Refugees and Asylum Seekers: Implications for ED Care in Auckland, New Zealand

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The increasing use of emergency departments by refugee and migrant groups reflects the shifting ethnic composition of central Auckland. Refugees are different from other immigrants and from low-income families in New Zealand in that they often have a history of trauma. In addition, they live with greater adversity—that is, more illness, unemployment, and isolation from support networks. These factors may account for the proportionately higher rate of presentation in the emergency department by refugees with urgent and nonurgent complaints. The health care needs of refugees are complex and place demands on both adult and children's emergency services.

Persons with refugee backgrounds in New Zealand

More than 30,000 people in New Zealand have refugee backgrounds, and the number of persons with refugee backgrounds is increasing by up to 2000 per year.[1] Most refugees and asylum seekers are concentrated in Auckland, New Zealand's largest city. The total population of New Zealand is 4 million, of whom one third live in Auckland.[2] In addition to a growing refugee population, New Zealand—and in particular, the Auckland region—has a rapidly growing multi-ethnic population. Net migration gains in New Zealand are at the highest levels ever recorded.[2] At the time of the Census of Population and Dwellings in March 2001, slightly fewer than 20% of New Zealand's residents recorded a birthplace overseas. This is one of the highest proportions of overseas-born persons in the population of any country in the Organization for Economic Co-operation and Development, exceeding the migration rates of Canada at 17% and 10% for the United States.[2] Refugees in New Zealand mainly come from the Middle East, the Horn of Africa, and Southeast Asia. In addition to an an-

nual quota of 750 refugees mandated by the United Nations, every week up to 40 asylum seekers make application for refugee status. All United Nations–mandated refugees and asylum seekers applying for refugee status are entitled to publicly provided health services in New Zealand.[3]

Refugees in New Zealand are a legally and constitutionally well-defined group.[4] New Zealand ranks first (equal per capita) in the world in the number of refugees accepted.[1] However, of the 10 countries regularly resettling refugees, New Zealand ranks lowest in support and services provided after arrival. It offers no barriers to resettlement for those with pre-existing medical conditions and disabilities.[5] Refugees in New Zealand are a high-risk health care population because they typically come from countries with high rates of communicable diseases and little or no functioning health care systems. Many refugees have experienced physical and mental trauma and ill health.[1,6] Often, secondary care has been interrupted and long-term illnesses untreated during civil war and refugee flight.[1] Refugees have some of the poorest health outcomes in New Zealand society.[5,7,8]

The following case is an example of the complexity of ED care for refugee children.

Case review

Hashem arrives at the Children's Emergency Department with a 3-day history of fever and vomiting. He is 13 years old, Afghani, and is an unaccompanied minor. A uniformed guard accompanies him from the detention centre where he has been placed on arrival. Hashem was rescued from a raft in the Indian Ocean by a passing freighter and has been resettled in New Zealand. He is from an ethnic minority group in Afghanistan. He says he had to flee because his community of Shi'ite Muslims is in conflict with Sunni Muslims, who ruled the area in which he was living. Before leaving his village, Hashem was badly beaten by the Taliban. Hashem is diagnosed with *Plasmodium vivax* malaria. He is hospitalised with secondary jaundice and anaemia. The issues involved in case management are discussed Table 1.

The impact of the refugee experience on the coping skills of refugee families

Because refugees usually have no extended family in the country where they are relocated, normal patterns of family care and coping are disrupted. Upon arrival in New Zealand, they experience additional financial problems, overcrowded housing, language barriers, culture shock, racism, unemployment, and ongoing anxiety related to family members left behind. Working with refugee families can feel chaotic and overwhelming.

Seeking emergency care and illness behaviour

Little research exists on the utilisation of emergency services by refugees and migrants with refugee-like backgrounds. For refugees, "illness behaviour" in seeking ED care is influenced by health care experiences prior to arrival and to barriers in accessing primary health services in New Zealand. Most refugee families are unused to the system of general practice and need instruction about how and when to use primary health and emergency services. However, significant barriers exist to accessing primary health care, particularly affordability and the inability to communicate.

Specific considerations for the care of people from refugee backgrounds in emergency departments

- **Using interpreters.** It is advisable to confirm the patient's preferred language, because the patient's place of birth and ethnicity are not always reliable indicators when booking an interpreter. Because tension may exist between persons of different language groups, it is important to establish the patient's preferred language. If possible, the patient's consent should be obtained prior to booking an interpreter. In small communities, the patient may know the interpreter socially, and a different interpreter may be needed. It should be established whether the patient prefers a male or female interpreter, and one should always abide by the chosen sex of the interpreter.
- **Decision making.** It is best to ask the patient who can be spoken to within the family or community and what they can be told regarding the patient's health, treatment, and ongoing care. Interpreters

TABLE 1
Case management issues for refugee families in the emergency department and strategies to address them

Problem	Action
Making an accurate diagnosis	
Patient is unable to give a medical or family history	Ensure that an interpreter is available, taking account of ethnic and gender sensitivities
Patient is from an ethnic minority and is mistrustful of the Afghan interpreters supplied by hospital services	If possible, provide an interpreter from same ethnic minority group; explain that interpreters are bound by confidentiality
The accuracy of the birth date given is doubtful	Obtain a bone density to ascertain an accurate age
Patient is malnourished	Refer to dietician services; child—referral to developmental specialist; treat malnutrition accordingly, eg, iron deficiency crosscheck includes iron studies, full blood cell count for haemoglobin, microcytosis; refer to haematologist
Are there symptoms of PTSD and other mental health disorders?	Avoid asking direct questions about mental health because mental health disorders are culturally highly stigmatised
Patient is awaiting determination of refugee status and has considerable anxiety about the impact of health testing on his or her refugee status claim	Reassure patient that medical information will not affect the outcome of his or her refugee status claim
Examination procedures	
The culture and custom of the patient forbid examination and care from female doctors and nurses	Ensure that a male doctor is available; explain what is happening and why; during examination, bodily exposure should be minimal
Hospitalisation	
Patient is not literate in any language	Provide appropriate interpreter
Patient cannot speak English	Explain ward layout and systems carefully through the interpreter
Patient has no family support	Explain to staff the circumstances of the patient, along with any customs and beliefs that may have an impact on care
It is the season of Ramadan and patient is fasting and does not wish to take any medication	Ask an appropriate Muslim religious leader to explain that ingesting food and medication during Ramadan is acceptable when a person is unwell
Patient has not yet been screened for tuberculosis or any other communicable disease and has spent considerable time in Indonesia, where he or she may have been exposed to parasitic infections and tropical diseases	Screening should include iron and vitamin deficiencies, common parasitic infections, and tropical diseases as well as haemoglobinopathies
The patient has never had any health care or any experience of hospitals previously	Protect patient from vicarious interest from other staff members
Follow up	
Patient is resident in a refugee reception centre; there is no residential medical care available at the centre after hours, and the patient is under the guardianship of social services	Arrange for a social work referral and for the coordination of care between the hospital and community health, social, and refugee resettlement agencies involved in care of patient
Patient does not have a general practitioner	Ensure patient is not discharged until proper arrangements have been made for the care of the client
Patient is in need of ongoing psychological support and management of mental health	Refer patient to the Refugees as Survivors Centre for ongoing psychological support
Relapses of *Plasmodium vivax* can occur months or years later	Provide patient education with regard to further medical care if he or she has a recurrence of malaria and ensure he or she understands medication regimes

PTSD, Posttraumatic stress disorder.

often can identify key decision makers within extended families in various cultures.

- **Specifying symptoms.** In some cultures, the patient's experience may emphasize and interpret somatic rather than psychological symptoms. History taking needs to include an awareness of culturally specific symptoms so that symptoms are not misdiagnosed or unrecognised.
- **Somatisation.** If physical symptoms persist after a full clinical investigation with no definitive findings, it may be useful to explore any underlying mental health issues such as posttraumatic stress syndrome, depression, and/or anxiety.
- **Communicable disease control**. Not all asylum seekers and family reunification refugees receive public health screening. A high index of suspicion should be maintained with regard to undiagnosed communicable diseases, including HIV and tuberculosis.
- **Trauma.** Common coping strategies in refugee families include minimising, denying, or being silent regarding war-related traumas, rape, and injuries. Sensitive questioning will be required so that trauma-related injuries and illnesses are not overlooked in refugee adults and children.[11]
- **Sexual and reproductive health.** In some cultures, any discussion of sexual matters and of rape and sexual assault in front of male family members is deeply shameful. When these topics must be discussed, consider using female interpreters and ask male relatives to leave the room.
- **Physical exposure.** At all times, bodily exposure should be kept to a minimum for Muslim peoples and others of Middle Eastern, African, and South Asian backgrounds.[9]
- **Family violence.** A number of studies of refugee health have confirmed an increased rate of risk factors for family violence such as poor mental health, trauma, family losses, parental unemployment, and cultural and social isolation.[1,10] When family violence is suspected, health care personnel should try to speak to the apparent victim without other family members present during history taking. It is appropriate to tell the patient that you are concerned about her, to ask if any violence exists in her relationship, and to provide information on support options and legal rights, including the fact that violence within marriage is illegal in New Zealand.
- **Prescribing medication.** Refugee patients may be unfamiliar with the system of prescribing medication in Western countries. It is helpful to explain how a prescription works, including the role of the pharmacist, the likely costs and waiting times, and how to get prescriptions refills. Many refugees come from countries where medication is provided by the health professional during the consultation, and thus the patient may expect to receive prescribed medicines at the time they are examined. To avoid poor compliance with medicine regimes, it is important to give detailed and clear explanations to patients when prescribing medicines. It is particularly important to emphasize the correct dose and course of the medication. Compliance is a problem in the general community and may be further exacerbated in refugee communities because of communication difficulties. We have found it best to prescribe the simplest and shortest course of treatment and to explain safety issues such as safe storage of medicines, expiration dates, and why it is important not to share medication.

Conclusion

In our experience, refugees often present late in the course of an illness because of a range of factors, including difficulty in understanding how the New Zealand health system works, in particular the role of primary health care. Poverty, the lack of interpreters in general practice, difficulties with transportation, and a preference for hospital-based care result in a disproportionate number of refugee families presenting to emergency departments. Whereas many families may present "inappropriately," in addition, they often delay in seeking care when illness is acute. To decrease this "inappropriate" or delayed ED presentation of refugee populations, many systemic issues need to be resolved. These include better processes of orienting newcomers to the New Zealand health system and improving access to primary health care through the provision of interpreters. Generally, the poor resettlement support and integration of refugees and migrants into New Zealand society will need to be addressed before "inappropriate ED attendance" can be resolved.

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