EDITORIAL

Prescribing for refugees

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Australia has resettled over 750 000 refugees since Federation in 1901. In recent years the annual intake has been around 14 000, and this year around 20 000 refugees are settling in urban, regional and rural centres across Australia. A significant proportion of these individuals have had refugee status awarded overseas and are settled here under Australia's Humanitarian Migration Program, with full access to Medicare. A smaller number arrive by plane or boat as asylum seekers and their access to health services varies depending on their situation.

While most recent refugees tend to be young, some are older and those who settled here decades ago are now ageing. Disease profiles have changed as countries of origin change. Chronic medical conditions are just as relevant as communicable diseases.

Recently arrived refugees in particular should undergo a thorough health check. There are Medicare Benefits Schedule health assessment items for refugees and other humanitarian entrants.

While many issues relating to prescribing in this population are shared by other migrants, some factors are accentuated in refugees.

The first step in prescribing may be diagnosing an unfamiliar condition and having the knowledge to manage it. Despite a degree of screening conducted overseas or in detention centres, testing for conditions prevalent in the region of origin may be needed, for example chronic hepatitis B. Conditions such as schistosomiasis and strongyloidiasis are unfamiliar, but in fact uncomplicated cases of either require only two doses of treatment – praziquantel and ivermectin respectively, both of which are available on the Pharmaceutical Benefits Scheme. In contrast, vitamin D deficiency is extremely common. Guidelines are available for GPs who work with refugees.[1,2]

Psychological conditions are very common, as is psychosomatic pain – patient education may be needed regarding realistic expectations of analgesia. For post-traumatic stress disorder, trauma-focused psychological therapy is the preferred first-line intervention. Drug therapy, particularly selective serotonin reuptake inhibitors, can be useful if psychological intervention is insufficient, declined or unavailable.[3]

Clear communication is key to effective prescribing, be it lifestyle and dietary advice or a drug. Practitioners who share their patient's language are at an advantage. If they do not, professional interpreters are a very important resource. Failure to use interpreters can contribute to treatment non-adherence, adverse events or failure to follow instructions, with potential medicolegal implications.[4] The Australian Government funds the Translating and Interpreting Service Doctors Priority Line (1300 131 450) which provides free phone interpreters for doctors in private practice. This service is also available to community pharmacists. By booking in advance the service can arrange for an interpreter to attend a consultation.

If working with an interpreter in the room, ask them to write down the treatment dose and instructions in the patient's own language. You can also consider pictorial diagrams to explain dosing regimens.

Refugees are often mobile in the early months of settlement or may not understand the importance of a regular healthcare provider, leading to possible duplication of therapy. Providing your patient with a medicines list can improve understanding and minimise errors. Another useful strategy is to ask the patient to bring in all their medicine containers. These may reveal drugs that are duplicated, old or dispensed from overseas. You can also use the containers to assess adherence on the next visit. A Home Medicines

From the Editor

Australian Prescriber is an international and independent medical journal. It is therefore appropriate that the journal has published two supplements, one on drug policies in the Asia Pacific region and the other on independence.

Australian Prescriber has quite a following in South America, so it is pleasing that we have a contribution from that continent to the article on topical corticosteroids.

Inhaled corticosteroids can cause concern for pregnant women with asthma. Angelina Lim, Safeera Hussainy and Michael Abramson provide reassurance about these drugs in pregnancy and lactation.

The new diagnostic manual for psychiatry DSM-5 was published earlier this year. Phillipa Hay provides an update on the management of eating disorders, and Bruce Tonge reviews the principles for managing attention deficit hyperactivity disorder in children.

Four new drugs are reviewed in this issue. Ben Ewald explains how some new drugs are assessed in 'non-inferiority' trials.

Review may be appropriate as one of the eligibility criteria is 'literacy or language difficulties'.[5]

It is important to ask whether the patient is using any traditional medicine, including products sent from overseas. These may interact with a prescribed drug, either reducing efficacy or increasing the risk of adverse reactions.[6]

Cultural beliefs and limited health literacy should also be considered. The concept of preventive care may not be well understood (for example taking an antihypertensive drug long term to prevent end-organ damage) and this could reduce adherence to treatment. Education of the patient and other family members is needed. This can be supported with translated information sheets for those literate in their own language.

Religious beliefs can impact on the acceptability of treatment, for example followers of certain religions avoid pork or beef products, leading to reluctance to take gelatin-containing capsules. However, a World Health Organization statement in 2001 made it clear that the transformation undergone in processing made it completely acceptable for Muslims to take such products. The same applies to vaccine additives.[7] Religions such as Islam that invoke fasting at certain times generally exempt people with medical conditions and pregnant women. However, many Muslim patients may still choose to omit their daytime drugs during Ramadan. Involving the patient and family members in discussion of these issues is likely to result in the best outcome.

A final but important issue is cost. Even for subsidised drugs, a large family with many members diagnosed with common conditions such as iron deficiency, vitamin D deficiency or *Helicobacter pylori* infection will face excessive costs that will hinder adherence. Additionally, a subset of asylum seekers live in the community without Medicare or Health Care Cards. While some may get assistance through organisations such as the Australian Red Cross, this is not the case for all. The cheapest effective treatment options should be offered, and asylum seeker health services and charitable organisations may be able to offer limited assistance with medications or funds.

In summary, prescribing problems in refugees can be minimised by taking the time necessary to undertake education and careful explanation, and to confirm the patient's understanding. Use a professional interpreter whenever required. Consideration of cultural and religious practices and the patient's socio-economic situation will also help promote adherence to treatment. ◁

Conflict of interest: none declared

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FURTHER READING

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Australian Prescriber supplements

Australian Prescriber recently published two conference supplements.

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