

Refugee and Asylum Seeker Health

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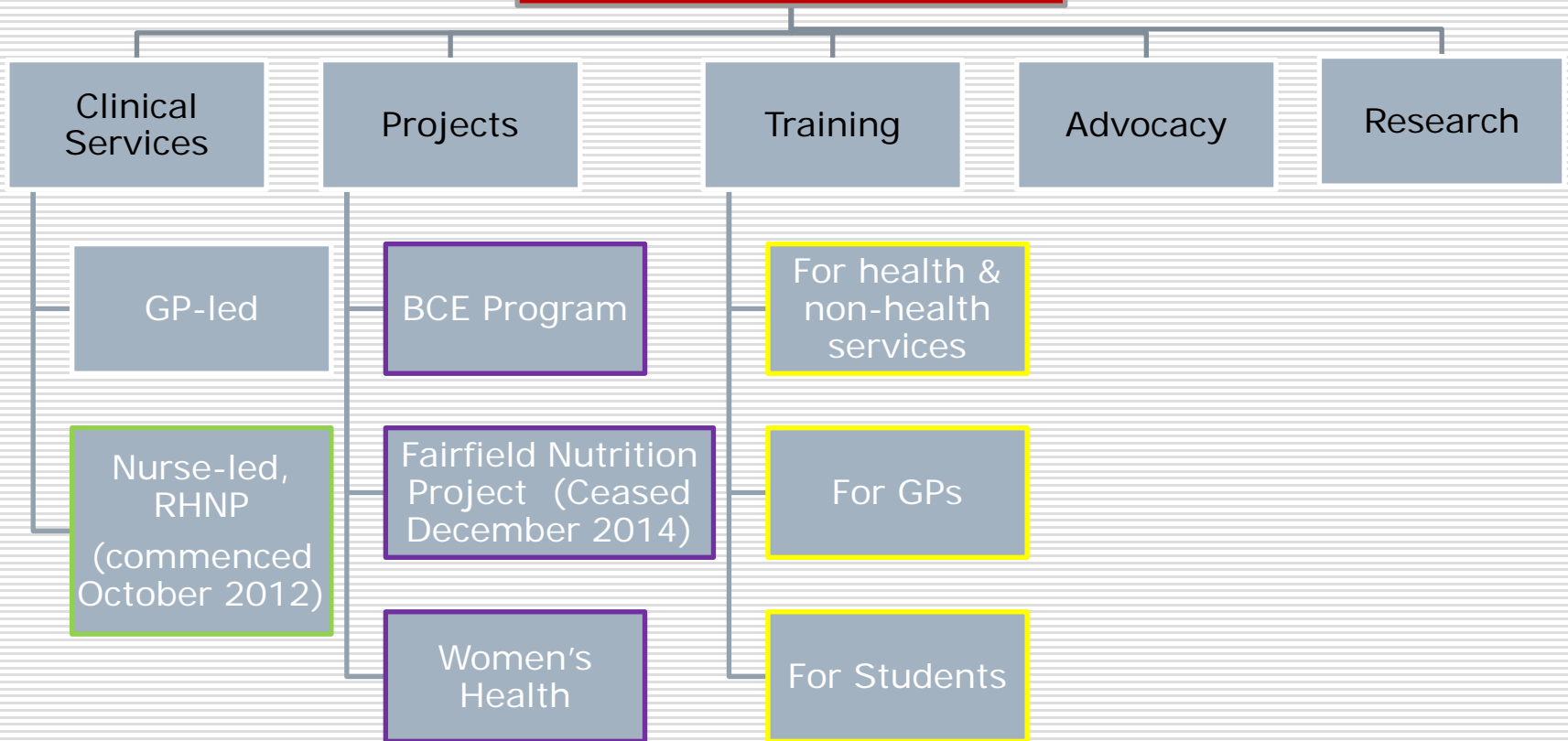
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NSW Refugee Health Service

NSW Refugee Health Service

- ❑ State wide health service funded by NSW Ministry of Health
- ❑ Aims to protect and promote the health of refugees and people of refugee-like backgrounds living in NSW
- ❑ www.refugeehealth.org.au

NSW Refugee Health Service



Definition

- A refugee is “any person who is outside any country of such person’s’ nationality...and who is unwilling or is unable to return...because of persecution or a well founded fear of persecution on account of race, religion, nationality, membership of a particular social group, or political opinion” (UNHCR, 2003)

Who is a refugee?

- They must have proved that they were at risk of serious human rights violations such as being killed; having their family members killed; being tortured; or being imprisoned without trial for one of the reasons above.

Who is an asylum seeker?

- Is a person who has applied for refugee status but is awaiting the outcome of their application

Global trends 2015

- ❑ Now at unprecedented levels, more refugees, IDP's and asylum seekers than any other time in history

Global Trends 2015

- ❑ **65.3 million** forcibly displaced people worldwide
 - 21.3 million refugees (16.7 million in 2013)
 - 40.8 million internally displaced persons (IDPs)
 - 1.8 million asylum seekers (1.2 million in 2013)
- ❑ **51%** of all refugees are children
- ❑ **86%** of the worlds refugees are hosted by developing countries

Global Trends 2015

Biggest refugee populations and by source country are:

- Syria (4.9 million)
- Afghanistan (2.7 million)
- Somalia (1.1 million)

Global Trends 2015

Top Hosts

1. Turkey (2.5 million)
2. Pakistan (1.6 million)
3. Lebanon (1.1 million)
4. Islamic Republic of Iran (979,4000)
5. Ethiopia (736,100)
6. Jordan (664,100)

Source: Global Trends Report – UNHCR, Geneva, Switzerland -2016

Global Trends 2015

- ❑ Developing regions are host 86% of the world's refugees under UNHCR mandate (13.9 million people)
- ❑ The Least Developed Countries provided asylum for 4.2 million refugees (about 26% of the global total)

Refugees in Australia

- ❑ Australia's humanitarian program (Offshore Program) accepts 13,500 refugees per year up to 18,500 by 2017/2018
- ❑ The vast majority of refugees are settled in NSW and Victoria, with close to 70% being less than 30 years of age.
- ❑ Seven in ten refugee entrants were found to have experienced some physical or mental trauma



Refugees to Australia

Annual Intake:

Annual intake **13,750** to continue until 2016-17 with small increases possible in 2017-18 (to 16,250) and then to 18,750 places in 2018-19

September 2015 Government announces acceptance of 12000 Syrian refugees in addition to the annual humanitarian intake

The settlement of additional Syrian refugees has commenced with 1709 settled nationally as at May 20. 48% of the entire group are expected to NSW over the next 18 months.

Refugees to Australia

Australia's Humanitarian Program has:

- ▶ an **offshore** component consisting of:
 - Refugee Category [subclasses 200 (Refugee); 201 (In-country Special Humanitarian Programme); 203 (Emergency Rescue); 204 (Woman at Risk)]
 - Special Humanitarian Program (SHP) Category
 - ▶ an **onshore** component (asylum seekers)
-

Refugees in Australia

Assisted under the Humanitarian Program

- ❑ Refugee status determined overseas
- ❑ Given permanent residency and all subsequent rights and privileges
- ❑ Evenly spread between Africa, Middle East and South East Asia

Asylum Seekers

Managed under the Onshore component of the program depending on means of arrival

- ❑ Plane arrivals generally not subject to detention, revert to a Bridging Visa when their original visa has expired
- ❑ Asylum seekers who arrived by boat after July 2013 diverted to 'Pacific Solution' facilities at Manus Island and Nauru, previously detained on the mainland or Christmas Island

Asylum Seekers

- ❑ Asylum seekers released from detention into the community are on bridging visas
- ❑ People who were IMA's already in the community and found to be refugees at the time of the election will not be given PPV's

Asylum Seekers

- ❑ Eligibility to services varies depending on mode of arrival and stage of refugee determination process
- ❑ Those without Medicare are entitled to a Ministry of Health Fee Waiver for any necessary service
- ❑ Material assistance through Status Resolution Support Service(SRSS) program administered by designated NGO's

The Refugee Experience

Distinct Entities

- ❑ Impacts from the refugee experience in their country of origin
- ❑ Whilst in transit
- ❑ As a consequence of resettlement

What have refugees experienced?

- ❑ Refugees are very different from migrants. Migrants choose to leave their country, refugees are forced to flee.
- ❑ Refugees have often been exposed to persecution in their country of origin, and have survived extreme hardship while fleeing and in their country of origin.

The Refugee Experience

May include:

- War or civil unrest
- Prolonged harassment by authorities, including imprisonment without trial
- Torture
- Loss of family and friends through violence
- Poor medical care (due to destruction of or disruption to health services by warfare, and through limited access to health care while seeking asylum)

The Refugee Experience

- ❑ Deprivation, overcrowding, and poor hygiene in refugee camps or prison
- ❑ Life in refugee camps, especially in countries of first asylum, is usually difficult.
- ❑ Conditions in most camps are primitive and dangerous, with some camps similar to third-world prisons

Resettlement difficulties

Include:

- Social isolation
- Overcrowded poor quality housing
- Employment and financial difficulties
- Changes in role and family structure
- Racism

Resettlement difficulties

- ❑ Unfamiliarity with the new community
- ❑ L/T impact of torture and trauma
- ❑ Ongoing concern about family members in country of origin and survivor guilt

Issues specific to asylum seekers

- ❑ Impact of prolonged detention
- ❑ Access to Medicare and welfare services
- ❑ Ongoing welfare and legal stressors
- ❑ Possible restrictions on work rights

Barriers to health care in Australia

- ❑ Language barriers, which can result in miscommunication, misdiagnosis, and lack of appropriate follow up
- ❑ Financial constraints, particularly for specialist services and private dental care
- ❑ Limited trust of health care providers arising from experiences of human rights abuses at the hands of govt. authorities and others in power

Barriers to health care in Australia

- ❑ Unfamiliarity with Australian healthcare services and systems
- ❑ Incomplete skills of health professionals to detect and manage unfamiliar diseases among refugees
- ❑ Risk of retraumatisation when health care assessment and treatments are conducted in a way that is reminiscent of past abuse

Global Health Risks

- ❑ Malnutrition
- ❑ Intestinal Parasites (amebiasis, giardiasis, ascariasis, strongyloidiasis, hookworm, trichuriasis, enterobiasis, schistosomiasis)
- ❑ Hepatitis B
- ❑ Tuberculosis
- ❑ Low immunisation rates (risk for measles, mumps, rubella, diphtheria, pertussis, tetanus)

Global Health Risks

- ❑ Dental Caries
- ❑ Malaria
- ❑ Sexually transmitted infections including:
cervical cancer, HIV/AIDs, Chancroid,
Chlamydia, gonorrhoea, granuloma inguinale,
lymphogranuloma venerum, syphilis
- ❑ Diarrheal Illnesses

Global Health Risks

- ❑ Long term effects of trauma, rape, torture (PTSD)
- ❑ Neonatal Tetanus
- ❑ Rheumatic Heart Disease
- ❑ High lead levels increasingly seen among children

Types of traumatic experiences

These experiences are often repeated in a variety of ways over long periods and

Include:

- Forced separation, disappearance or murder of family members
- Being subject to or witnessing trauma, physical and emotional abuse
- Sexual assault

Types of traumatic experiences

- ❑ Mock execution
- ❑ Imprisonment and solitary confinement, and
- ❑ Illness and death of family members during flight or in refugee camps
- ❑ The trauma of food and water scarcity, lack of shelter, untreated illness and lack of legal address is also common

Types of traumatic experience

- ❑ The loss of household, educational opportunity, occupation and social structure can compound the experience of trauma.
- ❑ The insecurity of years in transition, in refugee camps or in Australian detention centres, may also have profound psychological consequences

Effects of trauma

Physical presentations

- ❑ Musculo-skeletal and soft tissues damage
- ❑ Head trauma
- ❑ Chronic and regional pain syndromes
- ❑ Impairment of vision and hearing
- ❑ Dental problems due to trauma
- ❑ Motor and sensory neuropathy, gait disturbance

Effects of trauma

Physical presentations

- ❑ Female: amenorrhoea/dysfunctional uterine bleeding, sexual assault injuries, pelvic pain, problems related to female genital mutilation
- ❑ Male: erectile dysfunction, genital pain
- ❑ Sexually transmissible infections, sexual dysfunction

Mental Illness

Effects of trauma

- Cognitive impairment
- Somatisation
- PTSD
- Depression/Anxiety
- Grief, may be complicated and chronic
- Psychosis
- Substance abuse

Mental Illness

Effects of trauma

- Post Traumatic Stress Disorder (PTSD):
 - Re-experiencing phenomena: intrusive, distressing memories, flashbacks, nightmares
 - Avoidance and emotional numbing
 - Hyper arousal: exaggerated startle response, poor sleep, irritability

Effects of trauma

Psychological presentations

□ Complex PTSD

- Dissociation, personality change, poor relationships, self harm, loss of meaning of life
- Most Refugees in countries of second asylum have chronic (and often chronic and delayed onset) PTSD.
- The incidence of PTSD among adult and child refugees from war zones range from 25-94%

Consequences

- ❑ Ability to carry out everyday tasks and attend to basic needs can be seriously impaired
- ❑ Learning ability, crucial to adjustment, can be seriously disrupted with poor concentration, memory and sleep disturbance
- ❑ Pain from injuries or psychosomatic in nature

Consequences

- ❑ Relationships inhibited by distrust and loss of faith in people
- ❑ Survivor guilt
- ❑ Anger and aggressive behaviour from low frustration tolerance from
 - Stress
 - Lack of sleep
 - Protest against loss

Consequences

- Response to injustices
- Reaction to shame and guilt

(Steel, et al, 2006)

Women

- A highly vulnerable pop. due to cultural roles and traditionally subservient roles
- Tend to have more health problems, less treatment and in the new country, tend to be more isolated

Women

- ❑ Problems especially common to women, include:
 - Diet and nutrition
 - Shelter
 - Reproductive health (delayed prenatal care, greater parity, lower haematocrits, more complications, low birth weight babies)
 - Rape and Sexual abuse
 - PTSD
 - Relocation stress
 - Role strain and changes

Case Study

- ❑ 37 year old man from Pakistan, merchant seaman
- ❑ Applied for asylum after jumping ship in 2011
- ❑ Rejected at all levels of application process and final appeal through Federal Court rejected recently
- ❑ Had previously had Medicare but no work rights
- ❑ Self referral for assistance with hand problem after losing Medicare rights

Past Medical History

- ❑ Back pain secondary to beating by Taliban in 2008
- ❑ Depression
- ❑ Had seen a GP when had Medicare who began treating the depression and made appropriate referrals:
 1. Neurosurgery at Westmead
 2. STARTTS and more recently
 3. Physiotherapy for hand injury

Initial consult

- Hand injury improving with physio
- Depression improving with medication and had commenced at STARTTS
- Plan
- Continue physio
- Continue antidepressant and STARTTS counselling
- Follow up if not improving, deterioration or new symptoms

Second consult

- ❑ Remained anxious and depressed
- ❑ Medication and counselling partially helpful
- ❑ Back pain becoming more severe
- ❑ Dyspepsia from analgesics prescribed nexium
- ❑ Now on waiting list for surgery for L4/L5 disc prolapse with bilateral leg pain
- ❑ Surgeon had arranged Interlaminar Epidural Block to alleviate pain

Third consult

- ❑ Back pain improved after Intralaminar Epidural Block
- ❑ Dyspepsia resolved
- ❑ Remains anxious about application process and family in Pakistan

Plan

1. Continue analgesics and antidepressant
2. Continue STARTTS
3. F/U immediately if deterioration

Fourth consult

- ❑ With increasing lumbar pain since procedure with transient right leg symptoms
- ❑ Neurosurgery due
- ❑ Mental state had deteriorated due to deaths of family in Pakistan

Plan

1. Continue with current medications
2. Continue with STARTTS
3. F/U immediately if mental state deteriorates or thoughts of self harm

Fifth consult

- ❑ Back pain generally worse, surgery had been postponed
- ❑ Mental state further deteriorated after final appeal rejected
 1. Low mood
 2. Anhedonia
 3. Guilt due to pressure from family
 4. Thoughts of self harm (no intent/plan) any action inhibited by faith at present

Fifth consult

Plan

1. Support
2. Continue treatment for back pain and depression including STARTTS
3. F/U in 3 weeks
4. Contracted safety before seeing us again
5. Immediate f/u back symptoms deteriorate, further deterioration of MS, self harm intent/plan

Subsequent progress

- ❑ Spinal surgery early May 2015
- ❑ Stay of deportation until follow up with neurosurgeon six weeks post surgery
- ❑ General improvement with resolving symptoms
- ❑ Remain on present treatment with physio and STARTTS follow up as planned
- ❑ Visa extended October 2015

Subsequent progress

- ❑ Earthquake in home village injuring his wife
- ❑ Now occasional, brief, sharp chest pain, pleuritic in nature but no organic cause
- ❑ Anxiety and Depression unchanged, symptoms reactive to immigration situation

Subsequent progress

- ❑ Musculo-skeletal symptoms tolerable with medication
- ❑ All supports remaining in place
- ❑ 20th June 2016- has been directed by DIBP to return home

Social determinants contributing to MH morbidity (DSM V)

Refugees and asylum seekers are subject to all of these factors

- ❑ Primary support group (death of family member, family disruption, and abuse)
- ❑ Social environment (death or loss of friends; inadequate social support; acculturation problems; and discrimination)
- ❑ Educational problems
- ❑ Occupational problems
- ❑ Housing problems
- ❑ Economic problems accessing health care
- ❑ Problems accessing health care

Cultural Competence

At the most basic level is the practice of considering culture in order to effectively serve people of diverse backgrounds

Cultural Competence

Helpful to be aware of:

- The political and social history
- The reasons for conflict in the region
- The ethnic make-up of the region
- The level of persecution that exists
- Cross-cultural issues
- The effects of state terror on persecuted people

Cultural Competence

Profound importance on several levels

- ❑ Conveys respect and with respect the likelihood of compliance with medication and treatment regimes
- ❑ Acceptance and learning from cultural relativism

Cultural competence

Invokes compassion and empathy, an attempt to treat the whole patient by considering the person's state of health in the context of broader historical events

General Management Issues

Special Considerations

- ❑ Explain your role carefully in relation to the system, the types of services available and notions of confidentiality and consent
- ❑ Adopt a sensitive, gradual approach to history taking and assessment. Questioning may be reminiscent of past interrogations or abuse

General Management Issues

Special Considerations

- ❑ Use professional interpreters in preference to family or friends to ensure accuracy, competence and confidentiality.
- ❑ Think preventative health as there may have been limited access to immunisation, cancer screening and preventative health information prior to arrival

Effective Intervention

- The definitive answer to the question 'What treatments work for whom?' may not be possible to answer due to:
 - The diversity of experiences
 - The diversity of cultural backgrounds and
 - The range of responses to traumatic events

Effective Intervention

- ❑ Social environment important for successful settlement
- ❑ Individual care
 - Usual MH Approaches
 - Contextual and cultural considerations
 - Specialised referral services (STARTTS, TCMH)

Effective Intervention

- Recent review of research evidence on psychosocial interventions found 36 of the 40 studies (90%) demonstrated significant improvements in symptoms of PTSD, depression, anxiety and somatic symptoms (McFarlane & Kaplan, 2012)

Effective Intervention

- Interventions differed according to client needs, client characteristics, service philosophies, research priorities, the socio-political context and resource availability
- RCT's assessing CBT, NET, TT and healing and reconciliation workshops all had positive outcomes

Effective intervention

The remaining interventions reviewed included:

- Multicomponent rehab.
- Cognitive Processing Therapy (CPT)
- Exposure Therapy (ET)

Effective interventions

- ❑ Outpatient psychiatric services
- ❑ Psychotherapy
- ❑ Stress and Coping skills training and
- ❑ Trauma counselling

Health priorities and support needs

- Remaining connected to appropriate health care
- Preventative health programs
- Groups which promote connection, self care and belonging
- Family/individual counselling
- DV Services
- Re-establishing a meaningful existence
- Realistic expectations

Working with torture and trauma survivors

Issues it may be important to think about

Include:

- Your own behaviour
- Using Interpreters
- Not pushing for disclosure of personal details
- Having to be more patient because survivors have problems with memory and concentration

Working with torture and trauma survivors

- ❑ Avoiding things which may trigger fear responses
- ❑ Explaining what you are doing
- ❑ Not taking symptoms personally
- ❑ Avoiding questions that look like interrogation
- ❑ Emergency procedures
- ❑ Listening, acknowledging, thinking

General principles of communication

- ❑ Non-judgemental acceptance of the survivor
- ❑ Expect that you will have powerful reactions to the experience of the survivor
- ❑ Assume the stress reaction comes from traumatic event/s, not pre-existing psychopathology
- ❑ Take into account the political/religious/cultural dimensions of the individual

General principles of communication

- ❑ Adopt a flexible and client centred approach

The process includes:

- ❑ Building a trusting relationship
- ❑ Ensuring confidentiality
- ❑ Not reinforcing torture experiences in the way communication is conducted
- ❑ Dealing with strong emotions
- ❑ Remember traumatic stress causes loss of self-esteem and confidence

Their contributions

Despite the great difficulties that Refugees and asylum seekers have experienced they almost without exception display remarkable dignity and resilience.

Once successfully integrated they make substantial contributions to their new countries

NSW Refugee Health Service

- ❑ Providing health assessments, advice and referral for refugees and asylum seekers
- ❑ Training and support for health service providers across NSW on refugee health issues
- ❑ Delivering health information to refugees, including orientation to the NSW health system

NSW Refugee Health Service Roles

- ❑ Undertaking targeted health promotion projects in collaboration with Area Health Services and other agencies
- ❑ Facilitating and conducting research on health needs and service delivery issues for refugees
- ❑ Advocacy and advice at the health policy level and on a case by case basis, to promote health equity for refugees and others of refugee-like background

NSW Refugee Health Service

Can be contacted regarding:

- Information about refugee health issues and policy
- Advice on specific cases
- Training for health care workers on refugee health issues
- Research needs relating to the health of refugees

NSW Refugee Health Service

- ❑ Information sessions for refugees about the NSW health system
- ❑ Clinical assessments for newly arrived refugees or asylum seekers
- ❑ Educational resources for health professionals, students and others

Website: www.refugeehealth.org.au