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Beyond resettlement: long-term care for people who have had refugee-like experiences

Background

Since 1945, more than 700 000 refugees and displaced persons, survivors of conflicts in over 60 countries, have resettled in Australia. Every general practitioner (GP) will have patients who have had refugee-like experiences.

Objective

To describe the health needs of survivors of war and conflict in the immediate and long-term resettlement periods.

Discussion

In the immediate post-settlement period, refugees and asylum seekers will need assessment, catch-up primary healthcare and, in some cases, psychological support. Although refugees are generally a resilient group, enhanced support may be needed over key life periods: childbirth, rearing of young children and entering frail age. Asylum seekers (who do not have permanent visas) often face structural impediments to healthcare access and may be unable to meet basic health needs; GPs need to be aware of the enhanced need for psychological safety in addition to catch-up healthcare in this population.

Keywords

refugees; general practice

CPD

Enforced and violent civilian displacement has become part of the way modern conflicts are conducted. Since 1945, over 700 000 refugees and displaced persons have resettled in Australia.[1] The experience of war and conflict is so widely distributed among Australia's post-war population that all general practitioners (GPs) treat refugees, whether or not they are identified as such.

Refugees are generally very resilient; however, GPs looking after people who have had refugee-like experiences should be aware of the psychological impost exacted by their experiences, consequences of the limitations of health systems in their countries of origin and, for many, the impact of poverty on health status. The healthcare needs of refugees differ across the length of resettlement, from supporting successful resettlement to navigating healthcare concerns across the life course of patients. In addition, there are important differences between the needs of refugees with permanent visas and asylum-seekers who have long-term temporary visas.

Asylum seekers in Australia: the health impact

Less than 1% of the world's refugees participate in formal third-country resettlement programs,[2] reflecting the low numbers of places available in resettlement countries. Instead, most refugees who seek protection simply cross borders and request asylum.[3] In 2013, of >1 million global requests for asylum, only 2% asked Australia for protection.[3] Nevertheless, the numbers of asylum seekers have increased threefold over the last 5 years to over 33 000.[4]

The policy environment that governs healthcare access for asylum seekers can change rapidly. At the time of publishing, there are four types of asylum seekers:

- Inhabitants of immigration detention centres (IDCs) in Australia and on Manus Island and Nauru (around 6000 persons) have healthcare provided by International Health and Medical Services, contracted to the Department of Immigration and Border Protection (DIBP). Doctors associated with IDCs have made public statements about deficiencies in healthcare provision.[5,6]
- Asylum seekers in community detention (around 3000 persons) have healthcare provided by community GPs who are individual contractors to the IDC healthcare provider, which functions as a managed care organisation with approved providers of care, and limitations on certain types of care.
- Those on bridging visas in the community (currently, around 24 000) usually have a short-term Medicare card. These people will experience gaps in healthcare access when their Medicare card expires, because of structural delays in renewal of cards.
- A group of asylum seekers exists in the community who have no access to any Commonwealth support, including Medicare. They rely on the charity of the community and the willingness of state-funded healthcare to provide services.

Asylum seekers in the community do not have work rights, receive 89% of the Centrelink Newstart benefit, in most jurisdictions are not eligible for public housing and do not have access to healthcare cards to help them access low-cost medications. The United Nations High Commission for Refugees (UNHCR) recently found that many asylum seekers in Australia live in destitution, unable to meet their basic needs.[7]

GPs caring for asylum seekers in the community should be aware of the following issues:

- **Mental distress and suicide risk** – Asylum seekers can spend years in the community awaiting final determination of their case. The fear of being returned home, coupled with isolation and destitution, can be overwhelming. Statements of suicidal thought by an asylum seeker should always trigger an action response plan, from provision of enhanced support to calling in the specialist mental health crisis team.
- **Impact of poverty** – Asylum seekers eat poorly and frugally. Over winter, almost all asylum seekers economise on heating, and in summer on cooling. GPs should be aware of food banks in their community and the local charities that provide clothing and other essential items.
- **Ability to afford medications** – Asylum seekers with chronic diseases are often faced with choosing between medications (*Case 1*). GPs should assist them in decision-making about which medication to prioritise and, where possible, should prescribe the cheapest medication in its class or for the therapeutic purpose.

Refugees with permanent visas: the early resettlement period

Refugees with permanent visas may have entered Australia through the offshore humanitarian program, through family reunion or through the provision of a permanent visa after arriving by boat or aeroplane and successfully claiming asylum. All have the rights of every Australian permanent resident: they can work, access income support if needed, use Medicare and, if they qualify, access a healthcare card.

Many newly arrived refugees have a period of settlement euphoria.[8] Most refugees are able to muster some joy at the prospect of finally being granted permanent protection by Australia, usually after years of being registered with UNHCR and living under conditions of great hardship in flight from their country or in a refugee camp. The group least likely to express settlement euphoria are asylum seekers, particularly children, who may have spent a long time in the Australian community, living in poverty, or in immigration detention centres.[9,10] Patients who seem distressed at the first health assessment consultation after being granted a visa, or coming to Australia, warrant close follow-up to detect any escalation in their symptoms. Information on the first health assessment and catch-up healthcare has been provided elsewhere.[11–14]

Mental health

Despite their exposure to many traumas, it is not the case that all refugees inevitably suffer depression, anxiety or post-traumatic stress disorder (PTSD). Protective factors – described by refugees from South Sudan,[15] Afghanistan,[16] Burma[17] and Sri Lanka[18] – include a strong sense of community, a forward-looking narrative of survival and a religious or spiritual focus.

GPs are nevertheless likely to see refugees, including children, who do have depression, anxiety or PTSD. Persons at particular risk include those who have witnessed the loss of family members, suffered torture or spent prolonged periods in detention. People from many refugee-source countries can hold highly stigmatising views about mental illness and may present with somatic expressions of distress, or focus entirely on insomnia, fatigue or memory loss as presenting symptoms (*Case 2*). Culture frames the way refugees perceive and present their mental state, as it does for all of us. Recognising psychological illness and distress requires tact and the ability to take a good history, eliciting the patient's own explanatory model of illness and distress,[19] using a professional interpreter. Most GPs use the rapid telephone interpreters provided at no cost through the Translating and Interpreting Service (1300 131 450). Many refugees, particularly those from small communities, prefer this modality.[20] Specialist torture and trauma counselling services exist in all states and territories, and can provide advice or services.

Emerging issues over the life course

Refugees are not high users of health services.[21,22] One of the challenges for health services providing long-term care for refugees can be encouraging the monitoring of asymptomatic disease, such as hypertension, diabetes, chronic hepatitis B and renal disease. Failure to attend follow-up appointments usually reflects the comparative importance given to work as a means of ensuring security, rather than willful disengagement with healthcare.

War and environmental disasters in source countries, or countries where family members now live, can trigger significant distress, including survivor guilt. Specific life events may also lead to recrudescence of psychological distress and illness. The fact that this occurs years after resettlement should not deter GPs from recognising the impact of refugees' past on present experiences.

Childbirth

For women from refugee backgrounds, choosing to begin or continue their families in Australia is an act of faith in survivorship. Health workers should be aware of the unique challenges posed by delivery for women who have already experienced extreme violence, and in whose natal country operative interventions are conducted only in extremis, frequently resulting in hysterectomy or fetal death. The experience of pain, loss of control, being shouted at by people in a foreign language – all of which will probably happen in labour – may echo previous experiences as victims of violence. Health workers are sometimes perplexed by the refusal of a mother in complicated labour to countenance operative delivery. These responses make sense if the woman's reaction is viewed as a dissociative reaction to extreme distress, coloured by prior knowledge about the consequences of caesarean sections (*Case 3*).

Infant care

Many women from refugee source countries are used to collaborative systems where children are raised with assistance of female relatives from the extended family. Childraising in Australia can strike them as very lonely, and even experienced mothers can lose their confidence when faced with advice that is at odds with their own experience or the advice of female relatives back home. In the neonatal period, GPs should be alert to the risk of postpartum depression, and should encourage mothers to engage with communities of peer mothers, preferably from similar cultural backgrounds.

Ageing

With ageing, signal experiences from the past can come to colour the present life in new ways, a process that is even more marked in those with dementia. Elderly people who experienced starvation when living in Europe during the second world war may start to hoard food or to express extreme fear of people in authority. Sometimes the best policy response is to recognise the concern and accommodate it. In Melbourne, which has the highest proportion of Holocaust survivors outside Israel, ageing Jewish refugees were unwilling to call ambulances – with their vans staffed by strangers in uniforms who take people away – when unwell. The community-run first-response service Hatzolah was established to provide excellent first response emergency care by local Jewish volunteers.[23]

Conclusion

Australia has resettled refugees from conflicts in over 60 countries. Over the long-term, post-settlement period, survivors of conflict may experience recrudescence of psychological distress during life events or instability in source countries. Asylum seekers represent a special case of long-term deprivation in our community.

Case 1

Irfan was an asylum seeker from Iran, aged 28 years. He was granted a bridging visa, which gave him access to Medicare, but no healthcare card. Irfan had diabetes and had a myocardial infarction shortly after leaving immigration detention. His prescribed medications were metformin, metoprolol, rosuvastatin and low-dose aspirin, but he could only afford to purchase metformin. On review 12 months later, he had diabetic retinopathy, hypertension and an HbA1c of 8.2%. Irfan needed to switch to insulin, more involved monitoring and an ACE inhibitor in addition to rosuvastatin and metoprolol. To ensure he could afford the medications, the practice nurse costed the cheapest medications from a discount pharmacy, and the GP sought support from a local church organisation and diabetes educator to help pay for some of the medications and monitoring equipment.

Case 2

Mama Josie, a woman from Liberia, aged 48 years, presented with insomnia 8 months after resettlement. Her son, an Australian citizen who had sponsored her protection application, confirmed that she spent most of the night awake, walking around and checking the locks of the house. Mama Josie also had fatigue, generalised and intermittent aching across her limbs and abdomen, and shaking in her hands. Physical examination and investigations did not reveal any underlying cause for her symptoms. Mama Josie declined to discuss any of her prior experiences in Liberia ('that time is past') and her son was unable to shed light beyond saying that she had lost many family members while fleeing rebels. Mama Josie became angry when the suggestion was made that she see a counsellor, concerned that the GP was not paying attention to her symptoms. Her care focused on psychological first aid and closer engagement with the West African community. Many of her symptoms gradually settled after she began working with a local refugee-run catering company.

Case 3

Seraphine, 31 years of age, came to Australia as a teenager from Rwanda. As a very young girl, she was one of the few survivors of a household massacre, which she recalled as sensory memories of the smell of blood and the sound of screams. She had developed pre-eclampsia during her first pregnancy, went into preterm labour and, despite fetal distress, declined a lower uterine segment caesarean section. Delivery suite staff described her as 'not listening to us, even when we explained that the baby might die'. Seraphine stated later that she had little memory of the delivery, but that she had been very frightened. For her second pregnancy, a discussion was held early in the pregnancy about delivery

options, including her concerns about caesarean sections. She had a trial of scar in a planned way with a known midwife and female family member accompanying her through the delivery, and was able to deliver vaginally. She had active follow-up for postnatal depression and 1 year later recalled the delivery as a positive experience.

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