the patient-centred method, which they suggest requires:
“...a willingness to become involved in the full range of difficulties patients bring to their doctors, and not just their biomedical problems” (Mead & Bower 2000 pg 1088).

This is particularly relevant in the context of service provision to refugees, whose voices according to Watters (2001) are:

“...only heard within predefined compartmentalised contexts that conform to and reinforce institutional structures within the health and social care field” (pg 1710).

In line with such a body of literature, an argument can be developed that ideally it should be refugees’ concerns and needs that govern health service responses rather than health services dictating what responses will or will not be offered. It seems then that services are faced with two competing philosophies which are particularly borne out in the realm of health service provision to refugees; the idealism of the panacea and the ‘reality’ of not being able to encompass the panacea.

7.5 Imagining the ‘fair and decent’ service
At this juncture it is helpful to reflect upon what constitutes a ‘fair and decent’ service with respect to refugees. The themes articulated in Chapter’s Four to Six, complemented by insights from the literature, will be drawn upon in developing the idea of a ‘fair and decent’ service with respect to refugees. This in turn will provide a structure from which arguments and recommendations about health service development and improvement can proceed.

Broadly speaking there is consensus that every individual should have access to a decent minimum of health care, which one can interpret as including and being particularly relevant to refugees. This is despite differing philosophical arguments used to come to this conclusion. Daniels (1985), for instance, invokes the notion of justice, arguing that if society is responsible for ensuring equality of opportunity as Rawls (1971) believes, then access to a decent minimum of health care is needed to prevent any individual from reduced opportunity-range due to disease or illness as compared to others. Buchanan (1984) on the other hand argues for a decent minimum of health care on the basis of ‘effective charity’: that society has a moral obligation to help those in need – one form of which may be health care – and in which case people are entitled to “at least certain forms of health care” (pg 55). With respect to resettling refugees, legal and human rights arguments related to international humanitarian obligations for a decent minimum of health care can also be invoked.
The question of what constitutes a decent minimum of health care in practical terms is less well articulated. Matthews (1998) argued that both Daniel’s (1985) and Buchanan’s (1984) arguments were “hopelessly vague” (pg 160) when it came to answering this question. Perhaps one reason for this is the potential objection that any attempt to define ‘a decent minimum’ of health care runs the risk of universalism, and that instead it should be the responsibility of individual societies themselves to define standards according to their own values and local context. Daniels et al. (2000) have taken up the challenge, responding to the vagueness surrounding a decent minimum of health care by outlining nine benchmarks for fairness with respect to health care reform. Daniels et al. (2000) understood fairness to include:

“...equity in health outcomes, in access to all forms of care and in financing. Fairness also includes efficiency in management and allocation, since when resources are constrained their inefficient use means that some needs will not be met that could have been. For the public to have influence over health care, fairness must also include accountability. Finally, fairness also includes appropriate forms of patient and provider autonomy” (pg 740).

Benchmark one relates to the importance of a focus on the social determinants of health and an inter-sectoral focus. Benchmarks two and three stress the need for accessibility whilst benchmarks four and five highlight the need for equity of outcomes and of health care financing. Quality of care is the major concern of benchmark six, which emphasises the need for community participation in health care delivery decisions, integration, and evidence-based care. Benchmarks seven and eight are concerned with systemic factors such as administrative efficiency, and accountability, with benchmark nine outlining the need for patient and provider autonomy.

Whilst the benchmarks of Daniels et al. (2000) were developed in the context of assessing the fairness of health care reform measures they also have wider utility in terms of health services. The utility of these measures is enhanced by the fact that teams of collaborators from a number of countries worked to develop them. The themes developed in this thesis highlight important elements of health service provision to refugees and accord with many of the generic benchmarks developed by Daniels et al. (2000). These interconnected themes shape the discussion of what constitutes ‘fair and decent services’ to follow.

Working from the ideas articulated in the discussion to this point, one might understand the
‘fair and decent’ service as the service whose responses are directed by individual refugee’s needs rather than the service’s own limitations. In Chapter Four it was identified that rebuilding social worlds is likely to be a priority and thus services need to be equipped to address this. This is consistent with Daniels et al.’s (2000) first benchmark, which stresses the need to focus on a broad understanding of need, including the social determinants of health. Chapter Five illustrated, however, that often services are more comfortable providing narrow bio-medically based responses instead of holistic ones. In this research the structures and philosophies of services and the integration and partnerships between them were found to be particularly influential in enabling services to provide holistic care in line with needs. As has been established at the outset, the concept of need is not unproblematic and what constitutes need depends upon who is doing the defining (Billings & Cowley 1995, Bradshaw 1972). The theme of “Quality of Care” in Chapter Six highlighted that precedence and respect should be given to refugees’ own articulation of needs. Similarly this is consistent with the need for community participation evident in the “Agents of Change” theme presented in Chapter Six and also with the sixth benchmark described by Daniels et al (2000).

However, there is another element to the ‘fair and decent’ service that can be identified in the findings of this research. It relates not only to the capacity of services to respond to meet the needs of refugees but to the accessibility and quality of the service provided; both of which were major themes to emerge in Chapter Six. For instance a service may have the capacity to respond to ‘resettlement’ needs by having excellent group programmes to facilitate adjustment and social support, or by being able to provide practical information about navigating Australian systems and institutions, or by being willing to advocate on behalf of refugees with respect to housing or immigration issues. However if resettling refugees are unable to access the service then the responses on offer, even if they are aligned with what refugees need, essentially amount to nothing. Thus, as this research found, access barriers need to be overcome if the potential of services to meet the needs of refugees is to be optimised. This is similarly enshrined in benchmarks two and three described by Daniels et al. (2000) which articulate the need for services to reduce both financial and non-financial barriers to access.

The availability of a service in itself is not a guarantee of a quality care as the findings of this research attest. In unpacking the notion of quality further Chapter Six shows that cultural and linguistic sensitivity and the patient-provider relationship are important factors. Consider a refugee with minimal or no English language capacity that accesses a service where
interpreters are not provided. This person may with great difficulty be able to somehow communicate their needs and eventually get these met but there may be a considerable cost to the person. This may be in terms of the time taken, or in terms of the frustration or discomfort caused by the experience of the consultation, which may act to dissuade from subsequent utilisation. Or the cost might even be measured in terms of the negative impact on families where children or other family members may have been used to interpret sensitive and supposedly confidential information. Thus how services respond to needs is likely to be as crucial as the outcome of the response; both alongside access have the potential to impact upon refugees positively or negatively. This sentiment is encompassed in benchmark six of Daniels et al. (2000). Chapter Six underlined a number of factors that impact upon quality and highlighted the intersections between these. These included the structures and philosophies of services, workforce and training issues, and individual organisational factors, such as the emphasis and support for an increased focus on providing appropriate care to refugees.

Thus on the basis of the findings of this research one might imagine the ‘fair and decent’ service with respect to refugee health service provision as encompassing three interconnected dimensions:

1. Relevance: The service whose responses are primarily governed by individual refugees’ needs rather than the service’s own limitations.
2. Accessibility: The service whose responses are accessible to refugees, and
3. Quality: The services whose responses are provided in such a way that there is no or minimal ‘cost’ to (or negative impact on) refugees participating in such responses.

In the spirit of Daniels et al. (2000), these dimensions are offered here to encourage debate about what potentially constitutes ‘fair and decent’ services with respect to resettling refugees, rather than factors upon which services should be graded.

It is important to note that the first of these dimensions refers to a personalised form of care, which acknowledges the diversity within refugee communities. This diversity was evident throughout the findings of this research, and was particularly canvassed in the discussion of the needs in Chapter Four. Chapter Four showed that the highly educated, urban-background, English speaking refugee, for instance, is unlikely to have the same needs as a less educated, rural-background, non-English speaking refugee. Likewise it demonstrated that the lone refugee without any family in Australia is likely to have different needs to a woman who heads a large household. The ‘fair and decent’ service, according to the interpretation from
this research, would acknowledge the fact that refugees are individuals and personalise care accordingly. But, it would also recognise as Chapter Four highlighted, that many refugees are enmeshed in collective understanding of themselves, their families and their communities.

However as is also evident in the first of these three dimensions, one must acknowledge that all services have limitations; the nature of which was explored in Chapter Five and Chapter Six. The findings of this research highlight that different types of health services are likely to have different limitations, affecting their capacity – the ability and willingness – to provide care in line with the needs of resettling refugees.

Due to this variation in capacity, ‘levelling’ becomes an important issue. Services that have high capacity, such as refugee specific and community health services should not be made to downgrade such that they are equal to those services with lower capacity in the name of a decent minimum of health care. This would create complacency and ultimately effect innovation and systems development. Nor is it realistic or desirable to demand that the GP practice located in a suburb with few or no refugee residents increase their capacity so that it is equivalent to the standard of refugee specific or community health services. This would be costly, producing little or no benefit to the overall health of refugees.

As this research has found, and as is particularly evident in Chapter Six, there is likely to be a distribution of varying capacities to address the needs of resettling refugees among health services. Recognising this reality, the goal of health service and systems development with respect to refugees should be twofold:

1. To ensure that all services strive to become ‘fair and decent’, and those that are, strive to maintain fairness and decency.
2. To ensure that the entire distribution of health service capacity moves forward such that health system capacity is increasing.

7.6 Community and refugee specific services versus mainstream services

It is argued here that much of the variation in capacity relates to the structures and philosophies that govern service provision in different contexts. This research found that community health services and refugee specific services in particular have a greater capacity to encompass the ‘fair and decent service’ than mainstream services.

It has been argued that services with a high degree of refugee specificity may be particularly
well equipped in dealing with issues that may be rare within the general population (Lamb & Cunningham 2003). The arena of refugee mental health has been one area where refugee specific services have been particularly viewed as potentially beneficial (Silove et al. 1997). In Australia this has manifested in the establishment of specialist services for the survivors of torture and trauma (Allden 1998), which have increasingly broadened their focus to include supporting refugees in rebuilding social worlds. In addition to the perceived benefits of refugee specific services there has also been an acknowledgement of the difficulties services targeted at the general population may have in providing appropriate care to refugees. Such concerns were evident two decades ago (Reid et al. 1990) and are still held with respect to some areas of mainstream service provision. The quality of care provided to refugees in private General Practice settings was one area, in which this concern was raised in this research.

Similar issues were also evident in Johnson et al.’s (2008) qualitative study of GPs experiences of providing initial care to resettling refugees in South Australia, where a number of difficulties were cited by GPs. These included a lack of awareness of, and experience in, dealing with the often multiple and complex needs, with which refugees present; difficulties associated with language and culture, and structural deficiencies such as lack of support staff, established referral pathways and the fee-for service model, which constrained the ability of GPs to undertake longer consultations. Johnson et al. (2008) concluded that given the difficulties faced in General Practice settings, refugee specific and community health services should be supported with adequate resources in order to provide comprehensive primary care to refugees with ‘complex’ needs.

However, as Kelaher and Manderson (2000) point out there is a diversity of needs within migrant populations and thus not all refugees will have ‘complex’ needs. The highly educated, English proficient, and those capable of accessing services may not have a need for refugee specific or community health services whilst those who are less well educated, less proficient in English, socially isolated, and who experience barriers to care may find refugee specific services more desirable. The key point made by Kelaher and Manderson (2000) is that rather than getting distracted by unproductive and often politicised arguments for and against mainstream or refugee specific service provision, health service provision and interventions to migrants and refugees should be governed by the principle of matching health services to migrants’ needs. Despite many years of service provision to refugees and migrants in Australia, Kelaher and Manderson (2000) argue that this principal “has not usually been
applied” (pg 9). This may be one of the reasons why improvements have been incremental in terms of the quality and relevance of service provision to refugees.

For this principle to be upheld there needs to be a diversity of services and sources of support available to refugees, such that refugees can decide which service to access on the basis of what they believe will be best suited to meeting their needs. It is clear from this research that refugee specific services also acknowledged this point, aiming not to create dependence on the service but to ‘transition’ resettling refugees into mainstream services whenever refugees felt ready. The extensive effort of refugee specific services to build capacity within mainstream services underscores the importance of such services beyond service provision. It also highlights an acknowledgement of the need for well equipped mainstream services, which most resettling refugees will inevitably come into contact with at some stage after settling in Australia. This research thus provides evidence that service providers and community members also view the traditional dichotomous thinking about mainstream and refugee specific services (Lamb & Cunningham 2003) as being unhelpful. Besides the fact that research like that of Kelaher and Manderson (2000) has illustrated that services might be better understood as containing degrees of refugee specificity, the over simplistic dichotomy of mainstream and refugee specific constrains thinking and innovation around health service provision to refugees. A better approach is to try and understand what is it about the responses of particular health services that make them successful or unsuccessful in meeting the needs of particular groups of refugees, and what can be learnt. The starting point here is not one of ideology but of refugees’ needs, and the appropriate matching of services and sources of support accordingly.

7.7 Strategies for improving health service capacity

As is particularly evident in Chapter Six this research has highlighted a number of factors that determine the capacity of services to respond appropriately and successfully to the needs of resettling refugees. These include structures and philosophies, integration, cultural and linguistic sensitivity, community consultation and participation and access. In the discussion to follow practical strategies and recommendations for improving health service capacity – interpreted here as the pursuit of encompassing the ‘fair and decent’ service – will be offered in relation to each of the factors found to determine health service capacity. These are based upon the lessons for health service and systems improvement found in Chapter Six in particular, as well as those in the literature.
7.7.1 Structures and philosophy

The structures and service provision philosophies of individual health services were found to be major determinants of capacity. These two concepts were found to be so intertwined – philosophy affecting structures, and structures affecting philosophy – that they are discussed here together. In many ways the boundaries of services were governed by their structures and philosophies, with community health services having greater flexibility and scope to deal with a complex array of needs as compared to General Practice services, for example. As Lamb and Cunningham (2003) note this is likely to be because services with a high degree of refugee specificity, by definition, design their service structures and philosophies around the special requirements and needs of refugees. Thus, as found in this research, services with a high degree of refugee specificity were organised in multi-disciplinary team structures, which utilise a diverse range of skills to provide holistic care (Lamb & Cunningham 2003).

Generally speaking there are two ways in which the structures and philosophies of services can be altered to increase the capacity of services to respond appropriately to the needs of resettling refugees. As Chapters Five and Six attest, the first and most difficult way is to change the biomedical dominance over thinking about the role and organisation of the health system in general. In the same way that professional specialities have developed around diseases within parts of the human body so too has the health system (WHO 2007b). Consistent with the Cartesian split that views body and mind as separate entities, there exist health services for the pathology of the mind, and these are distinct from health services for the pathology of the body (McDaniel 1995). Until articulations of a biopsychosocial (Engel 1977) frame of reference, the pathology of the social being did not even figure in the mind-body dualism in the way services are organised; it was in many ways considered outside of biological reality and thus outside of the realm of the body – the health system (WHO 2007b). Furthermore, the preoccupation of the health system with pathology is another indicator of biomedical dominance over health system development (WHO 2007b).

Health services and health systems change as societies change. Advocacy movements can be and have been important sources of change within health systems. The Alma-Ata Conference endorsed the Primary Health Care movement, which aimed to “put people at the centre of health care” (WHO 2007b). Largely as a consequence of such philosophical and social-justice informed advocacy movements terms like ‘social determinants of health’, ‘the primary health care approach’, ‘holistic care’, ‘person-centred care’, and ‘integrated care’ are all commonly used terms to theorise and guide a non-dualistic vision of care; one that connects the mind,
body and the social reality that influences human experience. The proliferation of community health services after the 1960s (Lefkowitz 2007) may be interpreted as a practical manifestation of this non-dualistic thinking. Such services have been heralded as being conducive to providing holistic care to ‘disadvantaged’ populations such as migrants and refugees (Alcorso and Schoefield 1992). Although some hold reservations about the degree to which community health services have been assimilated into the biomedical model, Blackford (2005) notes that:

“…many community health services have specifically tailored their services and resources to provide appropriate equitable care to their local culturally diverse community” (pg 2).

It is important however, not to overstate the degree of ‘real’, as opposed to rhetorical, change within health systems as according to Raphael & Bryant (2006) the social determinants approach still remains subordinate to traditional medical paradigms in English speaking countries in North America, Australia and New Zealand. Having said this, changes in thinking and practice, however incremental, provide evidence that it is not impossible to alter the structures and philosophies that govern how people are cared for in society. It also highlights the potential role advocacy, such as the activities of agents of change found in this research, may play in resisting and influencing dominant values and philosophies that shape the way health systems are organised.

Policy was a major theme identified in Chapter Six, and was one tool that key informants in this research viewed as having the potential to alter health system structures and philosophies. A refugee or multicultural health policy was seen as providing a common direction for service provision, and engraining a holistic vision in all aspects of care. Whether the mere articulation of a policy or a strategic direction in refugee health would have any effect in practical terms is questionable. Thus many key informants in this research echoed what reform advocates argue; that ‘talk’ needs to be accompanied by political will, funding, and concrete action. Furthermore more research is needed to evaluate the impact of refugee and multicultural health policies on health service provision and on health outcomes. Whilst some states in Australia, such as New South Wales, Victoria, and Queensland, have developed policy or strategic directions in the realm of refugee and multicultural health, to the knowledge of the author, evaluations have not been conducted or if they have, they have not been made publicly available. Thus future research might address the question of the benefits of policy in the realm of refugee health and seek to identify the elements that contribute to ‘good policy’.
As noted throughout this thesis in ideas about rebuilding social worlds for example, the needs of refugees cut across social policy realms. For instance, the lack of appropriate public and rental housing stock was highlighted in Chapter Four as negatively affecting resettling refugees (as well as many others). Likewise, settlement policy with its short-term focus was also viewed as potentially resulting in unmet longer-term needs for some. Immigration policy regarding family reunification and the Special Humanitarian Programme, and the requirements for sponsors was found to place considerable pressure and anxiety on resettling refugees. Thus given this interconnectedness of needs it is argued that other forms of social policy could benefit from an awareness of potential consequences of policy on health.

The idea of Health in all Policies (HiaP) is one articulation that is useful in furthering this notion, and seems particularly apt in the case of refugees. HiaP is a policy strategy which seeks to embed the goals of increasing health and decreasing health inequalities across all sectors of Government (Kickbusch 2008). Given the integral role that health plays in all aspects of economic and social life, HiaP requires policy makers from a range of sectors to consider health consequences in policy development (Kickbusch 2008). Furthermore the HiaP approach calls for integrated policy responses, as a way of dealing with the social determinants of health (Kickbusch 2008). Thus it is the contention of this research that a refugee health policy or a refugee resettlement policy may be too inward looking. A refugee wellbeing policy that traverses systems such as health, education, settlement, immigration, housing and social welfare systems would be more valuable in terms of systems development and outcomes.

Recognising that shifting health system structures and philosophies is likely to be difficult, the second way to change the health system is from the ‘bottom-up’; at an individual service level. This research suggests both ways are important and need to occur concomitantly. In the absence of a refugee health policy or other health system level mechanisms, several examples of such change were cited in this research.

One practical example that could be implemented includes the diversification of the workforce within individual health services. Such diversity was found to bring new skills, creativity, and innovation in service delivery responses, thereby allowing services to cater to a broad range of needs. The employment of a nurse-practitioner within a General Practice context, was one example canvassed in Chapter Six, and is likely to increase the capacity of such a service to cater to issues arising from the social context of resettlement. Of course,
nurse-practitioner models of care in general practice are not only likely to be beneficial for refugees but also in the provision of primary care to other marginalised or minority populations (Makenbach et al. 2003) and, in fact to the general population (Horrocks et al. 2002).

In much the same way as refugee specific services in this research were found to employ intake workers to conduct initial needs assessments, Watters (2001) suggests that broad assessments of need focussed on refugees’ own explanatory models may also be a way of increasing service capacity and relevance. He suggests that responses could ensue on the basis of this needs assessment, which on the basis of this research and others, one might anticipate involving responses to a raft of issues related to resettlement. However, in the same way in which members of any population may require ongoing professional mental health support so too might some refugees. If ongoing professional mental health care is needed the intake worker could ensure that such support is forthcoming from within the service.

The employment of bi-cultural community health workers (CHWs) has been another approach highlighted in this research and elsewhere (Fuller 1995) as potentially affecting service structures and philosophy. This research found that such workers not only have an understanding of the needs of specific refugee communities but also often have the time, skills and motivation to undertake group programmes, advocacy, and social-work like activities. However this research has highlighted some of the difficulties faced by bi-cultural CHWs arising from their dual identities as ‘community members’ and ‘service providers’. The documented frustrations of some of the bi-cultural CHWs in not having their voices sufficiently heard are frustrations likely to be felt by fellow community members. Watters (2001) notes the possibility that bi-cultural CHWs may be used by the service to translate refugees’ articulated needs into a language more palatable to the service; that of the biomedical category. Along these lines, Werner (1981) famously posed the question of whether CHWs act as health system lackeys, used to carry out the will of services, or community liberators that give voice to communities. As this research and Watter’s (2001) observation illustrates, this question remains relevant today.

A review of the evidence on CHWs and CHW programmes found that one of the elements of successful CHW programmes was the degree to which CHWs were embedded within communities (Lehman & Sanders 2007). Where communities did not drive and did not have a sense of ownership over programmes, the authors of the review found that CHWs:
“...exist on the geographical and organizational periphery of the formal health system, exposed to the moods of policy swings without the wherewithal to lobby and advocate their cause, and thus are often fragile and unsustainable” (Lehman & Sanders 2007 pg v).

Furthermore Lehman & Sanders (2007) found that CHWs need to be “adequately and continuously supported” (pg v) by health service management and programme funders such that they have the flexibility, time, and resources to undertake their outreach work with communities. Thus if health service managers and policy makers take into account such lessons, CHWs, and bi-cultural CHWs in particular, can be an effective structural mechanism for improving capacity through providing outreach, facilitating access and bridging the gap between service provision and the felt needs of community members.

The “Agents of Change” theme articulated in Chapter Six drew attention to the many innovative programmes that have resulted as a consequence of the motivation and concerns of individual professionals or champions rather than ‘top-down’ policy or stewardship. In this way motivated professionals also help to increase the degree of refugee specificity within services. In a report surveying the landscape of mental health service provision to refugees and asylum seekers in Europe, Watters and Ingleby (2004) likewise observed that:

“Many of the examples of good practice cited in this report have been the result of initiatives taken by determined professionals with a deep concern for the welfare of refugees. These professionals often doggedly sought funding to build up a service by working through personal and professional networks and their respective health and social care agencies. The reason why there was a particular initiative in, say, Barcelona or Glasgow, was often less to do with top down planning than with individual initiative. On this basis, many commendable organizations have developed” (pg 566).

Thus the efforts of such individuals should be acknowledged and encouraged by health service managers being receptive to their efforts. However, as this research and that of Watters and Ingleby (2004) suggest, the continuity of such programmes and efforts at health service change may be reliant on ongoing funding, support, and the continued involvement of the motivated professional/s. Management support was one area that was identified in Chapter Six as ensuring that such efforts and programmes were encouraged, and in facilitating sustainability. Lawrence and Kearns (2005) also suggest that funding support is likely to be critical in allowing services to alter their structural environments in all of the aforementioned
ways, but particularly in the realm of supporting innovative programmes in the longer term, and hiring additional staff like bi-cultural CHWs, intake workers and those with social work experience.

Drawing upon a comparison of Dutch mental health services and British mental health services Watters and Ingleby (2004) highlight the benefits and pitfalls of ‘bottom-up approaches’ such as programmes developed by motivated professionals, on the development of service provision responses to refugees. The Dutch system of mental health service provision to refugees was considered to represent a ‘top-down’ approach being more hierarchically organised, systematic and amenable to change via policy. The issue with this centralised approach however is the potential for rigidity and an inability to respond to the diversity of needs within particular locations and within different refugee communities. In contrast, the British system was observed to represent a ‘bottom-up approach’, in which services developed organically from a grass roots level resulting in an array of different service initiatives. Whilst fostering innovation and being sensitive to local communities’ needs the British system was also considered to be sometimes chaotic, ad hoc, and less amenable to policy intervention.

In concordance with the views of Watters and Ingleby (2004) it is argued that on the basis of this research, a combination of both ‘top-down’ and ‘bottom-up’ approaches are needed to strengthen the capacity of systems of health and social care to refugees. The stewardship inherent in ‘top-down’ approaches such as policy making and strategic planning is likely to produce a co-ordinated effort to serve refugee communities and thus prevent duplication and gaps in service delivery. However, as Renzaho (2008), Simich et al. (2005) and Lawrence and Kearns (2005) have found, narrowly and strictly defined service mandates that are often tied to pre-prescribed funding agreements constrain the ability of providers to adapt their service provision to the needs of the communities they serve. Thus, ‘top-down’ approaches must be coupled with the flexibility to respond to the articulated needs and desires of refugees in local communities such that innovative service responses can be supported from the local level.

7.7.2 Integration

If properly fostered the strength of the health and social care system is its diversity. One service need not be able to address housing, employment, immigration issues, as well as social isolation if there are pathways to other services that refugees can easily access if directed and that are equipped to deal with one or more of these issues. The unpacking of the
theme of “Integration and Partnerships” in Chapter Six illustrates that the existence and building of bridges is important in ensuring that the diversity within the health and social care system is utilised to its full potential. This is a point that is also acknowledged by Daniels et al. (2000).

The literature on health service integration (Leichsenring 2004, Kodner 2003) and health care to refugees (Renzaho, 2008, Feldman 2006) further reiterates the benefits of integration as found in this research. Not only was this canvassed in terms of enabling practitioners to refer to services but also in terms of drawing upon collective creativity and resources to develop innovative responses and group programmes. Other research and articulations of integrated care models further reiterate the benefits of integration in the realm of care to refugees (Feldman 2006). This research has demonstrated that integration between resettlement services and primary and community mental health care services is extremely important. Not only was this canvassed in terms of enabling practitioners to refer to services but also in terms of drawing upon collective creativity and resources to develop innovative responses and group programmes.

Chapter Six highlights that the question of how services build bridges and relationships is often larger than services themselves. Policy directives of Health and Immigration Departments, the division of responsibilities between State and Federal governments and the competitive funding environment in which services operate, were found to affect the integration and partnerships between services. A state-wide study of health service provision to CALD communities in Victoria, Australia (Renzaho 2008), similarly found that:

“The pressure and competition for resources to address culturally and linguistically diverse communities’ needs allows little opportunity for partnership and collaboration between providers, leading to insufficient sharing of information and duplication of services, poor referrals, incomplete assessment of needs, poor compliance with medical treatment, underutilisation of available services and poor continuity of care” (pg 223).

Changing the policy and funding environment such that there is less reliance on often divisive competitive tendering and thus more collaboration would represent a ‘top-down’ approach that would have a positive impact on the entire health system as a whole. These are issues that are complex to resolve and change and require high level discussions between all stakeholders involved such that policy, programmes and funding ensue in such a way that does not
burn bridges or hinder their construction. The theme labelled “Policy” in Chapter Six uncovered some examples of such high level inter-sectoral discussion. For instance, the Multi-Jurisdictional Working Group on Refugee and Humanitarian Health established at the end of 2005 (referred to as ‘The Working Group’ hereafter) was one example of how many sectors, and levels of government with a stake in refugee health, can engage in high level discussions and produce action. In this way The Working Group may be seen as a manifestation of the HiaP approach discussed earlier. The Working Group consisted of representatives of the Federal Department of Health and Ageing, the Federal Department of Immigration and Citizenship, and representatives from State and Territory Health Departments and came together in order to develop a more coordinated response to meeting the health needs of refugees (Boyer 2007). One of the concrete outcomes to have come out of The Working Group’s discussions was the introduction of Medicare items to remunerate GPs for initial comprehensive health assessments (Boyer 2007).

If such discussions between stakeholders do not occur, well-intentioned programmes aimed at increasing integration may have little impact at all. A case in point highlighted by this research is the Federal Government’s Better Access to Mental Health Programme, which sought to facilitate access to allied health mental health care through GPs. However, at least initially, the programme did not provide free interpreter access to allied health practitioners, meaning that CALD individuals requiring interpreters were essentially unable to access services under the programme. Responsibility for free interpreter services such as those available to medical practitioners falls under the jurisdiction of the Translating and Interpreting Service administered by the Federal Department of Immigration and Citizenship whilst Better Access to Mental Health Care was a Federal Department of Health Initiative. It thus seems that there was an absence of discussion between two sectors of Government resulting in ‘not much better access’ for CALD people. Whilst this is unfortunate, the existence of a mechanism for inter-sectoral collaboration such as The Working Group enabled those charged with stewardship over the policy the ability to rectify the situation.

Short of affecting the policy and funding environment in which services operate this research highlights a number of practical measures are being or could be taken to foster relationships between services. The development of formal and informal networks of practitioners from different services interested in refugee health, resettlement and wellbeing was one example. Several examples of partnerships between individual services were cited in this research, resulting in the development of referral pathways and group programmes. The development
of such partnerships was found to be built upon dialogue, an understanding of the limitations and strengths of one’s own service delivery capacity, and goodwill between services. These three elements might provide a template for services wishing to develop partnerships and relationships with other services.

As noted earlier, research with community health workers (CHWs) suggests that, if adequately resourced and supported by organisations, they can play the role of integration agent by linking clients to other organisations (Swider 2002), and by fostering and developing relationships between different services and providers (Farquhar 2008). Thus organisations might like to consider the employment of CHWs or how they can support and utilise existing workers to perform this aspect of the role of CHWs.

7.7.3 Gap: Quality and accessibility of service provision responses
The second and third elements of the articulated ‘fair and decent’ service relate to the quality and accessibility of service provision responses. Even if a service can respond to a particular need, this does not mean that they will necessarily deliver that response in a way that has a positive impact on refugees nor that refugees will be able to access those responses. This research has highlighted a number of examples where this may or may not be the case. The existence of quality issues and access barriers with respect to culturally diverse communities is not new. In their discussion of access, equity and quality issues affecting culturally diverse people with regard to Commonwealth programs (health or otherwise) some eighteen years ago, Dean-Oswald and Colebatch (1992) cite similar barriers to those found in this research including inadequate consultation, inadequate information about services and programs, inadequate translating services, and the monocultural orientation of services. Thus the accessibility and quality of services was considered to constitute a gap that needs to be addressed in order to strengthen health service provision responses such that they are not only relevant to community needs but also are delivered in an appropriate way. Addressing this gap is all the more important given that it seems in relation to mainstream services in particular, access and equity are historical problems that have continued into the present. In the following sections of this chapter the ways in which factors related to the quality and accessibility of service provision responses can be improved will be discussed. These include cultural and linguistic sensitivity, community consultation and participation, interpreters, and access.
7.7.4 Cultural and linguistic sensitivity

The findings of this research accord with a well established body of literature, which highlights the role that culture and language play in help seeking behaviour, understandings of and ways of conveying health issues, and quality of care (Helman 2000, Kleinman 1980). Cultural and linguistic sensitivity was found to be an important component of quality care in Chapter Six. Likewise, Anderson et al. (2003) point out that quality of care can be compromised when clients and health providers do not share a common language and culture.

Johnstone and Kanitsaki (2006) take this argument a step further by evoking the notion of patient safety and arguing that:

“...the failure to recognize the critical link between culture and language (of both providers and recipients of health care) and patient safety stands as a ‘resident pathogen’ within the health care system that, if not addressed, unacceptably exposes patients from minority ethnocultural and language backgrounds to preventable adverse events...” (pg 383).

One widely acknowledged approach to quality of care with respect to culturally diverse populations is to ensure that services are provided in such a way that is culturally and linguistically sensitive. The literature is teeming with articles on cultural sensitivity and approaches to impart this in service provision, resulting in confusion for service providers and planners as to what the best approaches to cultural sensitivity may be for them (Dean-Oswald and Colebatch 1992).

This research reflects the array of approaches to impart cultural sensitivity evident in the literature (Anderson et al. 2003) with a number of approaches being canvassed including the use of interpreters and appropriately translated health information material, the employment of bi-cultural and bi-lingual workers, undertaking cultural sensitivity training, health service policies and accountability measures for cultural sensitivity (Betancourt et al. 2003). Possibly adding to the confusion of policy makers and providers is the lack of available evidence regarding the efficacy of the many articulated strategies and interventions to impart cultural sensitivity. In a systematic review of a number of aforementioned cultural sensitivity interventions, Anderson et al. (2003) found that there were an insufficient number of comparative studies or studies measuring similar outcome variables to enable them to determine the effectiveness of such interventions.
Hayes-Bautista (2003) argues in the American context that:

“To date, cultural competence initiatives have focused on the interpersonal aspects of medical care—language, provider sensitivity, ethnic concordance—and as the population becomes more diverse, these efforts at a more appropriate ‘bedside manner’ will continue to be useful. What is really needed, however, is good, hard-nosed, science-based research into the relationships among culture, behaviour, and health outcomes” (pg 8).

Such an evidence-based paradigm coupled with managerial discourses have spawned a movement advocating for minimum health service standards and benchmarks regarding cultural and linguistic sensitivity in health care. In the United States this prompted the Government to develop National Standards for Culturally and Linguistically Appropriate Services to guide the American health care system in March 2001 (US Department of Health and Human Services 2001). Australia has been slower to develop such standards (Renzaho 2008) but in 2006 the National Health and Medical Research Council (NHMRC) of Australia developed a set of guidelines for Cultural Competence in Health (NHMRC 2006).

Ironically however, the prevalence of rhetoric and ‘management-speak’ within such guidelines runs the risk of trivialising cultural sensitivity even further. Cultural sensitivity as such may be perceived as nothing more than a “well meaning but ultimately unproductive public relations effort” as Hayes-Bautista (2003) acknowledges (pg 8). However well intentioned, such guidelines are thus likely to leave providers, service managers and policy makers more confused as they wade through many pages – 85 in the case of the NHMRC Australian guidelines document – to decipher exactly what such guidelines actually mean in practice. Perhaps it is partly due to this that few key informants in this research expressed a desire for guidelines or standards.

Overwhelmingly however, the interpretation of key informants’ accounts in this research highlights a simple approach that providers and services can take to imparting cultural sensitivity within their care to refugees and CALD people. It is the idea of ‘becoming less expert’. This may sound counter-intuitive in a world where experts are exulted; and the pursuit of ‘becoming more expert’ is equally encouraged. People gather to listen to the monologues of experts and experts likewise speak, preach, and tell. The ‘expert’ is not encouraged to engage in a dialogue; to hear, to listen because the expert ‘knows’. Kleinman (1980) explains how this has traditionally played out in a health care context saying:
“The encounter between doctors and patients (and families) is one between experts and those who are ignorant, so the doctor’s role is to ‘tell’ or give orders to patients, and the patient’s role is to listen passively and comply” (pg.57).

But the post-modern era has seen a proliferation of languages, a need for nuanced understandings, a need for questioning, a need for dialogue; a need to ‘become less expert’. In relation to culturally diverse populations Ida (2007) argues that services need to go beyond entrenched paternalistic ways of working with people – “old ways of doing things” – in order to engage with CALD people and communities as “equal partners in the therapeutic process and experts in their own right” (pg 51).

With respect to cross-cultural interactions in health care, the examples provided by the key informants interviewed in this research highlight the need to take a position of not-knowing. This contrasts with the approach of cultural competency in some medical education programmes, which according to Wear (2003):

“...looks more directly at the language and customs of particular nondominant groups, especially their beliefs and behaviours surrounding health, illness, and health care providers and institutions. The thinking here is that doctors—mostly white, well educated, and middle-class or higher—don’t know enough about the range of people they will be caring for (be they people of colour; people from nondominant racial, ethnic, or religious groups; people who are economically disadvantaged; people who are disabled; people who do not speak English; or people who are not heterosexual). When medical students learn characteristics of these groups, they can provide better health care because they will no longer hold ignorant or biased beliefs about those groups” (pg 550).

Whilst there are various manifestations of cultural competency (focussing on knowledge) and cultural sensitivity/awareness (focussing on attitudes) approaches in use in health professional education and ongoing professional development, Wear (2003) is critical of approaches that essentialise and exoticise people on the basis of culture. The critique of such approaches can be mounted on a number of fronts.

Firstly, how much can one understand about a culture including one’s own from reading about it or taking a course, when anthropologists devote years of their lives to this task and still do not fully understand a culture? The difficulties associated with this task are amplified
in a health care context, where busy providers may only see people for short periods of time, and thus any knowledge gleaned about a person’s culture may be superficial (Fuller 2003).

Secondly, even if one can come to partially understand a culture, providers in a culturally diverse society come into contact with people from a number of cultural and sub-cultural backgrounds. It is unrealistic for them to ‘know’ about them all (Fuller 2003). Furthermore as Fuller (2003) points out ‘ethnic’ culture is unlikely to be the only or even dominant force in shaping people’s lives. Others have highlighted the role of socio-economic factors and gender as important factors in people’s lives and thus their health care needs (Manderson & Reid 1994). Thus the pursuit of ‘knowing’ about many cultures may not only be unrealistic for health providers but can obscure attention to other potentially important factors that shape experience and needs.

Thirdly, when one ‘knows’ one does not ask questions. Actions may be based not on the particular needs and desires of the person services are being provided to but on what the practitioner ‘knows’ or has been taught. Thus there is a tendency to generalise and make assumptions. As Wear (2003) notes, whether explicit or implicit the cultural competency framework often reduces the complexity of patients’ experience to stereotypes, thus neglecting the multiple identities that individuals may have, and the way in which these identities may shape patients’ experiences. A vast body of research has emphasised heterogeneity within cultures and the experiences of those that identify with them and warns against using generalisations and stereotypes to explain people’s beliefs and behaviours (Helman 2000). This is particularly likely to be the case for refugees like those from Sudan, who have been exposed to a number of cultural traditions as a result of forced migration. Thus for people with personal histories of movement as well as for those that do not, culture is a dynamic fluid entity, and the moment one has proclaimed that they have ‘become culturally sensitive’ one has inadvertently ‘become less culturally sensitive’ as this pivotal characteristic of culture is overlooked.

Finally often cultural sensitivity has an explicit focus on the ‘other’, and thus views biomedicine itself as culture neutral entity and thus overlooks the way in which the culture of medicine and the culture of the health professional shape biases, assumptions and prejudices (Wear 2003). Kleinman, as quoted by Fox (2005), warns against this, reminding service providers that they are immersed in the culture of their profession as much as a patients are influenced by their cultures, posing the question:
“If you can’t see that your own culture has its own interests, emotions and biases, how can you expect to deal successfully with someone else’s culture?” (pg 1316).

Likewise there needs to be an awareness of the power relationship that exists between people and healers and the context in which inequality occurs (Wear 2003). In many societies healers are respected for their knowledge and abilities, and thus are imbued with power. The organization and professionalization of groups of healers has acted to consolidate this power (Kleinman 1980). This may mean that people, irrespective of their cultural background, are inclined to listen to or comply with healers’ demands. At the same time people expect healers to listen to them. Whilst some may not view the power of healers as problematic, what is problematic is if healers do not listen, or misuse their power. This potential exists in any society but is perhaps amplified in multicultural societies, where people may not share the same cultural and linguistic background, and thus in which much more emphasis needs to be placed upon listening.

The idea of ‘becoming less expert’ overcomes the problems identified in the way cultural sensitivity has been interpreted and implemented in the past. It does this by first reassuring providers that it is acceptable to say “I don’t know”, and encourages providers to do so. In acknowledging their own uncertainty and limitations, providers avoid making assumptions about a person’s culture and basing their actions on these assumptions, which may or may not be appropriate for the individual for whom they are providing care. This kind of reflexivity encourages providers then to ask questions of their own culture as well as that of those for whom they provide care (Fuller 2003). Asking questions is how providers ascertain what is appropriate for the individual that they provide services for. Allotey et al. (2002) concur with this view emphasising the importance of consulting with clients on issues of ‘cultural appropriateness’ in order to individualise them. Therefore, providers need to recognise that the answers to the questions they ask are likely to vary amongst individuals and thus they must ask the same questions with each new person for whom they provide care. In summary the approach of ‘becoming less expert’ involves three stages:

1. Acknowledging that “I as a health provider may not know what the most appropriate approach is for this particular person.”
2. Asking the person who is being provided with care “What do you think?”
3. Acting on the basis of the answer, and the ensuing dialogue.
The articulation of ‘becoming less expert’ developed on the basis of this research corresponds with Fuller’s (2002) thesis that health workers need to be reflexive in cross-cultural practice. Fuller (2002) identified three vital components of reflexive cross-cultural practice including *self-awareness, sensitivity* and *negotiation*; all of which are encapsulated in the three stages of ‘becoming less expert’. Stage one of the ‘becoming less expert approach’ involves self-awareness on the behalf of the provider whilst stages two and three involve negotiation. Sensitivity is evident in all three stages.

Whilst the approach of ‘becoming less expert’ has been articulated in terms of an individual provider, it also provides a useful approach with respect to cultural sensitivity at a health service level. However, instead of an individual provider engaging in a dialogue with an individual client the health service can ‘become less expert’ by engaging in a dialogue with the communities they hope to serve. Whilst this may seem a self-explanatory way of understanding the needs of refugees and thereby increasing the relevance and appropriateness of care, refugee participation in service planning is lower than one might expect. According to a survey of mental health services to refugees in Europe, only two of eighteen countries had mechanisms for listening to the concerns, desires and needs of refugees (Watters 1998).

**7.7.5 Consultation and community participation**

The sub-theme of community participation in Chapter Six points to several ways that services can engage in a dialogue with communities in order to improve the quality and relevance of care. One way is to consult with communities on the needs, desires, and appropriate service responses. Community consultation has the potential to increase services’ understandings of the needs of refugees, and thus the relevance, acceptability, quality of programmes and responses provided (Watters 1999). However community consultation is not a clear-cut concept, with several authors pointing to such questions as the power relationships between the service and the consulted, who exactly in the community is consulted and who is not, and the motivation of the service as well as those consulted in participating (Watters 2001). Furthermore, research has illustrated that community consultation can amount to little more than tokenism, having no or little influence on health service planning and development. A Victorian study found that only 10.7% of services developed programmes on the basis of findings from consultations with CALD communities (Renzaho 2008). Instead Renzaho (2008) found that the majority of programmes and service provision responses ensued as a result of “opportunistic funding/tendering and in most cases were not commensurate with refugees’ stated needs” (pg 228). The concerns raised by such research, and this research,
point to the possibility that ‘genuine’ community consultation, or a ‘genuine’ dialogue may not always result and even if it appears to have occurred, it is not necessarily a guarantee that service responses will be more appropriate and relevant.

Rather than dissuading services from engaging in community consultation, concerns highlighted within the literature should motivate services to do it better, and to ensure that consultation has tangible outcomes. Renzaho (2008) provides some helpful recommendations that may enable services to improve their consultative processes such that both services and CALD communities benefit from community consultation. One of the key recommendations includes the need to engage in a dialogue with a diverse range of voices from within the community such that the powerful members of the community do not skew the outcomes of consultation to suit their own needs or ambitions.

Another of the key recommendations that concurs with the findings of this research includes the need to promote a sense of ownership by involving CALD community members in all stages of the process including the planning of consultation agendas and how consultations are run, the running of consultative activities and the implementation of consultation findings and recommendations. By involving CALD community members in all stages of the consultation process an egalitarian relationship may be created between services and communities, preventing services from dominating consultation agendas, and increasing the accountability of both services and the community.

Whilst acknowledging that research on community consultation approaches in refugee communities is sparse, focus groups are one approach to consultation that were utilised by some services participating in this research and that have been considered beneficial in refugee communities (Watters 2001). According to Pourgourides et al. (1996) focus groups may empower disempowered groups by providing participants with a sense of “safety in numbers” (pg 20) and thus encourage them to discuss sensitive material.

Consultations need to be an ongoing endeavour. If services conduct consultations as one-off or ad hoc events the accountability of the service and commitment to implementing recommendations and the findings of consultations are likely to wane. If there is no prospect of, or mechanism through which, the service can report back to the community, and if members of the community do not have any mechanism for holding the service to account, then post-consultation inaction becomes too easy. Thus Renzaho (2008) recommends that
ongoing relationships and open-channels through which the voices of refugees can continually be heard are important. He suggests that services might consider establishing a CALD review panel or advisory committee involving community members as a way of doing this.

This research also highlighted the potential for community participation in health services to extend beyond consultation to active service provision by community members. Services may be able to utilise the resources that exist within communities to strengthen responses. Such resources include counselling and mediation skills, community elders and leaders, the ability to organise community meetings and events, and the strong emphasis on family and community amongst members of some refugee communities. One outcome of this type of active participation in service provision could be the involvement of elders and community leaders in service delivery, group programmes, and information provision.

7.7.6 Interpreters

As has been identified in Chapter Six, the potential for poor quality care with CALD people often arises out of language and communication difficulties. McGee and Johnson (2004) argue that “so much of the therapeutic relationship is dependent on the ability of two individuals to talk to one another” (pg 380) underscoring the role of communication in quality health service interactions. This research has also illustrated that prior experience of, or the perceived potential for communication difficulties, affects subsequent access to care.

The findings of this research thus support calls for the widespread use of interpreters where required (Flores 2005, Gerrish et al. 2004, Ahmad 2000) but stresses that services and providers should be vigilant in order to overcome challenges associated with using interpreters. One set of challenges revolves around the impact of interpreters on the relationship and communication between health service providers and those to whom they provide care. As this research has found and as noted by Gerrish et al. (2004), these can include such issues as lack of control, the maintenance of confidentiality, difficulty in developing rapport, and trusting that interpreters are doing an ethical job.

In order to safeguard against communication breakdown with an interpreter, services can ensure that interpreters are appropriately matched to the client and the context. In concordance with the recommendations of Barker (1991) and Dean-Oswald & Colebatch (1992) this study also highlighted that gender was a key consideration in appropriately
matching people with interpreters. In addition, others warn that just because an interpreter and client are born in the same country does not necessarily mean they share the same political, ethnic, or religious background (Orb & Wynadem 2001). This is a particularly relevant point in the context of refugees who have escaped conflict situations where politics, ethnicity and/or religion may have been a basis for persecution or an important factor in perpetuating conflict. Furthermore, particular care needs to be taken in small communities to ensure that confidentiality can be maintained. Where this is not possible, and as some key informants suggested, services may like to consider offering people the choice of a telephone interpreter; preferably one from interstate.

As well as a quality of care issue, Chapter Six underlined that the use of interpreters is also an access and equity issue. This was particularly considered to be the case for services that are publicly funded and thus that should be accessible to all members of society regardless of the language they speak. In countries like Australia where multiculturalism is espoused as a societal value, diversity of language should be taken into account in the provision of services funded by the public, of which CALD people and refugees are a part.

Whilst interpreters were used readily where required in community health services, and other public sector health services, interpreter utilisation in General Practice and other private service provision contexts was considered sub-optimal. An Australian study of interpreter-use behaviour and attitudes within General Practice also found that the utilisation of interpreters was low, with GPs preferring to use family members instead (Atkin 2008) despite the growing consensus that the use of family members to interpret is sub-optimal (Flores 2005). Furthermore, Atkin (2008) found that 30% of practices surveyed reported that they would not organise a professional interpreter even if one was requested. This suggests that GPs are either unaware, or are willing to bear the risk of the threats to patient safety as a result of not using interpreters. Johnstone and Kanitsaki (2006) illustrate that if the possibility of misunderstanding is not taken seriously, adverse events for patients can result, and where this has occurred in places like the US, a number of medico-legal cases have been launched against providers.

However, services provided by GPs and some other practitioners are almost fully funded by public monies via Medicare, meaning that CALD people should be able to expect to understand and be understood by GPs in the same way that English speakers are. Concerns about the lack of interpreter use have long been harboured in relation to mainstream services,
such as private General Practice (Dean-Oswald & Colebatch, 1992). That this still remains an issue, suggests an urgent reassessment of how to improve interpreter uptake amongst GPs. GPs, and now other Medicare funded services, have access to free interpreting services via the Translating and Interpreting Service (Atkin 2008) however this research has found that this is not incentive enough to encourage providers to utilise interpreters where required. Consistent with other studies (Atkin 2008, Johnson et al. 2008), this research noted a number of logistic and time barriers to interpreter use, for which Medicare funded providers are not remunerated. It is difficult to change the incentive driven structure of General Practice and other forms of private sector service provision, or the fact that GPs, for instance, are busy people and thus have very little flexibility.

Short of changing structures and attitudes, one way in which to change the behaviours of providers that operate within an incentive driven system is to provide greater incentive. In relation to mental health care for instance, the most recent published evaluation of the Better Outcomes in Mental Health Care initiative illustrates that the introduction of previously non-existent mental health care Medicare items increased the number of mental health care services provided by GPs (Fletcher et al. 2009). One reason for this may be that baseline levels of mental health care services provided by GPs are likely to be low. Other research on newly introduced Medicare enhanced primary health care items illustrates that the general uptake of these items has been low in the general community, and comparatively lower still for Indigenous Australians (Kelaher et al. 2005). As well as issues of cultural appropriateness, low levels of consumer and allied health provider awareness of the existence of, and entitlement to new enhanced primary care health items, have been cited for the low-uptake amongst Indigenous Australians in particular (Kelaher et al. 2005, Wilkinson et al. 2004, Wilkinson et al. 2002). However, the introduction of the Medicare Item 714 for initial refugee health assessment has increased the number of GPs offering this service (Johnson et al. 2008). A critical difference between this and other items is that there are established initial care referral pathways for newly arrived refugees, which means many are referred to GP services specifically for initial health assessment whether they know about the item or not. This means that unlike other enhanced primary care items, consumer awareness is generally not necessary to facilitate demand and the uptake of this item. Thus, in order to overcome barriers to interpreter use within General Practice and other Medicare funded services, the introduction of a Medicare item to remunerate providers for the additional time and labour required to conduct a service with interpreters should be considered by policy makers as a supply side strategy. However, in order to ensure demand side barriers to accessing this item are
overcome, resettlement and other services that come into contact with refugees in the first few months after their arrival in Australia, need to inform refugees of the existence of and their entitlement to an interpreter item.

Increased incentive may increase utilisation of interpreters but it is no guarantee that interpreters will be utilised effectively. As this research and others have highlighted, working with interpreters requires certain skills and understanding about how to frame questions, the role of the interpreter, in detecting cues that indicate that understanding has or has not been reached, and in detecting signs that a person is comfortable or uncomfortable with a particular interpreter. One lesson from the introduction of the Medicare item 714 for initial refugee health assessment was that incentive without appropriate training and skills development will increase the number of providers offering a service, but cannot act to ensure the quality of the service (Johnson et al. 2008). Thus the introduction of a Medicare item to remunerate providers for interpreter use should only be made available to providers on condition that they have undergone some training in interpreter use. This can be done via existing mechanisms for continuing professional development that exist in a number of the health professions such as Continuing Learning and Professional Development points in General Practice.

However, the need for training goes both ways. Several key informants in this research highlighted a number of reasons why interpreting in a mental health care context is different and requires particular skills of interpreters. Not only are mental health consultations sensitive, language rich and thus labour intensive for interpreters, but the words used to describe mental health issues in different languages may vary and thus interpreters need to recognise this. Despite the specific skills and understanding required for interpreting in a mental health context, interpreter training in South Australia does not have a specific component on translating in mental health contexts. Thus providers of interpreter training could improve this situation by incorporating this into their existing training courses or by providing specific additional courses on interpreting in mental health contexts.

7.7.7 Access

As has been established in Chapter Six, quality of care and access are linked, with dissatisfaction or the perception that one will be dissatisfied with care acting as a disincentive to access care. The most highly cited reason for underutilisation of services in Renzaho’s (2008) study of service provision to refugees and migrants, for instance, was culturally insensitive care. Neale et al.’s (2007) survey of health service utilisation amongst refugees
similarly found that quality of care issues are important determinants of access to care, finding that the most commonly cited barriers to access were those associated with communication and lack of availability of interpreters. Thus increasing the quality of services provided to refugees will also increase access. The findings of this research highlight a number of other measures that could be taken to decrease access barriers and facilitate utilisation.

Unfamiliarity with health services and the health system was cited as a major barrier to access in this research and is likewise cited by others (Renzaho 2008, Sheikh-Mohammed et al. 2006, Lamb & Smith 2002). Information provision was one approach to overcome this barrier. Many of the structured approaches to information provision, particularly within resettlement services, were found to occur within the ‘chaotic’ first six months after arrival, in which refugees are likely to be bombarded with new information of all kinds. During this period information about the health system may not be of the highest priority, and thus retention may not be high. Thus services need to consider not only how but when they provide information. This research suggests that information needs to be provided and reinforced at several stages throughout the resettlement.

The development of alternative ways of communicating information by the refugee specific primary health care service provides an important example of how information can be reinforced and provided at different times. As well as more traditional means such as group programmes, printed information, the refugee specific primary health service utilised the ethnic media, and particularly radio to provide information not only about the health system and their service but also about particular health issues, and health promotion. Having a programme on ethnic radio at a regular timeslot enables those refugees that tune-in to access health service information irrespective of how long they have been in Australia, and whether they have accessed a service in the past. The use of the ethnic media and particularly radio is also advocated by Sheik-Mohammed et al. (2006) who found that most of the refugees they surveyed had access to radio, reiterating the point that it is a potentially useful medium for the communication of health and health services information. However, they also found that many refugees were unaware of radio broadcasts in their own languages. This highlights the need to raise awareness of the availability of the ethnic media, which is a task with which service providers can assist. The exploration of other creative and community sanctioned approaches to providing ongoing information to as many members of the community as possible is likely to be beneficial.
Lessons from behaviour change theory and health promotion campaigns highlight that the provision of information alone is not necessarily enough to alter attitudes and behaviours, which have been found to be mediated by a number of contextual factors (Kreuter & Strecher 1996). In the context of improving refugees’ access to services by providing information, Chapter Six highlighted that there are many other contextual factors that determine access in addition to familiarity with services. These can include practical issues like transport, time and cost (Lamb & Smith 2002), in addition to cultural barriers like stigma in the case of help-seeking for mental health issues (Misra et al. 2006). This means that even if refugees are provided with information about a service and know where it is, they still may be unable to access it because they do not have a car or they are unfamiliar with public transport systems for instance or alternatively, have other issues of higher priority, with which to deal. Thus the findings of this research suggest that a comprehensive approach to addressing access barriers is required.

Outreach is likely to be an effective way of combating practical access barriers, particularly for socially isolated refugees. Outreach reverses the imperative for community members to go to a service by services coming to the homes of community members. As this research suggests, this may not only be an effective way of working with a proportion of refugees but may also be consistent with the help-seeking beliefs of more collectively oriented cultures, to which refugees may subscribe. With respect to outreach, if properly supported by management and given enough flexibility and resources, community health workers (CHWs) were shown in this research to be a potentially important group of workers who not only possess the capacity to undertake home-visiting but also the ability to mediate access to other services. A UK study of CHWs who visited refugee mothers in the postnatal period found that increasing the ability of refugees to access services was perceived to be one of the most important aspects of their role (Drennan & Joseph 2005). Like the CHWs in Drennan and Joseph’s (2005) study, Fowler (1998) describes how the CHWs at a comprehensive primary health care service in Canada assist refugees to access the appropriate services and community resources to “deal with the bureaucracy of daily life” (pg 390) in a new country. CHWs perform this ‘interlocker’ function by drawing upon their knowledge of health, welfare and resettlement services (Fowler 1998), forging linkages with other services (Farquhar et al. 2008) and by arranging and accompanying refugees to appointments (Drennan & Joseph 2005).

In the first instance, outreach is reliant on a service having an awareness of the need or desire
of an individual to access the service. The only way this can occur is if a service comes into contact with a person in need via referral. Referral in turn is reliant on the existence of smooth referral pathways within the system, and again reiterates the importance of the integration of services, which has already been discussed. However several further ‘bottom-up’ strategies can be adopted by services to increase information about their service and thus referrals from peers. As was evident in the activities of key informants in this research and as Lamb and Smith (2002) note, services can increase awareness of their service and information about how others can refer to the service by participating in networking events, seminars and by going out to other services and ‘spreading the word’.

In relation to overcoming cultural access barriers such as the stigma associated with mental health and mental health services this research has highlighted a need to work closely with communities in devising stigma reduction strategies and programmes, as in all areas of service development. Representatives from five migrant and refugee communities in Simich et al.’s study (2009) likewise suggested that greater community involvement in mental health promotion and service responses, and greater opportunities for community members to participate in forums geared at facilitating an exchange of ideas about mental health would be beneficial in this regard. By working in collaboration with communities, services can better understand what mental health means to the people they serve, what constitutes a mental health issue in their eyes, the prevailing attitudes towards mental health issues within these communities, and what strategies might be effective in working to overcome stigma and facilitate access.

7.8 Competing or complementary priorities
Over the course of this chapter, a number of strategies for improving health service provision to resettling refugees have been suggested. However, there are many areas of the health system that require improvement and development, which raises the question of where the findings and recommendations of this research fit amongst broader health system development priorities. The argument put forward here is that the task of increasing the capacity of the health system to addressing the needs of refugees is not at odds with broader health system development priorities but is in many ways complementary.

The 2000 WHO World Health Report established three major goals of any health system. Understandably, better health is the first and primary goal of any health system. The second goal of a health system is fairness of financial contribution, which is needed to protect people
from the potentially high costs of health care. In order to ensure dignity, responsiveness to people’s expectations with regard to non-health matters is the third goal outlined by the WHO. The measures for health system development offered here in relation to refugees reinforce these goals. However, the WHO articulation of health system objectives prescribe what should be and not always what, in many cases, is. Health systems are subject to national priorities and pressures. Again, the argument here is that health system development in relation to refugees is, in the case of Australia, complementary to these national pressures.

Most health systems continue to face issues of fairness and inequity of access amongst certain population sub-groups (Gwatkin et al. 2004). In Australia, Indigenous peoples in particular are one population sub-group that have not been well served by the health system in the past and continue to experience poorer health outcomes and barriers to accessing relevant and appropriate care. Others sub-groups that have been identified as experiencing inequity of access and health status include people with low SES, people residing in rural areas, refugees and minority groups. Thus, the inverse care law, which states that “the availability of good medical care tends to vary inversely with the need for it in the population served” (Hart 1971, pg 405) still rings true with respect to such populations (Gwatkin et al. 2004). Subsequently, to varying degrees and according to political and societal values, health systems and services within them place particular emphasis on increasing the accessibility, quality and relevance of care to such populations in order to increase fairness. Much of the unfairness in health status can be attributed to social determinants of health like education, employment, social support networks, and housing (Raphael 2006); the very issues that resettling refugees require assistance with upon arriving in a new country. Enhancing the structures and philosophies of health services and systems to fully embrace a holistic focus and enabling providers to address the social determinants of health, will thus not only benefit refugees but many population sub-groups that experience health-related inequalities. Similarly decreasing access barriers to care to refugees is also likely to increase access in populations, which face similar access issues.

Increasing the integration between and within levels of health care and with different social welfare sectors is not only likely to facilitate holistic care to refugees but to be of benefit to other population sub-groups with potentially multiple and complex needs. The potential benefits of greater integration and coordination of care have also been recognised in relation to the general population. The 2001 US National Institute of Medicine report Crossing the
Quality Chasm: A New Health System for the 21st Century reiterates this according to Grone and Garcia-Barbero (2001), who interpret the report as arguing that:

“...it is no longer possible to provide better health services on the basis of improving skills, clinical procedures and high-technology alone. In order to achieve a safe, effective, patient-centred, timely, efficient and equitable health system the consolidation and harmonization of its parts will yield much better benefits” (pg 5).

Health system planners and policy makers in western nations are grappling with how to respond to epidemiological and demographic transitions, which have seen a rise in chronic diseases as populations age, and a subsequently increased demand for acute care. Amidst already escalating costs in terms of health system financing and health expenditure per capita (Grone & Garcia-Barbero 2001), the burden of chronic disease and ageing populations and the overreliance on costly health technologies is expected to place increasing financing and resource pressures on health systems in the future (Battersby et al. 2005). Such health system pressures have amplified interest in models of integrated care (Grone & Garcia-Barbero 2001) as policy makers recognise that, not unlike the needs of resettling refugees, chronic conditions are complex, often requiring other forms of care beyond acute hospital care (Wagner et al. 1996). Furthermore, by better utilising existing services and resources, integration is also seen as a means of containing health system costs, which are not only subject to pressures associated with ageing populations but with broader global financial issues affecting Governments worldwide. Whilst the task of developing integrated care for chronic disease patients might be considered different to that of developing integrated care to newly arrived refugees, both are part of the broader pursuit of developing an integrated health system. Thus, there is great potential for the sharing of lessons and expertise to drive innovations in integrated care further.

The third goal outlined by the WHO (2000) – responsiveness to people’s expectations with regard to non-health matters – pertains particularly to elements of quality of care. Everyone should expect to be treated with dignity; likewise that they should be able to understand and be understood by their health provider. In multicultural and multilingual societies like Australia, which has a diverse range of Indigenous cultures and languages, and with 24% of its population born overseas, and 16% speaking a language other than English at home (ABS 2008), this is a particularly important consideration (NHHRC 2009). Increasing interpreter use and emphasis on culturally sensitive care is thus likely to benefit a large segment of the
population, including but not limited to refugees. Cultural sensitivity and its core elements of reflexive practice, client and community participation, and egalitarian relationships also provide a broader blue-print for the way in which services and systems should interact with individuals and communities regardless of their cultural background.

The collective pressures of dealing with and managing costs associated with the growing burden of chronic disease, and inadequacies in health system responses to disadvantaged groups among other factors have prompted recent calls for new ways of providing services and for health system reform in countries like Australia (NHHRC 2009), and the US (US Department of Health and Human Services 2009). Whilst England’s health reform programme has been underway since 2005 (Policy and Strategy Directorate, Department of Health, 2006), the push for health reform in Australia has only recently gained serious attention from the Government. In 2008 the Australian Government established the National Health and Hospitals Reform Commission (NHHRC), which conveyed a number of recommendations for consideration. For the most part these centred upon areas mentioned in this section of the discussion, and included:

- Improving access and equity
- Redesigning the health system to deal with emerging challenges such as chronic disease, with emphasis on integrated care
- Improving the governance of the health system to impart flexibility and encourage ongoing improvement (NHHRC 2009).

Given the parallels between recommendation provided in this thesis and overall health system priorities, improving service provision to refugees should be seen as part of such broader equity, quality improvement, and health reform agendas. It should not be seen as a niche pursuit of little relevance to broader health system development. Undoubtedly, health service managers and policy makers are forced to make decisions about health system development in a resource-limited environment. Those charged with making decisions about resource allocation however, should not do so with an either/or mindset. The argument here is that health system development in relation to refugees is likely to have broader benefits in the same way that overall health system development is likely to have benefits for refugees. This needs to be taken into account when evaluating the costs and benefits of service improvement measures and interventions. Similarly those that advocate for improvements in refugee health may increase their success by acknowledging this broader health system perspective.
7.9 Conclusion
This thesis explored the perceived fit between the mental health needs of resettling refugees and current health service responses in order to facilitate better responses and decision making. It has taken a broad health systems perspective, which has allowed for a number of new insights to be made.

Much of the research on health service provision to refugees to date has focused on specific aspects of the health system, whether it is a single service such as a refugee specific community health service, a single group of professionals such as GPs, or a level of care such as primary care. Whilst such research has yielded important insights it is also important to maintain a focus on the system in its entirety and on all of its constituent and interconnected parts. This research has attempted to do this by interviewing a diverse range of key informants. As a result several contributions to the literature have emerged.

Whilst there have been calls for individual services and areas of the health system to reorient in order to better assist refugees in rebuilding social worlds, this research extends this notion further. It highlights the need to increase entire health system capacity, in order to improve accessibility, quality and responsiveness of care, and thus, health outcomes amongst resettling refugees.

Where research focussing on one particular area of the health system may not, this research explicitly illuminated the high degree of influence areas of the health and social care system have on others. The impact of the resettlement sector on primary care, and vice versa, was one of a number of examples of this.

The health system perspective taken in this research afforded it a new vantage point in terms of identifying factors that determine capacity at service and systems levels. As a result a number of positive responses and areas requiring improvement were highlighted. Furthermore, this research has extended the knowledge base on how health services and systems can increase their capacity to respond to the needs of resettling refugees. Utilising the notions of ‘fairness’ and ‘decency’ and the dimensions that comprise it – relevance, quality and accessibility – this research provides a framework for health service and systems development. This is significant because there are few, if any, frameworks to guide and assist policy makers, service managers, and systems planners in the development of appropriate responses to resettling refugees.
This research also offers a novel approach to cultural sensitivity. Where many discussions of cultural sensitivity limit their focus to the individual patient-provider interaction, the approach of ‘becoming less expert’, articulated in this thesis, extends this by also including health service interactions and dialogue with communities.

The malleable assumptions made at the outset regarding the definition of a ‘health system’ also facilitated new discoveries. The many ways in which material, social and mental health needs were being addressed by members of ‘the Sudanese community’ themselves would have been missed had this research taken a more fixed definition of what a health system is. To the author’s knowledge, no studies have documented “the Sudanese way of counselling” as described in this research.

Similarly this is the first study that has documented service and system responses to addressing the mental health needs of Sudanese refugees specifically. That some of the issues the health system has in responding to new refugee groups, such as the Sudanese, are similar to those of earlier refugee groups underscores the need for improvement.

Several measures were taken to ensure that this research conforms to established qualitative research conventions, enhancing its rigour and trustworthiness. Thus this research has a number of strengths.

The use of triangulation ensures that all stakeholders have had an opportunity to express their views. This enhances the rigour of qualitative research because consistency and divergent themes can be clearly identified. The keeping of an audit trail enhanced transparency, reflexivity, and enabled a clear exposition of methods of data collection and analysis. Likewise the systematic nature of the Framework approach also promoted transparency and rigorous analysis. Analyst triangulation, whereby interpretations of the data were presented to supervisors, was also conducted in order to check whether interpretations could be followed and were supported by the selected quotes.

However there are areas where this research could be improved. Whilst analyst triangulation was used as a means of checking interpretations of data, participant validation of themes could also have been used. Key informants were invited to validate the accuracy and completeness of transcripts but not the validation of themes.
The research could have been extended by running focus groups where themes were presented to key stakeholders. Given the small refugee health sector within South Australia, and its politics, this would have made key informants identifiable to others. This was perceived by the researcher to constitute a barrier for participation, and thus was not pursued.

Respondent validation of themes whether via focus groups or individually, was also not considered appropriate given the diverse nature of the sample and the diversity of viewpoints within. As Horsburgh (2003) suggests, participants are likely to seek themselves and their own reality when checking data and themes. For instance a Sudanese key informant who does not work inside the health system may not be able to comment on the validity of the researcher’s interpretation about organisational factors that influence capacity. Similarly, a policy maker may not be able to comment on the validity of interpretations about the “Sudanese way of counselling” because this may also be outside of their own experience or awareness. It therefore seemed unhelpful and unrealistic to ask key informants to comment on experiences that they might not be aware of but that have nonetheless helped to inform overall themes. Given this, respondent validation of overall themes was not considered useful in this context. However, as part of the process of constant comparison of themes during data collection, and where appropriate, themes or new bits of information that arose out of interviews were put to other key informants during interviews for their elaboration and discussion. In this way there was an element of iterative validation of themes.

Whilst the sample was diverse, there was one notable perspective missing, which if present, could have strengthened the research further. There were no key informants from an important resettlement service. Although people from this service were invited to participate, none took up this opportunity.

Despite these limitations, this research provides an in-depth and unique perspective on the responsiveness of services and of health and social care systems to meeting the social, material and mental health needs of resettling refugees. Importantly it also provides a platform from which further research could build.

In relation to resettling refugees’ needs and the experience of forced migration, this research highlighted a number of areas which could be investigated further. The health effects of, and how resettling refugees cope with, the intersections between the global – events and stressors abroad, and the need to maintain family and community connections abroad – and the local
requires further study. This research identified the use of information communication technologies as ways of maintaining connections. The novel use of these technologies, as was evident in the participation in internet discussion boards requires further exploration. In particular, there is a need to explore how services could assist or programs could be developed in order to assist resettling refugees in coping with living in ‘old’ and ‘new’ social worlds simultaneously. Action research would be helpful in this regard.

The highlighted possible connection between residential mobility and access to services, community supports, and wellbeing requires further study. Such research would have significant implications for resettlement and housing policy, as well as for considering ways in which to improve access to care.

More needs to be understood about community strategies for addressing and coping with mental health issues. Utilisation rates of “the Sudanese way of counselling” for instance, are unknown. The question of which particular groups within communities utilise such approaches, and the question of why they do so, could be illuminated further by both quantitative and qualitative research. In-depth ethnographic research would also be useful in further understanding how and why such approaches are conducted and utilised. This research thus provides opportunities for further exploration of how communities can be supported in order to continue playing a valuable role in addressing mental health issues.

In terms of health services and systems, this research also provides several areas requiring further investigation.

There is a need for empirical research to clarify issues flagged in this thesis related to emergency services utilisation for common and minor health issues. In particular the influence of referral pathways, primary care access barriers and quality issues on emergency service utilisation requires further study. For instance, the hypothesis posed by some key informants in this research that the direct referral of newly arrived resettling refugees from the IHSS provider to private general practice was resulting in an increase in emergency services use for minor health issues needs testing. In a study of hospital utilisation amongst refugees in Victoria Correa-Velez et al. (2007) found that emergency admissions were higher amongst those born in refugee source countries than for those born in Australia. However, they did not give any indication of whether refugees presented with issues that could have been addressed by GP services. This limits the ability to draw conclusions about any possible relationship
between emergency department utilisation and the accessibility and quality of GP care. A longitudinal study of health and resettlement services utilisation by newly arrived resettling refugees would be helpful in clarifying this issue, as well as providing further data as to how, why and where access has and has not ensued. It would thus provide further insights about the relationships between resettlement services and policy and health service access patterns.

Some isolated examples of psychosis and mandatory detainment of resettling Sudanese refugees were given by key informants in this research. However, this study could not ascertain the prevalence of psychosis, mandatory detainment, and psychiatric care utilisation amongst groups of resettling refugees. Thus, further research is required in order to clarify this.

This research focussed on the health service and system responses to Sudanese refugees. It was also focussed on services in urban areas. However, the composition of the humanitarian intake in Australia and other nations are constantly changing, with new groups of refugees being resettled in line with the global humanitarian situation (and national priorities). Furthermore, there has been some rural and regional settlement of refugees in Australia, and policies of dispersal seem attractive to the Governments of some resettlement nations. Further research could explore health service responses to new refugee groups and/or explore how health services in rural/regional areas respond to the needs of resettling refugees. A comparative study design could be helpful in this regard, as this would explicitly highlight how much or little systems have improved with the resettlement of successive refugee groups over time. Such a design could also be beneficial in comparing the capacity of rural and urban services with respect to refugees.

The role and effects of policy in increasing health system capacity in relation to refugees is unclear. To the author’s knowledge, few evaluations of State policies within Australia have been conducted. Thus there is a need to explore exactly what effects policy has in the realm of increasing health system capacity with respect to refugees. There is also a need to address the question of what the elements of good policy are. As well as drawing upon research like this present study, interstate and international comparisons of refugee health and resettlement policy would be useful. Such research would identify elements of policy that work in particular contexts and enable decision makers to reflect on the appropriateness of such elements in different contexts.
Comparative international research on how health systems respond to refugees, whether it is through policy or otherwise, is increasingly important. This is because of the emergence of a number of new ‘third countries of resettlement’ whose health systems have less experience in responding to the needs of refugees. Health system and service managers in these countries may be looking to the examples and lessons of more established resettlement countries.

Systematic and ongoing evaluation of services, programmes, and policies is needed generally. The content, implementation, and success of programmes, policy and responses are likely to differ according to the unique characteristics of local contexts. Thus, the adoption of any of the recommendations from this research needs to be evaluated. This could be the task of further research.

In addition to highlighting a number of areas for further investigation, this research extends health service and systems development theory further. Importantly, this has been accompanied by the development of strategies and recommendations for improving capacity with respect to resettling refugees. As is evident in Appendix J, dissemination of these findings is underway and ongoing. These recommendations will hopefully assist providers, health service managers, and policy makers charged with making decisions about the direction of services and systems.
References


Fuller J. (2002). *Implementing Cross-Cultural Practice in Health Care*. Faculty of Health Sciences, Flinders University (PHD thesis).


Appendices

Appendix A: Information sheet
Appendix B: Ethical clearance letter
Appendix C: Letter of invitation
Appendix D: Consent form
Appendix E: Post-mortem of practice interview 1/2/08
Appendix F: Interview schedules
Appendix G: Audit trail entry (about richest data coming through less reliance on interview schedules)
Appendix H: Indexed transcript in relation to research question one
Appendix I: Chart of a sub-theme in relation to research question one
Appendix J: Dissemination of findings
Health service provision to Sudanese refugees in South Australia: a qualitative study

Information for consent by research participants

Purpose of the Study
Sudanese refugees have been resettling in South Australia in increasing numbers over the past decade as a result of conflict in Sudan and are likely to have unique health needs as a result of their experiences before, during and after migration. Given the role that health services may play in meeting the needs of refugees, this study aims to provide an understanding of the health needs of Sudanese refugees and particularly in relation to mental health, current methods of service delivery to refugees and any gaps or issues. It is hoped that this study will contribute to the development of refugee health policy, practice and appropriate health service delivery models. In order to explore these issues, interviews will be conducted with health service managers, health providers, and with Sudanese refugee representatives.

The Role of Participants
As someone who may be able to contribute to our understanding of this important issue, we would greatly appreciate your help in conducting this study. If you agree to participate, an interview will be conducted with you in a location and at a time that suits you. The interviews will take about an hour. The interviewer is Michael Savic, a PhD student from the University of Adelaide’s Discipline of Public Health and the Discipline of Psychiatry. Michael is supervised by Dr Afzal Mahmood and Associate-Professor Anna Chur-Hansen from the University of Adelaide.

Before the interview, we will ask for your written consent for participation in the research. As part of this written consent we will ask for your permission to tape record the interview and for your permission to be recontacted. During the interview you will be invited to express your opinions, experiences and understandings of the health needs and health care to Sudanese refugees in Australia. We would also be most interested to hear your suggestions for the improvement of health care to refugees. As a tool for further discussion, we may share with you our preliminary analysis and recommendations if you agree to be recontacted. You will then be invited to provide feedback on the analysis and recommendations.

Whilst it must be acknowledged that this research may not have direct benefits to you, the knowledge gained may have potential benefits for those involved in the planning, and provision of health care to refugees and Sudanese refugees themselves.

Confidentiality
The University of Adelaide Human Research Ethics Committee has approved the study. We respect your privacy, and will keep all personal information confidential. There will also be no disclosure of your personal details in any research report, thesis or articles.

Your right to withdraw
We would also like to stress that your participation is voluntary. You have the right to refuse any questions and you may withdraw from interviews at any stage during or after the interview and your decision will be respected. Please refer to the attached “Contacts for Information Form” if you would like to speak to someone regarding this research.
The Human Research Ethics Committee is obliged to monitor approved research projects. In conjunction with other forms of monitoring it is necessary to provide an independent and confidential reporting mechanism to assure quality assurance of the institutional ethics committee system. This is done by providing research participants with an additional avenue for raising concerns regarding the conduct of any research in which they are involved.

The following study has been reviewed and approved by the University of Adelaide Human Research Ethics Committee:

**Project title:**

**Health service provision to Sudanese refugees in South Australia: a qualitative study**

1. If you have questions or problems associated with the practical aspects of your participation in the project, or wish to raise a concern or complaint about the project, then you should consult the project coordinator:

   **Name:** Dr Afzal Mahmood  
   Senior Lecturer, Discipline of Public Health, University of Adelaide.  
   Tel: 8303 3586  
   Email: afzal.mahmood@adelaide.edu.au

   **Associate Professor Anna Chur-Hansen**  
   Discipline of Psychiatry  
   University of Adelaide.  
   Tel: 8222 5785 or 8222 5141  
   Email: anna.churhansen@adelaide.edu.au

   **Mr. Michael Savic**  
   PhD Candidate,  
   Discipline of Public Health and the Discipline of Psychiatry, University of Adelaide.  
   Tel: 8303 6875  
   Email: michael.savic@adelaide.edu.au

2. If you wish to discuss with an independent person matters related to

   - making a complaint,
   - or raising concerns on the conduct of the project, or
   - the University policy on research involving human participants, or
   - your rights as a participant

   You may contact the University of Adelaide, Human Research Ethics Committee’s Secretary on phone 0061-8-8303 6028 or at the email address sabine.schreiber@adelaide.edu.au
Appendix B: Ethical clearance letter
1 November 2007

Dr MA Mahmood
Discipline of Public Health

Dear Dr Mahmood

PROJECT NO: H-136-2007

Health service provision to Sudanese refugees in South Australia: a qualitative study

I write to advise you that I have approved the above project on behalf of the the Human Research Ethics Committee. Please refer to the enclosed endorsement sheet for further details and conditions that may be applicable to this approval.

Approval is current for one year. The expiry date for this project is: 31 October 2008.

Where possible, participants taking part in the study should be given a copy of the Information Sheet and the signed Consent Form to retain.

Please note that any changes to the project which might affect its continued ethical acceptability will invalidate the project’s approval. In such cases an amended protocol must be submitted to the Committee for further approval. It is a condition of approval that you immediately report anything which might warrant review of ethical approval including (a) serious or unexpected adverse effects on participants (b) proposed changes in the protocol; and (c) unforeseen events that might affect continued ethical acceptability of the project. It is also a condition of approval that you inform the Committee, giving reasons, if the project is discontinued before the expected date of completion.

A reporting form is available from the Committee’s website. This may be used to renew ethical approval or report on project status including completion.

Yours sincerely,

[Signature]

Professor Garrett Cullity
Convenor
Human Research Ethics Committee
Applicant: Dr MA Mahmood

Department: Discipline of Public Health

Project Title: Health service provision to Sudanese refugees in South Australia: a qualitative study

THE UNIVERSITY OF ADELAIDE HUMAN RESEARCH ETHICS COMMITTEE

Project No: H-136-2007

APPROVED for the period until: 31 October 2008

It is noted that this study will be conducted by Michael Savic, PhD candidate.

Refer also to the accompanying letter setting out requirements applying to approval.

[Name] [Date 31 OCT 2007]

Professor Garrett Cullity
Convener
Human Research Ethics Committee

Page 1 of 1
Appendix C: Letter of invitation
9 December 2008

Your invitation to participate in a research study about the health service provision to Sudanese refugees,

My name is Michael Savic, and I am a PhD student in the Discipline of Public Health and the Discipline of Psychiatry at the University of Adelaide. As part of my PhD I am conducting a research project entitled “Health service provision to Sudanese refugees in South Australia: a qualitative study”.

I will be conducting a number of interviews with different stakeholders including those involved in the planning and provision of care or services to Sudanese refugees, and with Sudanese refugee representatives. I am interested in understandings of the health needs of refugees and particularly in relation to mental health, current methods of service delivery, and any gaps or associated issues.

I would like to invite you to participate in this research. Participation would involve having an interview conducted with you at a time and place of convenience to you. It is expected that interviews will last for about one hour.

You will find an information sheet attached that provides further information about the project and the interviews.

If you would like to participate in this research or have any questions relating to the project then you can contact me by email on michael.savic@adelaide.edu.au or by telephone on 8303-6875. Alternatively you can contact Associate Professor Anna Chur-Hansen, who is one of my supervisors from the Discipline of Psychiatry. Her email address is anna.churhansen@adelaide.edu.au and her work phone number is 8222-5785.

Please consider supporting this project by giving your time and insights. I look forward to hearing from you!

Yours Sincerely

Mr. Michael Savic
PhD candidate, Discipline of Public Health & Discipline of Psychiatry,
University of Adelaide.
Appendix D: Consent form
THE UNIVERSITY OF ADELAIDE HUMAN RESEARCH ETHICS COMMITTEE

STANDARD CONSENT FORM
FOR PEOPLE WHO ARE PARTICIPANTS IN A RESEARCH PROJECT

1. I, ................................................................. (please print name)

consent to take part in the research project entitled: Health service provision to Sudanese refugees in South Australia: a qualitative study.

2. I acknowledge that I have read the attached Information Sheet.

3. I have had the project, so far as it affects me, fully explained to my satisfaction by the research worker. My consent is given freely.

4. Although I understand that the purpose of this research project is to improve the quality of medical care, it has also been explained that my involvement may not be of any benefit to me.

5. I have been given the opportunity to have a member of my family or a friend present while the project was explained to me.

6. I have been informed that, while information gained during the study may be published, I will not be identified and my personal results will not be divulged.

7. I understand that I am free to withdraw from the project at any time and that this will not affect medical advice in the management of my health, now or in the future.

8. I am aware that I should retain a copy of this Consent Form, when completed, and the attached Information Sheet.

9. I give my permission for the interview to be tape recorded (tick the box):

YES ☐ or NO ☐

10. I agree to be recontacted in order to supply my feedback on the analyses and recommendations (tick the box):

YES ☐ or NO ☐

................................................................. (signature) ................................................................. (date)

WITNESS

I have described to ................................................................. (name of participant)

the nature of the research to be carried out. In my opinion she/he understood the explanation.

Status in Project: .................................................................

Name: .................................................................

................................................................. (signature) ................................................................. (date)

secretariat@humanconsent.ado
Appendix E: Post-mortem of practice interview 1/2/08
Practice interview post-mortem – 1/2/08

I would say the interview went reasonably well. It lasted about 30 mins, which may be a reflection of my inability to probe deeper on certain points. In concordance with this, I feel that the interview was perhaps too structured as difficulties in probing resulted in an over reliance on my interview schedule. This point was noted by both Anna and participant who commented that there were several missed opportunities for me to probe/follow up the last point that the participant had said. Some suggestions by Anna to rectify this included:

- Asking for examples, as these can illuminate what a participant means when they provider a general or vague response.
- Asking for clarification (i.e. What do you mean by…? What do you understand by the term…? etc.).

Anna noted that all of the questions I asked were open-ended however as the participant noted, I had a tendency to stutter and my questioning wasn’t always clear. The participant commented that I covered all of the things that he thought were important to cover, however upon further reflection I feel that it was not sufficient to contribute to answering all of my research questions. For example, one of my research questions is:

“How do the views and understandings of health service key informants and Sudanese refugees compare with regard to the health needs of Sudanese refugees, meeting those health needs and appropriate service delivery responses?”

However I did not ask any questions that would facilitate a deeper level of comparison. For example I might have asked something like “What is your understanding of the factors that affect the mental health of Sudanese refugees” (i.e. personal level of understanding) but did not ask “How do you think Sudanese Refugees perceive mental health?” (i.e. What do health providers think that Sudanese refugees think/want/need? etc.). These sorts of questions are of great importance when it comes to comparison of perceived needs. In any case the moral of the story is to ensure that I ask questions and collect data that will help me to answer my research questions. Some ways of doing this, as suggested by Anna, may be to:

- When beginning the interview, explicitly state the areas that I’d like to cover. i.e. “I’m really interested to hear your stories/experiences/opinions about providing care to Sudanese refugees. In particular I’d like to talk about: your understandings of the needs of Sudanese refugees, and how you think they view them, how the needs of Sudanese refugees are met and by whom, any issues associated with service provision, and how well the health system addresses the needs of refugees in general.”
- Modify interview schedule with research questions in mind.
- When ending the interview, I could summarize the areas that have been covered as a means of making mental notes about what I still need to cover.

Some other general comments

- Don’t scribble on page, look at participant.
- Put pen down and instead of preoccupying myself with writing, I should listen more intently.
- I should be careful not to start chatting with the participant about matters relevant to the research when the tape has been turned off.
Appendix F: Interview schedules used

Examples include schedules used with a:

- Sudanese key informant
- Health service provider key informant
- Policy maker key informant
Interview Schedule – Sudanese key informant (18/2/09)

Background

Before we begin talking about health needs and health care, I’d like to start by asking you a bit about your migration story, what you are doing now & your role in the community?

- Why did you leave Sudan?
- What were your expectations and feelings about life in Australia before you came to Australia? What was life like when you arrived in Australia?

Research questions 1 and 2: Needs and how needs are met

In your opinion what are some of the greatest needs that people within the Sudanese community have? What’s your understanding of what life has been like after settling in Australia for you or other members of the Sudanese community?

- What have been some of the difficulties for Sudanese refugees after settling in Australia that you are aware of? (Job, employment, housing, language difficulties, homesickness/social isolation, cultural differences, unfamiliarity with Aust system etc.) How have these affected people’s wellbeing?
- What sorts of things do you think have been helpful for Sudanese refugees in coping with or overcoming some of these barriers/difficulties? (time, support, Sudanese community, spirituality, culture etc.)
- How would you rate the reception of the Australian community towards the Sudanese? (i.e. media, racism, welcoming) What affect do you think this has?
- What affect do you think possibly being separated from family members who may be back in Africa, has on Sudanese refugees here? (i.e. remittances, worry etc.)
- In your opinion, what has been the effect of migration on Sudanese culture, family structures and gender roles?
- Are there any groups within the community that have higher needs than others? (i.e. adolescents, men, women, education level, pre-migration experiences etc.) Why do you think this is? What are the challenges that Sudanese young people are likely to face?
- How important is maintaining a sense of Sudanese identity and community?
What affect do you think time has on needs? How do the issues change the longer people have been in Australia?

Many people have talked about the Sudanese community and members of the community as being strong & supportive; could you explain why there is such strength in the community?

What affect has the increasing size of the community had on supporting people, providing information, community togetherness & solidarity?

Mental Health: A lot has been written about refugees and mental health, do you think ‘mental health’ is an issue for the Sudanese here in SA any more than it would be for any other community? Why/why not?

- How do you think Sudanese understandings of mental health compare with western understandings?
- Are there words for things like ‘mental health’, ‘depression’, ‘trauma’ in Sudanese languages? If not what other words would be used? (i.e. interpreting)
- What do you see as causing some of the mental health issues for some Sudanese refugees? (pre-migration trauma, post-migration difficulties, worry about family)
- How would someone with a mental health issue be viewed within the Sudanese community? (stigma)
- How are things like sadness, loss, social isolation, and grief dealt with within the Sudanese community here in Adelaide? Do Sudanese people here view individual counselling or other western treatments as culturally appropriate ways of dealing with mental health issues? Why/why not?
- What role do elders play in supporting people within the community who are in need?
- Are you aware of any occasions where Sudanese people have been detained under the Mental Health Act or required psychiatric care for severe mental illness? Could you tell me more about those cases?

Access: What do you think are some of the barriers for Sudanese refugees in seeking help or accessing services for a mental health issue? (stigma, transport, knowledge)
Do you think many Sudanese would go to a formal health service to seek help for a mental health issue? Why/why not?

Do you think Sudanese here in Australia would be aware of some of the formal health services available to help them? Why/why not?

Research question 3: Issues associated with service provision

What’s your understanding of how well equipped health providers and services are in meeting the needs of Sudanese refugees?

- **Satisfaction with care**: Do you think some services are doing better than others in terms of being responsive to the needs of Sudanese refugees? Why/why not?

- **Primary health care**: What’s your understanding of the level of satisfaction within the Sudanese community with GPs? Are there any barriers to access? Are you aware of any members of the Sudanese community who access emergency department care instead of going to a GP?

- **Cultural sensitivity**: There is a lot of talk about health providers being culturally sensitive or culturally appropriate. What are the sorts of things do you think health providers need to be aware of if they are providing services to Sudanese refugees? In your experience or from what you’ve heard has this been the case?

- **Interpreters**: Are you aware of many circumstances in which interpreters were not used within the health system when there was a need to use them? GPs? What’s your opinion on how helpful interpreters are? What should health service providers take into account when matching an interpreter to a Sudanese client?

- **Information**: In your opinion are members of the Sudanese community given enough information about the health system and about diseases and mental health? Why/why not? How should information be delivered?

- **Planning of services**: Do you think services understand exactly what Sudanese refugees want and need? How could they understand better?

- **Consultation**: Have you or other members of the community been consulted by health services to provide expertise about what the community needs and how services could respond? Why/why not? What
opportunities exist for someone who is not a leader or elder within the community to have a say about health services & the health system?

- Access: What are the barriers to accessing care for some Sudanese people?

**Research questions 2 and 5: gaps in service provision and improvement**

Are there any gaps in the health system where needs of members of the Sudanese community are not being met that you think needs to be looked at?

Do you think health service provision to Sudanese refugees needs to be improved? Why?

Do you have any ideas or suggestions about how this could be done?

How could mental health services, in particular, change so that they are better able to address the needs of members of the Sudanese community?

**Conclusion**

Thanks, we’ve covered a great deal of ground today and you’ve given me some wonderful insights.

Before we finish is there anything else that we haven’t talked about that you would like to add?

Whilst you think about that, if it’s OK, I’ll just take a moment to check that I’ve covered everything that I needed to cover.
Interview schedule – Health service provider (13/8/2008)

I’m really interested to hear your stories/experiences/opinions about planning or providing care to Sudanese refugees.

There are a few broad areas that I’d like to cover in this interview including:

- the needs of Sudanese refugees & mental health in particular.
- how the needs of Sudanese refugees are met and by whom,
- any issues associated with service provision,
- and how well the health system addresses the needs of refugees in general.

Research questions 1, 2 and 3: Needs and how needs are met

I’d like to start by asking about the needs of Sudanese refugees in general.

So, what is your understanding of some of the issues faced by Sudanese refugees in Australia? Are there any groups in the community with particular needs?

- How do you think some of these issues affect mental health in particular? What is your understanding of the causes of these health issues? (Pre-migration + Post-migration experiences) How do you think your understanding compares with those of refugees?
- How do the issues faced by Sudanese refugees compare to other refugee clients that you may have worked with or planned services for (similarities or differences)?
- How do the issues faced by Sudanese refugees change as the time they’ve been in Australia increases? What affect does this have on health care?

Now if I can get you to think specifically about the services you provide at the health service where you work, what are some of the issues that Sudanese refugees that you’ve seen present with? (Examples)
How do you address these? What approach to treatment do you take? (education, counselling, therapies, medication etc). Under what circumstances would you use medication?

Clinical interaction
How do you approach consultations with Sudanese refugee clients as compared to the approach you may take with other clients, if in fact the approach does differ?

- **Challenges:** What are the challenges involved, if any, of providing services to Sudanese refugees? What are some of the factors that impact on the quality of the consultation? How have you overcome any challenges? (Time, Trust/rapport, appointments etc.) Use of Medicare item no’s for mental health

- **Cultural sensitivity:** In your experience, how do cultural and language differences affect the consultation? What do you understand by the term cultural sensitivity? How do you become culturally sensitive? Example of cultural sensitivity in practice?

- **Explanatory models:** How do you think Sudanese Refugees perceive mental health? How do you think people with a mental illness are viewed within the Sudanese community? What has informed your understanding of Sudanese culture and explanatory models? How does this differ from a western understanding of health and illness?

- **Language barriers:** What is your experience of communication with refugees? What strategies have you used to overcome any difficulties? What influences the quality of communication?

- **Interpreters:** What is your experience of working with interpreters? How does it affect the services or programs you provide? How do you match interpreters with clients? What is your perception of how Sudanese refugees feel about using interpreters?

- **Emotional impact:** What is the emotional impact of working with refugees on you? How do you cope with maybe hearing distressing stories?
Help seeking and Access
We’ve talked about what happens when Sudanese refugees access the service where you work but how do they come to be there?

- What are the barriers to seeking help for a mental health problem or accessing care for Sudanese refugees? (Transport, mental health literacy, stigma, knowledge of service etc.)

Health Service/Organization
How has your organization/health service attempted to address or respond to the needs of Sudanese refugees?

- **Services provided:** How has your service decided what programs to provide? In it’s planning, how does your service know what the needs of Sudanese refugees are? Consultation?
- **Sessional therapists:** What role do sessional therapists play in service delivery at your service? How important are they?
- **Inter-organizational links:** How would you characterize the nature of the relationships between different services that are concerned with refugee health and resettlement in South Australia? How important are inter-organizational links in ensuring that needs are met?
- **Referrals:** How do the Sudanese refugees that utilize your programs come to access the service where you work? How do they hear about the service/programs? How do refugees move throughout the service? (could you provide some examples) What is the nature of referral pathways to and from your service and within the health system more generally? Under what circumstances would you refer a client out of the service? What impacts upon when & where refugees are referred to?
- **GPs role:** What are your thoughts about how well equipped GPs in private practice are in meeting the mental health needs of Sudanese refugees? What might be some of the challenges for them in meeting the needs of refugees in a general practice setting? (use of interpreters in general practice)
Private Psychiatrist’s role: What role do private psychiatrists play in meeting the needs of refugees? Are you aware of any private psychiatrists who provide mental health care to refugees? Why do you think that is? How could private psychiatrists be encouraged to take on a greater role in terms of refugee mental health, if in fact you feel they need to?

Research questions 2 and 5: Health system
How well do you think the health system in South Australia at large is addressing the needs of refugees?

- How smoothly do refugees move throughout the health and resettlement system? (Could you identify any bumps or potholes)
- What areas need the most attention? What do we need to work on the most? What are the major problems?

How do you think health service provision to refugees could be improved, if it needs to be improved at all?

- Ideas and Suggestions: What would you like to see done, if anything? What could be done to improve it? Why, in your opinion hasn’t this been done?
- Policy: What potential role do you think policy might play considering that we don’t currently have any refugee health policy in SA?

What might be some foreseeable barriers to the implementation of your suggestions?

Conclusion
Thanks, we’ve covered a great deal of ground today and I’ve got some wonderful insights!

Before, we finish is there anything else that we haven’t talked about that you would like to add?
While you’re thinking about that, would it be OK if I quickly double check to make sure I’ve covered everything.
Interview Schedule – Policy maker key informant (24/10/2008)

By way of introduction, I was just wondering whether you could tell me about your role in refugee health policy.

Needs
What’s your understanding of some of the health needs that refugees, like those from Sudan are likely to have?

Health system
How well do you think the health system in South Australia at large is addressing the needs of refugees that you just mentioned? Why?

- What are some of the things that we are doing well and what are some of the things that we are not doing so well?
  - Interpreters: What is the situation in relation to free interpreter access (i.e. TIS)?
  - Initial Health Care – direct referral to GPs; what impact does this have on access and outcomes?
  - What role do you see for private GPs and community health care in the health service provision to refugees?
  - Ongoing health care – doesn’t seem to be much emphasis on.
  - Mental health care (access to)
  - Consultation and refugee participation in influencing the system to better meet their needs.
  - Access to quality health and health system information.

- How smoothly do refugees move throughout the health and resettlement system? (Could you identify any bumps or potholes)

- Inter-organizational links: How would you characterize the nature of the relationships between different services that are concerned with refugee health and resettlement in South Australia?
Government

- What has been the response of the State government, and the Department of Health specifically, in relation to addressing the health needs of refugees? What has been the Federal Government’s response to the health needs of refugees?

- *Inter*-departmental collaboration: How would you characterize the nature of the relationships between different Federal and State Government departments who through their policies have an impact upon the health and wellbeing of refugees? (i.e. immigration, education, families and communities etc.)

How do you think health service provision to refugees could be improved, if it needs to be improved at all?

- *Ideas and Suggestions:* What would you like to see done, if anything? Why, in your opinion hasn’t this been done?

Policy

What potential role do you think policy might play in SA in relation to refugee health?

What would you consider to be the key policy issues in relation to refugee health in SA?

Why do you think SA doesn’t have a refugee health policy currently yet some other states like Victoria and NSW do?

Why do we need a refugee health policy? What would it look like? What would it achieve?

Refugees are likely to have multiple needs stemming across many
government departments, how would a health policy deal with this?

Conclusion
Thanks, we’ve covered a great deal of ground today and I’ve got some wonderful insights!

Before, we finish is there anything else that we haven’t talked about that you would like to add?

While you’re thinking about that, would it be OK if I quickly double check to make sure I’ve covered everything.
Appendix G: Audit trail entry
Audit Trail Entry – Interview 12 (13 Aug 2008)

Logistics
When:
Wednesday 13 August at 3pm.

Where:
In the consulting rooms at one of the health services where this participant works.

Who:
A female health service informant who is a GP and works at health service B.

How long:
1 hour and 25 minutes.

Interview Technique
Felt that the interview went quite well. For the most part I was able to allow the interview to roll in a relatively semi-structured fashion. That is to say that I was able to allow the interview to take the direction that the participant was taking the interview, so I didn't make too much use of my interview schedule, although there were a few times when I looked down at it for support. This made for a relaxed conversation, but also allowed me to access some really important insights. The participant was very willing to talk at length when prompted so that also enhanced the interview.

Content
From the outset the participant made it clear that she could only comment on Sudanese women as she works primarily with refugee women, although I believe there were some broader lessons. However seeing as Sudanese women have been identified by other participants as a group within the Sudanese community that has particular or high needs, the information gained was thus an in-depth exploration of these issues, which I think expanded and elaborated upon some of the things other participants had been saying about Sudanese women.

The participant talked about the very practical needs that Sudanese refugees have such as the need for a proper orientation to the health system, transport, social support and employment. The participant elaborated upon how these affected mental health. One issue that this participant saw as quite instrumental in determining the mental health of Sudanese refugees was the separation of families as a result of migration. The participant talked about one particular case where a Sudanese woman was extremely depressed and socially isolated because her husband was still in Sudan whilst she was here. The way this was dealt with by the health provider was to try and facilitate the process of family reunion by helping the Sudanese woman to apply for a visa for her husband. After this process began to happen it gave the Sudanese woman hope and according to the participant, she started feeling a lot better as a result. So this example really illustrates the need to address the practical issues that are affecting the lives of Sudanese; I don't think medication, or other psychological therapies would have alleviated the pain of this woman as much as dealing with the root cause of the problem - the fact that her husband was in Sudan whilst she was her by herself. Again this issue of separation may be yet another example of the global-local nexus; the impact of global events and people somewhere in the globe on the emotional wellbeing of refugees locally.

The participant really emphasized the strength of the Sudanese community and it's healing properties in terms of combating social isolation, information and sharing stories. She
suggested that linking in with the community is an important strategy in terms of combating mental health issues. Allowing the refugee client to tell their story was an important approach used by the participant, and also suggested that the building of a relationship with a refugee client is incredibly therapeutic.

There were some interesting and some novel things about the health service provision to refugees as well that the participant talked about. For example she talked about the importance of linking in with mental health services and psychiatrists to get advice about addressing mental health issues in a GP setting. She in fact said she used one of the new mental health Medicare item numbers, whereby she was able to have access to information from a psychiatrist. Need to learn a bit more about these Medicare item numbers and follow up on these with some other participants.

Participant also said that there are very few refugees being seen by private sector psychiatrists, whom no one else has really talked about but I guess I had a feeling that this was the case anyway.

The participant also talked about the ability of the private GPs to address the mental health issues of refugees suggesting that it would be very difficult for GPs to do this because of time constraints (i.e. mental health consultations generally take quite a while) and also counselling skill deficits. The participant also reinforced other participant’s suggestions that some GPs in private practice don't use interpreters, suggesting that many of the refugee clients that she had seen, who had their screening done by private GPs had not used an interpreter. It was felt that the time to organize interpreters may take a long time. Extending on the issue of GP capacity to meet the needs of refugees, the participant suggested that many of the refugees she had seen who had previously been to a GP had very little idea about the kinds of tests or treatments that they had been given by a GP, and some did not even know who their GP was, making it difficult to obtain this kind of medical information. This raises the issue of how involved are refugees in the care they receive; is it a partnership, or is it paternalistic - something to follow up on.

Follow up on...
- Use of mental health Medicare item numbers by GPs
- Linking up and sharing of expertise, particularly between specialist mental health services and GPs
- Use of interpreters by private GPs
- Ability of GPs to provide mental health care to refugees
- Involvement of refugees in their care, and how much they understand about what is happening to them.
- Impact of separation on Sudanese refugees
- Sudanese community and its importance to Sudanese refugees.

Other comments
When asked, the participant requested that I send her a copy of the transcript via email. I said this would be fine, although it may take a little while. She said that she would have a look at it and phone me or let me know if there is anything she forgot to say but would like to add. When I email the transcript back leave room on the transcript under the question “Is there anything more you would like to add?”, in which the participant can write down anything she missed or would like to add. I must also be sure to ask if it’s ok for this information to be analysed.
Appendix H: Excerpt of an indexed transcript in relation to Research Question One
being destroyed so that has made them leave their familiar surroundings and then flee. And then the flight itself has been severely traumatic for many people; they have to go into camps and live in conditions of severe deprivation, and in the journey they lose their friends or relations, a lot of hardships, crossing borders, going through different countries, and traumatic experiences there – whole journey itself and then the application process. Then the migration itself starting from the application to arrival and so that can be also a form of severe stress. A lot of them feel traumatized because many of them have been holding responsible positions in high and so there is a lot of stigma and the way they are treated by authorities even here in Australia some of them were detained when they came so the detention process itself is probably more stressful than what they've undergone before – very often it negates all the trauma and detachment itself has been quite traumatic for quite a number of people. And then the post-migratory phase after they come into Australia problems with resettlement and economic issues and housing visa application dealing with immigration and don't even, schooling of their children and dealing with the post trauma language problem and employment. So there’s a whole host of problems starting from pre-migration, migration, and post-migration.

1. And you mentioned trauma, what's your understanding of how Substance refugees for example view that? Does it have currency for them? (4:50)

P. Well it's a medical term. When we say trauma, the word trauma but behind the term is that they undergo an experience or experiences that are life threatening and out of the ordinary and beyond the normal person's coping skills; something that makes a severe impact on them. I mean I'm not restricting myself to the narrow medical definition of post-traumatic, or traumatic, or what happens in trauma but the whole experience of being uprooted and being separated from family and then all that is traumatic in that sense. If you want you can use another term so I'm just using the word trauma to describe this whole experience but that's what drives them so they feel insecure and threatened and feel that continuing to live or stay in that situation that they were is no longer possible. I would think that the majority of the people that I see anyway wouldn't have left unless they underwent this experience or they were in this situation. There are other migrants who come for economic reasons or for a job, employment but the ones that I see are people who have been compelled to leave their home so there's an element of uprooting also part of the trauma. There's an uprooting from familiar neighborhood relationships and that context they were in suddenly changes to a completely new so that's also part of the trauma.
Appendix I: Chart of a sub-theme in relation to Research Question One
So their mental health problem might come out of lack of housing, it might come out of family conflict, it might come out of cultural dislocation and so, you know, we can address that and we can often also find parameters that will tell us when the person is feeling better.

Reference 2 - 0.49% Coverage

Reference 1 - 0.83% Coverage

I: Could you elaborate on some of these issues relating to settlement? (3.24)
P: Housing has to be the number one stressor, really, for a lot of these people. I suppose their understanding of the system is limited when they come and within a fairly pressured rental, private rental system, anyway it’s often really difficult for them to find appropriate housing.

Reference 2 - 1.72% Coverage

But I think issues change over time too. You know, in the early years, you know, the first few years, the settlement issues; you know finding a house, learning English, trying to work out how to get an income, you know just really basic issues are predominant. They are the biggest pressures for families. As time goes on I think that, particularly when you have a situation where the kids learn English much more quickly than the parents and it’s through the kids that the parents are negotiating the school system and perhaps other systems as well, sporting systems, that I think that, I suppose the parents and the children have different rates of adjusting, really, to a new environment. I know the word acculturation is often used but I hate it.

Reference 1 - 2.07% Coverage

Um so it really, in terms of being able to work successfully with them they need to identify that there’s another way of feeling about something or working with something but a lot of Sudanese particularly, um they don’t really understand the concept of psychological support.

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Appendix J: Dissemination of findings
Conference Presentations


Invited Presentations