

Addressing the Needs of Syrian and Iraqi Refugees in the Nepean Blue Mountains Region

A Formative Assessment of Health and
Community Services Needs

PROFESSOR ANDRE M.N. RENZAHO and MS NIDHI DHINGRA



WESTERN SYDNEY
UNIVERSITY

phn
NEPEAN
BLUE MOUNTAINS
An Australian Government Initiative

 **Wentworth
Healthcare**

Blue Mountains | Hawkesbury | Lithgow | Penrith

© Wentworth Healthcare Limited 2017

Level 1, Suite 1, Werrington Park Corporate Centre,
14 Great Western Highway, Kingswood NSW 2747

Disclaimer

Findings and conclusions presented in this report reflect a summary of consultations with the communities in the target areas. The views contained in this report do not necessarily represent those of Wentworth Healthcare Limited and its entities. All reasonable precaution has been taken by the report editor to verify the information contained in this publication. Any opinions, findings and conclusions or extracted lessons expressed in this report are those of the authors.

Funding

This research was funded by Wentworth Healthcare Limited.

Citation

Renzaho, AMN and Dhingra, N (2016) Addressing the needs of Syrian and Iraqi refugees in the Nepean Blue Mountains region: a formative assessment of health and community services needs. Penrith: Wentworth Healthcare Limited

Acknowledgements

The research team acknowledges Nepean Blue Mountains Primary Health Network and Migrant Review Panel members for their inputs and support with study design and data collection; SydWest Multicultural Services for their support with data collection. We are thankful to Ms Blessing Akombi for helping with data collection. We would like to thank all the service providers for their time and for sharing valuable experiences and the focus group participants for sharing their personal stories and experiences.

Table of Contents

Foreword	1
Author's Preface	2
Executive Summary	3
I. Introduction	5
II. Methodology and Demographics	8
Design	8
Governance	8
Sampling	8
Data Collection	9
Data Analysis	9
III. Research Findings – Health Needs of Syrian and Iraqi Refugees	11
Theme 1: Health and Health Seeking	11
Theme 2: Settlement and Mental Health	12
Theme 3: Experiences with Health Services	15
IV. Research Findings – Provision of Healthcare to Syrian and Iraqi Refugee Communities from Service Providers	17
Theme 1: Common Health Needs	17
Theme 2: Health Seeking	18
Theme 3: Settlement and Mental Health	21
Theme 4: Health Service Provision	22
V. Triangulation of Findings, Recommendations and Key Priority Areas for Future Planning	27
References	34
Annexures	36
Notes	42

Foreword

Wentworth Healthcare, provider of the Nepean Blue Mountains Primary Health Network (NBMPHN) welcomes this report into the health needs of Syrian and Iraqi refugees. While the results are concerning, it provides the first in-depth look at the inequities in our region for a small but growing number of refugees and asylum seekers with complex needs and the challenges and barriers to improving their health outcomes.

The health needs of this population is specific and complex and is recognised as a priority for NBMPHN.

Our vision is to improve the health of our community and we are committed to working closely with General Practice and other primary healthcare professionals to increase their capacity to respond appropriately. We continue to work in partnership with stakeholders to identify service gaps, influence and shape local healthcare priorities.

NBMPHN is grateful to the refugees and service providers that participated in this research and appreciates their candour and honesty in providing the most accurate picture to date of the opportunities and challenges faced by both refugees and stakeholders alike.

Lizz Reay

*CEO Wentworth Healthcare,
provider of NBMPHN*



Author's Preface

"We are facing the biggest refugee and displacement crisis of our time. Above all, this is not just a crisis of numbers; it is also a crisis of solidarity."

Ban Ki-moon, former United Nations Secretary General (2007-2016)

The number of humanitarian populations has reached a staggering new high making the current crisis unprecedented, with a significant increase in human cost. The United Nations High Commissioner for Refugees (UNHCR)'s Global Trends Report found that there were 65.3 million humanitarian populations worldwide at the end of 2015, the highest in history. Of these, 40.8 million were internally displaced persons, 21.3 million were refugees and 3.2 million were asylum seekers. The conflicts in Iraq and the Syrian Arab Republic (Syria) have significantly contributed to the rise of people in need of humanitarian assistance, with an estimated 11 million Syrians having fled their homes since the outbreak of the civil war in March 2011 and over 4 million people reported to have been displaced in Iraq by the end of 2015.



While neighbouring countries bear a major burden of hosting the Iraqi and Syrian refugee population, the international community also pledged to support and resettle refugees, with Syrian refugees representing the largest number of resettled refugees since 2014. In response to the ongoing conflict in Iraq and Syria, the Australian Government committed an additional intake of 12,000 humanitarian migrants from Iraq and Syria in 2015, in addition to around 13,000 humanitarian migrants resettled every year under its Refugee and Humanitarian Program. Australia ranks third globally in terms of the number of people resettled, and fourth (in terms of) per capita resettlement behind Canada, Norway and Liechtenstein. The Australian Government has a strong commitment to meet the needs of its humanitarian population. However, with additional commitment to resettle Iraqi and Syrian refugee populations, there is a need to undertake rigorous needs assessment to provide data to inform programs geared towards meeting the diverse needs of these populations. This report is a welcome step in this direction. This report provides preliminary health needs assessment of the Iraqi and Syrian refugee communities residing in the Nepean Blue Mountains region, and identifies barriers and enablers to service utilisation. It also outlines gaps in service provision and suggests key priority areas going forward.

Professor Andre Renzaho, PhD, MPH

*Professor of Humanitarian and Development Studies
Director of Academic Programs
Western Sydney University*

Executive Summary

In the wake of recent global events, an increasing number of people have been forcibly displaced from their homes as a result of war, violence and human rights violations or for reasons of race, religion, nationality, political opinion or membership in a particular ethnic group. As a response to the global humanitarian crisis and ongoing conflict in Iraq and Syria, the Australian Government in 2015 committed to an intake of 12,000 humanitarian migrants^[1] in addition to the humanitarian yearly intake.

These Iraqi and Syrian refugee communities come with an extended background of war and displacement and it is imperative to understand their specific health needs and the impact of pre- and post-migration stressors on their mental health and well-being. It is possible that they may suffer from chronic health conditions, nutritional deficiencies and psychological problems. However, presently there is limited understanding of the growing health needs of these new refugees and the capacity of the system to adapt to their needs.^[2]

This research conducted a preliminary health needs assessment of the Iraqi and Syrian refugees living in the Nepean Blue Mountains region and assessed the services available to them. It focussed on understanding the (mental) health needs and priorities of the Iraqi and Syrian refugee communities and mapping these with the existing services to identify any gaps and challenges. Focus group discussions were conducted with the Iraqi and Syrian communities. Service providers who provide health, mental health, community and settlement services to migrants and refugees in the Nepean Blue Mountains Primary Health Network (NBMPHN) region were interviewed.

Key Findings

Common themes in FGDs and direct interviews	Different themes from focus groups	Different themes from direct interviews
<p>I. Common Health Needs and Health Seeking Behaviour</p> <p>Common health needs</p> <ul style="list-style-type: none"> • Physical and mental health <p>Health seeking</p> <ul style="list-style-type: none"> • Health literacy • Barriers to health seeking • Service utilisation 	<p>IV. Experiences with Health Services</p> <ul style="list-style-type: none"> • Long waiting times in seeking government health services • Expensive to seek specialist service • Poor quality of services 	<p>V. Health Service Provision</p> <ul style="list-style-type: none"> • Present health services delivery • Health service provision gaps • Health needs intervention to improve service delivery
<p>II. Settlement and Mental Health</p> <ul style="list-style-type: none"> • Settlement for individual and family • Employment and downward economic mobility • Interaction with settlement services 		
<p>III. Health Services Gaps</p> <ul style="list-style-type: none"> • Poor awareness of services • Experience with GPs • Language barrier • Poor use of interpreters • Limited or no follow-up 		



Halab (Aleppo)

SYRIA

IRAQ

SAUDI

ARABIA

I. Introduction

Background

In the wake of recent global events, an increasing number of people have been forcibly displaced from their homes as a result of war, violence, human rights violations or a well-founded fear of persecution for reasons of race, religion, nationality, political opinion or membership of a particular ethnic group.

According to the United Nations High Commissioner for Refugees,^[3] the estimated humanitarian migrant population (the majority including internally displaced persons, refugees and asylum seekers) was 65.3 million in 2015, an increase of 5.8 million from the previous year. A major part of this estimate includes people fleeing the war-torn countries of Iraq and Syria. An estimated 11 million Syrians have fled their homes since the outbreak of the civil war in March 2011 and over four million people were reported to have been displaced in Iraq by the end of 2015.^{[4] [5]}

This displacement has resulted in the absorption of refugees by various countries around the world, the three major countries of resettlement being: United States of America, Canada and Australia.^[3] The Australian Government embraces the humanitarian migrants and prioritises their settlement needs with a range of settlement services under the Humanitarian Settlement Services (HSS) program.^[6] Australia is high on the list of countries with an established resettlement program for refugees and other humanitarian migrants^[7] and ranks third in terms of the number of people resettled, with the highest per capita resettlement.^[3, 8]

In 2015, as a response to the global humanitarian crisis and ongoing conflict in Iraq and Syria, the Australian Government committed to the resettlement of 12,000 humanitarian migrants in Australia,^[1] in addition to the humanitarian intake committed to each year.

Settlement and Health Services for Humanitarian Migrants

The Australian Government provides a range of services under the HSS program for the first six to 12 months after arrival. The HSS program is delivered by community organisations to provide settlement support to newly arrived humanitarian migrants. These HSS providers work with their clients to identify their basic needs and develop a case management plan to deliver services tailored to these needs. The services would include: assisting with housing and providing an initial food package and start-up pack of household goods; assistance with accessing government-funded health services (Medicare), banks and schools; assistance with learning English through the Adult Migrant English Programme (AMEP); welfare support (government-funded benefits through Centrelink); and orientation to life in Australia (including healthcare, education, employment, Australian laws and culture). To ensure continuity, the government provides additional settlement services for those needing extra support under the Settlement Grant Program and Complex Case Support services.^[6]

These newly arrived humanitarian migrants (including refugees and asylum seekers) are assisted under the HSS program with accessing Medicare services from available General Practitioners and Practice Nurses.^{[9] [10]} In addition to these services, various states have also taken steps to provide

healthcare support for refugees. The Victorian state policy further supports the role of primary healthcare in the initial care of refugees!^[11] New South Wales has established state-wide and area-specific refugee health services. State-wide services include the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) and the NSW Refugee Health Service (RHS). A number of state-wide multicultural services focus at times on refugees and some identified Local Health Networks also provide refugee-specific programs. Refugee paediatric clinics have been established by the major children's hospitals and in Liverpool and Fairfield. However, as with the broader community, General Practitioners provide the majority of primary medical care for both newly arrived and more established refugees!^[12]

Health Issues amongst Humanitarian Migrants

These Iraqi and Syrian refugees come with an extended background of war and displacement and it is imperative to understand their specific health needs and the impact of pre- and post-migration stressors on their physical and mental health and well being. They may suffer from diseases and conditions rarely seen in Australia, including infectious diseases!^[2] It is possible that they may suffer from chronic health conditions, nutritional deficiencies and psychological problems. They may also have untreated health issues that have probably been exacerbated due to prolonged uncertainty from war, poor living conditions and lack of access to treatment!^[9, 13, 14] The physical conditions most frequently treated in asylum seekers at Australian immigration detention centres in 2005–06 were dental caries, digestive complaints, respiratory problems, skin lesions, dermatophytosis, otitis externa and infections of the upper respiratory tract!^[15] Asylum seekers may also experience psychological problems that could arise from pre- and post-migration stressors. The challenges of settlement into their new environment, along with prolonged periods of uncertainty due to displacement and war could be a significant determinant of health. Downward socio-economic mobility could further adversely affect their physical and mental health.

Barriers to Service Utilisation

Despite the concentrated efforts of the Australian Government, newly arrived refugees experience difficulties accessing healthcare in an unfamiliar health system. They are under-represented in the mental healthcare system and have been known to underutilise the mental health services. Barriers to accessing the services are identified (among others) as: language difficulties; difficulty in accessing interpreters; finding aspects of treatment strange or distrusting government services; unfamiliarity with the health system; transportation problems; long waiting times to get medical care; and a preference for their own cultural services!^[16, 17]

Research also demonstrates that economic hardships faced by refugee communities affect not only their mental health but also their service utilisation. Other factors identified as affecting utilisation of services are gender, the language barrier, discrimination, acculturation stress, the attitude of healthcare workers, beliefs concerning health, religious and other non-pharmacologic and alternate healing practices, and socio-economic position!^[18]

Rationale

The Australian Government has a regulated limited intake of migrants each year. The humanitarian intake in the past few years has been around 14,000 per year under the Humanitarian Migration Program.^[20] In 2015, the government committed to an extra intake of 12,000 humanitarian places in response to the ongoing conflicts in Iraq and Syria.^[1]

The Iraqi and Syrian refugee communities come with an extended background of war and displacement and there is limited understanding of their specific health needs. As the government commits to settling Iraqi and Syrian refugee communities in Australia, it is imperative to understand their specific health needs and the impact of pre- and post-migration stressors on their mental health and physical well being. However, presently there is limited understanding of the growing health and health service needs of these new refugees and limited studies of their specific needs and their experiences using primary healthcare services.^[22, 23]

The increased vulnerability of the Iraqi and Syrian refugee communities suggests that the health and settlement services required for these migrant groups may be unique and differ from those for existing migrant communities. Access to settlement and health services, along with increased awareness of the services available to them, will be instrumental in the successful integration and settlement of these refugee communities.

Project

The Nepean Blue Mountains Primary Health Network (NBMPHN) and Western Sydney University planned a preliminary health needs assessment of the Iraqi and Syrian refugees living in the Blue Mountains region and the services available to them. The project findings help identify the (mental) health needs and priorities for these communities, and map them with the existing services to identify any gaps and challenges. The findings will also help inform health planning for future interventions.

Specific Aims of the Research

- i. **To undertake a health needs assessment of Iraqi and Syrian refugees residing in the Nepean Blue Mountains region**
 - a. To investigate their common (mental) health needs
 - b. To investigate the impact of pre- and post-migration stressors on their (mental) health
 - c. To investigate their awareness, access to and utilisation of available settlement and (mental) health services, including potential barriers to service access and utilisation
 - d. To explore how they cope with post-migration settlement challenges, including initial settlement and its impact on their (mental) health; and to examine any systemic related factors that facilitate their settlement journey
- ii. **To assess the services available to them**
 - a. To understand the characteristics and effectiveness of present services to these migrant communities
 - b. To identify potential gaps in order to improve services outreach and access, including services literacy and cultural responsiveness of services

II. Methodology and Demographics

Design

The study used methodological approaches and data sources to develop a comprehensive understanding of (mental) health issues and priorities of Iraqi and Syrian refugees, the characteristics of services available to them and how to make existing and new health services accessible and culturally responsive to identified needs. The methodological approaches and data sources included:

- I. **Focus group discussions (FGDs):** The project draws on principles from Participatory Action Research frameworks^[24] to undertake community-based consultative focus groups. FGDs are able to produce collective narratives on research issues to generate a group perspective on issues and have proven to be a useful tool to understand various emerging issues with new migrant settlements.^[25, 26]
- II. **Consultations with service providers:** The study conducted one-on-one interviews with service providers assisting migrants and refugees in the Nepean Blue Mountains region. This elicited the service providers' perspectives on and understanding of the health needs of the Iraqi and Syrian refugee communities, the service provision to them and any potential gaps.

Governance

A project steering committee, including a NBMPHN representative and the Migrant Review Panel (MRP) of Western Sydney University was formed to oversee implementation of the project. The MRP is a de facto community-owned steering committee established by Western Sydney University. It is a voluntary group of community leaders representing various migrant communities living in Greater Western Sydney.

The research protocol was approved by the Western Sydney University's Human Research Ethics Committee (Ethics Approval No. H11213).

Sampling

Focus group participants were purposively recruited according to geography (settled in Nepean Blue Mountains region) and by country of origin (Iraq and/or Syria). Participants were recruited through community structures (organisations and community leaders from the MRP). FGD groups were formed on the basis of grouping together people from similar backgrounds and/or experiences. Groups were drawn from existing networks to enhance the contribution of participants, helping them discuss sensitive issues with ease as they were amongst known peers facing similar challenges.

Participants for direct interviews were identified by NBMPHN. They were purposively sampled to include service providers who provide health, mental health and community services for migrants and refugees living in the Nepean Blue Mountains region.

Data Collection

The research comprised three focus groups with a total of 21 participants, six to nine participants in each group. FGDs included participants with refugee backgrounds coming from Iraq and Syria. Each focus group discussion lasted for around 90 minutes. Participation in the research was voluntary through informed written and verbal consent. The project materials, including the consent form and the demographic sheet, were translated into Arabic. The FGDs were conducted in participants' preferred language of Arabic with the help of interpreters. All discussions were audio recorded and transcribed verbatim, for the purpose of research. FGD participants were given a \$25 Coles voucher each, in appreciation for their time. Table 1 provides the demographic characteristics of participants and the FGD topic guide is annexed (Annexure 1, pp 36).

It is useful to note that the Nepean Blue Mountains region has a very limited number of social community groups for the relevant migrant communities, hence the 'once-only' focus group discussion for the purpose of this research.

Twelve service providers were interviewed across 10 organisations for the research. These service providers, who provide health, mental health and community services, were interviewed along with health nurses who assist migrants and refugees living in the Nepean Blue Mountains region. All one-on-one interviews were audio recorded and transcribed verbatim. Participants were given a \$35 Coles voucher each, in appreciation for their time. Table 2 provides details of the participants' organisations and the interview guide is annexed (Annexure 2, pp 38). Interviews with General Practitioners were intended as part of the original design, but the General Practitioners were unable to participate, due to lack of time.

Data Analysis

All transcriptions from FGDs and direct interviews were independently and manually coded by two members of the research team. These were then confirmed by the third team member. The data was coded and analysed using Braun and Clark's six step process: (i) familiarisation with the data through reading and re-reading the transcripts and field notes; (ii) generating initial codes and inserting the initial codes in the transcripts; (iii) developing and searching for themes and grouping the codes into developing relevant themes; (iv) reviewing the themes against the coded extracts and the data extracts and creating a thematic 'map'; (v) defining and naming the themes and sub-themes; (vi) narrating the themes and sub-themes, with a selection of participants' voices for each theme.^[27] The steering committee was consulted at each step to ensure quality in the process.

Table 1. Demographic characteristics of focus group participants

FGD No.	Background	per FGD	Age range (Yrs.)	Avg. age (Yrs.)	Gender make up	First language	Year of migration
1	Iraq & Syria	6.0	34–56	41	M: 67% F: 33%	Arabic	2012–2016
2	Iraq & Syria	6.0	23–49	35	M: 67% F: 33%	Arabic	2013–2016
3	Syria	9.0	19–31	24	M: 89% F: 11%	Arabic	2016

Note: all participants were either residents of Penrith or St Marys or had recently moved to Mt Druitt or Blacktown.

Table 2. Characteristics of service provider participants

No.	Service provider's name	Organisation type	Region covered
1	NSW Transcultural Mental Health	Mental health services for CALD communities	Across NSW
2	Nepean Multicultural Access	Community organisation providing settlement services to CALD communities	Blue Mountains, Hawkesbury and Penrith
3	SydWest Multicultural Services	Community organisation providing settlement services to CALD communities	Blacktown, Mt Druitt and Penrith
4	Multicultural Health Service	NSW Government for Nepean Blue Mountains Local Health District	Blue Mountains, Hawkesbury, Lithgow and Penrith
5	Penrith Community Mental Health	Mental health services	Penrith
6	Child & Youth Mental Health Service	Mental health services	Penrith
7	Headspace Penrith	Mental health services	Penrith
8	LikeMind	Mental health services	Penrith
9	Neighbourhood Centres	Community organisation	Nepean Blue Mountains Region
10	NSW Refugee Health Service	NSW Government	Penrith

III. Research Findings – Health Needs of Syrian and Iraqi Refugees

This section highlights the key information specific to the health needs of the Syrian and Iraqi refugee communities, arising from the findings from the focus group discussions. The findings highlight the refugees' health and mental health needs, health seeking behaviours and level of (health) literacy, the enablers and barriers to accessing primary healthcare and their experiences with the available services.

The research reveals that the Iraqi and Syrian refugee communities, despite coming from a background of prolonged war and displacement, were resilient and make immense effort to settle in their new environment. Although happy to be secure and safe they are faced with challenges at multiple levels in beginning a new life in Australia. Their interactions with settlement and health services met various challenges. Key findings are set out below.

Theme 1: Health and Health Seeking

Participants commonly shared mental health issues of trauma, anxiety and depression and physical health issues of diabetes and blood pressure. However, despite these health issues there was poor healthcare seeking, which could be attributed to poor health and limited health services literacy and a low priority given to health and prior experiences of seeking services.

- 1. Common health needs** identified by participants were sleeplessness and trauma, with physical health issues of diabetes, depression, heart conditions and blood pressure and also psychological issues. Changes in dietary patterns leading to health issues such as obesity and diabetes were also identified.
- 2. Health seeking and literacy:** Participants stated that before arriving in Australia they had had long periods without any healthcare support. Health had not been given priority and even after arrival they wanted to prioritise settling into the new environment over health. As noted by one participant:

Because we are busy with the war and how to survive, how to flee from this place to that place ... and when we come to Australia you know the doctor said you have to do this test and this test. (FGD 1)

Poor awareness and understanding of general health and mental health issues and of the available services were common findings. The refugees did not identify any grey areas of mental health and said that a person is either normal or 'crazy'. There was also stigma attached to poor mental health, which was therefore not recognised, and seeking help for these issues was not encouraged in the family or community. Hence, they don't know how to talk about, and would 'turn blank' on, where to seek these services. Participants shared their past experiences of seeking a health service for mental health issues:

So in our country if anyone goes to psychologist doctor, people will point to him and say he's a crazy, he's a crazy, he's a crazy. (FGD III)

Sometimes yes we are willing to go and ask the doctors but most of the time we keep to ourselves ... and sometimes what we do, we walk and that's just to release the stress. (FGD I)

3. Service utilisation: Participants said that they didn't trust their General Practitioner enough to discuss their mental health issues. There was also a preference for having a doctor of the same sex as the patient and from a similar background. Participants commonly stated that they were not familiar with or did not trust the health system.

So once I want go to the doctor but I don't trust my GP what kind of medicine he will provide me. Give me some drugs, you know, sleeping drugs. (FGD I)

It's just a business. The doctors they need money and they don't care of you. (FGD II)

Theme 2: Settlement and Mental Health

Participants shared a common experience with poor settlement being linked to depression, isolation and anxiety. The new culture affected their family structures and, coming from a collective culture, they felt lonely and isolated with limited social capital. Additionally, participants shared challenges in their interactions with the settlement services. They were unable to find employment and this led to a feeling of lack of purpose and uncertainty which affected their well-being. As one participant said about his initial settlement challenge after arriving in Australia:

We are under pressure also because no work, no job, no, and have no rights. And it's very expensive. We wait for two years and when we arrive to Australia we are exhausted, we don't want to wait more. (FGD II)

1. Changing family dynamics: Participants noted that coming to the new environment and culture led to changes in family dynamics which led to confusion and sometimes to conflicts within families.

- **Changing power dynamics within families:** Children adapted faster to the new culture than parents and were able to navigate the system better. This often led to children having more authority and to role reversals within families.
- **Intergenerational acculturation gap:** Participants felt an increased acculturation gap and language barrier between parents and children, as pointed out by one participant, which resulted in poor communication between parents and children, affecting family cohesion.

Most of us parents can't speak English, the young kids they will forget their own language. (FGD I)

- **Fear of children losing culture:** Participants admitted that they were afraid of their children losing their native culture while they struggled to adapt to the new culture. This added to parents' constant stress in negotiating between two cultures.

Worried, concerned, sleepless because we think a lot of those stuff that we are losing our kids. So we are afraid of losing our kids. In Syria all one culture, we don't care. But here different cultures and you know the system, the freedom here. (FGD I)

Anyway parents in our country take care of their children but they have the right to punish him. But here in Australia the law or the children rights prevent parents to raise their children in good way. So all the time the parents are scared from taking any action. (FGD III)

2. Social capital: Participants stated that having family members and community around helped them recover from trauma, but most had limited or no family, no social circle or friends. This often made them feel lonely and isolated. One participant shared how his family helped him cope from the suffering of war.

Till 2007 I was suffering too much with [that situation] the war but I'm nearly half cured after I married and I have my child. Like my child is the sweet thing in my life, yeah. I'm half cured because of my son and I have a family now. (FGD III)

Some participants still had family back in Syria and Iraq, making them constantly worry for their well-being, as highlighted in one participant's experience. On the other hand, a few participants wanted to purposely isolate themselves from their community, as it helped them forget their past.

We are happy in Australia but we are still concerned about our families back in Syria, and we're thinking all the time for them to come to Australia. (FGD 1)

3. Settlement: Participants shared a common sense of comfort and security after migration and felt they could give their children a better future. But most also felt disempowered and distressed with immediate settlement challenges, as summarised by one participant:

What can we do? So we think about what is the benefit of escape and flee our country to come to a country where we are still in prison. (FGD 1)

- **Initial settlement challenges:** The language barrier was a common concern that affected daily life. Other challenges mentioned were: finding a house, as the refugees have big families and housing is expensive; adjusting to the new culture and changing lifestyles; financial issues and high expenses – most participants were new to Australia and were receiving a Centrelink payment which they did not find sufficient for themselves and their families.

We want to establish here ... but because of the language barrier we cannot establish or reach whatever we want to reach. (FGD 1)

- **Settlement services:** Most participants were not aware of the system and felt a need for closer engagement in order to settle into the new environment. They needed more outdoor and recreational activities, especially those with children. Participants also stated that the Settlement Services Program was linked to payments from Centrelink, which constantly pressured them to go either to English classes or to Centrelink or to the Job Active Providers in order to get the payment, as noted below. Participants felt they needed more than the initial three months to settle into the new system.

If we will be absent from English class or we won't go for our Job Active appointment, they will straightaway advise to Centrelink and our payment will be suspended. (FGD 1)

4. Employment and downward economic mobility: Most participants shared the necessity to rethink their careers – although they were well settled back home they were unable to use their degrees in Australia. They were unable to find employment in Australia due to the language barrier and non-recognition of overseas educational qualifications.

We have high qualification but we study in Arabic so it's not useful here. I need to start from the beginning now. (FGD 1)

They also felt a lack of guidance or support to help them find a pathway. Limited understanding of the system led to participants being exploited in ways such as through cash-in-hand jobs, not being provided health cover or not being paid for the work done. As one participant expressed his experience of being exploited by his employer:

And after one month of working I damaged my back badly and when I ask my boss for help he refused as he paid me cash money, hence no health insurance. I did not know of this. I stopped working there now. I live alone, I rent house and I work, I am good but this problem for me it's very, very, very bad. (FGD 1)

Participants linked these experiences to a lack of purpose which led to periods of feeling depressed and anxious for the future. Long period of uncertainty from the war and camp life plus added pressure here to find employment increased the constant stress they already felt to settle in.

The main problem is, I am a young person and sitting at home and I am very educated and I can't find a job. I don't know where to go for my education recognition at the same time I am sitting at home thinking about the culture, about my country and at the same time we face big pressure from job seeker. Give me my education recognition, give me a job and I have no time to think about anything else. I will live I will have my future here. But if I have no education and I have no job that makes me sit down at home and just thinking. And that's very bad for me. (FGD 1)

Theme 3: Experiences with Health Services

Participants agreed that their experiences of seeking health services from General Practitioners or other health services were not very positive. They stated that they preferred to travel long distances to see a doctor they knew, for reasons of familiarity, comfort and, most importantly, quality of service. Participants said that the quality of services at medical centres/government hospitals were poor, with long waiting times for specialist services, and that they could not afford a private hospital for specialist treatment as it is very expensive.

1. Long waiting times when seeking government health services and unaffordability of private specialist doctor services; poor quality of attention and care given except in an emergency – there were cases when the health staff had asked patients to endure the pain and return if it worsened; some participants had experienced a wait of as long as two years for a specialised government service.

2. Seeking General Practitioners: Participants commonly said that they preferred not to go to a General Practitioner, as in most cases they would be referred to a specialist doctor whom they couldn't afford. Additionally, participants felt that General Practitioners employ a tick the box approach, are not sensitive to their needs, and do not allow adequate time to discuss their patients' problems and issues.

Our GP he just collects my information for the system and when I go to visit him just opens the computer, read my information. I have no time to explain my situation, he gives me paper or medicine or something, and it's like quick meeting because there is many people waiting ... I never have enough time to talk about my situation to doctor. (FGD II)

3. Expensive specialist services: A common obstacle to seeking specialist services, especially for dental issues, was the expense attached. Participants found it difficult to utilise such services on their current income from Centrelink and preferred to endure pain rather than spend money on a doctor.

Problem is with the money and sometimes when I pay like \$250/\$300 to the doctor and I borrow money from a friend or from Centrelink, who cut it from my payment every two weeks. That's the only problem. (FGD III)

I prefer to stay at home and the have the money for family and not going to specialist doctor. (FGD III)

4. Quality of service: Participants experienced poor quality of service with General Practitioners (or at primary level). There was also poor follow up or none in some cases (such as for cases of children's immunisation and surgery).

After few days of the surgery I don't know where to go for a follow up and then I carry my son to the hospital and waiting for four hours asking for someone just to have a look. (FGD II)

5. Interpreters: Participants told of cases of unavailability of an interpretation service with General Practitioners where they were refused the service; participants preferred to go to the hospital rather than medical centres as there were no interpreters at medical centres. They also had experiences of specialists not wanting to provide interpreters.

The specialist they refuse to provide interpreter. I think the specialist doesn't have enough time to waste on phone waiting for interpreter to answer. (FGD I)

I prefer to go to hospital ... in the medical centres no-one speaks Arabic. (FGD II)

IV. Research Findings – Provision of Healthcare to Syrian and Iraqi Refugee Communities from Service Providers

This section provides the key information regarding the provision of healthcare services to Syrian and Iraqi refugee communities from a service provider's perspective. The findings highlight the current providers' knowledge of the physical and mental health issues of the Syrian and Iraqi refugee communities, the current service provision available and gaps within services, and the assistance and support identified by providers as necessary to improve their services.

The research findings suggest that service providers face challenges at multiple levels in meeting the growing demands of the diverse populations. They identify shortcomings in terms of limited resources, poor awareness of physical and mental health issues and limited provisions for these, poor cultural competency and lack of sensitivity of health staff and specifically General Practitioners, poor use of interpreter services, and the language barrier to service access and utilisation. They identified a strong relationship between settlement issues and mental health, where poor settlement often leads to anxiety, stress, depression and isolation. Service providers were keen to support these migrant communities and identified areas that could enable them to improve services and increase outreach. Key findings are set out below.

Theme 1: Common Health Needs

1. Physical health issues are commonly exacerbated due to prolonged periods of war and displacement with no time or provision for health check-ups. Common health issues were diabetes, dental health, women's sexual and reproductive health (with cases of rape and drug and alcohol abuse) and diet related issues such as malnutrition and changing food patterns post-migration leading to obesity.

2. Mental health issues were commonly identified with the background of war and the experience of losing family member/s leading to breakdown of family. Further, following migration, the unfamiliarity of the new environment, culture and community led to long periods of isolation.

- **Trauma was identified as the most common health issue** amongst these refugee communities. Trauma related issues include: torture, trauma of parents affecting children, and post-traumatic stress disorder.
- **Headaches and stomach aches** were commonly reported symptoms and could be attributed to the lack of mental well-being of refugee communities.
- **Depression, anxiety disorder, including separation anxiety** disorder in children, and in some cases obsessive compulsive disorder (OCD) were reported.

Theme 2: Health Seeking

Service providers noted that the health seeking behaviour of the Iraqi and Syrian refugee communities was different from that of other migrants or of locals. They did not commonly seek physical or mental health services and had poor awareness of physical and mental health issues, which could be one reason for their limited accessing of available services.

1. Barriers to health seeking: Potential barriers to migrants/refugees seeking physical or mental health support were identified as:

- Perceptions of health and health services which led to attaching stigma to mental health issues and to other issues such as domestic violence. There was poor awareness and understanding of mental health and mental health issues, hence the under-representation of these refugee communities at health services, as highlighted by a service provider:

I think that we're probably under-represented in the newly arrived group, like I don't think we're seeing one in five of that group, and I think that there might be some particular cultural ideas around how we manage a mental health problem.
(Service Provider 1)

- Members from the Iraqi and Syrian communities preferred not to seek support services for mental health issues, as a few service providers pointed out.

So everybody will go to see a doctor if they have stomach pain but if they cannot sleep or they have voices talking to them they won't go to a doctor. And the family unfortunately in many cases won't encourage going to see a doctor because of the associated stigma with mental health. (Service Provider 2)

I live here, I live in this area so I go to Penrith Westfield I can see people ... I see almost everybody in the restaurant is non-white, non-white face, right, it's the Penrith R.S.L. But how can it be that of all those people that I see in the whole restaurant, how can it only be seven per cent of our clients from CALD or refugee backgrounds? How is it possible? So my hypothesis - they're out there, they're vulnerable and they probably need some kind of help but they're not coming to Headspace, there must be some obstacle. (Service Provider 3)

- Poor knowledge of the English language was also identified as a barrier to knowing about the services and accessing them.
- Service providers noted that some services were not culturally appropriate and were not tweaked or modified to the cultural needs of refugee communities, which was also a potential barrier to service utilisation.

- Service providers said that their clients from Iraqi and Syrian refugee communities did not report very positive experiences concerning their interaction with health workers whom they commonly found did not spend enough time with them and followed a tick the box approach.

A service provider recalled her clients' experiences with General Practitioners:

And, I don't know, they usually don't like to go to the GP's so then we find out a lot when they're in our session. They'll only go to the GP to get the mental healthcare plan and then come back here. (Service Provider 4)

Another service provider highlighted that it was very important that General Practitioners and service providers give members of the Iraqi and Syrian refugee communities ample time to open up before they begin treating them.

And that's why we have to work in a particular way, being sensitive to that, and knowing that actually sometimes before you can get to the real work you just have to spend time with a person who's a refugee, or has had a refugee lived life experience, just spending time with them, getting to know them. (Service Provider 1)

- Service providers stated that their clients' had experienced breaches of confidentiality by interpreters, which affected the clients' trust in sharing personal information and further seeking these services.

With interpretation services you've either got an interpreter in the room which makes it, I think, sometimes harder for people to choose to disclose because they're not just disclosing to you, they're disclosing to a third party as well, who in effect should keep confidentiality, but not always. People know people and they've got to trust multiple people to want to disclose. (Service Provider 5)

Some interpreters are breaching the confidentiality without being reported.
(Service Provider 2)

2. Enablers of health seeking: Identified enablers of migrants and refugees seeking mental and physical health support were:

- Migrants and refugees needed more time and attention at the service they seek. They needed unhurried close engagement before they could feel comfortable sharing their problems. Hence they preferred to go General Practitioners who gave them enough time and attention and were sensitive to their background and culture.

- Service providers noted that modification of services to the cultural needs and backgrounds of service seekers helped to improve access to these services.

3. Health and health services literacy: Service providers found that health was not regarded as a priority by the Iraqi and Syrian refugee communities, as the newcomers were keen to get their families and themselves settled.

'What are your priorities for your health', in the initial phase when I see them it's going to be, 'Got to find long term accommodation', because they only get one month when they first arrive. Within that month they need to find where they want to live, try and find a house, they need to get the kids in school. So you ask them about their priorities and it's not going to be going to see a psychiatrist, or a psychologist, or a counsellor, it's going to be finding a house. (Service Provider 6)

Poor awareness and understanding of health and mental issues, coupled with cultural perceptions of health, led to stigma and taboos surrounding mental health issues and seeking services for them.

The biggest gap especially with refugees is the fact that they don't know the grey areas of mental health. You are either sane or you are crazy. (Service Provider 2)

Service providers also shared their experience that the Iraqi and Syrian refugee community members 'normalised mental health issues', having developed high resilience as a result of extended periods of war and displacement that prevented them from recognising mental health issues and reaching out to seek help.

And I think that that's very difficult to ... and also if you ... what I'd say is that it's also somewhat normal for a refugee person to experience a lot of stress because of what they've experienced. So even within the refugee community mental illness is normalised and that it's, well, it's expected and that it's part of your hardship. It's part of your, well, I've come, I've obviously come all this way to Australia and I've had to put up with all this stuff so of course I'm going to be. (Service Provider 3)

Service providers agreed that Iraqi and Syrian refugee community members often feared sharing their personal situation, as they feared that being diagnosed with a mental illness could have them 'sent back' or 'lose their children'.

Theme 3: Settlement and Mental Health

Service providers agreed that poor settlement and various uncertainties after migration were a major cause of stress and anxiety amongst Iraqi and Syrian refugee community members. Poor settlement was identified as being a result of stresses at multiple levels in the refugees' resettlement journeys: at an individual level, as they cope socially and economically with their new life and the culture in the new environment; at family level, with the disparate acculturation levels of parents and children; within the community; and in their interaction with the settlement services.

But mostly trauma and depression are some of the major things simply because of ... the expectation that they have in this country sometimes they may not get what they want and that also will lead into stress and depression. (Service Provider 7)

I think when people feel like I was coming for a better life or I was coming for something else or I had no choice, I had to get out of wherever I was, and then they can't find a place for themselves in the new area, it can be very upsetting, depressing in, not necessarily diagnostically depressing but ... and very isolating. I think that's social isolation only perpetuates feelings of mental health concern. (Service Provider 5)

1. Settlement for individuals and family: Service providers found that having social capital contributed immensely to a positive settlement experience for Iraqi and Syrian refugee community members. Coming from a collective culture to the new environment with a dominant individualistic culture, with few or no friends and family, led to isolation. Further, the change in culture, altered power dynamics within families, and a widening acculturation gap and poor communication between parents and children led to increased tensions for individuals and families.

You will be stressed and depressed and thinking about why I'm here. Also with kids learning English quickly and they getting control on what is happening at home and this is also something that disempowers the parent. And as parents not having full responsibility on their children or on their family at the same time. (Service Provider 7)

Service providers also identified lack of employment opportunities and the limited suitable career pathways for Iraqi and Syrian refugee community members as major causes of concern for their well-being. Additionally, they related that despite having a limited income their clients were under constant pressure to send back money to support family and friends at refugee camps. All these factors caused stress and anxiety.

2. Settlement and community: Service providers related that many Iraqi and Syrian refugee community members preferred to stay where they have a familiar community, as they felt a lack of acceptance amongst the Australian population at large. On the other hand, they told of the experiences of some clients who did not want to stay with their communities, as they wanted to isolate themselves and were not comfortable getting together in social groups because that made them recall their past. Service providers also shared the common experience of ignorance about migrants and refugees amongst the wider Australian population, which led to cases of discrimination and stereotyping.

And so out here people have significant opinions, usually it's more negative towards refugees. So that means that when you have that background, when you know that the region in which you live isn't very receptive to people who are different, people with different cultural beliefs, different backgrounds, then it makes it very hard to feel settled and to feel like you're a part of the community. And I think what then happens is that you isolate or you remain within your cultural groupings. (Service Provider 3)

3. Settlement services: Service providers identified a need for closer individual engagement with the Iraqi and Syrian refugee communities to meet their settlement needs. Additionally, they stated that settlement services needed to be tailored to address individuals instead of using a top down blanket approach, and that there was a need for more specific support services providing parenting workshops, better awareness about Australian culture, employment services and help with housing needs.

Theme 4: Health Service Provision

Service providers admitted that they faced multiple challenges in service provision; they identified potential gaps and highlighted what they needed in order to improve health services outreach.

1. Present health services delivery: Service providers stated that their existing staff was under constant pressure and overworked, and that in most cases they were understaffed. In addition, funding cuts were common, which led to pressure and uncertainty concerning the continuity of their employment, further affecting their output. One service provider also emphasised that the limited funding environment led to the services becoming territorial and competitive, rather than being cooperative. Providers also admitted that as they were already overworked and had few resources they had little need to modify services to increase outreach.

So I think if we were to see more Iraqi and Syrian families coming into the area, that would, sadly, boost the priority, and then we would be more proactive about getting the training. Time is limited, money is limited. ... And the funding environment makes services a little bit territorial and competitive, rather than cooperative. (Service Provider 8)

2. Health and health services literacy: Service providers asserted that while they were aware that there was poor awareness of health issues and services amongst refugee and migrant communities, they, the providers, were under-resourced to reach out and engage closely with these communities. The common outreach interventions aimed at creating awareness were through sharing information brochures/pamphlets and having these translated into various relevant languages.

I mean outside of ensuring that we had brochures and other stuff in a range of languages, we haven't done so much. I suppose in saying that, we've had so many young people come into Penrith that we haven't needed to go out finding more young people. (Service Provider 3)

3. Health service provision gaps: Common gaps identified by service providers were:

- **Language barrier:** Most services were provided in English and there was limited use of interpretation services.

I feel like [they] sort of get left in limbo to try and seek these services but they don't because they can't communicate. You know for a walk-in we don't have an interpreter, but we can use the phone, but that's different. (Service Provider 4)

I do believe that there is very low uptake of interpreters by GPs in our area, which is not good. (Service Provider 9)

- **Limited Culturally and Linguistically Diverse (CALD) and community engagement staff** and specific staff dedicated for the CALD community and especially for refugee communities.

There's not a lot of ethnic diversity in our team, so I think that could be challenging to meet the needs of a diverse population. (Service Provider 1)

- **Poor cultural awareness among General Practitioners**, especially for refugee/s families, and lack of awareness of settlement services for referral purposes.

I don't think they're [health workers] well equipped to deal with that at all. I think we get a very ... it's not a one size fits all, I think that's too broad to say but we get some very specific training around assessing and then what we need to do with disclosures of domestic violence and I think the fact that you come from a particular culture isn't included in that. So I think people then have to work it out on a case-by-case basis and I think that that can sometimes be really difficult. Especially when, you know if we're talking back to the refugee population, language is usually a barrier as well. (Service Provider 5)

- **Poor follow-up mechanisms** and limited mechanisms, if any, for recording patient background information which could help in better service provision. Poor communication and engagement amongst service providers was also identified as a barrier to successfully delivering services.

When [communication] it's needed I think it works well but I just don't think it's utilised very often. So the channels of communication might be a little rusty. (Service Provider 5)

4. Health needs intervention to improve service delivery: Service providers offered some suggestions towards improving service delivery and outreach for Iraqi and Syrian refugee communities.

- **Need to identify General Practitioners who are committed and interested** in working closely with refugees – commonly referred to by service providers as 'refugee friendly GPs'.

It is about identifying possibly four to five GP practices in the area and skilling them up, or doing the identifying of their particular skills and interests and resources, and then identifying what would be required to skill them up so that they can be providing that very important healthcare to the refugees. Because obviously the GPs, a lot of the times this is the first point of contact and the GP can provide the referral pathways and the follow-up, addressing all the health issues and that kind of thing. (Service Provider 9)

- **Need to provide cultural competence training** to identified 'refugee friendly General Practitioners', health staff and service providers.

Look, I think some of my clinicians probably don't know a lot about life as it is in Syria, or what it might be like, because they haven't had that experience themselves, because as I said we're not culturally and linguistically diverse as a team. So I think we'll need to ensure that the staff here have some good training as well in working with this population group, and as a manager I am saying, 'And it will take time, it will be different to your other client groups'. (Service Provider 1)

- **Need to create awareness** amongst the Iraqi and Syrian refugee communities concerning physical and mental health issues and services.

I think there's a need for community communication, education about mental health ... there really has to be some specialist way of developing and improving the perception of mental health services within the refugee CALD community. (Service Provider 3)

- **Need to find ways to achieve early diagnosis** and treatment of mental health issues, especially those that are trauma related. There is presently no mechanism for early diagnosis that would enable refugees to proactively manage their health.

I think it goes back to ... assisting [them] to proactively address the trauma so that it doesn't manifest into more serious mental health issues. And as a health service, I don't think we're very good at that, we wait until something hits a crisis before you really get access to mental health services, you know things have got to be ridiculously bad. As you know there's a high prevalence of mental health issues in the general population but mental health services are really dealing up in the moderate to severe range. So people that want to proactively manage their trauma, we don't really have a service for that. (Service Provider 5)

- **Need to be more flexible** in the health services to accommodate the needs of the Iraqi and Syrian refugees, and address limitations such as there being little scope for diagnosis unless for an acute form of mental illness which is 'visible', and also the high cost and hence inaccessibility of specialist services.

I just think they need to be a bit more flexible. So you know they've got quite rigid rules around everything, you know, this is the criteria, but our people do not fit within the criteria, they may not have a diagnosis, they may not have the money. (Service Provider 6)

- **Need for better awareness** of the physical and mental health needs of the Iraqi and Syrian refugee communities by service providers, as having more clarity on this issue could help them better prepare for service provision. Need to prioritise the requirements of Iraqi and Syrian refugee communities and invest resources accordingly to meet these needs.

I don't really know what are going to be the health needs of this population. What I do know is that they will come with health needs, and I don't know whether we have resources in place for them, because I don't feel like I have - well I mean I have to provide within the existing resources. So I do know that that is going to be an extra demand on my service, so that's just a given. (Service Provider 1)

Identifying that there is that history to there being major issues and they need to be addressed in the mental health realm. There's that big gap in the middle of how do we proactively help people make sense of where they've come from and all the experiences that they've had, that we don't really understand. (Service Provider 5)

- **Service providers highlighted a few best practices** of health services, such as the mobile (dental) health clinic and Westmead Specialist Health service for refugees, and SydWest Multicultural Services shared its successful engagement model. Providers identified a need to look at ways of learning and adapting to these models in the Nepean Blue Mountains region.

I think so far we don't have barriers because number one, we have got people who speak the language. Number two, we have got people from the community themselves who are working with us. And this also is very important simply because people will get connections. If you have seen someone is speaking your language from your cultural background, you very much come close to the person and listen to the person because language and culture are very important. Yeah, they will trust you because you will speak the language, you are from their community therefore they will trust you and also they will listen to you, rather than someone else who doesn't speak the language, who doesn't know anything about the group, it will take time to build trust and confidence between you and the client. (Service Provider 7)

V. Triangulation of Findings, Recommendations and Key Priority Areas for Future Planning

This section looks at the commonalities and differences in the findings from, the health needs of Syrian and Iraqi refugee communities from focus group discussions and existing service provision from direct individual interviews with service providers. It further proposes recommendations, highlighting key priority areas, and provides action points for the improvement of service delivery to meet the specific needs of the Iraqi and Syrian refugees, thus leading to their increased participation and, hence, improved health outcomes. These themes are summarised in Table 3.

Table 3: Key findings

Common themes in FGDs and direct interviews	Different themes from focus groups	Different themes from direct interviews
<p>I. Common Health Needs and Health Seeking Behaviour</p> <p>Common health needs</p> <ul style="list-style-type: none"> • Physical and mental health <p>Health seeking</p> <ul style="list-style-type: none"> • Health literacy • Barriers to health seeking • Service utilisation 	<p>IV. Experiences with Health Services</p> <ul style="list-style-type: none"> • Long waiting times in seeking government health services • Expensive to seek specialist service • Poor quality of services 	<p>V. Health Service Provision</p> <ul style="list-style-type: none"> • Present health services delivery • Health service provision gaps • Health needs intervention to improve service delivery
<p>II. Settlement and Mental Health</p> <ul style="list-style-type: none"> • Settlement for individual and family • Employment and downward economic mobility • Interaction with settlement services 		
<p>III. Health Services Gaps</p> <ul style="list-style-type: none"> • Poor awareness of services • Experience with GPs • Language barrier • Poor use of interpreters • Limited or no follow-up 		

Common Themes

Common health needs as identified by focus group participants and service providers were those related to both physical and mental health issues. Mental health issues were commonly linked with the background of war and experiences of losing family member/s leading to breakdown of the family. Further, after migration, the unfamiliarity of the new environment, culture and community led to long periods of isolation.

- **Physical health issues** were diabetes, dental health, heart conditions and blood pressure. The service providers also dealt with women's sexual and reproductive health, with cases of rape and drug and alcohol abuse, and diet related issues, such as malnutrition and changing food patterns post-migration which led to obesity.
- **Mental health issues** as identified by focus group participants involved sleeplessness and trauma. Service providers identified trauma, torture and anxiety disorders as common, along with headaches and stomach aches.

Health seeking behaviour: Poor health seeking behaviour was a common finding. Focus group participants admitted that they had had long periods without healthcare support before arriving in Australia, where their health was not given high priority. Service providers agreed that health was not seen as a priority in the Iraqi and Syrian refugee communities due to their background, and because they would prioritise getting settled, taking care of their families and integrating into the new environment over their own health.

- **Health literacy:** Poor awareness of general health and mental health issues was a common finding – this could also account for poor accessing and utilisation of services. Iraqi and Syrian refugee community members did not identify any grey areas of mental health and said that a person is either normal or 'crazy'. This cultural perception of mental health, which attaches stigma and taboos to mental health issues, also contributed to limiting discussion of these issues and hence the seeking of any support.
- **Barriers to health seeking:** Barriers to health seeking were identified as: cultural perceptions concerning mental health; poor awareness of health and mental health issues; culturally inappropriate services which were not sensitive to the refugees' needs; the language barrier and poor use of interpreters at health services; and breaches of confidentiality by interpreters. Service providers stated that, in their experience, Iraqi and Syrian refugee community members 'normalised mental health issues', as they had developed high resilience as a result of extended periods of war and displacement; this prevented them from recognising mental health issues and reaching out to seek help. Providers found that the refugees often feared sharing their personal situation as they felt that being diagnosed with a mental illness could 'send them back' or 'lose their children'.
- **Service utilisation:** Focus group participants agreed that they didn't trust their General Practitioner enough to discuss their mental health issues. There was also a preference for having a doctor of the same sex as the patient and from a similar background. They commonly said that they were not familiar with the health system and not aware of any mental health services; the specialist service in a government facility had very long waiting times,

while going to a private service was very expensive and they therefore preferred to endure any pain rather than spend money on a doctor. Service providers stated that they did not hear of very positive experiences regarding their clients' interactions with health workers, especially with General Practitioners; clients felt that the General Practitioners did not spend enough time with them and simply followed a tick the box approach.

Recommendation 1:

(a) It is recommended that culturally sensitive and appropriate health and mental awareness programs be prioritised to increase mental health literacy among Syrian and Iraqi refugees settling in the Nepean Blue Mountains region. Such programs will help generate awareness of general health and mental health issues, and address the otherwise sensitive mental health issues and the stigma associated with them. Incorporating bilingual workers in these programs would help address the language barrier and maximise information sharing about various other health services.

(b) It is recommended that social community groups of Iraqi and Syrian communities in the Nepean Blue Mountains region be promoted to facilitate socio-cultural integration. These social community groups could be a social platform for women, men and youth to discuss common issues that they experience. Such platforms could also be used to discuss issues around mental health, health and wellbeing and the importance of seeking health services. Health service providers need to effectively engage with local community and settlement services organisations for these groups, as they are the first point of contact in the initial settlement period.

Settlement and mental health: Research findings highlight that poor settlement and various uncertainties after migration were a major cause of isolation, stress and anxiety amongst these communities. Poor settlement was identified as being a result of stresses at multiple levels in their settlement journeys: at an individual level, as they cope socially and economically with the new life and culture in the new environment; at family level, with the disparate acculturation levels of parents and children; within the community; and in their interactions with the settlement services.

- **Settlement for individuals and family:** Social capital contributed immensely to a positive settlement experience for Iraqi and Syrian refugee communities. Coming from a collective culture to the new environment with a dominant individualistic culture, with few or no friends and family, led to isolation. Further, the change in culture, altered power dynamics within families, and a widening acculturation gap and poor communication between parents and children led to increased tensions for individuals and families. Focus group participants also shared that they were afraid of their children losing their hereditary culture while they struggled to adapt to the new culture. As parents, they felt constant stress in negotiating between the two cultures. Other initial settlement challenges included: the language barrier that affected daily life; finding a house as they have big families and housing is expensive; adjusting to the new culture and changing lifestyles; financial issues and high expenses – most participants were new migrants and were receiving a Centrelink payment, which they did not find sufficient.

- **Employment and downward economic mobility:** Focus group participants said that they were unable to find employment in Australia due to the language barrier and non-recognition of overseas educational qualifications, and a lack of guidance or support to help them find a pathway. Some participants shared experiences of being exploited by employers (cash in hand jobs, no health cover, not paying for the work being done) as they (the participants) weren't aware of the system. They linked these experiences, and especially not being able to find a job, to a lack of purpose which led to constant depression and anxiety. Past experiences of uncertainty from the war and camp life plus added pressure here to find employment increased the constant stress they already felt to settle in.
- **Interactions with settlement services:** Most focus group participants were not aware of the system and felt a need for closer engagement to help them settle in the new environment. Service providers thought that settlement services needed to be tailored to address individuals instead of using a top down blanket approach. They identified a need for more services, with specific services concerned with parenting workshops, awareness about Australian culture, employment and housing needs. Focus group participants shared the difficulty that the settlement program was linked to their payments from Centrelink, which constantly pressured them to go either to classes or to Centrelink or the Job Active Providers in order to get their payment. They felt they needed more than the initial three months to settle into the new system.

Recommendation 2:

(a) It is recommended that NBMPHN facilitate pathways for health services and settlement service providers to work together. This will enable early diagnosis of mental health issues in the initial settlement period and also help generate awareness around health and health services utilisation.

(b) It is recommended that all stakeholders work closely with stakeholders in government, public, community organisations and the private sector to develop interventions that address the settlement issues of Iraqi and Syrian refugees; this would help ease their settlement experience and address the anxiety and stress that arise as a result of it.

Health services gaps as commonly identified by focus group participants and the service providers in their interactions with the health services. Poor awareness amongst the Iraqi and Syrian refugee communities of the services available and poor knowledge of English language were identified as common barriers to accessing the services. Refugees' experiences with utilisation of present services, such as General Practitioner services and interpretation services, were not very positive.

- **Poor awareness of services:** Although the service providers were aware of this gap amongst the Iraqi and Syrian refugee communities, they were under-resourced to reach out and engage with them.
- **Experience with General Practitioners:** Focus group participants commonly agreed that they preferred not to go to a General Practitioner, as in most cases they would refer them to specialist doctor, whom they couldn't afford. They also felt that General Practitioners employed a tick the box approach and were not sensitive to them, and didn't allow adequate time to listen to their problems and issues. Service providers concurred with these findings and added that the General Practitioners had poor cultural awareness and sensitivity, especially for refugee/s families, and were unaware of settlement services for referral purposes.
- **Language barrier:** As most services were provided in English, poor knowledge of the language also was a barrier to knowing of the service and accessing it.
- **Interpreters:** Focus group participants shared their experiences of the unavailability of interpretation services with General Practitioners, or being refused the service; focus group participants preferred to go to the hospital as there were no interpreters at medical centres. They also recounted experiences of specialists not wanting to provide for interpreters. Service providers shared similar experiences and added their clients' experiences of breaches of confidentiality by interpreters, which affected their trust in sharing personal information and seeking these services.
- **Limited or no follow up:** Service providers identified poor follow-up mechanisms and limited mechanisms, or none, for recording patients' background information which could help in better service provision. Focus group participants also found poor follow-up, or none, in some health services, such as immunisation and children's surgery.

Recommendation 3:

(a) It is recommended that NBMPHN adapt a robust culture competency framework to assess the culture competency of health service providers and train them accordingly. Health service providers and General Practitioners need to be assessed and trained for culturally and linguistically sensitive awareness of how the background and culture of these communities impact health and access to health services. Health service providers also need to be trained in the various settlement services available for these refugee communities.

(b) It is recommended that a mechanism be developed that ensures interpretation services are provided and utilised at all medical centres and health facilities in the Nepean Blue Mountains region, and that confidentiality is prioritised and practised.

Additional Themes Emerging from Focus Groups and Interviews with Service Providers

Experiences with health services: In addition to the common findings, as provided above, focus group participants stated that their experiences of seeking health services from General Practitioners or other health services were not very positive. They said that they prefer to travel long distances to see a doctor they know, for the familiarity, comfort and, most importantly, for the quality of service. They felt that the quality of services at medical centres/government hospitals was poor, there were long waiting times for specialist services and they could not afford a private hospital for specialist treatment as it is very expensive.

Recommendation 4:

(a) Research identifies that there are interested health service providers, especially General Practitioners, who are keen to work with the Iraqi and Syrian refugee communities. It is recommended that such interested staff and 'refugee friendly General Practitioners' be closely engaged with to equip them with cultural and settlement skills to cater specifically to refugee communities.

(b) It is recommended that NBMPHN invest in community engagement activities to improve outreach. It is recommended that bilingual staff be engaged for these activities, who will address the language and cultural barriers and enable trust and comfort amongst these communities.

Health service provision: In addition to the service provision gaps identified by both focus group participants and service providers, service providers admitted that they faced challenges at various levels of service provision; they identified further deficiencies and highlighted their needs in order to improve health services outreach. They stated that they were understaffed and overworked and that funding cuts were common, which led to pressure and uncertainty about the continuity of their employment, further affecting their output.

A service provider also pointed out that the limited funding environment led to the services becoming more territorial and competitive, rather than being cooperative. Providers admitted that while they were aware of the limited outreach of services and refugees' poor awareness of them, they had too few resources to modify services to increase outreach. They provided some suggestions towards helping them improve service delivery and outreach for these communities, such as identifying and training interested 'refugee friendly General Practitioners' and other health staff and creating awareness amongst refugee and migrant communities about various physical and mental health issues.

They highlighted the need for early diagnosis and treatment of mental health issues, especially those that are trauma related. They pointed out limitations such as there being little scope for diagnosis unless for an acute form of mental illness which is 'visible', and that specialist services are expensive and hence inaccessible. Service providers admitted that they were unaware of the health and mental health needs of Iraqi and Syrian refugee communities and that clarifying this could help them

better prepare for service provision. They further highlighted the necessity to prioritise the needs of Iraqi and Syrian refugees and invest resources accordingly, and to be more flexible in the health services to accommodate these needs.

Recommendation 5:

(a) Research highlighted the limitations of resources in funding and personnel to cater to the present population in the Nepean Blue Mountains region. An increase in the refugee population, with complex health needs, would exert further pressure on existing health staff. It is recommended that various health and mental interventions be evaluated to assess these shortages and to prioritise funding to hire more bilingual staff in order to meet the needs of refugee communities.

(b) As the refugee population is expected to increase in the Nepean Blue Mountains, it is imperative to conduct an in-depth health needs assessment, identify priority interventions for the Iraqi and Syrian refugees and invest resources accordingly to meet their growing needs.

(b) Research highlighted some best practice models previously utilised, such as a mobile (dental) clinic and providing mobile health services at convenient and accessible spaces, such as community centres, thus taking the service to communities. It is recommended that such innovative models be further researched and adapted to enhance services access.

(c) It is recommended that platforms be developed that ensure increased inter-agency communication and better coordination of health service providers, migrant resource centres, community organisations and settlement service providers. This would facilitate smooth flow of information and a learning process in working together, and would avoid duplication of activities.

References

1. Protection DolaB. Australia's response to the Syrian and Iraqi humanitarian crisis. 2015.
2. Bowers Jackson E, Cheng I. Meeting the primary health care needs of refugees and asylum seekers. 2010;(16).
3. UNHCR. UNHCR Global Resettlement Report 2014.
4. UNHCR. Global Trends Forced Displacement in 2015. Geneva: UNHCR 2016.
5. UNHCR. UNHCR Statistics: The World in Numbers 2016. Available from: http://popstats.unhcr.org/en/overview#_ga=1.143788348.886116966.1477352560
6. Department of Immigration and Citizenship. The Settlement Journey: Strengthening Australia through migration In: Department of Immigration and Citizenship, editor. Australia: Australian Government 2012.
7. Khoo S-E. Health and Humanitarian Migrants' Economic Participation. *Immigrant Minority Health* 2010;12:327-39. Epub 339. doi: 10.1007/s10903-007-9098-y.
8. Refugee Council of Australia. 2015-16 Refugee and Humanitarian Program: Discussion Paper and Consultation Questions Australia: Refugee Council of Australia 2015.
9. Benson J, Smith M. Early health assessment of refugees. *Australian Family Physician*. 2007;36(1/2):41-3. PubMed PMID: 216302164; 17252083.
10. Health AGDo. Medicare Benefits Schedule (MBS) Health assessment for refugees and other humanitarian entrants, Fact Sheet Australian Government 2014.
11. Department of Health SGV. The Victorian refugee and asylum seeker health action plan 2014–2018. State Government Victoria 2014.
12. Department of Health NG. Refugee Health Plan 2011-2016. In: Department of Health NG, editor.: NSW Government 2011.
13. Tiong ACD, Patel MS, Gardiner J, Ryan R, et al. Health issues in newly arrived African refugees attending general practice clinics in Melbourne. *Medical Journal of Australia*. 2006;185(11/12):602-6. PubMed PMID: 235744921; 17181501.
14. Gould G, Viney K, Greenwood M, Kramer J, Corben P. A multidisciplinary primary healthcare clinic for newly arrived humanitarian entrants in regional NSW: model of service delivery and summary of preliminary findings. *Australian and New Zealand Journal of Public Health*. 2010;34(3):326-9. doi: 10.1111/j.1753-6405.2010.00535.x.
15. Green JP, Eager K. The health of people in Australian immigration detention centres. *Medical Journal of Australia*. 2010;192(2):65-70. Epub 70.
16. Finney Lamb C, Smith M. Problems refugees face when accessing health services. *NSW Public Health Bulletin*. 2002;13(7):161-3.
17. Services VDH, Region SM. Understanding the client experience: Refugees accessing and utilising the health system in Australia Victorian Refugee Health Network. In: Services VDH, editor. 2009.

18. Thomson MS, Chaze F, George U, Guruge S. Improving Immigrant Populations' Access to Mental Health Services in Canada: A Review of Barriers and Recommendations. *Journal of Immigrant and Minority Health*. 2015;17(6):1895-905. doi: 10.1007/s10903-015-0175-3.
19. Australian Survey Research. *Settlement Outcomes of New Arrivals Australia*: Department of Immigration and Citizenship 2011.
20. Department of Immigration and Border Protection. *Annual Report 2013-14*. In: Protection DolaB, editor. Australia Australian Government 2014.
21. Department of Immigration and Border Protection. *Fact sheet – Australia's Refugee and Humanitarian programme*. In: Department of Immigration and Border Protection, editor.: Australian Government 2015.
22. Cheng IH, Drillich A, Schattner P. Refugee experiences of general practice in countries of resettlement: a literature review. *The British Journal of General Practice*. 2015;65(632):e171-e6. doi: 10.3399/bjgp15X683977. PubMed PMID: PMC4337305.
23. Garrett PW, Dickson HG, Whelan AK, Whyte L. Representations and coverage of non-English-speaking immigrants and multicultural issues in three major Australian health care publications. *Australia and New Zealand Health Policy*. 2010;7(1):1. doi: 10.1186/1743-8462-7-1.
24. Chevalier M, Buckles D. *Handbook for Participatory Action Research, Planning and Evaluation Canada*: SAS2, Dailogue, Ottawa 2013.
25. Renzaho AMN, Green J, Mellor D, Swinburn B. Parenting, family functioning and lifestyle in a new culture: the case of African migrants in Melbourne, Victoria, Australia. *Child & Family Social Work*. 2011;16(2):228-40. doi: 10.1111/j.1365-2206.2010.00736.x.
26. Renzaho AMN, McCabe M, Sainsbury WJ. Parenting, role reversals and the preservation of cultural values among Arabic speaking migrant families in Melbourne, Australia. *International Journal of Intercultural Relations*. 2011;35(4):416-24. doi: 10.1016/j.ijintrel.2010.09.001.
27. Braun V, Clarke V. Using thematic analysis in psychology. *Qualitative Research in Psychology*. 2006;3(2):77-101. doi: 10.1191/1478088706qp063oa.

Annexures

Annexure 1: Focus Group Topic Guide:

Preliminary assessment of the (mental) health needs of, and services available for, Syrian and Iraqi refugees settling the Nepean Blue Mountains region

1. Grand Tour Question: *As a new migrant to Australia what have been your experiences so far?*

Probe and discuss changes with regards to:

2. What changes have you experienced following migration?
 - a. culture shock,
 - b. intercultural conflict,
 - c. changes in social status and social capital
 - d. acculturative stress
 - e. cultural integration
 - f. perceived prejudice and/or discrimination
 - g. gender role reversal
 - h. role of children
 - i. family support structures
3. Let us talk about general health: In your opinion, upon arriving in Australia, what do you think have been your most pressing health needs? Do they mirror your health needs prior to relocating to Australia? If not, what have been the differences?

Probe and discuss health needs with regards to:

- a. What are the most pressing health needs for your community? (prompts – mental health, chronic diseases, access to and utilisation of health services and their cultural appropriateness)?
 - b. Where do you go when facing a health issue or seeking support health related information?
 - c. What would encourage you to seek medical help?
 - d. What would prevent or get in the way of seeking medical help?
4. Let us now talk about finding medical help. Do you know what services are available to you? How would you choose which service to use? (Under what circumstances would you go to the hospital?)
 - a. Awareness of the available health services
 - b. Accessibility and reach?
 - c. Cultural appropriateness?
 - d. Responsiveness

5. This question presumes that the individual has a General Practitioner.
 - a. Why do you usually go to your GP?
 - b. What health issue would you see your GP for?
 - c. What health issues wouldn't you see your GP for? Who would you see instead or where would you go?
 - d. What has been your experience when visiting your GP?

Probe and discuss:

- a. What did you like?
 - b. What didn't you like?
 - c. What changes would you like to see happening to improve services?
 - d. What are the barriers for you visiting your GP?
 - e. Would you discuss your mental health with your GP? If not, why not?
6. Let us now focus on mental health, is this significant in your community?

Probe and discuss mental health needs with regards to:

- a. Understanding of mental health issues (is mental health acknowledged in your community? What is your cultural perspective on mental health?)
- b. Who are the most affected by mental health issues in your community? Why? How would describe they suffer?
- c. Do you seek any sources of information when either you or someone you know is facing mental health issues?
- d. How do use this information? Does it help in your health seeking practice for mental health services?
- e. What kind of mental health support services are accessible in your community? What would prevent or get in the way of someone in your community seeking professional help? What would encourage them?
- f. What would help a person in your community to access mental health services?
- g. What would mental health service look like that best suits your community needs?

Invite participants to ask questions of their own throughout the focus group and reiterate this at the end: *Did anyone have further questions or comments to share with the group?*

Annexure 2a: Interview Guide for Service Providers (non-GPs)

1. Demographic questions:

How long have you worked in this area? _____

How long have you been with this organisation? _____

What is your position in the organisation? _____

2. Let's talk about the health needs of migrant and refugee communities. Can you tell me about your experience in working with migrant and refugee communities?

Did you find they had significantly different health needs to the wider community? If yes, what were they?

Have you changed or modified your services to meet their needs? What did you do?

What worked? What didn't work?

Can you please share your understanding of the most important health needs of the Syrian and Iraqi refugee communities?

3. Can you describe the services that you provide that would address the health needs of the Syrian and Iraqi refugees? Could you make your services more accessible to Syrian and Iraqi refugees?

4. Are you aware of any issues that may discourage Syrian or Iraqi refugees (or other migrant groups) from seeking your services?

5. Do you know of other health service providers that you can refer refugees to? Who are they?

6. Let's talk about mental health more specifically:

What's your understanding of mental health issues that may affect Syrian or Iraqi refugees?
If relevant: Would your treatment plan and/or referral pathways be different for these groups?

7. What do you perceive as the gaps in service provision in this region for the Syrian and Iraqi communities (or other migrant communities)?

Probe: How do you know this? How can those gaps be filled? By whom?

8. What assistance and/or support would be beneficial to you in providing services to Syrian and Iraqi refugees?

9. Is there anything else you would like to add/discuss?

Annexure 2b: Interview Guide for General Practitioners

1. Demographic questions:

How long have you worked in this area? _____

How long have you been with this practice? _____

What is your position in the practice? _____

2. Let's talk about the health needs of migrant and refugee communities. Can you tell me about your experience in treating migrant and refugee communities?

Did you find they had significantly different health needs to the wider community?
If yes, what were they?

Have you changed or modified your services to meet their needs? What did you do?
What worked? What didn't work?

Can you please share your understanding of the most important health needs of the Syrian and Iraqi refugee communities?

3. Can you describe the services that you provide that would address the health needs of the Syrian and Iraqi refugees? Could you make your service more accessible to Syrian and Iraqi refugees?

4. Are you aware of any issues that may discourage Syrian or Iraqi refugees (or other migrant groups) from seeking your service?

5. Do you know of other health service providers that you can refer refugees to? Who are they?

6. Let's talk about mental health more specifically:

What's your understanding of mental health issues that may affect Syrian or Iraqi refugees?
Would your treatment plan and/or referral pathways be different for these groups?

7. What do you perceive as the gaps in service provision in this region for the Syrian and Iraqi communities (or other migrant communities)?

Probe: How do you know this? How can those gaps be filled? By whom?

8. What assistance and/or support would be beneficial to you in providing services to Syrian and Iraqi refugees?

9. Is there anything else you would like to add/discuss?



Halab (Aleppo)

SYRIA

IRAQ

SAUDI ARABIA

(Hamath)

Tadmur

Al Mayādīn

Abū Kamāl

Al Ḥadīthah

At Tanf

2579 +R

Ar Ruṭbah

Trebil

Sabal Unayzah

Kā'id

Nukhayb

3084

+1230

Badanah

Al Ma'āniyah

Al 'Uwayqilah

Ad Duwayd

Sakākah



Q
M
T
A

Baghdād

Kermānshāh

Kirkūk

Kifri

Balad

Ba'qubah

Al Musayyib

Karbalā

Al Kūfah

An Najaf

Ash Shināfiyah

As Sikr

Al Jumaymah

Qaqr-e Shirin

Khānaqīn

Mandalī

Badrah

Al Kūt

Al Hayy

Ad Dīwāniyah

As Samāwah

As Salmān

Makhtar

al Buqayyah

al Hijarah

Ilām

9186 +

Al Kūt

Al Hayy

Ash Shatrah

Al Uzayr

An Nāshiriyah

Makhtar

al Buqayyah

al Hijarah

Khorramābād

Dez

Thuris

Ash Shatrah

Al Uzayr

Al Qurnah

Hawr al Hammār

Al Qurnah

Malyer

Nahāvand

Borujerd

Darbānd

Khān

Dezfūl

Lā

Shūshta

Masjed

N

While the Australian Government Department of Health has contributed to the funding of this material, the information contained in it does not necessarily reflect the views of the Australian Government and is not advice that is provided, or information that is endorsed, by the Australian Government. The Australian Government is not responsible in negligence or otherwise for any injury, loss or damage however arising from the use of or reliance on the information provided herein.

Level 1, Suite 1, Werrington Park Corporate Centre
14 Great Western Highway, Kingswood NSW 2747
Post to: WHL, Bldg BR, Level 1, Suite 1,
Locked Bag 1797, Penrith NSW 2751
www.nbmphn.com.au | 02 4708 8100



Australian Government



Blue Mountains | Hawkesbury | Lithgow | Penrith

Wentworth Healthcare Limited (ABN 88 155 904 975) as Nepean Blue Mountains PHN.

www.nbmphn.com.au/reports

© 2017 Wentworth Healthcare Limited 169_0517