

# **Caring for Older Refugees in NSW:**

## A Discussion Paper



NSW Refugee  
Health Service

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NSW  HEALTH

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## Glossary of terms

<b>Asylum seeker</b>	A person who has applied for protection as a refugee, but has not yet received a decision about their status
<b>ACAT</b>	Aged Care Assessment Team: multi-disciplinary teams (e.g. geriatricians, social workers, nurses, physiotherapists, occupational therapists, psychologists and psycho-geriatricians) that assess a person's medical, physical, social, psychological and restorative care needs and their eligibility for required services. ACATs also provide advice on aged care services and act as an interface between aged care services and the health care system
<b>AMEP</b>	Adult Migrant English Program: provides up to 510 hours of basic English language tuition to migrants and refugees from non-English speaking backgrounds, or up to 610 for some refugees and humanitarian entrants. The program is provided by the Australian Government through DIMA
<b>ASAS</b>	Asylum Seekers Assistance Scheme: an Australian Government funded program administered by Australian Red Cross NSW. It assists asylum seekers in Australia who are in the process of having their refugee status determined. It provides eligible asylum seekers with financial and limited healthcare assistance, plus referrals to other agencies for help with settlement issues
<b>AoS</b>	Assurance of Support
<b>CACP</b>	Community Aged Care Package: provides a package of care services to assist frail older people with complex needs to remain living in the community. Services may include personal care, assistance with preparing meals, home help and assistance with transport. Clients need to be assessed as eligible by an ACAT before they can receive a subsidy for a Community Aged Care Package. Funded by the Australian Government
<b>CALD</b>	Culturally and Linguistically Diverse
<b>CCRC</b>	Commonwealth Carer Respite Centre
<b>Carelink</b>	Commonwealth Information and Referral Service
<b>CIARR</b>	Client Information and Referral Record: a client-held record of assessment and services information used by HACC services to provide agencies with a common tool to collect and share core information
<b>COTA</b>	Council on the Ageing (NSW)
<b>CPP</b>	Community Partners Program: is a program of aged care support services for established culturally and linguistically diverse communities. CPC tries to ensure these communities receive support to access culturally appropriate aged care services across the full continuum of care. This is achieved by building links between established communities and services, and helping aged care service providers understand the needs of established migrant communities
<b>CSSS</b>	Community Settlement Services Scheme
<b>DADHC</b>	NSW Department of Ageing, Disability and Home Care
<b>DIMA</b>	Department of Immigration and Multicultural Affairs
<b>Displaced person</b>	A general term for someone who has been forced to leave his or her native place, often used to describe one removed from his or her native country as a refugee, prisoner or a slave labourer during World War II and the resulting refugee outflows from Eastern Europe. An Internally Displaced Person (IDP) may have been forced to flee their home for the same reasons as a refugee, but has not crossed an internationally recognised border
<b>DoHA</b>	Department of Health and Ageing
<b>EAPS</b>	Ethnic Affairs Priorities Statement
<b>FaCSIA</b>	Department of Family, Community Services and Indigenous Affairs: is responsible for social policies and support affecting Australian society and the living standards of Australian families
<b>HACC</b>	Home and Community Care: a program providing services to frail older people (and younger people with disabilities) living at home who would otherwise be at risk of entering institutional care prematurely or inappropriately, and their carers. Services include home nursing, meals on wheels, home housekeeping, transport, respite care, home maintenance and other services. The Australian Government provides funding for HACC, but the day-to-day administration, priority setting and approval of project allocations is the responsibility of the state/territory governments

<b>IHSS</b>	Integrated Humanitarian Settlement Strategy
<b>Humanitarian entrant</b>	A term used to describe refugees and other people who are at risk of serious human rights violations who arrive as part of Australia's Refugee and Humanitarian Program
<b>LGA</b>	Local Government Area
<b>MAP's / Workers</b>	Multicultural Access Projects (HACC) / Workers
<b>MRC</b>	Migrant Resource Centre: non-government organisations that assist newly arrived refugees and migrants living in the in their local area with settlement. Traditionally DIMA funded
<b>NESB</b>	Non-English Speaking Background
<b>NRCP</b>	National Respite for Carers Program
<b>ORWG</b>	Older Refugees Working Group
<b>PADP</b>	Program of Appliances for Disabled People: a program operated by NSW Health Department to provide appropriate equipment, aids and appliances to enable people to continue living at home and avoid premature or inappropriate residential care. Examples include wheelchairs, oxygen cylinders (but not oxygen) and surgical shoes
<b>PTSD</b>	Post-Traumatic Stress Disorder: characterised by symptoms of intrusive thoughts, flashbacks, nightmares, numbing, avoidance, and/or hyperarousal including irritability, startle responses, sleeping, memory and concentration problems
<b>RACP</b>	Residential Aged Care Program: provides a framework of high quality and cost effective residential care services for frail older people - both high level care ('nursing home') and low level care ('hostel'). Aged care places are allocated in proportion to the number of people aged 70 years and older. The Australian Government subsidises the costs for each person in a residential care setting. The level of funding depends on the care needs of the resident. Also, residents can be asked to pay fees and charges. Each aged care home that provides care is required to meet specific care and building standards and to be accredited by the Aged Care Standards and Accreditation Agency in order to receive Government funding
<b>Refugee</b>	A legally defined term to describe someone who has <b>specified international legal protection</b> : a person who is outside his/her country of nationality or usual residence, and is unable or unwilling to return because of a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group, or political opinion
<b>Refugee-like background</b>	A general term used to describe people who have experienced fear of persecution, organised violence and/or war but who may or may not have been formally determined as a refugee
<b>RHS</b>	NSW Refugee Health Service
<b>RUDAS</b>	Rowland University Dementia Assessment Scale; a tool for use by GPs in assessing cognitive impairment in elderly people from culturally and linguistically diverse backgrounds
<b>SAFEE</b>	Sensitive Assessment for Ethnic Elderly: a culturally appropriate assessment framework developed for ACATs in 1999 when servicing people from CALD backgrounds. A Handbook was revised in October 2004 to accompany the Culturally Sensitive Assessment Guide, for distribution at the ACAT Symposium, Sydney
<b>STARTTS</b>	NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors
<b>SSWAHS</b>	Sydney South West Area Health Service
<b>TACS</b>	NSW Transcultural Aged Care Service
<b>TMHC</b>	Transcultural Mental Health Centre
<b>TPV</b>	Temporary Protection Visa: a three or five year visa given to asylum seekers who arrived in Australia without authorisation and were determined to be refugees
<b>Torture</b>	Deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of an authority, to force another person to yield information, make a confession, or for any other reason.

## 1. Executive Summary

An estimated 675,000 refugees have settled in Australia since World War II. Around 13,000 refugees and humanitarian entrants settle in Australia each year, 4,000 of them in NSW. However, the exact number of older refugees living in NSW is not known.

Most older refugees in our community have grown old in Australia after fleeing persecution in their own country. Some have arrived as part of Australia's Refugee and Humanitarian Program, while others have been reunited with their children through the broader Migration Program.

What older refugees have in common is that they were at risk of serious human rights abuses because of their race, religion, nationality, membership of a particular social group or their political opinion, and were forced to leave their country.

Their experiences of organised violence and/or war mean that, compared with other older people in the mainstream community or other migrants, older refugees have additional needs. While older refugees are likely to have a higher risk of poorer psychological and physical health than the mainstream population, this is largely unrecognised by policy makers or by service providers responsible for their treatment and care. How their additional needs intersect with ongoing settlement issues has rarely been examined, leaving older refugees and their carers with many barriers to using services.

While some individual services, including those who helped develop this paper, have recognised the issues of older refugees, there is little such acknowledgment either at the level of Australian and State/Territory Government policy, research, and planning, or at the level of service provision and practice.

A central recommendation of this paper is that the Australian and State/Territory Governments should acknowledge older refugees as a group with special needs related to their past experiences, and that this should be reflected in research policies, funding guidelines and service planning and delivery.

Australian and State/Territory Government policy needs to recognise settlement as a lifelong process in which issues may arise at different life stages, and take a 'whole-of government' approach where policy and funding guidelines for services to older refugees are shared between a number of departments. Providing services to older refugees should not be the responsibility of the Department of Immigration and Multicultural Affairs alone.

The following is a summary of some of the steps recommended by the Older Refugees Working Group to ensure that

- older refugees can access the services to which they are entitled, and
- that the services meet the needs of older refugees.

## Summary of Recommendations

- Older refugees should be recognised as a special needs group. This should be reflected in policies (National HACC, Mental Health and NSW Disability Standards), funding guidelines, and aged care service planning and delivery
- Aged care and mental health services should be required to collect data on older refugees and asylum seekers in a culturally relevant and sensitive manner using a culturally appropriate tool to identify refugee clients.
- Eligibility for aged care services and support should be extended to all asylum seekers and refugees with a Temporary Protection Visa.
- Service flexibility should be increased to allow for the needs of small and emerging refugee communities
- Certificate, diploma and degree courses for health professions and other occupations likely to work with older people of refugee background should include the needs of older refugees as part of a core cultural competency module.
- The Department of Health and Ageing (DoHa) and the NSW Department of Ageing, Disability and Home Care (DADHC) should develop guidelines for aged care services on how to promote these services to refugee communities.
- The DoHa and DADHC should develop, implement and monitor minimum standards for using professional interpreters for initial, comprehensive and follow up assessments. They should develop guidelines on and monitor the appropriate use of family, friends, volunteers and bilingual workers when communicating with older people from a culturally and linguistically diverse background (CALD).
- A policy on partnerships should be developed to encourage aged care providers and health services to work more closely with ethnic community organisations and with specialist services that are already working with older refugees, such as STARTTS, Transcultural Mental Health Centre and the NSW Refugee Health Service.

## 2. Introduction

“Leslo arrived in Australia in the 1960s as a 30 year old refugee from Hungary with his wife and young daughter. As he was from an educated, politically active family, he had been targeted after the communist repression in Hungary. After a period of increasing harassment by the security forces culminated in torture, his family decided to leave. He left with his wife and baby daughter, planning to meet his parents and two brothers some days later over the border. After waiting in vain for them for many months, he and his family were accepted as refugees into Australia.

In Sydney the young family tried to put their experiences behind them. Their attempts to find his family were unsuccessful and after some years he stopped talking about them altogether. He found unskilled work and focused on supporting his family and providing an education for his daughter. He became a very shy and quiet person who developed no close friendships.

Soon after he retired his health deteriorated. He developed sleeping problems, lost a lot of weight, and started experiencing pain for which his GP could find no cause. His wife thinks it may relate to Leslo’s experiences of torture. Although he never wanted to talk about it she knew he had been imprisoned and could see the scars on his body. His wife and daughter find him increasingly difficult to manage at home but don't know what else they can do for him. He neither trusts government services nor wants anyone outside the family involved in his affairs.



Finally they contacted a service behind his back. An Aged Care Assessment Team organised a visit but he was uncooperative, avoiding questions about his social history and physical problems. He was visibly distressed during the assessment and upset that visitors filled in forms and asked so many personal questions.

Since the team left he has not spoken to anyone for two days. His wife still doesn't know if she has done the right thing."

Torture and persecution can have a prolonged impact on people's health, behaviour and expectations. These experiences can influence how people approach aged care services, and can be important factors in the assessment and treatment of older people.

While the impact of war and organised violence on health and wellbeing is well documented<sup>i</sup>, there has been limited recognition among aged care services and policy makers in Australia of how these experiences can affect older refugees, even though around 675,000 refugees have settled here since World War II. This discussion paper aims to provide policy makers and service providers with an overview of older refugees' needs, discuss initiatives available to meet them, and make recommendations to meet gaps in service delivery. It highlights challenges specific to being an older refugee in Australia – challenges that are additional to those common to all older people, and those faced by migrants as they age.

It is important to respond appropriately to these challenges, not only to ensure services meet the needs of older refugees, but to help services meet their statutory requirements to ensure access and equity. (Ensuring access and equity of service provision is a requirement of all NSW Government services through the Ethnic Affairs Priorities Statement (EAPS), and Australian Government's 'Charter of Public Service in a Culturally Diverse Society'.<sup>ii</sup> Respect for cultural diversity of clients is also enshrined in Home and Community Care (HACC) Standards<sup>iii</sup>, Community Aged Care Packages Program Guidelines 2004 (CACP)<sup>iv</sup> and the Residential Care Quality of Care Principles 1997.)

This paper is the end result of many years' work:

- In 2000, consultations with refugee communities in Western Sydney by the NSW Refugee Health Service and STARTTS raised issues of older refugee health and access to services.
- In 2003, a state-wide forum on the Health and Settlement Needs of Older Refugees was organised by a number of agencies: NSW Department of Health; NSW Department of Ageing, Disability and Home Care; Ethnic Communities Council of NSW; NSW Refugee Health Service; NSW Transcultural Aged Care Service; Refugee Council of Australia; STARTTS; and SSWAHS's Ethnic Aged Health Adviser.
- The forum's recommendations were set out in an Outcome Paper and the Older Refugees Working Group (ORWG) was formed to take up the issues raised by the forum. The government and non-government agencies making up the ORWG established working parties to deal with specific issues including isolation, training and resources, service flexibility, and research and data sharing.
- The paper is also informed by the findings of research by ORWG with HACC workers on their knowledge of and work with refugees (see Appendix A and B). Relevant agencies were also asked to contribute to the paper, and submissions were received from the NSW Department of Housing, the Australian Government's Department of Health and Ageing, and the NSW Department of Ageing, Disability and Home Care.

**Case Study 1: Tran [Note: All people mentioned in Case Studies throughout this paper have been de-identified and their real names have not been used]**

Staff at the residential facility where Tran lived were finding his behaviour increasingly challenging. He was hoarding food in his room and would become very aggressive when staff tried to remove it. He was also crying out at night and would become very upset when he was placed in the same room as the only other Vietnamese resident. A staff member had noticed he would try to hide when he heard planes overhead. Tran had lost most of his English, although he had been relatively fluent when he was younger. Staff could not speak Vietnamese so did not know what he said during these outbursts and were at a loss as to how to help him.

A staff member asked the local ACAT for an assessment.

*History before referral*

Tran had been a lecturer in South Vietnam, was married and a father of two. When the communists took over after the Vietnam War ended in 1975, Tran was ordered to report for re-education. He was told to pack enough clothes for ten days or two weeks - he spent the next four years in re-education camps. The camps were effectively hard labour camps, no medical attention and rarely enough to eat, forcing prisoners to scavenge for food. He was also expected to denounce any fellow prisoners and acquaintances during regular “re-education sessions”.

After he was released, Tran tried to escape Vietnam in a fishing boat, risking attack by pirates, storms, shortage of fuel, food and water and loss at sea. He took his oldest son, but he had to leave his wife and daughter behind. After a perilous journey, he landed in Malaysia, where he spent eight months in a refugee camp, finally being resettled in Australia.

During this time he was unable to make contact with his wife directly for fear that it would place her in danger. He later found out that she was called to the police station every day to be asked about her husband’s whereabouts. Over the next few years, his wife and daughter made several unsuccessful attempts to follow him. In their last attempt they perished as their refugee boat crashed on the coast of Malaysia. Tran found out about the deaths some months later.

While Mr Tran and his son’s early years in Australia were marked by the tragedy, Tran tried to put it behind him. He rarely spoke of his wife and daughter and never talked about what happened in the re-education camps. While he was unable to take up academic employment in Australia, he discovered he had some entrepreneurial skills and did reasonably well in business. His son eventually got married and Tran became a grandfather. When Tran initially developed dementia he was able to be cared for at home but eventually he moved to a local nursing facility. He was 77 years old.

### *Assessment*

In trying to determine the cause of this behaviour ACAT staff went to the home with a Vietnamese interpreter, and then spoke to his son. He told them his father had been in a re-education camp but had never disclosed to his son what had happened there so he was not able to offer much assistance in explaining his father's behaviour.

Fortunately the team persisted. They contacted a Vietnamese community organisation and the Vietnamese counsellor at STARTTS who explained that food shortages were common in camps and may be linked to Tran's behaviour towards food now. The counsellor from STARTTS explained the symptoms of PTSD such as avoidance behaviours, intrusive thoughts and flashbacks and sleep disruptions.

The team concluded that Tran had a combination of dementia and PTSD related behaviours, and suggested that dementia had disrupted Tran's usual mechanism for dealing with his trauma: his guilt about surviving when his wife and child had not, his grief, and experiences in the war and re-education camps. He was suddenly unable to control his memories and was regularly reliving his trauma.

### *Outcome*

The team worked together with the nursing staff to develop a care plan that tried to limit the triggers and to make Tran feel safer. These included developing a routine where Tran would visit the kitchen each morning while lunch was being prepared, installing a mini fridge in his room so he had a private source of food, introducing more items from his home around the facility, and buying a night-light. The staff were given training on PTSD and dementia to help them anticipate problem behaviour and have the skills to deal with them.

With time, Tran's distress was markedly reduced. Had the ACAT team not had some awareness of refugee issues, things might have been different.

### 3. Profile of Older Refugees in New South Wales

#### 3.1 How older refugees and asylum seekers arrive in Australia

Australia's history of helping refugees and other survivors of human rights abuses started after WWII, when Australia accepted large numbers of people displaced by the war. Some 13,000 refugees and humanitarian entrants now settle in Australia each year, about 4,000 of them in NSW.

Refugees arrive in Australia in one of three ways.

- Most are selected from overseas by the Australian Government for resettlement. Typically their selection is based either on the recommendations of the United Nations High Commissioner for Refugees (UNHCR), or the willingness and ability of family or friends to propose people from refugee-like backgrounds. Few people are resettled when they are already old; instead most grow older in Australia after being resettled. Many refugees arriving after WWII and the resulting refugee outflows from Eastern Europe were called 'displaced persons' - a more general term for someone who has been forced to leave his or her native place as a refugee, prisoner or a slave labourer.
- Many people who come as migrants have a refugee-like background. While they may not have been formally recognised as refugees, their experiences are the same or similar as those who arrived as refugees. An example would be a Cambodian who survived the horrors of Pol Pot's regime, but who moved to Australia later on a business visa. Many people in this group have joined their adult children here as part of the Family Reunion (Aged Parent) migration category.
- Asylum seekers are people who claim they need protection from persecution as a refugee and are awaiting a determination of their status from the Australian Government. Some asylum seekers are detained by the Australian Government during this process, but most live in the community until a decision is made. Those asylum seekers found to be refugees are able to stay in Australia. Until recently they were allowed to stay permanently, but since 1999 only temporary protection has been offered to some refugees.<sup>vi</sup>

Unless otherwise stated, this paper will refer to people from all those groups generically as refugees.

#### 3.2 Experiences pre-arrival in Australia

While refugees come from many different backgrounds, countries and conflicts, the one thing they share is their escape from persecution. Some will have had first-hand experience of severe human rights abuses; others will have escaped in time and have had little experience of trauma.

The term refugee is a legal one, meaning someone who is outside their country of origin, and is unable or unwilling to return because they are at risk of persecution by the state or other authority on the grounds of their race, religion, political opinion, nationality or membership of a particular social group.

The experiences of refugees are all different, but some common experiences can include:

- exposure to war or civil conflict including aerial bombardments and hand-to-hand combat;
- imprisonment without trial;
- witnessing the killing or torture of close family members, friends and colleagues;
- separation from family and friends during flight or as a result of violence;
- actual or threatened physical violence and rape;
- severe harassment by authorities including the use of torture;

- overcrowding, poor hygiene and undernutrition, particularly for those who have spent time imprisoned or in refugee camps;
- poor medical care, due to destruction of infrastructure and disruption to health services by fighting in the country of origin, and through limited access to health services whilst fleeing and whilst seeking asylum;
- disruption to children's education and to adults' careers.<sup>vii</sup>

Many older refugees in Australia will have spent time in camps, where they are particularly vulnerable. Life in refugee camps is likely to mean poor medical care, overcrowding, food shortages, few educational facilities, and lack of safety. Older refugees can face additional hardships because of limited ability to build shelter, find food, access water and medical treatment. Older people in humanitarian emergencies report problems getting relief aid and are often excluded from support with economic and social recovery.<sup>viii</sup>

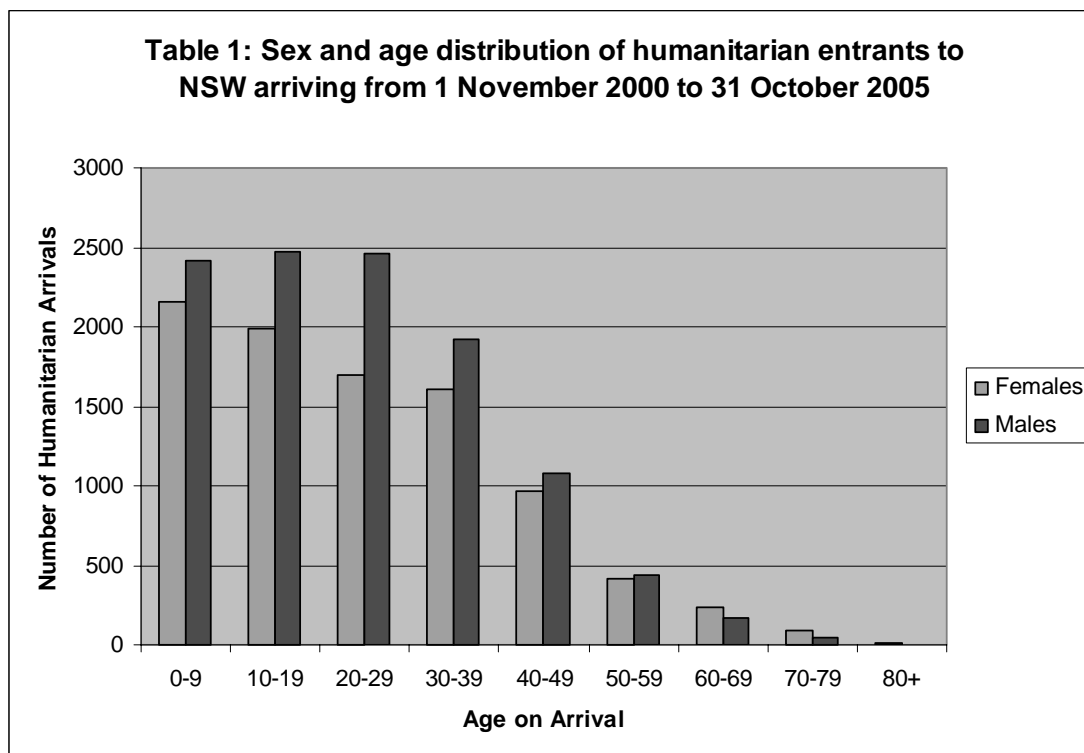
### **3.3 The number of older refugees and asylum seekers living in NSW**

#### *3.3.1 The number of older refugees*

The exact number of refugees over the age of 65 in Australia is difficult to estimate - refugee status is typically not recorded by Government agencies once a person becomes an Australian citizen. Health services do not collect data on refugee status, nor do most aged care services, as discussed in more detail later.

Of the refugees and displaced people resettled in Australia since WWII, 170,000 arrived straight after the war<sup>ix</sup>, so many must now be elderly or approaching old age. Data is needed urgently on how many are still alive, and how many subsequent arrivals are now over 60 years old.

Data on the number of refugees and humanitarian entrants arriving in the last five years as older people is more precise, although it captures only a small percentage of older refugees because most refugees grow old in Australia. Between 1 November 2000 and 31 October 2005, 563 refugee and humanitarian entrants aged over 60 settled in NSW (See Table 1).



We also know the number of older refugees with a Temporary Protection Visas (TPV) although they represent an even smaller proportion. A TPV is a visa given to refugees who arrive unauthorised, seek asylum, are detained, and found to need protection as refugees. While they are a small group, they are of note because their access to some services is limited (see section 5.1.3).

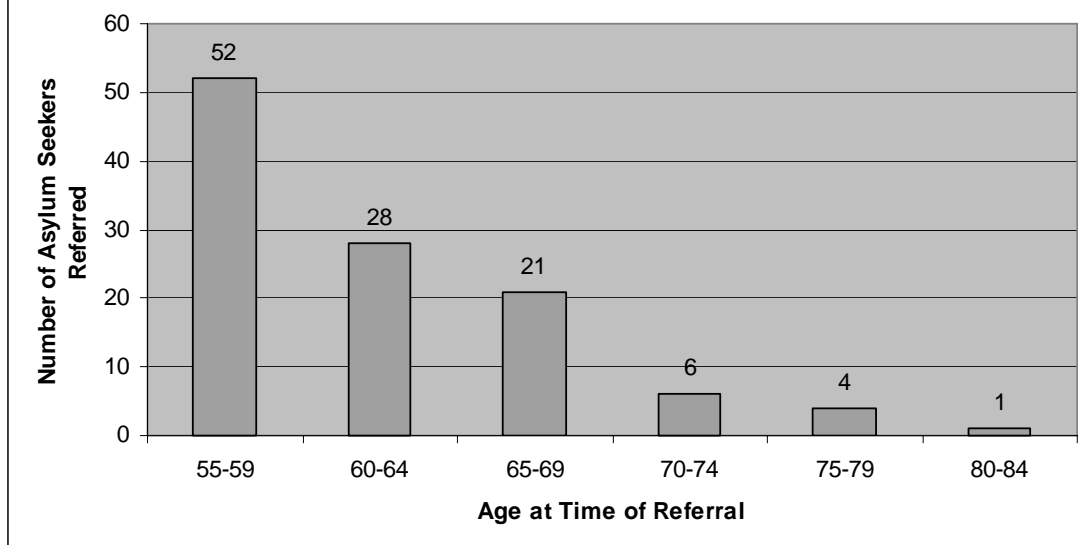
As at 28 December 2003, 92 TPV holders receiving Centrelink benefits were aged 55-65, while 43 were over 65 years. It is possible that if people who are working (i.e. not receiving Centrelink benefits) were included, this figure would be higher.

While more research is needed to determine the number of older refugees in NSW it is clear there are sufficient numbers for policy makers and services to recognise.

### 3.3.2 *The number of older asylum seekers*

The number of older asylum seekers living in the community is not available but, given overseas estimates, is expected to be small.<sup>x</sup> In the first eleven years since the Asylum Seekers Centre in Sydney opened, 112 asylum seekers aged 55 years or over have been referred, including one man in his 80s (see Table 2).

**Table 2: Number of Older Asylum Seekers over 55 years of age referred to the Asylum Seekers' Centre, 1 October 1993 – 30 October 2004**



But while numbers are small, they are particularly vulnerable because of lack of access to health services, settlement services, employment and income support. In Australia asylum seekers are not eligible for Centrelink benefits, and a third are ineligible for work rights and Medicare.

### 3.4 Backgrounds of refugees who have grown old in Australia and those who are elderly when they arrive

Broadly speaking, older refugees in NSW fall into two groups. The largest is made up of people who arrived in the past as refugees and have grown old in Australia. Those who arrived as elderly refugees are a smaller group, but have high settlement and recovery needs.

#### 3.4.1 *Refugees who have grown old in Australia*

Refugees who have grown older in Australia include people who arrived after WWII from Germany, Austria, Poland and various Soviet states. Jewish refugees began arriving from Germany in 1936. In 1947 the Displaced Persons Scheme enabled some 170,000 refugees from war torn Europe to live in Australia under the auspices of the International Refugee Organisation. Those arriving as refugees under the Scheme had to work a two year contract in jobs assigned by the Australian authorities. These were generally manual and usually unrelated to the refugees' training and skills.

In the 1950s they were joined by refugees fleeing the Soviet occupation of Hungary and, in the 1960s, by those fleeing Czechoslovakia. Most were indentured into major infrastructure projects, such as the Snowy Mountains Scheme. Once their period of indenture was over, they tended to settle with others from their community who provided good support.<sup>xi</sup> It has been argued that while this group did not have access to the range of services now available to refugees, their adjustment to Australia was made easier by high employment (albeit unrelated to their skills), relatively low cost of land, close communities and a smaller gap between rich and poor.<sup>xii</sup>

Most refugees who arrived at this time are now elderly (over 65). The 2001 census, for example, shows that nine out of the top ten oldest groups in the community, who are overseas-born, are also from refugee producing countries (see Table 3).

Table 3. Top 10 oldest-birthplace groups in Australia<sup>xiii</sup>

BIRTHPLACE	No. 65+	% of community 65+
<b>Estonia</b>	1,777	74.3
<b>Latvia</b>	4,536	68.6
<b>Lithuania</b>	2,462	66.3
<b>Ukraine</b>	7,006	49.7
<b>Slovenia</b>	2,879	42.6
<b>Hungary</b>	9,683	42.5
<b>Italy</b>	91,865	42.0
<b>Eastern Europe</b>	2,852	41.1
<b>Poland</b>	22,284	28.4
<b>Belarus</b>	359	35.5

In the 1970s and 1980s refugees arrived from conflicts in Central and South America including Chile, El Salvador, Colombia, Argentina and Uruguay. In 1976 the first Vietnamese refugees arrived by boat. Until the 1980s, Indo-Chinese refugees arrived from Cambodia, Laos and Vietnam. Many of these people are now approaching old age.

In the 1990s more refugees came from the countries of the former Yugoslavia, including Bosnia-Herzegovina, Croatia, and Yugoslavia, and from Africa, including Eritrea, Ethiopia and Somalia. Large numbers also arrived from the former Soviet Union and from China. Other countries that have produced refugees for some decades include Afghanistan, Burma/Myanmar, Iraq, and Iran.

#### *3.4.2 Refugees who are elderly when they arrive in Australia*

People who are elderly or approaching old age when they arrive are a smaller group. In the four years to 31 January 2005, 451 permanent refugee and humanitarian entrants over the age of 60 settled in NSW.

Most will have escaped recent conflicts; but a few may have experienced war trauma some time ago, reuniting with family in Australia after years of separation. Some will have spent long periods in refugee camps.

People who arrived in the last 20 years have been able to benefit from specialist services such as torture and trauma counselling, case work at Migrant Resource Centres, and more recently the Integrated Humanitarian Settlement Strategy. But they have also had to contend with higher unemployment, higher costs of home-ownership, and greater awareness of their relative disadvantage as disparities between rich and poor become greater.

### **3.5 Living and care arrangements**

While there are no definitive data on older refugees' living arrangements, inferences can be made from anecdotal reports, country of origin data and research with Culturally and Linguistically Diverse (CALD) communities.

It is believed that older refugees are likely to be cared for at home by either a spouse or children. This would be consistent with CALD data - in 1998 older overseas-born Australians were more likely to live with family members than those born in Australia (70% and 58% respectively).<sup>xiv</sup>



Older people from CALD backgrounds are also more likely to live in cities - almost 80% were living in capital cities in 1998.<sup>xv</sup> Older refugees may also be more likely to live in larger cities in NSW, rather than rural and regional areas.

## Case Study 2: Mrs Cruz

During an eye test in which bright lights were shone in her eyes, 83-year-old Mrs Cruz hyperventilated and collapsed. She was admitted to hospital, and assessed as having had a panic attack, characterised by flashbacks and intrusive thoughts. A hospital social worker referred her to STARTTS.

### *History at the Time of Referral:*

Before she fled to Australia, her husband and two sons were murdered by the state militia because of their political associations. Mrs Cruz had been imprisoned on and off for four years, often kept in wet cells without clothes, beaten and kicked, and had electric shocks applied to her genitals and nipples to extract information. When she fled her country in 1985, her oldest daughter was left behind.

Mrs Cruz lives alone. Her remaining son lives on the other side of Sydney and her other daughter lives interstate with her own family. Neither can provide her with support.

Her health problems include diabetes, heart disease and osteoporosis, and she has been advised to have a hip reconstruction. She has very Basic English, preferring to communicate in Spanish. She has many fears, including the fear of dying alone.

### *Assessment*

The Spanish-speaking counsellor at STARTTS assessed Mrs Cruz as suffering from trauma and grief-related symptoms, interacting with physical and psychological symptoms of ageing. She referred her to a number of doctors and provided long-term, supportive counselling in which her losses and traumas could be processed.

### *Action*

The counsellor spent many sessions developing trust with Mrs Cruz, sometimes at her home because of her physical limitations. She used a 'testimony model' of psychotherapy developed in Latin America. Mrs Cruz wrote letters to her dead sons to help express her grief and resolve her feelings. She also wrote about her torture experiences. The counsellor and Mrs Cruz read these letters and testimonies together, and eventually Mrs Cruz began talking about her prison experiences, and her fear of growing old or dying in Australia with no family nearby.

To address her depression, the counsellor referred her to a STARTTS psychiatrist. Since Mrs Cruz already trusted the counsellor, they saw the psychiatrist together. She began anti-depressant medication.

With Mrs Cruz's consent, the STARTTS worker contacted a number of agencies and professionals including Home Care, community nursing, the hospital social worker and the personal support worker for the aged. She also liaised with Mrs Cruz's Spanish-speaking GP. These partnerships involved clarifying Mrs Cruz's issues of torture, trauma and loss, and how they could affect her presentation at their services and her response to treatments. At Mrs Cruz's request, the Spanish-speaking counsellor took her to a hostel for Spanish-speakers to see if she could go on the waiting list.

### *Outcome*

Mrs Cruz's symptoms improved greatly. She decided not to move to the hostel, preferring to stay in her own home. She had continued help from Home Care, community nursing, and her GP. She was less anxious about going to hospital because she felt the social workers and other hospital staff understood her situation. She still sees STARTTS for occasional counselling and medication review.

Extract from NSW Refugee Health Service & STARTTS (2004) *Working with Refugees: A Guide for Social Workers*, Sydney

## 4. Overview of Issues for Older Refugees

While the needs of older refugees in Australia are under-researched (Bartolomei, Hugman & Pittaway, 2003<sup>xvi</sup>), the following section highlights some key issues relevant to their care. These include the impact of torture and trauma on psychological and physical health, ongoing settlement needs, financial needs, cultural issues and social support. This section does not focus on issues shared by all older people in NSW, nor those shared by older people from a migrant background. Issues affecting aged care and health services directly are set out more fully in Section 5.

### 4.1 The impact of torture and refugee trauma on psychological health

Because experiences of war and persecution can have a lasting impact on survivors, older refugees have a higher risk of poor psychological health than the mainstream population. This is exacerbated by disruptions to memory and by depression, a common feature of age.

#### 4.1.1 *Age-related memory problems – a special issue for older refugees*

Disruptions to memory, such as dementia, are common in old age. While this can be distressing to anyone, it can be compounded for refugees. Disruptions to memory can trigger painful suppressed memories. Problems with short-term memory can revive old memories, forcing people to relive events, such as torture or time in concentration camps.<sup>xvii</sup> This can manifest in challenging behaviour that carers and aged care services may not understand.

Age-related memory loss may also cause older refugees to lose English language skills and revert to their first language. If bilingual staff or interpreters are unavailable, the patient's confusion is likely to be heightened. These problems are addressed in more detail in Section 5.5.1.

#### 4.1.2 *Psychological health status of older refugees*

War and organised violence can affect people long after the event. Post-traumatic symptoms can remain many years after repeated war trauma,<sup>xviii</sup> and may develop long after the trauma has occurred.<sup>xix</sup>

Common reactions to refugee trauma can include:

- anxiety
- panic attacks and exaggerated startle responses
- flashbacks
- depression
- grief reactions
- dissociation or numbing
- sleeping problems, irritability or aggressiveness
- eating disorders
- psycho-sexual problems
- inability to plan for the future and preoccupation with the past
- post-traumatic stress disorder (PTSD).<sup>xx</sup>

Research suggests that PTSD can be a persistent psychiatric illness and therefore a concern for older refugees. In a community sample of Israelis aged 75 and older, 27% of male and 18% of female Holocaust survivors met criteria for PTSD compared to 4% percent of males and 8% of females who did not experience the Holocaust.<sup>xxi</sup> Research with Holocaust survivors has found that post-traumatic symptoms have developed long after the Holocaust ended.<sup>xxii</sup> Child survivors (now elderly) had higher

PTSD symptom scores with higher depression, anxiety, somatisation, and anger-hostility scores, and reported lower physical and social quality of life scores than control groups.<sup>xxiii</sup>

Even after 10 years in Australia, Vietnamese refugees with high exposure to traumatic events had a higher risk of mental illness, although this had reduced over time.<sup>xxiv</sup> However, there was no increased risk of mental illness among those refugees with less exposure to traumatic events, suggesting that trauma exposure was the most potent and consistent predictor of current mental illness.

In communities where mental health literacy is low and models of care are very different in the country of origin, people may be reluctant to seek help for mental health problems. As a result, older refugees may only use mental health services when they reach a crisis, or may come with physical problems that have a psychological cause.

While there are specialist services available, including the Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) and the NSW Transcultural Mental Health Centre, the interaction between these services and mental health and aged care services is often limited. This is partly because of aged care providers' lack of understanding of torture and trauma issues and insufficient attention to culturally appropriate assessment.

## 4.2 Physical health needs

Although there is growing research into the link between stress and physical wellbeing, there is less research on the impact of refugee related trauma on physical health. However there is evidence that exposure to war events is associated with poor physical health such as increased mortality,<sup>xxv</sup> increased heart disease,<sup>xxvi</sup> and lowered immune system function.<sup>xxvii</sup>

Older refugees may also have health problems related to previous injuries or lack of health care as part of their refugee experience. Stress-related psychosomatic illnesses are not uncommon in refugees generally, although more research is needed with older refugees.

Compared to refugees who have grown older in Australia, refugees who are older when they arrive may have more immediate health problems stemming from deprivation and limited access to medical attention in the past. While Australia screens refugees and humanitarian entrants for conditions such as tuberculosis, HIV/AIDS, and disability newly arrived people nevertheless often experience significant health needs.

Refugees may be particularly vulnerable to:

- poor dental health resulting from poor nutrition, lack of fluoridated water, poor dental hygiene practices and limited dental care;
- infectious diseases including tuberculosis or intestinal parasites;
- injuries and disabilities such as musculoskeletal pain or deafness resulting from war or torture;
- under-recognised and under-managed hypertension, diabetes and chronic pain;
- somatisation of psychological problems such as gastric dysmotility;<sup>xxviii</sup>
- lack of preventive health care in the past, especially cancer screening.

Apart from their decreased mobility and limited English, older refugees may face other barriers to accessing health services:

- Some Holocaust survivors distrust the health profession because some doctors were involved in the Holocaust.<sup>xxix</sup> Health professionals in some other refugee-source countries have also been complicit in torture – e.g. Iraq<sup>xxx</sup> and Turkey.<sup>xxxi</sup>

- Due to limited English, older refugees often seek help from GPs from the same ethnic and cultural background as their own, and hesitate to seek a second opinion even if they are dissatisfied with a doctor's service.
- Some older refugees, like older migrants, may also use traditional medicine as well as Western medicine.

### 4.3 Ongoing settlement needs of older refugees

Refugees face many challenges associated with settling in a new country with a new language and culture. While many issues are gradually resolved as people make a place for themselves in Australia, settlement is an ongoing process that can take a lifetime. Most older refugees in Bartolomei, et al. (2003) research had been in Australia for many years but still had settlement-related concerns. Their research with older refugees from Bosnia, Cambodia, Somalia, Sudan, and Vietnam found that common difficulties included:

- lack of English language;
- social isolation (due to lack of English and exacerbated by lack of extended family/neighbours);
- not understanding Australian systems;
- housing, employment and financial difficulties; and
- concern for family members left behind.<sup>xxxii</sup>

In addition, most new arrivals will be concerned about:

- finding secure, affordable accommodation suitable to their health needs;
- learning how to get around;
- maintaining their cultural practices and practicing their religion;
- experiencing discrimination and racism;
- regaining assets left behind in their country of origin;
- inter-generational conflict exacerbated by living in a new culture; and
- supporting friends and family overseas through remittances or sponsorship.

For refugees resettled under Australia's Refugee and Humanitarian Program, there is a network of settlement services to help newly arrived refugees find accommodation, set up house and organise Centrelink payments. However, these services do not specialise in older refugees and may have limited links to aged care services or resources for home and community care.

### 4.4 Financial security

Most refugees start life in Australia financially disadvantaged. Few are able to protect their assets before fleeing their country. Moreover, war disrupts the earning capacity of most people. Escape and survival in exile can deplete a family's resources, and put some people in debt. As they are unlikely to have had a full-working life in Australia their contributions to superannuation would be less than most Australians.

Refugees' earning potential is likely to be reduced because of disruptions to career and education, the need to learn another language and business culture, and to develop new networks in Australia. Those who arrive as older people often find it difficult to get a job or access vocational and skills training.

Still, the picture is not all gloomy. Some refugees who have grown older in Australia have been extremely successful - people from a refugee background are disproportionately represented in Australia's Top 100 Wealthiest list including Frank Lowy and Richard Pratt.<sup>xxxiii</sup>

More research is needed to determine the financial mobility of newer refugees, but obviously they face many obstacles. Real estate prices in Sydney have put home ownership out of reach of most new arrivals. Many older refugees apply for Public Housing as the most reliable option because eligibility considers their financial limitations, complex health conditions and/or torture and trauma issues.

Newly arrived refugees, as opposed to asylum seekers, are eligible for financial support through Centrelink, although refugees with a Temporary Protection Visa are only eligible for a limited range of benefits. In recognition of the needs of older refugees, humanitarian entrants are not required to live in Australia for 10 years without a break before receiving a pension.

Another source of income is overseas pensions – a result of Australia’s reciprocal pension arrangements with certain other countries. While this arrangement might suit most migrants, it can pose problems for refugees. Having to apply for a benefit from the country you have fled from for fear of persecution can be traumatic, particularly if there are fears that contacting the government of this country could endanger remaining family members.

Older asylum seekers are particularly vulnerable to financial hardship. No asylum seekers are eligible for Centrelink benefits, and only a few are eligible for assistance through the Asylum Seekers Assistance Scheme. Most asylum seekers are wholly dependant on income they can earn, but have limited access to jobs. Approximately one third of asylum seekers do not have work rights. This same group is ineligible for Medicare. Those with failing health may be unable to afford health care while their application is being determined, a process that can take years.

#### **4.5 Cultural needs and loss of status**

Being a refugee can affect an older person’s status. Instead of being a respected member of the community, some older refugees find their skills and opinions are not valued in Australia. Family roles can be reversed, with older people becoming more dependent on their children to help them negotiate their new country. This role shift may lead to family conflict, depression, anxiety or other mental health problems.

Because older refugees may be stricter in cultural and spiritual observance, they may be uncomfortable with services that do not accommodate cultural preferences in language, food, dress and religion.<sup>xxxiv</sup>

The desire to return to their country of origin can be important to many elderly refugees – older people have often taken the lead in returning after conflict.<sup>xxxv</sup> Moving back permanently will be a dream for many (although a nightmare for others). Even if it is safe to return, they know that getting older in their native country will usually mean living in worse economic conditions, with little care and social provisions.<sup>xxxvi</sup> Their support system may have been disrupted by the war and their family may live in Australia or elsewhere, unwilling to return with them.

#### **4.6 Support networks and social isolation**

Elderly refugees, like many elderly people, are often unseen in the community due to ill health and isolation. While social isolation can affect many older people because of reduced mobility, the risk is higher for older refugees due to:

- lack of family or extended family in Australia;
- the small size of their community, limiting relationships with people from the same age and background;

- lack of bilingual workers who can meet the specific needs of older people including case work;
- limited English and, for some, low literacy in their own language;
- inappropriate housing; and
- financial hardship reducing mobility.

The refugee experience can also have an impact on communities. Traditional support structures are often destroyed by conflict, and trust between people is broken.<sup>xxxvii</sup> Exposure to organised violence and conflict also affects a community's ability to organise, advocate for their own needs and communicate with Government structures.

How refugee communities develop when resettled varies. Much depends on factors such as:

- how dissimilar their culture is to their adopted country;
- their levels of education;
- English language skills and other skills;
- and whether or not they have consolidated community structures and resources.<sup>xxxviii</sup>

Smaller communities may bond together well, but they can also be fragmented, leaving people with few supports to draw on. Larger, more established communities may have developed strong support networks including provisions for aged care.

Few extended families remain intact, and are often scattered across the globe, limiting the social networks available to older refugees. Any social interaction outside the family is hampered by lack of English and difficulties using public transport.

Older refugees can play a critical role in the family, taking on childcare so their children can work. But their isolation can increase when this role changes as children start school. Although older refugees are important for upholding cultural traditions and values within the family, this can also cause family problems as different generations, often at different phases of settlement and adaptation to Australian culture, come into conflict.<sup>xxxix</sup> Family breakdown, lack of connectedness and lack of community infrastructure can affect mental health.

#### **4.7 Caring for older refugees**

The people who care for older refugees are usually a spouse or children. The largest group of primary carers are women of middle age.

People caring for a spouse while they are getting older themselves are likely to be dealing with their own age-related problems like reduced mobility, social isolation and financial limitations, as well as the stress of being a carer.

First and second generation carers can also face pressures related to lost income and the demands of raising children while caring for an older relative. They may be caught between two cultures, that of parents with more traditional expectations, and that of their children who have adopted Australian ways of doing things. A recent Australian study of Jewish women (aged 30-69 years) caring for older relatives found that caring and supporting multiple generations with different cultural expectations affected their health, wellbeing, and financial and social circumstances.<sup>xi</sup>

Nevertheless, living with elderly parents can benefit refugee families. Grandparents may be invaluable care-givers for young children, provide advice and support, help with family decision-making, and can play a key role in resolving community conflicts.<sup>xii</sup>

### Case Study 3: Mariam

#### *History at time of referral*

Mariam had lived her whole life in Afghanistan. She had raised three children as the third wife of a successful businessman. When she was widowed at 35, she came under the care of her son, Mohammed. Mariam had been largely insulated from the hardships of Taliban rule until Mohammed was identified as a member of an opposition group. He was arrested, interrogated, subjected to mock executions and told that members of his family would be killed if he didn't send his son to the frontline. Two months later the body of his brother was found on his doorstep. That night Mohammed escaped the country with his wife, two children and Mariam, who was then 77 years old.

They arrived in Australia on forged passports, sought protection as asylum seekers, and were taken into detention while the Australian Government considered their claims. During this time there were many disturbances in the centre, including a riot and attempted suicides. After 10 months they were recognised as refugees, granted Temporary Protection Visas and released into the community.

While she missed life in Afghanistan, Mariam enjoyed living with her family, meeting their growing network of friends and cooking for the family. Her mobility was increasingly limited by arthritis and she also had some incontinence problems, but her daughter-in-law was able to help her shower and move around the flat.

Mariam only came to the attention of a volunteer support service after her daughter-in-law was killed in a road accident. They were concerned that Mariam had become extremely isolated: not only had she lost the company of her much-loved daughter-in-law but her son had grown increasingly depressed, and her granddaughter had left home to get married. Her grandson avoided the grieving household and was rarely at home.

The service thought she needed more support with her day-to-day care. Her granddaughter tried to help, but she lived an hour away by train and was working. Neither she nor Mohammed were eligible for a Carers Allowance because of their temporary visa status. The support service wanted to apply for subsidised incontinence pads through the Commonwealth Government's Program of Appliances for Disabled People (PADP) but were told they thought TPV holders were ineligible.

It was culturally inappropriate for Mohammed to help with Mariam's personal hygiene. Female friends could not offer much help, as it meant spending time in the home of a single man with no appropriate chaperone. To make matters worse, the landlord refused to have any safety rails installed that would have improved her mobility. Despite the growing pressure on the family, Mariam and her son were extremely reluctant to use aged services. Mohammed was caught between his responsibility for his mother, and the fact that Mariam needed more intensive care. The family's experience of detention contributed to their fear of institutionalised care in Australia, a fear that was compounded by negative stereotypes in this community of people who 'unloaded their old people to nursing homes' in Australia. Mariam did not want to be cared for by strangers, especially when she could speak only a few words of English.

### *Assessment*

An ACAT assessed Mariam as needing the intensive support of a residential program. They made a referral to Community Options and sought a nursing home liaison officer to look for appropriate facilities. While Mariam was eligible for HACC services (HACC is administered by the State Government) many services were unsure if she was eligible, causing delays.

Because Community Options had no vacancies Mariam was placed in a high care residential facility.

### *Outcome*

Mariam moved to a residential home, close to her son, and subsidised from her Special Benefit Payment. There were no Persian/Afghan specific homes, nor could facilities with Persian-speaking workers be found. As a result she could not communicate with other residents or staff and relied heavily on family and friends to relieve the monotony between meals of unfamiliar food. The move was difficult for Mariam but she accepted it as a temporary measure.

## **5. Older Refugees, Aged Care and Health Services**

### **Part A: Policy, Research and Planning**

#### **5.1 Policy Development and Implementation**

##### *5.1.1 Recognition of older refugees as a special needs group*

Few services recognise older refugees as a special needs group in policy. While most have a policy relating to CALD clients, they do not recognise older refugees as a separate group with specific needs.

Refugees are not identified as a special needs group in the national HACC standards, although there is the potential to promote them as such (Objective 1). As these are national standards, any changes would need wide support. The standards have not been revised since 1991. Queensland Health's *Meeting the Standards in our Multicultural Society: An ideas guide for HACC Services* (2001) is an example of what could be developed for NSW.

Similarly, refugees are not recognised in the Community Partners Program (CPP).<sup>xliii</sup> The Program targets *established* CALD communities – yet those in most need of culturally appropriate aged care services are often from small and dispersed communities, which are predominantly from refugee backgrounds.



Conversely, the Department of Housing's new strategic policy framework *Housing Multicultural NSW* recognises older refugees explicitly as a 'special need group whose requirements will be taken into account in the planning and delivery of Department programs and products'.<sup>xliii</sup>

Mental health plans have recently acknowledged the needs of refugees and older people. The *Framework for the implementation of the National Mental Health Plan 2003 – 2008 in Multicultural Australia* and the *Draft NSW Multicultural Mental Health Plan 2005 – 2010* refer to 'older people from CALD background' and to 'refugees', including those who have experienced torture and trauma, as does the *NSW Health Service Plan for Specialist Mental Health Services for Older People 2005 -2015*.

**Recommendations:**

- The Australian, State/Territory and Local Governments should acknowledge older refugees as a special needs group with particular issues. This should be reflected in relevant policies, funding guidelines and service planning and delivery;
- The National HACC, Mental Health and NSW Disability Standards should be revised to include refugees as a special needs group;
- The Department of Health and Aging should extend the Community Partners Program criteria to include small and dispersed communities from a refugee background;

5.1.2 *The challenge of age-based eligibility*

A difficulty of applying age-based criteria to refugee populations is that ages are based on the average life expectancy and health status of Australians – it does not necessarily match mortality rates and health status of people coming from refugee-source countries.

In many cases refugees' life expectancy and health status will approach that of the general population because of better lifestyle and health practices in Australia, but for newly arrived older people this may be less likely. Experiences of torture and trauma are thought to accelerate ageing<sup>xliv</sup> and therefore impact on life-expectancy and health.

Part of the problem is lack of data on life expectancy of refugees in Australia (or equivalent countries). Table 4 details the life expectancy rates in the top ten countries of birth of refugees and humanitarian arrivals.

Table 4: NSW Refugee and humanitarian entrants arriving from 1 Jan 2002 to 1 July 2004, top 10 countries of birth: Life expectancy in country of birth

Country of origin	Arrivals *	Life expectancy at birth male/female**
Iraq	2,368	59.1/63.1
Sudan	1875	54.9/59.3
Afghanistan	925	41.9/43.4
Former Yugoslavia -not further defined	658	69.7/74.9 <sup>xlv</sup>
Iran	432	66.5/71.7
Croatia	236	71.0/78.6
Sierra Leone	223	32.4/35.7
Egypt	169	65.3/69.0
Other Central and West Africa	155	43.5/47 <sup>xlvi</sup>
Lebanon	105	67.6/72.0

Sources:

\* Department of Immigration & Multicultural & Indigenous Affairs Settlement Database, accessed 23 August 2004

\*\* World Health Organisation, <http://www.who.int/countries/en/>, accessed 26 August 2004.

**Recommendations:**

- DoHA and the NSW Department of Health should research the health status and life expectancy of older refugees;
- Corresponding to health status and life expectancy, CACP and relevant services should allow newly arrived refugees eligibility for relevant Commonwealth-funded programs before they are 65 years old.

### 5.1.3 Eligibility criteria related to visa status

Most refugees in Australia are granted permanent residence, and can apply for citizenship after two years, allowing them access to the same aged care services as Australians. However, a small group of elderly people of refugee background are not eligible for a range of aged care services – these are asylum seekers, refugees with a Temporary Protection Visa, and others staying long-term with their children on a visitor’s visa.

**Asylum seekers** are ineligible for many services including Public Housing, Centrelink benefits and many migrant support services such as seniors groups run by Migrant Resource Centres. About a third of asylum seekers are ineligible for Medicare, requiring them to pay for most health services as overseas visitors. Although assessments made by ACAT are not determined by the type of visa a person has, the services they can be referred to will be very limited – e.g., ACAT may determine that an asylum seeker needs residential care but he or she will have to pay the full costs, which most cannot afford.

**Refugees with a Temporary Protection Visa** face restricted access to services. While they should be eligible for HACC services they may be ineligible for Australian Government-funded services such as Hearing Services and the Program of Appliances for Disabled People (PADP) (see Case Study 3).

**Older refugees staying long-term with their children on a visitor’s visa** are ineligible for Medicare and some Aged Care Services. They rely on their children to fund any expenses that arise, but their children may be unaware of the real cost of health services as their own care has been subsidised by Medicare. This can create significant debt for families.

**Parents who have joined their children under the family reunion scheme of Australia’s Migration Program** In most cases their children must provide an Assurance of Support (AoS). An AoS is a legal undertaking to provide financial support to the parent for the first two years so that they will not have to rely on any government support.<sup>xlvii</sup> If medical or care costs spiral this can create significant pressure on families and affect the kind of assistance the parents receive.

**Recommendations:**

- Eligibility for Australian Government Hearing Services and the Program of Appliances for Disabled People (PADP) and Commonwealth Rehabilitation Services should be extended to refugees with a Temporary Protection Visa;
- DIMA and the Health Insurance Commission should extend Medicare eligibility to all elderly asylum seekers in the community, subject to means testing.

#### 5.1.4 Access to and affordability of services for older people

As discussed in section 4.4, newly arrived refugees may face significant economic disadvantage.

Financial hardship can significantly affect service use. HACC services are arguably available at low cost, but even these costs can be a barrier. Residential facilities require a higher financial contribution. For some, this will mean the difference between accessing those services or not. As many refugee communities, like migrant communities, feel they should pass their property on to their children, they may be worried that they will be forced to sell their home to pay for aged care. As a result, some people delay moving to a residential home long beyond the point of needing help, putting their health at risk.

Cost can have a significant impact on older refugees' overall mobility, which in turn influences their social isolation. The Asylum Seekers Assistance Scheme (ASAS), a Australian Government funded program administered by the Australian Red Cross, helps eligible asylum seekers in the community to meet some basic financial and health care needs. To be eligible for ASAS, an asylum seeker must have applied for a Protection Visa with the Department of Immigration and Multicultural Affairs (DIMA), and not had a decision on their primary application within six months of applying. Elderly applicants (females over 62 or males over 65) can be considered for an exemption from the 6-month waiting period, and also may be eligible for ASAS at the Refugee Review Tribunal stage.

#### **Recommendations:**

- DIMA should extend eligibility for financial support through the Asylum Seekers Assistance Scheme (ASAS) to elderly asylum seekers at all stages of the appeal process;
- DIMA should pursue legislative change to extend Medicare eligibility to all elderly asylum seekers in the community, subject to means testing;
- DoHA, Centrelink and FACSIA should consult with refugee communities on how best to implement shared social security agreements;
- DADHC and DoHA should give service providers the responsibility and mechanisms to apply for overseas pensions on behalf of refugees who have experienced torture and trauma, and develop the necessary guidelines to protect the client.

#### 5.1.5 Flexibility of reporting

To meet the complex needs of older refugees, services must be flexible. This means that funding agencies must also be flexible. Experiences of organised violence can make some refugee clients fearful of services' keeping records on them, especially where the services are associated with the Government. CACP have provisions where, if a client does not want to formally acknowledge a care recipient agreement, care providers can instead document the reasons for this, and the basis on which agreed care is delivered. Likewise, HACC has provisions in its Minimum Data Set for clients who don't wish to disclose information.

Some ethno-specific residential facilities have also been granted exceptions when they argue that refugee clients may refuse service if they are suspicious of the use of documentation (for Australian Government accreditation, these facilities have to develop a Health Care Plan with each client). In these cases, a worker or family member signs the Health Care Plan instead of the client. However, other mainstream services are unlikely to know this is possible, so are unlikely to try to negotiate this arrangement for clients who are wary of documentation.

**Recommendation:**

Commonwealth funded services should be able to establish partnerships with family members in cases where, owing to their refugee experience, clients are concerned about the use of information required in Health Care Plans. Aged care providers should be made aware of this policy

### 5.1.6 *Access to services across operational geographical boundaries*

A concern raised at the Older Refugee Forum was lack of flexibility regarding the geographical boundaries of aged care services. Limiting services only to clients living in the services' operational areas can disadvantage older refugees from small and dispersed communities which have few services available for their needs in their own areas. **This can create another barrier to accessing appropriate support.**

Many ageing ethnic groups, especially smaller groups, are scattered throughout Greater Metropolitan Sydney and around NSW. HACC ethno-specific services or those offering a clustering system are not equally represented in every area or region. It is hard for people to understand why a Lao client living in the Baulkham Hills LGA, for example, can access a Lao group at a day care centre, while a Lao client living in Blacktown can't join this group, even though there is no similar service in the Blacktown area.

This lack of flexibility occurs across service type. There have been instances reported to the Service Flexibility Working Party of the Older Refugees Working Group where someone living outside allocated areas has been refused culturally appropriate CACP's because of these boundaries. In addition, if a provider agrees to help someone outside the allocated area, it takes up to 60 days for the provider to get approval to vary the conditions of the package.

To identify the nature of this problem, in 2005 a short questionnaire was given to 27 respite services<sup>xlviii</sup> across the Cumberland/Prospect area by the HACC Multicultural Aged Access Project. Most services said they couldn't accept clients from outside their geographical boundaries because of the conditions of their funding agreements. Yet with two exceptions, all the services said that in situations where CALD clients had no appropriate services in their areas, they would be willing to accept these clients.

**Recommendation:**

- The Department of Health and Ageing and DADHC should explore less stringent admission criteria for HACC services and aged care related services. They could, for example, enable 10 per cent of the allocation of packages to incorporate flexibility for providers to assist clients in regions outside allocated areas. DADHC should write this into the Service Description Schedule.

### 5.1.7 *Participation of older refugees in the delivery of aged care and health services*

Including older refugees in the development of programs is one way to ensure their needs are incorporated into program planning and delivery.

Since the Ethnic Aged Care Advisory Committee was dissolved, there has only been one representative from ethnic communities representing the issues of nearly one third of the NSW population. There is no formal process by which communities can access the planning process.

The interests of older refugees can inform planning and service delivery and can be sought through community consultations, surveys, talkback on ethnic radio and/or participation on interagencies that address aged or refugee issues.

#### **Recommendations:**

- The Department of Health and Ageing, DIMA, DADHC and the NSW Department of Health should develop protocols/practices to ensure refugee communities are consulted and informed about aged services and services policies;
- FACSIA and Centrelink should develop protocols/practices to consult with refugee communities when implementing offshore pension arrangements;
- The Aged Care Planning Advisory Committee should hold an annual consultation with ethnic communities on the allocation process, including contact details of the NSW Transcultural Aged Care Service, with whom communities should be actively encouraged to consult;
- The Council On the Ageing (COTA) should seek representation from older refugees to sit on the Council, and should consult with older refugees when developing policy.

### 5.1.8 *Support for Carers*

Carer support seems to be a big influence on whether or not older people use services. The family is generally the main provider of support for aged people of CALD background, although this varies across different groups according to individual circumstances and migration patterns. To provide what is often a high level of care, these families need support that meets their specific needs.

Not all carers recognise the term ‘carer’ as applying to them. Most see themselves simply as family members responsible for the support of an older relative. They may not identify with the term ‘carer’, and may not realise services and information for ‘carers’ are aimed at them.

Respite care options are often good ways to support carers. Ethnic Day Care or cluster day care is well received and used by older people from CALD/refugee backgrounds. Services need more encouragement and support to attract older refugees.

The inter-generational needs in public housing should be recognised – e.g. providing public housing with a granny flat to allow carers and elderly people independence, enabling carers to provide care for as long as possible.

Developing projects that support carers requires funding and thus support in policy. One project that has had support from NSW Health, under the Family Carers Program, is the NSW Transcultural Mental Health Centre's carer's support program (see section 5.5.2).

**Recommendations:**

- DADHC and the Department of Health and Ageing should support research on the support needed for carers, and implications of findings from the evaluation of the Transcultural Mental Health Centre's Carer Support Program;
- DADHC should support HACC services to target service information to refugee communities;
- The Department of Housing should provide housing suitable for older refugees and their carers that incorporates inter-generational needs.

## 5.2 Research

### 5.2.1 Identification of needs

Research is required on the service needs of older refugees in Australia and how to meet those needs. Although Bartolomei, et al. research highlighted many important issues for older refugees, more data on service use and demographics are needed. Such research would enable service providers and policy makers to include the needs of this group in decision making – e.g. creating benchmarks to determine how each department is faring in service delivery.

While research on the profile of older refugees is critical to demonstrating need, existing data collection, such as the Census and Survey on Disability, Ageing and Carers, could be improved to better identify refugees.

**Recommendations:**

- Funding should be made available through the National Framework for Action on Dementia to research the interface between dementia and trauma-related mental health issues, with a particular focus on diagnosis and treatment.
- The Department of Health and Ageing, the DADHC and the Department of Health should allocate grants to map the profile of older refugees and their carers, including the following information:
  - how many older refugees live in Australia and NSW
  - their country of origin, language spoken
  - the geographical areas where they live
  - their living arrangements: in residential facilities, public housing, with a spouse, or other family
  - what services they use, and how patterns of use compare to the mainstream population
  - the number of older asylum seekers living in Australia and NSW
  - how many aged asylum seekers are ineligible for Medicare
  - what services they use.
- The Department of Health and Ageing, the DADHC and the NSW Department of Health should fund qualitative research on how older refugees and their families are coping with issues relating to both their past experience and ageing.

### 5.2.2 Service utilisation by older refugees and asylum seekers

We know little about what services are accessed by older refugees in NSW and how they are accessed. Aged care providers are not required to collect information on refugee status or background, and most do not. For example, 75 per cent of services surveyed for this report did not know how many of their clients were from a refugee background.

Lack of research makes it impossible to measure equity of access, but what we already know about service use in CALD communities, together with the many barriers older refugees face when accessing services (detailed in the following section), suggests older refugees have limited access to aged care services.

Northern Sydney Multicultural Health's Literature Review on the use of aged care services in CALD communities' found that HACC services were under-used. There was poor access to:

- nursing/residential homes;
- Aged Care Assessment Teams (ACATs);
- respite care;
- day care;
- personal care;
- meals on wheels; and
- community transport services.<sup>xlix</sup>

The same review also suggested that CALD communities over-use other more intensive services such as hospital outpatient clinics and hospital emergency departments.<sup>1</sup> Anecdotal evidence suggests this is also the case with older refugees who often come to the attention of aged care services when they have developed very complex needs, or during a crisis (e.g. at an Emergency Department), whereas early intervention would often be better.

Service use for asylum seekers is likely to be different - without an income such as a pension or other benefit they cannot access residential care and may have problems accessing other services such as CACP or HACC. About one third of asylum seekers in NSW are ineligible for Medicare. As a result, their aged service use is probably low and asylum seekers would be even more likely to present only at a crisis point, if they present at all.

Without reliable data it is impossible to give more detail on what services refugees use or don't use. This makes it difficult to examine equitable service provision to older refugees, to map services providing care, to identify gaps in services, and to develop national or statewide approaches to service provision for older refugees.

#### **Recommendation:**

- Aged care and related services should be required to collect data on older refugees and asylum seekers using services.

### 5.3 Funding

The Department of Immigration and Multicultural Affairs (DIMA) had traditionally been expected to have a major role in providing services to refugees, including older refugees. In recent years there has been a shift, with DIMA increasingly seeing its responsibility as being limited to the initial period of a person's settlement in Australia. As a result of the Settlement Services Review of 2004, DIMA have restructured their funding program and encourage "mainstreaming" of service provision to established communities. It is arguable whether other government departments are fully aware of this shift and have yet to see the welfare of older refugees as a shared responsibility.

Another shift is the increase in competitive tendering for Government funded social services (as is required for the National Respite for Carers Program and the Community Partners Program for example). This has made it harder for small and under-resourced ethnic organisations to compete with larger organisations to write elaborate submissions and to have the desired infrastructure (e.g. liability, code of practice, and quality management). This means that some organisations are overlooked, despite their networks and expertise in working with their community. This could affect older refugees' access to services. That said, in a recent funding round, a number of CPP positions have targeted refugee communities including the Vietnamese, Ukrainian and Armenian communities.

The impact of large faith-based charities providing many of the services is unknown, although it is possible that many refugees from different religious backgrounds may be reluctant to access such services, particularly if they have experienced religious persecution.

The relationship between funding structures and equitable access was recently raised by the Service Flexibility Working Party which is concerned that current funding procedures lead to inequitable access for refugees in NSW across services subject to aged care approval rounds. The working party identified the following barriers to accessing Aged Care Facilities (low and high care) and **Community Aged Care Packages (CACPs)** including:

- Smaller communities are often overlooked in the allocation of places. Many are from a refugee background, are under-resourced and under-represented, and many are scattered across different regions of NSW.
- People travel from different areas of NSW, and even interstate, to try to access ethno-specific services.
- While people may come from a similar geographical area, they may belong to communities with a history of conflict – yet they are sometimes inappropriately clustered together in services.
- The allocation of CACPs by Local Government Area or by region creates artificial barriers (as discussed in 5.1.6).
- Within CACP packages there are no resources to help service providers promote the service to refugee communities.

While refugee communities might not be as big in numbers as some other migrant communities, they have additional needs that should be incorporated in the funding selection criteria. As many refugee communities have lived in Australia for some time they will not be considered a priority for DIMA's Settlement Grants Program (SGP).



**Recommendations:**

- Both the Australian and State/Territory Governments should recognise settlement as a lifelong process where issues may arise at different life stages. They should take a ‘whole of government’ approach where policy and funding guidelines for services to older refugees are shared between a number of departments.
- Allocation of places for ethno-specific services should be based on statewide data and not by regions, and refugees from different nations and communities should be appropriately identified during service planning;
- The DoHA should provide for specific resources to allow partnerships between small communities and low and high care services;
- DoHA should allocate a percentage of CACPs for clients living outside allocated areas but needing to access the service.
- DADHC should allow older refugees to access HACC services outside their region if there is no equivalent service in their local area;
- DoHA and DADHC should help service providers target refugee communities by providing resources such as settlement statistics in their areas, community profiles, training, and manuals on how to market their service to refugee communities.

## 5.4 Training of aged care and health service providers

Cultural competency is not a core requirement of current training for the health professions and other occupations likely to work with people of CALD background. This applies to people training as doctors, nurses, social workers, or those studying for Certificates III and IV in Aged Care. The National Competency Standards course has units on cultural competency only as an elective. Students who do not choose the elective, are ill-equipped to work with CALD communities. Although documents refer to providing culturally and linguistically appropriate services, service providers are neither trained nor given the tools and skills to do so.

There is no systematic, accredited or resourced training for people working with clients who are older refugees. Of 130 HACC services surveyed, only 18 per cent said their staff had had any training on refugee issues.<sup>li</sup> Any training currently provided is done so on a one-off basis by a few agencies including Jewish Care, STARTTS, the NSW Refugee Health Service, and by Multicultural Aged Care Workers. Training for accreditation for the Aged Care Certificate III does not recognise the needs of refugees. While ad hoc training is often useful, it risks missing those who need it most, and whilst raising awareness may fail to have a long-term impact.

Linking the care of older refugees to a national competency standard would ensure that training had a measurable impact on service provision.

While cultural competency is not a core training requirement, there are encouraging developments – the NSW Transcultural Aged Care Service (TACS) has developed accredited cultural competency training on transcultural aged care, while DADHC is funding the development of culturally competent training for HACC services. However the latter does not specifically include the needs of refugees.

### **Recommendations:**

- Certificate, diploma and degree courses for the health professions of welfare and other occupations likely to work with older people of CALD background should include older refugees as part of a core Cultural Competency module.
- Training for service providers on using interpreters effectively should be included in Aged Care Certificate level III and IV.

## Case Study 4: Jasna

When Jasna went into hospital after a fall, a hospital psychologist assessed her as suffering symptoms of Post Traumatic Stress Disorder (PTSD) related to her refugee experiences, and made a referral to STARTTS. She was seen by a bilingual counsellor from STARTTS some months later, after leaving hospital.

### *History at time of referral*

Jasna was 65 when the war started in Bosnia-Herzegovina. After her village was caught in the conflict she fled to a neighbouring country with her family. During this period her husband died. After spending five years in Germany, the family was resettled as refugees in Australia six years prior to her admission.

Following an accident six months earlier, Jasna was wheelchair bound. She had been getting rehabilitation services at the hospital and now had a Community Aged Care Package (CACP) from an aged care service. This provided a bilingual worker to help her with personal care, cleaning and getting to appointments.

### *The issues*

Jasna's physical and psychological problems were exacerbated by inappropriate accommodation. She could not leave her flat unassisted because of stairs at the entrance to the building. Construction in a neighbouring apartment block made it difficult to sleep.

She was also very isolated. Her most regular social contact was the worker who came for two hours three times per week. She felt she needed more support from her family but did not want to 'impose' as they had problems themselves. Settling in Australia had not been easy for the family, her daughter was having marriage problems and was quite depressed. Jasna's once-close relationship with her grandchildren had deteriorated as they rapidly adapted to Australian life.

Her limited English exacerbated this isolation - she had found it impossible to learn a new language at her age and in her situation. Besides limiting her interactions with people outside her community, it further distanced her from her grandson who had an Australian-born partner with whom Jasna could neither communicate nor relate to. Jasna's inability to communicate made her very sad, especially as her great-grandson spoke only English.

Even before her accident she had limited contact with her ethnic community. She had attended ethnic day care once but felt she had little in common with the people there. She did not want to go to an English-speaking group because of the language barrier and feeling she did not belong. However, she was interested in improving her computer skills and reading, and wanted to attend a group.

Jasna also had financial difficulties. She had lost her assets during the war, had accrued no superannuation here and was dependant on the Aged Pension. Since being wheelchair-bound, her phone and electricity costs had increased and she was finding it hard to make ends meet.

Jasna felt she needed more help but had little knowledge of aged care services, even those already providing her with support. For example, she didn't know she had a care manager at the aged care service that provided the cleaner. Her family did not know how to help her connect with services either, particularly as aged care services were run differently in her country of origin.

### *Assessment*

The worker from STARTTS concluded that Jasna was suffering not from PTSD but from depression and anxiety. The depression was primarily related to difficulty adjusting to her increasing frailty and limited independence, her isolation and settlement issues. As these issues were not trauma-related, STARTTS services were not the most appropriate for her needs.

Having assessed that she needed extra support, the worker tried to refer Jasna to another service that was better able to coordinate her care, provide counselling and address many of her settlement issues.

### *Trying to find a service for Jasna*

Because the counsellor had limited contact with aged care services before this case, it took several months to navigate the aged care service system and find appropriate services. In this time he contacted about 20 services.

Part of the problem was that Jasna did not understand who was involved with her care. Two separate teams had been involved: one at the hospital following her accident, and a community-based service that provided the bilingual support worker through CACP. When the counsellor contacted the latter service they said Jasna was already getting the maximum service available and they were not responsible for case management. They did not know she was a refugee, nor did they know what PTSD was, nor about specialist torture and trauma services. After the conversation with the STARTTS worker, they agreed Jasna needed further assessment but it was not a service that they offered. They did not refer him to an ACAT to reassess her needs at this point, perhaps assuming that he was already familiar with their role.

The worker then contacted the Housing Department, Centrelink, Centrecare Aged Services, Multicultural Disability Service, the local mental health service and the hospital where she had had treatment. While each service could suggest another service to contact, no one could tell him who could coordinate the case. The mental health team reviewed her medication but could not provide general support and counselling. Her doctor was of limited help, given he did no home visits and knew little about aged care services including the role of ACATs. None of the services appeared to know how being a refugee might affect her case.

The search was further limited by her need for services that could provide home visiting because she was in a wheelchair. .

### *Outcome*

The counsellor was finally directed to an ACAT based at the health service which organised a reassessment. A social worker from the Team visited Jasna and helped her apply for financial help, appropriate housing, and provided her with support; an occupational therapist helped with mobility, supportive devices and exercises; the Team's nurse helped with incontinence and linked her to a community health nurse for further care; and a geriatrician reviewed her medication. They recommended that Jasna have more hours per week provided for her care. Community mental health looked for general support and counselling for her in the local area. Jasna's GP, the hospital team and the ethnic aged care provider were informed and connected with the team. The care manager at the CACP now understood more about Jasna's needs and could monitor her needs accordingly.

Eight months after first seeing Jasna the counsellor was satisfied she could be discharged from STARTTS. If Jasna's needs had been exclusively settlement related it is not clear from where she would have received help.

## Part B. Service Provision and Practice

### 5.5 Resources

#### *5.5.1 Information needs of older people from a refugee background*

##### *Community education*

While we know little about how older refugees access services, we do know of barriers that limit their access to aged care services. These barriers are in addition to those that apply to all older people. Some relate to the refugee experience; others are common to small and emerging CALD communities. They can include:

- Suspicion of bureaucratic processes, record keeping, and assessments, particularly for people who escaped totalitarian regimes where such information could be used against them or their family.
- Communication problems - using mainstream aged care services is stressful. If they are not fluent on English or have lost English as a result of age-related illness,
- If few people in their own community use aged care services, there is little word-of-mouth information on what is available.
- Being unfamiliar with the government's role in providing services to older people – many come from countries where governments provide no support.
- Negative views of Australia's 'aged care' system.
- Misunderstanding of what aged services offer them and their carers.

Even where a client has accessed services, cultural and linguistic differences may hinder communication so much that accurate assessment is compromised. .

There are many strategies to address older refugees' information needs that require resource development. The NSW Multicultural Health Communication Service recently assessed how information about HACC services is communicated to non-English speakers. Although this project did not focus specifically on refugees, it identified many information gaps. Commissioned by the Department of Ageing, Disability and Home Care (DADHC), the research is part of a broader project to produce multilingual information/education kits to communicate HACC services across NSW.

##### *Information Provision and promotion*

Some of the strategies that need resource development to address older refugees' information needs are discussed in more detail below:

- Use of ethnic media and dissemination of information through community organisations where there is established trust. Ethnic radio often has a good reach into target communities, and is accessible to people with limited literacy. However, the coverage of ethnic radio (even SBS Radio) varies so it will not be appropriate for all service providers.
- Translated information is not enough in itself – it must be coupled with distribution strategies to ensure the information reaches people who need it – e.g. distributed to ethno-specific community organisations and to places used by the target community. This takes ongoing promotion, whereas producing resources is often considered a one-off investment.
- There's also a need for translated information about patient treatment and care. The only translated information relevant to Aged Care assessment and referral currently provided at a state level is a letter on privacy in relation to the Minimum Data Set. Compared to English

speaking consumers, non-English speakers are less likely to get written information about the result of their assessment.<sup>lii</sup>

- Other useful strategies could include information road-shows, Bilingual Community Education group programs, use of Bilingual Access Workers, the funding of small ethno-specific information strategies, and short-term case management to support clients to access services and ‘settle’ in.
- While providing older refugees with information on services that can support them is important, other community education is also needed. Many older refugees provide childcare to grandchildren for example, but are not targeted by early intervention services through the Families First initiative. As a result, they may miss out on services that could enhance their participation in the community.
- One of the major providers of information to CALD communities is the Community Partners Program (CPP).<sup>liii</sup> CPP cannot provide casework, only information and referral.

### *Interpreters*

While the above strategies are useful, they don’t replace the need for older refugees to be able to talk to aged care services. Although there are few data on the use of interpreters by aged care staff, anecdotal evidence suggests interpreters are not well used, even when an aged care assessment is being made. One survey of HACC services in Western Sydney (which has one of the largest refugee populations in Australia) found that in a six month period only 16 services used professional interpreters, and 21 services used none at all.<sup>liv</sup> It is not uncommon for friends, family or unqualified staff to act as interpreters for HACC services.<sup>lv</sup>

A professional interpreter must be used for assessments of non-English speaking clients. Using family, friends or volunteers instead can lead to misunderstandings and deny clients the opportunity to present their needs from their point of view. Relatives or friends may change the meaning and accuracy of what is said due to shame, lack of trust or lack of skills. While family and friends should be encouraged to be involved in the assessment to provide support and additional information, they should not be used as interpreters. Even when there is a bilingual/bicultural worker available, interpreters may still be needed.<sup>lvi</sup>

Many factors influence a service’s willingness to use interpreters. These include staff skills, ease of access to interpreters, costs of interpreting, availability of bilingual staff, and whether clients and families are willing to use professional interpreters and the extent to which management supports and promotes the use of interpreters.

Managerial support in turn is affected by cost and contract requirements. Until recently most aged care services have had no specific funding for interpreters. In Western Sydney Area Health Service’s study of access to HACC services by CALD frail aged people, and their carers in the Cumberland/Prospect Area, service providers said the high costs of interpreters were one of the main difficulties in providing services to CALD clients.<sup>lvii</sup>

Funding guidelines and structures have an impact too. Australian Government funded community and residential care services have to draw on the care subsidy for each client who needs an interpreter. Spending this subsidy on interpreters leaves providers with less money for each client’s care, putting non-English speaking clients at a disadvantage.

Because of this, the Department of Ageing Disability and Home Care (DADHC) recently allocated funding for interpreters from the Home and Community Care Program for three regions in the Sydney metropolitan area. Health Care Interpreter Services from Northern Sydney/Central Coast and the Sydney South West Area Health Service are providing these services to HACC services in that area. The Ethnic Child Care Family and Community Services Co-operative Ltd broker interpreter services from the Sydney South West Area Health Service. While the scope of the project is limited and use is currently low, it is a positive development.

The availability of interpreters for aged care services is inconsistent. Most aged care services rely on the Translating and Interpreting Service (TIS), which has limitations in aged care. TIS interpreters are given no training on aged care, and are unfamiliar with the assessment process, including how to work with people with dementia and other aged-related conditions. Communicating over the phone for an older person from CALD background can be difficult, and is even harder if they need an interpreter. Some ethnic groups will not disclose private information over the phone even to a worker from their own culture. Since 1 July 2005 services can no longer apply for an exemption through TIS for free interpreter services.

Other aged care services have access to Health Care Interpreter Services either because they are under the auspices of an Area Health Service, or because they can access DADHC, or HACC interpreter funded services. The benefits of Health Care Interpreters are that they are trained in assessments and generally understand the HACC program and aged care issues such as dementia.

Despite the clear need for interpreters there is no system – internal or external, to ensure aged care services use them when they are needed, even where there are policy guidelines<sup>lviii</sup>. Yet some procedures cannot be done reliably or safely without an interpreter.

Service providers should also be aware that it may be important to book an interpreter who not only speaks the client's language, but who identifies with the same ethnic group. Refugees from countries with a history of internal conflict (e.g. countries of the former Yugoslavia) may be reluctant to interact with an interpreter from a different background.

Another way to improve communication is providing ethno-specific aged care services such as residential care or day care programs. Where this is not practical, employing bilingual/cultural staff can help greatly.

#### *English language skills*

Helping older refugees develop their English language skills is another way to ensure they know about services, and reduce social isolation. The Australian Government provides 510 hours of English tuition to humanitarian entrants. However, learning a language gets harder with age, and these hours of tuition are not increased for older refugees. Nor do Adult Migrant English Program (AMEP) providers always have classes for older refugees – instead they share classes with younger adults, even though their pace of learning may be slower.

While many older refugees find it hard to learn in the English programs provided during early settlement,<sup>lix</sup> many people wish to pick it up later, for example in ethno-specific groups.<sup>lx</sup> But Australian Government funding of English classes is only available for a couple of years after settlement in Australia. As most older refugees have been in Australia for many years, they are ineligible for government funded AMEP classes.

Information should not just target the frail aged. Providing information on aged care services before people become frail aged is important. As people become older they become more isolated making it harder to access information and services.

**Recommendations:**

- Australian and State Government funding bodies should require aged care and mental health services to develop and implement strategies to promote their services to refugee communities;
- DoHA and NSW Department of Ageing, Disability and Home Care (DADHC) should develop guidelines to help aged care services promote their services to refugee communities; DoHa and DADHC should be responsible for translating information into the languages of small and emerging communities;
- The Families First Initiative should pilot a project to provide support to grandparents who have a childcare role;
- DADHC should extend its HACC Interpreter Service funding coverage to the whole of NSW and provide ongoing training to ensure HACC interpreters clearly understand the Program;
- Commonwealth government funded services should include interpreter costs as a separate line item or have their care subsidy increased to support, rather than penalise, services who use interpreters with non- English speaking clients;
- DOHA and DADHC should develop and implement minimum standards in the use of professional interpreters for initial and follow up assessments;
- DOHA and DADHC should develop guidelines on appropriate use of family, friends, volunteers and bilingual workers in communicating with older people from CALD backgrounds, and explore ways to monitor the guidelines;
- DIMA should provide training on aged care to TIS interpreters
- DIMA should include aged care systems and referral pathways in its training for all settlement workers who help newly arrived refugees and humanitarian entrants with early settlement.
- TAFE Outreach should include the needs of older and frail aged refugees into their program planning, based on settlement statistics and consultation with local refugee communities. English classes should focus on health literacy, aged care services and retirement issues;
- The Community Partners Program should specifically target refugee communities, in recognition of their additional needs. Funding should be provided to promote information/community development to refugee communities before refugees become frail;



### 5.5.2 *Information needs of carers of older people from a refugee background*

If carers are to provide good support for increasingly frail parents or for spouses, they need to know what services are available.

Any strategies developed to do this should recognise that many carers access information in a different way to the client. Unless they are spouses, most carers will be younger family members – this means they are less likely to get information from word of mouth from other elderly people. If they are second generation they may not understand their parent's first language well so translated materials and ethnic radio may be less useful to them. Some will use Internet resources but still need to be linked to translated information to show their parents. An on-line database listing bi-lingual health professionals and pharmacists, in conjunction with the Divisions of General Practice could be useful to carers.

Developing projects that work with both older people and their carers is essential. One example is the Vietnamese Elderly Accommodation Project (Van Lang Housing Co-operative Ltd) in 1993 (see Box 1).

The NSW Transcultural Mental Health Centre runs a support program for NESB carers that may offer a best practice model. Targeting families caring for people with a mental health problem, this program provides, amongst other things, culturally and linguistically appropriate group education and professional support for NESB carers. It also encourages informal networking amongst carers for peer support and to reduce stigma and isolation.<sup>ixi</sup>

#### **Recommendations:**

- Peak bodies such as Carers NSW Inc should be supported by funding to take a leading role in promoting aged care and health services to carers of older refugees.
- The Department of Health and Ageing and the NSW Department of Ageing, Disability and Home Care should develop strategies to promote support services to carers of older refugees, including an on-line database listing bi-lingual health professionals and pharmacists, in conjunction with the Divisions of General Practice.

### 5.5.3 *Information needs of aged care and health care providers*

In order to meet their consumers' needs, services have to know what these needs are. The first step is to identify people from a refugee background who are using these services (see 5.6.1).

It is also important to identify what information service providers need. Many aged care agencies at the Older Refugees Forum recommended that the following information be given to service providers, and promoted through newsletters and forums:

- how the refugee experience might affect their client
- profiles of communities
- needs of different communities
- using the ethnic media to disseminate information.

Few resources on these issues are available for service providers. One exception is the NSW Refugee Health Service's *Fact sheet on Older Refugees* developed with the Older Refugee Working Group. It was circulated to aged care services via HACC and other aged care networks in 2004. There are also many multicultural resources that may be relevant to older refugees (such as the Ethnic Aged Care Services and Resource Directory), but do not specifically address their needs.

Protocols on conducting culturally appropriate and sensitive assessment should also be developed. They should focus on data collection, tools and use of interpreters. Some tools have already been developed. One example is the Sensitive Assessments for Ethnic Elderly (SAFE) Project for Aged Care Assessment Teams aimed at developing a culturally appropriate assessment framework for use by ACATs with people from CALD backgrounds. The framework incorporates:

- protocols for conducting culturally appropriate assessment,
- generic plain language resources in a range of community languages,
- models of best practice,
- ethno-specific contacts and resources.

Refugee issues are already included in the tool. This tool could improve assessments of older people from a CALD background but has not been implemented throughout the state because of lack of resources and policy commitment.

Other relevant tools include:

- The Rowland University Dementia Assessment Scale (RUDAS) – to help GPs to assess cognitive impairment in elderly people from CALD backgrounds.
- The Kessler Psychological Distress Scale (or K10), which measures anxiety and depressive symptoms, has been adapted into 10 community languages.

While these tools are available, they are often under-used by services when making an assessment.

#### **Recommendations:**

- Aged care services should work together to develop and implement strategies to promote their services to refugee communities;
- The Department of Health and Ageing and DADHC should provide funding for educational resources to improve the skills of aged care services to meet the needs of refugee clients. These would include website links, training modules, casework handbooks or specialised fact sheets on topics such as making assessments with older refugees and working in partnerships with refugee communities;
- The Department of Health should allocate funding to implement the Sensitive Assessments for Ethnic Elderly (SAFE) Project across NSW;
- Findings from the NSW Multicultural Health Communication Service's HACC project should be publicised and distributed widely. Effective information communication strategies identified by this project should be promoted as best practice models and resources allocated accordingly.

## 5.6 Service Provision

### 5.6.1 *Aged care and health services' identification of clients of a refugee background*

The Older Refugee Forum recommended that services have resources to help them identify if a client is from a refugee background. Very few services do this – of 130 HACC services surveyed by the Older Refugee Working Group, only 16.4 per cent said they recorded which clients were refugees,<sup>lxii</sup> while 75 per cent did not know how many of their clients were refugees.

- Refugee background is not included in the Client Information and Referral Record (CIARR), the assessment tool that all HACC funded services are mandated by DADHC to use for assessments and referrals.
- Refugee background is not included in the reporting data of the Commonwealth Carer Respite Centres nor required by CACP services, although some ethno-specific or multicultural services/workers will collect this voluntarily.
- Refugee background is not identified in standardised intake forms for health service recipients.
- Mental health service providers may not pick up an older person's refugee background – as a result, experiences of torture and trauma and other mental health problems may be overlooked in diagnosis and management.

This issue of identifying refugee background affects not only planning and policy but also the quality of care refugees receive.

If people with refugee experiences are not identified, there is a risk of inaccurate diagnosis. Where specialised gerontology services with linguistic and cultural support are not available, a person may be misdiagnosed, resist recommended treatment, or avoid necessary treatment altogether.<sup>lxiii</sup> One example is where workers who are unfamiliar with the needs of older refugees don't understand why a person with dementia becomes distressed when night staff do routine checks in a residential facility – they might not realise the client has confused night shift staff for prison guards (see reference: Joffe, Joffe & Brodaty, 1996).

Being able to identify whether a client has a refugee background requires skill. If services had to include refugee background as part of their data collection process, as they are with people of Aboriginal and Torres Strait Islander descent, they would need training in how to accurately collect data at both the point of service entry and the assessment stage.

Developing tools to help service providers determine if a client has a refugee background would be useful. However, any tool would have to consider that some people may not want to be identified as refugees to avoid being stereotyped, to avoid re-traumatisation, or for other reasons. As such, any identification tool must be developed with sensitivity. Including a question about prior or current refugee status on standardised forms is not necessarily the solution as form questions can be intrusive. Arguably, one factor in CACP's popularity with CALD populations is that using a broker/case manager to negotiate different services on behalf of the client avoids lengthy and repetitive questions at each referral step.

Consultations with refugee communities would be needed to decide the most appropriate way to implement models and programs. As a starting point, information sheets could let services know which communities have a high proportion of people from a refugee or refugee-like background. This should include information on what a refugee is.

**Recommendation:**

- The Department of Health and Ageing should provide funding to industry experts to develop a culturally appropriate identification tool for refugee clients and implement it across services with training, where required.

### 5.6.2 Bilingual and bicultural workers

Employing trained bilingual/bicultural workers can help service providers learn more about their clients, and can help train other staff in cross-cultural practice.

However there are many issues affecting the availability of trained bilingual and bicultural workers across mainstream, multicultural, and ethno-specific services including:

- recruitment
- training that targets bilingualism
- retention of workers
- professional development, e.g. help to improve language skills
- portability and sharing of workers across services.

In mental health, the shortage of bilingual/bi-cultural mental health workers means there are very few of these workers who have additional skills in aged care. One way of tackling this is for aged care providers and health services to work together with ethnic community organisations, and specialist services such as STARTTS, the Transcultural Mental Health Centre and the NSW Refugee Health Service during assessment and diagnosis to draw on their expertise with older refugees.

Relevant Government agencies should take leadership to address these issues systematically and effectively.

### 5.6.3 Access to aged care and health services

Ensuring equity of access to aged care services is a priority of aged care providers in NSW.<sup>lxiv</sup> While there is no Australian research available that compares access to aged care services of older refugees with either that of the broader CALD community or the mainstream population, preliminary research by the Older Refugees Working Group suggests that refugees are not accessing aged care services. This is consistent with other resettlement countries.<sup>lxv</sup>

In NSW, efforts to improve access of older CALD populations to aged care services include ethnic day care, ethno-specific residential facilities, the appointment of Multicultural Aged Workers (Health) and the Multicultural Access Project Workers for HACC services, among others. While many refugees have benefited from these strategies, their additional needs have not been widely recognised by mainstream services as reflected in the ORWG findings.

**Recommendations:**

- Following mapping of the profile of older refugees in NSW, DoHA, the NSW Department of Health and DADHC should fund research to examine elderly refugees' access to aged care and mental health services and provide strategies to improve access and outcomes;
- Joint Commonwealth and State/Territory policy and guidelines for mainstream service providers should be developed to facilitate the management of older refugees;
- Mainstream services should develop partnerships with specialist mental health services (e.g. STARTTS, Transcultural Mental Health Centre), the NSW Refugee Health Service and relevant community organisations to share information and expertise, and thereby improve the management of older refugees;
- DADHC should invest in workforce issues relating to care for CALD clients to encourage recruitment, training, retention and professional development of bilingual/bicultural workers, and the development of a model to pilot portability and sharing of workers across aged care services;
- DADHC should explore ways to encourage aged care providers to develop links to ethno-specific interagencies, and groups in their local areas, such as STARTTS, Transcultural Mental Health Centre and the NSW Refugee Health Service and those listed on the Ethnic Communities Council of NSW website.

### **Case Study 5: Safar Ali**

In August 1999 Safar Ali awoke near a roadside amongst a pile of 12 blood-soaked bodies. He had been unconscious for many hours and could hardly believe he was alive. With his muscles swollen and some of his joints dislocated, walking was impossible so Ali crawled to the road and waited for a passing vehicle to take him home.

Sixty-two year old Ali had been beaten by Taliban soldiers who caught him trying to escape across the Afghan border into Pakistan. As an ethnic Hazara and Shiite Muslim, Ali was regarded as insuperior by the Taliban who then controlled most of Afghanistan. He had suffered decades of war in his country but since the Taliban had emerged from Afghanistan's post-communist chaos in 1994, his life had become intolerable.

Ali spent three months in bed, recovering from his beating. He then pooled the savings from his transportation business - about \$8000 US - and recruited a 'people smuggler' to ensure his escape from Afghanistan.

Two weeks later Ali, along with 27 other Afghan Hazaras, was on a small rickety boat heading from Indonesia to Australia. Today he lives in the south western Sydney suburb of Auburn, as do many other Afghan refugees who arrived in Australia having had to rely on people smugglers.

Ali strongly believed the Australian government would help anyone who was genuinely escaping persecution in his or her homeland. "I didn't come only to save myself; my aim was to save my family as well," says Ali whose wife and children remain in Afghanistan.

Upon arriving in Darwin in November 1999, Ali and his companions were taken to a new detention centre located at Woomera in the South Australian desert. For the first few weeks, detainees endured the scorching desert heat without air-conditioning. To keep cool Ali wrapped himself in a wet sheet, which had to be dampened at half hourly intervals.

Ali had plenty of time to ruminate over the tragic events that forced him to flee Afghanistan. His mother and nephew had both been killed during outbreaks of fighting. In 1994, Ali and his family moved to the northern city of Mazar-i-Sharif, which was subject to several battles as the Taliban tried to take control. The Taliban were victorious and approximately 1000 citizens were killed, many of them ethnic Hazaras. Ali escaped death by hiring a taxi and escaping from Mazar-i-Sharif with his wife and children. "On the way I saw about 400 to 500 dead bodies lying on the ground," he says.

These memories churned in his head as he sat, day after day, sobbing by the wire fence at Woomera. After seven and a half months, the Department of Immigration and Multicultural Affairs were satisfied that Ali was a genuine refugee according to international legal guidelines for determining refugee status and Ali was released from the detention centre with a bus ticket to Brisbane.

But Ali has not been granted permanent residency in Australia and instead was given a three-year temporary protection visa (TPV). Recipients of TPVs like Ali, cannot access the full range of social security benefits and immigration services. They can work, but as they are unable to attend the free English lessons available to other refugees their prospects of finding work are diminished. The TPV holder has no family reunion rights so Ali will be unable to bring his family to join him in the next three years. If he decides to go overseas in this period he will be denied re-entry into Australia.

Ali left Brisbane for Sydney, hoping to find work. He realises that at 63 and without any English it will be difficult to find employment but he is prepared to do anything. He has dyed his white hair black and shaved off his beard to try and be more appealing to potential employers. So far, he remains unemployed.

Ali is trying hard to make the best of things in Sydney so that in 30 months he can apply for permanent refugee status. Maybe then, he will be able to reunite with his family: "I don't have any wish or any desire [for the future] except to bring my family to Australia. This is all that I want".

Extracted from Basili H (2001) Living in Limbo, Transitions, Issue 9, (Autumn) 2001 STARTTS

This case study highlights some of the issues faced by people who come to Australia as older refugees. These include the ongoing impact that experiences of war and organised violence can have on psychological health, and how it can be exacerbated by ongoing stresses after arrival. Unlike most of his Australian-born contemporaries who are approaching old age, Mr Ali is in no position to plan for retirement because of the insecurity of his visa status and his financial position. His age has made it more difficult to learn English and find employment to ensure his financial security.

## **6. Conclusion: Priority Issues for Action**

Essential to meeting the needs of older refugees is the recognition that settlement is a lifelong process in which issues may arise at different life stages. There must be a 'whole-of government' approach where policy and funding guidelines for services to older refugees are developed between all relevant departments.

Aged care service providers and Governments must also develop guidelines in partnership with communities as to the best strategies to promote their services to refugee communities and to work affectively. Other strategies should include; building capacity of the aged care workforce by including core cultural competency modules into existing health professional courses, will result in a more competent and capable workforce. Developing, implementing and monitoring minimum standards for using professional and paraprofessional interpreters will ensure quality interpreting within our aged care system, for older refugees.

Aged care providers and health services must also partner ethnic community organisations and with specialist services that are already working with older refugees, including NSW Refugee Health Service, STARTTS, Transcultural Mental Health Centre, and Multicultural Aged Workers. These partnerships should be driven by a whole of Government policy to guide the best possible process to achieve successful outcomes for older refugees.

Fundamentally, there is a need for policy makers to acknowledge older refugees as a special needs group and respond appropriately, through policy, research, service planning and delivery. In order for this to occur, in some areas, targeted ongoing funding will be essential.

Funding guidelines need to be revised taking into consideration some of the issues raised in this paper, in particular in regard to service delivery and flexibility to ensure that there are no added barriers to those already existing for older refugees accessing aged care services.



### **Box 1: The Vietnamese Elderly Accommodation Project (Van Lang Housing Co-operative Ltd)**

The Vietnamese Elderly Accommodation Project (Van Lang Housing Co-operative Ltd) was established in 1993 with funding from the Office of Community Housing under the NSW Department of Housing. The aim of Van Lang Housing Co-operative is to provide high quality accommodation that is affordable, secure, culture- specific and managed by the older Vietnamese tenants. Van Lang is the first example in Australia of an independent, self care and sustainable community for elderly Vietnamese people.

Key benefits include:

- Maintenance and promotion of a sense of independence and belonging
- Avoiding unnecessary admission to mainstream nursing homes that are often culturally inappropriate
- Offering a substitute for the loss of traditional extended family and welfare system
- Reducing the demand on health and community services
- Providing a model for effective co-operative management
- Increasing social capital.

Van Lang Housing Co-op is strongly linked to local Ethnic Health Services, through the local Vietnamese worker based at the Cabramatta Community Health Centre providing advocacy, information, education and counseling.

There is anecdotal evidence of a reduced need for referral to some health and community services due to mutual support and assistance offered within the Co-operative - cooking for members who are ill is one example.

A survey into resident feedback conducted for the Department of Urban Affairs by the Hostel and Care Program (1998) indicated overall, that the main reasons for tenant satisfaction were shared language and culture, excellent location, mutual support and the assistance of the local ethnic health worker. All tenants reported that living in the co-operative had 'surpassed their expectations'.

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## 9. Appendices

Appendix A: Older Refugee Working Group Survey Results

Appendix B: Older Refugee Working Group Survey

## Older Refugee Working Group

### The Quickest Survey of All Time

At the Older refugee Working Group meeting on the 28<sup>th</sup> of June 2004 it was agreed that a simple 1 page survey would be developed to identify if aged care service providers identify refugee clients as one of their target group, or have any policy, procedures or training to address their needs. The result would inform the Policy Discussion Paper.

The survey was developed and distributed to aged care services primarily through HACC development officers e-networks.

A total of 161 questionnaires were returned.  
130 questionnaires were from HACC funded services  
22 were from health services  
6 were from ethno-specific and multicultural services

#### Results:

#### Question 1. *Do you record which of your clients are refugees?*

##### **HACC**

**Yes** – 21 participants 16.4%  
**No** – 105 participants 80.6 %  
**Don't know** – 4 participants 3%

##### **Health**

**Yes** – 5 participants 23%  
**No** – 16 participants 72.7%  
**Don't know** – 1 participant 4.5%

##### **Ethno-specific/multicultural**

**Yes** – 3 participants 50%  
**No** – 3 participants 50%  
**Don't know** – nil

#### Comments

Just in their personal files not recorded in any stats.

We record country of origin & language spoken at home. These fields alert clinicians to potential for special needs and cue questions to further assess the need, and the need for interpreters assistance.

Record country of origin & language spoken on data but not refugee status.

We have a question about residency but don't actually ask if the client is a refugee.

Information not specifically sought but recorded if it comes up.

**Question 2. Do you have a refugee-relevant policy/procedure in place?**

**HACC**

**Yes** – 5 participants 3.8%

**No** – 116 participants 89.2%

**Don't know** - 9 participants 7%

**Health**

**Yes** – 3 participants 13.6%

**No** – 18 participants 81.8%

**Don't know** – 1 participants 4.5%

**Ethno-specific/multicultural**

**Yes** – 2 participants 33.3 %

**No** – 4 participants 66.7%

**Don't know** – nil

**Comments**

Have a genetic referral policy which includes refugees, plus does not discriminate against.

Have multicultural/ CALD support policies & procedures but not specific for refugees.

The Area Health Service Cultural Equity Unit has policy and procedures in the broad issues of addressing and assisting services in this area.

**Question 3. Has your staff attended any training in relation to refuge issues?**

**HACC**

**Yes**- 23 participants 18%

**No**- 103 participants 80%

**Don't know**- 3 participants 2%

**Health**

**Yes** – 6 participants 27.2%

**No** – 15 participants 68.2%

**Don't know** – 1 participants 4.5%

**Ethno-specific/multicultural**

**Yes** – 3 participants 50%

**No** – 3 participants 50%

**Don't know** – nil

**Comment**

Clearly training around refugees and their issues required.

**Question 4. Do you know how many of your clients are from a refugee background?**

**HACC**

**Yes** – 32 participants 25%

**No**- 97 participants 75%

**If yes provide an estimate** – 11 reported 0%  
2 reported 1%  
3 reported 2%  
1 3%  
1 10%  
1 18%  
1 40%

**Health**

**Yes** – 3 participants 13.6%

**No**- 19 participants 86.3%

**If yes provide an estimate** – 1 reported 1%  
1 reported 2%  
1 reported 5%

**Ethno-specific/multicultural**

**Yes** – 5 participants 83.3%

**No**- 1 participants 16.6%

**If yes provide an estimate** – 1 reported 10%  
2 reported 15%  
1 reported 70%  
1 reported 100%

**Comments**

Only because we were asked to provide transport specifically for Sudanese Refugee

**General comments**

I had a few people wanting to do volunteer work with refugees.

Staff work closely with settlement worker from Migrant Network Service for individual client support with refugee families.

Working for the Red Cross has highlighted awareness of refugee issues even though this has not translated to formal procedures.

We have never been in this situation. We would identify them if they demonstrated “special needs” as a result of their refugee status eg. Interpreter service, Trauma counselling etc. or specific cultural requirements.

Your survey has actually made me realise that maybe we do need to know more about refugees and the issues that they face. I’d be really interested to make contact with your Department to gain some information about receiving training.





## Older Refugee Working Group

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### The Quickest Survey of All Time

The Older Refugees Working Group<sup>lxv</sup> wants to know if your service works with refugee older people so we can identify service needs across NSW. Refugees are not recognised as a special needs group under aged care standards, so aged care services are not expected to have special strategies or policies in place. However, if you do, we would love to know about it.

1. If your client is from a refugee background, do you record this information?

Yes \_\_\_\_\_

No \_\_\_\_\_

Don't know \_\_\_\_\_

2. Do you have a refugee-relevant policy/procedure in place?

Yes \_\_\_\_\_

No \_\_\_\_\_

Don't know \_\_\_\_\_

3. Has your staff attended any training in relation to refugee issues?

Yes \_\_\_\_\_

No \_\_\_\_\_

Don't know \_\_\_\_\_

4. Do you know how many of you clients are from a refugee background?

Yes \_\_\_\_\_ If yes, please provide an estimate \_\_\_\_\_ %

No \_\_\_\_\_

Name: \_\_\_\_\_ Service: \_\_\_\_\_

Thank you for your time in completing this survey

Please fax your response to 8778 0790, e-mail to [Cathy.Preston-Thomas@swsahs.nsw.gov.au](mailto:Cathy.Preston-Thomas@swsahs.nsw.gov.au) or send to NSW Refugee Health Service, PO Box 144, Liverpool BC, NSW 1871.

<sup>lxv</sup> The Older Refugees Working Group aims to promote issues facing older refugees in NSW. It is made up of representatives from a range of organisations including NSW Refugee Health Service, STARTTS, Multicultural Health Services, other Government and non-government organisations. For more information on the Working Group or the needs of older refugees please contact the NSW Refugee Health Service or see [www.refugeehealth.org.au](http://www.refugeehealth.org.au).

# NOTES

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