VIRTUAL THERAPY

Outreach to refugees in remote areas

MARC CHAUSSIVERT explores the viability of using video conferencing technology to service refugees in rural areas.

About 700 refugees living in rural NSW are not able to use specialised health services due to their geographical isolation. Over the last few years STARTTS has received a few referrals from rural areas and has also engaged in training and consulting with local health services in order to equip them to provide a more specialised assistance to refugees. However, it has not been viable for current STARTTS staff to travel to rural areas due to the low numbers of refugees.

The fact that there have been few referrals from refugees in these areas does not mean that the needs don't exist. The potential number of referrals would probably increase if a more regionally based specialised assistance was available. It is sometimes only after services are in place that some needs become apparent.

When STARTTS was founded in 1988 a particular model of service provision was adopted. This psychosocial model starts with the premise that the refugee trauma experience is often complex, involving multiple factors. Traumatic events as such are usually only one component of the overall picture, which also includes previous life experience, the process of migration and resettlement in the host country, and the social and cultural context of the person.

There is now a body of research that suggests that these factors are critical to be able to understand the refugee person's distress and difficulty. Previous life experiences will have an impact on levels of both resilience and vulnerability. Migration might involve additional violence as well as losses and changes. Resettlement may also involve a range of material and psychological difficulties. In this case, access to support services and resources will be vital for coping with the cultural, linguistic differences and prejudice.

In addition, the refugee experience takes place within a social and cultural context. Martin Baro (1989) has shown how state sponsored violence can have a broad impact across a population even if individuals are not the victims of killings or torture. This occurs through the pervasive fear and terror such violence elicits along with the destruction of social and cultural institutions and relationships. Moreover in many cultures there is greater emphasis on social roles and relationships than in the west where more importance is attached to the individual's wishes and aspirations.

Research conducted with the East Timorese community found that their concept of trauma was tied to a collective memory of Indonesian occupation of East Timor. This means that the notion of recovery from individual personal or family trauma needs to acknowledge and be consistent with such a shared social memory in this case relating to aspirations for independence and the recognition of their rights to asylum with the consequent access to services. Social strategies may include assisting individuals to reconnect to their communities as well as rebuilding and maintaining community structures. In this case the *normalisation* of 'symptoms' and experiences takes on a social focus drawing from the resources and resilience within the community. Other strategies would include informing communities of services, requesting their input into the structure of services and working with families.

From the perspective of our psycho social model where resettlement is treated as a critical factor in understanding the difficulties faced by refugees, the expertise and assistance provided locally (in rural areas) will be a central factor in the provision of adequate care. Any client or patient will need to establish a relationship with the local health professionals who will then shape and influence any intervention involving other services.

Lately a number of rural health services have requested that STARTTS become involved in providing direct assessment and treatment for some referrals. How can we do so in a way that is viable and effective? One strategy can be the use of video-conferencing technology.

A trial of this technology took place in 1999 when a rural Mental Health Service referred someone of Afghani origin for trauma counselling. The client had been assessed as suffering from clinical depression and post-traumatic symptoms. He had seen a psychiatrist and had been prescribed anti-depressant medication. This client was 'seen' eight times with an interpreter over six months. Treatment using video technology ceased when he moved to Sydney.

The client reported improvement in his symptoms and improvements were also observed by others most notably a significant decrease in his level of withdrawal from the Afghani community. We can draw the conclusion that in this case video-conferencing technology did not impede the achievement of certain therapeutic outcomes, on the contrary it made them possible. However rather than focus on the details of this particular intervention, the aim here is to explore issues relating to the application of this technology more generally. For this purpose we need to look at how video conferencing technology might fit within the psychosocial framework for the provision of counselling services for refugees and evaluate its appropriateness according to criteria implied by this model.

Video conferencing has potential limitations in terms of the development of community development strategies in rural areas to address both community trauma and difficulties associated with the refugee experience and resettlement. Refugees may not be familiar with mainstream services and feel they are not be able to understand their difficulties. Some clients may associate video conferencing with surveillance or the recording of interrogations. It is also not amenable to group interactions.

A way of addressing these limitations exists, however, if video-conferencing is used as part of a broader repertoire of strategies, integrating it with other social strategies implemented locally that address community trauma and resettlement difficulties faced by refugees.

If we look at the above example, the groundwork done by local mental health workers in building a relationship of trust with the patient prior to linking him to assistance from STARTTS was critical to the success of the intervention. It is the local service providers who best understand the local context of service provision and the kinds of stressors and opportunities associated with resettlement. They are also in the best position to understand and assess mediating variables such as families and support networks. Thus through developing partnerships with local service providers a community-oriented focus can be brought to bear on addressing the needs of persons of refugee background.

Geographical isolation can also be minimised by utilizing other communication strategies such as the internet chat rooms as a way of linking people to other members of their communities in the same way that such technologies are currently used by some refugees to maintain contact across different countries.

Video conferencing technology offers an interesting and innovative way of addressing the needs of refugees in remote areas. The challenge is to do this in a way that addresses the *full picture* of the refugee experience including the social cultural context of trauma along with the experience of migration and resettlement. Given the early stage in the development of such an approach, the challenge ahead lies in its implementation and evaluation. ❍

Marc Chaussivert is a generalist counsellor and team leader at STARTTS. This article was adapted from a paper given at the NSW Rural Mental Health Conference, 2000.