Chapter 13
Cycles of settlement: generating responsive health services for refugees in rural Australia

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Learning objectives

- Define the terms migrant, refugee, asylum seeker, internally displaced person, temporary protection visa, developmental status of a country, trauma and posttraumatic stress disorder.
- Acknowledge the change in a refugee's cultural identity over time and place.
- Document the elements of a culturally and developmentally responsive service, and a framework for developing such services in rural settings.
- Understand and describe the concept and practice of duty of care, in the context of the complex multiple perspectives of the individual, the host community and the settlers' community.
- Describe the implications for refugee settlement when terms are derived from an urban-industrialised perspective (independence), compared with a human ecological health perspective (interdependence).

Introduction

> After that battle no one mentioned Battalion 27 anymore, though numerous souls … were still loose, wandering in every corner and bush in the jungle, refusing to depart for the Other World. From then on it was called the Jungle of Screaming Souls. (Ninh 1993)

In January 2004, the Australian Government proposed an increase in the settlement of migrants and humanitarian entrants in rural regions, particularly where 'employment opportunities exist and appropriate services and community support exist or may be developed' (DIAC 2007). With such shifts in settlement policy, it is timely to consider how refugees who settle into rural settings face issues that are different from those faced by refugees who are placed in urban settings. A policy that encourages settlement in areas

where professional support is limited diminishes the importance of equal access to appropriate health care and support services. In under-resourced rural communities, voluntary agencies and nongovernment organisations (NGOs) often become the principal providers of services, with marginal professional support. This can contribute to frustration for providers and distress for settlers. In addition, as in the quote above, refugees carry the memories of the living and the dead with them as they move into the Australian rural landscape.

This chapter is concerned principally with the provision of health care to refugees who have permanent residency status and whose initial settlement is supported by agencies contracted to the Department of Immigration and Citizenship (DIAC). The permanent residency status entitles them to government health and social services, access to employment and other nongovernment services.

Refugees commonly have little control over their country of destination or the timing of the move. For most, the choice to leave their country of origin is a reluctant or forced choice, and involves separation from family and community. They may have spent extended periods in refugee camps, or as internally displaced persons, and may have suffered from torture and war.

Asylum seekers are another category of entrant. Many asylum seekers in Australia have been issued with Temporary Protection Visas (TPVs). Settlement is particularly challenging for those with TPVs, because they are excluded from settlement schemes that facilitate employment, safe housing, and predictable lifelines (Mitchell and Kirsner 2003).

Settlement: assimilation, integration and marginalisation

Settlement refers to the early stages of adaptation or acclimatisation of refugees to the host culture and the ecological environment. Although immediate settlement challenges are mostly practical, the process of settlement is also influenced by assumptions, held by refugees and their host communities, about ideas such as ‘fitting in’, which are in turn influenced by cultural origins, policy and broader debate about immigration. Members of host communities can have attitudes ranging from delight at the prospect of exposure to different cultures through to overt racism and hostility. Refugees can arrive with contradictory feelings of excitement and hope, and fear and worry. There can be an underlying conflict between culturally-based assumptions of ‘who should accommodate whom’ in relation to issues such as religious practices, family structures and decision making.

It is often assumed that these differences will be resolved by the processes of assimilation or integration. Policies that promote integration in preference to assimilation, with attention to generational trauma, may decrease mental health distress if discrimination is minimised (Bertrand and Lescarret 2003). An assimilation model can lead to a settlement experience which appears successful, but which entails only a superficial sense of belonging. A gap can develop between a refugee’s espoused beliefs and public behaviour, and her/his deeply held beliefs, invoking feelings of alienation. Refugees who openly

reject attempts at assimilation can be marginalised by both the host and the settled communities.

Regardless of the preferred model, there is no reliable method for predicting or evaluating the pace of settlement of an individual, family or cultural group. Refugees are likely to move from place to place, often including return trips to their homeland, before deciding on the best available option or becoming reconciled to their new home. A typical scenario is that of a resourceful and family-oriented father succeeding in the competitive process of qualifying for resettlement, only to find himself in futile conflict with his partner's and teenage children's status as the recipients of family and youth payments.

Where initial settlement is in a rural area, a refugee's self-resourcing is likely to take a more extreme form, compared with the same process in urban areas where moving over short distances can lead to significant differences in opportunity or experience. Refugees are in a double bind because they cannot predict what a new place will be like without experiencing that place first-hand. If the new place is not what someone had hoped it would be, then the experience of 'dis-placement' can add another layer of disappointment and distress. Many refugees are seen as seeking short-term solutions, and members of the host community can easily interpret this behaviour as offensive, ungrateful or foolish, which can lead to marginalisation.

If settlement success is evaluated in a complex manner, there will be uncertainty associated with a refugee's unicultural, bicultural, and multicultural identities. A refugee's attitude to their own cultural identity can vary across time and place, and is often characterised by a tension between relief and gratitude at being safe, and regret and anger at being displaced. A refugee assisting more recent arrivals can experience complex feelings associated with revisiting traditional practices; for example, pride and guilt about having made a shift in cultural identity. A refugee may have ongoing insecurities in relation to permanent status, triggered by media reports of deportation, gang violence, or contact with police or immigration officials.

It is imperative that health professionals understand the context from which a refugee flees, as this will influence her or his potential for settlement (Cernea 1995). For example, if people have been living in a refugee camp outside their home country, their sense of culture may be different from those who migrated directly from their country of origin. It is not unusual for a refugee child or young person to have the experience of a refugee camp as a transitional place.

Australian Government policy on issues such as family reunification can have a powerful effect on the overall settlement experience, overshadowing any relative successes. Consider the case of a man from Eritrea who fled to a refugee camp without his wife and children. He settled in a community with refugee status and three years later is still trying to find the economic means to bring his family to Australia under a family reunion scheme. Recent news about the drought in Australia has triggered worries about his family's wellbeing in Eritrea, as drought is a constant threat there. The man's sense of cultural integration is clearly less than his Eritrean male friend who arrived with his family at the same time.

Duty of care

The Australian Government has an international duty of care to refugees (under the 1951 United Nations Convention Relating to the Status of Refugees). Singer and Gregg (2004) contend that the 'issue of refugees should be part of a discussion of Australia's record as a good global citizen'.

Health professionals working with the refugee population in Australia have a duty of care to seek specialist training in working with the refugee population, beyond attempts to become knowledgeable about cultural norms and the refugee experience, or coming to terms with realities of human-rights abuses such as torture and associated trauma. Hauff and Vaglum (1997) point to the need for physicians to account for trauma related to torture, as well as to non-torture experiences. Health professionals need to be culturally, as well as clinically, competent and health services need to be culturally secure.

De-marginalising services

In rural regions in particular, when health (including mental health) care is underdeveloped for servicing special populations, there is a tendency for NGOs to 'pick up the pieces on the ground'. The lack of direct feedback to government (as the initial settlement decision maker) can lead to the creation of an even more tenuous model of accountability. For example, in rural regions it is common for religion-based organisations to provide social services and education in keeping with their own religious beliefs, practices and places for worship. This can challenge the legitimacy of some culturally-based responses to trauma histories (eg calling to deceased ancestors or unwillingness to forgive), and result in the delegitimisation of alternative religious beliefs and the spirit rituals of their clients. When a refugee feels grateful for assistance, he or she may feel an obligation to adopt the beliefs and ritual practices of the supporting agency. Alternatively, useful services may be rejected because to some extent all services are imposing; for example, one Muslim woman disengaged from a service because she was discouraged from reading the Koran. Although these problems are not restricted to rural areas, it is difficult to find medical schools and psychology training programs in Australia that train clinicians to work with complex trauma issues and ritual systems embedded in refugee histories, much less attend to traditional or Indigenous practices alongside medical practices.

Despite these inadequacies, health professionals can play a key role in outreach activities, if a good structure is provided. Withers and Powell (2003), in their report *Immigration and the Regions: Taking Regional Australia Seriously*, call for 'strengthening pro-active outreach activities by officials and holding them accountable for improvement'. Some practitioner–researchers have indicated a need for more culturally appropriate outreach services for refugees, who had formerly relied on traditional rituals and treatments used in their country of origin. These services can sit side by side with Western medical practices (Bahadur et al 2003).

Case study 13.1 Carla needs a hot drink

Carla, a Sudanese woman, settled in Tasmania in 2006. During the delivery of her fifth child, an Australian-born nurse contended that Carla was being uncooperative because she refused to take liquids during labour. However, when an attendant offered Carla a hot cup of tea, she accepted the drink. In Sudan, cold liquids are avoided during labour as a way of protecting the baby.

The hospital was not culturally secure, the nurse clinician was not culturally competent and Carla was not feeling culturally safe (see Chapter 10). If she had accommodated hospital protocol, her anxiety over the safety of her baby would have increased dramatically during the delivery.

It is a widespread observation that for years after arrival, refugees typically report more distress at the challenges of settlement and at their separation from loved ones or their homeland than problems associated with their pre-arrival experience (McMichael 2003). Even when the focus is on pre-arrival experience, it is easy to overlook critical issues. This is particularly the case where physical torture has occurred during the same period as other more conventional traumatic events (eg the natural death of an estranged family member). Faced with such presentations, the health professional is likely to seek an account of the torture, which is superficially more dramatic, rather than exploring the significance of the loss.

A compelling example is provided by a Muslim family subjected to racist violence after settlement in rural Australia, which included the forced removal of a woman's hijab. Family members' experiences of imprisonment during civil war caused far less emotional difficulty for them than the off-hand way this taboo behaviour was handled in their new country.

Given the natural response of horror and empathic concern in the face of extreme histories, it can be difficult to form sufficiently broad clinical experience to respond to such subtleties. Clinical expertise in the diagnostic category of complex trauma (itself an emerging idea) is not common, even in urban areas. In a rural area, which might host one or two waves of refugee settlement, the professional ethical task is a step-by-step challenge.

Reliable mental health intervention: accounting for complex trauma and cultural identity

When accounting for personal histories that involve long-term political violence, poverty, captivity and torture, trauma responses may be more complex than a posttraumatic stress disorder (PTSD) symptom checklist can capture (Kleinman 1995, van der Kolk and Fisler 1995). When people have been exposed to traumatic events for long periods of time, their responses include extreme emotions, such as horror, hatred and panic. They tend to

vacillate between a fight or flight response through cycles of settlement experience. Exaggerated responses often become patterned:

- compulsive behaviours in children that may increase over time
- nightmares with repetitive themes
- night or day dreams with culturally-based symbols, such as a black bird that signifies a bad omen
- total withdrawal from or over-engagement with social contact
- increasing alcohol and substance use
- feelings of detachment and amnesia leading to daily distress
- overattachment or underattachment in children to a person or object.

PTSD has some symptoms in common with other diagnoses, such as depression, phobias, schizophrenia or psychosis. Conversely, clinical depression or other enduring disorders can be a long-term consequence of PTSD.

Assessment of the way traumatic history contributes to mental health requires attention to cultural factors in addition to language and ethnicity (LeVine 2003a). Culturally meaningful events, such as spirit visitations or visions, can be confused with common trauma symptoms including images of the dead and flashback experiences. Some traditions emphasise signs or features of the physical environment (eg activities of animals or changes in weather patterns) as confirmation of community emotional and mental health. In such communities, displacement to different countries and the consequent disruption of protective rituals can provoke profound unease; which may be interpreted as trauma symptoms.

In addition, a person's age and stage of development when trauma events occur has an influence on the repertoire of symptoms that are experienced and expressed. It is not unusual for a young person or adult to regress as an expression of fear, particularly if they were traumatised at a young age, as is often the case for refugees. In addition, for refugees who have to migrate to Australia, their sense of cultural identity may become challenged as they attempt to integrate. There is a duty of care to ensure that the refugee is not misdiagnosed and that culture-specific concerns are considered.

The Launceston Project is an example of a project that has been designed with attention to the interaction of culture and trauma, and the long-term cycles of settlement for refugees. A group of general practitioners have formed a consortium for treating refugees who have settled into the region. Most refugees are from Africa (primarily Sierra Leone and Sudan), with a recent influx of Burmese. The composition of country of origin changes as international circumstances change, making service delivery challenging. A health clinic is held weekly in the Migrant Resource Centre, which administers the settlement contract and provides funded counselling and community support. Specialist cross-cultural trauma support and outcome-oriented research capability are provided to the clinic by experienced psychologists from the University Department of Rural Health. The clinic and the university teams include male and female practitioners. This

interprofessional team approach to refugee service provision enhances the support for the community as well as for the professionals who are providing the service.

A number of models to guide appropriate service delivery exist, including those developed by specialist agencies in Australia, such as the Victorian Foundation for Survivors of Torture (Kaplan 1998). LeVine (2003ab) proposed a cultural framework that is fluid enough to account for shifts over time in a person's cultural identity and comprises ten cultural factors, as represented by the acronym LANDSCAPES:

- language and accent
- ancestry and indigenous identity
- nationalities
- disability (physical, social, and psycho-emotional)
- sexual roles and birth order, and sexual identities
- community affiliations (group belonging)
- age and development (including developmental delays)
- place and geography (relationship to water and topography)
- existential — meaning-making systems, religious associations, and the metaphysical realm (including animistic perceptions)
- social status(es) (noting that status is influenced by the categories above, across gender, disability, age, sexual identity, religious affiliation, language and accent, etc).

LANDSCAPES has been used in training mental health professionals for work in developed and developing countries across urban, rural and remote settings. Such contextual frames can decrease a clinician or researcher's tendency to over or underestimate the impact of a person's minority status.

Research decisions, such as the choice of demographic categories, taken without consideration of the refugee's identity or community affiliation, can distort findings in ways that work against successful integration. Judd (2006) identified the need to aggregate data more sensitively in rural mental health research, invoking the idea of 'dimensions of locations' to account for community resource factors alongside rural and urban place indicators. The case study that follows discusses the ways in which 'place' affects a refugee's identity over time and his experience of 'support' resources.

Case study 13.2 A longitudinal study of Paulo at the ages of 10 and 19

Paulo came to rural Australia under a settlement policy when he was ten years old. He and his mother had fled to the refugee camps in the country of Wadu (a country that borders a tropical zone near the equator). Paulo lived in a refugee camp from the age of four to the age of nine, and spoke little English when he arrived in Australia. His mother was fluent in Italian and had some English; they spoke a dialect in the home.

After six months in an Australian primary school in rural Australia, Paulo was referred to a clinical trauma psychologist for an assessment of suspected attention deficit hyperactive disorder (ADHD). The school counsellor indicated that Paulo was unable to sit still very long and would roam in the class, appearing distracted. During a play assessment session, the youth said that he was worried about his mother being at home alone during the day and that he would go to the window to look towards the house. He said that he wished he did not have to come to school. As the session progressed, Paulo indicated that his bottom hurt when he sat in his chair at school and that he liked sitting on the floor. It was later revealed that he had been raped by men on a number of occasions when he was in the camps and that the chairs at school made it difficult for him to sit too long. He said that he tried to endure his pain and remain still so that his teacher would like him; he felt disappointed in himself that he wandered in the classroom. This dynamic of faltering in his attempts to please others led to his self-deprecation.

Paulo was eventually examined by a female general practitioner with his mother's permission and presence. A female physician was preferred by Paulo and arrangements were made accordingly for his physical recovery. Details of the violence endured by Paulo were not disclosed to school personnel as the referring counsellor believed confidentiality would be compromised if this became known by teachers.

At this early stage of settlement, aged 10 years, Paulo's salient cultural features were:

- disability — physical and psychosocial injury related to trauma
- sexual roles — male gender
- community affiliations — dependency on mother; no friends
- age and development — childhood developmental disruption of trust due to abuse, including fear-based attachment to his mother
- place — relationship to home as a safe place and school as an uncomfortable place; repercussions from his former life in the refugee camp.

At 19 Paulo attempted to look for gardening work, since he preferred working outdoors. He became more and more argumentative with his mother and claimed he had wasted years by studying to no avail. He had an Australian-born girlfriend and he was concerned that his mother did not approve of his choice due to their different cultural backgrounds. But what Paulo liked about his girlfriend was that she believed him when he told her that different bird calls brought messages to him from his father who had died just before he had migrated to Australia as a young boy.

He remained untrusting of relations with men and felt awkward when in their presence at the workplace; some of this related to his childhood sexual abuse while he was in the camps and the

fact that he had lived much of his life without an adult caring male in his life. He also felt as if he needed to protect his mother since he was the sole son, sometimes feeling as if he were the substitute father in the family system.

At this stage, aged 19 years, Paulo's salient cultural features were:

- disability — social disadvantage and past trauma
- sexual roles and sexual identity — heterosexual and love relations
- community affiliations — dependency on mother; no male friends
- age and development — late adolescence and confusion about his role as a son and adult, including social roles (male occupational options)
- place — shifting relationship to home and work, and a preference for outdoor environments
- existential and meaning-making systems — unsure of his future occupation and family role
- Paulo had thoughts of returning to his country of origin so that he could seek assistance from a spirit medium and assist his father to the 'other world'. When he was young, he became aware that a death by violent means (akin to his father's), could make the spirit roam restlessly. He knew his father was unsettled and wanted to assist him.

This case study shows the progressive developmental challenges of a migrant over time and place. Paulo came to Australia from the country of Wadu at the age of ten. Considering the LANDSCAPES factors at 10 and 19 years of age makes it clear that 'settlement,' and 'adjustment' are not straightforward and produces a more complex and dynamic view of Paulo's cultural identity.

Key points

- A responsive health service will pay attention to the ways in which refugees make meaning of their symptoms and life history, as it is critical to health outcomes. Because people's identities shift across time and context, it is useful to assess the cultural factors that the refugee and her or his community define as most salient.
- Ethnicity and gender are assumed to be most salient, when in fact the birth order in a family or sexual identity may be most pressing for the refugee.
- Social status is influenced by the LANDSCAPES factors across gender, disability, age, sexual identity, religious affiliation, language and accent, etc.
- The developmental history of someone's settlement experiences is crucial to assess when treatment is being designed (as seen in Paulo's case).

Recommended readings and resources

- Miller A (2005). *The Body Never Lies*, Norton & Company, Inc, New York.

In this book, Miller discusses the relationship between physical and mental health and how the body can store traumatic experiences that surface as physical ailments. In turn, symptoms are evidence of lived experiences and may require a contextual approach to health assessments.

- NHMRC (National Health and Medical Research Council) (2006). *Cultural Competency in Health: A Guide for Policy, Partnerships and Participation*, NHMRC, Canberra.

This guide offers a straightforward way for health practitioners to conceptualise and work toward cultural competency at both systemic and individual professional levels.

- Ninh B (1993). *The Sorrow of War,* Random House, Great Britain.

This biographical novel offers the perspective of a Vietnamese national who fought in the Vietnam war. Most of the evidence-based research on Posttraumatic Stress Disorder comes from American Vietnam Veteran studies. Ninh's book invites the reader to contemplate trauma in a culture that associates trauma with place.

- Read P (1999). *A Rape of the Soul so Profound,* Allen & Unwin, Australia.

Though this text is about Indigenous Australians, reflections on the ways in which assimilation policies disengage people from their geography and culture resonates with the depth of losses experienced by refugees.

- Taylor J (2004). Refugees and social exclusion: What the literature says. *Migration Action* XXVI (2):16–31.

Taylor gives an overall view of the history of policy development in Australia as it relates to those with refugee and asylum-seeking status. In addition, consideration is given to the relationship between poverty, language barriers, lack of health and education infrastructure and their contribution to the dynamics of social exclusion.

- van der Kolk BA and Fisler R (1995). Dissociation and the fragmentary nature of traumatic memories: overview and exploratory study. *Journal of Traumatic Stress* 8(4):505–525.

This is a classic article within the traumatic stress field. The authors give a coherent account of how experiences of torture and trauma disrupt people's capacity to stay oriented to time, place and person. Understanding the ways in which a refugee's history is experienced in nonlinear fragments is useful for clinicians who attempt to take timeline histories.

Learning activities

1. In small groups, contemplate the cultural shifts in Paulo's identity when he turns 25 years of age.
2. Generate some alternative paths Paulo may traverse and the contexts that may facilitate constructive development.
3. How might service providers participate in Paulo's future sense of purpose in the Australian context?
4. List practical life challenges you face in your own daily life (eg meaningful employment, paying monthly bills, finding or sustaining a constructive friendships and love relationships, maintaining a sense of belonging to place and 'home').
5. Discuss ways in which deficits in the areas listed above impact on your own physical, psychoemotional and social health.
6. How might someone with refugee experiences meet such challenges?
7. What support and duty of care might he or she require from health professionals along the way?