Enhancing the Lives of Older Refugees

A Self Improvement Resource for Community Service Providers

Acknowledgements

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For more information or copies of the resource visit the South West Sydney's Ageing & Disability website at:

www.**supportservices.**org.au or email Yvonne Santalucia - Yvonne.Santalucia@sswahs.nsw.gov.au

or the NSW Refugee Service website at: www.refugeehealth.org.au

"We are all alike
on the inside"

Mark Twain

A foreword

I am extremely pleased and honoured to be writing the foreword to this important publication and resource.

In an environment in which the ageing of the post war baby boomers grabs the public attention and dominates the policy debates, it is hard to wrest enough air to suggest that this is not the whole story. In fact there are many ageing stories which need to exist within and effect the consideration of the ageing population in Australia. Not least of these are the stories of immigrants and refugees who have come to Australia and are now ageing in Australia.

Enhancing the Lives of Older Refugees is a welcome and necessary contribution to the way we perceive, understand and respond to the specific needs and effects that a refugee experience can have and its impact on the ageing process.

The resource is not presented as a didactic set of instructions but rather a set of considerations which are necessary to ensure that assessment processes and aged care providers have the competency to work with and deliver services to older refugees.

The resource is framed by a notional cultural competency in which service providers and program managers need to have the knowledge, skills and empathy to enhance their engagement with older refugees. Fundamentally it reinforces that knowledge of the refugee experience is necessary to provide a context for understanding but not to predict or assume a specific cultural response. In doing this it suggests that the real competency is in knowing which questions need to be asked and how to ask them.

The result should be the delivery of quality care which is effective in meeting the need of older refugees.

In this way an understanding of the indignity of the refugee experience should lead to aged care practice which delivers on the objective of ageing with dignity in Australia.

Pino Migliorino

Chair, Federation of Ethnic Communities' Councils of Australia
Chair, NSW Ministerial Advisory Committee on Ageing

A glossary of terms used in this resource

Asylum seeker	Someone who has arrived in Australia and applied for protection as a refugee, but is still waiting for a decision on their status. According to the UNHCR, an asylum seeker is 'an individual who is seeking international protection. Not every asylum seeker will ultimately be recognised as a refugee, but every refugee is initially an asylum seeker' (UNHCR 2006).
Community service providers	Government and non-government organisations providing care and support services to the community.
Community Relations Commission (CRC)	The leading government agency supporting multicultural communities in NSW. It builds strong relationships with ethnic community groups and provides advice to government on multicultural issues.
Cultural competence	Being able to interact well with people from different cultures. It has four components: • awareness of how your own culture affects your view of the world (i.e. the assumptions and biases you might have) • a positive attitude towards cultural differences • knowledge of different cultural practices and world views • cross-cultural communication skills. **Source:** *NSW Health*.
Diversity	The wide range of cultures, beliefs, values and ideas in a population.
Empathy	The ability to recognise and share how another person feels.
Humanitarian entrant	Someone who migrates to Australia under one of three migration programs: • the Refugee Program • the Special Humanitarian Program • the Special Assistance Category. For more information see www.**immi**.gov.au
Life expectancy	Life expectancy is an indication of how long a person is expected to live. The average life expectancy at birth of the world's people is 67.2 years (65.0 years for males and 69.5 years for females) according to United Nations World Population Prospects 2006. However, life expectancies can vary from country to country depending on a range of factors including access to health care.

Manager/ Coordinator	In this resource this means the manager or coordinator of community care workers.
Person centred care	A system of care based on the work of British psychologist Tom Kitwood, considered the' father' of person centred care for people with dementia. Kitwood's approach is based on the assumption that all human beings (particularly those who are older and living with dementia) have five important psychological needs: • comfort - the provision of warmth and strength • attachment - forming of specific bonds or attachments • inclusion - being part of a group • occupation - being involved in the process of life • identity - having a sense of who one is.
Refugee	A person who: • has a well founded fear of being persecuted because of their religion, nationality, membership of a particular social group or because of their political opinion • is outside their own country • is unable or unwilling to return to that country because of fear of persecution.
Refugee competency	A term developed for this resource. It means the skills and competencies needed to provide appropriate and accessible aged care for refugees or people who have had refugee-like experiences.
Refugee-like	A term to describe people who have settled in Australia through migration programmes and who come from areas of war and/or organised violence. They may not have come to Australia formally as refugees but would have had similar experiences.
Resettlement	This means the selection and transfer of refugees from a State which they have asked for protection to another State which has agreed to give them permanent residence. Providing refugees with residence status should ensure they have: • protection from being returned to a country where their life or freedom is threatened • access for them and their family and/or dependents to civil, political, economic, social and cultural rights like those of all other people in the State • the opportunity to eventually become a naturalised citizen of the resettlement country. UNHCR 2004, p1.

Resilience	The ability to cope with stress and adversity. Personal resilience is our ability to recover from setbacks and to embrace change.
Torture	Any act which intentionally inflicts severe pain or suffering, either physical or mental, on a person as a way of getting information or a confession from them or from a third person; punishing them for an act they have committed (or are suspected of committing); intimidating or coercing for any reason based on discrimination of any kind. **Source:** *UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984) Article 1.*[1]
Vicarious trauma	This is the trauma sometimes experienced by workers when they become aware of the suffering of other people. In other words, workers who empathise deeply with the suffering of others may feel traumatised themselves. Over time, vicarious trauma can lead to changes in psychological, physical and spiritual wellbeing.

Table of acronyms

CALD	Culturally and Linguistically Diverse
CCW	Community Care Worker
CSW	Community Support Worker
CRC	Community Relations Commission
UNHCR	The United Nations High Commission for Refugees
STARTTS	NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors
	Stop, think and reflect on these ‘practice points’

[1] Adapted from NSW Refugee Health Plan 2011- 2016.

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The background to this resource

Did you know?

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

How this resource can help you

This resource aims to raise awareness, provide guidance, information and resources for aged care workers when working with older people from a refugee or refugee-like background. This resource refers to these people as older refugees.

The goals of the resource are to:

- **build** the capacity of aged care services to recognise and respond to the care needs of older refugees
- **increase** the capacity of aged care services to provide care and support to older refugees
- **help** staff undertake assessments of older refugees and plan for their care in a way that is culturally competent
- **improve** communication and relationships between different services as well as between staff working in these services
- **inform** and assist the ongoing development of policies, practices and procedures related to caring for older refugees.

This resource promotes trust, access and equity and social justice. These values are very important for working with older refugees and are based on international, national and state service policies, plans and legislation. Some of these are explained below.

United Nations Convention relating to the Status of Refugees (1951) and the Protocol relating to the Status of Refugees (1967)

Key Issues: The UN Refugee Convention is a legally binding treaty which has been agreed to by a number of countries. All countries which agree to the treaty must provide protection for people who have had to flee their country because of persecution. Australia ratified (agreed to) the 1951 Convention in 1954 and the 1967 Protocol in 1973. Countries that are part of the convention agree to provide refugees with legal status and appropriate standards of treatment including access to services.

The United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984)

Key Issues: This requires states, which agree to the convention, to take effective measures to prevent torture within their borders. It forbids states to return people to their home country if there is reason to believe they will be tortured. Parties to the convention are also obliged to prevent other acts of cruel, inhumane or degrading treatment or punishment, and to investigate any allegation of such treatment within their jurisdiction (Article 16).

The UN Millennium Declaration (2000)

Key Issues: A meeting of all member states of the United Nations in 2000 that resulted in eight Millennium Development Goals to be met by 2015. Goals included tackling poverty, hunger, maternal and child mortality, disease, gender inequality, environmental degradation and developing a global partnership for development.

The People of Australia: Australia's Multicultural Policy (2011)

Key Issues: This is Australia's Multicultural Policy. It outlines a number of initiatives including access and equity policies to make sure that government programs and services respond to the needs of Australia's culturally and linguistically diverse communities. The policy opposes all forms of racism, discrimination, intolerance and prejudice and is committed to measures which counter racism and discrimination.

National Mental Health Plan 2009-2014

An agenda for government action in mental health for 2009-2014. It has five priority areas:

- social inclusion and recovery
- prevention and early intervention
- service access
- coordination and continuity of care
- quality improvement and innovation
- accountability - measuring and reporting progress.

Community Relations Commission and Principles of Multiculturalism Act (2000)

Key Issues: This Act establishes four principles of multiculturalism as state government policy. All state services are based on these principles which are:

- All individuals in NSW should have the greatest possible opportunity to contribute to and participate in all aspects of public life in which they may legally participate.
- All individuals and institutions should respect and make provision for the culture, language and religion of others within an Australian legal and institutional framework where English is the common language.
- All individuals should have the greatest possible opportunity to make use of and participate in relevant activities and programs administered by the Government of NSW.
- All institutions of NSW should recognise the linguistic and cultural assets in the population of NSW as a valuable resource and promote this resource to maximise the development of the State.

Multicultural Planning Framework - Community Relations Commission (2009)

Key Issues: This helps government agencies in NSW plan for and demonstrate their achievements relating to the principles of multiculturalism. It also makes agencies accountable because they have to report annually on their outcome performance in a Multicultural Planning Framework. (This framework replaces the previous Ethnic Affairs Priorities Statement). This annual report gives details of the progress agencies make in multicultural planning and evaluation, capacity building and resourcing, programs and services. This framework also applies to services for refugees.

NSW Multicultural Mental Health Plan 2008-2012

Key Issues: This is the state-wide policy and service delivery framework for improving the mental health of Culturally and Linguistically Diverse (CALD) communities. It identifies refugees and survivors of torture and trauma as a priority group, and supports the development of mental health services for refugees. Its five priorities are:

- Integrated polices that guide planning systems, renewing the focus on education, prevention and early intervention.
- Delivering culturally inclusive and responsive mental health services.
- Enhancing cultural competency in mental health service delivery.
- Promoting culturally inclusive research, evaluation and innovation.

NSW Refugee Health Plan 2011 – 2016

Key Issues: The NSW Refugee Health Plan (2011-2016) is the state-wide plan for improving the health and wellbeing of refugees and people with refugee-like experiences in NSW. It aims to ensure that refugees receive safe, high quality services through both refugee-specific health services and accessible, culturally and linguistically competent mainstream health services. The plan includes a range of strategies to improve refugee and asylum seeker health and wellbeing.

Specialist Mental Health Services for Older People (SMHSOP) - NSW Service Plan - 2005-2015

Key Issues: This plan guides the development of Specialist Mental Health Services for Older People (SMHSOP) in Health Services across NSW. It outlines the key mental health issues for older people, the broader service system of which SMHSOP are a part, and strategic priorities in older people's mental health.

How to use the resource

This resource aims to give Managers and Coordinators (M/C) the knowledge and resources to help Community Care Workers (CCW) provide a more informed level of care for older refugees.

To develop this resource, the authors consulted service providers and carers in South West Sydney who identified the issues that can impair older refugees' quality of life. Understanding these issues better can help staff to work more effectively and sensitively with older refugees. These issues include:

1. The older refugee's individual life experience.
2. The impact of loss and grief on older refugees.
3. The older refugee's ageing process.
4. The wider impact of the refugee experience on older age.

The following pages provide information on each of these four key areas, along with strategies and resources to improve workers' knowledge, skills and competencies. Although the resource is mainly for the community sector, it will also be useful for other organisations (government, non-government, voluntary, or charitable) who work with older refugees. It can enhance the personal development of staff in these organisations and contribute to improving older refugees' quality of life.

Additionally, practice points are provided throughout the resource, as an opportunity to stop and to think and to reflect further.

Each key area includes:

- Information to help community M/C put knowledge into practice in their own organisation. This includes suggested care (skill) goals for CCW, and strategies that managers and coordinators can use to help staff meet these goals. Resources to help with this are in the resource section on page 63.
- A checklist of skills for the key area. These can form the basis of a self-improvement tool for your team.

Key Areas

KEY AREA 1

Understanding the individual life experiences of the older refugee

I want to be able to:

1. Identify and sensitively assess the needs of older refugees.
2. Apply person centred care.

KEY AREA 2

Understanding loss and grief of older refugee

I want to be able to:

1. Understand and work more effectively with older refugee issues of grief and loss.
2. Identify and respond to abuse of older refugees.

KEY AREA 3

Understanding the ageing process

I want to be able to:

1. Understand the normal ageing process.
2. Understand possible changes in ageing including dementia, depression and delirium that may be influenced by the older refugee's experiences and culture.

KEY AREA 4

Understanding the impact of the refugee experience on older age

I want to be able to:

1. Understand the impact of post traumatic stress disorder on ageing.
2. Work more effectively with older refugees whose behaviour is changing.

KEY AREA 1

Understanding the individual life experiences of the older refugee

Did you know?

People from East Timor who lived there after 1975 would have lived in a climate of oppression and harassment. Some may have been tortured and frequently beaten. Anyone living in Cambodia in the years 1975-1979 is a survivor of extreme trauma. People who fled Vietnam on boats were commonly subject to raids by pirates who raped women and killed family members.

KEY AREA 1

Understanding the individual life experiences of the older refugee

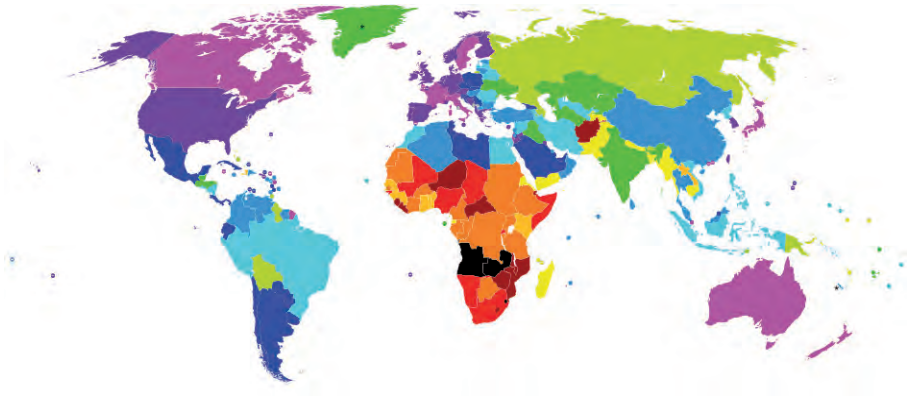
CARE GOALS FOR STAFF

I want to be able to:

1. Identify and sensitively assess the needs of older refugees.
2. Apply person centred care.

An introduction

Life expectancy at birth varies a lot from country to country. The following illustration shows life expectancy differences across the globe.



CIA World Factbook 2008 Life Expectancy Estimates at Birth (years)

over 80	70-72.5	55-60	under 40
77.5-80	67.5-70	50-55	not available
75-77.5	65-67.5	45-50	*/* Dependent territory
72.5-75	60-65	40-45	

Ageing in Australia is seen as a process that begins at 65 years of age. Entry to the aged care residential system is generally for those aged 70 plus.

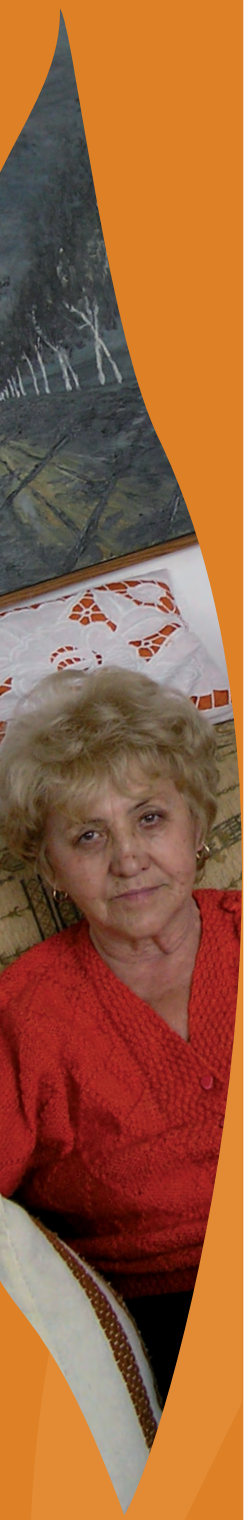
The definition of 'ageing' is complicated when applied to refugees who may come from countries with shorter life expectancies, or be uncertain of their real age. Some refugees may have chosen (or been forced) to hide and/or deny their age as part of their displacement history and resettlement process. Some older refugees may need services at younger ages than those of other elderly people.

Who are older refugees?

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

People who are already elderly when they arrive in Australia are a smaller group, but they have high needs for settlement and recovery. (NSW Refugee Health Service.)

The table below gives a time line of refugee arrivals in Australia, along with a snapshot of refugee policy in Australia at the time.



OVERVIEW/TIMELINE OF REFUGEES SETTLEMENT IN AUSTRALIA 1947 - 2011[2]	
Countries of Origin Language & Cultural	Political context in Australia at the time
1947-1950 The first group of refugees arriving in 1947 were 843 Estonians, Latvians and Lithuanians, selected by Australian immigration officials in European displaced person's camps. Later arrivals from Europe were from Poland, Ukraine, and Germany and from the Balkan states (mainly Croatia). Asian arrivals were from India and Sri Lanka.	Assimilation policies 1947; new arrivals were expected to learn English and adopt the Australian culture and way of life as quickly as possible. Australia agreed to settle 12, 000 displaced persons per year with provision to increase this number.
1950-1960 30,000 arrivals from Yugoslavia, Poland, Hungary, USSR, Romania, Czechoslovakia and Bulgaria. Some Assyrian arrivals (Assyrians are a Christian minority from what is now Iraq, southern Turkey, Iran and Syria).	**1952:** The displaced persons' scheme ended. **1956:** Operation Reunion introduced. The Menzies Government decided that Australia would take up to 3000 refugees from Hungary who had fled after the anti-communist uprising of 1956 was supressed. This number was later increased.
1960-1970 Large intakes from Soviet-bloc countries such as Hungary, Latvia, the USSR, Ukraine and the then Czechoslovakia.	Integration policies in the period from **mid-1960s to mid-1970s**. Introduction of Special Passage Assistance Program. In **1967** Australia became a signatory to the Refugee Protocol which enshrines the rights of refugees to protection from persecution.
1980-1990 Germany, Poland, Vietnam, South America (Guatemala, El Salvador, Nicaragua), Afghanistan, Cambodia, Iraq, Lebanon, Sri Lanka.	Policies focused on increasing the intake of skilled migrants to build the economy. Australia opened business to international competition. **1981:** Australia's Special Humanitarian Program was launched. **1985:** Recognition of the positive effects of economic migration, and strong commitment to assisting refugees. **1988:** NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) established.

OVERVIEW/TIMELINE OF REFUGEES SETTLEMENT IN AUSTRALIA 1947-2011[2]	
Countries of Origin Language & Cultural	Political context in Australia at the time
1990-2000 Balkan states (Bosnia, Serbia, Croatia, Kosovo), China, Iraq, Afghanistan, Somalia, Ethiopia.	**Early 1990s:** The onset of recession and a reduction in migration targets. National Integrated Settlement Strategy. **1996:** The Humanitarian Program set at 12,000 places. **1999:** NSW Refugee Health Service established. **1999:** Operation Safe Haven – temporary asylum provided for displaced Kosovar from camps in the former Yugoslavia. These refugees were later repatriated.
2000-2008 Refugees from Sudan, Iraq (from the Mandean community), Afghanistan, Burma (Myanmar), Iran, Democratic Republic of Congo, Liberia, Sierra Leone, Burundi, Ethiopia, Sri Lanka.	Safe Haven provided to East Timorese refugees who were later repatriated. Immigration policy mainly focussed on the issue of unauthorised boat arrivals. Temporary Visas for 3 years issued to onshore arrivals found to be refugees. People with these visas were not eligible for family reunion or access to Commonwealth funded services in that period. Negative debate over multiculturalism particularly in regards to Muslim Australians.
2009-2011 One third of the refugee and humanitarian program is made up of people from Africa, Asia and Middle East. Source countries include Sudan, Iraq (including people from the Mandean community), Afghanistan, Burma (Myanmar), Iran, Democratic Republic of Congo, Liberia, Sierra Leone, Burundi, Ethiopia, Sri Lanka.	The Australian government recognises the magnitude of global trend of refugee and asylum seeking. Despite this recognition, there is confusion and misinformation about the terms asylum seekers, refugees, 'queue jumpers' and 'boat people' which are often used interchangeably and incorrectly.[3]

Australia accepts 13,750 people each year through its Humanitarian Program. This includes:

- refugees who arrived in Australia as asylum seekers and are found to be in need of protection by the Australian government
- refugees who have been selected from overseas. These include people who meet the definition of a refugee, and humanitarian entrants escaping gross human rights violations who have been sponsored by someone in Australia.

Another group are people referred to as coming from 'refugee-like backgrounds' who may not have come to Australia formally as refugees but may have had similar experiences.

[2] Refs: Department of Immigration and Multicultural Affairs (DIMA), Statistics Section, Immigration: Federation to Century's End, 1901-2000, DIMA, Canberra, 2001.

Immigration to Australia During the 20th Century- Historical Impact on Immigration Intake, Population Size and Population Composition – A Timeline.

Department of Immigration and Multicultural Affairs (DIMA), Report on the Review of Settlement Services for Migration and Humanitarian Entrants, 2003.

[3] Background Note, Parliamentary Library, Parliament of Australia: Department of Parliamentary Services Background Note 10 May 2010, 2009-10.

The experiences of older refugees

Older refugees (or those from refugee-like backgrounds) may have experienced traumatic events like bombing, severe harassment by authorities, torture, disappearance of friends and family, rape, and witnessing their loved ones suffer atrocities.

This kind of trauma affects the whole society, not only those being tortured, so that everyone lives in fear. Torture is a tool of social control used by regimes that rule individuals and societies by fear.[4]

However, it may be difficult for professional carers to recognise that a client is a refugee with extra needs if the client hides their past.

Some older people may deny their refugee experience because they don't want to be stereotyped as poor and uneducated or 'victims'. Another reason for hiding their past may be fear of retaliation and retribution. For many refugees their past experiences make it difficult to trust people who work for government departments or in health care – or even their own relatives.

Did you know?

In 1945, the Department of Immigration was established, headed by Arthur Calwell. It resolved that Australia should have an annual population growth of two per cent, of which only half could come from natural increase. 70,000 immigrants a year were needed to make up the difference.

However, although the government wanted the majority to be Anglo Celtic – and Arthur Calwell declared, "It is my hope that for every foreign migrant there will be 10 people from the United Kingdom". In fact the British Government was both unable and unwilling to meet such a high target. At the same time, some 11 million people had survived the Nazi labour and concentration camps and many, particularly Poles, Yugoslavs, Latvians, Ukrainians and Hungarians, were unable or unwilling to return home. Visiting Europe in 1947, Calwell therefore agreed to accept a minimum of 12,000 of these refugees a year.

On 28 November 1947, the first Displaced Persons – 844 young Estonians, Latvians and Lithuanians – arrived on the General Heintzelman in Melbourne and were transferred to Bonegilla migration hostel. In exchange for free passage and assistance on their arrival, they agreed to work for the government for two years. During the seven years this scheme operated, nearly 171,000 arrived.[5]

Many refugees live alone and become increasingly isolated because of their experiences and history.

The strain of coping in a community that they may not feel a part of can lead to many frustrations. Many have a strong desire to go back to their home country because of these issues - despite their relief from having fled persecution.

[4] STARTTS, 2010.

[5] www.migrationheritage.nsw.gov.au/belongings/about-belongings/australias-migration-history/

A personal story[6]

In August 1999 Safar Ali woke up near a roadside amongst a pile of 12 blood-soaked bodies. He had been unconscious for 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 inferior by the Taliban who then controlled most of Afghanistan

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.

On arriving in Darwin Ali and his companions were taken to a detention centre at Woomera in the South Australian desert. For the first few weeks, detainees endured 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 on 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, where there were several battles as the Taliban tried to take control. 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 (as it was known then) were satisfied that Ali was a genuine refugee, according to international legal guidelines for determining refugee status. Ali was released from the detention centre.

Ali hopes 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, he can reunite with his family.

To empathise with a person you need to have at least a broad understanding of their past, the era they were raised in and the cultural influences that help shape them. Keep in mind that some older refugees may not feel confident about sharing their story or may have chosen to suppress it.

Workers need to be willing to spend time getting to know their client and their background – this is the key to understanding how their past may affect the person they are now.

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

How do I know if I'm working with an older refugee?

Many people may not identify themselves as older refugees, while others may volunteer this information. Sometimes the information may come from another service provider or from a family member.

Sensitive questions may help the CCW to recognise that someone has a refugee background. Just knowing where a person comes from and how they came to Australia can sometimes suggest that an older person was a refugee. The timeline on page 16 may also help with this.

Other options for staff to establish if a client is an older refugee may include staff casually asking questions such as:

- How long have you been in Australia? Or when did you leave your country?
- Did you choose to leave or were you forced to?
- What was your journey to Australia like?
- What countries have you lived in?
- Did you spend any time in a refugee camp?

You could also ask a more open ended question such as:

"Some terrible things have happened to people who have been forced to leave their country. You do not have to tell me the details about what you have been through but can you just tell me if you have had any bad past experiences that you may be thinking about and may be affecting you now?"[7]

Did you know?

Some refugees may be particularly suspicious of people in positions of authority, as a result of their experiences in their home country. In addition, language barriers may exist. Even when language is not a barrier because an interpreter is available or the service provider and refugee speak the same language, communication may still be affected by complex religious and ethnic interconnections. As a result, talking about trauma with the help of an interpreter doesn't necessarily make for culturally relevant care.[8]

Person centred care for older refugees

What is person centred care?

Person centred care is based on the principle that all human beings are valuable and worthy of respect. It puts the client at the centre of care and aims to enhance their quality of life as much as possible, regardless of any cognitive impairment or physical disability. Using person centred care principles with older refugees will greatly improve their care.

[7] Rebuilding Shattered Lives pge 21, Foundation House.

[8] Elisa Bolton www.ptsd.va.gov/professional/pages/ptsd-refugees.asp

Developing person centred care for older refugees

To help achieve the best possible quality of life for older refugees it's important to:

- understand each person's unique needs so that these needs can be the focus of care
- understand the strengths of the individual person. Many older refugees have great resilience and wisdom because of their past experiences. These strengths may need to be reaffirmed and valued
- develop relationships with genuine partnership that are based on mutual trust and respect. Establishing trust is particularly important with older refugees who may have difficulty trusting others, especially those representing government or other organisations
- have a clear understanding of the client's current family relationships and the quality of those relationships. This is essential for determining the holistic needs of the older refugee
- get to know each person's individual story. It's by sharing and understanding our stories that we connect through our similarities and our differences. We connect more meaningfully with others when we are able to empathise with them
- be aware that for some older refugees retelling their story may mean that they will be reliving very painful memories. This can be detrimental to them. Consider giving older refugees opportunities to retell some of their story in a supportive environment. This may involve referring them to a STARTTS program or to counselling or helping them access group activities with older people who may have had similar experiences.

Why staff members need to de-brief

Hearing people's stories can affect the staff caring for them.

Some staff may share the same background as the people they care for and may be affected by hearing some of the experiences.
It's important to monitor this and get help for staff if you suspect this is happening.

Staff should have opportunities to debrief regularly and talk to people in positions of trust.

Aged Care Workers may talk to their M/C whereas M/Cs may choose to talk to specialised services about any concerns they may have.

Did you know?

Between 1924 and 1939 many Estonian families fled their homeland to avoid conscription by invading German or Russian armies. Australia offered the promise of cheap land, prosperity and a safe life. The Commonwealth Government offered Estonian migrants plots of Crown land at Thirlmere and Wollondilly, 15kms south-west of Camden near Sydney.

After the defeat of fascism in Europe in 1945, millions of people were left homeless from the carnage and chaos of the Second World War. Britain, the United States, France and Russia set up displaced person camps to house the millions of refugees. Many of these were in Germany to house the millions made homeless by years of bitter fighting and bombing of cities and towns.

People from the countries of Eastern Europe were expected to return to their homelands. The Soviet Union claimed Eastern Europe as war booty and introduced a rule of Orwellian tyranny. This included Estonia. The Soviets installed a conceptual 'iron curtain', closing the borders of Eastern European countries. Behind this iron curtain Soviet leader Joseph Stalin reigned over a regime of terror. Stalin's secret police known as KGB (Committee for State Security) ordered regular purges to wipe out dissent and install fear in the population. Many people 'disappeared' or sent to work in concentration camps at Siberia in the remote wastelands of the vast Soviet empire.

Between 1945 and 1955 some Estonians caught up in displaced persons camps decided not to return and sought freedom in the west. They lived in terror of being sent back to their homelands and the hands of the KGB. Many chose to migrate to Australia to start new lives, traumatised by the loss of family members and friends in the KGB purges, and because they could never return home. Some Estonian families made their way to Thirlmere to join family and friends who had set up farms in the first wave of migration before the war. They brought skills and knowledge to further assist the development of the poultry industry and start other businesses at Thirlmere and the surrounding districts.[9]

[9] www.migrationheritage.nsw.gov.au/exhibitions/fromestonia/

SOME REFLECTIVE QUESTIONS
for Managers/Coordinators

What skills would be useful for CCW to develop in this key area?

- To be able to identify older refugees.
- To sensitively assess the needs of older refugees.
- To provide person centred practice.
- To recognise the impact of war, displacement and torture and trauma.
- To have more cultural awareness and a better knowledge of historical events related to refugees.

What strategies could I (we) use?

- Sensitively collect information about the person at times of referral and assessment.
- Regular meetings (or other communication options) to provide opportunities for discussion about clients or sharing concerns.
- Promote reflective practice – team discussion and reflection around older refugee issues.
- Set up an older refugee resource group within the team.
- Develop a journal club for all staff.
- Source culturally appropriate, refugee sensitive resource information and develop a library of resources for staff.
- Source information about specific cultures, avoiding stereotypes and use as a focus of team discussion.
- Enhance team communication techniques – particularly around developing a client's 'story'.
- Consider getting staff to do some training exercises from the resource *Working with HACC clients* from refugee-like backgrounds Resource Kit (Further information in the resource page 63).
- Consider specific refugee training from the NSW Refugee Health Service or STARTTS.
- Look at the information on person centred care and start putting it into practice.

SKILLS CHECKLIST

This is a checklist of skills for **Key Area 1** to help develop competencies for M/Cs and CCWs. Some of these skills relate more to the role of M/Cs and others to CCWs. You may like to use this list as a self improvement tool for your team.

SKILLS TO ACHIEVE - *Have I:*	HOW WOULD I (WE) DEMONSTRATE THIS?	WHO?	
		M/C	CCW
Identified that my client is an older refugee or of refugee-like background?	From referral/assessment. Identified that with my team. Documented status or documented 'assumed' status in file.		
Made a detailed assessment of my client's issues?	Holistically document client's issues.		
Looked for culturally appropriate resources?	Used (or referred to) the most culturally appropriate services for the client.		
Looked for refugee specific resources?	Used (or referred to) the most appropriate refugee services for the client.		
Explored strategies with other team members?	Take part in regular team discussion around issues to do with older refugees.		
Increased my awareness about issues of war, displacement, torture and trauma?	Increased understanding of how these issues are affecting my client's behaviour. I have shared this new knowledge with my colleagues.		
Attempted to explore "the story" of my client?	Without breaching confidentiality, I am able to tell others in my team about my client and something about their life before coming to Australia.		
Worked to understand the social and family network that my client is part of?	I am able to document the support networks that my client has.		
Learned more about my client's birthplace and culture?	I can share with my colleagues some knowledge of my client's birthplace and the history of war and displacement that has occurred there.		
Explored strategies with other team members that can help us be more people-centred in all that we do?	Each team meeting has an agenda item focusing on how to improve our person centred practices.		

KEY AREA 2

Understanding loss and grief of the older refugee

“Loss and grief
can lead to many
emotions including

**anger, sadness,
shock, disbelief,
denial, and anxiety.”**

KEY AREA 2

Understanding loss and grief of the older refugee

CARE GOALS FOR STAFF

I want to be able to:

1. **Understand and work more effectively with the older refugee issues of grief and loss.**
2. **Identify and respond to the abuse of older refugees.**

Introduction

For older refugees there can be many layers of loss and grief including:

- profound losses caused by migrating from one country to another
- losses that can come with ageing
- changing social roles and increasing physical limitations or disabilities.

Loss and grief can lead to many emotions including anger, sadness, shock, disbelief, denial, and anxiety. It takes time to adjust and process loss and grief. There is no time limit on grieving, nor are there right or wrong ways to grieve. Grief is not depression but sometimes, particularly in complicated grief, depression may become a feature of grief. Loss will be different for every person. Culture can also influence the grieving process.

There are different stages of loss:

- Survival
- Denial
- Bargaining
- Anger
- Grief and acceptance

Different people may experience shorter or longer periods in some of these stages.

Loss and grief may cause great turmoil in every aspect of life and involve a range of physical, behavioural, emotional, and spiritual responses. These can all be normal responses. However some of these responses can have other causes, including serious health problems which shouldn't be overlooked.

What are the physical symptoms of grief?

- feeling discomfort in the stomach or a 'knot' in the stomach
- changes in appetite
- tightness or lump in the throat
- frequent sighing
- shortness of breath
- tightness in chest
- fatigue and lack of energy
- muscle weakness
- dry mouth
- nausea, diarrhoea, indigestion
- feeling 'hollow' or 'emptied out'
- feeling weak or faint
- headaches
- oversensitivity to noise

How can grief affect people's behaviour?

- feeling 'numb' and unable to do things
- inability to sit still or concentrate
- sleeplessness or oversleeping
- forgetfulness
- lack of motivation or energy
- crying, sobbing (often at unexpected times)
- social withdrawal

What are the emotional symptoms of grief?

- shock, numbness, disbelief
- anxiety, panic
- anger
- guilt
- intense sadness
- depression
- helplessness, powerlessness
- fear of 'going crazy' or fear of the future
- envy of others who have not experienced a loss
- loneliness
- denial
- disorganisation
- confusion
- thinking about or retelling the events surrounding the loss over and over
- yearning and longing for 'what was'

What spiritual affects can grief have?

- anger directed toward God, clergy, or religion in general
- turning to spiritual beliefs or scripture for consolation'
- examining the meaning of life
- seeking meaning in the loss itself
- strengthening of beliefs
- wavering of faith
- searching for evidence of afterlife
- change in priorities (e.g. increased or decreased tolerance for minor irritations in life)

Grief can be unpredictable

Grief is rarely predictable. Often when people think they have dealt with much of their grief, a smell, touch, sound or image may be a powerful reminder. In people with complicated grief the symptoms are intense. They may last a long time, even interrupting daily activities. People with complicated grief are stuck in a state of chronic grieving.

Did you know?

Death rituals are used to send the soul of the deceased into a new life, or to help comfort grieving family members. For instance, those of the Jewish faith practice a "sitting shiva," in which mourning takes place for seven days following the death. A candle remains burning to remind family members of the deceased, and no food is cooked. The sitting shiva ritual gives family members a feeling of closure, a week to think and mourn, and then an official end to mourning.

How survivor guilt can affect older refugees

Many older refugees have suffered survivor guilt which compounds any other problems they may have. Examples of survivor guilt can include:

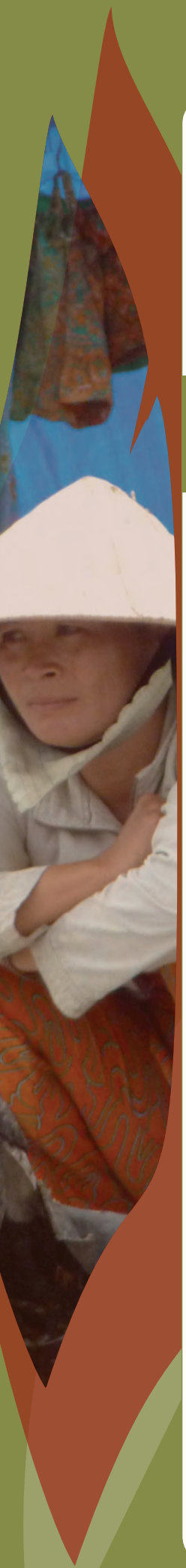
- beliefs such as feeling they must grieve for a long time to show their respect to the person they have lost. This may prevent them from seeking, or accepting services, even if they know they are available to them
- consciously or unconsciously depriving themselves of things, or feeling they have no right to ask for help
- a deep sense of obligation and commitment to look after their children and grandchildren, and sometimes their children's homes. This can be detrimental to their own health and social life.

Cultural differences and grief

Each culture has its own way of dealing with grief after the death of a loved one. While some cultures concentrate on celebrating a life that was, others mourn the loss of life. Culture affects the way people grieve as well as how long they grieve for publicly. Some cultures can be very vocal in their grief with crying and wailing, while others have quieter way of grieving or may even disapprove of very open expressions of grief.

Did you know?

In Mexican-American cultures, individuals celebrate the Day of the Dead, known in Spanish as Dia de los Muertos. It occurs on All Saints Day (November 1) and All Soul's Day (November 2). According to popular belief, the deceased have divine permission to visit friends and relatives on earth, and to share the pleasures of the living. Portrayed with affection and humour by artists, bakers and craft workers, these cemetery and community celebrations show a different attitude toward the loss of a loved one.



In some cultures there may be a sense of humility that makes it harder for people to get help to deal with grief. A Vietnamese worker explained that Vietnamese refugees 'do not feel entitled to anything. They are so grateful, they are so humble but they feel they do not deserve any help'.

Did you know?

There is a Vietnamese saying "Quân tử hận tam niên, tiểu nhân hận nhãn tiền" which suggests that cultured people can bury their feelings for three years whereas unrefined people express them immediately. In other words, there is a sense that a person's social class affects their ability to maintain control even when they are angry. Anger in social relationships is forcibly discouraged with such discourse as 'gian mât khôn' – to get angry is to lose reason and 'Môt sự nhịn chín sự lành' – ignoring one bad thing done to you yields nine good things for you.[10]

The losses experienced by refugees are different to those of migrants

Although immigration can cause a sense of loss, it's different to that felt by those forced to flee their homeland. Choice and self determination (or lack of it) affects how people experience loss and grief. This is where there are big differences between the experiences of migrants and refugees. Migrants choose to leave their homeland and have time and energy to plan for their departure. They are in control of their lives and can return to their home country if they wish. But a refugee has no choice about leaving home. They often leave without any preparation and are cut off abruptly from the support of family and friends.

Letting people tell their stories

Story telling has great potential for helping older refugees deal with grief, and sometimes resolving it, according to the workers and carers consulted for this resource.

Story telling can be therapeutic. Writing their story – or having someone write it for them – may raise a person's self-esteem. The writing process, along with talking about their experiences to people they trust, may help by providing closure as well as a recognition of what they went though. Older refugees may benefit from having their experiences validated but they need a place where they feel safe for this to happen.

The workers and carers who helped inform this resource suggested that the benefits of story telling could include letting other generations hear the stories of the past, and that sharing past experiences with others could help build strength and camaraderie.

[10] The Vietnamese community in Sydney, STARTTS.

Developing good listening skills

Good listening skills are extremely important. They need to incorporate empathic listening which encourages people to talk. Developing these skills should be part of ongoing skill development in teams working with older refugees.

Use of support groups

Support groups are a way to help older refugees socialise and are another opportunity to put them in touch with others who've had similar experiences and can empathise with them. Workers consulted for this resource spoke of refugees who had been able to build up trust in a support group setting even after long periods of isolation and introspection.

Helping older refugees to network

Networking may provide opportunities for older refugees to communicate meaningfully with others. Along with face to face support groups, other ways to do this include telephone support groups or by using church and places of worship networks more effectively.

Use of radio

Radio is an effective way of accessing people from different cultures, especially older refugees. Consultation participants gave examples of how SBS[11] helped them get information to specific ethnic groups. They suggested that this strategy was under-used and that radio offered many opportunities to reach older refugees.

Religion and places of worship

Religion and places of worship may be an important part of older refugees' life. However care workers shouldn't assume that places of worship, even within the same religion, will necessarily give comfort and understanding. People consulted for this resource gave examples of how places of worship could remind some older refugees of their loss of relationships and increase their grief.

Educating refugees about loss and grief

Educating refugees about the stages of loss and helping them access therapy by trained professionals to deal with any dysfunctional beliefs may help the process of recovery.[12] If therapy is needed, it may be necessary to get advice from refugee services such as STARTTS.

[11] www.sbs.com.au/radio

[12] STARTTS, 2011.

Strategies for helping older refugees deal with loss and grief

Strategies for working with older refugees need to consider cultural sensitivities. Grief can be very isolating, but although some people will benefit from sharing with others who have had similar experiences, this must be optional and cannot be imposed upon older refugees. However, it's important to provide opportunities for older refugees to share their grief with others if they wish to do so.

Abuse of older refugees

Being dependent on younger family members for social relationships and networking can make older refugees vulnerable. It can sometimes compromise and significantly change long held power relationships.

Examples of abuse of older refugees raised during consultation included:

- carers taking control of financial matters
- manipulation
- carers physically overpowering the older person
- domestic violence.

Another issue raised in consultations for this resource was that of young families 'using' older people as carers for their children and for other domestic duties.

These problems for older refugees were compounded by not understanding their rights or how they could get help. It was also suggested that some carers were receiving carers' pensions but not doing a good job of caring.

The limited research into the abuse of older people in CALD communities suggests the following may increase the risk.[14]

Communication problems:

Difficulty speaking English and/or having difficulty reading in their own language.

Cultural issues:

Different definitions or understanding of what is abuse; beliefs about family/domestic issues being kept within the family.

Gender:

Traditional gender roles in some cultures may mean women have less power; abuse of older women is often related to historic patterns of abuse of women in general.

Being very dependent on family and friends:

Needing help to manage financially or manage a pension; being totally dependent on the family for support.

Neglect or abuse of older people should never be ignored

Although these issues exist in aged care generally, older refugees may be more vulnerable. One way to tackle this is ensuring that staff can identify abuse and understand their obligations to seek guidance and report the abuse. Neglect or abuse of older people should never be ignored.[13] Your organisation will also have policies and protocols on this issue available for you to refer to.

[13] The Interagency protocol for responding to abuse of older people (2007) can be found at www.adhc.nsw.gov.au

Cultural differences between generations:

Lack of respect; children, especially daughters, having too little time because of family and work commitments.

Length of residency in Australia:

This can affect a person's understanding of systems and services to provide help.

Social isolation:

Being unable to drive or use public transport.

Lack of information:

There are few education programs targeting CALD communities on abuse of older people.

Carers' stress:

Can occur when care is the responsibility of one person. The carer is unaware of services and support, or there may be issues of guilt that prevent carers getting outside help and education to help them in their caring role.

Lack of awareness about their rights and the availability of services and under reporting of abuse:

There may be beliefs about protecting family honour resulting in low use of services.

[14] Research on Abuse of Older People from a Non-English Speaking Background, NSW Advisory Committee on Abuse of Older People, 1998.

Non-English Speaking Background Women and Abuse Project, Immigrant Women's Speakout Association of NSW Inc., 1999.

The community hides such problems, A Model for Dealing with Abuse of Older People in an Ethnic Community, University of Western Sydney, 2003.

SOME REFLECTIVE QUESTIONS
for Managers/Coordinators

What skills would be useful for CCW to develop in this key area?

- To understand the impact of grief on the life of the older refugee.
- To accurately empathise with their clients.
- To increase communication (including listening skills) with clients and with their managers/coordinators and other team members.
- To be aware of the abuse of older people.
- To be able to respond to abuse of older people.

What strategies could I (we) use?

- Additional reading and/or research presentation as part of team meetings.
- Encourage staff to share stories of clients at team meetings (ensuring confidentiality) as a way of learning more about how older refugees can be affected by their experiences.
- Consider formal communication training for staff.
- Encourage team communication.
- Consider formal education and training around grief and loss in different cultures.
- Consider formal training for staff from STARTTS on loss and grief in older refugees.
- Learning about policies and protocols addressing the abuse of older people.
- Developing a library of material around the abuse of older people.

SKILLS CHECKLIST

SKILLS TO ACHIEVE - *Have I:*	HOW WOULD I (WE) DEMONSTRATE THIS?	WHO?	
		M/C	CCW
Been able to empathise with the losses that older refugees have experienced?	I am able to discuss the types of losses that impact on older refugees.		
Increased my knowledge about the impact of grief on the older refugee?	I can identify grief as an issue in my clients and would report my observations and concerns accordingly.		
Increased my knowledge about the cultural impact of loss and grief?	I am able to demonstrate more empathy for my older refugee clients from other cultures.		
Worked on improving my communication?	I am able to communicate more effectively with my team members and my clients. I am able to listen more effectively to my clients' stories.		
Developed a better understanding of elder abuse.	I understand the requirements of identifying abuse of older people.		
Become familiar with the protocols for abuse of older people in my organisation.	I am able to confidently report any type of abuse of my clients to my supervisor.		

“It takes time to adjust and process loss and grief. There is no time limit on grieving, nor are there right or wrong ways to grieve.”

KEY AREA 3

Understanding the ageing process

“Ageing

is an inevitable
process that
affects us all.”

KEY AREA 3

Understanding the ageing process

CARE GOALS FOR STAFF

I want to be able to:

1. **Understand the normal ageing process.**
2. **Understand possible changes in ageing including dementia, depression and delirium that may be influenced by the older refugee's experiences and culture.**

Introduction

Ageing is an inevitable process that affects us all. However, the ageing of people of refugee background may be accelerated by traumatic events, settlement processes and poor health caused by the refugee experience.

An understanding of both normal ageing and changes that may be symptoms of dementia or other problems will help staff to distinguish between what is normal ageing and what's not.

Remember that there may be a number of factors affecting an older refugee (or any older person) all at the same time. Along with the normal ageing process, there may be other health issues that are having an impact on them physically, socially and psychologically.

Did you know?

In Sierra Leone it is estimated that up to 75,000 people were killed during the civil war while a further two million people were displaced both within the country and throughout the region. Sierra Leone's civil war became infamous around the world for the brutality inflicted on its population. Many civilians were killed. The mutilation of victims became the signature of the rebel fighters, particularly the removal of limbs. The sexual assault of women as a weapon of war was also common. Sierra Leonean arrivals to Australia may have been personally affected by acts of violence or have witnessed attacks on family members, friends or neighbours.[15]

[15] www.immi.gov.au/living-in-australia/delivering-assistance/government-programs/settlement-planning/_pdf/community-profile-sierra-leone.pdf

Physical ageing

Some of the main physical changes are listed in the following table:

PHYSICAL CHANGES IN AGEING

Organ	Changes
Skin	Decreased sensation and thinning of the upper layers of skin (epidermis) increases the risk of infection and problems with wound healing.
Bones	Increased risk of fracture and problems with mobility caused by brittle bones or thinning of the cartilage in joints .
Muscles	Decrease in numbers of muscle cells affects muscle strength, leading to less physical activity and an increased risk of falls.
Heart	Walls of the heart thicken; heart rate slows leading to pump not working as efficiently.
Lungs	Decreased lung capacity means there is less oxygen available to the body so physical tasks make people tire more easily.
Eyes and Ears	Changes in the eye lead to difficulty seeing close objects (thus need for glasses). Changes in hearing lead to difficulty with high decibel sounds or ability to identify where sounds are coming from. Both of these increase loss of independence and lack of confidence.
Taste	Decline in the number of taste buds leads to a reduced sense of taste.
Nervous system	Changes can affect reaction times and balance, and increase the risk of falling.
Gastro intestinal system	Changes to the bowel can increase the risk of constipation.
Kidneys	Decreases in the kidneys' ability to filter waste products and reduced bladder capacity can increase the risk of infection and affect how medication is metabolised.
Reproductive system	Changing hormone levels lead to menopause in women while in men there is a decrease in viable sperm.
Cognitive abilities	Some decline in memory and other cognitive abilities is part of normal ageing and can vary from person to person. Abilities that rely on short term memory such as speed and problem solving show declines from early adulthood, and abilities that rely on long term memory such as knowledge and expertise increase until old age. The significance of decline in an older person's cognitive ability can depend on how good their ability was to begin with. Someone who starts out with low cognitive abilities may need to decline just a little to reach the point where they have a disorder, while someone with high cognitive abilities may need to decline more before they are diagnosed with a problem. Source: Normal cognitive changes in ageing, Kaarin Anstey Australian Family Physician Vol. 33, No. 10, October 2004.

Along with the physical changes of ageing, there may also be psychological, emotional and social changes.

According to psychoanalyst Erik Erikson, older age is the time when people review their lives. Those who feel their life has been well lived have a sense of wellbeing, but others who are less satisfied with their lives feel despair.

There can also be social and emotional changes that come from retirement and changes in income, or from the loss of social networks through death, isolation and other life changes. How people meet these challenges can depend on their approach to life and their personality.

What is dementia?

Dementia is not a normal part of ageing. It's the name for a collection of symptoms caused by disorders affecting the brain. These symptoms generally include problems with:

- memory, emotional control or motivation
- judgment/planning/organising
- social behaviour.

These problems may affect a person's everyday living activities.

There are different types of dementia. The most common types are Alzheimer's disease, vascular dementia, Lewy body dementia, fronto-temporal dementia(s) and alcohol related dementia.

In some types of dementia the early signs are subtle and vague and may not be obvious. Some signs of dementia may also mimic other conditions, including depression. Some common symptoms may include:

- progressive and frequent memory loss (particularly short term memory)
- periods of confusion and forgetfulness
- some change in personality
- apathy and withdrawal
- the loss of the ability to do everyday routine tasks including bathing and dressing.

Cultural definitions of dementia

Different cultures have different ways of defining and understanding dementia. Some communities may see dementia as madness or insanity, while others see it as part of the normal ageing process.

Research shows that people of culturally and linguistically diverse backgrounds (CALD) are less likely to be diagnosed in the early stages of dementia. The reasons for this include:

- Lack of awareness among CALD families of the support and medical services available.
- Many CALD families take longer to ask for support, and may seek help only when a crisis occurs.
- Communication and language problems may be barriers to getting a diagnosis.

A community's attitude to dementia can affect whether or not the problem is picked up early or whether families seek help. Barriers to getting help include whether the problem is seen as treatable, whether it is considered 'shameful' and whether it can be freely discussed within the family and the community.[16]

Early diagnosis when symptoms first appear is important to ensure that a person with a treatable condition gets the right care. If symptoms are caused by dementia, an early diagnosis will mean early access to support, information, and medication if it's available. Consulting a doctor at this early stage is critical - there may be treatment options which can significantly improve the quality of a person's life.

The diagnosis and the impact of dementia can act as a trigger for reviving suppressed memories that are painful and confusing. Time and place can be also be confused so that the older person may be re-living old painful memories as if they are happening now. This can lead to challenging situations for everyone involved.

Staff at the residential aged care facility where Thanh lived were finding his behaviour increasingly challenging. Admitted with a diagnosis of dementia 2 weeks before, he was now regularly hoarding food in his room, including under his bed mattress, and was becoming very aggressive when staff tried to remove it. As this facility had a focus on caring for people of Vietnamese culture, and employed a number of Vietnamese staff, they understood that these behaviours may have something to do with Thanh reliving elements of his past when in a re-education camp in an environment of scarce food and persecution. Staff within the aged care facility reflected on these issues and determined to work consistently in trying to create a sense of calm and peace and safety for Thanh. They agreed to only remove food which created a sense of danger through rotting or smelling when he was not in his room so as not to distress or further confuse him.

Some people may actually have a form of **Post Traumatic Stress Disorder (PTSD)** which is further explained on page 49.

What is delirium?

Delirium is a sudden, unexpected episode of confusion. Signs can include:

- mood changes and levels of confusion which fluctuate throughout the day
- personality change and or behaviour change
- periods of restlessness and/or lethargy
- irritability
- anxiety
- hallucinations and suspiciousness.

Some older people are more susceptible to delirium because of health problems or changes to their environment.

[16] Wall, S, Shanley Chris and Russell, K

Factors that can trigger delirium include:	How to reduce the risk of delirium
• going into hospital or residential care • loss and grief • illness • multiple medications • use of some drugs including alcohol • electrolyte imbalances	• use clear communication • minimise changes and other factors in the person's environment likely to cause confusion • reassurance • good hydration • keep to normal routines • regular exercise and rest and a regular review of medications

People can have delirium even if they don't have dementia, but impaired thinking can increase the risk of delirium. It's likely that symptoms of delirium are overlooked when someone has dementia.

Depression can complicate things even more.

Did you know?

An estimated 100,000 to 400,000 female sex slaves were forced to deliver sexual services to Japanese soldiers, both before and during World War II. They have been variously called 'comfort women,' 'military sex slaves', 'MSS', 'military comfort women,' and -- in Japanese – 'jugun ianfu'. This program was approved by the Imperial Conference composed of the emperor, representatives from the armed forces and the main Japanese cabinet ministers. The conference was formed after Japan invaded Manchuria in 1937. "This system resulted in the largest, most methodical and most deadly mass rape of women in recorded history. Japan's Kempeitai political police and their collaborators tricked or abducted females as young as 11 years old and imprisoned them in military rape camps known as 'comfort stations', situated throughout Asia. These 'comfort women' were forced to service as many as 50 Japanese soldiers a day. They were often beaten, starved, and made to endure abortions or injections with sterilizing drugs. Only a few of the women survived, and those that did suffered permanent physical and emotional damage.[17]

Depression in older refugees

Symptoms of depression in older people include a low mood, loss of pleasure in activities, feelings of hopelessness, disturbed sleep, change in appetite, poor concentration and, sometimes, thoughts of death. Many depressed older people are lethargic and slow but some will appear agitated. Some may also have psychosis and experience delusions.

In older people depression may appear in later life for the first time or be a chronic condition they've had for many years. Either way, the illness may often be complicated by factors like declining levels of functioning, frailty and problems with thinking and memory.

[17] www.religioustolerance.org/sla_japa.htm

Research shows that the experience of trauma in older refugees may cause depression. There can be striking similarities between depression and dementia, but there are also differences.

To complicate things even more, some people could also have depression, dementia and delirium all at once. This makes it challenging to do an accurate assessment. All three conditions need a different approach and treatment.

Telling the difference between the 'three Ds' - **Delirium**, **Depression** and **Dementia** takes skilled assessment. The differences and similarities are shown in the following table.

	Dementia	Delirium	Depression
Thoughts	Repeating things over and over again. Reduced interests. Difficulty making logical connections. Slow processing of thoughts.	Thoughts and ideas that are bizarre, vivid and frightening. Paranoia (irrational fears that others are trying to harm you).	Thinking may be slowed. May be preoccupied by sadness and hopelessness. Negative thoughts about self. Reduced interest in a range of things.
Sleep	Often a disturbed sleep/wake cycle (when the disease is more advanced).	Confusion disturbs sleep – may have a reverse sleep wake cycle. Confused behaviour and thoughts at night. Vivid and disturbing nightmares.	Early morning waking or intermittent sleep patterns (sometimes the person may sleep too much – but this is less typical).
Orientation	Increasingly confused about time and place.	There is confusion about time, place and who people are – but it comes and goes rather than increases.	Usually normal.
Onset	Usually gradual over several years. Insidious in nature.	Sudden – it can happen over the course of a few hours or a day.	Usually over days or weeks. May coincide with life changes.
Memory & Cognition	Impaired memory of recent events. As disease progresses, long term memory also affected. Other cognitive problems such as word finding, judgement and abstract thinking.	Immediate memory is impaired. Attention and concentration are impaired.	Recent memory sometimes impaired. Long term memory generally intact. Patchy memory loss. Poor attention.
Duration	Months/years.	Usually brief/hours to days.	At least two weeks – but can be several months to years.
Course throughout a day	May be variable depending on type of dementia.	Fluctuates – usually worse at night in the dark. May have lucid periods.	Commonly worse in the morning with improvement as the day continues.

	Dementia	Delirium	Depression
Alertness	Usually normal	Fluctuates – lethargic or hypervigilant (meaning they are very much 'on alert' or overreacting to things going on around them).	Normal
Other	May be able to conceal or compensate for problems (early on in the disease).	May occur as a result of a drug interaction or a reaction to a drug, physical disease, psychological problem or changes to the person's environment.	

SOME REFLECTIVE QUESTIONS
for Managers/Coordinators

What skills would be useful for CCW to develop in this key area?

- An understanding of the normal ageing process.
- Being alert to the signs and symptoms of dementia, delirium and depression in older refugees.
- An ability to recognise the difference between dementia, delirium and depression.

What strategies could I (we) use?

- Additional reading/research.
- Develop reflective practice – improving the quality of the care we give to clients by continuously evaluating our practices with team members and learning from our discussions.
- Library resources.
- Consider formal training for all staff.

SKILLS CHECKLIST

SKILLS TO ACHIEVE - *Have I:*	HOW WOULD I (WE) DEMONSTRATE THIS?	WHO?	
		M/C	CCW
Improved my understanding of the ageing process?	I can distinguish between signs of normal ageing in my clients and signs that may be symptoms of a problem.		
Improved my understanding of dementia, delirium and depression?	I am able to identify early signs in my clients of dementia, delirium and depression and report immediately.		
Worked on improving my communication with my team and my client?	I am able to confidently pass on information about my older refugee clients to my team.		
Increased my holistic understanding of the differing needs of older refugees?	I regularly explore good practice strategies with other team members.		

KEY AREA 4

Understanding the impact of the refugee experience on older age

“Many older refugees

have shown great resilience
in adapting to new
circumstances following
traumatic events of the past.”

KEY AREA 4

Understanding the impact of the refugee experience on older age

CARE GOALS FOR STAFF

I want to be able to:

1. **Understand the impact of Post Traumatic Stress Disorder (PTSD) on ageing.**
2. **Work more effectively with older refugees who are experiencing changing behaviours.**

Introduction

Many older refugees have shown great resilience in adapting to new circumstances following traumatic events of the past.

But this same resilience which helped them 'survive' may be undermined by cognitive changes that can occur with either normal ageing or dementia.

This means that the ageing process may be an extra risk factor for those who have had traumatic events in their life. Often it's a change in someone's behaviour that may alert carers that help is needed.

Post Traumatic Stress Disorder

PTSD is a common response to war and similar traumas. The chances of someone developing PTSD – and how severe it is - may be influenced by:

- the frequency and severity of the trauma
- how prepared the person was for the traumatic event
- a person's spiritual beliefs or other protective factors.

Although there is a growing understanding of PTSD and its effect on physical and psychological health in younger refugees, less is known about the impact on older refugees, particularly over a prolonged period of time.

Research shows that the prevalence of PTSD in survivor refugee populations is common - between 32% and 100% while the rate of depression is between 47% and 72%.[18]

[18] Rebuilding shattered lives, 49

A personal story

"The evacuation of Phnom Penh was in April 1975 when Pol Pot came to power. The Khmer Rouge told the people that the Americans will bomb soon, so to survive we have to get out of the city fast.

We learned later, that they wanted to punish people who lived in the city because we were considered the enemy of state. They said people who worked with the government would be called back in a few weeks when the new regime was installed. Who was to know that they killed because they wanted to clean out the old regime and start the new one?

They evacuated three or four million people in a few days. It was total shock and disbelief. It was terribly chaotic, there was no planning. As a result a big tragedy unfolded; we did not know what to say except to follow orders. There was always gun fire in the air, to push and order people to move on. The streets were full of people. People died along the street, some woman gave birth to her baby on the street. It was horrible, horrible." [19]

Psychiatric conditions are listed in a guide called the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (known as the DSM-IV). It is published by the American Psychiatric Association and covers all mental health disorders in children and adults. It lists known causes of these disorders, statistics on gender, age of onset, and prognosis, as well as research on the best treatment.

According to the DSM-IV, PTSD occurs within six months after the traumatic event, with delayed-onset PTSD appearing any time later than six months after the event. Symptoms may include:

- panic, terror and feelings of helplessness
- reliving the original trauma as dreams, flashbacks or intrusive memories
- avoidance behaviour (e.g. numbing of emotions, reduced interest in others and the outside world)
- physiological hyper-arousal (being very agitated) with symptoms like insomnia, agitation, irritability or outbursts of rage that may affect work, education and the ability to function well.

In older people symptoms may include:

- anxiety
- feeling emotionally numb
- depression
- problems with thinking and memory
- physical symptoms or problems with no apparent cause
- flashbacks
- sleep disturbance.

[19] www.migrationheritage.nsw.gov.au/stories/phiny-ung

Sometimes there will be obvious triggers for PTSD symptoms. But it's important to remember that these can vary from person to person and will be influenced by a number of issues. Certainly the loss of a spouse (or significant other) is a major trigger. Like other elderly people, older refugees may manage well until the death of the person that they had leaned on most. This loss can compromise their coping strategies, leaving them vulnerable to the traumas of their past. The death of a spouse may also increase the risk of social isolation and problems with both mental and physical health.

Big changes to a person's environment like going into hospital or into an aged care facility may also trigger deterioration in their mental and physical health. This is made worse if people have no contact with their own culture and can lead to increased isolation, loneliness, fear and despair.

There have been many documented stories where older people of refugee-like background with these symptoms were misdiagnosed with physical or mental illnesses including delirium and dementia, meanwhile the real cause – PTSD – was overlooked. This has a major impact on the treatment and recovery options for the client and their family.

Did you know?

In Afghanistan 'They witnessed the death of people in combat or bombardment, mutilation, the retrieval of bodies, complete devastation of the houses, villages and agricultural land. Some of them have actively participated in killing of their enemies, in mortar bombing, ambush, hand-to-hand fights, assassinations and interrogations. Many of them have been through the experience of a prolonged journey through mountains in very rough terrain. On this journey they experienced fatigue, change in diet and climate, and travel across time zones coupled with the constant fear of being caught, killed or imprisoned.' [20]

Changes like going into hospital or aged care can also cause fear and anxiety that contribute to delusions. A Polish health worker shared the experience of one of her clients with this story.

> Mr B, a resident in a nursing home, became increasingly agitated when people (politely...but loudly) knocked on his door before entering. The Polish worker knew from talking to his family and from her own experience that this was probably triggering his fear and anxiety because during World War II Nazi soldiers would knock on the doors of people's homes and then take the people away. This observation, based on sensitive understanding, was shared with the staff who agreed to use different strategies to get Mr B's attention.

Some clients may also look flushed, perspire profusely or appear to be having a panic attack when interacting with people in authority. This may be related to past experiences of persecution from people in authority in their home country.

[20] Wardak, 1993, 350

Did you know?

In older Polish people, World War II is a subject that should be handled with tact and understanding. It should not be forgotten that older people born in Poland have lived through a very traumatic time arising from not just the war experience but also the years post-war when times were very tough. From 1945-1953 a "people's democracy" arose, based on the Soviet model (effectively under communist control) which eased somewhat in 1953 when Stalin died. From 1970 - 1981 outbreaks of strikes, demonstrations and civil unrest led to dire food shortages. During these years many people were imprisoned as political prisoners and large numbers of the younger educated people left Poland. Many families were split up and scattered to countries that gave asylum. Older people may have lived through these times and consequently suffered trauma, so tact is also required to uncover whether there are any persistent problems.[21]

Sleep problems may also trigger a health or psychological crisis. Older refugees may have recurring nightmares and may build up a fear of sleep or darkness, or may be unable to sleep because they're reliving past events. This can build up a cycle of extreme fatigue, affecting their physical and mental health.

Painful memories may cause behaviour changes. People at home or in residential care who have experienced hunger or food restriction in the past may hide uneaten food in places (like under pillows) or may refuse to dispose of food that has gone off.[22] The underlying cause may be vivid recollections of rape, murder, torture or other trauma.

Did you know?

The graphic nature of these old memories is a kind of brutal version of 'flashbulb memory', the name given to the phenomenon of remembering significant events vividly, "like where you were when Princess Diana died", says Dr Greg Savage, a clinical neuropsychologist and researcher. "It's as if our senses become inflamed by the moment and the memory becomes more deeply engraved. The more meaningful the memory, the more potent it is - but the sting in the tail is that for some people these are memories they don't want to revive." Although it's still a contentious area of science, some research into PTSD also suggests that the effect of stress chemicals released in the brain at the time of the trauma may change the temporal lobe, the part of the brain where memories are made, Savage says. "Too much cortisol is toxic to the brain and some studies using brain imaging suggest that with PTSD, there's some shrinkage in the temporal lobe. It may be that this, combined with ageing, contributes to the problem of traumatic memories emerging when people get older."[23]

[21] Polish Culture Profile Published 2006 by: Diversicare.
[22] Caring for Older Refugees in NSW: A Discussion Paper 24.
[23] Press release Caring for Older Refugees in NSW: A Discussion Paper 24

When working with older refugees who may have PTSD, it is crucial to identify the triggers and find ways to avoid them if possible. This requires staff to be aware that the person may be of a refugee-like background and to accept that the behaviour may relate to their past experience.

Triggers may be something that someone sees, smells, hears or feels. It's important to be alert to these triggers. While it's not always possible to know why they cause behaviour change, the main thing is to identify them and find ways to deal with them.

Trial and error is a good approach. If a strategy works in improving behaviour, continue. If not try something else. If the behaviours continue, the emphasis should be on preventing them from getting worse.

Remember that older refugees may be unable to control their reactions to triggers. Each person has a unique story and a unique way of responding to triggers. Any interventions or strategies to help them should be tailored to their needs.

Being respectful, supportive and caring is the basis of person centred care and should underpin any strategies to deal with PTSD.

Strategies need to:

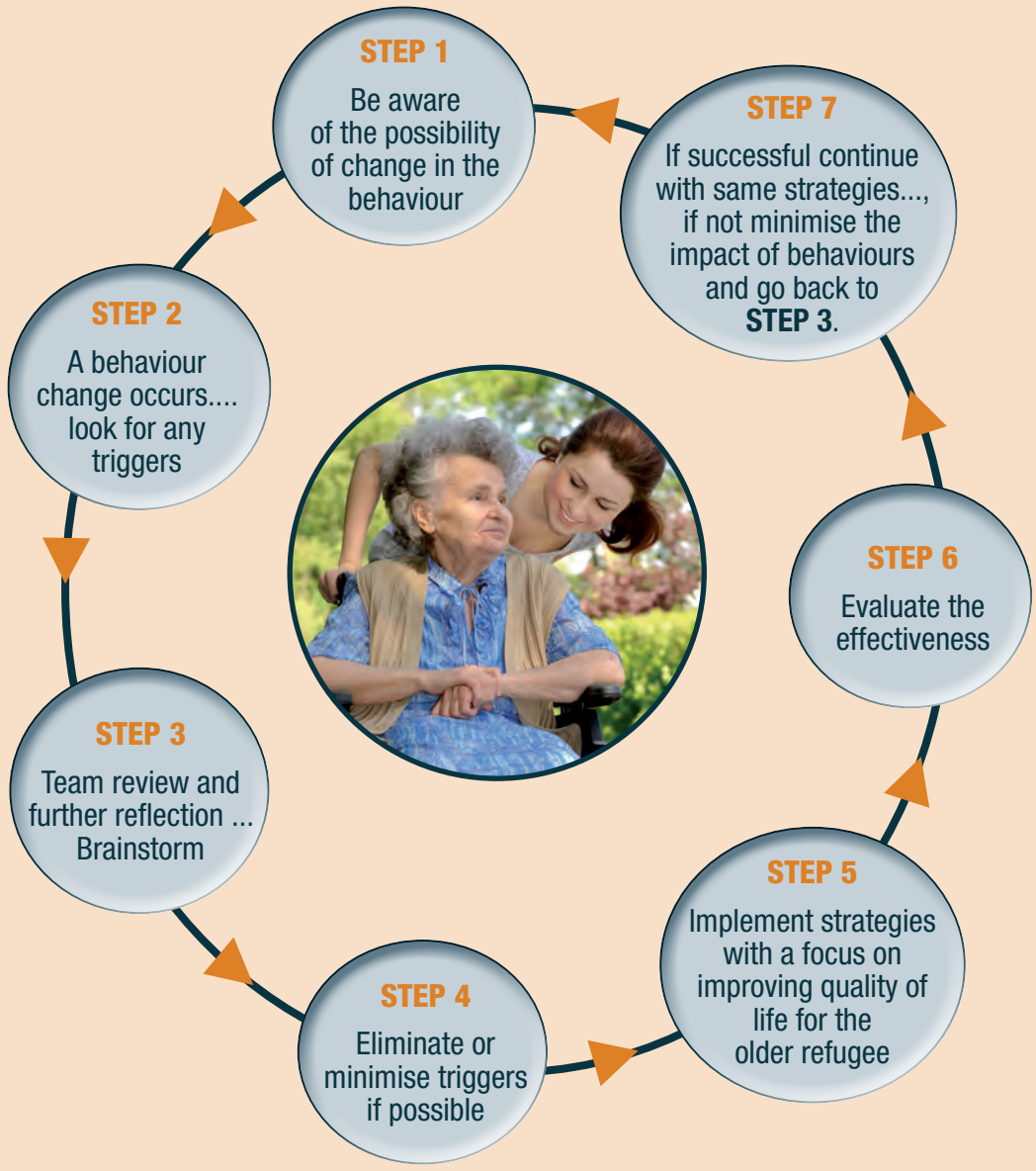
- focus on making people feel better about themselves
- focus on the person's reality - not the reality of the person who cares for them
- be appropriate for the person's culture and their era and must never set people up to fail.[24]

Over time the incidence or severity of PTSD tends to decrease. Although healing is slower in people who are more traumatised, there is generally an overall decrease in symptoms and less distress.

The diagram overleaf provides a plan for working with changing behaviours of someone who you suspect may have PTSD. It's important to remember that this plan is an ongoing process that continues until you're sure there has been an improvement in the quality of life of the older refugee and those around them.

[24] Wall, S, Shanley Chris and Russell, K Cultural Diversity and Dementia.

THE CYCLE OF WORKING WITH CHANGING BEHAVIOURS IN OLDER REFUGEES



SOME REFLECTIVE QUESTIONS
for Managers/Coordinators

What skills would be useful for CCW to develop in this key area?

- Having a better understanding of PTSD and changing behaviour in older refugees.
- Being able to respond more empathically to PTSD and to changing behaviours in older refugees.
- To communicate more effectively with peers and staff about PTSD and changing behaviour in older refugees.

What strategies could I (we) use?

- Additional reading/research in this area.
- Incorporate what we learn from working with older refugees into the development of policy and practice.
- Develop reflective care and practice.
- improve team communication.
- Consider formal training.

SKILLS CHECKLIST

SKILLS TO ACHIEVE *Have I:*	HOW WOULD I (WE) DEMONSTRATE THIS?	WHO?	
		M/C	CCW
Increased my understanding of PTSD in older refugees?	Showing empathy with clients and team members.		
Recognised that my client's behaviour is affected by PTSD?	Identifying changing behaviour as a result of PTSD triggers.		
Looked for PTSD related resources?	Sharing and using information from resources with the team.		
Looked for refugee-specific resources?	Sharing and using refugee specific resources with the team.		
Worked on enhancing my team communication?	Sharing learning, concerns and events with the team in a reflective way.		
Explored strategies with other team members?	Case review – am able to brainstorm strategies confidently with my team.		

Enhancing the Lives of Older Refugees

was written to raise awareness and provide guidance and information for aged care workers caring for older people from a refugee or refugee-like background.

We hope you find it helpful.

Sharon Wall, Yvonne Santalucia,
Marisa Salem, Debbie Giacomin,
Regina McDonald and Franka Bosnjak

Conclusion

Putting this information into practice

This resource provides the additional knowledge to help care workers to work more confidently and effectively with older refugees.

Sometimes there will be incidents that need an immediate response. The following story shows how this might look like in the real world - and how informed workers might respond to similar issues in their own workplace.

Anna's story

Anna, who was 84, was referred to the community care service via her General Practitioner (GP) who had become increasingly concerned about how she was caring for herself at home. She was a strong, independent woman who had always protected her privacy and was of Polish background (as was her almost retired GP). But recently she had become noticeably frailer. As she lived alone, she was at particular risk and her GP had been keeping a close eye on her.

His initial assessments indicated she had very early dementia. He noticed that when she visited him her personal appearance was not as it used to be. He was also concerned about her becoming more isolated and not spending time with friends as much as in the past.

He decided to refer her to the local neighbour aid service that had a home visiting service using Polish volunteers.

Rosie, a 50 year old volunteer, had been visiting Anna each week for a few months. She had built a relationship of trust and looked forward to her visits as much as Anna appeared to enjoy them. Mostly they met over coffee at home but sometimes went to the local coffee shop where Rosie helped Anna buy a few groceries and carry them home.

Anna had shared a number of stories with Rosie about her life, much of which was filled with sadness. Her husband had died 20 years ago, following a long history of depression. Anna had come home one day to find him unconscious beside an empty jar of antidepressants. He died in hospital two days later. Rosie knew that it was not considered good etiquette to ask about Anna's life during the war but Anna had told Rosie that her husband and she had been politically active during the war and cried openly each time she mentioned that period. She said he had been a political prisoner and had never recovered from some of the things he encountered in that time.

Rosie used their time together to also observe Anna's functioning and any apparent decline. She had certainly noticed that Anna now took a lot longer to make a cup of tea and had greater difficulty finding things. In the past there had always been home cooked Polish food like piroshky or beetroot whenever Rosie visited, but they no longer appeared. Rosie had reported all this to her service manager. They discussed the possibility that Anna may have been a refugee. The manager told Rosie about a range of resources that were available in the main office and invited her to attend some non compulsory training on the needs of older refugees. Her manager also asked her to keep observing Anna and to feed back anything that concerned her.

At Rosie's next visit things were very different. When Anna opened the door she appeared particularly anxious and concerned. Her face was very flushed and she

was perspiring heavily. She opened the door a fraction and said she could not see anyone today except her husband as it was All Saints' Day. Rosie knew this did not make sense because All Saints' Day, a special day of remembrance for those who have died, falls in November and it was only March. Rosie introduced herself as if for the first time to Anna, reminding her that she was with a Polish community organisation and was there to help. Anna appeared not to recognise Rosie and remained very suspicious, whispering that the 'bad people' were here to take her and her husband away.

Reluctantly, Rosie left – she didn't want to distress Anna any further. But she immediately reported her concerns to her manager.

Given Rosie's description of what had occurred, along with Anna's gradual decline, the manager rang the GP. After discussion, they both agreed that the issues appeared urgent and both acknowledged that Anna's safety and security may be at risk. The GP provided an appointment time and asked if the staff could ensure that Anna attended. He felt that it would be more acceptable to Anna to come to the surgery for a consultation, as this is something that she had done many times before.

As well as telling Rosie, the manager also rang Anna who appeared to understand vaguely who she was. She explained that she had made an appointment for her to see her GP for 2pm that day. The manager said she would, with Anna's permission, pass on information to him about how she was going on the visitor program. She also reminded Anna that Rosie would pick her up to take her to the GP. After some gentle persuasion, Anna complied when Rosie arrived.

The GP was very concerned about Anna's appearance. Anna was highly suspicious and disoriented. She kept referring to the letters she was receiving from the 'bad people' who were going to take her husband away again and he decided to make an urgent referral to the psychogeriatric team. They in turn admitted her to an urgent bed in the psychogeriatric ward for assessment and care

While collecting Anna's things for hospital Rosie noticed a pile of letters in Anna's home requesting payment of an electricity bill. The last letter threatened legal action if it wasn't paid. Anna passed this information on to her manager.

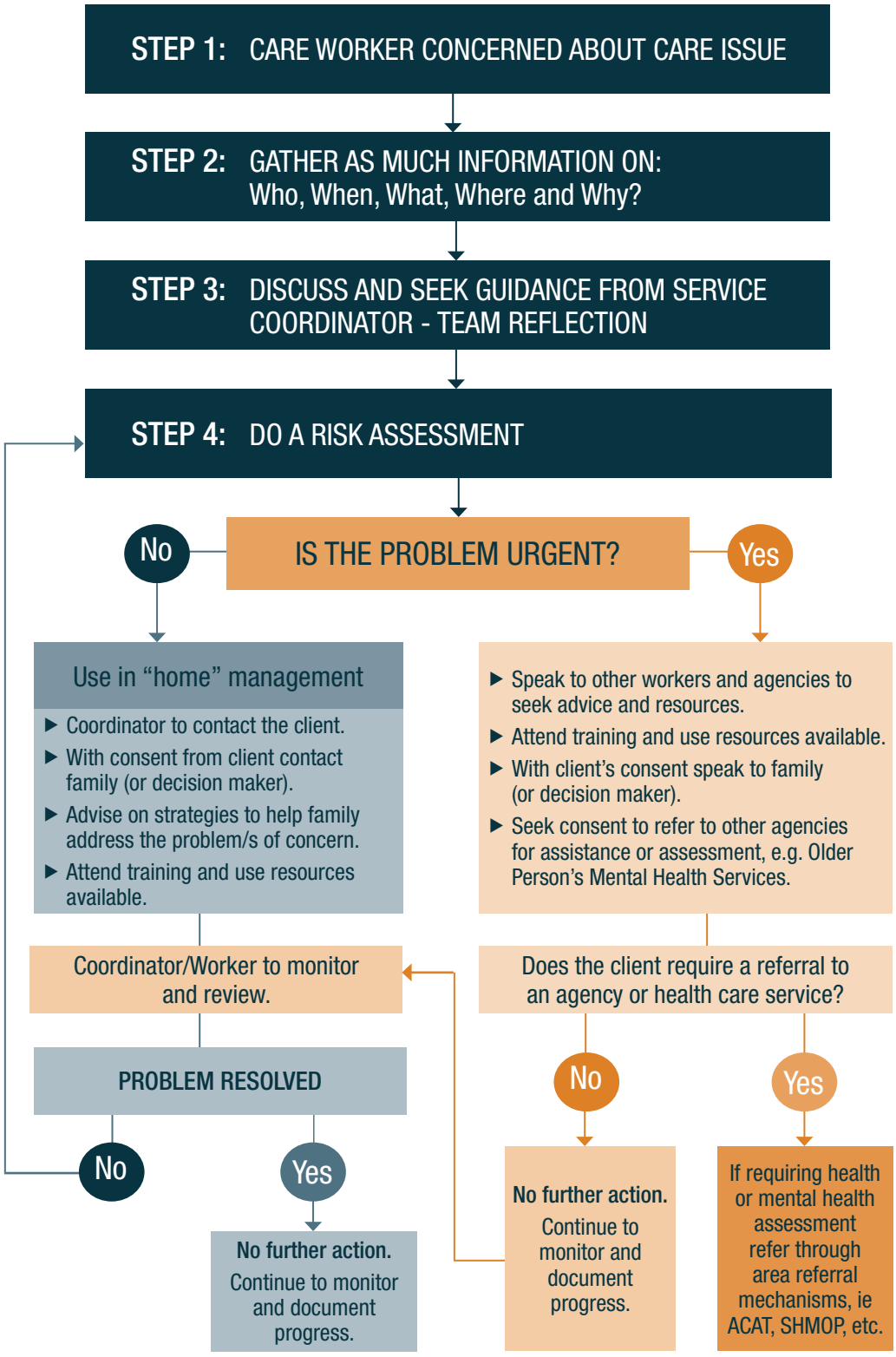
Anna was admitted into a very caring environment where she was constantly reassured. She was slowly taken off her medications and was carefully assessed. It was noticed that Anna had been taking triple doses of medication (out of three dosette boxes) thus contributing significantly to her confusion. It was also suggested that the threatening letters may have triggered memories of experiences in her past, causing her increasing fears and suspicion. In a caring environment, removed from these obvious triggers, her condition improved although her cognitive frailty remained.

It was recommended that she would be suitable for a Polish specific care package to begin on her discharge. This would be provided by the same organisation that had provided her visits from Rosie.

Anna remains stable at this time but staff keep a close eye on her. With help, she attends Polish Mass at her local church every Sunday and sometime has lunch at the Polish club afterwards. At the suggestion of the service manager, Anna is picked up one day a week to attend the Polish-specific day care service held for older people at the Polish club. She seems to enjoy this and looks forward to it every week now. The link between the packaged care and the visits is Rosie who continues to visit Anna regularly.

The elements of this story are shown in the following flow chart which provides a practical plan for responding to issues with older refugees living at home.

ACTIONS FOR RESPONDING TO IDENTIFIED CARE ISSUES IN OLDER REFUGEES LIVING AT HOME



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20. *Research on Abuse of Older People from a Non-English Speaking Background*, NSW Advisory Committee on Abuse of Older People, 1998.

21. *Religious Tolerance Organisation*: www.religioustolerance.org/sla_japa.htm

22. *The community hides such problem, A Model for Dealing with Abuse of Older People in an Ethnic Community*, University of Western Sydney, 2003.

23. The Vietnamese Community in Sydney – A resource: www.startts.org.au

24. Victorian Foundation for Survivors of Torture Inc *Rebuilding Shattered Lives*, Foundation June 1998 ISBN: 0 9585657 Printed by Melbourne Printing Professionals.

25. Wall, S, Shanley Chris and Russell, K *Cultural Diversity and Dementia – A planned approach to residential care for people with dementia who come from a non – English speaking background*: www.cera.usyd.edu.au/manuals_cultural.html

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Written resources

1. Caring for Older Refugees in NSW: A Discussion Paper
   www.sswahs.nsw.gov.au/sswahs/refugee/pdf/OlderRefugees.pdf

2. Working with HACC clients from refugee-like backgrounds resource kit. Commissioned by the NSW Department of Ageing, Disability and Home Care Metro North Region and NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) Available as download:
   www.startts.org.au/ContentFiles/Startts/Documents/HACC%20Resource%20Kit_NSW%20Wide_2010.pdf

3. Foundation House develops publications and resources to enhance the understanding of the needs of people from refugee backgrounds among health and other professionals, government and the wider community. Recent publications include areas such as refugee health and wellbeing, school and education resources and curriculum material. Includes the following:

   - Promoting Refugee Health: A guide for doctors and other health care providers working with people from refugee backgrounds. Although not ageing-specific, it is a comprehensive and very informative guide to working with clients from refugee backgrounds.
   - Rebuilding Shattered Lives was developed to help improve services to survivors of torture and trauma. The focus of the guide is on adults and the family. Both these resource are available from:
     www.foundationhouse.org.au/resources/publications_and_resources.htm

4. Community Profiles have been developed to help service providers to better understand the backgrounds and needs of Humanitarian Programme arrivals. The Profiles contain information on key settlement locations, demographic characteristics of recent arrivals, likely settlement needs and cultural and country backgrounds. Development of the Community Profiles series is ongoing and further communities will be added in the future.
   www.immi.gov.au/living-in-australia/delivering-assistance/government-programs/settlement-planning/community-profiles.htm

5. The La Trobe Refugee Research Centre is a part of the School of Social Sciences and a core affiliate of La Trobe University's Institute for Human Security. LaRRC works to promote the wellbeing, participation and social inclusion of people with refugee backgrounds through applied and foundation research, teaching, continuing education and professional development. There are two excellent documents which although relating to Victoria are relevant for increasing understanding of all older refugee populations.
   www.latrobe.edu.au/larrc/documents-larrc/reports/report-vic-senior-refugees-section-1.pdf
   www.latrobe.edu.au/larrc/documents-larrc/reports/report-vic-senior-refugees-section-2.pdf

6. Information on other countries and other very useful information are available from the Multicultural Disability Advocacy Association of NSW (MDAA)
   www.mdaa.org.au/publications/ethnicity/specificcommunities.html

7. The final report from the 'Caring for Older Survivors of Genocide and Mass Trauma' project of 2008-09 is now available. The project was conducted by Lincoln Centre for Research on Ageing, at the Australian Institute for Primary Care & Ageing at La Trobe University, Melbourne, in collaboration with Jewish Care Inc (Victoria).
   www.latrobe.edu.au/aipca/aipc_pdf_docs/aged_care_older_survivors.pdf

(All websites accessed on the 25.11.11)

Resources and organisations

STARTTS

The NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) helps refugees recover from their experiences and build a new life in Australia.

Ph: 02 9794 1900

www.startts.org.au

NSW REFUGEE HEALTH SERVICE

Set up by the NSW Department of Health in 1999, the service aims to promote the health of people from a refugee background living in NSW by assisting refugees, and the health professionals who work with them.

Ph: 02 8778 0770

www.refugeehealth.org.au

MULTICULTURAL ACCESS PROJECTS

The aim of Multicultural Access Projects is to help the Home and Community Care (HACC) system and services be more responsive to current and future HACC service needs of diverse cultural communities, and to improve knowledge of HACC and related services in culturally diverse communities.

CONTACT

Bankstown Area Multicultural Network (BAMN)

POB 3164
Bankstown Centro
BANKSTOWN NSW 2200
Ph: 02 9796 3717
Email: swsmars@bamn.org.au
www.supportservices.org.au

Central Coast Multicultural Access Project

Central Coast Disability Network
PO Box 4309
EAST GOSFORD NSW 2250
Ph: 02 4324 2355
Email: Keikoc@ccdn.com.au

Cumberland Prospect Multicultural Access Project

SWAHS Multicultural Health Network
Cumberland Hospital
Locked Bag 7118
PARRAMATTA BC 2124
Ph: 02 9840 3768
Email: Desiree.Leone@swahs.health.nsw.gov.au

Eastern Sydney Multicultural Access Project

Ethnic Child Care, Family and Community Services Co-op
Suite 3, 1-3 Elizabeth Avenue
MASCOT NSW 2020
Ph: 02 9700 8872
Email: coordinator@esmap.org.au

Hunter Multicultural Access Project

Northern Settlement Service
8 Chaucer Street
HAMILTON NSW 2303
Ph: 02 4969 3399
Email: map@nsservices.com.au

Inner West Multicultural Access Project

Ethnic Child Care, Family and Community Services Co-op
Building 3
142 Addison Road
MARRICKVILLE NSW 2204
Ph: 02 9569 1288
Email: iwmap_coordinator@eccfcsc.org

Macarthur Diversity Services

Level 2 Centre Court Building
101 Queen Street
CAMPBELLTOWN NSW 2560
Ph: 02 4627 1188
Email: Maureen@mdsi.org.au

Multicultural Access Project, State Wide

Ethnic Communities Council NSW
221 Cope Street
WATERLOO NSW 2017
Ph: 02 9319 0288
Email: hacc@eccnsw.org.au

Nepean Multicultural Access Project

Tri Community Exchange Inc
PO Box 63
EMU PLAINS NSW 2750
Ph: 02 4732 6301
Email: map@tricomm.org.au

Northern Sydney Multicultural Access Project

Northern Sydney Multicultural Health Service
The Lodge
Macquarie Hospital
NORTH RYDE NSW 2113
Ph: 02 8877 5317
Email: GRAChan@nsccahs.health.nsw.gov.au

St George/Sutherland Multicultural Access Project

St George MRC
CALD Community Care Program
552 Princes Highway
ROCKDALE NSW 2216

Ph: 02 9597 5455

Email: cccpaccess@sgmrc.org.au

DIVERSITY HEALTH INSTITUTE

The Diversity Health Institute (DHI) is a consortium of public health organisations working together to improve the health and wellbeing of Australia's culturally and linguistically diverse (CALD) community.

CONTACT

Cumberland Hospital

5 Fleet Street
North Parramatta NSW 2151
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NATIONAL PARTNERS IN CULTURALLY APPROPRIATE CARE (PICAC)

The Australian Government Department of Health and Ageing (DoHA) funds the Partners in Culturally Appropriate Care (PICAC) program. PICAC has one organisation in each state and territory working towards equipping aged care service providers to deliver culturally appropriate care to older people from culturally and linguistically diverse communities.

Multicultural Communities Council of Illawarra provides services in NSW to help connect culturally and linguistically diverse communities with aged care providers to improve access to services. It aims to build the capacity of aged care services to deliver culturally competent care by providing cross-cultural training and multicultural resources.

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PLANETREE

A non-profit alliance of hospital and health care organisations that promotes patient centred care in the US and internationally.

www.planetree.org/index.html

AMNESTY INTERNATIONAL, AUSTRALIA

Amnesty International is a worldwide movement of people campaigning to protect human rights. It has good information to help staff broaden their knowledge of issues affecting affect older refugees.

www.amnesty.org.au

APPENDIX 1

The background to this resource

In 2000, a consultation with refugee communities in Western Sydney by the **NSW Refugee Health Service and STARTTS (NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors)** raised issues of older refugee health and access to services. In 2003 a state wide forum on the *Health and Settlement Needs of Older Refugee*s was organised. The Forum's recommendations were set out in an Outcomes Paper and a Working Group was formed to take up the issues raised by the forum. In 2006 The NSW Refugee Health Service published a Discussion Paper *Caring for Older Refugees in NSW* and presented this document at the Australian Association of Gerontology's Diversity in Ageing conference in November 2006. In 2007 South West Sydney (SWS) and Macarthur hosted an *Older Refugees Seminar for Aged Care Service Providers* so that they could provide better care to older refugees. In 2008 in response to the feedback received from Aged Care Service Providers at the seminar, the **Older Refugee Working Committee – Good Practice Guidelines South West Sydney** was formed. The committee's brief was to develop a set of practice guidelines to help carers, workers and managers better care for older refugees living in the SWS community.

The *Good Practice Guidelines for SSW Service Providers on Caring for Older Refugees* project acknowledged from the outset that consultations would be needed to inform knowledge and understanding of the needs of older refugees. This would then lead to the development of guidelines which would ultimately help service providers deliver more person centred care for this group.

It was determined that the groups that would best inform the development of the guidelines were carers caring for older refugees, workers working with refugee communities in the SWS region and aged care service providers and managers and coordinators working in mainstream ageing services.

Three consultations took place in Bankstown, Wetherill Park and Liverpool. They were held in response to an open invitation to workers in the South West Sydney (SWS) who were working with, or in contact with, older people from their communities who had a refugee background. In SWS there are a number of workers funded by different Government Departments who work with migrant and refugee communities. There are also unpaid workers e.g. Seniors Group Leaders in the area that provide social support to groups and the communities they represent. It was anticipated that these workers would have experience of the issues and concerns raised by their community about older refugees and aged care. A total of 29 people attended the consultations, along with a facilitator and two core members of the steering group for each consultation.

A variety of ethnic communities were represented including:

- Polish
- Vietnamese
- Macedonian
- Assyrian
- Cambodian
- Congolese
- Chinese
- South American

There were also participants of different cultural backgrounds representing mainstream or broader multicultural organisations.

The format of each consultation was the same and each was facilitated by Sharon Wall from Ageing by Caring Pty Ltd. The following trigger questions were used to stimulate discussion and response:

- What do you think are the specific issues for older refugees?
- What do you think aged care service providers need to know about older refugees from your community?
- Do you have a specific situation where an older person behaved in an unusual way (that you suspect might have had something to do with them having a refugee background).
- What skills would you like to personally enhance to assist you to care for older refuges clients more effectively?
- What would you like to know more about?

Each participant was also given a questionnaire to complete and send back to the working committee. This information and the material from the consultations have been used to inform this resource. The complete proceedings were carefully scribed by Regina McDonald and reviewed by other members of the working committee who attended the consultations. This material was then further analysed by the facilitator Sharon Wall.