Access Issues for Kurdish and Turkish Migrants in Relation to Health and Community Services in Regional Victoria, Australia

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Abstract

Social inclusion is recognised by the World Health Organisation as one of the key determinants of health. For newly arrived migrants and for some cultural groups the structures established by the Australian Government do not always facilitate inclusion. This paper highlights the particular needs of Culturally and Linguistically Diverse (CALD) communities living in regional areas of Australia. In particular the paper reports on a study of access to health and community services for Kurdish and Turkish migrants in a regional town in Victoria, Australia. The study found that these people experienced and are still experiencing barriers to accessing essential health and community services and this impacts on their social inclusion. Barriers to access include language, concerns of privacy, and issues of shame and stigma in relation to mental health issues. The findings suggest that services need to be more culturally aware of cultural barriers in order to provide better access to services. The participants of the study identified strategies of making services more accessible such as making advertisements more culturally appropriate, employing bilingual workers and establishing a community house.

Keywords

Access; Health and Community Services, Kurdish and Turkish Migrants, Regional Victorian Town, Social Inclusion, Social Exclusion

Introduction

Social inclusion is measured by surveying the social capital and social cohesiveness of people and also focuses on identifying the strength of social ties, networks and trusting relationships (Department of Economic and Social Affairs, 2010; Spoehr et al, 2007). The Australian Government has identified that being socially included means that people have the resources, opportunities and capabilities they need to ‘learn’ (participate in education and training), ‘work’ (participate in employment, unpaid or voluntary work including family and carer responsibilities), ‘engage’ (connect with people, use local services and participate in local cultural, civic and recreational activities), and ‘have a voice’ (influence decisions that affect them) (Chenoweth & Stehlik, 2001; McDonald et al, 2008; Social Inclusion in Australia: How is Australia Fairing, 2010).

Achieving social inclusion is now recognised as a preventative factor against a number of social risk factors. In 2009 the Australian Rudd Government launched the Stronger Fairer Australia policy to promote social inclusion in Australia. This agenda aimed to ensure that every Australian ‘has the capability, opportunity and resources to participate in the economy and their community while taking responsibility for shaping their own lives’ (A Stronger Fairer Australia, 2009, p. 3; Vinson, 2009). The policy recognises the multi facet nature of diversity and the social, political and economic factors which can lead to the exclusion of specific individuals and groups. In 2014 the current Australian Abbott Government announced the new focus of their policy which is to support vulnerable groups in society.

The Parliamentary Secretary Minister for Social Services (2014) further articulated this government policy of its relevance to newly arrival migrant communities in a speech for the Settlement Council of Australia. This speech highlighted that in order to achieve policy targets the government from all levels and, community organisations need to work in collaboration to ensure that services are not duplicated and meets the needs of newly arrived migrant communities. Reference was made to the Scanlon Foundation’s Mapping Social Cohesion 2013 Report which indicated that there were higher levels of discrimination in Australia compared to previous years (Parliamentary Secretary Minister for Social Services, 2014).

This speech is relevant to two studies which explored the perceptions of refugees in Western Australia in relation discrimination and well-being. Fozdar & Tozezani (2008) and Fozdar & Hartley (2013) reported that economic stability and income were of the highest priorities amongst these refugee groups. Discrimination was found to be a
barrier to employment in these studies.

Access to health and social services is a key factor in individual and community wellbeing (Cannon, 2008). For the majority of Australia’s population this access is taken for granted, but for newly arrived and settled migrants obtaining services can be problematic. Lack of access can lead to social exclusion as it impacts on people’s opportunity to participate in society fully and to receive their full entitlements. Social exclusion can result from racism, hostility, discrimination, stigmatisation and unemployment and can significantly impact on the health of individuals and communities (Wilkinson & Richard, 2003; Herrman et al, 2005; Nettleton et al, 2007; Cannon, 2008). The consequences of exclusion can create major impacts on health and wellbeing. The risk of exclusion is particularly strong on the health of people living in rural and regional areas (Vinson, 2009). Rural and regional areas can lack the level of services available in urban areas and this can heighten the risks of settlement problems for families.

There has been some attention in previous Federal and State Government policy about the importance of information about services being available in languages other than English (Department of Immigration and Citizenship, 2007). However, language translations of service brochures are only a part solution to the problem. Access requires people feeling culturally safe in approaching a service. Culturally safe includes not only having materials translated and using interpreting services but also employing bilingual workers, having artefacts or symbols which are culturally friendly, offering a welcoming atmosphere and showing empathy.

Participation and exclusion from community services can be difficult to interpret (Wilkinson & Marmot, 2003). Both under and over representation of a particular social group in a social service program can demonstrate a level of exclusion in the wider community. For example young people from lower socio economic groups are over represented in youth correction (Frederico et al, 1996). Another example of over representation which highlights the impact of social exclusion is that of Aboriginal and Torres Strait Islander children and young people being over represented in child protection services in Australia (Frederico et al, 1996).

The same phenomenon can be observed in reverse when certain groups become invisible to services. This is more likely to occur in services such as health services, maternal and child services, family support services. The reasons for the lack of representation of these groups in services may not be because they do not require the services, but that they do not come to the notice of the services because of accessibility issues (Klimidis et al, 1999; Taylor, 2004). The phenomenon of being invisible to services and therefore not having services planned to be culturally inclusive is the situation for the people involved in the study reported on in this paper.

The participants of this study were significantly invisible to services and this is a prime reason for their needs not being taken into account for service planning purposes (Alston, 2002b; Taylor & Stanovic, 2005). This paper focuses on access issues of Kurdish and Turkish migrants in relation to health and community services provided in a regional area. Whilst there has been research on similar issues locally and internationally, there is limited research which focuses on social exclusion of migrants on a regional level in Australia. This study aims to contribute to this gap in research.

**Cultural Diversity in Australia**

Australia is a country of high cultural diversity with approximately 22 million people who speak over 260 different languages. According to the Australian Government 2011 census data, approximately 26 per cent of Australians were born overseas which makes up a quarter of Australia’s overall population (ABS, 2011a). The 2011 census data also revealed that a further one fifth or 20 per cent of Australia’s population had at least one parent born overseas (ABS, 2011a). In particular approximately 47 per cent of Victorians were either born overseas or have at least one parent born overseas (Victorian Multicultural Commission, 2001; Victorian Multicultural Commission, 2013a). This data emphasises the importance of the availability of non-English language services on a national level (Roth, 2007).

The cultural communities in Australia are not homogenous and therefore have differing needs and issues (Cox, 1987; Reid & Trompf, 1990; Cox, 1996, Napier, 2006). The previous Australian Government sought to develop a new cultural diversity policy framework which would have contributed to social inclusion by pursuing respect, fairness and opportunities for participation in community life for all Australians (Social Inclusion in Australia: How is Australia Fairing, 2010). In September 2013 however, the incoming Australian (Abbott) Government disbanded the Social Inclusion Board. However the issue of social inclusion remains a social justice and community issue. Although the focus of this study reported upon in this paper is with Kurdish and Turkish migrants, the findings can contribute to informing such policies which promote social inclusion for new settlers and minority cultures.

**The impact of the Migration Process**

Khawaja (2004) conducted a comprehensive research study which investigated the impact of migration and the psychological distress predictors for Muslim people in Australia. There were 280 participants in Khawaja’s study who came from 43 different countries. The participants came from Asia, Middle East, Africa, and Europe. According to Khawaja (2004) Muslim migrants experience both long term and short term psychological distress such as depression and anxiety. The two main predictors of psychological distress were resettling in Australia with the difficulties of low level English language skills. Women stated they were often more isolated than men and therefore were more prone to...
developing long term psychological distress (Khawaja, 2004). Similarly, another study by Alston (2002a) identified that there are higher rates of health issues of people from rural and regional parts of Australia which could suggest greater need for service access.

Access Barriers to Services in CALD Communities

The most significant and common reported barrier to service access is low proficiency in the English language (Minas & Hayes, 1994; McDonald, 1994; HREOC, 2004; Khawaja, 2004; Victorian Government Department of Justice, 2005; Hardgrave, 2003; HREOC, 2005). Limited English skills have many negative psycho-social implications for CALD people. Low level English language skills prevent people from understanding information about health and community and also inhibit people from fluently expressing their needs (Khawaja, 2004; Adler & Rodman, 2006). The language barrier as identified by Khawaja (2004) also has implications for poorer health outcomes and increased risk of developing psychological distress in Muslim migrants.

In 2007 the Department of Immigration and Citizenship (DIAC) conducted a research study which evaluated over 100 Australian Government agencies to determine how effective health and community services were in promoting services to CALD communities (DIAC, 2007). The study consisted of over 1,600 representatives from government agencies across Australia, including the Federation of Ethnic Communities Council of Australia (FECCA). The report found that government services are underused by CALD communities and it was predicted that this was a result of primarily the language barrier. A limitation in DIAC’s (2007) study was that the focus was on the perspectives of agency representatives across Australia. It would be appropriate for future studies to focus on consumer perspectives in order to gain further understanding about the underutilisation of health and community services (Ruzzene, 2002).

Presenting Problems

CALD people in Australia may present to their family doctor for physical complaints even though their complaint may have psychological underpinnings. This was highlighted in a comprehensive research study on CALD communities and gambling services which was conducted by the Victorian Department of Justice (2005). The research sought to identify health promotion and best practice services for CALD problem gamblers. The conclusion of the study was that CALD people considered doctors to be a major source of assistance for health and emotional needs (Victorian Government Department of Justice, 2005).

Kurdish History and Migration to Australia

Since Federation over 740,000 people have settled in Australia under a refugee or humanitarian visa (Department of Immigration and Citizenship, 2010). Kurdish people began migrating to Australia under humanitarian refugee visas in the late 1960s when the first wave of immigrants were admitted to Australia under bilateral labour agreements (Babacan, 1996, p. 159). Many Kurdish people have settled in Australia as refugees (Peralta, 1997).

Refugees are defined as people who have been forced to flee their country due to political factors such as fleeing to avoid war and persecution or fleeing because they have been subjected to persecution due to race, religion, political and social associations (Department of International Protection, 2005). Many refugees and in particular Kurdish refugees have suffered from torture and trauma. Research indicates that generally these people have a higher need to access health and community services because of ongoing physical and psychological damage (Graham, 1989; Mansfield, 1991; Lewis, 1995; cited Batrouney in Babacan, 1996, p. 160; Goldschmidt, 2002; Castles, 2004).

The Kurdish people are the largest ethnic group living within the borders of Iran, Iraq, Syria, Turkey and the former Union of Soviet Socialist Republics. Although Kurdistan is not recognised on the world map and is sometimes said not to exist Kurdish people regard their homeland as a distinct entity called Kurdistan.

Below is a map of where Kurdistan is located in the Middle East (www.theguardian.com, 2014).

Figure 1. The map of where Kurdistan is located in the Middle East

Many Kurdish people mask their Kurdish identity due to fears of persecution and for this reason often claim themselves as; Turkish, Iranian, Iraqi, Syrian or other ethnicities (Kurdish Institute of Paris, 2013). Kurdish people have suffered extremes of political, economic, cultural and physical oppression in the Middle East (Short & McDermott, 1975; Sugden, 2002). There are approximately 40 to 50 million Kurdish people living around the world. Due to the diaspora of Kurdish people and the denial of the race in some countries these figures are said to only be estimates and not exact statistics of population (Hardgrave, 2003; Koc, 2008).

There are limited Australian statistics which show exact figures of Kurdish people living in Australia and the native Kurdish languages/dialects spoken at home (Kurmanji, Sorani, Zaza). In 1992 there was an estimated 10,000 to 15,000 Kurdish people said to be residing in Australia in mainly
Sydney and Melbourne (cited Kurdish Institute of Australia in Babacan, 1996). According to the 2011 Victoria, Australia census data there were approximately 22,000 speakers of Iranian languages of which 3,000 people disclosed ‘other’ as their Iranian language (ABS, 2011b). The ‘other’ languages could very well include Kurdish dialects.

The Needs of Kurdish People in Australia

A community consultation was conducted in 2003 by Citizenship and Multicultural Affairs Minister which aimed to assess the effectiveness of the Liverpool Migrant Resource Centre located in Sydney (Hardgrave, 2003). In this study an informal consultation was made with 40 Kurdish people residing in Liverpool. The aim of the consultation was to gain an understanding of Kurdish community needs and link participants to local services. The results showed that the participants had general knowledge of Centrelink, Medicare, the Department of Housing and the Liverpool Migrant Resource Centre and limited knowledge about other health and community services. The participants identified that limited English skills was the largest barrier that prevented Kurdish people from gaining employment and noted that information sessions in their own language could improve access to health and community services (Hardgrave, 2003).

Turkish Migration to Australia

Turkey (as shown on the map on the left) is located mainly in Western Asia and on East Thrace in South-eastern Europe (Wikipedia, 2013a). Turkish people are an ethnic group who reside in the country of Turkey (Wikipedia, 2013b). In 1967 a bilateral migration agreement was signed between Australia and Turkey (Department of Foreign Affairs and Trade, 2013). They were considered the first largest 'Asian' population to settle into Australia after 1901 and also the first largest Muslim population to settle into Australia.

In 2013 there was said to be 300,000 Turkish people living in metropolitan Melbourne (Wikipedia, 2013c). The 2011 census data showed that Victoria was the state with the majority of Turkish born residents (ABS, 2011b). The Turkish born people reported that the top two ancestry responses were Turkish and Kurdish. Approximately 30 per cent of the Turkish born people stated that they either did not speak English very well or spoke no English at home (Department of Immigration and Citizenship, 2013).

The Research Study

The aim of the study was to explore the experiences of the Kurdish and Turkish community in accessing services in a regional town in Victoria. The study explores the impact of exclusion from services on a social and cultural level. The participants provide recommendations on how to improve access for services.

The main distinction between Turkish and Kurdish participants in this study was ethnicity. Some participants identify themselves as Turkish from Turkey while others identify themselves as Kurdish from Kurdistan or Turkey. All of the Kurdish participants in this study were illiterate in their own Kurdish language. This is why the preferred language for the participants of this study was Turkish.

The lead author identified through employment as a social worker that there was under representation of these groups in services even though there was an observed need for such services. Her observations were supported by research studies which emphasised that although such groups may be under represented as consumers in health and welfare services it does not mean that there is no need there for access, in fact it can mean the opposite that there is a high need for services (Wilson, 2005; Onyx, 2006; Ozonal, 2007). In an earlier unpublished study, Ozonal (2007) investigated factors associated with the under representation of cultural communities accessing a particular ‘Gamblers Help’ community service in the region. It was found in that study that many barriers prevented over ten cultural communities accessing much needed health and community services. These barriers included the language barrier, lack of knowledge of health and community services and shame and stigma associated with receiving support from services.

Kurdish and Turkish Migrants in the Victorian Regional City

The regional city is located in Victoria’s North-West and has over 75 different cultures and nationalities residing in the area. The 2008 Social Indicators report indicated that the city has a population of approximately 60,000 people. Turkish and Kurdish people make up the fourth largest cultural demographic group in the region. The Turkish and Kurdish languages are among the top ten languages spoken at home in the region (Vinson, 2008; Vaughan, 2011). The Kurdish and Turkish community is fairly integrated in this regional city.

Method

The Research Design

The purpose of the study was to gain an understanding of the access issues experienced by the Kurdish and Turkish migrants in relation to health and community services in a regional Victorian city. The study used a qualitative approach as it has been identified as the most appropriate method to use for under researched populations (Lincoln & Guba, 1985; Minichiello et al, 1995; Cronin, 2001; Khawaja, 2004). Qualitative approaches promote the lived experiences of people and enables people who have low literacy skills to be included and participate in research studies (Creswell, 1998; Miles & Huberman, 1994; Sandelowski, 2000; Alston & Bowles, 2003).
Sample and Data Collection

Prior to commencing the study ethics approval was applied for and obtained from the La Trobe University Human Research Ethics Committee. The research study took approximately a full year to complete, the sample and interview collection phase took approximately 3 months. Both short term and long term residents over 18 years of age participated. Five participants responded to the advertisements and contacted the researcher via telephone to organise interview times. The other three participants contacted the researcher through word of mouth. In total there were eight participants between the ages of 25 and 53 years old, with an even spread of males and females.

Advertisements in both English and Turkish were displayed at a local Turkish continental store which was accessed by many of the Kurdish and Turkish people in the area. Selection of participants was based on two main non-probability sampling techniques which were purposive and snowball sampling (Sandelowski, 2000; Alston & Bowles, 2003). Non-probability sampling is used for exploratory research studies and is used when a new area is being investigated (Ezzy & Liamputtong, 2005). Purposive sampling requires a sample to be generated for a particular purpose to gain a richer understanding of the area under investigation. Snowball sampling is where participants are encouraged to recommend other people to participate until the information is saturated (Tesch, 1990; Sandelowski, 2000). There are however, limitations in obtaining samples using this approach. People who are socially isolated or marginalised are usually unlikely to volunteer in such research studies.

A frequently reported qualitative research principle is called ‘saturation’. Saturation refers to a stage in the data collection process where the researcher decides not to collect further data because no new themes emerge (Creswell, 1998; Padgett, 1998). It was found that eight interviews were sufficient enough to saturate the general themes raised and supported by similar themes in previous research studies.

Structured in-depth interviews were selected as the method to gather the data. Structured in-depth interviews are used in qualitative research because they promote deeper understanding of the research topic (Alston & Bowles, 2003; Thomas, 2003). The interview questions were divided into four key areas which were family and relationship services, mental health services, financial counselling services and broader issues. All interviews were conducted separately in Turkish as the participants of the study had low English and Kurdish language proficiency. Notes were taken during the interview sessions with permission from each participant. Audio recording was not used as there was indication that this would have deterred people from participating in the study.

Based on the lead author’s previous professional role in a health organisation case vignettes were developed to align with common issues faced within the Kurdish and Turkish community. Each key area had a case vignette in which the characters were given Kurdish and Turkish names so it would appeal to the participants. The vignettes described situations in which people were experiencing either: mental health, relationship or financial issues. After the vignettes were read out, participants were asked to explain ‘who’ they would refer the person in the vignette to for assistance and explain their reason ‘why’. The final set of questions was asked to get an idea of other issues participant wanted to raise.

Data Analysis

The qualitative data was analysed and interpreted using thematic analysis and in particular with the use of a general inductive approach (Padgett, 2004). There were three main stages of the data analysis process. The first stage involved viewing each transcript and grouping information into categories (Creswell, 1998; Sandelowski, 2000; Alston & Bowles, 2003; Berg, 2004). The second stage involved grouping the categories into themes and the third stage involved interpreting the data using codes to identify repetition, patterns, similarities, differences, connection to theories and events (Miles & Huberman, 1984; Kellehear, 1993; Padgett, 2004). In order to validate the data collected, several weeks later, each participant was provided with a summarised version of their interview outlining the common themes that they raised. Each participant signed a form which indicated their approval of the interview summaries.

Discussion of findings

Knowledge of Family and Relationship Services

The results showed that five of the eight participants indicated that they had no knowledge of family and relationship services in the regional area. Three participants were able to name and briefly describe one well known family and relationship service. These same participants also stated that their understanding of family and relationship services were limited and commented on the difficulty of access. One of these participants stated that:

‘There are actually a lot of services but we do not know about them and other people seem to get the benefits, not our community’. (Serpil 31 years old, female participant).

This statement suggested that there was an awareness of the existence of services however, more information was needed about the types of services provided.

Knowledge of Mental Health Services

Participants explained that there was a general need for all health and community services for Kurdish and Turkish

1 In order to protect the privacy of the participants, pseudonyms have been given to participants when using direct quotes.
people because of the effects of migration and living away from families, having limited social supports and limited economic opportunities. The results showed that two out of eight participants had an understanding of the existence of private psychologists and of the mental health department at the local hospital. Although, these two participants had some level of knowledge of mental health services provided they also commented on how mental health services should become more accessible and known to Kurdish and Turkish people. One participant who stated they had knowledge of mental health services asked:

‘I wonder if people actually get enough help from these services, we don’t know if they get good help’. (Fatma 37 years old, female participant).

Participants were read the statement ‘1 in 5 people in Australia experience a mental illness at some point in their life’ and were then asked if these statistics were applicable and relevant to Kurdish and Turkish people in their region. All eight participants reported that they thought these figures may be higher for the Kurdish and Turkish people in their region. The reasons for their assessment of higher incidence are because of the language barrier and the lack of employment opportunities that contributed to their everyday stress. One male participant stated:

‘Yes, definitely, if this is the general number then ours would be three out of five. The language barrier contributes to our psychological state because of the stress of not being able to seek rights and communicate’. (Seyit 33 years old, male participant).

Financial Counseling Services

Two of the participants had limited understanding of financial counselling services and one of these participants expressed their lack of knowledge caused guilt. He stated:

‘We need more information because I blame myself for not knowing’. (Aydin 33 years old, male participant).

These two participants were able to specifically identify a financial counselling service because of prior contact and experience with the service. There was confusion about what was meant by financial counselling services. One participant identified that they knew about financial counselling services and identified Centrelink as being a financial counselling service in the area. One participant stated that:

‘We do not know where to go after Centrelink’. (Baran 45 years old, male participant).

Preference of Health and Community Services over Doctors

The majority of female and male participants stated that they would rather approach health and community services either in the first or second instance and not a doctor. The participants did not emphasise the idea of presenting with physical symptoms but rather would approach a doctor for mainly mental health issues to be referred to specialist services. This is interesting given that many participants had a lack of knowledge of health and community services and were affected by the language barrier. This suggests a need or preference to access specialised services.

Language as a Barrier to Service Access

Low level English language was stated by all participants as the main barrier to service access. All eight participants reiterated that the language barrier acted as a major stressor in everyday life. The language barrier was said to cause daily problems to escalate or stack up and therefore, contributing to increased levels of psychological distress. One participant stated:

‘The language barrier prevents us from meeting our other needs like taking out a bank loan because we cannot explain ourselves’. (Cuma 49 years old, male participant).

There seemed to be a fear of being judged on low English language proficiency. One participant spoke of her prior experience with a local service provider and described how she felt very uneasy because she felt that her English was being ridiculed. This participant stated:

‘If we have bad English chances are we are already well aware of this. We do not need people to keep pointing this out and making fun of us. We need the confidence to go to such services without fearing that we will be judged, ridiculed or laughed at because of our language barrier. I remember this one lady at this service and she kept on saying ‘what!’ to everything I was saying. I never went there again and it is an experience that has stuck with me’. (Fatma 37 years old, female participant).

Participants offered suggestions to minimise the language barrier in relation to the broader social problems. Some suggestions included seeking assistance from government bodies to provide more free foundational level courses in English after their granted hours have been completed. Generally participants noted that English courses need to be provided on a consistent basis and that they themselves need to take individual responsibility for their learning. One participant stated:

‘We need more time to learn English and not just two or three months, this is not enough time to learn a second or third language’. (Cuma 49 years old, male participant).

Another participant stated that:

‘Learning English is absolutely crucial for both Kurdish and Turkish people as it enables people to be informed citizens and contribute to society. It allows people to be informed because they can read.
newspapers, watch and understand the news on TV’.
(Fatma 37 years old, female participant).

Privacy, Shame and Stigma as Barriers

Alongside the language barrier, participants recognised the difficulties of living in a close knit regional community. In particular concerns over privacy, shame and stigma were raised as factors that would prevent Kurdish and Turkish people from accessing health and community services. The participants identified that some people might not approach services because of the already existing stigma which is attached to the concept of counselling and mental illnesses. It was highlighted that some Kurdish and Turkish migrants would hide their mental health issues as a result of this stigma associated with mental illness.

The participants highlighted concerns of confidentiality particularly in relation to mental health services. Participants shared the view that there are fears of approaching health and community services because of how others would perceive them. Others spoke of concerns of their confidentiality with interpreting services.

Participants described the importance of confidentiality, especially in a close knit regional community and discussed how the seriousness of this concept was taken lightly by some people in their community and local face-to-face professional Turkish interpreters. Several participants spoke of witnessing people in their community group relaying confidential information about others. Some participants discussed their concerns with local face-to-face professional Turkish interpreters who they have witnessed discussing confidential patient information with others. One participant stated:

‘I have seen with my own eyes and heard with my own ears, a local Turkish interpreter discussing a confidential case in front of a group of people. This made me very uncomfortable. I thought to myself, I wonder how many other cases like this would have been discussed. This is not good and obviously makes us think twice about whether or not we want to use these interpreters for sensitive health topics.’
(Aysel 26 years old, female participant).

Concerns over stigma were found to be particularly relevant for males in the study. Three male participants revealed that approaching health and community services would make them feel ashamed and guilty because of the socially engineered ‘breadwinner’ role assumed for Kurdish and Turkish males. One male participant stated:

‘We would feel embarrassed, uncomfortable, and guilty if people see us at a service and this would probably aggravate the situation for us. We will just not go unless we absolutely have to go’. (Baran 45 years old, male participant).

Cultural and social norms were identified as contributors that would prevent the three participants from approaching a service for mental health issues. One male participant stated:

‘We would feel ashamed because we have been grown up to be private people’. (Aydin 33 years old, male participant).

Another participant stated:

‘Males would have an issue to go to such services because our culture has a male dominated family and social structure. Males would feel guilty if they are seen as not coping financially and mentally. That is when we would become more stressed’. (Cuma 49 years old, male participant).

Broader Social and Economic Concerns

While the primary focus of the research was to identify access issues and unmet needs of Kurdish and Turkish people in relation to health and community services a new set of findings emerged. Participants associated lack of access to health and community services with important broader unmet needs. These were: the lack of employment opportunities for people with limited English, difficulties with keeping up with everyday financial demands and difficulties with travelling to visit family overseas. One female participant stated that:

‘All of our problems are related to the language barrier and there is a lack of employment opportunities for people who have limited English language skills here’. (Serpil 31 years old, female participant).

Another female participant stated a similar response to the one above:

‘We suffer social, emotional and financial hardship because we are isolated by the language barrier and employment issues’. (Gule 35 years old, female participant).

The regional city has a large agricultural sector which imports and exports fruits and vegetables to markets nationally and internationally. Many participants spoke of the hardships associated with working on farms and being unaware of work rights and responsibilities.

One participant stated:

‘Our people work on fruit blocks (farm labourers) mainly because of our language barrier, we do not have rights (at least we do not know about them). We are more prone to injuries in our jobs in the agricultural sector. We work so hard and yet we cannot keep up, we are always short of money’. (Aydin 33 years old, male participant).

One male participant stated that life in general is consumed by physically demanding working lives that broader issues become masked and hidden. Therefore, this makes it difficult for issues to be immediately dealt with. This is how one participant frames this:

‘We came to this town because we had to, for jobs, but we are more prone to injuries and risks related to jobs in the agricultural sector and cannot keep up with the financial demand at home. We get so caught up with our day to day lives trying to make ends meet that we forget the issues our community
faces. Thank you for helping us with becoming more aware of issues in our community. Thank you for alerting us. The answers to all your questions are in this last comment’. (Seyit 53 years old, male participant).

One female participant also spoke about the difficulty of visiting families overseas because of financial costs associated with travelling. This female participant stated:

We are unlucky to go to visit our families overseas because of financially constraints which causes us to stress. Some of us go back to our home country 5 or 10 years later and this is too long. I think the government should help us with this and maybe they can allow for special funding for people like us to travel and see family’. (Serpil 31 years old, female participant).

Participant Recommendations

Participants made reference to several recommendations for health and community services and also the broader unmet needs of Kurdish and Turkish people in their region. Participants recommended informing CALD people about services through translated and interpreted advertisements. One participant even suggested coming up with a specific service directory specifically for Kurdish and Turkish people. Strong emphasis was placed on employing bilingual workers and also utilising telephone and face-to-face interpreter services. Participants also encouraged workplaces to promote cultural awareness and empathy among health professionals as these would assist people in feeling more at ease when attending such services. Participants constantly raised the idea of establishing a community house to hold regular social gatherings for the Kurdish and Turkish people in the regional town.

There was a sense that Kurdish and Turkish people felt isolated from the larger community because of the language barrier as it was stated by one participant that:

‘Our community is fragmented and isolated from the rest from the community because of our language barrier’. (Ajda 29 years old, female participant).

The idea of the establishment of a community house was to build a sense of community and act as a one-stop-shop for Kurdish and Turkish people in the regional town. Participants indicated specifically that a reference person or group should be established within this community house. The role of the reference person or group would be to liaise with the people and health and community services about issues within the community and vice versa.

One female participant described an image of the desired community house in some detail:

‘We need a gathering point such as a place where a person is employed to provide information about health and community services. This place should have kitchen facilities so we can get together and cook. The community house can act as a gathering point for older people. We could have language classes, knitting classes, computer courses and organise picnics. If we have this house then maybe our children would not be affected like us because our jobs are very physically tiring. We could have a youth group and organise social events and educational sessions for youth, especially young girls. If such a place was established I would volunteer and so would many others’. (Fatma 37 years old, female participant).

Findings in Relation to Previous Research

The lack of social inclusion was identified as being a major contributor to a person’s health and well-being (Wilkinson & Richard, 2003; Herrman et al, 2005; Nettleton et al, 2007; Cannon, 2008). The study identified consistent themes with previous literature in regards to social capital and settlement issues for newly arrived community groups (Chenoweth & Stelhik, 2001; Taylor & Stanovic, 2005; McDonald et al, 2008). The majority of participants had little or no knowledge of family and relationship, mental health or financial counselling services in the region and hence hindering their social capital and settlement into Australia. The participants who had no knowledge of these services raised general needs for such services, identified access issues and ways out overcoming these barriers. The participants who responded to having knowledge of these service areas were participants who had prior contact with such services. In particular, there were a lot of discussions around the need of mental health services and the factors that contributed to this need.

Limited job prospects for people with limited English language, limited social supports and the effects of migration were described as the main social and economic contributors of mental health issues among the participants. Khawaja’s (2004) and Alston’s (2002a) findings are consistent with this study as participants emphasised that mental health was a major concern and that there was a general need for all services. The regional context in which participants resided could also be a factor which contributes to limited resources. Alston (2002a) identified that there are higher rates of health issues of people living in rural and regional parts of Australia. Khawaja (2004) identified that prior research studies indicated that migrants experience long term and short term psychological distress such as depression and anxiety.

The findings of the study are consistent with previous research studies mentioned in the literature review. Previous research studies found that the most significant service access issue for CALD people was the language barrier (Minas & Hayes, 1994; Alston, 2002a; Alston, 2002b; Ruzzene, 2002; Khawaja, 2004; HREOC, 2004; Victorian Department of Justice, 2005; HREOC, 2005). All Kurdish and Turkish participants in the study highlighted that language was the most prevalent and significant barrier to health and community services. The participants also
identified other barriers such as concerns about privacy and cultural attitudes to mental illness, seeking help as well as lack of employment issues for people with limited English language skills (Fozdar & Tozezani, 2008; Fozdar & Hartley, 2013).

There was a notable difference in the findings of this research and previous research studies in relation to presenting problems. Previous research studies found that people from CALD communities consider doctors to be a major source of assistance for health and emotional needs in which males would present mainly for physical symptoms (Victorian Government Department of Justice, 2005). This research however, showed otherwise, as both the majority of female and male participants stated that they would rather approach health and community services either in the first or second instance and not a doctor regardless of the language barrier. This is an interesting finding given that participants had limited knowledge of the available health and community services. Perhaps this suggests greater need for specialised services.

The broader unmet needs that were identified in the study reveal that economic exclusion or unemployment placed significant demands on the participants. These findings are consistent with Smyth’s (2010) research which identifies the ways in which ‘our labour market and social services either enhance or constrain the life chances of Australians’ (Smyth 2010, p. 84). This statement is applicable to the current research study as participants indicated that their economic opportunities have been shaped by the language barrier. There was also consistency with previous research in that that economic stability, employment and income were of the highest priorities amongst the participants in this study (Fozdar & Hartley, 2013; Fozdar & Tozezani, 2008).

Implications for Services and Practice

The findings of the research study have implications for practice, education, and social policy. For maximum exposure the findings were circulated to health professionals across the region. The aim of the dissemination was to expose services to the cultural needs and broader unmet needs of Kurdish and Turkish migrants in the regional area and encourage the development of more culturally appropriate services for all cultures.

There are particular implications for the development of new approaches relating to rural and regional CALD communities in terms of social inclusion and social work. The study adds to the knowledge that language is a barrier but not the only barrier that these groups have in accessing services. It signifies the importance of service providers offering a diverse range of language services for people from non-English speaking backgrounds. Encouraging service access needs to be promoted within cultural communities as well as within services.

The study identified ways service providers can increase access for CALD groups and ensuring that the programs are seen as culturally acceptable include the employment of bilingual staff, translating material, showing empathy and delivering internal continual cultural awareness training to promote knowledge of culture, religion and customs. In addition community consultations where people can meet in their cultural groups to receive information and discuss services are also important.

The study has other implications for Kurdish and Turkish people the regional town. There are indications that certain aspects of lives of Kurdish and Turkish people may have improved with an increased awareness the awareness of the services offered by a key health and community service (Wilson, 2005; Onyx, 2006).

On a national level the key targets set by the current Australian government will ensure that gaps in services will be addressed. Partnerships with all levels of government and community organisations will be strengthened through collaboration. This will essentially assist in reducing levels of social discrimination and increase social cohesion. Research such as the current study can influence this process of collaboration by influencing the service delivery of programs.

Conclusions

The findings of this study identify the experiences of a group of Kurdish and Turkish people in accessing health and social services. The study highlights the particular needs of CALD communities living in regional areas of Australia. The response of participants demonstrated that they were at risk of social exclusion and they associated lack of access to health services to other social and economic difficulties they experienced.

Social workers through their mission and education have particular roles and responsibilities to work to enhance social inclusion of vulnerable groups. They also draw on research knowledge and implications and bring this to the forefront of service delivery in their workplaces and policy development. The Australian Association of Social workers defines social work as: ‘The social work profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance wellbeing. Utilising theories of human behavior and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work’ (AASW, 2010). This research is one such example of achieving this international definition of social work. This research identifies gaps in service delivery for vulnerable groups and promotes ways of improving service access.

A more extensive study into the experience of CALD communities in regional and rural areas would be ideal with both service and consumer input. This recommended research could explore the similarities and differences of the impact of the migration process, social and financial hardship and access issues for CALD communities. The outcome of this larger study could assist in targeted service
planning and delivery of programs which would promote social inclusion in all health and community services.

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