Managing the refugee patient

by Dr. Margaret Kay

Managing the refugee patient is a complex task. This article will touch on a number of issues, though the recommendations here should be considered within the context of the individual's presentation.

Background issues

Over 800,000 refugees have been resettled in Australia since federation. The federal government, after discussions with the UNHCR, determines how many people come from which countries to Australia.[1] Currently nearly 14,000 humanitarian entrants are resettled each year. During 2000-2006, an increasing number of refugees came from Africa. More recently, about 1/3 come from Africa, SE Asia and the Middle East.[2] The large number of refugees from Africa arriving between 2001-2005 brought the issue of refugee health to the fore because health providers were confronted with a range of unfamiliar medical issues.

There are political, racial, ethnic and religious issues that provide the background to every consultation. When the doctor is providing care to the patient who is a refugee, these issues may be more apparent. Being adequately educated about these issues, rather than accepting the current discourse of the local media, is the only responsible approach. Doctors should be familiar with the terminology of the Department of Immigration and Border Protection (DIBP).[3] Most patients from a refugee background are Humanitarian Refugees. They are not asylum seekers. Refugees have been processed offshore and have permanent residency visas on arrival in Australia. This means they have access to Medicare and Social Security services.

Medicare item numbers (701,703,705,707) can be used when providing a comprehensive assessment for refugee patients who have arrived within the last twelve months. These item numbers can only be used once for each refugee patient. Consent is necessary before undertaking the health assessment and before arranging blood tests. Specific consent is required for the HIV test. The health assessment item number includes the development of a management plan with the patient.[4]

Asylum seekers are people seeking refugee status who arrive in Australia without being processed offshore. They have different access to health care. Some have access to Medicare (with a blue Medicare Card) while others do not. Some have work rights. They do not have access to a health care card, though they may have some very limited support through the settlement agency. The Queensland Government provides free treatment within the Queensland Health system if acute care is needed. The Mater Refugee Complex Care Clinic will provide pro bono primary health care.

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[1] http://www.immi.gov.au/media/fact-sheets/02key.htm
[2] http://www.immi.gov.au/media/fact-sheets/60refugee.htm#b
[3] http://www.immi.gov.au/media/publications/publication05.htm
[4] http://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&qt=ItemID&q=701

Approaching the consultation with a refugee patient

It is essential that the patient's background is considered when caring for the refugee patient. While this is the usual approach for patient-centred care, but the need for cultural sensitivity in care delivery is vital for the refugee patient. Being of refugee background can affect communication skills, expectations, cultural beliefs, and attitudes to medical care as well as the very illnesses that are likely to be present.

Attitudes to medical care vary greatly and it is important to be aware that some patients may have had very negative experiences with medical personnel. Previous experiences with government agencies overseas have often been disillusioning and sometimes medical personnel have been complicit in participating in torture. Some refugees are concerned that, if a serious medical problem is diagnosed, they will not be able to stay in Australia. Sometimes fear can alter the presentation of illness in the initial consultations until trust in developed within the therapeutic relationship.

Some refugees have a 'health undertaking' when they arrive. It is the responsibility of the settlement agency (HSS) to ensure that the refugee can access the agency responsible for monitoring this health issue. Currently this is arranged through BUPA. It is important for the GP to be aware that the patient may be undergoing other medical care so that communication between practitioners is facilitated.

If the patient is acutely unwell then they may need a more urgent appointment, prior to the health assessment. Sometimes the health issue is identified at the pre-departure health check and the patient may have a health alert requiring attendance with a health practitioner soon after arrival in Australia.

Many doctors feel a little overwhelmed when caring for a patient from a refugee background. It is not uncommon for the refugee patient to present with very complex health needs. It is never possible, and usually unnecessary, to address **all** of these issues in one consultation. While exotic illness may be present in the refugee patient, it is refugees often present with the same health issues that the general community presents with including arthritis, URTI and accidents. The general practitioner is usually the best placed person to respond to these needs initially. The GP plays a vital role in care coordination for the refugee patient.

Focusing on the main reason for presentation is essential for the patient. However, it is important to ensure that other health issues are followed-up at subsequent visits. Many refugees have only had access to acute care services in the past and may lack an understanding of the need for continuing care and preventive health care, even when the symptoms have settled. The practice plays an important role in health literacy education of the individual and their family.

Effective communication is essential for the delivery of quality health care. Many doctors avoid using interpreters. Some doctors are not aware that an interpreter is **freely** available over the

phone through the Translating and Interpreter Service.[5] All doctors, GPs and specialists, who are providing a Medicare rebatable service are able to use TIS. Pharmacists also have access to this service.

Doctors need to be registered with this service and use their client code to request an interpreter. Practice staff need to know how to book an interpreter. If the patient does not need an urgent appointment then an on-site interpreter may be booked. It is important to be aware of the process involved. There are some private services that provide interpreters, but there is a charge for these. All interpreters should be accredited to ensure that they have been adequately trained in the interpreting process. This training includes understanding confidentiality must be protected. Family members and friends should not be used as interpreters even though it may appear to be convenient. While a patient may have social English, they are still likely to need an interpreter for the medical consultation as this is more complex.

Reducing the language barrier by using an interpreter is one part of providing a culturally sensitive consultation. Being cultural sensitive also includes an assessment and awareness of the patient's health belief system and how their cultural and religious practices impact upon their health.

[5] https://www.tisnational.gov.au/Agencies/Help-using-TIS-National-services/How-to-become-a-client

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The comprehensive health assessment.

A health assessment is ideally undertaken in the first few weeks after arrival in Australia. Consent for this health assessment is important and should be discussed with the patient. Blood tests that are arranged should be explained to the patient and the results should be explained in detail when they are available, even if they are normal. Some people forget to do this. It is often assumed that because there is a language barrier, the patient would not want complex information like test results. Although it may take longer when using an interpreter, this is important to build a trusting relationship with the patient and the community.

Prior to leaving a country, the Australian government will arrange for a basic health assessment for the visa. Investigations generally include a CXR for those >=11 years, HIV and Syphilis testing if >= 15 years, HBV Serology for Pregnant women and unaccompanied minors. These tests may be performed 6-12 months prior to departure and the person is often still in an at risk environment after this time. Until recently, most refugees who were HIV positive were often not granted a Visa, though this is changing. Refugees found to have active TB are treated and re-assessed before they travel to Australia. Just prior to departure, Departure Health Check[6] is arranged. This may include a routine physical examination and a repeat CXR if deemed necessary. A malaria antigen (P falciparum) test is performed and treatment provided if positive. Empirical treatment of parasites and infestations with a stat dose of 400mg albendazole is given to those over 1 year old. A dose of MMR vaccine is given and a dose of OPV is provided if the refugee is from specific countries. Sometimes a pregnancy test is performed. It is often difficult to access the records of this medical information (the health manifest) from the DIBP. If the patient is found to have a significant health problem, for example TB or Hepatitis B, then they may be granted a Visa with a Health Undertaking that requires them to present for treatment within a specified time after arrival.

When the refugee arrives in Australia they are met by someone from the local Settlement Agency (HSS)[7] who arranges for their transport to their accommodation, helps arrange for banking, Centrelink and Medicare access and shows them where they can shop. They will have a Case Manager assigned to them. They will also have a bicultural worker who may assist them to get to the medical centre. The bicultural worker is likely to speak the language of the refugee patient but they are not and interpreter and should not be expected to act as an interpreter.

If they have a Health Undertaking then they will be assisted with the relevant arrangements, although the GP may not be aware of these.

When arriving in Queensland, there is no routine medical health assessment arranged through the state health system on arrival. Many doctors have been under the false assumption that all refugees have had health screening and vaccination on arrival. The reality is that most refugees

[6] http://www.immi.gov.au/media/fact-sheets/67a-dhc.htm
[7] https://www.dss.gov.au/our-responsibilities/settlement-and-multicultural-affairs/programs-policy

who have arrived over the last 25 years have not had the opportunity to have a formal refugee health assessment. Many remain inadequately vaccinated. Other states have different opportunities for health assessments and doctors should be aware of the situation in their community. Some states have an overarching Refugee Health Policy that helps to support a coordinated response to refugee health.

Doing a Refugee Health assessment.

A detailed health assessment requires the taking a full history (including systems review) and performing a thorough physical examination. This should be followed by appropriate investigations which depend upon where the patient has lived previously and their refugee journey. Medicare has an MBS item number for a health assessment that is performed on a refugee patient within 12 months of arriving in Australia. Many refugees face significant barriers accessing health care, especially in the early part of the settlement process.

The history should include a narrative of the refugee journey. Allowing the patient to tell their story of what happened before they came to Australia (and since their arrival here), will help to contextualise many medical problems. It helps to understand the patient's previous health care experiences, the person's health beliefs and their current expectations of their management. Failure to do this can result in misunderstandings that ultimately compromise the patient's care. A genogram can be very helpful in understanding the family dynamics. This initial history may take a long time, but it is usually relevant for the whole family and it helps put many of the subsequent health issues into context, expediting care later.

Past medical history, surgical history and trauma including exposure to war or atrocities should be documented. The obstetric history can be very difficult for a mother to tell as this often requires a reminder of loss of a child. While it is important to document, it is also important not to re-ask and re-traumatise when other health practitioners are involved in her care. The extent to which cultural or religious beliefs affect dietary and medical decisions (including female genital mutilation, often referred to as 'circumcision', 'cutting' or 'being cleansed') should be considered. A simple screen for psychological illness includes asking how they are managing with settling in and asking about sleeping and eating. Refugees need to be aware that help is available for these problems. Many refugees do not present for treatment of the psychological problems arising from their previous experiences until they have been settled for many months or years. Others may be more traumatised by the acculturation process as they settle in Australia and require counselling for this. QPASTT (Qld Program for Assistance for Survivors of Torture and Trauma) is able to provide assistance to refugees who require counselling.[8]

If the patient has documents that are relevant then these can be translated.[9]

[8] http://www.qpastt.org.au/

[9] https://www.dss.gov.au/our-responsibilities/settlement-and-multicultural-affairs/programs-policy/settle-in-australia/help-with-english/free-translating-service

The examination should include the Height and Weight and for children the head circumference and their development should be assessed.
Physical examination of all systems should be performed with a focus on areas indicated by the patient's history. Visual acuity is important and ideally audiology should be performed on everyone. A dental check is also important.

Investigations that need to be considered for the newly arrived refugee patient are listed in Box 2 below. Informed consent should be obtained for all tests. Nutritional deficiencies are common. Assessment for specific exotic conditions should be considered if the patient has lived in a region where these illnesses are endemic.[10] TB should be screened for in the patient's history and through testing. The current recommendation is for a Mantoux test as the Interferon-gamma release assay is not available for refugee health screening through Medicare, and there has been debate about its reliability in this situation. Consider lead levels in children <7yrs especially those from the Middle East and Africa. Pregnancy testing is useful in women 15-50 years old. Many refugees come from areas where malaria is endemic so haemoglobinopathy is common. If there is significant microcytosis, then consider this diagnosis but ensure that iron deficiency is corrected and that consent is obtained before arranging haemoglobin electrophoresis. Routine screening for the usual health checks like Pap smears should be arranged where appropriate, though they are not urgent and can be part of the follow care arranged.

If a refugee has recently arrived, then they will have a person supporting them from the settlement agency (case manager) who may assist them to organise the necessary tests.

Medical management
Engage the patient in a shared decision-making process to help prioritise the medical conditions that need to be addressed first.
Explain every result, don't just summarise a large group of tests as normal. Trust needs to develop in the health partnership. Many refugees have had very negative experiences in other countries where health workers can be a part of the torture process. Remember some illnesses, like TB, HIV and Hepatitis B, may have cultural as well as health implications. These conditions may carry a great deal of stigma and may be poorly understood.

During the consultation, it is important to ensure that an understanding is reached about the patient's expectations of the consultation. Failure to address the expectation of the patient can result in failure of concordance with treatment and frustration for both doctor and patient. The health beliefs of patients vary enormously. Many patients have specific expectations related to the usual treatment they have experienced in their own country.
For most patients, multiple blood tests for 'follow up' without any obvious treatment can be difficult to accept. Many patients expect a medication when they present with a symptom and

[10] Tiong ACD, Patel MS, Gardiner J, Ryan R, Linton KS, Walker KA, et al. Health issues in newly arrived African refugees attending general practice clinics in Melbourne. Med J Aust 2006;185:602-606.

they may find it difficult to feel that they have been adequately cared when a medication is not provided. This concern may need to be addressed directly during the consultation.

Nutritional deficiencies need replacement therapy and often require continuing treatment. The concept of continuing to take medications can be difficult for some to accept, if this was not the usual approach in their previous experience.

'Exotic' diseases may require consultation or referral.[11] [12]
Schistosomiasis is treated with Praziquantel.
Strongyloides is a serious condition and advice should be sought about continuing follow-up after treatment. As it is an auto-infective worm it remains active, though often asymptomatic, for many years after arrival in Australia. Immunosuppression of those with strongyloides can result in rapid death from disseminated strongyloides.

Preventive health issues are vitally important in the refugee community. It is important not to make assumptions about the general health knowledge of the refugee family. Their knowledge may be very different to that of the Australian community. Although the need for immunisation is often understood, other preventive health activities (e.g. dental hygiene, basic dietary requirements) cannot be assumed. Most refugees are inadequately vaccinated on arrival in Australia and require a course of vaccinations. If there is any doubt, then full immunisation should be provided. Refugees are entitled to full immunisation (including hepatitis B and polio) through the public health unit who can also recommend what vaccinations should be given.

Referrals should be comprehensive and state the need for an interpreter and the language spoken. Remember that allied health services may not have access to interpreter services. Pharmacists have access to the telephone interpreter service, although interpreters are not often used.
Refugees are often mobile after they arrive. The appointment letter may not be received if they have changed address. Try to ensure that the hospital is kept up to date with these changes when the general practice becomes aware that the address has changed. Often the letter is sent in English and may not be understood by the patient, resulting in a missed appointment.
While mental health issues may not be evident until some time after arrival, they can interfere with the patient's ability to engage with their health management. Although counseling is routinely offered early in the settlement period, it should be offered again after the frantic settlement period is over.
Remember to provide optometry and dental health referrals and referrals for TB screening.

[11] http://www.rch.org.au/immigranthealth/resources.cfm?doc_id=10577
[12] Murray RJ, Davis JS, Burgner DP. The Australasian Society for Infectious Diseases guidelines for the diagnosis, management and prevention of infections in recently arrived refugees: an abridged outline.
Med J Aust 2009;190:421-5.

From a practice management perspective, the refugee patient requires an understanding environment. All practice staff need specific education about these issues. A practice manual helps to ensure that all necessary information is collected e.g. to ensure that all staff know how to arrange an interpreter. Patient's contact details especially a mobile phone number enables a special reminder to be sent to reduce missed appointments. Contact details of the case manager working with the family and the patient's preferred language should be clearly documented in the chart.
Follow-up is easier if names of all family members are listed together in the chart. It may help to arrange complex appointments at the end of a session so that there is more time if the consultation takes longer and paperwork can be completed if the patient fails to show up. This can reduce the cost of missed appointments.

Initially there may be frustration related to poor communication despite using interpreters. Frustration can be increased if there is poor compliance. Ultimately time and the development of trust will solve many of these problems. If problems persist, these issues will need further exploration. Mental health issues, substance abuse and continuing violence are easy to miss in cross-cultural consultations and should be considered.

Ultimately, there are so many rewarding aspects to caring for a refugee family that initial difficulties fade. The resilience of spirit is refreshing and provokes serious contemplation about how we would manage when confronted with challenges in our lives.

Box 1. Preventive Health Care Issues to consider in the refugee patient.

1. **Immunisation**
2. **Dietary advice** including food options, soft drink
3. **Exercise** – this changes dramatically during settlement
4. **Smoking** – advice to cease
5. **Alcohol and substance use** – advice regarding safe alcohol and information on drugs
6. **Health literacy** – including how to access health care
7. **Dental Health checks**
8. **Preventive health checks** - Pap smears, cholesterol, BP

Box 2 – Possible Screening Tests (Investigations are for all ages unless indicated)

Usual tests to consider:
FBE with thick and thin blood films for Malaria
U+E/LFTs
serum ferritin
serum B12 levels
Hepatitis B (HBsAg, HBsAb) } these need to be negotiated with the laboratory as Medicare will only cover 2 of these tests.
Hepatitis C Serology
Syphilis Serology – RPR, TPHA
HIV 1 & 2 serology
Schistosomiasis Serology
Strongyloides Serology
Vitamin D level – remember to add the specific indication for your patient

Other tests that may need to be considered in the future:
Iron studies
Faeces OCP - especially if eosinophilia or positive Schistosomiasis serology
Urine for WTU- if positive for Schistosomiasis – and send for OCP, MCS
Urine PCR –Chlamydia and Gonorrhoea (if sexually active)
Serum beta HCG
Faecal Ag for H. pylori

Thyroid function tests may be considered eg for Chin community.

In children, may consider:
Vitamin A (<15yrs)
Lead levels (<7yrs)

Screening for tuberculosis for all people of refugee background:
Mantoux test

Consider:
Rubella serology etc for women who may become pregnant in the near future

Box 3. General health issues to consider in the refugee patient

1. **Chronic Diseases** -
    - Many refugees have the same chronic illnesses that are found in the Australian community eg IHD, osteoarthritis
    - Other illnesses that commonly present after years settlement eg diabetes

2. **Poor Nutrition**
    - Low iron causing anaemia
    - Low Vitamin B12 – especially in some communities
    - Low Vitamin D esp in women and children
        - risk is higher in covered communities and people with darker skin.
    - Low Vit A - in children

3. **Infective Agents**
    - Hepatitis B –ensure household contacts are vaccinated
    - Hepatitis C
    - Malaria – may be acute or chronic
    - Schistosomiasis – may aggravate hepatitis, may affect pregnancy
    - Strongyloides – this worm is auto-infective
    - Syphilis
    - TB
    - HIV
    - Helicobacter pylori

4. **Genetic predisposition** to illness
    - Thalassaemia
    - Sickle cell anaemia

5. **Cultural practices** - FGM

6. **Mental health issues** – related to pre-migration experiences, torture and trauma
   - related to acculturative stress experienced after arrival

7. **Dental Health issues** - caries, loss of teeth, malocclusion

8. **Exposure to toxins** – high exposure to lead in some communities esp children
   - other chemical exposure due to minimal regulations

Resources:

Useful websites

Immigrant Health Service:
provides links to websites with lists of relevant clinical conditions and their treatment, and to websites that give a little information about the countries that many refugees come from
http://www.rch.org.au/immigranthealth/resources.cfm?doc_id=10577

Telephone Interpreter Service:
information about how to arrange an interpreter
http://www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/

A guide on how to use interpreters is available at:
https://www.tisnational.gov.au/Agencies/Help-using-TIS-National-services/Working-with-TIS-National-interpreters

Victorian Refugee Health Network / Foundation House:
Promoting Refugee Health: A guide for doctors and other health care providers caring for people from refugee backgrounds
and
Caring for refugee patients in general practice: A desk–top guide
http://refugeehealthnetwork.org.au/learn/guides/

Refugee Health Network of Australia (RHeaNA)
http://www.refugeehealthaustralia.org/

Refugee Council of Australia:
provides information on and advocacy for refugees and humanitarian entrants
http://www.refugeecouncil.org.au/

Qld Program of Assistance to Survivors of Torture and Trauma
http://www.qpastt.org.au/

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