Working with HACC clients from refugee-like backgrounds

Resource Kit

for Home and Community Care Service Providers in New South Wales

This project was jointly funded by the Australian Government and the New South Wales Government under the Home and Community Care (HACC) Program

STARTTS

NSW GOVERNMENT Family & Community Services
Ageing, Disability & Home Care

Working with HACC clients from refugee-like backgrounds

Resource Kit

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Family &
Community Services
Ageing, Disability & Home Care

This project was commissioned by the then NSW Department of Ageing, Disability and Home Care Metro North Region in 2008, it was updated in 2011 funded by the Department of Family and Community Services, Ageing, Disability and Home Care

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1. About this Resource Kit

1.1 About the project

This **Resource Kit** is one component of information and training resources produced for the project, 'Working with HACC clients from refugee-like backgrounds'.

This project was first commissioned by the then NSW Department of Ageing Disability and Home Care Metro North Region (DADHC). It was the result of community consultations in the Cumberland-Prospect and Nepean Local Planning Areas (LPAs) of Western Sydney in 2005, which identified the need for specialised training for HACC service providers to assist them respond appropriately to the needs of frail aged and disabled clients, and their carers, who are survivors of torture and refugee trauma. The project ran from February-November 2008.

In 2009 further funding was received to adapt the kit to be used in the Northern Sydney LPA. It was a partnership project between the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) and the Northern Sydney Multicultural Access Project, managed by the Northern Sydney Central Coast Health Service. This project ran from March to June 2010.

In July 2010 Ageing, Disability and Home Care provided further funding to STARTTS to expand the project across New South Wales of which this current updated version of the resource kit is a part of. This is in recognition of the reality that CALD people from refugee and refugee-like backgrounds that are ageing and/or have a disability, and their carers, reside in widespread communities across the state.

Service providers throughout NSW would benefit from developing an understanding and skills that will enhance their ability to deliver appropriate services that respond to the specific needs of this target group of clients. For service providers in regional areas where there may be fewer CALD-specific services available and a lower level of general community awareness and exposure, this training is particularly important. It will help to equip HACC services personnel, in particular direct care workers, case managers, co-ordinators and volunteers, with strategies they need to meet these challenges.

The population of people from refugee and refugee-like backgrounds varies greatly across these regions, with a much higher concentration in the Sydney Metropolitan Area, particularly in Western and South-Western Sydney. However, there are people from the target population in communities right across the state, particularly longer term residents who are now ageing. Typically, in these smaller

communities, there are fewer services and resources designed specifically for the needs of these people, and so while the numbers of people are small, the training needs of service providers are a priority.

Project Aims

This project aims to develop resources and training tools to assist HACC service providers to deliver appropriate and responsive service that meets the needs of clients from refugee backgrounds, including those who may be survivors of torture and trauma.

To achieve this aim, the project comprised four key components:

i) Implementation of **a five-hour training module** designed to equip direct care workers, case managers, volunteers, co-ordinators and other relevant personnel of HACC-funded service providers with knowledge, skills and strategies to inform their delivery of services to clients from refugee and refugee-like backgrounds.

ii) Adaptation of the **Resource Kit** to be relevant to HACC services across NSW which extends the training module content for the continuing use of service provider personnel at all organisational levels.

Distribution of this Resource Kit to participating HACC funded non-government service providers.

iii) Development of **6 regional handouts** about languages and case studies to complement the State-Wide resource kit.

iv) Distribution of a **fact sheet** that captures the key messages from the Resource Kit for wider distribution.

1.2 Using this Resource Kit

This Resource Kit has been developed to complement the training module for HACC direct care workers, case managers, volunteers and co-ordinators, 'Working with HACC clients from refugee-like backgrounds'.

This Resource Kit will be of use to all service provider personnel, including

- direct care workers
- volunteers
- service co-ordinators
- managers and
- Board/Management Committee members.

It can be used as a reference tool by personnel at all levels in service provider organisations. The aim is to encourage a greater awareness across the organisation of the special needs of this client group.

It will provide all personnel with information about the refugee experience and the special needs of people eligible for HACC services who come from refugee and refugee-like backgrounds, including those who are survivors of torture and trauma.

The kit follows a similar structure and includes similar content to the five-hour training module. The kit extends this content by including additional information on the refugee experience from various perspectives.

The first part of the kit (Sections 1-5) provides information about the refugee experience and the effects of torture and trauma on individuals, their families and their communities. In this section, the impacts of ageing on survivors are discussed, and the needs of those with disability and their carers are addressed.

The second part of the kit (Sections 6-9) deals with service delivery, and provides strategies and guidelines for meeting the special needs of HACC clients from refugee and refugee-like backgrounds who are ageing and/or have disability and their carers.

Factual information in this kit is supported by **17 case studies** that illustrate issues by way of personal experiences. Some of these case studies are reproduced with permission and acknowledgement from other publications. Other case studies are based on the actual experiences of HACC workers delivering services to clients from refugee and refugee-like backgrounds.

1.3 Acknowledgements

This Resource Kit has been compiled with the assistance and contribution of many people. The following contributors are acknowledged with thanks:

- Members of the project Steering Committee, who provided information and support throughout the project: Monika Latanik, Multicultural HACC Access Project Officer, Cumberland/Prospect; Diane Boyde, Multicultural HACC Access Project Officer, Nepean; Dana Rosinski, Western Sydney Community Forum; Adama Kamara, NSW Multicultural Disability Advocacy Association; Marisa Salem, NSW Refugee Health Service; Amy Butcher, SydWest Multicultural Services Inc. (formerly Blacktown Migrant Resource Centre); Elizabeth Chavez, Nepean Migrant Access; Heather Farmer, BCS; Angelika Rotsos, DADHC

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- The MAPS Worker and team from the Multicultural Health Service, Northern Sydney Central Coast Health Service.

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2. The refugee experience – Facts & figures

2.1 Definitions

Who is a 'refugee'?

A **refugee,** as defined by the United Nations Convention relating to the Status of Refugees 1951 and the Protocol relating to the Status of Refugees 1968 is

- any person who has a well-founded fear of being persecuted because of their
    - race
    - religion
    - nationality
    - membership of a particular social group
    - political opinion
- is outside their country of nationality or the country they normally live in, and
- is unable or unwilling to return because of that fear.

People who are defined as refugees are eligible for resettlement in other countries through humanitarian settlement programs.

Refugee 200 visa

To be granted a *Refugee 200 visa*, the person must be:

- living outside their home country
- not have moved outside the country of first asylum
- be subject to persecution in their home country, and
- in need of resettlement

Woman at risk 204 visa

The *Woman at risk 204 visa* is another category of visa for a person identified as a refugee. This is specifically for a woman who is alone or with children, and is recognised as being particularly vulnerable.

People who arrive as refugees are entitled to a full resettlement package of services through the IHSS - Integrated Humanitarian Services Strategy (this will become the HSS – Humanitarian Settlement Services sometime in 2011) and are granted permanent residency in Australia. They also have their airfares paid by the Australian Government.

Who is a special humanitarian entrant?

Just over half of the places in Australia's humanitarian settlement programme are set aside for **special humanitarian entrants**.

Global special humanitarian 202 visa

The person must

- be subject to substantial discrimination amounting to gross violation of human rights in their home country
- be living outside their home country
- not have moved outside the country of first asylum
- have proposer support in Australia.

People coming under this special humanitarian program (SHP) must be supported by a proposer (either an individual or an organisation). They are granted permanent residency and have access to the same mainstream services as Visa 200 entrants.

Other schemes are:

- **In-country special humanitarian 201 visa**
- **Emergency rescue 203 visa**

These two visa categories are for people who are experiencing persecution and are at considerable risk within their own countries. There are very limited places available in these visa categories.

Who is an asylum seeker?

Asylum seekers are people who have arrived in Australia and then apply for an **On-shore protection visa 866**. People may be granted asylum on the grounds of fear of persecution if they are returned to their home country

Asylum seekers enter Australia two ways:

i) With a valid visa, eg. a tourist, student or business visa; they can then apply for asylum while their visa is still valid (if their visa has expired they may be placed in detention while their application for asylum is being processed)

ii) Without a valid visa, e.g. by passage on a boat obtained through a people smuggler. Asylum seekers without valid visas are placed in immigration detention centres while their applications are processed. *Please check the website of the Department of Immigration and Citizenship for the most up-to-date information.*

The Federal Government abolished **Temporary Protection Visas (TPV)** in August 2008 that had granted 3 years' protection to successful applicants for asylum who had entered Australia without a valid visa. These asylum seekers are now eligible for permanent protection.

Who is someone from a 'refugee-like' background?

People from 'refugee-like' backgrounds are those who have settled in Australia through migration programs (such as family reunion or skilled migration programs) and who have come from areas of war and/or organised violence.

These people did not come to Australia as refugees, but they have been through similar experiences and they may have experienced torture and trauma.

Examples

Refugee: Sudanese family from the Dinka ethnic group fled religious and cultural persecution and lived in a refugee camp in Kenya for three years before they were granted entry to Australia as refugees.

Special humanitarian program (SHP): Bosnian man fled his home country in early 1990s, entered Australia on refugee visa. As a permanent resident, he then was proposer for his wife and children as SHP entrants.

Permanent protection visa: Young Chinese woman in Australia on student visa applies for asylum after 1989 Tiananmen Square uprising in Beijing.

Temporary protection visa (formerly): A Tamil family from Sri Lanka were placed in detention after arriving in Australia by boat without visas. They were found to be refugees and were granted a 3-year Temporary protection visa (TPV).

People from refugee-like background: A family from rural Lebanon who were forced to leave their home in dangerous circumstances in mid 1970s when armed conflict reached their village. They made their way to Cyprus where they lived in poverty before they were able to settle in Australia, sponsored by family members under the Family Reunion migration program.

For further examples of refugee and refugee-like experiences

See ***Section 3: The refugee experience – Cultures and stories***

2.2 Australia's humanitarian program intake

Australia will accept approximately 13,750 people in 2010-2011 through the Federal Government's humanitarian settlement programme.

In **2009-2010,** Australia's total humanitarian intake was **13,770 people.**

Table 2.2.1 Humanitarian program intake 2009-10

Humanitarian visa grants 2009-10	
Offshore humanitarian program	**Visa grants**
Burma	1959
Iraq	1688
Bhutan	1144
Afghanistan	951
Congo (DRC)	584
Ethiopia	392
Somalia	317
Sudan	298
Liberia	258
Sierra Leone	237
Total offshore humanitarian program	**9236**
Onshore program	4534
Grand total	**13 770**

Source 'Fact Sheet 60 – Australia's Refugee and Humanitarian Program', Website of the Department of Immigration and Citizenship, December 2010, http://www.immi.gov.au/media/fact-sheets/60refugee.htm

The table below provides an example of the numbers of people who settled in NSW in a recent eighteen-month period, according to their visa category.

Table 2.2.2: NSW humanitarian intake, Jan09-Jun10

Visa category	Number of arrivals
Refugee	2,426
Special Humanitarian	2,521
Permanent Protection	1,474
Total	6,421

Sources:
Department of Immigration and Citizenship Settlement database, 2010

2.3 Where do people from refugee and refugee-like backgrounds come from?

Table 2.3
Main countries of origin of refugees settled in Australia 1930 - 2010

2000-2010	Burma (Myanmar), Bhutan**,** Iraq, Afghanistan, Iran, Congo DR, Liberia, Sudan, Sierra Leone, Burundi, Ethiopia, Sri Lanka, Bhutan, Somalia
1990-2000	Bosnia & Herzegovina, Former Yugoslav Republic (now Serbia, Montenegro), Croatia, FYR of Macedonia, China, Iraq, Afghanistan
1980-1990	Vietnam, South America, Afghanistan, Cambodia, Iraq, Lebanon
1970-1980	Vietnam, Laos, Chile, El Salvador, Argentina, Uruguay, Colombia, Turkey, Poland, Lebanon
1960-1970	Czechoslovakia
1950-1960	Hungary
1947-1950	Europe – Poland, Ukraine, Baltic states (Latvia, Lithuania, Estonia) Germany, Balkans (mainly Croatia)
1930-1940	Germany – Jewish refugees

People have been coming to Australia as humanitarian entrants since the 1930s, with approximately 700,000 people being resettled since then. Those who arrived in the 1930s and 1940s as children and young adults are now aged over 75. Young people who arrived as displaced persons after World War II will now be 65 years and over.

Adults who arrived in the years 1970 -1995 are now ageing. Those who arrived as older persons during the past decade will also be eligible for these services.

People who arrived as humanitarian entrants at any time and set up families may have a child with disability. Others may have acquired a disability through accident or illness.

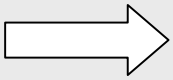
All these people are potential clients of HACC services.

Other countries that people from refugee and refugee-like experiences have come from

Table 2.3 provides information about the main groups of humanitarian arrivals. However, people who have been through refugee and refugee-like experiences have come to Australia from a number of other countries as well such as

East Timor, Argentina, Bangladesh, Egypt, Pakistan, Albania, Indonesia, India, Thailand, Zimbabwe.

How do you find out if your HACC client comes from a refugee or refugee-like background?



*Go to **Section 7, Guideline 1: Identifying HACC clients who are survivors***

2.4 What experiences have refugees been through?

In country of origin

While the specific experiences that people have been through differ according to the location and situation, there are some common elements associated with organised violence. These include:

- Exposure to war and violence
- Displacement and dislocation
- Separation from loved ones
- Degradation and humiliation
- Prolonged harassment by authorities, including torture
- Imprisonment without trial
- Physical and/or sexual abuse
- Many different forms of torture including sleep deprivation; burning; heat, cold and water torture
- Witnessing the torture and/or deaths of others

Those who have escaped major human rights abuses will have suffered physical and cultural dislocation, fear, starvation and other severe hardships.

In Sierra Leone amputation of the limbs of civilians is used by militants as a form of torture

Photo courtesy of Sierra Unite

What is 'organised violence'?

Organised violence is violence that is sanctioned by the state, such as war or forms of violence inflicted by government or paramilitary forces.

The quotations below from commentators describe the effects of organised violence on individuals and on communities.

'This involves terrorising the whole population through systematic actions carried out by forces of the state, eg. the military and the security forces'.

Martin-Baro 1989

'Organised violence as state terrorism leads to breakdown in relationships, community fragmentation, prevention of initiative and ability to organise and pervasive mistrust in authorities as well as other community members.'

Martin-Baro 1989

'… organised violence is aimed at severing the connections between people, controlling their ways of being together and relating to each other and destroying the possibility of free dialogue and thought .'

Blackwell 1993

'… *each person is considered isolated; each person has to take care of herself or himself and therefore must behave according to what is required, but as an individual, without looking at others, without trying to organise for mutual support.'*

Blackwell 1993

During escape

People escaping organised violence often spend an extended period in refugee camps in neighbouring countries. It is not uncommon for people to be in camps for over ten years before they are processed for resettlement, generally through the United Nations High Commissioner for Refugees. For each person who is granted a refugee visa, there are many who are left behind, including family members.

Life in refugee camps typically includes these hardships and sources of anxiety and frustration:

- Lack of food and starvation
- Lack of adequate shelter
- Disease
- Squalor
- Danger and fear
- Sexual violence
- Separation from loved ones, and uncertainty of their whereabouts
- Distrust
- Helplessness
- Lack of schooling
- No employment
- Prolonged uncertainty about the future.

Those escaping face other challenges, depending on their locations. These hardships include those experienced by Vietnamese 'boat people' in the 1970s and 80s.

This photograph of Afghans living in a refugee camp in Pakistan was taken by a STARTTS counsellor who worked as a doctor in the camp for several years

At resettlement

Resettlement in a new country after many years of uncertainty and hardship represents a positive step towards the future. But for refugees, there are further challenges to face in making a meaningful life for self and family in a new country, and in coping with the traumas of the past.

Practical considerations:

- Language learning
- Housing
- Schooling
- Health care
- Employment
- Finances

Cultural issues and problems:

- Cultural dislocation, including religious, moral and gender issues
- Lack of understanding about the 'system'
- Discrimination by host society; expressions of racism

Personal issues:

- Post traumatic reactions including depression, anxiety, PTSD, panic attacks
- Fear and distrust of authorities
- Fears about missing family members
- Family stress after long separations
- Inter-generational conflict as younger family members engage more readily with host culture

For an example of a resettlement experience

*Read **Case Study 1: Resettlement as an older refugee - Safar Ali***

2.5 Statistics: Cultural and Linguistically Diverse (CALD) Populations across NSW

This section provides some data on the settlement patterns of people who have come to Australia as humanitarian entrants in recent years and a summary of the CALD populations across NSW.

Table 2.5.1 shows the settlement patterns for a four year period in Sydney.

Table 2.5.1 Where humanitarian entrants settled in Sydney 2005/06 – 2009/10

	Key settlement locations	No of people
1	Fairfield-Liverpool	7,319
2	Central Western Sydney	5,763
3	Canterbury-Bankstown	2,337
4	Blacktown	2,236
5	Inner Sydney	599
6	Inner Western Sydney	516
7	St George-Sutherland	467
8	Outer Western Sydney	369
9	Central Northern Sydney	339
10	Northern Beaches	297
11	Lower Northern Sydney	221
12	Outer South Western Sydney	167
13	Eastern Suburbs	136
14	Sydney	99
15	Gosford-Wyong	16
	Total	**20, 881**

Source:
Department of Immigration and Citizenship, 2010

METRO SOUTH REGION

South West Sydney LPA

South West Sydney is the most culturally and linguistically diverse region in NSW, in particular the LGAs of Fairfield, Liverpool and Bankstown. Based on 2006 Census Data, in these three LGAs:

- 54.4% speak a language other than English (67.2% in Fairfield)
- 39.1% speak English at home (27.5% in Fairfield), compared to 74% in NSW
- 41.9 % of SW Sydney's population were born overseas (51.5 % in Fairfield), compared to 23.8% in NSW
- 50.4% of people over 65 years were born in a non English Speaking country (67.1% in Fairfield).

These three areas are amongst the top ten LGAs for settlement of humanitarian entrants in NSW. These three LGAs also have a higher percentage of residents aged over 65 (Fairfield: 21.3%, Liverpool: 14.4%, Bankstown: 19.4%) than across NSW (13.3%).

The largest groups who come from refugee and refugee-like backgrounds in the 70+ age group are Vietnamese, Arabic, Spanish speakers, Polish, Croatian, German, Assyrian, Serbian, Russian, Macedonian, Ukranian, Khmer and Dutch.

In contrast, the other four LGAs in this Local Planning Area (Campbelltown, Camden, Wollondilly and Wingecarribee) have significantly fewer residents from CALD backgrounds, and far lower proportions of ageing residents (7.4%, 8.5%, 8.9%, with Wingecarribee the exception at 18.0%).

South East Sydney LPA

While South Eastern Sydney has a significant CALD population, the largest groups in this area come from Greek, Italian, Chinese, Indonesian and Korean backgrounds (i.e. not the target population).

The largest communities from refugee and refugee-like backgrounds in the 70+ age group are Russian, Arabic, Hungarian, Macedonian, Spanish speakers, German, Croatian, Polish and Dutch.

The LGAs of Rockdale, Kogarah and Hurstville have the highest populations in the region of people from the target group, including those from former Yugoslavian states (in particular the former Yugoslav Republic of Macedonia), Lebanon and Egypt. In Botany Bay 3% of the population was born in Bangladesh.

Sydney's Eastern Suburbs (Waverley and Woollahra) are home to ageing people from German, Polish, Russian and Hungarian backgrounds.

While Sutherland Shire has a relatively low CALD population, in 2006 there were between 500 and 1,000 people from each of the following communities: Egyptian, German, Lebanese, Dutch and the former Yugoslav Republic of Macedonia.

Inner West LPA

The Inner West is home to many CALD people, with a large number from East and South Asia.

The largest groups in the 70+ CALD population in the Inner West are Italians and Greeks (i.e. not the target population). The largest group of people from refugee and refugee-like backgrounds is Arabic speaking (primarily from Lebanon), consisting of approx 1500 people. Other significant groups are Spanish speakers, Vietnamese, Croatian, Russian, Polish, Tamil, Hungarian and German.

Canterbury LGA has significant populations of people from Lebanon (5.5%) and Vietnam (3.3%); Strathfield has a large Tamil population (4.4%); and Marrickville has significant numbers of Vietnamese and Arabic speaking people. Burwood has a higher than average proportion of the 65+ age group (15%) and a wide variety of multicultural populations.

METRO NORTH

Cumberland Prospect LPA

Cumberland Prospect LPA has a high population of migrants and half of the world's nations are represented among its residents. More than a third of people in the Cumberland Prospect LPA were born overseas and just under one-third speak a language other than English at home. The main languages spoken at home are: Arabic, Cantonese Tagalog Mandarin and Hindi, Among the 65+ age group, 14.4 per cent speak English 'not well' or 'not at all'.

In the 60+ age group, people from China, Vietnam, Lebanon, Afghanistan, Turkey, Sri Lanka, countries of the former Yugoslavia, and Spanish speakers, could be from refugee-like backgrounds. While fewer in number, those from Cambodia, Laos and the Baltic States may also have come from refugee-like backgrounds.

Nepean LPA

According to Australian Bureau of Statistics Census 2006 data, approximately 18% of people living in the Nepean LPA were not born in Australia.

The most common non-English speaking countries of birth varied between the three LGAs. In the Blue Mountains the top three were Malta, the Netherlands and Germany; in the Hawkesbury LGA they were Germany, the Netherlands and the Philippines; and in Penrith they were the Philippines, Malta and India.

Germany and the Netherlands were strongly represented in Australia's post-war Humanitarian Stream program which makes it a strong possibility that older people in Nepean LPA who arrived from these countries have had refugee-like experiences.

Northern Sydney LPA

Approximately one-third of people living in the Northern Sydney LPA were not born in Australia and the most common non English speaking countries of birth are China and Hong Kong. The highest number of people born overseas was living in Willoughby, Ryde, North Sydney and Ku-ring-gai LGAs. The most common non English speaking countries of birth are China and Hong Kong.

The highest number of people speaking other languages at home in the Northern Sydney LPA used Cantonese, Mandarin, Korean and Italian. However, German is the most widely -spoken other language in Pittwater and Mosman.

As with other LPAs in the Metro North Region, there are a number of countries represented in Northern Sydney LPA. People from countries such as China, Sri Lanka, Iran, Hungary, Germany, the Netherlands, the countries of the former Yugoslavia, Lebanon and Vietnam could come from refugee-like backgrounds.

HUNTER REGION

Hunter LPA

This area does not have a large CALD population, particularly outside the LGAs of Newcastle and Lake Macquarie. These LGAs are home to people from Macedonia, Germany, Netherlands and Poland. In recent years Newcastle has also become home to several hundred new humanitarian arrivals, primarily from African countries of origin. Other LGAs in the area have small populations of people primarily from German, Dutch and Polish backgrounds.

The CALD groups from refugee-like backgrounds who are 70+ in the Hunter are primarily German, Dutch, Polish, Hungarian, Arabic, and Spanish speakers.

Central Coast LPA

While the Central Coast LGAs of Wyong and Gosford have a high proportion of residents over 65 (18.3% and 18.2% respectively), the CALD population in these areas is low (approx 88.5% and 86% respectively are Australian born). There is a relatively small population of people from Germany, Netherlands and Poland who may come from refugee-like backgrounds, particularly in the Wyong LGA.

SOUTHERN REGION

Illawarra LPA

Wollongong LGA has by far the highest CALD concentration in this area, with significant populations of people from Macedonia, Germany, Netherlands, Lebanon and Turkey. Over the past few years, Wollongong has also become home to new humanitarian arrivals primarily from African countries of origin, but also from Iraq and Burma.

In the 70+ age group, German, Macedonian, Spanish, Dutch, Polish, Serbian and Hungarian are the main languages spoken by those from the target population.

Southern Highlands LPA

The largest CALD language group in the 70+ age group is German, with just over 300 speakers spread across the area. There are also between 40 and 100 speakers each of Dutch, Polish and Hungarian. The LGAs with the highest CALD populations from the target groups are Queanbeyan (1.5% Macedonia, 0.7% German) and Cooma-Monaro (1.6% German, 0.7% Dutch).

WESTERN REGION

The Western Region has comparatively small numbers of people from CALD backgrounds (3.5%).

Central West LPA

Main languages spoken by the 70+ age group CALD population in the 2006 ABS census were Italian (n=111), German (n=78), Dutch (n=37), Polish (n=28), Hungarian (n=25) and Greek (n=25). With the exception of Italian and Greek speakers, these people are likely to have come to Australia as post World War II settlers, and as such, are part of the target population.

Bathurst LGA has a slightly higher proportion of CALD speakers than other LGAs.

Orana/Far West LPA

This LPA has a very small CALD population. Languages spoken by the 70+ age group CALD population are: Italian (n=approx 142), German (n= approx 50), Polish (n= approx 25), with others including Greek, Croatian, Dutch and Hungarian in very small numbers.

Interestingly, there are some communities such as Walgett LGA (pop 6949) which have a multicultural community of people from the states of the former Yugoslavia.

Riverina/Murray LPA

This LPA is by far the most multicultural in the region. The largest CALD community in this area is Italian, with over 1,000 speakers aged 70+. Other main languages spoken by the over 70 age group (albeit by small numbers, approx 20-160) are German, Dutch, Greek, Polish, Hungarian, Spanish, Slovene and Ukrainian.

In addition, Griffith LGA has an emerging Afghan community (1.8%). Albury has populations of German and Dutch people above the national average, as well as Lao and Arabic speaking communities. Nearby Wagga Wagga is now home to several hundred new humanitarian entrants, primarily from African countries of origin and Burma.

NORTHERN REGION

Far North Coast LPA

The largest groups of people aged 70+ from the target population are German and Dutch. There are also small numbers of Spanish, Polish, Hungarian and Czech speakers. The LGA with the largest number of people from the target group is Clarence Valley.

Mid North Coast LPA

This area has a very similar profile to the Far North. The LGAs with the largest representation are Coffs Harbour and Greater Taree. This profile is changing with the arrival over the past few years of several hundred new humanitarian entrants in the Coffs harbour area, primarily from Burma and African countries of origin.

New England LPA

This area has smaller numbers than the coastal areas of the region. In the over age 70 population, there are approx 72 German speakers and just over 40 Dutch speakers, with other main CALD groups Italian, Greek and Cantonese.
The Armidale-Dumaresq LGA has the largest CALD population.

2.6 Languages spoken by people from refugee-like backgrounds

In many countries of origin, different languages are spoken by different ethnic and/or religious groups. For example, many humanitarian entrants who came from Iraq speak Assyrian, Kurdish or Turkmani rather than Arabic.

It is important for service providers to be aware of this so that they obtain the most appropriate interpreting services for clients who may be survivors. It is essential that interpreters speak the language preferred by the client. Service providers need to ask their clients what their preferred language is. If they make an assumption and organise interpretation for a not preferred language, clients may suffer considerable distress.

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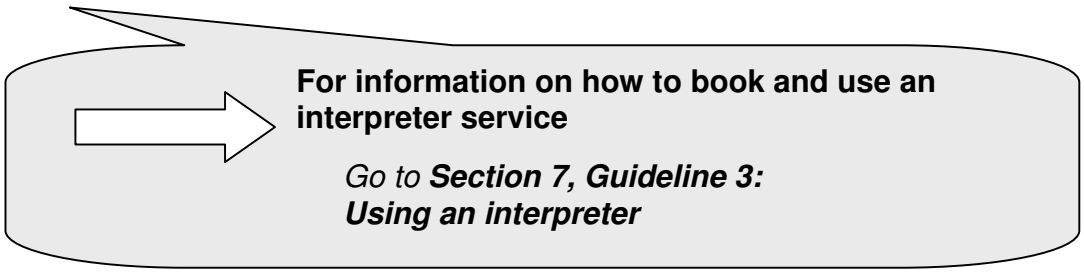

The table overleaf provides information about the different languages spoken in many countries that people from refugee and refugee-like backgrounds come from. Please note that this is not a comprehensive list.

Table 2.6 Languages spoken by people from main countries of origin

Country	Main language(s)	Dialects and other languages
Afghanistan	Pashtu*, Dari*, Hazaragi	Uzbeki, Turkmani, Baluchi, Pashaii, Nuristani
Bosnia-Herzegovina	Bosnian*	Croatian*, Serbian*
Burundi	Kirundi*	Swahili, French
Cambodia	Khmer*	Mandarin*, Cantonese*, Teo Chiew*, Vietnamese*, French*
Chile	Spanish*	Amerindian Languages
China	Cantonese*, Mandarin*	Hakka*, Tibetan, Mongolian*, Hokkien*, Fukkien & many others
Croatia	Croatian*	Bosnian*, Slovenian*, Serbian*
Congo, DR	Kikongo, Lingala* Swahili* Tshiluba	French
Czech Republic	Czech*	
East Timor	Tetum*	Portuguese*, Hakka*
Eritrea	Tigrinya, Tigre	Amharic*
Estonia	Estonian*	Russian*
Ethiopia	Amharic*	Tigrigna, Oromo*, Italian*, Arabic*
Germany	German*	
Hungary	Hungarian*	Romanian*
Iran	Persian (Farsi)*	Azeri*, Kurdish*, Armenian*, Arabic*, Turkish*, Baluchi, Assyrian*
Iraq	Arabic*	Kurdish*, Assyrian*, Turkmani
Kenya	Swahili*	Kikuyu*, Gujarati*, Masai
Laos	Laotian*	Hmong, Chinese dialects, French
Latvia	Latvian (Lettish)*	Russian*, Polish*
Lebanon	Arabic*	Armenian*, French*
Liberia	Grebo, Liberian pidgin*,	Bassa, Bandi, Gola, Dan and others
Lithuania	Lithuanian*	Russian*, Polish*
Mauritania	Hassaniya Arabic	Pulaar, Soninke, Wolof, French
Montenegro	Serbian*	Croatian*, Albanian*
Myanmar (Burma)	Burmese*	Karen*, Chin, native languages
Netherlands	Dutch*	Friesian
Pakistan	Urdu*	Punjabi*, Sindhi, Pashtu*, Baluchi
Poland	Polish*	Ukrainian*
Rwanda	Kinyarwanda*	French, English
Serbia	Serbian*	Croatian*, Albanian*
Sierra Leone	Krio*	English, Mende*, Fullah*
Somalia	Somali*	Arabic*, Swahili*, Italian
Sri Lanka	Sinhalese*	Tamil*
Sudan	Arabic*	Nubian, Dinka*, Madi, Acholi
Turkey	Turkish*	Kurdish*, Arabic*
Ukraine	Ukrainian*	Russian*, Polish*
Uruguay	Spanish*	
Vietnam	Vietnamese*	Cantonese*, Khmer*, Teo Chiew*
Zimbabwe	English, Shona, Ndebele	

* languages available from the Health Care Interpreter Service

3. The refugee experience – Cultures & stories

This section provides detailed information about some of the main countries of origin of people from refugee and refugee-like backgrounds.

Information comes from three sources:

3.1 STARTTS – **Survival and beyond sheets**

3.2 Multicultural Advocacy Association of NSW (MDAA) – **Ethnicity and Disability Information sheets**

3.3 The website of the Australian Government Department of Immigration and Citizenship – **Community Information** sheets.

3.1 Survival and Beyond sheets

These sheets have been compiled from STARTTS community consultations, reports and articles, and from interviews with STARTTS bilingual counselors. They provide:

- a summary of the recent history of the country, including conflicts leading to organised violence
- a description of the experiences of displacement and trauma that people who have come to Australia from that country may have been through
- a summary of attitudes to ageing and disability shared by many people from that country.

Countries of origin included are:

Survival and beyond: Afghanistan

The world's largest population of refugees – over six million – come from Afghanistan, as a result of 30 years of internal turmoil.

Background

In 1978 the Soviet-backed regime in Afghanistan began systematic political repression, targeting 'enemies of the revolution', mainly educated people from the middle class. Tens of thousands of people disappeared, and were imprisoned, tortured and often killed. This was a time of chaos when Soviet spies infiltrated the population, spreading suspicion and distrust.

Prior to this time, Afghanistan had been a modern Islamic state with a modern economy. Women wore Western-style clothes and participated in education and work. While the values of life were guided by Islamic principles, it was a liberal form of religion that was practised.

The population of Afghanistan consists of the following ethnic groups in order of prevalence: Pashtun, Tajik, Hazaras, Uzbak, and several other minority groups. Prior to the Soviet invasion, the ethnic situation in Afghanistan was stable, and there were many mixed marriages.

After the collapse of the communist regime, tensions broke out between rival political and ethnic groups. From 1996 to 2001 power was held by the Taliban, who imposed severe restrictions on the rights and freedoms of the general population, particularly women. As universities and schools were closed down by the repressive Taliban, education standards deteriorated and the literacy rate fell to 6%. Since 2001 the Afghan people have been caught in the 'war against terrorism', fought between US-led forces and the Taliban, resulting in further deaths and widespread disability.

In the past 30 years over two million people have died, two and a half million have war-related disabilities and two million have been internally displaced. Experiences of violence include exposure to mortar bombing and hand-to-hand combat, rape, and landmine injury. Those who were tortured report the following, among other abuses: beatings; electric shocks; burning with cigars; use of drugs; repeated sexual assaults; deprivation of food, water and light; exposure to extreme hot and cold; and witnessing the torture of friends and relatives.

Escape experiences

During the Soviet occupation, when members of the middle class Pashtun ethnic group were persecuted, a small number who were financially well off and had contacts abroad left their homeland for safety.

The most common route of escape for most persecuted people, however, was to gain entry to neighbouring countries such as Pakistan, Iran or India as places of first asylum. There Afghan people could apply for resettlement under humanitarian programs to, for example, European countries, the US or Australia. But this process was slow, and could take between one and ten years. In the crowded refugee camps in Pakistan, families lived in tents and makeshift clay homes for many years. In summer the temperature reached 44 degrees. Many became seriously ill with infectious diseases, and most suffered from malnutrition.

The next wave of refugees from Afghanistan consisted mainly of people from the minority Hazara ethnic group who suffered severe discrimination and persecution under the rule of the Taliban after 1996. The most common mode of escape for these people was to pool financial resources for the payment of a people smuggler who would then take a family member across the border to Pakistan. The refugee then spent a short time (a week to a month) waiting for further passage to a country such as Indonesia. From there, a rickety boat ferried them to illegal entry into Australia where they were granted temporary protection (TPVs), interred in detention centres and provided with little access to services. (See **Case Study 1: Resettlement as an older refugee -- Safar Ali)**

Family, ageing and disability

Afghanistan is a society based on Islamic ideals of collectivism, in which each person has a clear role assigned to them that is relative to others in their immediate family, extended family and community. The individual is not on their own, but part of a web of interactions, rights and duties. Parents must provide for the spiritual and physical needs of their children; children are obliged to look after their ageing parents.

Ninety-nine per cent of Afghans are Muslim. Afghans follow the teachings of the Qur'an in regard to the obligations of people to care for the needy. Children are regarded as gifts from God, and all children are accepted and loved equally as creations of God. A child born with disability is seen as an expression of God's will. The family will not feel shame, but an obligation to provide care for that child within the extended family and community.

Likewise, ageing people are cared for by their children as an unquestioned obligation. If any ageing person does not have children, the duty of care falls to a close blood relative.

In Australia, Afghan people will be committed to carrying out their cultural obligations to care for family members who are ageing or who have disability within their family circle. However, families will generally be without the extended network of their former lives that support them in their caring roles.

Because Afghan families are determined to keep their family members with them at home, they will need services, particularly personal care and respite services, to support them. These services will need to be presented to the family as enhancing and adding to the family's care rather than replacing it.

Service providers will need to be aware of cultural issues, and in particular show respect for the Muslim way of life. This includes an awareness of gender issues (such as gender of workers) and food preferences.

Source: STARTTS

For information about delivering services to Muslim people

Go to the brochure ***'Islam: A guide for service providers working with people with disability'*** *in* ***Section 5.9***

Survival and beyond: Assyrian & Chaldean people of Iraq

Iraq continues to be one of the world's two greatest sources of refugees. Over 60% of Iraqi people in Australia have arrived since 1996 in the aftermath of the Gulf War through family reunion, humanitarian and refugee programmes. This population includes Arabs, Kurds, Assyrians, Armenians, Chaldeans, Mandaeans, Turks, Turkmen and Jews.

The ethnic groups with the largest number of settlers are the Assyrian and Chaldean groups. These Christians have experienced long term persecution for their religious and political beliefs.

Brief history – Assyrian people

The Assyrian people are the indigenous people of Mesopotamia and have a history spanning over 6700 years. The Assyrians belong to an ancient people whose kingdom 5000 years ago lay to the north of Baghdad, Iraq. By 700BC their empire extended from Egypt in the west, to the Persian Gulf in the east, and to Turkey in the north. The Assyrian kingdom fell in 612 BC and many people migrated to the mountains of Kurdistan to a district known as Hakkiari where the population was based for 2000 years. During the first century AD, Assyrians adopted Christianity as their national religion. Today, religious services in the Apostolic Church of the East are conducted in Aramaic, the language spoken by Christ.

The Chaldean people share the same ethnic background as the Assyrians, but they follow a branch of Western Catholicism rather than the Church of the East.

During the First World War Great Britain persuaded the Assyrians to ally with them against the Ottoman Empire. During this war the Turkish Army devastated their country and many people died of hunger and disease. This period has been called the Assyrian Holocaust. The remnants of the Assyrian people resettled in Baqubah in Iraq where Britain held the mandate.

In 1932 the British relinquished the mandate of these areas to Iraq. The Iraqi government promised that minorities under their care would receive the same treatment as they had received under British rule but after six months the Iraqi army massacred 3000 Assyrians and destroyed many farms, houses and animals.

Prior to the Gulf War more than 400 Assyrian villages were obliterated by the Iraqi government and much of the Assyrian population in the north of Iraq were transferred to the larger cities such as Baghdad. In 1991 the Gulf War further aggravated the situation and more than 250 000 Assyrians fled Iraq. Since 1996 internal fighting between two parties of Kurds led to further unrest in the region. The people who were not aligned with either party suffered persecution in Assyrian villages.

Assyrian and Chaldean people in Australia
Today over 20,000 people of Assyrian background live in Sydney. The vast majority of Assyrian people in Australia live in Sydney, particularly south-western Sydney. These people have come as humanitarian and family reunion entrants not only from Iraq, but from Iran, Syria, Lebanon and Turkey. In the 2006 census, over one-third of people of Iraqi background reported Assyrian or Chaldean ancestry and spoke Assyrian (also known as Syriac) at home. The Assyrian and Chaldean communities are well established, with churches, schools, social clubs and welfare organisations servicing these communities.

Many people have experienced dislocation and long exposure to war, as well as torture and trauma. In STARTTS community consultations, the participants mentioned that they felt that they suffered depression, isolation, difficulties accessing doctors and difficulties getting information about health in their own language. They also reported experiencing discrimination, and some people expressed their fear of discrimination and violence in the streets.

Access to services
As welfare and community services were non-existent in their countries of origin, most Assyrian and Chaldean people will be unfamiliar with the concept and process of accessing services, including services for people who are ageing and/or have disability. Traditionally, caring and support is provided within a broad extended family network. Carers may feel distrustful of services provided external to the family, and deeply held cultural values around duties and obligations may further inhibit people from accessing services.

However, reports indicate that as people from this community settle into Australian society, they will be willing to accept services, particularly those that provide respite and support for a child or young person with disability. People may be less willing, however, to surrender care for an ageing relative to a service provider. Residential care would be out of the question, but there is considerable scope for HACC service providers to engage with the community and promote in-home services for ageing people of Assyrian and Chaldean background and their families.

Source:
STARTTS

Survival and beyond: China

China is one of the world's greatest powers, with the third largest land area and the world's biggest population of approximately 1.4 billion people. Over 90% of China's population is Han Chinese and the official language is Mandarin. The remaining people make up 55 minority groups with their own languages, cultures and traditions, such as Zhuang, Uighur, Hui, Yi, Tibet, Miao, Manchu, Mongol, Buyi, Korea and others. It is ruled by the Communist Party under a single party system.

Brief History
China has a recorded history of over 5,000 years. It has been ruled under different ethnic groups over several dynasties and experienced invasions as well as civil wars. Such history contributed to the creation of a rich but complex civilisation.

China was at war with multiple European countries prior to the collapse of the last dynasty in 1911. Following this the country descended into a civil war between the Nationalist Party and the Communist Party. The Communist Party emerged the victor in 1949 and the chairman, Mao Zedong, established the People's Republic of China. During this time parts of China were occupied by the Japanese (from 1931 to just after WWII) and an estimated 2.7 million Chinese were killed in a Japanese "pacification" program that targeted males between the ages of 15 and 60.

The economic and social plan called the Great Leap Forward began in the 1950s. It amounted to the Communist Party controlling the country and introducing land reforms, strong industrialisation and enforced collectivism. Poor planning meant that many of these efforts failed and the resulting famine was reported to have resulted in the deaths of around 30 million people.

The Cultural Revolution which began in 1966 (and lasted until 1978) was largely motivated by power struggles within the party, which saw suspected enemies such as rich peasants, landlords, students, intellectuals and anti-communists sent to work camps in the countryside for 're-education', or charged with corruption and sent to prison. Numerous incidents of torture, killings, beatings and humiliation were recorded across the country. Religion was banned, and temples, churches, mosques, monasteries and cemeteries were closed down or destroyed.

In the early 1970's China established closer ties with the USA and joined the United Nations and the UN Security Council. By the late 1970's China had begun a program of modernisation and economic reform and today it is one of the world's fastest growing economies.

Other Human Rights Issues

Despite the opening of its market economy and recent reforms to the legal system, China is still a state-controlled country. It is regularly criticised for its poor human rights record especially in regard to freedom of expression and religion; children's and women's rights; and access to a fair legal system. Reports of abductions, house arrests and media censoring are common; as are riots and demonstrations that are often repressed by the government. The massacre of hundreds of protesters demanding political reforms in Tiananmen Square attracted worldwide condemnation in 1989.

In some cases the right to worship is limited, and mosques, congregations, monasteries and temples are closely monitored by the government. Non-registered institutions, such as the classified 'evil cults' (example: Falun Gong), are strongly restricted and its followers prosecuted.

The Muslim population of the Xinjiang Uighur Autonomous Region of China is also under strict government repression including forced indoctrination. Historically this central Asian territory was invaded by China and many there still fight for its independence.

Similarly, the indigenous people in Tibet are forcibly removed from their fragile environment to make place for development projects, as well as to weaken their cultural ties and allow for more integration with mainland China. Around 700 000 have already been resettled and 100 000 more will be relocated to other cities according to recent government policies. Widespread repression against Tibetan residents, monks, nuns and children are known to be a regular occurrence.

Chinese People in Australia

Early Chinese settlers in Australia can be traced back to the mid 19th century. Predominantly they came to Australia for the discovery of gold, but also to avoid or escape civil disorder, famine and environmental issues. More recently they have come as overseas students, skilled and economic migrants, to reunite with family, as asylum seekers, or as refugees and humanitarian entrants.

Chinese people in Australia are geographically and culturally diverse. The Chinese population comprises of people arriving from places as far away as Russia, and also includes people from Malaysia, Singapore, Hong Kong, Taiwan, Vietnam, Cambodia, Laos, Tibet, Christmas Island, Indonesia, Brunei, and Thailand. Sometimes they only share ancestral heritage with each other and speak over five different languages. Many Chinese people practice a variety of religions such as Taoism, Confucianism, Buddhism, Islam and Christianity

including people from Mainland China, although China is a communist state and officially atheist. Some settlers have been in Australia for many generations and commonly share the same beliefs and values as Anglo-Celtic Australians.

Cantonese is commonly spoken and the vast majority of Cantonese speaking people consider that they speak English very well or well. The Mandarin speaking population is growing rapidly, especially in the older population group, and the majority speaks English not well or not at all. The Chinese community in NSW has established several active, community-based organisations (see: http://www.nla.gov.au/asian/lang/cis.html for more information).

Attitudes to Disability and Ageing
Family has a fundamental role within Chinese culture. There are set family structures, and mothers are responsible for the provision of care for children and the elderly. All parents, however, share responsibility for the care and well being of children. Older people are respected, loved, held in high esteem and generally cared for by their families.

Disability is mostly viewed as something negative. Religious and philosophical influences provide the basic framework for the thinking and behaviour about disability and other health issues. Some traditions and popular views about disability and illness include: lack of morality or virtue; paying for a debt owed in a past life; and punishment.

A lack of cultural sensitivity and language barriers are considered to be the main reasons preventing people from using services. HACC workers should establish a dialogue with clients to understand each individual's circumstances (including their cultural, linguistic and religious background) and existing support networks. It is also important to accommodate individuals' traditional beliefs and practices, both in the treatment and the explanation of illness/issues, and include family members in the care plan as much as possible. Social roles usually influence interactions, thus social behaviour should be observed as much as possible. Eye contact is avoided, shyness and passivity are a cultural norm and saying 'no' is considered impolite. Same-sex health workers are preferred and open discussion about sensitive issues, such as experience of mental health issues and sexuality, are avoided.

Sources:
Materials from: *Multicultural Disability Advocacy Association of NSW (MDAA), Department of Immigration and Citizenship , The World Bank, Adult Migrant English Program Research Centre (AMEP), The Disability Council of NSW, University of Queensland, Human Rights Watch and other articles* were used to develop this sheet.

Survival and beyond: Croatia

Croatia is located on the Adriatic Sea in Central South Eastern Europe. The official language is Croatian. Croatia has a population of approximately 4.5 million of which the majority (89%) are Croats. Minority groups include Serbs (4.5%), Bosniaks, Hungarians, Italians, Slovenes, Romanis and others. The dominant religion is the Roman Catholic faith.

Croatia has had a turbulent history for parts of the last century with the population being exposed to war and violence. This has contributed to several waves of migration to countries like Australia in search of political freedom, safety, and economic opportunity.

Brief History

Croatia has had a diverse history which has shaped Croatians' culture, heritage and presence in Australia. Until the end of World War I Croatia, as we know it today, was part of the Austro-Hungarian Empire. With the end of the war in 1918, Croatia, Serbia, and Slovenia established a kingdom that became known as Yugoslavia in 1929.

Croatia was occupied by German and Italian forces during World War II and the resulting fascist state was responsible for a range of atrocities such as the attempted extermination of minority groups. In 1945, at the end of WWII, the Socialist Federal Republic of Yugoslavia (SFRY) was formed which comprised the independent states of Slovenia, Croatia, Bosnia and Herzegovina, Serbia, Montenegro, and Macedonia.

After the Croatian declaration of independence from the SFRY in 1991, a war broke out between the Serbia controlled Yugoslavia Peoples Army allied with many ethnic Serb militias inside Croatia which opposed Croatian independence, and the Croats and other supporting minority groups of the newly independent Croatia. After 4 years of fighting which saw many people displaced or killed in the violence, and war crimes committed such as ethnic cleansing, rape as a weapon of war and torture, peace was declared in 1995 with the signing of the Dayton Peace Accords.

The war had a drastic impact on the lives and livelihoods of the people in Croatia. Although estimates vary, the death toll has been reported upwards of one hundred thousand people and an estimated 1.5 million people were exiled as

refugees. Additionally, livelihoods and safe living conditions in Croatia were diminished due to destroyed factories and farms and the wide use of landmines.

History in Australia

Croatia has had a long history of immigration to Australia, with records dating back to the early part of the 19th century. Drawn by the booming gold fields in Victoria and limited economic opportunities in parts of Croatia, this economic migration continued into the early part of the 20th century.

After WWII there was another large wave of migration from the people of the countries of the former Yugoslavia. This included twenty-two thousand Croatians as a result of the Displaced Persons Scheme established by the Government of Australia. Many of these displaced persons had spent time in refugee camps.

The largest wave of migration to Australia was from the 1960s through to the mid 1970s when people came looking for employment and economic opportunities. By 1976, nearly one hundred thousand displaced persons and migrants from the countries of the former Yugoslavia were living in Australia.

During the 1980s the Family Reunion Program and the Skilled Migration Program allowed for continued migration of Croatian communities to Australia.

The second largest wave of migration occurred during the 1991-1995 war. Refugees from the countries of the former Yugoslavia made up the largest population of humanitarian entrants to Australia during the 1990's.

By the 2006 census there were more than one hundred thousand Croatian Australians living in Australia.

It is important to note that many recently arrived migrants and refugees who identify as being Croatian have come from Bosnia-Herzegovina and other parts of the former Yugoslavia. They may have also experienced war and violence.

Attitudes to family, disability, health and ageing

An important feature of Croatian culture is the notion of hospitality; it is highly regarded and is often seen as essential in maintaining relationships with family and friends. Families often share their burdens and help in the care of one another.

Care for the elderly and the disabled usually falls on the women in the family and is seen as a life-long obligation. The mother is typically the primary caregiver, with sisters and other women in the family often assisting as needed. In general it is the responsibility of the family, spouses and children, to do all of the caring and outside services may not be readily sought. This high dependence on family support may result in the carer becoming overburdened and isolated.

Honour and respect are highly valued in Croatian society. Disability, particularly mental illness and intellectual disability are often seen as taboo. Many Croatians may perceive the effects of having a person with a disability in his/her family as negative and may be looked down upon by the community. As family honour and community respect are held in such high regard it is also possible that people with disability may hide their problems or the family may hide them. The shame associated with having a family member with a mental illness, or intellectual disability, might cause social exclusion for the individual and the entire family.

As a result of the social stigma associated with disability, families may also feel that they need to support and care for the person with disability without the assistance of outside services. In some cases, religious beliefs can also be a factor in how the disability is perceived; the disability may be seen as punishment for sins previously committed.

During the wars in the former Yugoslavia, many people experienced trauma and even torture, loss of family members and separation from family and friends. These experiences may impact on the mental health of people from this region and make traditional family care more challenging.

When working with refugee clients from the Croatian Australian community, it is important to keep cultural aspects such as language and religion in mind, as they differ across ethnic groups (Example: Croats, Serbs, etc).

Sources:
Information included in this fact sheet has come from a number of sources including The Department of Immigration and Citizenship (DIAC), Australian Department of Foreign Affairs and Trade (DFAT), US CIA, Multicultural Disability Advocacy Association (MDAA), Australian Croatian Community Services (ACCS) and other academic sources.

Survival and beyond: Jewish Survivors of the Holocaust

There are over 13 million Jewish people worldwide, although it is very difficult to estimate the actual number. The definition of 'a Jew' varies slightly depending on whether a religious or national approach to identity is used. Generally Jews include three groups: people who were born to a Jewish family regardless of whether or not they follow the religion; those who have some Jewish ancestral background or lineage; and people without any Jewish ancestral background or lineage who have formally converted to Judaism and therefore are followers of the religion.

Brief History

Judaism is one of the world's oldest religions whose origins date back to 1900 BC when Abraham travelled to the area now know as Palestine and Israel. Some 450 years later Moses guided the Jewish people to this Promised Land to escape slavery in Egypt (The Exodus). Following this the Jewish people received the 10 Commandments and other rules on Mt Sinai.

After the Exodus, the Jewish population successfully established a strong civilization around this area now known as Israel and Palestine. However, following the invasions by the Babylonians in 598 BC and the Romans in 70 AD, many of the Jewish population fled and dispersed to live in exile around the world (diaspora).

Since then the Jewish people have continued to face persecution in different parts of the world. Anti-Semitism in Europe had its origins in the differences between Christian and Jewish communities, persecution by the Catholic Church and theories of racial superiority around at the time. Before 1900 many European states had already imposed civil restrictions, persecuting and killing Jewish people.

The Nazis, when they took power in Germany in 1933, made several legislative changes and Germany was the first European country to openly discriminate against members of its own community. Restrictions were imposed on civil liberties and forced emigration was seen as a solution to the 'Jewish problem'. However the outbreak of the World War II in 1939, followed by the occupation of Jewish populated Poland and the decision to invade the Soviet Union, resulted in the establishment of concentration camps designed to exterminate the Jewish people and other "undesirables". These camps had a transportation system and a bureaucracy, as well as gas chambers and mass crematoriums, and were responsible for the murder of 6 million Jewish people. This is commonly referred to as the **Holocaust**.

As a result of the Holocaust and the end of the war, many of the surviving Jewish population in Europe resettled in other parts of the world including Australia. Many migrated to the new State of Israel which was created in 1948 by the United Nations. No such state had existed there for over 2000 years and the lack of consultation and denial of political and other rights to the local population living in the area has resulted in one of the most unsettling issues of the 20th century. Today violent disputes still exist in this territory.

Jewish People in Australia

The Jewish community in Australia is culturally and linguistically diverse. They have originated from the former Soviet Union (USSR), South Africa, Israel, Poland, Hungary, former Czechoslovakia, England, Austria, Germany (and other parts of Europe) and South America. In NSW, there are approximately 44 000 Jewish people but not all practice Judaism. In Sydney, the majority of Jewish people live in the eastern suburbs (64%) followed by northern suburbs, especially St Ives (19%).

The majority of Jewish people aged 65 and over come from non-English speaking backgrounds and they are mostly Holocaust survivors. Only 5% of Jewish population do not speak English, however 68% of those are aged over 65 years. The traditional language of prayer is Hebrew and some elders speak Yiddish.

There are mainly three (3) groups with special needs within the Jewish community in Australia: Holocaust survivors; Ultra-Orthodox Jews; and Jewish people originating from the former USSR.

Holocaust survivors have been exposed to extreme trauma and torture. Their special needs relate to health issues, reliving traumatic events, depression, mistrust, fear, higher levels of dementia and paranoia, sensitivity to change, resistance to health support and other difficult behaviours.

Ultra-Orthodox Jews follow strict cultural and religious practices that may be barriers to service provision such as gender separation, strict dietary requirements, and limited contact with other groups. They have very large families and tend not to access mainstream services.

Jews from the former USSR share some of the above needs. They can struggle with the English language and be reluctant to trust people and sign documents.

Attitudes to Family, Ageing and Disability

The Jewish religion follows the Torah, the sacred book, and has many symbolic and iconic associations like the 'Kippah' (head covering) and the 'Magen David' (six-pointed star). Jewish people follow a different religious calendar than the Roman calendar and celebrate festivals and other festivities throughout the year. Rites of passage and dietary laws are also important aspects of the culture. There are rites for birth, adulthood, marriage, divorce, death and mourning. Dietary requirements include the preparation and selected consumption of food known as 'Kashrut'.

There are some set values and beliefs within Jewish culture such as 'Mitzvot' meaning doing good deeds; 'Tikkun Olam' meaning making the world a better place; 'Tzedakah' meaning a strong sense of charity; and 'Mishpacha' meaning family, which is one of the most important values of Judaism and can often involve their community and friends.

Most elderly Jewish people prefer to remain at home and be assisted by the family, primarily the women as well as the immediate community. Traditionally, Jewish families have always cared for their elderly. However, many elderly Jewish people do not live with their children, with 25% living alone. A significant proportion of the elderly (38%) are on low incomes, with women being the most disadvantaged. There are a number of aged care providers in the Jewish community, mainstream services may also be utilised but the extent is unknown, and residential care is also now commonly used.

In the past and in more Orthodox communities, disability could be considered a punishment, a sin or lack of faith in God. However much work has been done in developing inclusive communities within the Jewish community and contemporary Jewish families see disability as a condition that requires support and all individuals are valued regardless of their condition.

It is recommended that workers avoid asking direct questions about Jewish people's ethnicity due to past experiences and the fear of anti-Semitism. Instead focus on alternative methods to assessing their ethnicity like background information, language, and religious faith.

Sources:
Materials from: Jewish Care Victoria and NSW, Jewish Board of Deputies, Israel & Judaism Studies website, Suzanne D. Rutland (IJS), Great Synagogue, Home and Personal Care Kit by Migrant Information Centre (MIC-Melbourne) as well as telephone interview with Jewish people have been used to produce this fact sheet.

Survival and beyond: Karen people of Burma

The Karen people form the second largest of the seven main ethnic groups that inhabit the frontier areas of Burma today. For over 50 years they have struggled against persecution by the Burmese military regime, and large numbers have escaped over the border into Thailand. In the last few years, many Karen people have been resettled in Australia under our humanitarian scheme, after spending ten years or more in refugee camps.

Background

The Karen people originated in Mongolia, and gradually migrated southwards to enter Burma about 700 BC. They are recognised as the first settlers of this country, which became known as Kaw Thoo Lei, or pleasant, plentiful and peaceful land.

Later settlers were the Mon and Burman peoples, who lived under feudal sociopolitical systems. The Burmans subdued other nationalities, and as a result the Karen were oppressed and pushed back into the mountains and jungles of the southeast.

The British occupied Burma in the 19th century. The colonisers established law and order, and during this relatively peaceful period the Karen were able to re-establish their culture and social position in Burma, particularly in the areas of education, music, health care, sport and defence. At this time many Karen converted to Christianity; at present approximately 50% of Karen are Christian and 50% are Buddhist.

When Japanese forces invaded Burma during the war, Burmese General Aung San (father of Aung San Suu Kyi, the popular later leader) had sided with the invaders to expel Britain from Burma and therefore gain independence. The Karen were accused of being pro-British, and during the Japanese occupation Karen villages were destroyed and thousands of civilians killed.

In February 1947, when negotiations around independence from Britain were taking place, General Aung San brought together representatives of the ethnic groups to sign the Panlong Pact, an agreement that gave each of the main ethnic

groups the option to secede from Burma ten years after the country gained independence if that group was dissatisfied with their treatment by the Burmese government. However, the Karen were not invited to participate as signatories to this agreement; their goal, made clear to General Aung San, was to achieve an independent homeland following independence. General Aung San was assassinated later that year, and negotiations floundered.

In January 1948 Burma gained independence from Britain after over 100 years of colonial rule. Following this event, the Karen people demonstrated to show their determination for an independent homeland. The new Burmese regime began systematic oppression of the minority ethnic groups, particularly the Karen. On Christmas Eve 1948 Karen villages were razed and many people killed, both in rural areas and in the cities of southern Burma. Early in the following year, headquarters of the Karen National Union (KNU) and the Karen National Defence Organisation (KNDO) in Insein (10 km from Rangoon) were stormed and burnt, and leaders were imprisoned. A large number of Karen people 'disappeared' at this time.

Civil war erupted. With the experience and expertise of Karen military leaders, the Karen were able to gain hold over much of southern Burma. They then entered into peace talks with the regime, and a cease-fire was declared. The regime, however, used the opportunity to amass troops behind Karen lines, and attacked, thus betraying the cease-fire. The Karen army lost ground and was pushed into the mountainous area of the Karen state. Many Karen civilians also moved eastwards out of the fertile delta area to escape persecution in all walks of life by the regime.

For several decades the Karen Resistance in the eastern region fared reasonably well through border trading with Thailand, and mining and forestry industries. In 1991 the Karen community was devastated by attacks on Karen people, particularly young men, who remained in the Irriwaddy delta area. Then, in 1995, the Burmese regime launched an intensive offensive in the Karen state that included the use of chemical weapons, and Karen survivors had to withdraw across the border into Thailand. A large number of Karen people continue to be internally displaced in Burma.

2008 has been a year of tragedy for the Karen people. In February, the Secretary-General of the KNU was assassinated in Thailand. In May, the President of the KNU died. In the same month, Cyclone Nargis devastated the Irriwaddy delta, still home to a large proportion of Karen people; the Burmese regime refused to allow international support into the area.

Life in camps on the Thai border

Today there are seven Karen and two related Karenni camps along the Thai border, housing over 150,000 refugees.

As an example, one of these camps contains 10,000 people in an area of 16 acres. Families, typically with 5-6 members, are allocated an area of 5 square metres and provided with bamboo poles and plastic sheeting to build their homes, generally two-storey to provide enough accommodation space. Without employment or other financial resources, inhabitants rely on the limited rations provided by aid agencies. Serious disease is rampant, particularly dengue fever, malaria, typhoid and dysentery, exacerbated by poor wet season conditions and lack of nutritious food. Community leaders work to maintain community cohesion and to develop schooling for children. Children and the elderly are particularly vulnerable. Many children are orphaned, and their care is taken up by relatives and other community members.

The Thai government refused to register these refugees with UNHCR until 1999. As a result, refugees have spent many years in these camps in limbo, unable to return to Burma and without hopes for the future. When the UNHCR was finally admitted, Karen people were able to be processed as refugees and resettlement to other countries organised, particularly the US and Australia.

Attitudes to ageing and disability

As in most Asian cultures, elders in the Karen community are respected and honoured. Karen families do not consider placing aged relatives in residential care, but are committed to caring for them at home.

Having a family member with disability is often seen as a sign of good luck or blessing. The caring role brings with it opportunities for service and selflessness, which are highly valued in religious practice and in the community.

Karen people are generally open to accessing services that will assist them with caring for their family members. Service providers will need to build trust with clients, however, as there are those who fear that a network of spies exists in resettlement countries who report back on the activities of those opposed to it.

The Karen people in Sydney form a small but cohesive group that looks after its members and creates positive opportunities for the future.

Source:
STARTTS

Survival and beyond: Lebanon

Lebanese people have been migrating to Australia since 1890, mainly for economic reasons. In the past 30 years, however, a large number of Lebanese people have settled here in order to escape conflict in their homeland as a result of the 1975-1990 civil war. These migrants did not enter Australia as refugees, but their experiences are refugee-like in that they experienced the trauma of war, they were forced to flee their homes as the war advanced, and they suffered loss, hardship and deprivation.

Background

Political conflict in Lebanon came to a crisis when, in 1975, war broke out between the Lebanese forces consisting of mainly Christian political allies and the opposition Progressive National Front, a coalition of communist, Muslim and Palestinian refugees in Lebanon. Syria led a league of joint Arab forces that entered Lebanon to restore the peace. However, after establishing a foothold, these Arab partners left the country. Syria maintained control, and proceeded to inflame the situation by exploiting religious differences within the country. In the rising climate of tension, people in the countryside were forced to leave their villages as fighting advanced, and those in the city fled their urban apartments as bombing escalated. Atrocities were committed against civilians, including the massacre of several hundred people in Tripoli and other cities. The war continued for 15 years, leaving the population devastated by grief and loss. More conflict occurred in 1990 due to further political upheaval.

While the wealthy Lebanese were able to relocate to Europe at the beginning of the war, those from poorer backgrounds fled to safety in Cyprus as well as Syria as their countries of first asylum. Those from this first wave of escapees were not admitted to Australia as refugees, but migration laws were relaxed at the time in recognition of their critical needs. Many also had family members already in Australia who sponsored them through the family reunion program. In this way, their experience can be recognised as 'refugee-like'.

'They came not just for a visit, they came to build a new life'

Lebanese people brought with them hopes for the future, along with their memories and their losses. But especially those who came from rural areas experienced considerable cultural dislocation, as they struggled to deal with the very different religious and cultural values of Australia. They have also had to face discrimination at times from sections of the Australian community.

Many who arrived from the 1950s onwards, including those who had been through the war experience, are now ageing. As a result of their exposure to war, violence, and in some cases, torture, a significant proportion of these people suffer from post traumatic stress disorder (PTSD), but this is hidden and borne silently in a culture in which mental illness is a closely guarded secret. A proportion will also have experience of disability, either personally or through a child or other family member, either acquired or present from birth.

Lebanese people traditionally care for those who are ageing and/or have disability within the confines of the family. Parents will expect to be cared for fully by their adult children when they age, and may perceive it as shameful to seek out government-funded services, as this indicates to themselves and their community that family members are not fulfilling their obligations. Likewise, a family and particularly a mother will view the care of a child with disability as her duty. By accepting externally provided services, the family may feel that the child will be exposed to danger and the family to shame.

For those providing services, it is important to validate the role of the carers, to explain that it is the right of the carers to receive support, and to emphasise that this support will enhance the lives of everyone involved, including the person who is ageing or has disability.

Source:
STARTTS

Survival and beyond: Sudan

Sudan is the largest country in Africa. The dry, desert north is inhabited mainly by Arab Muslims, and the wet south is inhabited by black African Christians and animists.

Approximately 1.5 million Sudanese people died in a civil war between the north and south that lasted from 1983 to 2004. Following this war, further conflict erupted in the western region of Darfur in 2003, leaving 200,000 dead and more than two million displaced.

Roughly 70% of the population of Sudan is Muslim (mainly Sunni), 15% are Christian, and the remainder follow traditional religions. Arabic is the official language; English is widely used and African languages are spoken in the south.

Brief recent history

On January 1, 1956 the Republic of Sudan was formally established, following the final withdrawal of the British. Sudan became a member of the Arab League and later in the same year joined the United Nations.

The process of 'Sudanisation', or replacement of all foreigners in official and military roles, had begun in the previous few years. This process, while important for the autonomy of the country, accentuated the geographic and social differences between the north and south. The first elected government was overthrown, and a period of martial law ensued. A revolt in the south against the Arab north continued as a civil war until 1972, when the south was granted some autonomy.

In 1969 a coup by army officers lead by Gaafar Muhammad al-Nimeiry seized power, and Nimeiry became the first elected president in Sudan in 1972. He ruled until 1985 when he was ousted and replaced a year later by a new prime minister, Sadiq-al-Mahdi.

Opposition in the south to policies of 'Islamicisation' was increasing during this period. Guerrilla warfare against the Muslim Arab government escalated, led by southern rebels known as the Sudanese People's Liberation Army (SPLA). A further coup took place in 1989.

In January 1994, 100,000 refugees fled to Uganda when Sudanese troops led an offensive against the SPLA. Attempts to negotiate peace agreements failed, and after a two-month cease-fire in 1995, the SPLA resumed fighting.

In 1996 government power was won by the fundamentalist National Islamic Front. The civil war continued. By the mid-1990s the SPLA controlled most of southern Sudan. In 1998 peace talks took place in which the SPLA and the Sudan government agreed to an internationally supervised vote for self-determination in the south. But these talks stalled and war continued. Finally, a peace accord was signed in 2004, leading to a new constitution that would grant significant autonomy to southern Sudan.

In 2003 the site of conflict moved to Darfur in the west. Rebel groups attacked government garrisons, demanding increased autonomy. The government responded with a brutal campaign in which villages were destroyed, and civilians tortured, raped and killed. Despite intervention by the UN Security Council and African Union peace-keeping troops, violence continued. In July 2007, after negotiations with the Sudanese government, a large contingent of UN peace-keepers was deployed. As a result of this conflict, more than 200,000 people died from violence, starvation or disease. Over two million crowded refugee camps in Chad, creating a humanitarian crisis.

The need to flee

As the war in southern Sudan and the associated persecution of religious minorities escalated, families were forced to flee their homes and ancestral lands. These people, mainly from the Dinka and Nuer tribal groups, had to move from place to place, internally displaced, finding food and shelter where they could. Their journey often took them across borders into the relative safety of refugee camps in Uganda (to the south), Ethiopia and Kenya (to the east), or the Central African Republic (to the west). They may have spent several years in these camps, unable to return to their homes, awaiting processing of refugee visas and subsequent travel to and resettlement in other countries, including Australia. Many will hope to return someday to reclaim their ancestral lands.

Because flight from their homes was usually very sudden and unplanned, many displaced persons were separated from family members. Typically, they have waited many years to discover the whereabouts or fate of their relatives.

Refugees from rural areas were usually displaced when the advancing military attacked their villages. Refugees from urban areas, however, are more likely to have experienced imprisonment and torture as a result of their political and religious activism.

'If you don't have children, who will bury you tomorrow?'

Traditional life in southern Sudan is based around the family and the land, to which the people are strongly connected spiritually and economically. Families

are large; parents regard their children as an investment in their future. The common view is that the elderly without shelter are those who do not have children.

The large family, often with eight or ten children or more, is sustained by a complex web of obligations and a hierarchy of respect according to age. Parents accept the responsibility of caring for their children until they marry; older children assist in the caring of younger siblings; children grow up understanding their obligations to look after all the needs of their ageing parents.

Grandparents are regarded with esteem, and play a strong role in the socialisation of grandchildren, telling them the stories of the tribe that are preserved through their oral histories. The care of ageing parents is not seen as a burden, but rather as an intrinsic aspect of family life. Care of the ageing outside the family is not an option, as government services are not available in Sudan. To access these services in a country such as Australia may be regarded as shameful: it is the pride of the parents to be cared for by their children, and the pride of the children to be able to do so.

Likewise, people with disability are cared for within the family circle. A child born with disability will be valued and accepted in the same way as other children, and supported without question by the whole family and community. Those who acquire disability through illness or accident will be accepted and cared for in the same way.

These attitudes and obligations mean that typically the family will not directly access services for their family members who are ageing or have disability. Services need to be offered in a culturally appropriate way and shown to enhance the quality of life for the person, and to be safe.

In some Sudanese areas a man may have more than one wife. Polygamy is prohibited in Australia, and consequently a refugee man settling in Australia may be accompanied by one wife only. If he has another wife or wives, they must remain behind. However, the man may have brought with him children of his other wives, i.e. children who are not the biological children of his accompanying wife. The resulting family structure is highly complex. When settled and employed, the man may wish to send money to his remaining wife or wives in Sudan, and this can be a source of tension within the family in Australia, particularly as Sudanese women become familiar with Australian law and customs regarding marriage.

Sources:
www.encarta.msn.com
STARTTS

Survival and beyond: Vietnam

People from Vietnam arrived in Australia in large numbers in the 1970s and 1980s. Most had experienced hardship and trauma prior to their departure from their homeland and during their perilous journeys to Australia.

Post war experiences

On April 30 1975, after the fall of Saigon had signalled the end of the American War, South Vietnamese military personnel and public servants were instructed to report to the new government to register and have their paperwork updated. After reporting, all were able to return directly to their homes and families.

Several months later, in June, these same people were called back to report for 're-education'. They were told to bring with them provisions for the following periods of detainment: low ranking military personnel – several days; officers from lieutenant to captain – ten days; officers of major rank and above – 1 month. Similar periods applied to public servants, according to their seniority in the administrative hierarchy. All complied with this order; their previous experience of reporting had been without incident, and they were anxious to have their situation sorted out so that normal life could resume after the prolonged war. All were to regret this naïve compliance.

These people were sent to 're-education' or concentration camps that were hidden in secluded areas. One of the most infamous camps was the Gate of Heaven camp close to the Chinese border in the north, where inmates were exposed to extreme cold. The periods of internment extended well beyond the advice they received: from three years for low ranking military personnel, to between eight and 12 years or more for military of major rank and above. During this time, they were subjected to hard labour, starvation and mental torture. They were humiliated and their existence was reduced to the level of animals as they struggled for survival under great deprivation.

Not only were military personnel and government officials interred. Teachers, particularly those who taught philosophy and social sciences, were also arrested and sent to camps for re-education for periods of up to four years. More than 500,000 people were sent to re-education camps in the postwar period.

During this time, family members were also subjected to persecution. Often they bargained with government officials, and agreed to relocate to isolated areas in return for the release of their relatives. This release did not occur. For several years, family members did not know where their relatives were being held. Eventually they were informed, and were able to take limited provisions to their loved ones. However, this process was dangerous as the camps were located in inaccessible areas, and could take many days of travel for a half hour meeting. In one case, the wife of a former major became lost in the jungle for five days. As a result of this traumatic experience, this woman has since been unable to venture into any parkland or bushy area without her old fears being reawakened.

Voyages of escape

Many family members attempted to leave Vietnam, and negotiated passages for themselves and their children on boats that were setting out on hazardous journeys to Indonesia, Hong Kong and other destinations where refugee camps had been established. Most of these boats were operated by people smugglers, and were often unseaworthy. Boats were also attacked by pirates, and passengers were subjected to many deprivations, theft, and physical attacks including rape. Many died on these voyages, and those who survived were emotionally scarred deeply by their own experiences and by witnessing the distress and death of their loved ones. Among these were the Vietnamese 'boat people' who eventually arrived in Australia.

In the refugee camps, these fleeing people endured further deprivations. Their future was uncertain. They were eventually processed by UN officers and arrangements made for their settlement in other countries, primarily the US, Australia and some countries of Europe.

After years of internment, those who survived the re-education camps were released, and many attempted to leave the country, also via boats. Many also were sponsored by their family members who had newly arrived in Australia as refugees, and were able to follow them here under humanitarian scheme provisions. While they brought with them hopes for a new future, they also came with physical and emotional consequences, including post traumatic stress disorder (PTSD).

Resettlement

In Australia, these new settlers faced problems with language and culture, along with the legacy of their years of suffering. Many were able to ‘put the past behind them’ for the sake of their children, and lead productive and often very successful lives.

But as this group of survivors age, the burden of loss and pain can re-emerge as they take stock of the past and evaluate the meaning of their lives while dealing with the physical, social and psychological limitations that are part of the ageing process.

For those who emerged from these times with disability and their carers, the disability is a constant reminder of past experiences. While they may try to cope from day-to-day, routine occurrences such as medical appointments and more challenging issues such as decisions about housing and financial matters can trigger memories around the cause of the disability and other losses.

For those who have endeavoured to build a new life, the birth of a child with disability can rekindle feelings of individual worthlessness, loss, and helplessness regarding destiny.

Source: STARTTS

3.2 MDAA Ethnicity and Disability Information sheets

These sheets on the following pages have been reproduced here with the generous permission of the Multicultural Disability Advocacy Association of NSW (MDAA). They include detailed background information, as well as specific information about disability and culture, and case studies of people with disability.

Countries of origin included are: page

Information on other countries and other very useful information is available from the MDAA website:
http://www.mdaa.org.au/publications/ethnicity/specificcommunities.html.

ETHNICITY AND DISABILITY INFORMATION SHEET
Reproduced with the permission of MDAA (Multicultural Disability Advocacy Association of NSW)

Bosnia and Herzegovina

Population 4,025,476 (July 2005 estimate)

Government Emerging federal democratic republic

Ethnic Groups There are three main ethnicities in Bosnia and Herzegovina. Nearly half the population are Bosniaks (Bosnian Muslims), about one third are Bosnian Serbs and 15% are Bosnian Croats. 2% are from other ethnic groups.

Religions Approximately 40% of the population are Muslim, 30% are Orthodox-Christian and 15% are Catholic.

Languages The official languages are Bosnian, Croatian and Serbian (formerly 'Serbo-Croatian').

Background

In the course of its history many different groups have ruled the area now called Bosnia and Herzegovina (Bosnia). From 1463 till 1878 Bosnia was under Ottoman rule and throughout that period many Bosnians became Muslim. After years of Austro-Hungarian rule and the turmoil of two World Wars, Bosnia became one of six republics in the new socialist Republic of Yugoslavia led by Josip Broz Tito.

Communism held the different states and ethnic groups together but when Tito died in 1980 the Communist Party lost control and two years later, Croats and Muslims in Bosnia voted for independence. Most Serbs living there opposed that because they wished to remain part of Yugoslavia, which Serbia dominated. A fierce civil war broke out in April 1992 after Bosnian Muslims and Bosnian Croats declared independence. Within two months about two-thirds of Bosnia fell under the control of the Bosnian Serbs. In March 1994 Muslims and Croats in Bosnia signed an agreement creating the Federation of Bosnia and Herzegovina. The conflict continued throughout most of 1995, ending with the Dayton Peace Agreement. Today Bosnia consists of two entities: the Bosniaks/ Bosnian Croat Federation of Bosnia and Herzegovina, which is largely Bosnian and Croatian, and the Republika Srpska, which is primarily Bosnian Serbian.

Since the Dayton Agreement Bosnian refugees have been returning. They often find that other refugees or returnees now occupy their pre-war homes, or that their houses were destroyed during the war. This poses a big obstacle to the return of refugees. The communities struggle with the effects of the war and it will take many years for trust to return. Before the war, life in Bosnia's cities such as Sarajevo was very similar to that of

other industrialised countries. Almost two-thirds of all Bosnia's people lived in small rural villages, where farming was the main source of income.

The war disrupted people's lives and its effects continue. Most people lost their source of income, as factories and mines closed down. Landmines litter the countryside, making farming impossible. Unemployment has become a huge problem and economic revitalisation is the current focus. Foreign aid has been the key to the growth and redevelopment of the economy and infrastructure. Gradually economic reforms are taking place in Bosnia to make the shift from socialism to capitalism by privatisation and deregulation of the economy. One of the critical problems faced by Bosnia today is the withdrawal of foreign aid agencies. Bosnia now has to face the transition from international foreign aid recipient to self-reliance.

History of Migration to Australia

The history and heritage of the former Yugoslavian communities such as the Bosnian community have added an important chapter to the history of multicultural Australia. The earliest recorded immigrants from the Balkans region came to Australia during the Ballarat gold rush in 1854. Following the outbreak of World War I people from the Balkans were interned in Australia as illegal aliens. They experienced racism from local communities and trade organisations.

In the period between the two World Wars economic and social conditions deteriorated in the Balkans and there was significant migration to Australia to escape high unemployment and high frustration. The 1933 census estimated that there were 7,000 Yugoslav-born people in Australia.

Following the end of WW II, large numbers of displaced people from the former Yugoslavia migrated to Australia for political reasons, settled here and participated in post-war development. It is difficult to estimate the number of Bosnians who migrated to Australia, as it was not until the 1961 census that Yugoslavia included the new classification 'Bosnian Muslims' as a separate national identity.

In 1970 an official migration document was signed between Australia and Yugoslavia. Signs of Bosnian Muslim community life have been evident since the early 1970s with the establishment of Mosques in Melbourne and Sydney. The 1986 census recorded over 150,000 Yugoslav-born Australians, including an estimated 5,500 Bosnian Muslims.

During the civil war in the former Yugoslavia (1991-1995) about 2.2 million Bosnians were displaced and fled to many parts of the world, including Australia. Refugees from Bosnia were the largest group in the Australian humanitarian immigration program during the 1990s. Almost without exception, Bosnians arrived as 'quota refugees'. This means they applied for refugee status from offshore, arrived with permanent visas and went through a government funded resettlement program. They settled mainly in the outer suburbs of large Australian cities, such as Sydney, Melbourne, Perth and Brisbane. Nowadays about 200,000 Bosnians are permanently resettled all over the world; of these 30,000 settled in Australia during the past decade.

Language and cultural barriers seriously affect the resettlement of Bosnian refugees in Australia, especially where people from rural areas are concerned. Often their

qualifications are not recognised or are only partially recognised. Unemployment, under-employment and occupational downgrading are widespread.

In the 2001 census the estimated total number of the Bosnian community in Australia is about 24,000.

Bosnian Community in NSW

- Approximately 7,000 people or 0.1% of the population living in NSW were born in Bosnia.
- Approximately 4,300 people or 0.1% of the NSW population speak Bosnian.

(2001 Census)

Some Cultural Aspects of Bosnian Life

The Bosnian population is divided into three different ethnic groups: the largest group are the Bosnian Muslims, followed by the Bosnian Serbs who mostly belong to the Christian Orthodox Church, and the Bosnian Croats, most of whom are Roman Catholic. Various languages are spoken in the Bosnian community. The official language is Bosnian but Serbian and Croatian are also spoken.

Mediterranean, Western European and Turkish influences are all felt in Bosnian cultural life, which has been enriched by its diverse population. There are big variations between traditional and modern and between rural and urban cultures. In general the Bosnian culture is very community based and affectionate. Family ties are strong and friendship and neighbourhood networks are well developed. The family is very important and individual and family reputations are highly regarded and honoured. Nowadays it is common for several generations to live close by in separate households and to support each other. Hospitality is a very important value and leads to a deepened social exchange between friends and neighbours.

Prior to the civil war Bosnia's urban population aspired to a living standard similar to Western Europe and the different ethnicities increasingly intermixed by residence, occupation, friendship, and marriage. The rural population remained more divided ethnically and less well off. Following the war, religious identification and adherence to religious rules has risen among Muslims, Croats and Serbs.

After arriving in Australia the tensions within the Bosnian community between Bosnian Muslims, Bosnian Croats and Bosnian Serbs were evident. Bosnian Croats and Serbs often joined already established Croatian and Serbian communities and the Bosnian Muslims created Bosnian clubs and resources, information and welfare centres, which mainly represented the Bosnian Muslim population. Some Bosnians preferred to adopt Croatian and Serbian identities, but many also still feel more comfortable declaring themselves as 'Yugoslavs'.

In recent years there seems to have been an understanding of the Bosnian identity as including the three main ethnic groups, not just the Bosnian Muslim identity. The Bosnian identity is seen as a civic rather than an ethnic identity. Some Bosnians, mainly

those living in ethnically mixed families, are eager to replace the exclusive nationalist identity by this more inclusive understanding. The Australian multicultural environment may foster this process.

Attitudes towards People with Disability

There is much variety within Bosnian culture about how people with disability are treated and have been treated in the past. Sometimes people were hidden away within the family, separated from the community, as the family and the person with disability felt ashamed about the disability. This was more common than people with disability being seen and included as part of the community.

Attitudes towards people with disability generally tend to be negative. Disability is usually seen as an embarrassment within the family. When there is a family member with disability often the whole family will feel disgraced. People will avoid the family and not want to marry into the family.

Rasim
Rasim's story is very unusual. He was a man with a mental illness living in a small city in Bosnia. He spent time with and talked to many people and in this way he was accepted as part of the community. He had somewhere to live and people were always generous, giving him food and he could come and go as he pleased.

A person with disability is often cared for by their parents at home, if necessary with support from other family members, usually sisters. Sometimes mothers are blamed for causing the disability by doing something during the pregnancy they should not have done. More often religious beliefs are involved, such as the belief that god is punishing the mothers of children with disability for their sins.

Many people are afraid of people with intellectual disability or mental illness, believing that they will behave in a violent way. Some Bosnians think of people with intellectual disability or mental illness as having no mind of their own, not seeing them as whole people and believing they will never have a 'life' or money. This negative thinking is generally stronger towards people with mental illness or intellectual disability than towards a person with physical disability or someone who is blind or deaf.

The war in Bosnia had a huge effect on everyone's lives. The numbers of people with disability (mainly people with physical disability and mental illness resulting from torture and trauma) greatly increased, making disability more common and visible in the community. People who acquired a disability because of the war were often more accepted by their community after the war. Since the war the stigma and isolation of mental health issues has reduced significantly. Overall there appears to be much more integration of people with disability in day-to-day life and some of the aid provided by international non-government agencies has gone to assist people with disability.

Many of the Bosnian refugees who fled to Australia experienced torture and trauma and the war had a huge impact on their physical, emotional and mental wellbeing. The effects of trauma have been an added pressure for Bosnians who settled in Australia. Many people are accessing specialist services, such as trauma counselling here. Sometimes dealing with a 'new' war-acquired disability or the birth of a child with

disability may trigger and magnify former trauma experiences from war. Torture and trauma are likely to play a role in most families and may emerge in any dealing with the Australian health or disability system.

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Community Contacts in NSW

Bosnian Information & Welfare Centre
(02) 9749-9177

Bosnian Resource and Advisory Centre
(02) 9821-1207

ETHNICITY AND DISABILITY INFORMATION SHEET
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Serbia and Montenegro

Note: Serbia and Montenegro are now independent countries but the cultural information below continues to be relevant to both

Population 10.8 million people (July 2005 estimate)

Government Republic

Ethnic Groups Ethnic Serbs make up 62.6% of the population. Albanians, the largest ethnic minority, 16.5%, with ethnic Montenegrin 5%, Hungarians 3.3% and others 12.6% (1991).

Religions 65% of the Serbian population is Christian Orthodox, 19% are Muslims, 4% are Roman Catholics, 1% are Protestants and 11% practise other religions.

Languages 95% of the population speak Serbian and 5 % speak Albanian. The Cyrillic script is used. In Australia, if an interpreter is needed, it is important to book a Serbian interpreter for Serbian clients even though many Serbs may understand and speak Croatian.

Background

After the emergence of the first Serbian state in the mid-tenth century (Raska) some family dynasties marked the course of Serbian medieval history. The Dynasty of Nemanjic (ca 1166-1371) ruled longest and established the First Kingdom of Serbia in the mid-14th century.

The Turks invaded Serbia at the end of the 14th century and occupied Serbia for over three centuries, during which Serbs were taxed to support the Turkish imperial rule. Pre-teenage boys were separated by force from their parents to be raised as Turkish soldiers and converted to Islam, and girls were taken to Turkish harems. Serbian Orthodox churches were destroyed and vandalised. After two Serbian uprisings in 1804 and 1815 and subsequent wars against the Ottoman Empire, the independent Principality of Serbia was formed and granted international recognition in 1878. Internal politics marked this period and revolved largely around the dynastic rivalry between the Obrenovic and Karadjordjevic families.

At the turn of the 20th century the Serbian dynasties entwined their foreign policy with neighbouring Europe. After the assassination of the heir to the Austro-Hungarian throne in 1914 in Sarajevo, Austro-Hungary declared war and occupied Serbia. France, England, Russia and the USA sided with Serbia in the ensuing world war.

In 1918 the Kingdom of Serbs, Croats and Slovenes was established. In 1941 Germany attacked and occupied this kingdom. The western part of the country was turned into a German puppet state ruled by Croatian Fascists, who committed systematic persecution and genocide against the Serbian people. After World War II a new government headed by Josip Broz Tito took control and proclaimed the Federal People's Republic of Yugoslavia. From 1945 Serbia, as well as six other Yugoslav republics, was under communist rule until 1990 when a multi-party system was introduced.

In 1991-1992, the Socialist Federal Republic of Yugoslavia as a multi-ethnic, multi-religious and multicultural state ceased to exist after the unilateral secessions of the Republics of Slovenia, Croatia, Bosnia and Herzegovina, and Macedonia. The resulting conflict grew into a civil war for the next 6-7 years. The war in the Former Yugoslavia escalated particularly in Croatia, Bosnia & Herzegovina and Kosovo until the involvement of NATO and USA forces.

After the war Serbia remained united with Montenegro in the Federal Republic of Yugoslavia (FRY). In 2001 the Serbian Government responded to international pressure and arrested former president Slobodan Milosevic on charges of embezzlement and abuse of power and extradited him to The Hague, The Netherlands, to face trial for war crimes. Western leaders then pledged more than $1 billion in economic assistance to FRY. In 2002 the Belgrade Agreement redefined Serbian and Montenegrin relationship as a joint federation, which was remodelled and renamed 'Serbia and Montenegro' in 2003.

History of Migration to Australia

This eventful Serbian history, full of wars, occupations and migration ensuing from them, strongly influenced the migration and location of Serbs.

The history and heritage of former Yugoslavian communities, such as the Serbian community, have added an important chapter to the history of multicultural Australia. The earliest recorded immigrants from the Balkans region came to Australia during the Ballarat gold rush in 1854. Following the outbreak of World War I people from the Balkans were interned in Australia as illegal aliens. They experienced racism from local communities and trade organisations.

In the period between the two World Wars economic and social conditions deteriorated in the Balkans and there was significant migration to Australia to escape high unemployment and dissatisfaction. The 1933 census estimates that there were 7,000 Yugoslav-born people in Australia.

Following the end of WW II, large numbers of displaced people from the former Yugoslavia migrated to Australia for political reasons, settled here and participated in post war development. In the 1950s Australia initiated a spate of inter-government agreements designed to assist non-British immigration. In 1970 an official migration document was signed between Australia and Yugoslavia. Yugoslav migration to Australia held steady into the 1980s, shifting its focus towards the poorer southern districts. The 1986 census recorded over 150,000 Yugoslav-born Australians.

During the civil war in the former Yugoslavia (1991-1995) millions of people were displaced and fled to many parts of the world, including Australia. Refugees from the former Yugoslavia were the largest group of people accepted under the Australian humanitarian immigration program during the 1990s. Almost without exception, Serbs arrived as 'quota refugees'. This means they applied for refugee status from offshore, arrived with permanent visas and went through a government funded resettlement program. From 1999 to 2001 over 33,000 Serbian refugees and humanitarian entrants settled in Australia. 74% of the Serbs who settled in NSW from 1996 to 2001 were born in Bosnia or Croatia. 85% of those people are refugees. Ethnically, Serbs born in Bosnia or Croatia identify as Serbs, clearly linking themselves to other Serbs through their shared language, religion, etc.

The Serbian population in NSW settled mainly in Liverpool, Fairfield, Blacktown and Wollongong where many institutions now give community and cultural support. Language and cultural barriers seriously affect the resettlement of Serbian refugees in Australia. While Serbian people have a high rate of employment, Serbs with overseas university and other tertiary qualifications experience problems getting these qualifications recognised. There is a lack of government support and programs to employ university educated migrants.

Serbian Community in NSW

Approximately 19,700 people or 0.3% of the population living in NSW were born in the Federal Republic of Yugoslavia. Approximately 20,500 people or 0.3% of the NSW population spoke Serbian. *(2001 Census)*

Some Cultural Aspects of Serbian Life

Serbia's heritage is based mainly on the Serbian Orthodox Church, which is very important in the religious, social and cultural life of Serbian people. Connection to the church is very strong and nearly every Serb celebrates Serbian Orthodox Christmas and Easter.

Much of Serbian music and dance has been based on Serbia's strong tradition of folk music, and even today modern musicians mix folk themes with street jazz and poetry. Serbian food is varied due to Serbia's close contact with other cultures such as Turkish, Hungarian and Greek.

In Serbia family is an integral part of community life and family honor is very important. Younger generations often live close to their relatives and all generations remain in close contact and supportive relationships with one another. Rights and duties in Serbian families are more often defined by family relationships than in contemporary Western societies. There are some inter-ethnic families, where partners from different ethnic origins married, e.g., a Serbian person married a Croatian or Bosnian partner. During the war in the 1990s many people fled for their lives, and had to leave some family members behind. As a result, many families have been torn apart and this has been extremely traumatic for the families concerned.

Attitudes towards People with Disability

There is much variation in the way people with disability are treated, but across Serbian communities attitudes generally tend to be negative. This negative view is generally stronger towards people with mental illness or intellectual disability than towards someone with physical or sensory disability. The community tends to be more supportive of persons with physical disability. Many people feel pity towards people with disability.

Family honor is an important part of Serbian community life. Sometimes this means that suffering is hidden and this may include hiding disability. When there is a family member with a disability often the whole family will experience social stigma. People will not want to marry into a family were there are family members with disability. A common belief is that disability is inherited and people are fearful of marrying into a family where a person with disability lived/ lives, in case the disability is passed on from one generation to the next.

Draginja
Draginja has a vision impairment and finds it difficult to cope with her disability. While she wants to access services she does not know where to go and she does not know the full extent of her condition due to language difficulties. Moreover, she is trying to hide her disability as her immediate family, relatives, friends and her own community refuse to acknowledge her impairment and she herself is embarrassed about her disability.

Currently, Serbia has approximately 800,000 people with disability who are fighting for their rights and equal opportunity in Serbian society. Economic sanctions imposed on the Serbian government by the USA and European Union had negative effects on funding, treatment and support for people with disability in Serbia.

Current Serbian legislation states that people with disability have the same rights as other people in the community. In reality, however, this is not followed. For instance, people with disability have difficulty using public transport and accessing appropriate services or public buildings, such as hospitals, churches and post or police offices.

Due to the war in the former Yugoslavia, the number of people with disability, mainly physical disability and mental illness resulting from torture and trauma, increased greatly in Serbia. Disability became more common and visible in the community. People who acquired a disability because of the war were often more accepted after the war and since the war the stigma and isolation of people with a mental illness has reduced significantly. Overall, there appears to be more integration of people with disability in day-to-day life.

Dragoslav
Dragoslav and his family came to Australia as refugees. He is 39 years old and has post-traumatic stress disorder and hearing impairment due to his experiences in the war. His family controls his finances and does not allow him to go out by himself for fear that he will get lost or ripped off as he does not have money skills. His only recreation is sitting in a café and meeting other Serbian migrants in the local area.

Many of the Serbian refugees who fled to Australia have experienced torture and trauma and the war has had a huge impact on their physical, emotional and mental wellbeing.

The effects of trauma have been an added pressure for Serbians who settled in Australia. Many people are accessing specialist services, such as trauma counselling here. Sometimes dealing with a 'new' war-acquired disability or the birth of a child with disability may trigger and magnify former trauma experiences from war. Torture and trauma are likely to play a role in most families and may emerge in any dealing with the Australian health or disability system.

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Community Contacts in NSW

Serbian Orthodox Welfare Association
(02) 9569-4526

3.3 DIAC Community Profiles

The **Survival and Beyond** sheets and **MDAA Community Information** sheets cover only a small number of the many countries that make up the countries of origin of Australia's population of people from refugee and refugee-like backgrounds.

Information about many other countries of origin is available from the Australian Government Department of Immigration and Citizenship (DIAC) website.

DIAC's **Community Profiles** give excellent detailed background information on the following communities:

- **Bhutanese**
- **Burmese**
- **Congolese**
- **Eritrean**
- **Ethiopian**
- **Liberian**
- **Sierra Leonean**
- **Sudanese**
- **Togolese**
- **Uzbek**

These **Profiles** are available at:

http://www.immi.gov.au/living-in-australia/delivering-assistance/government-programs/settlement-planning/community-profiles.htm

The DIAC website also provides summary information on a broad range of other communities, including:

- Cambodia-born
- Chile-born
- Colombia-born
- East Timor-born
- Ethiopia-born
- El Salvador-born
- Eritrea-born
- Estonia-born
- Hungary-born
- Iran-born
- Iraq-born
- Laos-born
- Latvia-born
- Lebanon-born
- Lithuania-born
- Poland-born
- Sri Lanka-born
- Ukraine-born
- Uruguay-born
- Viet Nam-born
- Zimbabwe-born

These summaries are available at:
http://www.immi.gov.au/media/publications/statistics/comm-summ/index.htm

4. CALD migrants and people from refugee-like backgrounds – similarities and differences

4.1 Different circumstances and experiences

People from refugee and refugee-like backgrounds have needs similar to those of other CALD people in our community in terms of receiving culturally appropriate services. But the circumstances of their arrival and the experiences that they have been through mean that service providers need to be aware of and able to respond to their specific requirements.

The refugee experience overrides the general experience of migration in long term impact on the individual.

Table 4.1 Differences in circumstances of arrival – migrants and humanitarian entrants

A migrant	**A person from a refugee or refugee-like background**
Chooses to leave their homeland	Has no choice about leaving home
Can plan their departure	Must leave without preparation
Knows where family members are and can access them	Often separated from family members who may have been killed or scattered
Can bring precious objects and mementos	Must leave belongings behind
	Must leave homes and money behind
Can organise their finances	Cannot return to homeland due to persecution
Can return if they want to	
Arrives in safety	**May have been through torture and/or trauma**

4.2 Compounding of life challenges

The experience of being a refugee lies at the intersection of:

- the normal life cycle, with the range of possible experiences including childhood, schooling, adolescence, marriage, parenthood, divorce, illness, death of loved ones, own death
- the experience of migration, including separation, language barriers and cultural dislocation, and
- the experience of surviving torture and trauma.

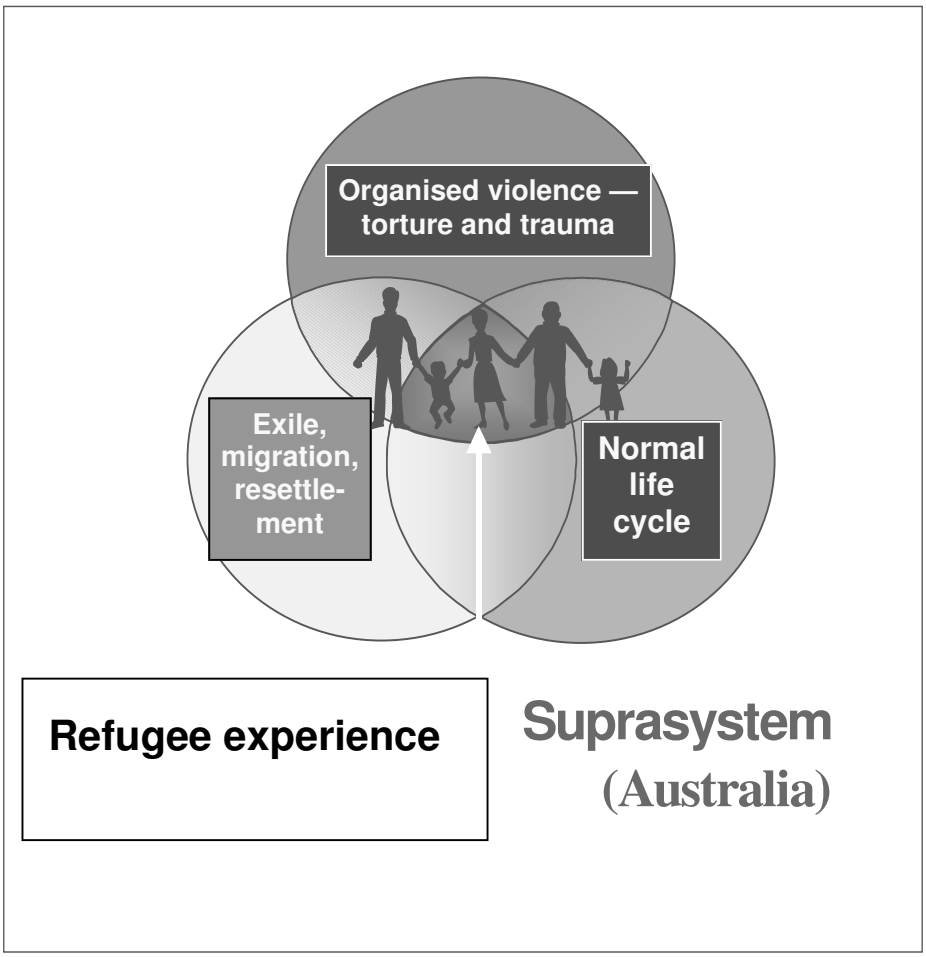


Figure 4.2 The refugee experience

4.3 Issues for service providers

Organisations that provide services to people from refugee and refugee-like backgrounds need to make sure that their personnel are equipped with **cultural competence** and **understanding of impacts of torture and trauma**.

Organisations also need to realise that they have an obligation to provide communication assistance and culturally appropriate services under anti-discrimination legislation.

Cultural competence

- Being culturally aware, including being aware that our own values, beliefs and attitudes come from our own cultural experience (as European background or indigenous Australians, or from a CALD community)
- Communicating effectively, and providing appropriate language support (i.e. interpreters) when necessary
- Understanding, acknowledging and respecting family and community relationships
- Understanding, acknowledging and respecting attitudes and beliefs around ageing and disability
- Having skills to access information and additional support for clients when necessary.

PLUS

Understanding of impacts of torture and trauma

- Understanding the refugee experience
- Understanding the effects of trauma and torture on the individual and the family
- Understanding the effect of ageing on those who have experienced torture and trauma
- Understanding the impacts of disability for the person and their carers
- Having strategies for managing effects and impacts when they arise.

For examples of ways to recognise and provide *culturally competent* services

*See **Case Studies 2 – 6***

5. Effects of torture and trauma, and impacts of ageing and disability

5.1 Effects of torture and trauma on the individual

Torture and trauma affects people on a number of levels, and will persist throughout the lifetime of the individual. This section provides a very brief summary of these impacts.

Experiences of torture and trauma will impact on the person at the **biological, psychological and social levels** (see figure below).

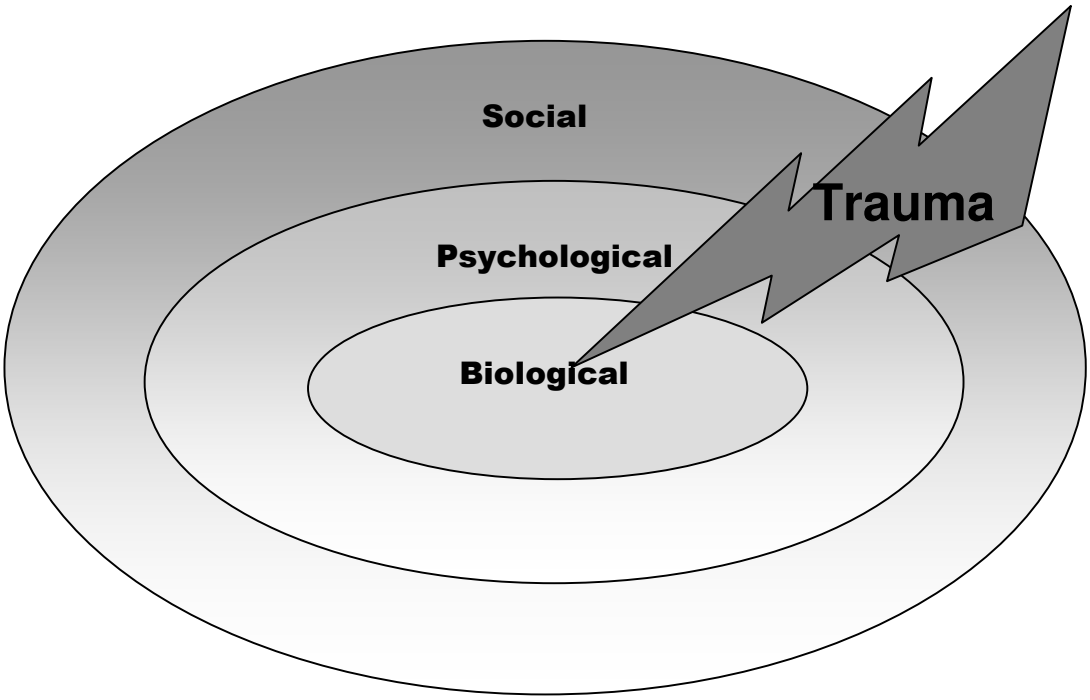


Figure 5.1 Effects of torture and trauma on the individual: the STARTTS bio-psychosocial model

The table on the next page provides examples of these effects. At each level these effects interact to produce a complex web of impacts on the individual.

It is important to note that each person will have an individual response based on the type and severity of their experience; their age; their resilience; and a range of other psychosocial factors.

Table 5.1 Biological, psychological and social effects of torture and trauma

Biological effects	Psychological effects	Social effects
• Infectious disease • Poor dental health • Injuries and chronic pain • Disability • Hypertension • Diabetes • Gastric problems • Premature ageing • Gynaecological problems	• Post traumatic stress disorder (PTSD) • Panic disorder • Anxiety • Depression • Anger • Grief, loneliness • Sleep disturbances • Eating disorders • Substance abuse • Dissociation, numbing • Inability to plan • Fear of authorities, medical personnel	• Communication barriers • No understanding of culture and system • Discrimination, racism • Isolation • Loss of social position and status • Inter-generational conflict • Financial hardship – housing and employment problems

The effects listed above are examples, and do not provide a comprehensive list of the complex range of possible impacts on the individual.

This summary provides a basis for understanding the additional, compounding effects that occur when the person is ageing and/or has disability.

5.2 Impacts of ageing and disability

Survivors who are ageing and/or have disability, and their carers face compounded disadvantage.

The impacts of ageing and disability affect the traumatised individual across the biological, psychological and social levels.

In this section we will look at concepts of ageing and disability in the CALD communities of people from refugee-like backgrounds. We will also look at:

- the impacts of the ageing process on survivors, and the particular needs of survivors who are ageing
- issues for people from refugee-like backgrounds with disability and their carers.

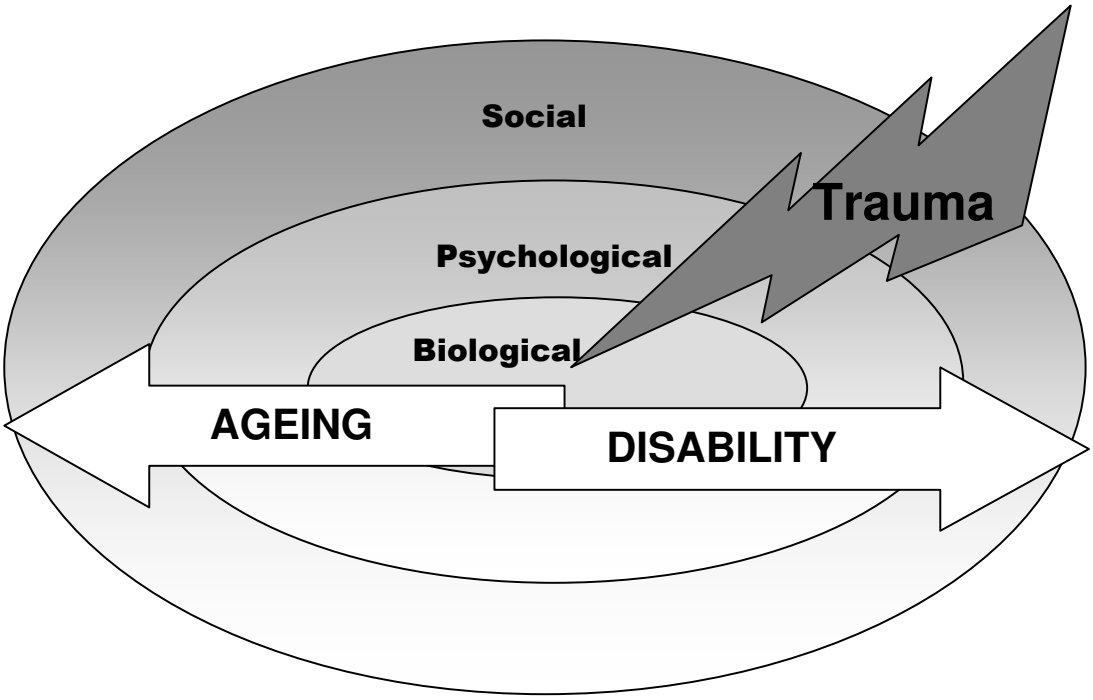


Figure 5.2 Compounding effects of ageing and disability on survivors of torture and trauma, using the STARTTS bio-psychosocial model

5.3 Ageing in CALD communities

In many CALD communities, an ageing person will expect to be cared for and supported in their own home by family members. This is a source of pride for the ageing person: they have raised their children and grandchildren to fulfil obligations to their parents.

The ageing person will also expect to be treated with reverence and respect by younger generations. They will expect to play an important role in the lives of grandchildren, including teaching them about cultural traditions.

If the ageing person comes from a refugee or refugee-like background, they are unlikely to have support available through their family network to provide the same level of care. They may also feel that the younger generations do not show them the level of respect that they expect: younger people are quicker to take up the values of the new society and may not be interested in preserving their language and learning about the old customs.

As a result, the ageing person may experience feelings of shame which emerge when these life-long expectations cannot be met.

5.4 Concepts of ageing -- assessment of HACC clients

HACC guidelines define 'frail aged' as over 65 years, with the qualification that 'individuals do not qualify for HACC services solely on the grounds of advanced age. Eligibility for services is based on the level of functional disability which makes it difficult to perform the tasks of daily living without help or supervision.'

In Australian society, the age of 65 corresponds with the expected age of retirement from paid work and the age at which government old-age pension benefits commence. However, there is a wide range in people's experience of the effects of ageing at age 65.

Service providers need to be cautious when using standardised guidelines (i.e. over 65 years) for identifying eligible frail aged clients who are survivors. The following issues need to be considered:

- survivors are at risk of **ageing prematurely** due to trauma and hardship, and so may require support at an earlier age than the mainstream population
- survivors may **not know their actual birth date**; they may have

nominated or been assigned a birth date that does not correspond to their actual age

- survivors may have assumed a **different identity** with a different birth date to escape identification and persecution.

Examples

Bosnia: People from rural areas of the Balkans region of Europe may regard themselves as ageing when they are over 50 years.

Sierra Leone: The life expectancy of people from Sierra Leone is 41 years; therefore, the concept of ageing will be much different from our own. Elders will be those in their 40s. Also, Sierra Leoneans, among other groups of survivors, may have changed their identities to escape imprisonment and execution, and/or to access services. Typically, they will nominate a birth date that makes them younger than their real age. They may believe that this will assist them to obtain a refugee visa more easily.

For more examples of attitudes to ageing in refugee communities

Go to ***Section 3: The refugee experience – Cultures & stories***

5.5 Effects of ageing on trauma survivors

The physical effects of ageing, in particular limitations on mobility and decline of cognitive function, can lead to increased social isolation and depression, and re-emerging of long-buried memories associated with post traumatic stress disorder (PTSD). Table 5.5 shows some of the more common symptoms associated with ageing in trauma survivors.

Table 5.5 Effects of ageing on trauma survivors

Effects of ageing on trauma survivors		
Biological	**Psychological**	**Social**
Premature ageing	**PTSD**	Increased **isolation**
Physical effects of torture/trauma →chronic pain, arthritis, cardio-vascular disease, stroke	**Anxiety**	**Loss of dignity** self-esteem
Short term memory deficits → earlier memories re-emerging	**Panic attacks**	**Increased dependence** on family members
Dementia → disorientation, loss of 2nd language skills, increasing dependency	**Distrust**	**Alienation** from younger family members
	Depression	**Lack of social support** for those without family
	Vulnerability to triggers associated with PTSD	**Exploitation/abuse** by family members
	Delayed mourning	
	Survivor guilt	
	Fear of death	

As **short term memory declines**, ageing survivors may experience resurfacing of painful memories and symptoms of unresolved post traumatic stress disorder.

As **physical problems limit mobility**, ageing survivors may experience increased social isolation, depression and feelings of cultural dislocation.

As **cognitive function diminishes**, ageing survivors may lose second language (English) competence and revert to mother tongue.

5.6 Post traumatic stress disorder (PTSD) and ageing

Post traumatic stress disorder is a common reaction to an event or events that are outside normal human experience. PTSD involves re-experiencing the traumatic memories through nightmares, flashbacks, intrusive thoughts, memories, etc.

Flashbacks are memories of past traumas. They may take many different forms. They may involve intense feelings and bodily sensations.

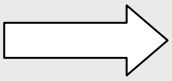
A **trigger** is something that provokes a memory or reaction. Triggers are activated through one or more of the senses and are very personal. Different things are triggers for different people, but for refugee clients they may be things that remind them of war, being detained or interrogated.

As people age and their cognitive function and short-term memory decline, the mechanisms that kept the traumatic memories under control may weaken. The person may be more vulnerable to flashbacks.

Examples of triggers

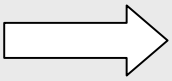
- Showering or bathing
- Having a medical procedure
- Shaving, haircuts
- Certain foods
- Staff or family member leaving
- National or religious holidays
- Birthdays or anniversaries
- Being questioned
- Figures of authority, uniforms
- People writing things down
- Bright lights; shutting blinds
- Certain sounds or smells
- Confined space
- Closed doors

For Guidelines on what to do if a client has a PTSD-related response



Go to ***Section 8, part 4.v: Know what to do if your client experiences a flashback***

For more information about experiences of PTSD



Read these case studies:
Case Study 7: Ageing and PTSD – Leslo
Case Study 8: Flashback

5.7 NSW Refugee Health Service Fact Sheet 7: 'Older refugees'

This publication of the NSW Refugee Health Service appears on the next page.

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www.refugeehealth.org.au

Fact Sheet 7:

Older Refugees

Older refugees face a number of challenges that are *additional to* those of the Australian-born and migrant elderly population.

Refugees, by definition, have fled serious human rights violations as a result of war or organised violence. Some will be survivors of torture, some will have had children, siblings or parents who were killed, and all will have lost their homes, way of life and community. These experiences can have a profound impact on their health, the way they will access services and the way aged care services are provided.

Broadly speaking, there are two groups of older refugees living in NSW:

1. People who arrived in the past as refugees and have aged in Australia form the largest group. They include people escaping from Southern and Eastern Europe after WWII and from later conflicts in South East Asia and Central and South America.

2. People who arrived in Australia as elderly refugees form a smaller group, but one with high settlement and recovery needs. Some will have escaped recent conflicts; others may have experienced war trauma a number of years ago, reuniting with family in Australia after many years of separation.

- **Identifying refugee clients**

Refugees are not identified in standard assessment tools. Using non-probing, gentle and supportive inquiry is the best way to identify refugee clients. Reflecting this approach in your history taking forms will be helpful. Asking your patients' country of origin and time of arrival will also help. They are likely to have a refugee background if they:

- arrived after WWII from Germany or Eastern Europe;
- came from countries such as Afghanistan, Argentina, Burma/Myanmar, Cambodia, Chile, El Salvador, Eritrea, Ethiopia, Iraq, Iran, Laos, Somalia, Vietnam or Uruguay; or arrived in the last ten years from countries such as Bosnia, Colombia, Croatia, Kosovo, Serbia or Sudan.

- **Psychological health needs**

War and organised violence can continue to affect people long after the event. Post-traumatic symptoms can remain many years after repeated war trauma (Steel et al, 2002), and may develop long after the trauma has occurred (Eitinger & Major, 1993). These symptoms include:

- chronic states of anxiety
- depression
- guilt about surviving
- nightmares and flashbacks
- Post Traumatic Stress Disorder.

Anxiety will be higher if relatives remain at risk overseas. Symptoms may also resurface when the death of a spouse or of friends here triggers memories of previous losses during war and exile.

There may be some cultural variation in how psychological problems are manifested and addressed. Some people may be suspicious of workers coming into their homes, and reluctant to seek help outside the family. Others may find that the way they usually coped is not effective (e.g. people who usually suppress painful emotions may find it more difficult to do so when memory is disrupted by the aging process).

Explain the role of counselling, if needed.

- **Physical health needs**

As well as the usual conditions of old age, older refugees may face health problems from previous injuries and inadequate access to health care as part of their refugee experience (See RHS Factsheet 1 for more information on the impact of the refugee experience on health).

Stress-related psychosomatic illnesses are not uncommon and require sensitive investigation.

- **The impact of dementia**

Disruptions to memory, such as dementia, can trigger painful suppressed memories (Joffe et al 1996). When short-term memory is impeded, old memories can 're-emerge' forcing people to relive extremely painful events, such as torture experiences or time spent in concentration camps. This is extremely distressing for clients and can manifest in challenging behaviour.

People at home or in residential care who have experienced hunger or had their food restricted in the past may collect their uneaten food, hiding it in inappropriate places (under their pillow etc) or may refuse to throw away food that has expired.

As a result of age-related memory loss, older refugees may also lose English language skills and revert to their first or second language. If bilingual staff or interpreters are not made available from the earliest assessment time, the patient's confusion is likely to be heightened. Language is a crucial factor in determining a client's needs and abilities - a reliable aged care assessment of non-English speaking people cannot be made without a professional interpreter.

Consider retraumatisation as a cause of distress & challenging behaviours. Always use interpreters when making assessments

- **The impact of institutionalised aged care**

Some older refugees find institutionalised aged care reminiscent of their experiences in concentration camps or in prison, triggering painful memories. This can be manifested in a variety of ways. For example, people may be concerned about why their personal histories are being recorded; staff may be confused for guards/torturers (Joffe et al 1996); or they may become distressed when night staff at hospitals or residential facilities do security checks.

Be aware that certain events & actions may trigger past memories of torture & trauma

- **Loss of status**

The refugee process can have a significant impact on the status of older refugees. Instead of being a respected member of the community, some older refugees find that their skills and opinions are not valued in the same way in Australia. Roles may be reversed, with people who arrived as older refugees becoming dependant on their children to negotiate their world. This cultural change may be expressed through depression, anxiety or conflict with the family.

- **Social isolation**

For some older refugees, social isolation is a product of their refugee experience. Their experiences may make it difficult to develop the trust needed to develop a supportive social network. Additional risks include: their lack of family in Australia; the small size of their community in Australia making it difficult to link with people from their own age and background; the lack of bilingual workers; and financial hardship.

Create opportunities for older refugees to meet

- **Limited access to Aged Care Services**

Older refugees tend to be cared for in the home by their children and may not know about aged care services available in the community. Older refugees may only come to the attention of Aged Care Services when they have developed very complex needs, or during a crisis.

Older people may not accept services that do not try to accommodate preferred language, food, dress and religion. Culture is particularly important for older people. Unintentional cultural transgressions by staff can cause distress.

A smaller group of people from a refugee background may not be eligible for certain support services. For example, those who do not receive an Australian pension will not be eligible for Commonwealth Hearing Services. Others may be staying long-term with their children on a visitor's visa and will not be eligible for Medicare and some Aged Care Services.

Develop ways that refugee communities can be consulted and informed about aged services.

- **Supporting the Carers**

Families caring for aging parents often do so without the support of extended family networks, as refugee families are often fragmented in exile. Caring for a frail parent while families struggle to meet the multiple demands of settlement can be stressful. Different generations will adapt to Australian culture at different rates, a further source of conflict within the family.

Carers may not know about Respite Care and Day Care options that could help support them.

Target information on home support services to refugee communities

- **Relevant services and organisations**

NSW Refugee Health Service	8778 0770
STARTTS (torture/trauma counselling & services)	9794 1900
NSW Transcultural Aged Care Service	8585 5000
NSW Transcultural Mental Health Centre	9840 3800

Multicultural Aged Health/Access Workers are located at:

Hunter Migrant Resource Centre	4969 3399
SE Sydney Multicultural Health Service	9533 3000
W Syd Multicultural Health Service	9840 3768
SW Syd. Multicultural Health Service	9828 6931
Central Syd. Multicultural Health Service	9515 3273
Illawarra Multicultural Health Service	4223 8282

For a copy of the Ethnic Aged Care Services & Resources Directory, contact: yvonne.santalucia@swsahs.nsw.gov.au.

- **Recommended Readings**

Bartolomei L, Hugman R & Pittaway E (2002) You never stop being a refugee', School of Social Work, University of NSW.
Eitinger L & Major E (1993) 'Stress of the Holocaust', in Goldberg L, Berznitz S (eds) *Handbook of Stress*, NY: The Free Press.
Joffe H, Joffe C & Brodaty H (1996) 'Aging Jewish Holocaust survivors: anxieties dealing with health professionals' *MJA* 165: 517-20.
Steel Z, Silove D, Phan T, Bauman A (2002) 'Long-term effect of psychological trauma on the mental health of Vietnamese refugees resettled in Australia' *The Lancet* 360 (9339): 1056-62.

5.8 Prevalence of disability

In Australian society, about 19% of people are reported as having one or more of the following types of disability:

- physical
- sensory
- intellectual
- psychiatric
- affected by disease or illness.

This disability may be present at birth or may be acquired.

Approximately 25% of people with disability in Australia are from non-English speaking backgrounds (see *Culture, religion and disability*, NSW Multicultural Disability Advocacy Association, www.mdaa.org.au).

People from refugee and refugee-like backgrounds who have been through torture and trauma are at a higher risk of having **hidden disability** in the form of psychiatric disability as a result of their trauma-related experiences. They may also be affected by sensory disability (e.g. hearing loss), acquired brain injury, physical disability or chronic illness as a result of their trauma-related experiences.

5.9 Concepts of disability

The term ‘disability’ is used to refer to the way in which a person’s ability to participate fully in the social world is diminished as a result of a physical, sensory, intellectual or psychiatric impairment. For example, a person who is short-sighted has vision impairment, but they are not regarded as having disability because their impairment is remediated by wearing glasses or contact lenses.

The ‘social model of disability’, which is recognised by researchers and activists around the world, maintains that it is society that disables people with impairment by not providing the support to enable them to participate fully in the life of their communities. For example, a person who is blind is regarded as having disability when the society does not provide them with the support and resources to ‘enable’ them, such as fully accessible formats for information, guide dogs and accessible transport, and accessible housing.

In Australia, while many advocates favour the social model, the predominant model is the medical model of disability. The society places great importance on

early diagnosis of the disability; establishing aetiology or causal factors; intervention and remediation; and integration of the person and their care-givers into the government-funded community services system.

Different cultures have different interpretations of 'disability' and different responses to people who have disability, and their level of inclusion in society. In many cultures, social roles have been more readily available for people with disability than they are in Australian society today. Conversely, in many cultures, disability continues to be associated with shame and stigma.

Different cultures also use different treatment strategies, including traditional medicine approaches which may not be readily available in Australia.

In countries where war and other forms of organised violence have greatly increased the incidence of acquired disability, the population has become more widely exposed to people with disability. This has ironically brought about more general acceptance of disability, some reduction in the stigma associated with disability, and in some countries, more services for people with disability.

Examples

Afghanistan: In this Islamic culture, a child is regarded as the expression of God's will. This attitude is inclusive of a child with any type of disability or medical condition. Parents will be obliged to follow God's will and provide all their children with their physical and spiritual requirements, according to their needs. Likewise, people who acquire disability will be cared for by their relatives.

Bosnia, Serbia and Croatia: In the past, for people in the Balkans region of Europe, the birth of a child with disability was traditionally regarded as a source of shame. Often the person with disability was hidden and protected within the confines of the family. Lack of government-provided services perpetuated this situation, with families duty-bound to manage the person's needs without outside help.

During the armed conflicts in the early 1990s, a large number of people acquired disability due to war-related injuries. This increase in personal and family experience of disability resulted in a widespread change of attitudes, leading to more acceptance of people with disability in the community.

Those with mental illness, however, continue to experience stigma, particularly amongst the older generation. This means that those who may be suffering from PTSD are unwilling to seek help, and likely to be socially isolated and depressed.

Sudan: In the African tribal populations of southern Sudan, a person with impairment is traditionally valued equally with others, and is supported within the family and the community to participate in the social world. People with disability

are regarded as part of the broad human spectrum. Consequently, the term 'disability' and the need for interventions may not be recognised as so important, particularly when the disability is hidden, such as in a learning disability or a hearing impairment.

Vietnam: In Vietnam the causes of disability are linked to fate and spirituality. Having a disability may be the chosen destiny of that person, or it may be seen as the result of past family wrongdoings. A child with an obvious disability will be cloistered within the family to protect the child and to spare the family from social stigma. One result is that siblings may find that their chances of advantageous marriages reduced due to perception of disability in the family.

Traditionally mental illness is feared and stigmatised. Many Vietnamese in Australia experience mental illness as a result of their traumatic wartime experiences, and this entrenched attitude has been a barrier to accessing appropriate mental health care services.

For more information about attitudes to disability and different types of disability

Go to ***Section 3: The refugee experience – Cultures and stories***

5.10 Compounded disadvantage -- people with disability and their carers from refugee-like backgrounds

All parents who have a child with a disability, and all persons who are born with a disability or acquire a disability through accident, illness or violence face a period of adjustment as they try to come to terms with the change in potential and their life experiences. This is a form of grieving.

For people from refugee and refugee-like backgrounds, this experience is compounded as they have to deal with the following issues as well:

- Australian attitudes to and beliefs about disability, which may differ from their own cultural attitudes
- Unfamiliarity with the health and service system in Australia
- Different approaches to the treatment of disability which don't always support and acknowledge the value of traditional treatments
- Different ways of caring for and supporting the person with disability, with expectations about access to the family's private realm and the private realm of the person, including the person's body
- Expectations that family members (particularly female family members) will manage all aspects of the caring role, often without the support of an extended family structure

PLUS

- Distrust of government-funded services due to their experience of organised violence
- Their own unresolved post traumatic stress, and the possible re-traumatising effects of coming to terms with disability.

These issues can lead to:

- **a low rate of service uptake for the person with disability**
- **a high level of carer stress.**

5.11 Role of family members and carers

In many CALD cultures, caring for family members who are ageing or have disability is the role of family members rather than government-funded services. This may be due to cultural traditions and because there were few, if any, funded services available in their country of origin. However, in the country of origin, carers are typically part of an extended family network that provides ongoing support. This network may not be available to them here.

Clients from CALD backgrounds and their families may experience a range of responses when they access HACC services, and they may have waited until a time of crisis.

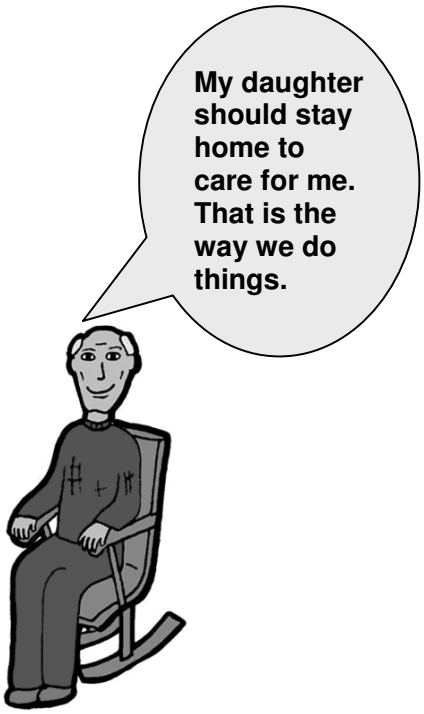
For CALD carers who come from refugee or refugee-like backgrounds, to these cultural issues are added fears and anxiety about admitting figures of authority and government representatives into the private sphere of the family.

Client's response

The **client** may feel that family members are neglecting them by turning them over to external providers of care. The client might feel resentful of family members and distrustful of the service's ability to understand their particular needs.

The family's inability to fulfil all the traditional roles of carers may cause **intergenerational conflict**, and increase the client's experience of **cultural dislocation**.

If the client is a survivor of torture and trauma, this change may be a **trigger** for re-emergence of earlier experiences of abandonment, fear and uncertainty.



Response of family members

Family members may experience **role conflict and guilt** when they approach services for assistance.

They may have been struggling to manage the demands of their own lives while providing care to their ageing relative or relative with disability, and have reached a crisis point. They may feel that their own community is critical of them for not fulfilling their cultural obligations.

They may express this by attempting to maintain full control over the way service is provided to their relative. They may try to reject the service that is offered for various reasons, or be overly critical of the way services are delivered.

Service providers need to recognise that this is a point of major transition for clients and their families. Service providers need to be prepared for these responses, and to deal with them sympathetically. Clients and their families need to be reassured that it is possible to achieve a positive outcome for everyone involved.

For examples of carer issues

Go to these case studies

Case Study 9: A complex situation
Case Study 10: Family matters

5.12 Islam: A guide for service providers working with people with a disability

The publication overleaf will help you to deliver appropriate services to your client from a Muslim background. It is reproduced with the permission of the Muslim Women's Support Centre of WA (Inc.).

It was prepared as part of the Muslim Carers Project, in partnership with the Ethnic Disabilities Advocacy Centre and the Muslim Women's Support Centre of WA (Inc.). Carers WA supported the project (December, 2006).

Islam:
A Guide for Service Providers Working with People with a Disability

Islam: A Guide for Service Providers Working with People with a Disability *aims to enhance the delivery and quality of service to Muslim clients.*

This booklet provides basic and general information about the Islamic way of life and is best utilised in conjunction with specifically designed workshops for various service providers. To arrange a workshop/presentation and for more information please email MWSC at info@mwsc.com.au

This information booklet was prepared as part of the Muslim Carers Project, in partnership with the Ethnic Disabilities Advocacy Centre and the Muslim Women's Support Centre of WA (Inc). Carers WA supported the project (December, 2006).

Contents

Section One – The Muslim Faith

1.1 Understanding the faith

Islam means '**submission**' or '**surrendering**' to God. It also means '**peace**'. The followers of Islam are called Muslims. Islam is a way of life (*deen*) that impacts every part of life, from eating and sleeping to working and playing. It is not only a personal religion, but also a social one. Therefore, it sometimes becomes hard to distinguish between cultural and religious practices of Muslim people.

Under an Islamic system all people are first and foremost accountable to God. Allah is the Arabic word for God. No distinction is made between countries, nationalities or "social classes".

Muslims seek to live in accordance with God's laws. By doing so, they strive to obtain nearness to God and victory over temporary trials and temptations in this world. All aspects of their practice including prayer, fasting, charity, and pilgrimage are intended to help meet this goal. Although strict by secular standards, Islam is not an ascetic religion. Islam requires its followers to be active participants in their communities. For a Muslim to work and study are considered acts of worship as these are activities that contribute to the advancement and betterment of society. Even simple actions such as removing a harmful obstacle from a path are considered a rewarding action!

Muslims believe that God is One, indivisible, and also believe in all the prophets that Christians and Jews believe in including Adam, Noah, Abraham, Ishmael, Isaac, Jacob, Joseph, Job, Moses, Aaron, David, Solomon, Elias, Jonah, John the Baptist, and Jesus (peace be upon them all). Muslims believe that the final Prophet is Muhammad (peace be upon him) to whom the Qur'an was revealed.

It needs to be highlighted that a Muslim's actions does not necessarily equal Islam. As with all religions, Muslims practice their faith to varying degrees. Some people are very 'strict' in their practices whereas others are not. Regardless of a persons degree of 'Islamic implementation' all Muslims will unanimously agree on the fundamental principles and beliefs.

1.2 Basic Principles and Beliefs

The Prophet Muhammad (Peace Be Upon Him):

Muhammad (PBUH) was born in Makkah in the Year 570. His father died before his birth, and his mother shortly afterwards. His uncle was the one who raised him. As he grew up he became known for his truthfulness, generosity and sincerity, so much so that he was given the nicknames "Al-Amin" (the Trustworthy) and "Al-Saadiq" (the Truthful). At the age of 40 while engaged in a meditative retreat, Muhammad (PBUH) received his first revelation from God through Angel Gabriel. This revelation, which continued for 23 years, is known as the Qur'an.

The Qur'an:

According to Islam, the Qur'an is a record of the exact words revealed by God through the Angel Gabriel to the Prophet Muhammad (PBUH). It was memorised by Muhammad (PBUH) and then dictated to his companions, and written down by scribes, who crosschecked it during his lifetime. Not one of its 114 chapters has been changed over the centuries.

The Qur'an is the main source of a Muslims faith and practice. The Qur'an's basic theme is the relationship between God and His creatures, but it also deals with all the subjects that concern us as human beings: wisdom, doctrine, worship, and law.
The *Sunnah* is the practice and example of the Prophet Muhammad (PBUH). This is the second authority for Muslims after the Qur'an. Compilations of *Ahadith* (singular: *Hadith* – a reliably transmitted report of what the Prophet Muhammad (PBUH) said, did or approved of) and his life history form the *Sunnah*. Thus, Muslims follow the Qur'an (the word of God) and the *Sunnah* (the example set by Prophet Muhammad).

The Five Pillars of Islam:

All Muslims have to fulfil the five major requirements known as the 'Five Pillars of Islam'. These form the framework of a Muslims life and they are:

1. Testimony of Faith (*Shahadah)*

All Muslims will declare their faith by proclaiming: 'La illaha illalah Muhamadur rasullulalah'- 'There is none worthy of worship except Allah and theProphet Muhammad is his messenger'. This declaration is called the *Shahadah.*

2. Ritual Prayer (*Salat*)

Salat is the name for the obligatory prayers, which are performed five times a day, which are a direct link between the worshipper and God. The five daily prayers provide a meditative re-direction of person's thoughts. This achieves a renewed sense of purpose, spiritual fulfilment and physical rejuvenation.

These five prayers contain verses from the Qur'an and other phrases praising God said in Arabic, the language of the revelation. Prayers are said at dawn, noon, mid-afternoon, sunset and nightfall/before retiring to bed.

Although it is preferable to worship together in the mosque, Muslim may pray almost anywhere but they pray in the direction of the *Kaaba* which is a cube shaped building, which God commanded Abraham to build over four thousand years ago. Muslims may pray alone or in a group. There is no clergy in Islam, but a learned person (known as the *Imam*) who knows the Qur'an usually leads prayers.

To find out more about how prayers are performed and how to make ablution see:

http://www.islamonline.net/english/introducingislam/Worship/Prayers/article04.shtml

Or contact MWSC on 08 9451 5696.

3. Obligatory Charity Tax (*Zakat)*

It is a religious duty for every Muslim to give a portion of his/her wealth to the needy each year. These alms are called *Zakat* in Arabic, which literally means purification. Paying these alms is a way for people to purify the ethically gained wealth that God has bestowed upon them and it is also a means to distribute wealth throughout the society. It also purifies the soul of the giver, reducing greed and strengthening compassion and generosity.

4. Fasting (*Sawm*)

Every year in the ninth Islamic month called Ramadan, all Muslims fast from first light until sundown, abstaining from food, drink and sexual relations. Since the lunar calendar is 11 days shorter than the solar calendar, the month of Ramadan gradually passes through all seasons of the year. Those who are sick, elderly, or on a journey and women who are pregnant or nursing are permitted to break the fast and make up an equal number of days later in the year. By abstaining from worldly comforts, even for a short time, a fasting person gains true sympathy with those who go hungry as well as gaining growth in ones spiritual life.

5. Pilgrimage (*Hajj*)

The annual pilgrimage to Makkah- called the *Hajj*- is an obligation only for those who are financially and physically able to perform it. Nevertheless, approximately 3 million people go to Makkah each year from every corner of the globe providing a unique opportunity or those of different nations to meet one another. Pilgrims wear special clothes: simple garments which strip away distinctions of class and culture and all stand equal before God. The *Hajj* is the major example of the universal message of Islam and its teachings on equality.

1.3 Main Islamic Occasions

Friday – Just as Christians observe Sundays and Jews observe Saturday as their religious day, for Muslims it is Friday. The noon prayer is a special time where people congregate at the mosque if they are able to and pray together.

Ramadan - Ramadan is the ninth month of the Muslim calendar. It is during this month that Muslims observe the Fast of Ramadan. Lasting for the entire month, Muslims fast (through avoidance of food, drink and intimacy) during the daylight hours and in the evening eat small meals and visit with friends and family. It is a time of worship and contemplation. It is a time to strengthen family and community ties. Muslims usually break their fast with some water and dates. During Ramadan, Muslims read the entire Qur'an, and perform special prayers called *Taraweeh* after the daily nighttime prayer.

Eid ul-Fitr - The beginning of the Islamic holiday called Eid ul-Fitr or "feast of fast breaking" marks the completion of the month-long period of fasting during the blessed month of Ramadan. During Eid ul-Fitr Muslims rejoice over a month-long achievement of fasting, which was performed for the sole purpose of pleasing and serving Allah. For a Muslim, Eid is a day of thanksgiving and gratitude, and marks personal triumph over one's desires. On the morning of Eid ul-Fitr, normally before the start of prayer, Muslims are to pay Zakat ul-Fitr (charity) to the needy of the community -- an alms for the month of Ramadan. Eid is a happy time for Muslims. Many decorate their homes to celebrate this blessed holiday and frequently invite and visit friends and loved ones. Big

feasts are made for guests, and Muslims usually prepare trays of delicious sweets to be shared with neighbours and the local community over coffee and tea.

Eid ul-Adha - The Festival of Sacrifice
Eid ul-Adha takes place on the tenth day of the twelfth month of the Islamic calendar and is a time of much celebration. The holiday commemorates Prophet Abraham's willingness to sacrifice everything for God. This celebration coincides with the yearly pilgrimage to Hajj and is where Muslims will organise (if they have the means) for an animal to be sacrificed and the meat is shared amongst family, friends and the poor.

Section Two – Interacting with Muslims

2.1 Islamic greetings and responses

Muslim greetings:
The *Salaam* is a distinctive aspect of a Muslim's social conduct. Greeting someone with Salaam is a kind of invocation for his welfare and blessings. It instills brotherly love and strengthens the ties of brotherhood and closeness, and mutual relationships result in a strong and unwavering society. Muslims greet by saying the following:

The Greeting: *As-salaamu Alaikum* – Peace be upon you

The Reply: *Wa-alaykum Salaam* –And may peace be upon you too.

A non-Muslim may greet his/her Muslim friend/client and associates in any way that is considered acceptable and decent in society.

2.2 Creating a receptive environment

Below are a few to keep in mind while seeing Muslim clients:

- Feel free to ask questions if unsure about anything; Muslims would most likely appreciate your interest and care on that matter and feel happy to explain their beliefs.
- Because cleanliness is of utmost importance, Muslims are more receptive to clean environments.
- Do not be offended if a Muslim guest/client refuses something, for e.g. refusing to eat meat if they are unsure if it's *halal* or not.
- Do not be offended if a Muslim doesn't shake your hand (if you are of the opposite sex) or avoids eye contact or keeps to small talk (i.e. doesn't go personal, avoids any unnecessary chatter) this is just for the purpose of modesty.
- Generally Muslims do not celebrate or partake in events such as Christmas, Easter, New Years Eve, Birthday parties, Good Friday etc.
- Religious books (e.g. the Qur'an) should be handled with respect.
- Avoid insulting any of the Prophets or God – Including any physical depictions or pictures.
- Avoid joking about any Islamic practices and beliefs.
- Avoid physical contact with a Muslim member of the opposite gender, where possible.

2.3 Facilities /Venues requirements at conferences or other gatherings

- Prayer room facilities should be available and a prayer timetable (or sunrise and sunset times) made available for your guests/clients
- Muslims pray in the direction of the city of Mecca (in Saudi Arabia) wherever they are. The direction of Mecca is known as the *Qibla* (approximately 295° from North clockwise). It will greatly assist your guests/clients if you show them the direction of the *Qibla*.
- A suitable room for prayer is one, which is clean, private and has no statues or pictures of animate objects.
- Bathroom facilities (i.e. taps) to perform ablution should be available and water for use inside the cubicles (for washing the private parts).

Section Three – Etiquette

3.1 Diet

Halal Food:

Halal - The Arabic word (*Halal*) means lawful. In the Holy Qur'an, Allah commands Muslims and all of mankind to eat of the *Halal* things

Animals such as cows, sheep, goats, deer, moose, chickens, ducks, birds, etc., are *Halal*, but they must be ***Zabihah*** (slaughtered according to Islamic Rites) in order to be suitable for consumption, hence the term *Halal Meat.* The meat should be purchased from a Certified *Halal* Supplier/Butcher, as they hold a special certification, which must meet certain guidelines in order to be certified supplier.

For more information about suppliers of halal food, please visit ww.aussiemuslims.net and click on the "community directory" and follow the prompts.

Examples of foods that are already *halal* in their natural state include: Milk (from cows, sheep, camels, and goats), Honey, Fish, Plants which are not intoxicant, Fresh or frozen vegetables, Fresh or dried fruits, legumes and nuts like peanuts, cashew nuts, hazel nuts, walnuts, etc. Grains such as wheat, rice, rye, barley, oat etc.

Haram **(Forbidden)**

Muslims are forbidden to consume:

- Pork (Swine)
- Blood
- Carnivorous animals
- Almost all reptiles and insects
- The bodies of dead animals
- *Halal* animals that are not slaughtered according to the Islamic Law.
- Wine, Ethyl Alcohol, and Spirits (and other intoxicants).

Some foods may also contain animal derivatives, which are not *Halal*. Examples include biscuits, ice cream (gelatine and animal fats) and cheese (animal rennet).

If you would like to obtain some simple multicultural recipes please contact MWSC on 08 9451 5696 or email.

3.2 Clothing Customs

Guidelines of proper modesty for males and females (dress and behavior) are based on revelatory sources (the Qur'an and authentic Sunnah) and as such are seen by believing men and women as divinely based guidelines with legitimate aims, and divine wisdom behind them. They are not male imposed or socially imposed restrictions.
Each culture and country where Muslims live will have his or her own clothing style. It should be noted that there is a distinction between religion and culture.

Muslim Women and Clothing:

A Muslim woman is not required to fully cover in the presence of her husband and close family or among females. However, when she goes out or when men other than her husband or close family are present, she is expected to maintain certain requirements for the purpose of her modesty and respect such as:

- Only the face and hands are shown (covering the face and hands is optional according to most scholars).
- Headscarf is obligatory;
- Clothing should be loose and opaque to not reveal the shape of the figure

Muslim Men and Clothing:

Muslim men are required to:

- Fully cover the area between the navel and knees
- Wear clothing loose enough as to not describe what he is covering
- Wear clothing not designed in way to attract attention. Here the basic rule of modesty and avoiding "show off" applies to all believing men and women in Islam.
- In addition men are discouraged from wearing silk and gold.

Section four - Other

4.1 Islamic view on disability:

The word "disability" cannot be found within the Qur'an or Hadiths (*religious texts of Islam*), but the concept of Muslims having inabilities or special needs and how they interacted in society can be found throughout the history of Islam. In particular is the example of Itban bin Malik, a religious leader who was blind (*Bukhari 2:279*).

Disability is seen as neither a blessing nor a curse in Islam. It is the belief of Muslims that everyone was created with different abilities and disabilities with the objective for a Muslim to focus on their abilities and show gratefulness rather than focus on the disability. With this being said a Muslim has the right to improve the situation of their disability through prayer, medical, educational and advocacy resources.

Within Islam there are allocations for Muslims with disabilities and the aged to be exempted from some of the Islamic practices such as prayers, fasting and performing hajj, as mentioned in the Qur'an. *"Allah desireth for you ease, he desireth not hardship for you". (Al-Baqarah 2:185).*

Due to the diversity of medical conditions and disabilities it is a preferred practice to refer to a Muslim religious leader to determine what (if any) exemptions of Islamic practices are placed upon a person with a disability or the aged.

Human life is to be valued within Islam and every Muslim regardless of their abilities or inabilities should be regarded as valued members of the community. Islamic history highlights many examples of people whom, while having some form of a disability, excelled to very high positions and prominent status in society.

The community as a whole is enjoined to be accepting of all people regardless of their disability and Muslims are required to support them in addressing their needs as well as creating an inclusive environment and encouraging full participation of all members of the community.

Caring for a family member with a disability is viewed as being highly rewarding. Generally speaking, Muslim carers prefer to remain with the care recipient at all times and prefer to have activities that involve the whole family. Respite care is often avoided unless absolutely necessary.

4.2 Islam and Health

In Islam the body is a gift from God and needs to be looked after and not abused. Thus keeping the body healthy is part of one's religion. Any illness is to be received with patience and prayers and Muslims are strongly encouraged to seek treatment and care.

Death is seen as part of a journey to meet the Creator. However assisted suicide and euthanasia are not permitted. The deceased should be buried as soon as possible after death. Burial rituals include washing and shrouding the body as well as congregational funeral prayers.

Increased devotion, receiving visitors and condolences, and avoiding decorative clothing and jewellery are observed during mourning. Muslims observe a 3-day mourning period (widows will mourn for a longer period of four months and ten days). It is discouraged for people to erect elaborate markers, or put flowers or other mementos on the grave. Rather, one should humbly remember God and God's Mercy, and pray for the deceased. For assistance with burials contact the Muslim Burial Society of WA: Ismail Fredericks 08 9418 5238 or Adiel Franke 08 9249 3802.

Main References:
J Lang, Even Angels Ask (1997)
Z Sardar and Z A Malik, Introducing Muhammad (1994)
H Abdulati, Islam in Focus (1975)

Ethnic Disability Advocacy Centre

Address:	320 Rokeby Rd, Subiaco, WA 6008
Telephone:	(08) 9388 7455
Fax Number:	(08) 9388 7433
Email Address:	admin@edac.org.au

The Muslim Women's Support Centre of WA (Inc)

Address:	Ground Floor, 1127 Albany Hwy, Bentley.
Postal Address:	PO Box 1398, East Victoria Park, 6981
Telephone:	(08) 9451 5696
Fax Number:	(08) 9451 5696
Email Address:	info@mwsc.com.au

6. Towards recovery

This kit has provided you with information about the refugee experience and its effects on the individual and the family.

The refugee experience is a life-long one. Those who go through it will pass through different phases at different rates of progress.

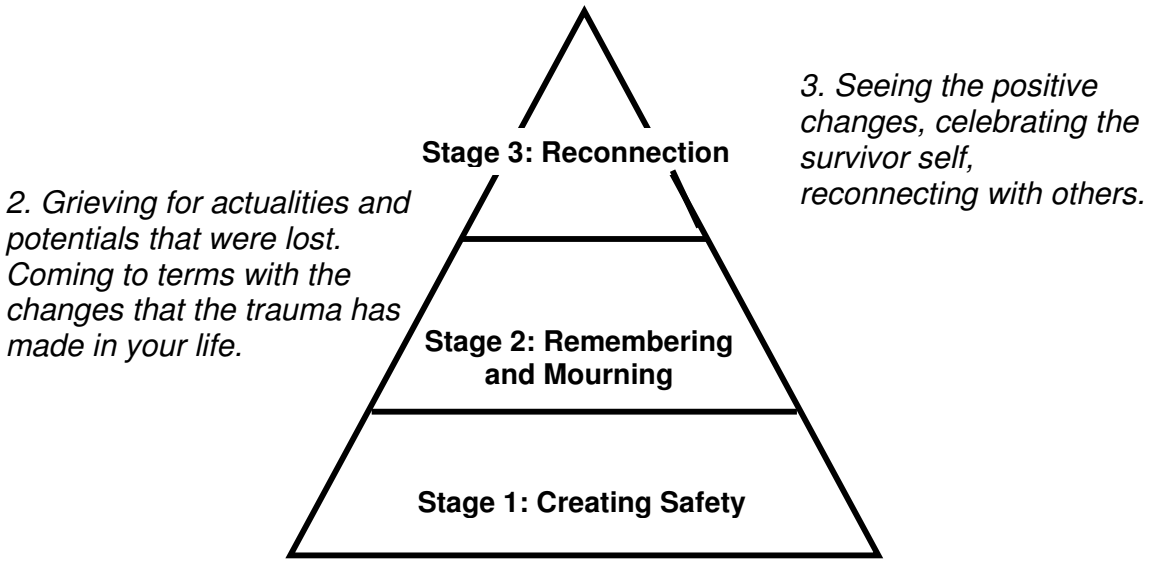
This section includes information about 'recovery models' to help you:

- understand the processes that people go through following experiences of torture and trauma
- deliver services that can positively assist survivors in their journeys toward recovery.

This section provides summaries of:

- the Judith Herman model of recovery stages
- the 'systemic' approach to recovery from torture and trauma developed by STARTTS
- the 'Recovery Goals' developed by the Victorian Foundation for Survivors of Torture.

6.1 Judith Herman model – 3 stages of recovery



In the early stages of trauma recovery, the person concentrates on the priorities of escaping and attending to the basic human needs of himself or herself and the family. The primary impulse is for security and protection.

As these priorities recede and life begins to normalise, many people will find that they are confronted with tremendous grief over their compounded losses. This grieving process is a normal part of recovery, and people will need to go through this before they are able to begin to heal and create a positive future.

The final stage, ‘reconnection’, represents the stage when the survivor comes to terms with their past experiences and is able to move on to a new, positive stage.

The reality is that many survivors will struggle to move beyond the middle stage. For example, in Case Study 7, Leslo spent many years concentrating on ‘creating safety’. As an older person, following his retirement, he finds himself facing the challenges of the middle stage.

6.2 STARTTS systemic approach: where HACC services fit in

Figure 6.2.1 below illustrates STARTTS' holistic approach to survivor recovery, taking into consideration the network of relationships that surround the individual.

The **STARTTS model** incorporates a number of different levels, beginning with a focus on the individual, and then moving outwards through the individual's primary networks and into the wider society.

For effective recovery of survivors, interventions need to occur at each of these levels.

As an example, STARTTS services begin with individual assessment, counselling and therapy services. At the family level, family therapy, parenting workshops and youth programs are provided. At the community level, STARTTS develops projects and programs to strengthen refugee communities. At the final level of the wider society, STARTTS provides training and awareness raising, advocacy and community education.

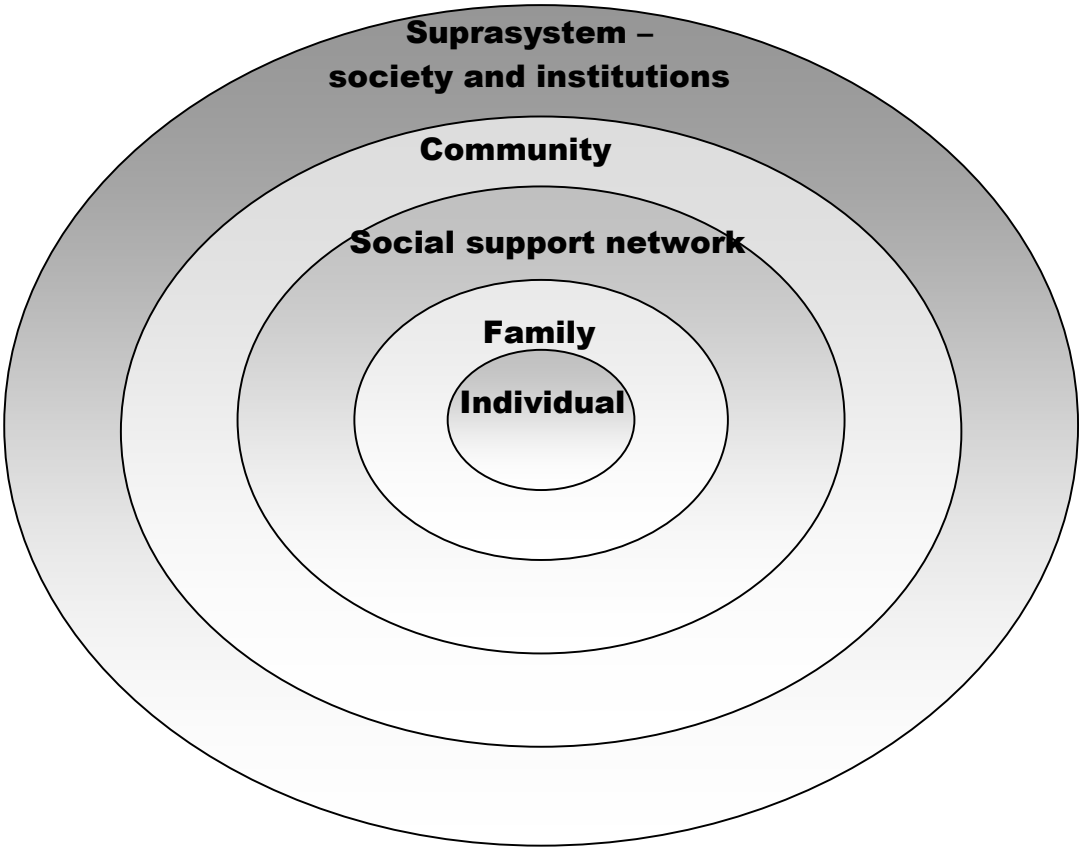
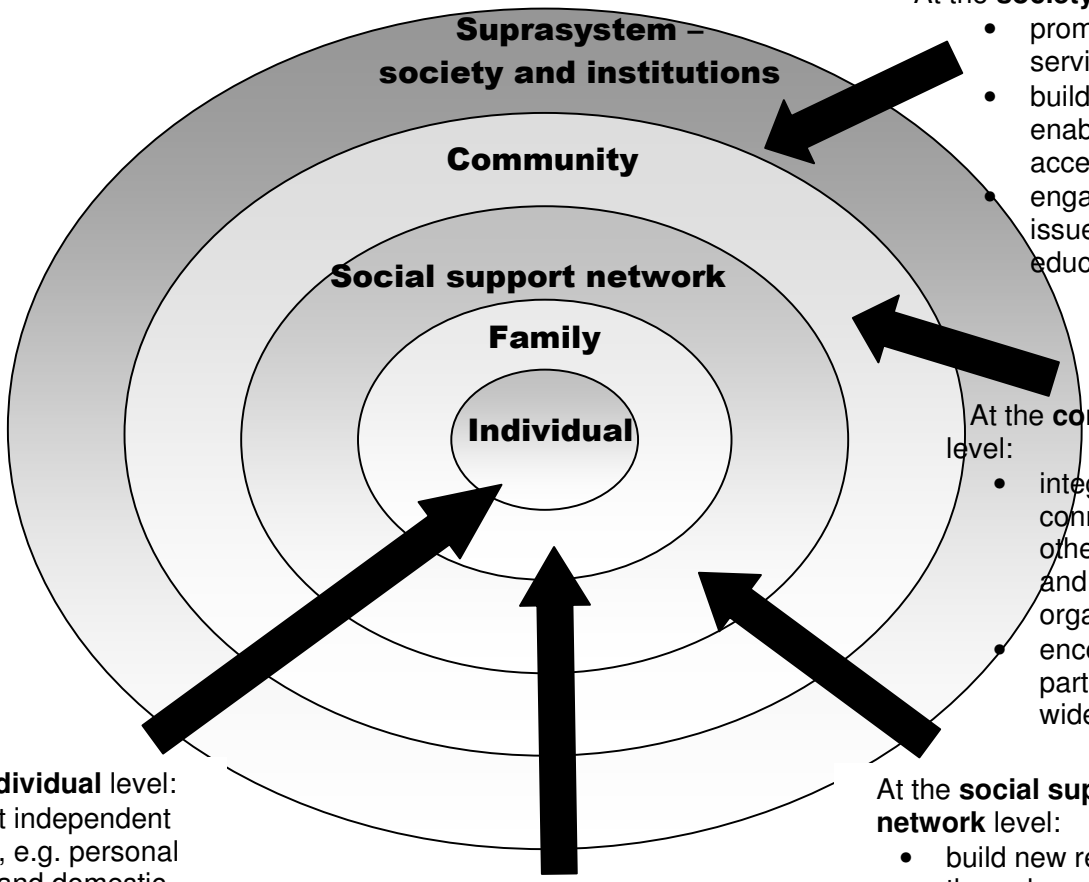


Figure 6.2.1: Systemic approach to recovery from torture and trauma developed by STARTTS

Relevance for HACC service providers

HACC services can play an important part in this system. HACC services are an integral part of the client's personal network, and HACC services impact at several levels of the model, as shown in Figure 6.2.2 below.



At the **society** level:
- promote services
- build capacity to enable equity of access
- engage with issues and educate staff

At the **community** level:
- integrate and connect with other services and community organisations
- encourage participation in wider community

At the **individual** level:
- assist independent living, e.g. personal care and domestic assistance
- provide choice
- enhance self-respect and dignity

At the **family** level:
- support family members who are carers, through e.g. respite
- strengthen family network through support
- respect cultural values

At the **social support network** level:
- build new relationships through services such as aged day care and Neighbour Aid
- act as 'substitute extended family'
- connect with other services

HACC SERVICES

Figure 6.2.2 Role of HACC services in the systemic approach to recovery from torture and trauma

Individual level
All HACC services contribute to the well-being of the individual, and promote self-respect and dignity through enhanced independence. Quality services delivered by trained personnel who understand the specific requirement of survivor clients can contribute to the recovery process.

Family level
HACC service providers recognise the valuable role of family members who are carers in the service provision equation, particularly through respite services.

By understanding and responding positively to the role of family members and carers of survivor clients, HACC service co-ordinators and workers can help to strengthen the supporting family system.

By providing services that enable survivor clients to remain with their families in their own homes, HACC services demonstrate respect for the cultural traditions of survivor clients.

Social/support network level
HACC services can help survivor clients build new relationships through services such as aged day care and Neighbour Aid.

HACC services can provide a 'way in' to the services sector for families, and help them connect with other relevant services.

Community and society levels
HACC service providers can work with other service providers and community groups to strengthen their ties, build their skills and capacity, and promote their services to refugee community groups.

HACC services can be a key component of the survivor client's social support network. For those whose existing networks may be non-existent, weak and/or vulnerable. HACC service personnel can effectively take up the role of 'a substitute extended family'.

Survivor clients may be fearful of accessing community services. HACC service providers need to recognise this apprehension, and reach out to potential clients in new ways. These ways help clients to see that the service provider and workers are an extension to their personal network rather than an intervention by an external agency.

HACC services can be a strong part of the survivor's recovery process by recognising the important role that they play in the systemic approach.

6.3 VFST Recovery Goals – how HACC workers can make a difference

The table on the following page sets out how the acts of violence perpetrated by a repressive regime impact on the individual by setting up the trauma reactions that contribute to post traumatic stress disorder (PTSD). The table then identifies corresponding **recovery goals.**

People working with survivors can use the four **recovery goals** to assist with service delivery. The information on the following pages will help you develop strategies that respond directly to the needs of your clients who come from refugee and refugee-like backgrounds.

This information was developed by the Victorian Foundation for Survivors of Torture (VFST).

Table 6.3: Recovery goals for survivors of torture

Acts of organised violence	Experiences that can cause trauma	Trauma reactions	Recovery goals
Violence Killings Assaults Disappearances' Lack of shelter and health care	Chronic fear and alarm No escape Unpredictable	**Anxiety** **Feelings of helplessness** **Perceived lack of control**	**safety** **Restore safety** **Enhance control** **Reduce fear and anxiety**
Death Separation Isolation Dislocation Bans on traditional practices	Disruption of connection to family, friends, community, religious and cultural systems	**Relationships changed** **Capacity for intimacy altered** **Grief** **Depression**	 **Restore attachment and connections to those who offer emotional support and care**
Abuse of human rights Mass killing Exposure to brutality	Central values about life destroyed	**Loss of trust** **Meaning and identity destroyed** **View of future altered**	 **Restore meaning and purpose to life**
Personal boundaries invaded No right to privacy Impossible choice Insults	Humiliation Degradation	**Guilt** **Shame**	 **Restore dignity and value** **Reduce guilt and shame**

Recovery strategies – Client checklists

The checklists on the next pages have been adapted from the VFST Recovery Goals to help service providers translate the goals into practical strategies for service delivery.

Co-ordinators and workers can use this checklist to document strategies that have been put in place to support clients from refugee and refugee-like backgrounds. You will find that many of these strategies are already part of your service procedures, indicating that you are already helping your client work towards recovery.

Place a tick in the relevant box on the checklist to show that this strategy is being applied. Include your own additional strategies on the lines provided.

Working with HACC clients from refugee backgrounds
Recovery goals and strategies checklist

Client name: …….

Country of origin: …… Preferred language: ……..

How to use this checklist
The four VFST Recovery Goals are summarised in the main headings in the checklist. Under each heading are a number of strategies that can be put in place to help realise this goal for your survivor client. Tick the strategies that are most appropriate for your client, and include these in your service plan for this client. There is space to include your own strategies as you identify them during delivery of service to this client.

Recovery goal 1: To restore control and safety → Reduce fear and anxiety

safety

Strategies

- ☐ Provide a structured and predictable environment
- ☐ Give clear information about services, including fees
- ☐ Be clear about service guidelines, rules, obligations of clients and procedures
- ☐ Respect the privacy of the client; explain privacy provisions
- ☐ When completing documentation, allow client to see the forms and watch you writing; if possible invite client to contribute by writing name, etc, on form
- ☐ Avoid common triggers that may provoke anxiety in the client
- ☐ Don't ask unnecessary questions or probe issues from the past
- ☐ Give choices
- ☐ Develop trust by speaking about yourself
- ☐ Explain your role as a worker, case manager or volunteer
- ☐ Explain clearly what tasks you are doing and how you are doing them
- ☐ Respect the client's request for you to undertake tasks in certain ways that may be preferred or culturally appropriate
- ☐ …….

Working with HACC clients from refugee backgrounds
Recovery goals and strategies checklist

Recovery Goal 2: To restore attachment connections → Overcome grief and loss

Strategies

- ☐ Provide a consistent and stable relationship
- ☐ Provide emotional support when needed, or have access to those who can provide this support
- ☐ Prepare client for any separation from yourself if necessary
- ☐ Introduce new worker, overlap services if possible to emphasise consistency
- ☐ Show that you understand grief responses and that these are long lasting
- ☐ Show interest when client talks about relationships past and present but don't probe
- ☐ Encourage social activities and participation in groups if this is part of your role
- ☐ Create opportunities for enjoyment and pleasure
- ☐ ……
- ☐ ……
- ☐ ……
- ☐ ……

Working with HACC clients from refugee backgrounds
Recovery goals and strategies checklist

Recovery Goal 3: To restore identity → Find meaning and purpose

Strategies

- ☐ Treat client with respect
- ☐ Acknowledge client's competencies and coping skills
- ☐ Acknowledge client's difficulties
- ☐ Expect distrust, withdrawal, anger and demanding behaviour as your services may be challenging the client's perceptions of their own level of independence
- ☐ Validate client's description of events past and present, i.e. say you accept and understand
- ☐ Encourage client to participate in completion of your tasks, particularly if they have special skills; show that you value these skills
- ☐ Be aware of client's interests, and encourage these by speaking about them, bringing along relevant items, etc.
- ☐ Validate client's cultural identity by engaging in culturally appropriate behaviour
- ☐ Give client opportunities for self-expression
- ☐ Give client opportunities for participation in meaningful events
- ☐ ……
- ☐ ……
- ☐ ……

Working with HACC clients from refugee backgrounds
Recovery goals and strategies checklist

Recovery Goal 4: To restore dignity and value → Reduce guilt

Strategies

- ☐ Treat the client with respect
- ☐ Respect the client's need for privacy
- ☐ Respect the client's unwillingness to disclose information
- ☐ ……..
- ☐ ……..
- ☐ ……..

7. Some guidelines for service co-ordinators

These guidelines are for co-ordinators who are conducting assessments of new HACC clients who are from refugee backgrounds, including those who may be survivors of torture and trauma.

The aims are to help you:

- identify clients who are from refugee backgrounds and may be survivors of torture and trauma
- manage the assessment interview appropriately
- assign the appropriate worker to the client following the assessment
- document incidents so that all personnel are fully briefed
- provide workers with on-going support and strategies for reporting and managing any challenging incidents that may occur
- obtain further information and make referrals

Guideline 1
Identifying clients who may be survivors

It is important to establish if your new client is from a refugee background. While gathering this information is not a requirement of the CIAR, it is vital for ensuring that you provide the client with the most appropriate service.

Many people who come from refugee or refugee-like backgrounds will not identify themselves as such. There are several reasons for this:

- the person has been in Australia for many years and has attempted to put the experience behind them
- the person may have come to Australia under Family Reunion or an economic-based migration scheme, and so will not identify themselves as having had refugee-like experiences, or
- the person may choose to forget or deny their past experiences.

For these reasons, **don't ask your client if they come from a refugee background.** This question could be deemed to be rude and intrusive, and may trigger responses from your client that range from confusion to anger. On the other hand, some clients may choose to volunteer this information.

If you suspect from a referral that your new client may be from a refugee background, it will be helpful to organise an informal meeting before the formal assessment to find out more about them and their needs.

i) Find out from the referring body, if you can, when the client arrived in Australia and which country they came from, or ask a family member of the client these questions; make sure that your questions are put sensitively and respectfully to the client and their family.

ii) Check **Table 2.3.1: Main countries of origin of refugees settled in Australia 1930-2010** to see whether the client's settlement in Australian coincides with Australia's intake of humanitarian entrants. If so, there is a strong likelihood that the client has been through a refugee experience.

After you have established that the client have a refugee background, you can then put into place the guidelines that follow.

Guideline 2
Interviewing your client

Your client and/or their family members may find the assessment meeting stressful due to the formal, interrogative nature of the interview and your role as a representative of authority. You need to be able to put your client at ease, and you need to take a flexible approach to the way you gather information.

Before the assessment

- Find out about language needs, and organise a professional interpreter if necessary. See the section below, 'Using an interpreter'.

- Make sure the **setting** for the assessment is appropriate for the client. Clients from refugee backgrounds may experience anxiety if they are required to undergo formal questioning, with answers recorded in writing, in their own home which they regard as a place of safety and refuge.

  Some services prefer to meet first with clients informally to 'break the ice' and establish trust. The service then conducts the formal assessment interview at another time.

- Tell the client and family members what will be **expected of them** at the assessment: what papers they will need, and what information they will need to give you. Explain that their information will be kept private, and that everyone who is applying for services has to follow the same process.

- Wear **culturally appropriate clothing** to your meetings. Make sure your arms and shoulders are covered, and avoid low-cut tops, shorts and short skirts.

At the assessment

Many of the guidelines below will apply to all assessment situations. However, it is important to be aware of the client's possible response to what is for you a routine assessment. The client may be distrustful because you are a representative of the government, you are asking personal questions, you are writing things down that will be kept on records, and you are looking around the personal space that is their home. This response may be expressed even if the client's traumatic experience occurred many years before.

- **At the outset, explain your role and the purpose of the meeting**; emphasise that the services you will be talking about are offered to enhance the care given by the family, not as a replacement.

- **Introduce everyone present** who is not known to the client and their family members.

- **If an interpreter is present, introduce them** and explain what their role is. Ask the client to speak directly to you, not to the interpreter.

- **Remind the client of what sort of information they will need to give you**, and the level of detail required.

- **Explain that this information is confidential** and will be kept private.

- Emphasise that **you follow the same process for all your clients** in order to make sure you can give them the best service. Avoid explaining this in terms of data collection and reporting to government funding bodies.

- **Explain that you need to write things down**. Lay out your papers openly and allow those present to observe you writing. (Co-ordinators from some service providers prefer not to write everything down, but to remember key points and record this information straight after the interview.)

- **Be patient**, and be prepared to repeat what you say.

- **Be aware of and respectful of any cultural requirements**, such as removing shoes. If drinks and food are offered, accept, or decline graciously if this is not permitted by your service guidelines.

- **Invite your client and their family members to ask questions** and express any concerns. Focus on the needs of the client, not on the capacities of your service. If disagreement occurs between family members, be patient and respectful, and emphasise that services are there to help everyone.

- **Don't ask irrelevant questions about the client's background**. Intrusive questions may provoke anxiety and distrust.

- **Be prepared to answer questions about yourself**, including personal questions. Your client may want to place you in the social world, as a way of establishing if you are trustworthy.

- **Maintain a calm tone of voice throughout**.

- **Avoid touching your client** or their family members; this includes hand-shaking. Take the client's lead; for example, if the client extends their hand, take this cue and shake their hand.

- **Don't stereotype your client** because they may be a survivor of a traumatic refugee experience – individual responses vary greatly.

If you are interviewing in your office, you can help to achieve a calm environment by:

- keeping your office door open
- making sure lights are not too bright
- keeping noise to a minimum
- avoiding interruptions
- sitting in a 'round table' situation, rather than placing yourself behind a desk.

After the assessment

Contact the client or family member soon after the assessment. It may be a while before you are able to confirm services and commence service delivery, but it is important that you maintain communication with your client throughout the process. This is important to dispel uncertainty and develop a relationship of trust with your client.

Refer to these case studies:

Case Study 4: How NOT to learn about each other

Case Study 7: Ageing and PTSD – Leslo

Guideline 3
Using an interpreter

If your client does not speak English, you will need to organise an interpreter for the assessment interview. **Using professional interpreters for assessments and client interviews should be part of your organisational policy.**

Interpreters are currently available to all ADHC funded services free-of-charge through the Interpreting Services Administrative Framework (ISAF) Project.

To book an interpreter through the Health Care Interpreter Service
Phone 9840 3456 – urgent requests only
For non-urgent requests:
Fax: 9840 3789
Email: hcis@wsahs.nsw.gov.au
See the ISAF flyer and booking form at the end of this Guideline

Professional interpreters are bound by ethical principles to accurately translate all verbal communication between you and your client.

Don't make assumptions about the language preferred by your client. Always ask the client which language they wish the interview to be conducted in. Two reasons why this is important are:

- The client may come from a minority language group in their country of origin, and will be more likely to trust an interpreter who speaks this language. The client may object strongly to communicating with someone who comes from the ethnic background of their enemies or persecutors.

- The client may have lived in several different countries and experienced different education systems. They may be more comfortable using a particular language when communicating on a formal basis with figure of authority such as a service provider.

See **Table 3.5.1 Languages spoken by people from main countries of origin** for a list of languages that may be preferred by your client, and which of these are available from the Health Care Interpreter Service.

Do not rely on family members to interpret at the assessment interview. You need to obtain accurate information about your client's wants and needs, and these may be different from those of family members. You also need to make sure that your explanation of services is conveyed accurately to your client.

However, family members may be able to assist with straightforward tasks such as interpreting for phone calls to set up meetings.

Do not rely on bilingual workers to interpret at the assessment interview. This may seem like a cost effective solution, but there are issues you need to consider, in particular:

- your ethical obligations to your client regarding privacy and confidentiality of information taken at assessment
- your worker's cultural, religious and/or ethnic background, which may conflict with that of the client
- your worker is not a trained professional interpreter.

Bilingual workers are a valuable service delivery resource, but professional interpreters should be used for assessment and other confidential interviews.

Telephone conversations: Interpreting for phone conversations is covered by the ISAF project (see previous page). You can book a phone interpreter in the same way as you book a face-to-face interpreter.

If your client needs to contact you using a telephone interpreter, they can call **TIS** (Telephone Interpreter Service) on **131 450.** Your organisation needs to be prepared to accept calls from TIS on behalf of clients, and to set aside some money in your budget for payment of this service.

Before the assessment interview

- Book the interpreter to arrive 20-30 minutes before the interview commences so that you can brief them on HACC services (if necessary) and the purpose of the assessment interview.

At the assessment interview

- Introduce the interpreter and explain what their role is, i.e. the interpreter is an independent professional who is not part of your organisation and who is there to translate what everyone says.
- Speak directly to the client, not the interpreter.
- Ask the client to speak directly to you, not to the interpreter.
- Expect the interpreter to translate everything that is said at the interview, including discussions between the client and any family members who are present.

If you are aware that parts of the conversation are not being translated for you, you should stop the interview and remind the interpreter that their task is to translate all communication that occurs during the interview.

After the assessment interview

- Ask the interpreter to spend a few minutes with you to debrief about the interview. You can ask the interpreter to go over with you any communication that was not translated, and to report on any issues that arose that might have particular cultural significance, etc.

Refer to these case studies:

Case Study 5: Getting the right message across
Case Study 6: The right interpreter?

Training in using interpreters

Training for service providers in using interpreters effectively is offered by the Health Care Interpreter Service. For further information, contact your area HACC Multicultural Access Project (MAPS) Coordinator (see section 10.1 for contact details).

Sydney West Area Health Service Health Care Interpreter Service (HCIS)
INTERPRETING SERVICES ADMINISTRATIVE FRAMEWORK PROJECT
DADHC Pilot in the Metro North and Hunter Regions

EXTENSION OF ISAF PILOT PROJECT
INFORMATION FOR SERVICE USERS

1. Eligibility

- **All ADHC funded services (HACC and disability) continue to have free access to HCIS until further notice.**

2. Booking an interpreter

- **For urgent requests call 9840 3456**
- **For non-urgent requests fax or email the HCIS**
  Fax 9840 3789
  Email hcis@wsahs.nsw.gov.au (Use the form attached)

3. Hours of Operation

- **24 hours a day seven days a week**
- Services available in over 120 languages, including AUSLAN

3. Accessing the free interpreter services

- When booking an interpreter it is essential to indicate to booking clerks or on the booking form that you are part of the **ADHC/ISAF Project!**

4. Cancellation of Bookings

- If the interpreter is no longer required please contact HCIS as soon as possible to **cancel the appointment**.

5. Language services provided

- Face to face interpreting
- Telephone Interpreting
- Group talks

6. Feedback & Complaint Procedures

- Please see the attached Quality Assurance Form and SWAHS HCIS Complaint Procedures.

Sydney West Area Health Service

Health Care Interpreter Service Booking Form

Interpreting Services Administrative Project

Pilot in the Metro North and Hunter Regions of the Dept of Ageing, Disability and Home Care

DATE		**TIME**	

HOME VISIT (Please circle)	**YES**	**NO**

LANGUAGE REQUIRED	

DATE REQUIRED				
TIME REQUIRED	**FROM**		**TO**	
ALTERNATE DATE(S) (Required Field)				
ALTERNATE TIMES(S): (Required Field)				

SERVICE NAME				
SERVICE TYPE	**Please circle:** *Group Home, Respite, Post School Options, Case Management, Personal Care, Day Care, Social Support, Meals, Domestic Assistance, Transport, Other……*			
VENUE ADDRESS				
No OF CLIENTS				
CLIENT'S NAME(S)				
PROVIDER TYPE				
SERVICE PROVIDER NAME				
PERSON BOOKING APPOINTMENT				
	CONTACT No.		**FAX No.**	
CALL CLIENT?	**YES**	**NO**	**CONTACT Nos**	
RELATED COMMENTS (special requests eg preferred sex of interpreter)				

Thank you for using our services SWHCIS. We speak your language!

Guideline 4
Working with family members

In many CALD cultures, caring for family members who are ageing or have disability is the role of family members rather than government-funded services. This may be due to cultural traditions and because there were few, if any, funded services available in their country of origin.

As a result, clients from CALD backgrounds and their families may experience a range of emotional responses when they do access HACC services, usually due to increasing stresses and demands on the extended family.

The **client** may feel that family members are neglecting them by turning them over to external providers of care. The client might feel resentful of family members and distrustful of the service's ability to understand their particular needs. The family's inability to fulfil all the traditional roles of carers may cause **intergenerational conflict**, and increase the client's experience of **cultural dislocation**. If the client is a survivor of torture and trauma, this change may be a **trigger** for re-emergence of earlier experiences of abandonment, fear and uncertainty.

Family members may experience **role conflict and guilt** when they approach services for assistance. They may have been struggling to manage the demands of their own lives while providing care to their ageing relative or relative with disability, and have reached a crisis point. They may feel that their own community is critical of them for not fulfilling their cultural obligations. They may express this by attempting to maintain full control over the way service is provided to their relative. They may try to reject the service that is offered for various reasons, or be overly critical of the way services are delivered.

Service providers need to recognise that this is a point of major transition for clients and their families. Service providers need to be prepared for these responses, and to deal with them sympathetically. Clients and their families need to be reassured that it is possible to achieve a positive outcome for everyone involved.

See Section 5.8 for further discussion of this topic.

Refer to these case studies:

Case Study 9: A complex situation
Case Study 10: Family matters

Guideline 5
Assigning workers

It is always a challenge to match HACC workers and clients. But there are some critical concerns that need to be addressed when providing services to clients who may be from refugee backgrounds.

Priorities

1) *Training:* Workers who are assigned to clients from refugee backgrounds should have attended the training module, 'Working with HACC clients from refugee backgrounds', or have access to the project Resource Kit.

2) *Language skills:* Ideally, a worker who has skills in the client's language should be assigned if available. It is important to make sure when assigning a CALD worker that they not only have relevant language skills but that they come from a culturally appropriate ethnic or religious background that does not conflict with that of the client. For example, Arabic is spoken widely across the Middle East and Northern Africa by many groups of different cultural and religious traditions.

   If no worker with relevant language skills is available, there should be no problem in assigning a worker from an Australian or other CALD background, providing these workers have demonstrated cultural awareness.

3) *Stability:* It is important to provide the survivor client with service that is as **consistent and stable** as possible so that the survivor feels secure and is able to develop a relationship of trust with the worker. If it is necessary to change the worker, there should be a period of transition when the client is given an opportunity to meet and familiarise themselves with the new person.

Refer to these case studies:

Case study 2: Sang – the impact of culturally competent care

Case study 3: Achmed – the impact of culturally incompetent care

Case study 12: Speaking up

Guideline 6
Documenting incidents

It is important that incidents related to the refugee experience are reported and documented, and kept in **confidential client files.**

It may help to use a form such as the one overleaf to document these incidents. By doing this, you will help to make awareness and acknowledgement of such incidents a normal part of your service delivery. By including a management plan in the case of a further incident, you will help your staff to understand the issues better and feel confident about providing services to the client.

By keeping clear records about your client's responses related to their refugee experience, you can help to ensure that:

- new and relief workers will be prepared by having access to information about triggers and the possible responses of the client

- your client will be spared the trauma of another similar flashback as far as possible.

Working with HACC clients from refugee backgrounds

Incident related to client's refugee background

Client name: …….

Country of origin: …… **Preferred language:** ..……..

Date of incident: …… **Workers name:** ……..……..

Briefly describe what happened to the client: ……

……

……

……

What do you think was the *trigger* for the client's reaction? ……

……

……

What action did you take? ……

……

Who did you report the incident to? ……..

For completion by Manager/Co-ordinator

Outline management strategy in the event of future incident: ……..

……

……

……

Signed: …… **Date:** …….

Guideline 7
Supporting workers

The case studies referred to below provide examples of situations where workers have had to deal with incidents relating to the specific needs of clients from refugee and refugee-like backgrounds.

Workers who are assigned to clients who show post trauma symptoms may be at risk of **vicarious trauma**. That is, the trauma stories that workers hear may cause cognitive and emotional responses in workers. These responses can lead to disillusionment, withdrawal, health problems and depression. Workers need to be reassured that they are supported by an organisation-wide approach to these issues so that they do not attempt to 'go it alone'.

Vicarious trauma is an OH&S issue. Managers and co-ordinators can support staff who may be at risk of developing vicarious trauma by:

- **validating the worker's experience**
    - scheduling debriefing sessions as part of regular supervision meetings to acknowledge responses and provide support
    - organising 'get-togethers' for workers, volunteers and case managers who may be working with clients from refugee-like backgrounds to give them an opportunity to share their experiences and support each other

- **developing safety mechanisms**
    - the worker's supervisor is available for phone contact, and will return phone calls as soon as possible
    - co-ordinators and/or co-workers are rostered to be available by mobile phone for reporting critical incidents
    - workers are encouraged to report all incidents in writing as soon as possible to their supervisors; these reports are held on confidential file to provide an on-going profile of the client
    - workers have access to regular staff development that is funded by the organisation.

- **establishing systems through the organisation's human resources function to respond to possible vicarious trauma in workers, e.g. by promoting an Employee Assistance Program (EAP) to personnel.**

Refer to these case studies:

Case study 11: Pet distress
Case study 12: Speaking up
Case study 14: Stocking up
Case study 16: In/different times

Guideline 8
Obtaining information and making referrals

A list of relevant agencies and organisations that can provide specialist services to people from refugee-like backgrounds and their families and carers is in **Section 10.**

These organisations are divided into the following categories:

10.1 HACC Multicultural Access Project (MAPS) contacts

10.2 Carer support services

10.3 Cultural specific and multicultural organisations

10.4 Health, counselling, mental health and carer support services

10.5 Settlement Grants Program services

In the two case studies referred to below, service providers recognised that clients who demonstrated symptoms of PTSD required specialist service, and referred clients to STARTTS.

Examples of situations in which co-ordinators may need additional information or to refer clients on for further assessment include:

- Referral to STARTTS

  If a client shows symptoms of distress, anxiety or panic attacks, a referral to STARTTS would be appropriate. Service providers can ring STARTTS to talk about the issues and if appropriate, and with client consent, make a referral. Phone 02 9794 1900.

- Referral to Multicultural Disability Advocacy Association (MDAA)

  A client with disability and their family or carers may need some assistance in obtaining appropriate services, making their specific needs known or understanding the range of services available to them. Service providers can encourage their client to contact MDAA, or service providers can discuss the issues with MDAA.

Refer to these case studies:

Case Study 8: Flashback
Case Study 13: The need to keep moving

8. How you can help your HACC clients

Guidelines for direct care workers, volunteers and case managers

The guidelines in this section will help you to work out how you can best support your HACC client from a refugee or refugee-like background.

These guidelines are:

1. Use your experience
2. Be informed
3. Understand family relationships and attitudes to ageing and disability
4. Understand effects of torture and trauma on survivors
5. Communicate well
6. Know when and where to get help for your client
7. Look after your own needs

How you can help your HACC clients

1. Use your experience

As a HACC worker you have a wealth of knowledge and experience of working with all kinds of people. You understand the needs of people who are ageing and/or have a disability. This experience is your most valuable resource for meeting the needs of your client from a refugee or refugee-like backgrounds.

Your positive personal qualities, too, make you an asset to your organisation and a valuable part of your client's circle of care.

You may be familiar with some of the guidelines in this section, and they may already be part of your kit of skills. If so, we encourage you to use parts of this section as a 'refresher'.

There will be other guidelines that are new to you. By practising these guidelines and adding them to your skills set, you will be able to make your service even better, and add to your own levels of confidence.

2. Be informed

Does your CALD client come from a refugee or refugee-like background?

i) Talk to the co-ordinator who conducted this client's assessment:

- What country does the client come from?
- When did the client arrive in Australia?

ii) Check the 'Countries of origin' chart in **Section 2.3**

- Check if the client's time of arrival matches the countries and dates in the chart
- Remember that the client may come from a 'refugee-like' background, i.e. did not arrive as a humanitarian entrant, but may have been through similar experiences

iii) Refer to the information in **Section 3** of this Resource Kit

- Read the **Survival and Beyond Sheet** or the **MDAA Country Information Sheet**
- Get the relevant **DIAC Community Information Sheet** from the DIAC website.

How you can help your HACC clients

3. Understand family relationships and attitudes to ageing and disability

Read Section 5.12 of this Resource Kit: *Role of family and carers*

- Read, if relevant, the **Survival and beyond sheet** for this country
- If your client has a disability, read the relevant **MDAA Ethnicity and Disability Information Sheet**
- If your client comes from a Muslim background, read the sheet: **Islam: A guide for service providers working with people with a disability**

Refer to these case studies:

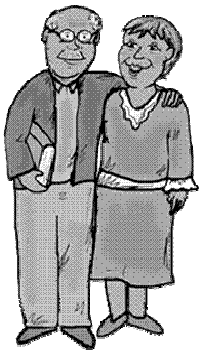
Case study 2: Sang – the impact of culturally competent care

Case study 3: Achmed – the impact of culturally incompetent care

Case study 4: How NOT to learn about each other

Case Study 9: A complex situation

Case Study 10: Family matters



How you can help your HACC clients

4. Understand effects of torture and trauma on survivors who are ageing and/or have disability and their carers

Read: Section 5: *Effects of torture and trauma and impacts of ageing and disability*

i) Understand the impacts of ageing on survivors of torture and trauma, including

- how decline in short term memory can lead to re-emergence of traumatic memories from long ago
- how cognitive decline can lead to problems with remembering a second language
- how physical limitations can lead to social isolation, loss of self-esteem and depression
- read about other symptoms in Section 5.

Refer to this case study:

Case Study 7: Ageing and PTSD – Leslo

ii) Recognise the symptoms of trauma-related reactions

- Read the definitions of **PTSD, flashback and triggers** in **Section 5** of this Resource Kit
- Recognise these when they occur in your client

Refer to these case studies:

Case Study 8: Flashback

Case Study 11: Pet distress

4. Understand effects of torture and trauma on survivors (continued)

iii) Be aware that different people have very different responses to their traumatic experiences

- **Don't stereotype** your client because they may be a survivor of torture or trauma; people have different coping skills and levels of resilience.

iv) Avoid common triggers – see **Section 5** for examples such as:

- Avoid questioning your client about the past and past relationships
- Avoid sudden loud noises
- Avoid confined spaces
- Avoid sudden changes of staff without clear explanation.

v) Know what to do when your client has a trauma-related reaction

DO:	**DON'T:**
Do **identify** the trigger; remove it if you can	Don't **panic** -- your calm will help to diffuse the situation
Do **validate** the client's experience	Don't take symptoms **personally** -- this is not about you
Do put **behaviours into context –** this is a common response to abnormal experience	Don't breach the client's **privacy** by relating the episode to others
Do **seek help** at the time if you need it — before the situation escalates.	Don't try to **manage the situation** on your own!

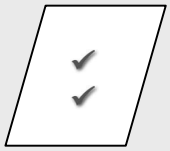
Refer to these case studies:

Case Study 12: Speaking up
Case study 16: In/different times

4. Understand effects of torture and trauma on survivors (continued)

vi) Understand the Recovery Goals and apply these where possible

- See **Section 6.3** for a full description of the **Recovery Goals**.
- The Recovery Goals will help you and your co-ordinator to develop strategies for meeting the needs of each client



Use the Recovery Goals Checklists in Section 6.3 to develop positive strategies for your client!

How you can help your HACC clients

5. Communicate well

i) Tell your co-ordinator if an interpreter is necessary

- Your client can speak some English, but they may not understand all that you are saying

Refer to these case studies:

Case Study 5: Getting the right message across

Case study 6: The right interpreter?

ii) Listen!

- Listening skills enable you to find out about your client's needs

Refer to this case study:

Case Study 12: Speaking up

iii) Build trust

- Be reliable and consistent
- Don't judge
- Respect your client and validate his or her experiences

Refer to this case study:

Case Study 14: Stocking up

5. Communicate well (continued)

iv) Be patient

- Don't rush your client with your speech or your actions
- Allow the client time to trust you
- Explain everything that you are doing and why you are doing it.

Listen	Understand	Respect	Accept

How you can help your HACC clients

6. Know when and where to get help for your client

i) Be familiar with your organisation's referral processes

- Know how to report an incident
- Know who to contact in an emergency
- Know how to go about getting other services for your client (e.g. notifying your co-ordinator)

ii) Seek help before a situation escalates

- If your client needs help
    - don't try to deal with things yourself
    - get help as soon as you can

iii) Know about the organisations that can help your client

- See the referral information in **Section 10**.

7. Look after your own needs

You need to look after yourself if you are going to be able to help your client!

Accept your own powerful reactions

As a witness to your client's responses to past traumatic experiences, you may experience distress, anxiety and sadness

This is called **vicarious trauma**, or trauma felt at second-hand, through the experiences of another person.

If you feel distress or anxiety as a result of your relationship with your survivor client:

- you need to **debrief**, or talk about your feelings with someone – your co-ordinator, your colleagues or a counsellor
- don't **ignore** your feelings of distress; these are real and you will need some help; otherwise you are at risk of burn-out and depression.

Talk to your co-ordinator about ways in which the organisation can support you. Vicarious trauma is an OH&S issue.

9. Case studies

These case studies have been used in the one-day training program.

Organisations will find them useful as they are based on real experiences and illustrate key issues. Where appropriate, points for discussion and problem-solving are included on the page following the case study.

Case study 1

Resettlement as an older refugee: Safar Ali

Extracted from 'Living in limbo' by H. Basili, in *Transitions* (STARTTS, Issue 9, 2001)

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

Ali spent three months in bed recovering from his beating. He then pooled the savings from his transportation business – about $8,000 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 Afghan refugees who arrived in Australia having had to rely on people smugglers.

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

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

[His] 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 was satisfied that Ali was a genuine refugee according to international legal guidelines for determining refugee status and Ali was released from the detention centre with a bus ticket to Brisbane.

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

Note: The TPV was abolished in mid-2008; now asylum seekers are eligible for permanent protection.

Case study 2

Sang – The impact of culturally competent care

Reproduced from Harris (2005) *Cultural competence works* with the permission of NSW Multicultural Disability Advocacy Association

Sang is a 26 year old woman from Korea with an intellectual disability. Ten years after arriving, Sang now accesses a Disability Employment Support Service. Sang loves going to the service because the workers there understand that her English is not so good, and they realise that being Korean is very important to her and her family. They even invite people from the community to talk about Korean culture.

When Sang first got to the service she was scared of using a telephone interpreter, but the workers encouraged her and now she uses one all the time. She has also been learning English, and enjoys practising with the workers and teaching them some words in her language, *Han-gul.* People at the service always ask her how she and her family feel about the support and activities they provide.

Question

What makes Sang's experience 'culturally competent'?

Case study 3

Achmed – The impact of culturally *in*competent care

Reproduced from Harris (2005) *Cultural competence works* with the permission of NSW Multicultural Disability Advocacy Association

Achmed is 26 and has cerebral palsy. His parents migrated from Lebanon just before he was born. He was diagnosed with cerebral palsy early in life. Achmed is Muslim. He lives independently and receives support services in his own home.

Achmed feels that he has never been in control of his life and is at the mercy of insensitive services. Ten years ago he was playing some Arabic music and a worker told him to turn it off because she didn't like 'That Wog S*^t'. When he complained the manager said told him that his music was offensive to some people and he should consider their feelings. Recently, he was watching the news on TV and he heard his personal carers saying that 'All those bloody tea-towel heads are criminals and terrorists'.

He feels nothings has changed in 10 years but is too scared to complain because he thinks the service will be taken away.

Question

Is Achmed's a common experience? Provide some evidence for your answer.

Case study 4

How NOT to learn about each other

Reproduced from Harris (2005) *Cultural competence works* with the permission of NSW Multicultural Disability Advocacy Association

Steve couldn't understand what had gone wrong. He had gone to assess a Greek consumer, Alysia, and her elderly parents but had come away with nothing, except feeling frustrated. They spoke good English, so why had this family seemed so uninterested and, well there was only one word for it, rude to him?

Steve was busy that day, so when Alysia's parents greeted him at the door he looked at his watch and said, 'Nice to meet you too. I'm sorry, I am in a hurry today, do you mind if we begin straight away?'

So they all went to the kitchen, and the mother put on some coffee. She asked Steve if he would like some coffee before they began, and he said, No thank you. I don't drink coffee.'

'How about some baklava?'

Steve looked at the baklava and said, 'No, I've had that stuff before and it's too sweet for me! Look, I'm sorry but I really must begin.'

The mother shrugged and the father sat down. Steve then proceeded to tell them about the service and what it could do for Alysia. He was quite clear that they were a very experienced professional service. He said they were experts in providing the support Alysia obviously needed.

As he was about half way through talking the father stood up and said, 'I am sorry. This is not going to work. We will keep looking after Alysia. We don't need your help. Thank you for coming but we don't need you.' He stood up and walked out of the room, leaving Steve slack-jawed in amazement. The mother showed him out with barely a word spoken.

See overleaf for some better approaches that Steve might have used.

How could Steve have done better?

- First he would understand that he was there to learn about Alysia and her family, most importantly by allowing enough time for the meeting. He should have organised another time and date if he was pressed for time on the day of the initial appointment.

- He would set up a positive and respectful discussion by drinking the coffee (or accepting an alternative drink, or politely declining) and by participating in chit chat (saying how nice the house was). He would be prepared to answer personal questions about himself to encourage the family to trust him.

- When he believed that it was appropriate to begin discussing support, he would make it clear that he needed to learn from Alysia and her mother and father. He would also say that he would be happy for them to ask questions any time, particularly if they didn't understand what he was saying.

- He would then explain what his service was offering, making it clear that the service had a great deal of experience working with people with disability and their families. He would point out that Alysia's relationship with the family was of the utmost importance and that the service always respected their consumers' families' values and traditional ways of providing support. He would ask the family what sort of support they needed. All the while he would check that the family understood what he was talking about and ask how they felt about what he was offering.

- The formal assessment could then begin.

Case study 5

Getting the right message across

Adapted from Harris (2005) *Cultural competence works* (p 48) with the permission of NSW Multicultural Disability Advocacy Association

'In the last place I worked an African couple from Sierra Leone brought their daughter to respite. We explained the situation to them: what was for dinner, who was going to care for her, shower and all that.

They didn't understand. Everything we said they nodded. We asked, 'did you understand?' and they nodded.

They went home, they got very upset. Then one of their neighbours rang and said they were very upset. The neighbour said that they didn't speak English very well. They speak Krio. But how would we know this? We did ask them if they spoke English, and they nodded.

The neighbour said they were petrified for their daughter as they didn't want her to be showered by male staff. They didn't want any interaction with male staff at all. Apparently we had given them completely the wrong idea!

It made me think. I mean, put yourself in the place of someone from a CALD background. And who knows what these people have been through? How would you feel to go to another country and try to understand what was going on without speaking the language?'

Worker

Discussion

Use the following themes to discuss the worker's words:

- language
- power relations, authority figures and trust
- culture and gender relations

See overleaf for some responses to these topics for discussion.

Discussion points

Language

The service provider needs access to background information about people from Sierra Leone. (This is available from the DIAC website – see Section 3 of this Resource Kit.) Although English is the official language, the first language of many recent arrivals is Krio. Krio speakers may understand and speak some English, but it will not be the appropriate language for conveying formal information about services, etc.

The service needed to ask the couple which language they preferred to communicate in. This open question prevents a simple 'yes' response, and it acknowledges that people – even those who come from the same geographic area -- have specific language needs. The service should have organised an interpreter for the couple.

More information about the communication style of people from Sierra Leone would have made the service personnel aware that asking questions, particularly in an unfamiliar, formal environment is considered rude in that culture.

Power relations, authority figures and trust

People from Sierra Leone would be unfamiliar with the idea of family support services that are funded by the government. Their initial response would be puzzlement, and as a result of their experiences of organised violence, distrust. The family's decision to access respite services may have followed a program of information and awareness building between the Sierra Leonean community and government/service providers. They will still feel very apprehensive.

The couple will be very aware of the power relation between themselves and the service personnel. They will not ask questions for cultural reasons, but also because they may feel intimidated.

The service provider needs to understand the couple's fears, and to build trust so that the couple feel safe about raising their concerns, and entrusting their child to the service.

Culture and gender relations

A culturally competent service provider will understand the sensitivity of gender issues for this family. Personnel will take care to address the way personal care will be managed, and the service will be prepared to take a flexible approach to the way service is normally delivered to accommodate the needs of this family.

Case study 6

The right interpreter?

Reproduced from Harris (2005) *Cultural competence works* (p 53) with the permission of NSW Multicultural Disability Advocacy Association

'We have one service user, when we use the TIS with him, he gets really embarrassed, so we try to use his brother. But the brother doesn't always communicate the message the way we want it. So that it is a problem too.

But with TIS he gets embarrassed because it is about his personal life and he doesn't know the person he is speaking to, and he feels more comfortable communicating through his brother, because he is more open with his brother. But his brother's English isn't the best either.'

Service provider

Questions

1. What are some ways the service provider can help this service user to use the TIS service?

2. What are some of the issues of concern about using a family member to interpret?

3. Are there any other solutions to this communication dilemma?

See overleaf for some responses to these questions.

Discussion points

1. The service provider could incorporate familiarisation with TIS into the service user's care plan. This could involve practice with telephoning firstly to familiar people (such as his brother), then using the telephone to obtain routine information. When the service user felt comfortable using the telephone in these ways, the service provider could help him to access TIS.

   The service provider should also provide the client with information about how TIS works, and TIS's obligations around privacy and confidentiality.

2. Issues of concern:
   a. The best interests of the client, and the client's own preferences, may not always be the same as those of the family member; in such cases the client is vulnerable to misinterpretation, as the family member may not be providing a fair and accurate account of the client's wishes

   b. The family member's skills in English may not be adequate to express clearly the preferences of the client.

3. The service provider could book a face-to-face interpreter, particularly for more important communication events such as meetings. This could be organised free of charge through the Interpreting Services Administrative Framework Project (see **Section 7, Guideline 3**).

Case study 7

Ageing and PTSD: Leslo

Reproduced with permission from NSW Refugee Health Service (2006), *Caring for older refugees in NSW: A discussion paper*, p 8

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

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

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

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

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

Case study 8

Flashback

Extract from NSW Refugee Health Service & STARTTS (2004), *Working with refugees: A guide for social workers,* Sydney, p 17

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

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

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

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

Note: Mrs Cruz was provided with counselling through STARTTS, and linked up with services including Home Care, community nursing and a Spanish-speaking GP.

Case study 9

A complex situation

Sameh is a 52-year-old man from Afghanistan who came to Australia as a refugee 15 years ago. He lives with his wife and three children aged 16, 10 and 12 in a very small public housing flat.

Sameh and his family receive HACC services as Sameh has had Parkinson's disease for the past five years. These services include domestic assistance and respite. Sameh's wife is his carer, and as his disease progresses, the stress on her has been increasing. Their HACC service co-ordinator is aware that Sameh's wife is suffering from depression.

Sameh's wife reports that he cannot remember most of his past life in Afghanistan, and that friends no longer visit the family or assist her as they cannot understand Sameh's speech and are unable to communicate with him.

The HACC co-ordinator finds out that Sameh was a school teacher in Afghanistan. After the Russian invasion, he was forced to serve in the army for four years, during which time he witnessed many traumatic events. He finally managed to escape from the army and flee to a camp in Pakistan. After several years he gained entry to Australia as a refugee. He then sponsored his wife and children to join him here.

When Sameh was diagnosed with Parkinsons disease, doctors operated on him, but the operation was not a success and he was left with further injury. Sameh's wife had a lot of difficulty coping after this, and was finally able to get him into residential accommodation, in spite of much pressure to look after him herself at home. However, after two days in care, Sameh was declared a danger to staff and other residents and sent back home. He had drawn a knife on a staff member and threatened him.

When Ali, an Afghan man who speaks the same language as the family, joined the HACC service, he began to work with Sameh as his respite worker. Ali takes Sameh out into the community and this gives his wife a break. Now Sameh waits by the window and gets very excited when he sees Ali coming to his home. Sameh's wife reports that he is much happier, and is even starting to remember bits and pieces from his past life.

How does this case study illustrate these topics that we have talked about today?

- Culture, disability and family roles
- PTSD
- Providing responsive HACC services.

Discussion points

Culture and family roles

Sameh's wife cares for Sameh as well as their three children. She comes from a society in which social services are limited or non-existent, and she feels strong cultural obligations to provide all care for her husband herself, within the family. We don't know whether this pressure comes from Sameh, his extended family members, the community, or from within herself. In her traditional culture, caring roles would be shared by the female members of her extended family who all lived in close proximity. Now, she finds that the support of family and friends is dwindling, but she is still firmly caught up in her traditional social role as carer.

Service providers need to respect that these values are deeply entrenched. Sameh's wife may feel shame and guilt about accessing services, and about her inability to cope with these demands herself. She may be distrustful of services as she is unfamiliar with them, and because she has experienced persecution by authorities.

Service providers need to present their services as a complement or positive addition to the caring and support that carers like Sameh's wife provide. They need to focus on the way that their services can enhance the carer's care, and make life that much better for the person who is ageing or has a disability. Service providers should avoid suggesting that their services replace family-based care. They can also avoid the implication that the primary reason for their service is to provide respite to carers, as this may not be a culturally sensitive position.

PTSD

Sameh's behaviour in residential accommodation indicates symptoms of PTSD. We don't know what type of accommodation this was, but it clearly triggered memories of Sameh's incarceration and possible torture during the war in Afghanistan.

Providing responsive HACC services

The service provider has shown an understanding for the situation and a recognition of issues around care provision (delivery of respite focuses on activities for Sameh), culture (a worker from the same ethnic group has been assigned), and gender (a male worker works one-to-one with Sameh). Not all service providers will have access to workers from a specific ethnic group, but there are other ways that they can reach out to clients in appropriate ways.

Case study 10

Family matters

Mrs V. came to Australia from Chile as a humanitarian entrant in the late 1970s. Mrs V. had lost her husband and two sons in the conflict, and came with her teenaged daughter, Marcella. When she settled in Western Sydney, Mrs V. remained closely part of the South American community. She learnt very little English and her daughter helped her with filling in paperwork and acted as interpreter when necessary.

Now that Mrs V. is in her late 70s, she requires domestic assistance to help her stay in her own flat. Marcella is now married with a family of her own, and she works. But she lives close by and continues to visit her mother often. Marcella attends the assessment session to interpret for her mother, but the HACC co-ordinator reports that Marcella often answers the questions herself, rather than translating for her mother. The co-ordinator finds it very difficult to find out what services Mrs V. really wants.

The co-ordinator gives the domestic assistance job to Consuela, who speaks Spanish and is able to communicate well with Mrs V. Consuela is able to help Mrs V. buy South American ingredients and cook food for her that she enjoys. Consuela is a young woman who was born in Australia; her parents come from South America.

After several weeks, Consuela tells her co-ordinator that she is having a lot of difficulty doing her work at Mrs V.'s home. Mrs V.'s daughter is there each time she comes. Marcella criticises everything that Consuela does and complains angrily that Consuela does not know how to do things the way Mrs V. likes. Consuela is sure she is doing everything correctly.

Question

What information about family responsibilities and obligations will help Consuela to understand more about Marcella's response to her, and the relationship between Mrs V. and her daughter?

See overleaf for a response to this question.

Discussion points

1. Marcella feels the strong obligation to provide all care and support to her mother herself. She needs to look after her own children and she needs to work, so she is not able to do this. But she feels a great deal of conflict over this. She tries to fulfil her obligation by 'controlling' the way that Consuela provides care to her mother. Her criticism is her way of assuring her mother that she would be able to provide her with better care, if only she could. It is also a way of managing her own feelings of guilt.

Case study 11

Pet distress

Mrs D., a woman in her late 70s, regularly attends an aged day centre. Mrs D. has a Russian background, and she was interred in a prisoner of war camp in Germany for several years during World War II.

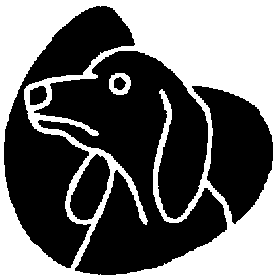
Mrs D. was always very placid at the centre. She did not mix easily with other people, but she seemed to enjoy her weekly outing.

One day as a special activity, a Pets as Therapy dog attended the centre with a trainer. The dog was a beautiful golden labrador. As soon as Mrs D. saw the dog enter the room she became hysterical. Staff had to remove her and then attempt to calm her down.

Questions

1. What could be the explanation for Mrs D.'s reaction?
2. How could this incident be avoided in the future?

See overleaf for responses to these questions.



Discussion points

1. In the prisoner of war camps in which Mrs D. was interred, the appalling conditions led to many attempts to escape. Dogs were used to hunt down escapees, and these dogs were paraded around the camps. When camp authorities were alerted to an escape, in the inmates would hear the wild barking of the dogs as they were set upon those attempting to flee.

2. Services cannot be expected to be on the alert for all possible triggers, and the best way to avoid an episode is to inform the client or a family member about all proposed activities beforehand. Don't be tempted to surprise your clients! However, an anxiety response to dogs is relatively common, so that this should be approached with caution, even with well-trained gentle animals.

Case study 12

Speaking up

Mr W., a HACC services client in his 70s, is from a Polish background. Two HACC workers, Mary and Laura, were providing Mr W. with personal care services on different weekdays.

One day Mr W. told Laura that he had a problem with Mary, and he did not want her to come any more. Laura was surprised about this as Mr W. is a very quiet man who never complains. She told her co-ordinator. The co-ordinator then contacted Mr W., who confirmed that he had a problem with Mary but he would not talk about it or give any reasons. The meeting ended with the co-ordinator promising that Mary would no longer be Mr W.'s worker.

The co-ordinator then discussed the complaint with Mary. Mary said she had not had any troubles with Mr W., and she did not understand why he was upset. Mary said that she always tried very hard to give him the best service. She always tried to show that she was very interested in him and asked him questions about his background.

The co-ordinator sent a different worker, Amanda, in Mary's place. After a couple of weeks the co-ordinator wanted to check how things were going, and so she met up with Amanda. Amanda said that Mr W. was very quiet at first, so she didn't bother him. But after a while he started to speak to her, and now he talked so much that she could never get a word in! Mr W. asked the co-ordinator if Amanda could keep working with him.

Questions

1. What do you think was the problem that Mr W. had with Mary?

2. How does this example make you think about your own communication with clients?

See overleaf for responses to these questions.

Discussion points

Mary was providing personal care services to Mr W., which probably included showering and shaving. He might have felt very vulnerable in this situation, right from the start.

Mary's questions about his past produced anxiety as they caused painful memories from the past to resurface. Mary was innocently attempting to build rapport with Mr W., but this is not the way to do so with a survivor of trauma. Mary would be advised to build the relationship by talking to Mr W. about positive things in the present, rather than leading him back into a past that he has tried for many years to forget.

Case study 13

The need to keep moving: Mrs Y

Mrs Y. is a woman in her late 60s who came to Australia from Bosnia in 1995. While she was recovering from surgery to her knees at a hospital in Western Sydney, hospital staff observed that Mrs Y. was experiencing distress, probably related to her refugee experience. She was referred to an ACAT for assessment. The ACAT then referred Mrs Y. to a HACC service provider for domestic assistance upon her discharge from hospital. Mrs Y. was also referred to STARTTS for counselling at this time.

When she returned home after being in hospital, Mrs Y. was very unhappy. She lived alone in a fourth floor home unit in Western Sydney. The block of units had a lift, but there were steps at the front of the building that prevented her access to the street. Two months after her operation, Mrs Y. was still unable to go out without help.

Her HACC worker, Janie, felt that Mrs Y. was being impatient about her recovery. She urged Mrs Y, who was able to speak some English, to be patient and everything would be all right. But one day Janie arrived to do the cleaning and found Mrs Y. sobbing uncontrollably. Janie contacted her co-ordinator, who phoned the ACAT. Through STARTTS, the ACAT provided some information about Mrs Y.'s background.*

Mrs Y. had come to Australia as a refugee with her two grandchildren, escaping conflict in their homeland . Her husband had been killed. During her flight from Bosnia, Mrs Y. had had to keep moving constantly with the children to avoid danger. She had been strong and in control of the situation. Her daughter had stayed behind with her husband who was in the army. Mrs Y. and the children crossed the border into a refugee camp. She had been strong then, too, and in control of things for the sake of the children.

After their arrival in Australia, Mrs Y. set up home and arranged to sponsor her daughter and son-in-law to come to Australia when the war was over. She took care of her grand-children while her daughter settled in. But as the years went by, family troubles developed. Her daughter's marriage broke down and her grandchildren were growing away from her.

For Mrs Y., her immobility after the knee operation was the last straw. She was no longer in control. Meaning in her life had revolved around keeping things in motion. Mrs Y. had been used to looking after others. Now she needed others to look after her.

** Information about a STARTTS client can be released only with the informed consent of the client.*

Role play: Janie and Mrs Y.

Janie, a HACC domestic assistance worker, has come to take Mrs Y. shopping. She finds Mrs Y. in a distressed state when she arrives. Apparently Mrs Y. had tried to go out shopping by herself the day before but had found herself stuck at the top of the steps outside her block of units.

Mrs Y. tells Janie that everything has stopped for her now. She feels stuck. She has been through so much, done so much. She doesn't think she will ever get moving again.

Janie attempts to deal with this situation.

Case study 14

Stocking up

Mrs P.'s village in Bosnia was destroyed in the1990s conflict. Her husband and most of the men of the village were killed. She had witnessed many atrocities, and suffered starvation, injury and illness as she fled with her teenaged some to a refugee camp.

Mrs P. and her son settled in Australia in 1995. Five years ago, Mrs P. experienced another loss when her son died from a cerebral aneurism. Now aged 68, Mrs P. lives alone in Western Sydney. Fearful of leaving her home and suffering from arthritis, she is socially isolated, without friends or relatives to assist with her care.

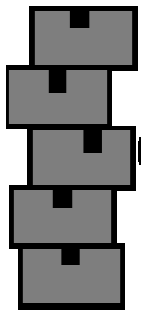
Mrs P. was referred for HACC services by her GP. The HACC co-ordinator visited her home to conduct an assessment, and noted that the house was stocked with food items. The bathroom, including the bath, was stacked with packets of biscuits; the bedroom was filled from floor to ceiling with boxes of canned food; and the kitchen benches were laden with food, some of it perishable.

Suzy, a HACC direct care worker, now provides Mrs P. with domestic assistance, including help with shopping and paying bills. When Suzy takes her shopping, Mrs P. insists on buying large quantities of food items, even those items she already has a large stock of at home.

Questions

1. Why do you think Mrs P. has so much food in her home?
2. What do you think Suzy should do when Mrs P. wants to buy more of the same food items?

See overleaf for responses to these questions.



Discussion points

1. People who have experienced starvation or scarcity of food over a long period can feel compelled to make sure that this never happens again. Their strategy is to hoard food, sometimes in large quantities. Typically, they will not respond to rational discussion about this, as their behaviour comes out of a primal response to threats to survival.

2. Suzy needs to understand Mrs P.'s hoarding behaviour. However, if the situation is causing squalor in Mrs P.'s home, Suzy needs to alert her supervisor, as part of her duty of care to her client.

   As Suzy's relationship with Mrs P. develops, she can provide assurances to her client about the safety and security of her environment, such as:
   - Mrs P. can rely on Suzy and the service provider to look after her
   - Mrs P.'s needs are understood and respected by the service provider
   - meals can be provided and food made available when Mrs P. needs them.

   When or if Mrs P.'s trust and security are better established, Suzy can start to talk about reducing the amount of food that is stored in the apartment.

   Suzy can use strategies such as listing all the types of food that are currently in the house, and drawing up a shopping list before they go out shopping. Then Suzy and Mrs P. can check the shopping list against the list of food in the house to see if items are really needed.

Case study 15

On the buses

Mrs I. has been referred to a community transport service by the Children's Hospital. She needs to take her four-year-old daughter, Samira, to regular appointments as Samira has a physical disability.

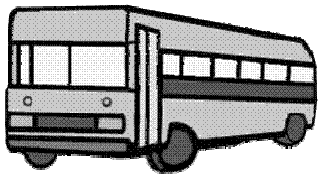
Mrs I. comes from Iraq, and arrived in Australia with her husband under the humanitarian program almost six years ago. As well as Samira, she has a two-year-old son. The family lives in Western Sydney. Mrs I. stays home with the children while her husband works as a labourer. She speaks a little English, which she learnt in English classes as part of her settlement package.

This community transport is the first service that Mrs I. has accessed to help her care for Samira.

Question

What are some of the issues that the service provider and staff members need to think about regarding these new clients and their needs?

See overleaf for a response to this question.



Discussion points

Issues to consider

- Mrs I.'s language needs, and whether an interpreter is required
- Mrs I.'s attitude to government-funded services (as a result of coming from a society with limited services, and her own experiences of organised violence)
- Gender issues (in terms of staff allocation, and the role of Mrs I.'s husband in decision making)
- Mrs I.'s caring obligations and how this might affect communication about service delivery
- Cultural attitudes to disability, and whether staff need more information.

Case study 16

In/different times

Mrs Z. came to Australia in the 1950s from Eastern Europe. Toula is a HACC worker who provides Mrs Z. with personal care and domestic assistance services.

Mrs Z. has a throat infection and needs to go to the doctor. Toula accompanies her. In the doctor's waiting room, Mrs P. becomes very distressed and refuses to go into the doctor's surgery.

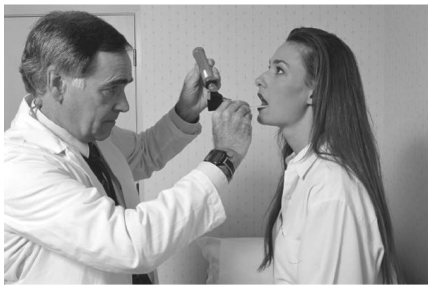
Toula takes Mrs Z. home and calms her down. Toula then phones her supervisor, who organises to visit Mrs Z. to talk about what happened at the doctor's surgery.

It takes some time for Mrs Z. to tell her story. She relates that when she first came to Australia, she was unable to speak English. She had a toothache and went to a dental clinic. She was given something to make her sleep. When she woke up, all her teeth had been extracted. She was angry and very upset, and she lost trust in Australian health providers.

Over the years she has regained some of that trust, but her current illness meant that she would have to open her mouth for the doctor's inspection. This is not something she can do.

Activity

Imagine yourself in a similar situation to Mrs Z. You have arrived in a foreign country after experiencing trauma in your home country. You cannot speak the language. You experience intense pain and go to hospital for treatment. You cannot understand what the doctors and nurses are saying. No-one attempts to get an interpreter for you. You undergo treatment, and you are shocked by the result.



How do you feel? Talk about this in your small group.

Case study 17

Talking about traumatic experiences

This real example was put together by the Northern Sydney Multicultural Health Service in consultation with a HACC Service Provider from the Northern Sydney region.

A HACC social support service provided group support to HACC clients from a range of cultural and linguistic backgrounds.

In preparation for a multicultural celebration, the groups from different communities were invited to participate in the 'My Story' project in which individual clients had the opportunity to tell and record their personal stories.

The service provider was very surprised when the Chinese group refused to take part whilst groups from other communities participated in the project enthusiastically and reported benefits of the exercise.

The service provider asked the leader of the Chinese group why they had refused to participate.

The leader said that the group members did not want to revisit their life story. They preferred to focus on the present and move on from the painful memories from the past.

Discussion points

1. HACC service providers should be aware of the possible traumatic experiences their clients may have been through.

2. HACC service providers should respect the way clients choose to deal with their past traumas and provide support that is appropriate for their role. It is not the role of HACC service providers to explore traumatic stories with clients.

3. HACC service providers should refer clients to relevant counselling and support services where appropriate.

10. Information and referral

The information in this section will help you find the right service if you need to:

- refer a client to get more help and support
- get advice about a client's needs and how to support these needs

This section is divided into the following parts:

Please note that services, including their contact details may change. Please contact the Multicultural Access Project Worker for any up-to-date information.

10.1 HACC Multicultural Access Project (MAPS) contacts

Your HACC MAPS co-ordinator can provide you with:

- information about all HACC services including CALD specific services
- information about other appropriate services for referral of your CALD clients
- service information in different languages
- recommendations and advice about using interpreters
- advice on a range of multicultural issues

Follow this link for more information about the Multicultural Access Project and an up-to-date list of MAP Worker contacts:

http://www.cnet.ngo.net.au/component/option,com_docman/Itemid,288/task,cat_view/gid,278/

10.2 Carer Support Services

Organisation	Services	Contacts
Anglicare Migrant and Refugee Services	Works with mainstream services to build their capacity to work with clients from small and emerging communities Provides advocacy state-wide with/for minority communities.	**Ph 13 26 22 or 02 9895 8000**
ARAFMI	**CALD Carer Support Project** Provides individual support and advocacy; information and referral; education and training; and peer support for carers of people with a mental illness.	**Ph 9888 1819** http://www.arafmi.org
Carers NSW	Provides emotional support and counselling to carers, bilingual counsellors available. Also provides Carer Support Kits and information factsheets in community languages.	**Ph 1800 242 636** www.carersnsw.asn.au
Diverse Community Care	**Dementia Respite Service** Provides support, assistance and respite for carers of people with dementia in Arabic, Chinese or other CALD communities.	**Ph (02) 9898 0000**
Transcultural Mental Health Centre	**CALD Carer Support Groups** Support groups for carers of someone with a mental illness. Run in a number of community languages.	**(02) 9840 3901** www.dhi.gov.au/tmhc/carers/NESBCarer Support Groups.htm

10.3 Cultural Specific and Multicultural Organisations

Organisation	Services	Contacts
AFGHAN		
Afghan Community Support Assoc of NSW Inc	Provides settlement and welfare support for the Afghan community, including casework, referrals, advocacy and consultancy.	**Ph (02) 9831 2436**
AFRICAN		
African Communities Council	Provides settlement and community development services.	**Ph (02) 9558 0999**
ARABIC		
Arab Council Australia	Provides a range of services including advice, advocacy, referral, education, problem gambling counselling, information and support.	**Ph (02) 9709 4333** www.arabcouncil.org.au
ASSYRIAN		
Assyrian Resource Centre	Provides information and referral, assistance with form filling, immigration advice, direct support work, case management, educational groups and community development programmes; and runs senior, women and other groups throughout the year.	**Ph (02) 9728 2594**
BOSNIAN		
Bosnian Information and Welfare Centre	Provide outreach services.	**Ph (02) 9749 9177**
BURMA-KAREN		
Australian Karen Organisation	Represents the interests of the Karen people in Australia	**Ph (02) 9788 7633**

Organisation	Services	Contacts
CAMBODIAN		
Khmer Community of NSW Inc	Provides case work, community development, group work and recreational activities.	**Ph (02) 9823 3479**
CROATIAN		
Croatian Australian Welfare Centre	Provides counselling, information and referral services.	**Ph (02) 9610 1146**
GERMAN		
German-Australian Welfare Society Inc	Provides welfare services and social activities for German speaking people in NSW, particularly the elderly.	**Ph (02) 9746 6274**
INDO-CHINESE		
NSW Indo-China Chinese Association	Provides welfare, cultural and recreational services to people of Chinese background.	**Ph (02) 9728 1773**
IRANIAN		
Iranian Community Organisation	Provides information, referral and casework for people of Iranian & Afghan backgrounds; group for women, men's health group, English language and computer classes.	**Ph (02) 9683 2833**
KURDISH		
Aust Kurdish Association	Provides settlement, and community development services	**Ph (02) 9627 4825**
MUSLIM		
Mission of Hope	Provides health and community development services to the Australian Muslim population.	**Ph 1300 787 257**
Islamic Women's Welfare Association	Provides support to Muslim women of multicultural backgrounds in Sydney.	**Ph (02) 9759 1675** www.iwwa.org.au
Muslim Women's National Network Australia	Provides education and support to Muslim women and girls in relation to Islamic rights and duties; advocates on behalf of Muslims, especially women and children; and assists refugees and others in need of help in our society.	**Ph 0402 778 366** www.mwnna.org.au

Organisation	Services	Contacts
United Muslim Women's Association Inc	Provides support to the religious, educational, social, welfare and recreational needs of Muslim women of all ages and ethnic backgrounds.	**Ph (02) 9750 6916** www.mwa.org.au
SERBIAN		
Serbian Australian Welfare Centre	Provides casework, community development, and advocates for the needs of the Serbian community in Australia.	**Ph (02)9727 9817**
TAMIL		
Tamil Senior Citizens Association (NSW) Inc.	Provides support for men over 55 years, women over 50 years.	**Ph (02) 744 8263**
SOUTH AMERICAN (SPANISH)		
NSW Spanish and Latin American Association for Social Assistance Inc	Provides welfare assistance, community development and information. Runs computer training courses, art and craft lessons. Also has an Aged Care Worker and a Youth Worker.	**Ph (02) 9724 2220** www.slasa.com.au
TURKISH		
Turkish Welfare Association Inc	Provides casework, information and referral services. Also runs group activities and publishes a Turkish newspaper.	**Ph (02) 9649 7502** www.communilink.org.au/turkevi
UKRAINIAN		
Ukrainian Welfare Association Inc	Provides casework, counselling, information, referral and community development services.	**Ph (02) 9649 9704**
VIETNAMESE		
Vietnamese Community in Australia NSW Chapter Inc	Provides information, referral, counselling and support service, and a range of community development programs.	**Ph (02) 9796 8035** www.vietnamese.org.au
MULTICULTURAL		
NSW Multicultural Disability Advocacy Ass. (MDAA)	Provides advocacy and support to people from a non-English speaking background (NESB) with disability and their families and care.	**Ph (02) 9891 6400** **Toll free** 1800629 072 **TTY** 02 9687 6325

10.4 Specialist Health, Mental Health and Counselling Services

These are local, regional and state-wide specialist health, mental health, and counselling services that also provide consultancy services to service providers working with people from CALD backgrounds.

Organisation	Services	Contact
AMAL Telephone Helpline	A telephone crisis line for Australia's Muslim community.	**Ph 1300 787 257** www.amal.org.au
Co-Exist NSW	Provides clinical consultation and assessment service for CALD people experiencing: • two or more concurrent mental health difficulties or • a mental health condition with a substance abuse. Services provided by a pool of trained bilingual professionals.	**Intake 02 9840 3767** **Tollfree 1800648911** www.dhi.gov.au/coexist
Multicultural Health Communication Service	Manages a multilingual website with more than 450 publications on health in a wide range of languages. New publications are added regularly. All multilingual resources are endorsed by NSW Health, and links are provided to other sites which have multilingual health information. Also produce multilingual health resources, as well as guidelines, protocols and policies for staff working with multilingual information.	**Ph 02 9816 0347** http://www.mhcs.health.nsw.gov.au/

Organisation	Services	Contact
Multicultural Mental Health Australia	Information and fact sheets on mental health issues available in over 20 languages	www.mha.org.au
NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS)	Services for refugees who have been exposed to torture and trauma: • culturally appropriate counselling and therapy for individuals, families and groups. Outings, camps for children and young people, English classes and physiotherapy also provided. • early health assessment and intervention services for newly arrived people from refugee- like backgrounds. • consultancy services, information and advice provided for other organisations working with torture and trauma survivors.	**Ph (02) 9794 1900** www.starts.org.au
NSW Transcultural Aged Care Service	Services for aged care service providers, community organisations, carers and other members of the community. Provides cross-cultural resources including training resources, translated materials, recipes, demographic data, contacts and links. Information and advice on: • culturally and linguistically diverse care options • culture and language based co-placement options • language and religion based clustering • Annual Aged Care Approvals Round • cultural competence training for aged care staff • resources to assist the provision of culturally competent aged care.	**Ph (02) 8585 5000** www.seniors.gov.au/internet/seniors/publishing.nsf/Content/NSW+Transcultural+Aged+Care+Service

Organisation	Services	Contact
NSW Transcultural Mental Health Centre	Provides consultancy service for health workers and other professionals who provide care to people CALD backgrounds. Services: • information and consultation about mental health and cultural issues • information and/or referral to appropriate health and mental health services for people of CALD backgrounds • short-term clinical intervention through a pool of over 100 bilingual, qualified, mental health professionals.	**Ph (02) 9840 3767/ 9840 3899** www.dhi.gov.au/tmhc
NSW Refugee Health Service	Provides: • consultation and support to health care workers and others working with refugees and asylum seekers; • targeted health promotion programs for refugees • provides clinical assessments and referrals, particularly for recent arrivals including 3 G P clinics at Auburn, Liverpool and Blacktown.	**Ph (02) 8778 0770** www.refugeehealth.org.au/

10.5 Settlement Grant Project Services

Settlement Grant Project (SGP) workers are funded by the Department of Immigration and Citizenship. SGP workers provide information and referral, community development and casework services. They may be able to provide bilingual, case work and offer advice on cultural issues and service provision. Often these services are funded on a year to year basis.

Please note that SGP Services are often referred to as Migrant Settlement Services.

Your local MAPS Worker should have information about these services in your area.