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Prepared by the Victorian Foundation for Survivors of Torture Inc. on behalf of the Refugee Health and General Practice Development Program

Caring for Refugee Patients in General Practice

a Desk-top Guide
2nd Edition

Prepared by the Victorian Foundation for Survivors of Torture Inc. on behalf of the
Refugee Health and General Practice Development Program with assistance from
the Victorian Infectious Diseases Service Royal Melbourne Hospital, Department of General Medicine
Royal Children's Hospital and the University of Melbourne Departments of Medicine and Paediatrics.

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This guide has been produced to support GPs in caring for refugee patients.
More detailed information can be found in the companion publication, *Promoting Refugee Health: A Handbook for Doctors and Health Practitioners Caring for People from Refugee Backgrounds,* available
from the Victorian Foundation for Survivors of Torture

phone: 03 9388 0022 fax: 03 9387 9828 email: administrator@survivorsvic.org.au

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Caring for the Refugee Patient

Each year many thousands of people settle in Australia as refugees from regions such as the Middle East, former Yugoslavia and the Horn of Africa, where they have endured conflict and persecution. These people have a higher rate of long-term physical and psychological problems than other migrants , due in large part to their exposure to conflict and oppression. One in four will have been subject to torture or severe human rights violations, with almost three in four being exposed to traumatic events such as forced dislocation, prolonged political repression, refugee camp experiences and loss of or separation from family members in violent circumstances.

Many will not have had access to comprehensive health care for some years. They:

- will usually require a professional interpreter,
- may have physical and psychological sequelae associated with pre-migration trauma and torture,
- may need a thorough medical examination,
- may be struggling with the practical tasks of settling into Australia and not know where to get assistance,
- may require an approach to consultation and management which accommodates the impact of past trauma, prior experience of health care, cultural differences and the stresses of resettlement.

Identifying
Refugee Patients

If your patient speaks a language other than English, consider the possibility that they may be from a refugee background. In the past two decades Australia has offered settlement to people from the following territories in which there has been a history of systematic human rights violations:

AFGHANISTAN	ETHIOPIA	GUATEMALA
ARGENTINA	FORMER YUGOSLAVIA* (INCLUDING SERBIA, BOSNIA-HERZEGOVINA, CROATIA & KOSOVA)	IRAN#
BURMA (MYANMAR)		IRAQ#
CAMBODIA		LAOS
CHILE		SIERRA LEONE
EAST TIMOR		SOMALIA
EL SALVADOR		SUDAN
ERITREA		VIETNAM

*Entrants may be of Serbian, Croatian, Albanian or Bosnian background. Country of birth is not necessarily an indication of ethnicity or religious background. #Includes Kurdish entrants.

Patients from the following countries may also have had traumatic pre-migration experiences:

ALBANIA	INDONESIA	PORTUGAL
BALTIC STATES	KUWAIT	SAUDI ARABIA
BOTSWANA	LEBANON	SRI-LANKA
BULGARIA	NICARAGUA	THAILAND
CZECHOSLOVAKIA	PAKISTAN	TURKEY
EGYPT	PERU	UKRAINE
INDIA	PHILIPPINES	FORMER USSR

Consider marking patient files to aid future identification, particularly of refugee patients with special needs.

FOR FURTHER INFORMATION ON COUNTRY BACKGROUNDS:
Amnesty International: www.amnesty.org
Human Rights Watch: www.hrw.org
One World: www.oneworld.net
United Nation Development Program: www.undp.org
United Nations High Commissioner for Refugees: www.unhcr.ch
US Committee for Refugees: www.refugees.org
World Health Organisation: www.who.int

Engaging a Professional Interpreter

Most recently arrived refugees do not speak English. There is the risk in involving family, friends or untrained personnel as interpreters, that confidentiality will be compromised or that they will be exposed to material of a sensitive and traumatic nature. Further, a high level of technical competence in both English and a second language is required to interpret medical information. Confidentiality is part of a professional interpreter's code of ethics. Optimal communication reduces anxiety as well as facilitating the consultation.

Booking and using an interpreter

- In a community health centre or hospital, check existing booking procedures and interpreter access as arrangements vary from service to service.
- GPs and specialists in **private practice** can book an on-site interpreter for Medicare-related services free of charge. **Bookings must be made two weeks in advance** and by the doctor (or their staff). The advance booking requirement may be waived if medically indicated.
- On-site interpreters are available for appointments commencing in the hours between 9am and 4.30pm. In extraordinary circumstances they can be arranged outside of these hours.
- Fax information to the Translating and Interpreting Service (TIS) using the *Request for On-site Interpreter* form enclosed.
- Plan consultations in advance where possible so that an interpreter can be present, and a longer consultation time allowed.
- Where advance booking is not possible, the TIS telephone interpreter service is also available free of charge to private practitioners (24 hours, 7 days a week), phone **1300 131 450** (this is a priority line for doctors).
- A telephone interpreter can also be booked in advance of the consultation using the *Request for Pre-booked Telephone Interpreter* form enclosed.
- Ideally a 'hands-free' speaker telephone should be used when working with a telephone interpreter.
- Consider enlisting the cooperation of your administrative staff to implement a system for booking interpreters.
- Establish if the patient has a preferred language, ethnicity or gender of interpreter.
- Choose seating arrangements that will enable direct communication with the patient.

Consultation and Management

Medical consultation may be a source of anxiety for refugee patients, especially those experiencing psychological sequelae (see Section 6, p14). Symptoms such as memory loss, confusion, distractability, poor concentration and self blame may affect the client's capacity to hear and understand instructions and to provide information to the doctor. Intrusive memories may be triggered in the course of consultation.

Refugees may have a distrust of authority figures, among them medical professionals. For some this fear may be based on doctors having been actively involved in perpetrating or supervising torture in their country of origin. Others may have uncertainties about their immigration status, fearing deportation if they are found to have a serious health problem.

Communication difficulties may be further complicated by cultural and religious differences and the patient's lack of familiarity with the Australian health care system.

In consultation

- Allow time in earlier consultations to establish rapport and trust.
- Explain and emphasise doctor–patient confidentiality, patient consent, choice and control.
- Explain procedures and be prepared to repeat information.
- Provide opportunities for the patient to ask questions or seek clarification as some will have come from cultures in which this was not encouraged.
- Providing an explanation for your line of questioning may be helpful.
- Patients may openly show fear and hostility, which are characteristic responses to trauma and may have little to do with the consultation *per se*.
- Be aware that the surgery and aspects of the consultation may be reminders of past trauma (eg being made to wait, sudden movements, seating arrangements, medical instruments).
- If the patient becomes overly anxious, consider suspending and rescheduling procedures.

Ongoing management

- Assessment and management can take place over several sessions when a gradual approach is indicated.
- When deciding whether or not to proceed with or defer certain questions or an invasive procedure, consider the importance of establishing a rapport and trust with the patient, and of ensuring that they fully understand any procedure and the reasons for performing it.
- Consider gender issues, for example, male GPs may consider referring female patients to a female doctor; a male Muslim patient may prefer a male doctor.
- Consider a patient-held record, particularly for immunisations, as refugee patients are likely to move frequently in the early settlement period.
- Establish if there are any cultural or religious factors that need to be accommodated in your care.
- Explain the culture and structure of the health care system; the general practitioner's role; and the patient's health care entitlements and rights.
- Allow some flexibility with appointments as sleeping and memory problems, anxiety and lack of past experience with appointment systems for health care may all affect compliance.
- Where required consider an appointment reminder call.

Referral for investigations and specialist management

- Be aware in assessing the need for investigations and specialist referral that these can involve a great deal of organisational effort on the part of the refugee patient.
- The patient may require additional practical support to pursue investigations and referrals.
- With the patient's permission, brief specialists about the need for an interpreter and any other special needs.
- Given language difficulties and lack of familiarity with specialist referral procedures, consider making the first appointment for the patient.
- Consider requesting that patients be charged the Medicare Benefit Schedule fee only for specialist services, or alternatively refer to a public hospital.

Prescribing

- Many refugee patients come from areas where pharmaceuticals are poorly regulated and they may be unaware of the consequences of inappropriate dosing.
- Compliance may also be affected by language problems. An interpreter can write instructions in the patient's own language or instructions may be conveyed diagrammatically.
- A PBS listed drug is highly preferable owing to financial difficulties, as is generic prescribing.

Medical History and Examination

Consider offering a thorough medical examination, particularly to those patients resident in Australia for less than two years as:

- Routine post-arrival screening is no longer offered in most Australian states and territories.
- Pre-arrival screening is limited and selective and follow-up treatment is only offered in respect of serious communicable disease.
- A disease may be contracted subsequent to, or be missed in, the screening process.
- The opportunities for early intervention, particularly for diseases and conditions that are asymptomatic, can be optimised.
- Patients may be in poor health as a result of their experiences of trauma and torture and disrupted access to health care.
- The strict health requirements applying to other migrants can be waived for entrants from refugee backgrounds.
- If it yields normal results, the examination may reassure the patient if they fear they have been irreparably harmed by their experiences.

The Health Undertaking

Entrants in whom certain infectious diseases are detected in the course of pre-arrival screening may be subject to a Health Undertaking (ie approved for entry on the condition that they present for follow-up monitoring). It is the responsibility of the applicant to contact the Health Undertaking service by ringing the number listed on the Health Undertaking form issued prior to migration. However, some applicants may be uncertain about their obligations or how to fulfil them. Contact your state or territory public health facility or TB service (see Section 7, p19) if you require more information about a patient on a Health Undertaking.

Translation of medical documents

If a patient has a medical report or vaccination certificate issued prior to migration the Translating and Interpreting Service (see Section 7, p19) will provide translation into English in the form of an extract or summary of about 100 words. This service is free-of-charge to Australian citizens or permanent residents within two years of their arrival or grant of permanent residence.

Table 1 : Additional issues to consider in history taking and physical examination

CHECK FOR/CONSIDER	NOTES
BREAST & CERVICAL SCREENING	- No or disrupted access to these services in developing countries and situations of prolonged conflict. - Requires sensitivity, including possible referral to a female practitioner. - When deciding whether or not to offer clinical breast examination, breast x-ray screening or a pap smear, consider the possibility that such procedures may be traumatic. Take into account the importance of establishing trust with the patient. - A significant factor in determining the appropriate time to offer these procedures will be whether or not the patient is symptomatic. - Consider the option of providing information on breast and cervical screening and offering a follow-up appointment or referral to a family planning or women's health clinic.
CHRONIC MEDICAL CONDITIONS	- Delayed diagnosis, poor management; periods without treatment/management in country-of-origin. - May be exacerbated by refugee/resettlement stress.
DENTAL REVIEW	- Dental problems attributable to poor access to dental care, poor diet and/or injuries sustained in the course of torture. - Treatment of dental problems can contribute to physical and psychological recovery. - See Section 7, p18 for referral sources.
DEVELOPMENTAL SCREENING (CHILDREN)	- Developmental delay may result from chronic infections in childhood (eg cerebral malaria) and/or recurrent illness and environmental deprivation resulting from experiences of war and famine. - Refer to Maternal and Child Health Service.
FAMILY PLANNING	- Contraceptive prevalence low in many developing countries. - Programs a low priority in emergency and conflict situations.
FEMALE GENITAL MUTILATION	- Prevalent in Horn of Africa in particular. - Has impact for antenatal care and gynaecological management. - See Section 7, p18 for specialist referral centres and detailed management guidelines.

CHECK FOR/CONSIDER	NOTES
HEARING IMPAIRMENT (SCREENING)	- Past or current infection. - Possible poor management and screening. - Exposure to noise associated with explosive activity in war zones. - Blows to the head in conflict and torture.
IMMUNISATION REVIEW	- Not formally undertaken at/before arrival. - Likely to need vaccination to bring in line with Australian schedule eg children under 5 likely to need HIB and Hepatitus B. - See Section 5, p11 for guidelines.
INFECTIOUS AND PARASITIC DISEASE	- See Section 5, p12.
MENTAL HEALTH	- Anxiety, depression, Post Traumatic Stress Disorder (PTSD) symptoms and other disorders may be present. See Section 6, p15 for management guidelines.
NUTRITION	- Vitamin A deficiency. - Vitamin D deficiency (especially dark-skinned settlers). Investigate and treat mothers of affected infants and counsel re prevention in future pregnancies. - Iron deficiency anaemia (especially women and children). - Malnutrition may be associated with intestinal parasites (see Section 5, p12). - Micro-nutrient deficiency disorders. - Counsel women of child-bearing age re folate supplementation.

CHECK FOR/CONSIDER	NOTES
NUTRITION (CONTINUED)	- New diet-related disorders (eg non-insulin-dependent diabetes mellitus). - Eating disorders may result from torture and trauma experiences (eg poor appetite, anorexia, excess consumption). - Caffeine consumption and tobacco use may exacerbate anxiety and PTSD symptoms.
RHEUMATIC HEART DISEASE	- More common in developing countries. - Management may have been poor.
SEXUAL ASSAULT/SEXUALLY TRANSMITTED DISEASES	- Rape and sexual torture not uncommon in female and male survivors. - Extreme sensitivity required. - Consider guidelines in Section 5, p11 before screening for STDs. - Concerns about future fertility may be present.
SKIN DISEASE	- Check for ulcers, fungal skin disease, scabies, lice and secondary infection and, less commonly, parasitic-related skin disease.
VISUAL IMPAIRMENT (SCREENING)	- Past current infection (eg trachoma) or deficiency (eg Vitamin A). - Poor management and delayed diagnosis. - Optometry referral.
WAR-RELATED INJURIES	- There may be evidence of old fractures, mine injuries or other trauma untreated or poorly managed.

Infectious Diseases/ Immunisation

- Infectious diseases are common in many of the countries from which refugee patients originate (Table 4, p12).
- Regional variations in infectious diseases can be checked using current information sources listed in Section 7.
- Limited tests for infectious diseases will have been conducted as part of pre-arrival screening (see Table 2).
- Some helminths infections (strongyloides, opisthorchis, schistosomiasis) may be asymptomatic and persist for many years before causing serious disease.
- TB (pulmonary, extra-pulmonary) is common in refugee groups especially in the first five years after resettlement and should always be considered. As TB is associated with considerable stigma in many countries, particular sensitivity and confidentiality should be observed and appropriate counselling offered.
- HIV is a concern, but testing needs to be carried out in a sensitive manner with informed consent and appropriate counselling.
- Patients with Hepatitis B or Hepatitis C will require referral to an infectious diseases specialist as they are at increased risk of developing cirrhosis and hepatocellular carcinoma.
- To avoid repeat testing/immunisation consider documenting in a patient-held record.

Table 2 : Health checks to consider for asymptomatic settlers

CHECKS TO CONSIDER	NOTES	RELEVANT PRE-ARRIVAL SCREENING PERFORMED*
CXR MANTOUX	- To exclude TB (if not done in pre-arrival screening or indications exist). - Consider Mantoux as first step. - Normal pre-arrival CXR does not exclude TB post arrival.	**Chest X-ray:** Applicants aged 16 years or more and some younger people in certain circumstances.
FBE	- Anaemia (gut parasites) - Eosinophilia (parasitic infection)	
SEROLOGY	- Schistosomiasis - Strongyloides In association with informed consent and adequate counselling: - HBV - HCV - HIV - strongly recommended for people from countries with high prevalence of infection.	**VDRL:** - Any applicant suspected of having a STD. - Refugee applicants aged over 16 years who have lived in 'camp-like' conditions. **HIV Serology:** - Applicants aged 15 years or more. - Those under 15 years if there is a reason to suspect HIV infection. **Hepatitis B Serology:** - Confined to international adoptees, unaccompanied refugee minor children, pregnant women.
STOOL	- MCS/OCP x3 fresh stool or x1 stool in preservative	

*See Section 4, p8 for limitations of pre-arrival screening

Table 3 : Infectious diseases sometimes diagnosed in settlers in Australia: A syndromic approach

EOSINOPHILIA	- Intestinal nematodes: strongyloides,ascaris lumbricoides, hookworm - Filariasis - Flukes: schistosomiasis, fasciola hepatica, opisthorchis spp - Hydatid disease - Cysticercosis - Cutaneous larva migrans
FEVER	- Malaria - Typhoid - tuberculosis (pulmonary and extra-pulmonary) - Rickettsial disease - yellow fever/Haemorrhagic fever (if < 2/52) - Dengue
DIARRHOEA	- Salmonella - Shigella - Cholera - Campylobacter - Giardia - Amoebiasis - Strongyloides
JAUNDICE	- Malaria - Typhoid - Hepatitis A/B/C - Leptospirosis - Amoebic liver abscess - Rickettsial disease - Sepsis - Viral Haemorrhagic fever

Table 4 : Infectious diseases to consider in refugee patients: By infectious agent type

BACTERIAL	- Tuberculosis (esp. extra-pulmonary) - Typhoid - Rickettsial disease - Salmonella/shigella/campylobacter/ cholera - Septicaemia
VIRAL	- HBV - HCV - HIV - Measles/Mumps/Rubella - Arboviral (eg dengue, yellow fever) - Haemorrhagic fever (rare but need to consider if < 2/52 since left endemic area)
PARASITIC	- Malaria - Intestinal helminths: strongyloides, hookworm, ascaris lumbricoides, trichuris trichiura - Amoebiasis - Giardia - Flukes: schistosomiasis, fasciola hepatica, opisthorchis spp - Hydatid disease - Cysticercosis - Filariasis

Table 5 : Immunisation in refugee patients: **ADULTS**

GENERAL QUESTIONS TO ASK	- Previous vaccinations? - Documentation?
STANDARD CHILDHOOD IMMUNISATIONS	- Offer primary course if no satisfactory history or documentation (eg HIB, Polio, Diptheria, Pertussis, Tetanus, Measles, Mumps, Rubella).
HEPATITIS B VACCINATION	- Serology recommended (HBsAg, HBcAb) before vaccination. - Provide to: . Susceptible household contacts of acute/chronic carriers. . Susceptible sexual partners of carriers/acute HepB PLUS HepB Ig.
BCG	- Not routinely recommended. - Consult your state or territory TB Program.
RUBELLA	- Offer MMR to all sero-negative women of child-bearing age. - Must not be pregnant or planning pregnancy for next 3 months.
ADULT DIPTHERIA/TETANUS	- Required only at aged 50 years provided childhood immunisations complete.

Table 6 : Immunisation in refugee patients: **CHILDREN**

GENERAL QUESTIONS TO ASK	- Previous vaccinations? - Documentation?
STANDARD CHILDHOOD IMMUNISATIONS	- Offer primary course if no satisfactory history or documentation (eg HIB, Hepatitis B). - Aim to bring up-to-date with Australian Schedule, see *The Australian Immunisation Handbook,* 7th Edition, part one, section 9 (eg HIB, HepB).
HEPATITIS B VACCINATION	- Vaccinate all children less than 10 years of age if no satisfactory history or documentation. - Serology NOT necessary prior to or after vaccination.
BCG	- Not routinely recommended. - Should consider, following consultation with your state or territory TB Program, for: . All children with ongoing exposure to person with active TB. . Young children travelling to endemic areas, or in households with people from endemic areas. . All children with ongoing exposure to person with active TB where the child cannot take Isoniazid.

It is rare for a patient to disclose a history of psychological trauma. Talking about past experiences can be psychologically beneficial. The time available to you to listen and respond will be a factor in determining whether you explore these. Generally, your awareness that the person has come from a country where they are likely to have had 'refugee-like' experiences (see Section 1, p3) will be sufficient for you to orient your care. However, psychological and psychosomatic symptoms may persist and acknowledgement of their causes may be required for ongoing management.

Discussing the patient's trauma history

The following questions may be helpful to establish the likelihood and extent of exposure to trauma:

- When did you leave your country of origin?
- Were you forced to leave?
- What was your journey to Australia like?
- Have you spent time in a refugee camp?
- Terrible things have happened to people who have been forced to leave their countries. Have you had any terrible experiences that might be affecting you now?

Responding to a disclosure

- Validate the patient's reaction by acknowledging their experience and its associated pain (eg "that must be a terrible thing you have been through").
- Remind them that their reaction is a characteristic response to their circumstances. This is important because survivors often blame themselves – seeing their reactions as abnormal or weak.
- Avoid false reassurances. Nevertheless, indicate that with time and appropriate support, improvement can be achieved.
- Expect that the person who has disclosed a painful event may be unwilling to talk about it in subsequent consultations. Rather than pushing them to do so, talk about other things that may be troubling them in the here and now.
- Expect inconsistencies in the person's telling of their trauma history.
- In closing the interview, explain to the person in what areas you are able to assist them.

Management

Medication may be required to manage symptoms which are sufficiently severe that they interfere with the patient's functioning. However, there is a consensus among practitioners experienced in caring for this patient group that optimum treatment involves non-pharmacological approaches either in addition to medication or as the primary treatment modality.

Where a patient presents with persistent symptoms believed to be related to trauma, consideration should be given to referral to a psychiatrist, psychologist or the specialist service for survivors of trauma and torture in your state or territory. These services (see Section 7, p19) are non-denominational, politically neutral and non-aligned, and are free and confidential.

It is important to do the following:

- Provide feedback to the patient on your diagnosis or opinion of their condition.
- Explain what are understood to be the likely causes of the condition (both psychological and physiological).
- Outline treatment options so that the patient is able to make a choice.
- Arrange urgent psychiatric management in the usual way for patients with symptoms and behaviours such as violence to others or self harm.

Somatic complaints

It is not uncommon for refugee patients to somatise their psychological stress. Consider the following approaches:

- Take complaints seriously and conduct appropriate examinations as this can serve to reassure patients when nothing is physically wrong. This is particularly relevant for patients reporting rapid heart beat.
- Help the patient to make connections between the body and mind. Explaining the body's physiological response to extreme danger can be helpful in making this link.
- Avoid dismissing somatic complaints or giving reassurances that they will 'go away with time'.
- If somatic symptoms persist, consider a referral for counselling and support. This may involve establishing the patient's trauma history if they have not already disclosed this to you.

COMMON PSYCHOLOGICAL SEQUELAE OF TRAUMA AND TORTURE

- grief,
- guilt and shame,
- distrust and anger,
- anxiety,
- depression,
- Post Traumatic Stress Disorder symptoms, commonly: intrusive and recurrent memories, flashbacks, nightmares, avoidance of reminders of traumatic events, detachment from others, numbing, hypervigilance, proneness to startle.

Settlement support

For refugee patients the normal stresses involved in settling into a new country are often compounded by the stressful, forced and unplanned nature of their departure and the fact that many are in poor health on arrival. Accordingly, they may require the assistance of a community support agency.

Consider a referral if your patient is experiencing difficulties in accessing:

- housing,
- English language classes,
- schooling for their children,
- advice on legal or migration matters,
- income support,
- adequate household and personal effects,
- employment,
- child care,
- support for complex medical follow-up,
- social support.

If your patient has been in Australia for six months and has entered through the Commonwealth Government's Humanitarian Program they may be eligible for support through the Integrated Humanitarian Settlement Strategy (IHSS) (see Section 7, p19 for contact details).

If they have been in Australia for longer than six months or are otherwise ineligible for IHSS support, consider a referral to a Migrant Resource Centre or Community Health Centre (see Section 7, p19).

Migrant Resource Centres can also advise if there are any local ethnic services. Consider streamlining the referral process by developing a list of local support agencies.

Asylum seekers

Asylum seekers are people who arrive in Australia and subsequently apply for protection as refugees. Those arriving with valid entry documentation (eg a student or visitors visa) are permitted to reside in the community while their application is considered.

- Some will have access to Medicare (ie those with 'work rights'), while others will not.
- They may not have undergone Commonwealth Government health screening (but will do so as part of their application).
- You may be in a position to offer them a report to assist them in their application for permanent residence. Detailed notes will be required for this purpose. In preparing reports assistance may be available from the torture and trauma service in your state or territory (see Section 7, p19).
- Steps to contain the costs of care will be important as asylum seekers may face restrictions on their rights to employment, income support and other benefits.
- They may be eligible for assistance with health care and income support through the Asylum Seekers Assistance Scheme (see Section 7, p18).
- The process of applying for refugee status can be highly stressful, exacerbating any pre-existing sequelae associated with psychological trauma.
- Public hospitals have a duty of care at common law which curtails the refusal to provide emergency care regardless of a patient's capacity to pay. Hospitals may seek to recover costs later if they believe a patient has income or assets.

Temporary Protection Visa Holders

Those arriving without valid entry documentation are subject to a period of mandatory detention. If found to be refugees before 2001, they were released on a three year Temporary Protection Visa (TPV) in the first instance.

In 2001, the Australian government established centres to process refugee claims in the Pacific region (known as the 'Pacific Solution'). People seeking protection from one of these centres, if found to be refugees, are granted a five year TPV.

TPV holders may face repatriation, if at the time of applying for a subsequent protection visa, they are no longer deemed to be refugees owing to changed conditions in their country-of-origin. Depending on a complex range of circumstances, some TPV holders may only ever be eligible for temporary protection in Australia.

- They will have undergone screening for serious communicable diseases prior to their release from detention.
- They are entitled to Medicare, a Health Care Card and CentreLink payments (Special Benefits) but not to job search assistance, further education, or provisions enabling them to sponsor immediate family to join them in Australia.
- While they are not entitled to Commonwealth settlement support or English language classes, some state and non-government agencies will provide assistance.
- Detention centre experiences (particularly if prolonged), uncertain migration status, limited access to settlement support and no prospect of reuniting with family members may be sources of stress, compounding existing psychological sequelae.

Referral and Further Information

ASYLUM SEEKERS:
- Australian Red Cross Asylum Seekers Assistance Scheme (ASAS) 07 3835 1271
- Refugee Claimants Support Centre (RCSC) 07 3357 9013

CHILD PROTECTION SERVICES:
www.families.qld.gov.au/families/index.html#CP
- Brisbane Crisis Care 07 3235 9999
- Queensland country areas 1800 177 135

COMMUNITY HEALTH CENTRES: Under **Queensland Health** in white pages.
- **Coorparoo** Community Health 07 38470999
- **Logan** Community Health 07 3290 8900
- **Mt Gravatt** Community Health 07 3343 4104
- **Southport** Community Health 07 55263573

DENTAL SERVICES (Public):
- South Brisbane Dental Hospital 07 3240 1444

FAMILY VIOLENCE:
- Domestic Violence Telephone Service 1800 811 811
- Domestic Violence Resource Centre 07 3217 2544
- Domestic Violence Information and Support Line (**Brisbane only**) 07 3217 2344
- Immigrant Women's Support Service 07 3846 3490

FEMALE GENITAL MUTILATION:
- Family Planning Queensland 07 3250 0250 or Clinic 07 3250 0200

IMMUNISATION:
Local Public Health Unit (please refer to Infectious Diseases section)

INFECTIOUS DISEASES:
- Communicable Diseases Network Australia, Australian Department of Health and Ageing - www.health.gov.au/pubhlth/cdi/cdihtml.htm
- Hospital Infectious Diseases Services Princess Alexandra Hospital 07 3240 2111

Communicable Disease Sections of local Public Health Units:
- Centre for Disease Control Central Public Health Network **Brisbane Northside** 07 3250 8555
- Communicable Diseases Control Services Southern Public Health Unit Network **Brisbane Southside** 07 3000 9148/9147
- Communicable Diseases Control Tropical Public Health Unit Network **Cairns** 07 40503600
- Health Surveillance and Disease Control Southern Public Health Unit Network **Darling Downs** 07 4631 9888
- Health Surveillance and Disease Control Central Public Health Unit **Rockhampton** 07 4920 6987
- Communicable Diseases Control Services Southern Public Health Unit Network **South Coast** 07 5509 7222
- Health Surveillance/Immunisation Tropical Public Health Unit Network **Townsville** 07 4750 4000
- Health Surveillance and Disease Control Southern Public Health Unit Network **West Moreton** 07 3810 1500
- Health Surveillance and Disease Control Central Public Health Unit **Wide Bay** 07 4197 7277

INTERPRETERS:

Telephone interpreter: Translating and Interpreting Service (TIS) 131 450

On-site interpreter: Fax bookings to TIS on 1300 654 151 two weeks in advance.

LEGAL CENTRES:

- South Brisbane Immigration and Community Legal Service 07 3846 3189
- Women's Legal Service 07 3392 0607 or Queensland country areas 1800 677 278
- Caxton Legal Centre 07 3254 1811

MATERNAL AND CHILD HEALTH: Under **Queensland Health** in white pages.

- Child Health Line 07 3862 2333 or Queensland country areas 1800 177 279
- Riverton Early Parenting Centre 07 3860 7111

NUTRITIONAL DEFICIENCY: Refer to nutritionist at nearest hospital.

OPTOMETRY:

- Princess Alexandra Hospital outpatients 07 3240 2495 or 07 3240 2455
- Ros van Hearingen **Stones Corner** 07 3397 4824
- Ron Bowden **Moorooka** 07 3848 8979

PSYCHOLOGICAL SUPPORT/COUNSELLING:

Specialist trauma and torture service: The Queensland Program of Assistance to Survivors of Torture and Trauma (QPASTT) 07 3391 6677

Queensland Transcultural Mental Health Centre 07 3240 2833 or statewide 1800 188 189.

Contact your nearest public hospital for information on local mental health team.

REFUGEE HEALTH:

Qld Integrated Refugee Community Health Clinic 07 3840 2880

SETTLEMENT SUPPORT:

- Australian Red Cross 07 3835 1271
- Centre for Multicultural Pastoral Care 07 3876 3294
- Lifeline **Darling Downs and South West Queensland:** Migrant and Refugee Officer 07 46329299
- **Logan & Beenleigh** Migrant Resource Centre (Access Inc.) (north Gold Coast, Logan City, South West Brisbane & Ipswich regions) 07 3808 9299
- **Logan City** Multicultural Neighbourhood Centre 07 3808 4463
- **Mackay** Regional Council for Social Development 07 4957 3208
- **Maroochy** Neighbourhood Centre (Maroochy, Caloundra & Noosa) 07 5443 9706
- Migrant Resource Centre **Townsville-Thuringowa** 07 4772 4800
- **Mt Isa** Community Development Association 07 4749 1404
- Multicultural Development Association **(greater Brisbane region)** 07 3394 9300
- Multicultural Families Organisation **(Gold Coast)** 07 5571 0381
- Migrant Settlement Services **Cairns** 07 4041 7699
- Romero Centre **(Brisbane)** drop-in centre 07 3393 2500

SEXUAL ASSAULT:

- Immigrant Women's Support Service: Sexual Assault Program 07 3846 5400
- Crisis Care **(24 hour number)** 1800 010 120

TUBERCULOSIS:

Specialised Health Service, Queensland TB Control Centre 07 3896 3947

This publication has been prepared on the basis of a first edition developed by the Victorian Foundation for Survivors of Torture (VFST) on behalf of the Western Division of General Practice. It draws on the experience of the Refugee Health and General Practice Development Program, in particular, a study engaging 19 Victorian GPs in piloting and evaluating the approach proposed in the first edition.

The VFST is indebted to those GPs who contributed their time and expertise to the study, this revision and other activities of the Program.

The Refugee Health and General Practice Development Program is a collaborative venture of:

- the Western Melbourne, Monash, North West, Dandenong and Greater South Eastern Divisions of General Practice,
- the Royal Melbourne Hospital Victorian Infectious Diseases Service, the Royal Children's Hospital Department of General Medicine and the University of Melbourne Departments of Medicine and Paediatrics,
- the Victorian Transcultural Psychiatry Unit,
- the Australian Red Cross,
- General Practice Divisions Victoria,
- the Victorian Department of Human Services General Practice and Communicable Diseases Section.

The Western Melbourne Division of General Practice is the lead agency.