



Working with Refugees

A guide for
Social Workers

This resource was produced by the NSW Refugee Health Service and STARTTS (NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors), under the guidance of a Steering Committee and with the support of social workers and multicultural health staff from the Bankstown, Fairfield and Liverpool Health Services.

The following documents served as key information sources:

Bowles, R. (2001) *'Social work with refugee survivors of torture and trauma'*. Reproduced by permission of Oxford University Press Australia from *Social Work Fields of Practice* by Margaret Alston and Jennifer McKinnon © Oxford University Press, www.oup.com.au.

Refugee Council of Australia (2003). NSW Advocates' Help Kit. Available at: www.refugeecouncil.org.au/html/resources/advocateskit.html.

STARTTS, General Practice Unit (South Western Sydney Area Health Service), CHETRE (Centre for Health Equity Training, Research & Evaluation) and NSW Refugee Health Service (2000). *'Managing survivors of torture and trauma. Guidelines for General Practitioners'*. NSW Refugee Health Service: Sydney.

ISBN 1-74079-055-3
Sydney Australia September 2004



NSW Refugee Health Service



S.T.A.R.T.T.S

NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors

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In recent years the situation of refugees has again become a major issue for Australia. It is rare to see a day in which some aspect of Australia's response to those who seek asylum here is not debated in the various media. In this context it is timely that social workers should seek to improve their capacities to contribute to care for all those who have sought refuge.

Social work as a profession clearly has much to offer in services for refugees. From a skill base that integrates intra-personal and inter-personal helping with the practicalities of assisting people to negotiate their way around the social welfare system, social workers can respond to the complex needs of refugees within an understanding of the wider context of family relationships and social institutions. The values of social work, acknowledging principles of both social justice and the dignity and worth of each individual person, likewise enable social work to focus on the importance of ensuring that responses to refugees are well considered and appropriate.

The resource material presented here provides social workers with important information about refugees. Refugees are diverse ethnically, including people of all ages and socio-economic backgrounds, both women and men. At the same time there are shared factors in the refugee experience that set people apart from others who may share their ethnicity or background. These materials carefully portray the diversity of refugees while at the same time guiding social workers in thinking about what is unique in the refugee experience and ways in which social workers can respond appropriately. There are facts and figures, tips for good practice and the use of case studies to illustrate issues more clearly.

This is a comprehensive guide for busy practitioners that will prove invaluable as social workers seek to develop and extend responses to the particular needs of refugees in our community.

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August 2004.



Chapter 1:

Who is a refugee?

1.1 Essential definitions

Who is a Refugee?

Someone who has fled their country of origin and is at risk of persecution because of race, religion, political opinion, nationality, or membership of a particular social group. Persecution usually means execution, torture, imprisonment without trial, mistreatment and/or other serious denial of rights.

'Refugee' is an internationally accepted legal term to describe someone needing protection from another country because they are being targeted by authorities or other groups involved in an organised violence campaign in their own country. It cannot be applied to people seeking to escape random violations of their rights, escaping violence in a civil conflict, fleeing natural disasters, or escaping starvation.



Who is an Asylum Seeker?

Someone who has applied for protection as a refugee and is awaiting determination of their status. All refugees have been asylum seekers either in Australia or in another country, but not all asylum seekers are found to be refugees.

Who is a Humanitarian Entrant?

In Australia, this means refugees and other people at risk of serious human rights violations.

This guide will use 'refugee' to describe all people from a refugee background, including humanitarian entrants and migrants who have had refugee-like experiences before arriving in Australia.

1.2 What have refugees experienced before arriving in Australia?

Experiences in the country of origin

The persecution that refugees try to escape from includes:

- imprisonment without trial
- severe harassment by authorities
- torture
- witnessing killing or torture of close family members, friends and comrades
- aerial bombardments
- disappearance of close family members.

Experiences in exile

Some people take extreme risks to reach safety. Some will have left in secret or in a time of chaos, and had little opportunity to say goodbye to family and friends, or even pack their belongings. Many families become separated in the process of escaping.

Before arriving in Australia, refugees may have spent many years in refugee camps. Life in camps is extremely difficult, with poor medical care, overcrowding, food shortages, few educational facilities, and a lack of safety. Sexual assault is endemic in many camps.

Some possible consequences of these experiences:

- psychological trauma due to persecution, war or civil conflict, and the circumstances leading to and surrounding it
- social dislocation
- loss, including separation from family and friends
- insecurity, including real actual or threatened physical violence and rape
- overcrowding, poor hygiene and under-nutrition, particularly for those who have been imprisoned or in camps
- poor medical care, due to destruction of infrastructure and disruption to health services by fighting in the country of origin, and through limited access to health care whilst fleeing and whilst seeking asylum
- disrupted education of children
- lost or interrupted careers for adults.

1.3 Australia's Refugee and Humanitarian Program

Australia has a long history of helping refugees and other survivors of human rights abuses. Since World War II, approximately 600,000 refugees have settled here. Currently, some 12,000 humanitarian entrants settle in Australia each year, about 40% of them in New South Wales. Many people who arrive as migrants may have refugee-like backgrounds i.e. they have experienced war or organised violence.

Refugees arrive in one of two ways. Most are selected from overseas by the Australian Government to settle in Australia as part of our commitment to protecting vulnerable people worldwide. A smaller number have come to Australia to seek protection as asylum seekers.

There are a number of different visas that fit under Australia's Refugee and Humanitarian Program, but the most important distinctions to remember are:

Implications for Social Workers

You need to understand your client's migration status so you can:

- better understand their needs and anxieties - e.g. if your client is an asylum seeker, you can anticipate that they may have considerable anxiety as they go through the refugee determination process. They may be afraid of being sent back, and be unable to set medium to long-term goals.
- determine their eligibility for services. For example, around 3,300 asylum seekers living in the community are ineligible for Centrelink services.

Refugees and humanitarian entrants selected from overseas with permanent visas

Most refugees settling here are selected from overseas by the Australian Government. With a few exceptions, all are given permanent residence and thus access to services that all permanent residents can use, such as Centrelink and Medicare, as well as access to some specialist settlement services to assist new arrivals. Humanitarian entrants are ineligible for some initial settlement services, on the grounds that their proposers are able to provide them some support. The degree of support available can vary, particularly where the proposers are newly arrived themselves.

Women at Risk

This category is a subgroup of the above category of refugees. They have permanent residence and the same access to services. They are single women or solo mothers and may need more support than people arriving as part of intact family groups. They are also likely to have had recent experiences of danger - they have been resettled because they were at particular risk of sexual or physical violence in the country where they first sought asylum.

Refugees with a Temporary Protection Visa

People with a Temporary Protection Visa (TPV) have been recognised as refugees by the Australian government after claiming asylum in Australia. Because they arrived without authorisation they are granted protection for three to five years only. After this they can undergo refugee status determination again. Only if successful will they be allowed to remain in Australia on another visa.

Refugees with a TPV have only some entitlements of refugees on permanent visas. They may work and use Medicare, but are not entitled to the full range of social security benefits. They cannot use most settlement services or access English language programs funded by the

Department of Immigration and Multicultural and Indigenous Affairs (DIMIA). They have no right of re-entry if they leave. Of particular significance, they have no right to be reunited with their spouse or children.

Asylum Seekers

There are two distinct groups of asylum seekers in Australia:

- those who arrived in an authorised way (e.g. on a visitors' visa) - they are allowed to live in the community while their applications are processed;
- those who arrived in an unauthorised way by plane or boat. They are put in detention centres until they are either granted a visa to remain, or they leave the country (voluntarily or otherwise).

Most asylum seekers in Australia live in the community. They are ineligible for Centrelink benefits, although two thirds are allowed to work. The other one third are not permitted to work, and have no access to Medicare. The Asylum Seekers' Assistance Scheme provides limited financial assistance to some asylum seekers experiencing financial hardship, but not all asylum seekers can access this support.

Asylum seekers who are not found to meet the legal definition of a refugee are required to leave Australia.

1.4 What countries do refugees come from?

Most conflicts since World War II have produced refugees. As the political situation in various regions changes, so do the countries that produce refugees, e.g:

- ▶ After WWII: from Germany and Eastern Europe.
- ▶ 1970s & 80s: from conflicts in Central and South America including Chile, El Salvador, Colombia, Argentina and Uruguay; in the 1980s, Indo-Chinese refugees arrived from Cambodia, Laos and Vietnam.

- ▶ 1990s: from countries of former Yugoslavia including Bosnia-Herzegovina, Croatia, Kosovo and Serbia; from Africa, including Eritrea, Ethiopia and Somalia. Many refugees also came from the former Soviet Union and China.
- ▶ 2000s: an increase in people arriving from Africa, in particular Sudan, Liberia, Somalia, and Sierra Leone.

Afghanistan, Burma/Myanmar, Iraq, and Iran have also produced refugees for some decades.



Map 1. Countries that are significant sources of uprooted people in 2000.
Source: US Committee for Refugees (2001) World Refugee Survey 2001.



Mr T, a man in his 20s, was referred to STARTTS by his solicitor. According to the solicitor, Mr T had great difficulty talking about his trauma history - his concentration was poor and he became overwhelmed when remembering the past. He had problems sleeping and seemed agitated and depressed.

History at Time of Referral

Mr T was arrested and tortured in his home country due to his involvement in a pro-democracy party. He was imprisoned for two years. His father was also arrested and died in prison. The other members of his family were in hiding.

Mr T arrived on a visitor's visa and applied for asylum. He was unemployed and living on a small allowance from the Red Cross. He had no relatives in Australia.

His trauma symptoms included nightmares of torture, flashbacks of experiences in prison and intrusive traumatic memories. He had periods of dissociation when he lost awareness of his surroundings, and went into an altered state of consciousness. He tended to withdraw from company yet longed for the comfort of friends and family. He felt guilty because many friends and close relatives had been unable to escape and were in prison, in hiding, or had been killed.

He had difficulty concentrating or remembering day to day details and appointments, was irritable, had poor control of his emotions and often felt overwhelmed with terror and panic. He fantasised about avenging his father's death.

Assessment

A STARTTS social worker assessed Mr T as suffering from trauma-related symptoms, fitting into the broad categories of re-experiencing, numbing and hyper alert symptoms. As a result of torture, he had backache, toothache and pain from his wounds. He was socially isolated and unemployed.

Action

The social worker provided weekly psychotherapy treatment and the STARTTS physiotherapist provided physiotherapy and pain management. The NSW Refugee Health Service referred him to a doctor and a dentist. After settling into treatment, he began to trust the social worker. His life gradually became more contained and stable. He joined a men's group for asylum seekers at STARTTS which included educational and self care components. He was given help with resettlement and further referrals.

Outcome

Mr T eventually gained permanent residency. With continued treatment, his psychological and physical symptoms gradually subsided. He has a partner and is now working. His condition tends to deteriorate when events in his home country erupt, causing concern about his family's safety. He stays in touch with the STARTTS social worker and requests help during crises.



While this section describes how the experience of conflict and organised violence may affect your client, remember that the view that refugees are traumatised people with multiple problems is only one side of the story. As a social worker it's also important to affirm the survival skills, resilience, and hope that refugees try to maintain through their lives. Refugees are neither 'victims' nor 'heroes', but determined people who have survived overwhelming life experiences to reach Australia.

Chapter 2:

The impact of refugee experiences

2.1 Psychological consequences of the refugee experience

Refugees react and cope with trauma differently. Not all develop post-trauma symptoms. Some may only experience the impact of trauma at a later time, as a result of additional stresses.

Common reactions after traumatic life events include:

- anxiety
- panic attacks; startle responses
- flashbacks
- depression
- grief reactions
- dissociation or numbing
- sleeping problems irritability or aggressiveness
- emotional stress
- eating disorders
- psycho-sexual problems
- inability to plan for the future; pre-occupation with the past.

Some people may also have symptoms of post traumatic stress disorder (PTSD), including:

- ▶ intrusive thoughts, memories, flashbacks and nightmares of traumatic/persecutory content
- ▶ numbing and blocking responses such as avoiding thoughts, memories, people and situations that trigger traumatic memories

- ▶ hyper-arousal symptoms such as sleeping, memory and concentration problems, startle responses, and irritability.

Typically, intrusive phenomena are stronger soon after the trauma; eventually, numbing symptoms begin to dominate.

Clients may swing from being overwhelmed by past experiences to becoming numb and withdrawn, unable to discuss the past. Severely traumatised people could be misunderstood as deliberately withholding information, being uncooperative, lying, giving inconsistent stories or being unreliable.

Some people try to block memories of trauma by excessive drinking, smoking, gambling, self-medication and risk-taking behaviours.

Tip: Framing trauma reactions

Using psychiatric labels can deflect attention from the broader political injustices, which have made a person traumatised – it's also important to see their symptoms as 'normal responses to abnormal situations.' However, categories of symptoms can be a useful framework to help people understand their reactions and to reassure them they are not 'going mad'.

Factors that can exacerbate psychological distress

▶ Treatment on arrival

The way refugees are treated on arrival will affect their attitude to Australia, and their trust in institutions and the people around them - e.g. refugees who spend time in Australia's Immigration Detention Centres may feel differently about Australia than those who were resettled from overseas. Preliminary research by the Centre for Population Mental Health Research at the University of NSW (UNSW) found that refugees who had spent time in detention had twice the risk of depression and three times the risk of traumatic stress compared to refugees who had not. (see reference in box below)

▶ Uncertain status

If your client's permanent migration status is uncertain (e.g. asylum seekers or refugees with a TPV) they are likely to be preoccupied with the fear of being returned home and have little psychological space for processing the past.

The same UNSW study (above) found that refugees with a TPV had seven times the risk of depression and post-traumatic stress disorder compared to refugees with permanent protection visas. Eighty per cent of those interviewed had intense and disabling feelings of fear and terror about the future, compared to only eight per cent of those with permanent protection visas.

More about the psychological impact of temporary protection:

Centre for Population Mental Health Research at the University of New South Wales (2004) Media Release: *'Temporary protection visas compromise refugees' health: new research'*, http://www.unsw.edu.au/news/pad/articles/2004/jan/TPV_Health.html, 30 January 2004.

Fernandes, P (2002) *Trauma strikes the soul: An attempt to explore and understand the impact of the temporary protection visa on clients in New South Wales, MOTS Pluriels*, <http://www.arts.uwa.edu.au/MotsPluriels/MP2102pf.html>.

WESROC & the Centre for Refugee Research (2003) *A Life Devoid of Meaning: living with a Temporary Protection Visa in Western Sydney*, http://www.refugeecouncil.org.au/docs/current_issues/life_devoid_of_meaning.pdf

2.2 Physical consequences of the refugee experience

Although Australia requires health screening for adults before a substantive visa is issued, many people need health care when they arrive. This is because of a chronic lack of resources in many asylum countries, or because medical services have been disrupted by war.

Physical health problems may include:

- ▶ poor dental health resulting from poor nutrition, lack of fluoridated water, poor dental hygiene practices and limited dental care
- ▶ infectious diseases including tuberculosis or intestinal parasites
- ▶ injuries and disabilities such as musculoskeletal pain or deafness resulting from war or torture
- ▶ undiagnosed/under-managed hypertension, diabetes and chronic pain
- ▶ delayed growth and development among children
- ▶ low levels of immunisation
- ▶ somatisation of psychological problems such as gastric dysmotility.

Some refugee women will also have experienced Female Genital Mutilation (FGM). Variations of FGM are practiced in some parts of the Horn of Africa, the Middle East and parts of Southeast Asia for complex socio-cultural reasons. As a result, some women have long-term complications such as recurrent urinary tract infections, incontinence, obstructed menstrual flow and obstetric problems.

2.3 Implications for settlement

It can be difficult to settle in a new country after escaping persecution and organised violence. An important part of the social work role is to support refugee clients to resettle successfully in Australia.

Most refugees will have concerns about:

- ▶ money
- ▶ finding employment and being under-employed
- ▶ finding secure accommodation
- ▶ education
- ▶ learning English
- ▶ maintaining their cultural practices, and understanding Australian culture
- ▶ developing a social network
- ▶ experiencing discrimination and racism
- ▶ tracing friends and family still in danger
- ▶ supporting friends and family overseas through remittances or sponsorship.

TIP: Taking a holistic approach

Your client's settlement needs are as critical as their psychological and physical health needs. If settlement needs are unresolved, they're unlikely to be able to address their psychological or physical needs.

Interventions with refugees will often require you to work across a number of sectors. Developing partnerships with other organisations will help you build a coordinated response to complex needs (see section 5.1)

Ms Y was referred to the local mental health team because she was sobbing during a prenatal consultation - there had been no interpreter present during the consultation even though Ms Y needed one.

History at the time of referral

Ms Y came from a culture where women stayed at home with the extended family and were expected to obey their parents, husbands and in-laws. She was educated at home and lived a protected life before civil war broke out in her country.

At the time of referral, Ms Y was pregnant with her first child. She married her husband in their home country but soon after, he was interrogated and sentenced to hard labour in a concentration camp. Soldiers came to Ms Y's house demanding information about his political activities.

Following her husband's release, they escaped in dangerous circumstances to a refugee camp where they stayed for several months. These experiences affected them deeply. They had been in Australia for ten months and had no relatives here.

In a second interview, Ms Y told the social worker that after his imprisonment, her husband had changed, becoming suspicious, controlling, nervous and violent. She said that in her culture the husband is usually the head of the family and she felt powerless and vulnerable to his changing moods and temper outbursts. She was unused to negotiating with people outside the home.

Ms Y was constantly teary, had suppressed appetite and sleeping problems. She had nightmares about the war and their escape. She was nervous, irritable, had poor concentration and memory and was startled by loud noises. She avoided places and people that reminded her of the past such as men in uniform, large crowds, or the sea. Her husband's violent behaviour made her feel that she and her baby were not safe.

Assessment

Ms Y experienced both political and domestic violence. She had no income, was living in an unsafe situation, with no family support. She felt hopeless, had post-trauma and depression symptoms but did not report thoughts of suicide or self-harm. She was socially isolated from her community, had no knowledge of support services, spoke little English and was unable to negotiate the health system.

Action

The social worker provided ongoing support during Ms Y's pregnancy and after, ensuring that she worked with same female health care interpreter in each session to provide continuity. Ms Y was able to discuss many of her traumatic experiences and losses. Her husband was referred to STARTTS for assessment and counselling but did not attend these initially.

The social worker liaised with and made referrals to the NSW Refugee Health Service, Centrelink, community housing programs, community mental health team, the ethnic obstetric liaison officer (EOLO) and the Walter and Eliza Hall Trust for financial help, and continued to liaise with Ms Y's GP and the

antenatal clinic. A number of those referrals took significant levels of advocacy and the social worker being able to clearly articulate refugee issues and impact on settlement.

Outcome

Soon after the baby was born, Ms Y decided she could no longer stay with her husband. With the help of the social worker and the EOLO she moved into supported housing. She was linked with a child and family health nurse, and a parent craft education program in her own language. Centrelink reviewed her situation and granted her Special Benefit. She is now learning English with a home tutor and attends a group at the local health centre for single mothers who speak her language.

Her husband blamed the health services for what had happened between him and Ms Y, but was persuaded to have counselling at STARTTS with a male social worker who spoke his language. He began to understand his own trauma symptoms and behaviour, and hopes to be reunited with Ms Y and their child in the future.



Chapter 3:

Working with specific refugee populations

Participating in a community that shares one's language and culture and that can offer advice and support is often the best resource for newly arrived refugees.

However, there are reasons why some refugees may not trust such a community. Some have come from countries where a breakdown in community relationships has led to war, or have survived military regimes that promote mistrust by recruiting people to inform on others.

Just as it is impossible to "leave behind" the impact of trauma on individuals and families, it is also impossible to discard the effects on communities. In Australia refugee communities may be suspicious of government-related services, and may be fragmented with a significant amount of internal conflict and little formal structure.

Effects of trauma coupled with the challenges of resettlement process can affect how communities develop in Australia:

- Communities may be polarised and mistrustful. As a result, some people may distrust interpreters and workers from their own country. Others may withdraw from their community to avoid evoking traumatic memories.
- Small and emerging refugee communities may have little in resources or infrastructure. They may have few experienced leaders, particularly as few older refugees settle in Australia. Initially, leadership roles may be assumed on the basis of English ability or familiarity with the Australian system, rather than leadership skills. Additionally, in many communities men assume the leadership roles such that women's and youth issues may not be adequately communicated to service providers.
- There may be significant levels of diversity within refugee communities along ethnic, linguistic, religious and political lines.
- Refugees may arrive knowing no one and needing to build a social network from scratch. While this can create close-knit communities, it can also mean people are isolated with limited support, particularly in small, geographically dispersed communities.

- There may be divisions between people recently arrived from a conflict in their home country and more established migrants - even though they share the same ethnicity or country of origin. Often, however, the established community will be very supportive.
- Tensions increase if there is pressure on the community. If renewed conflict breaks out in the home country, it can affect the whole community. If some people are having their protection claims reassessed and are at risk of being returned (e.g. refugees with a Temporary Protection Visa), it can make the whole community anxious.

TIPS: Working with refugee communities

If you're involved in community development, think about ways to support community leadership skills, community infrastructure, and reconciliation.

Avoid making generalisations about how much support a refugee gets from their ethnic community – just because a community exists doesn't mean it's willing or able to offer support to your client.

Don't assume clients are linked to their community. Ask your client if they know about local ethnic organisations. If not, contact your local Migrant Resource Centre for details. If your client needs social support, link them with local community groups such as places of worship, sports clubs or volunteer programs such as the Mercy Refugee Service.

Remember that every continent and every country is made up of many communities. African refugees, for example, are not a community, each country in Africa represents numerous communities, commonly based on tribal affiliation. Similarly, viewing Arabic speakers as belonging to one community is imprecise as they are of various nationalities, cultures and religious backgrounds.

3.2 Refugee women

Just fewer than 50% of humanitarian entrants arriving in Australia every year are female. Besides accepting women who are part of a family, Australia also takes several hundred people through the “Women at Risk” category. These women have lost or been separated from their fathers or husbands and are at risk of sexual or physical violence in the country where they first sought asylum.

Refugee women are also vulnerable to sexual violence during war. Swiss et al (1998) reported that 49% of Liberian women surveyed had experienced physical or sexual violence from a combatant during the war. Sexual violence is endemic in some refugee camps due to poor security and the vulnerability of unaccompanied women.

Sexual assault can be a key underlying factor in the psychological and physical health issues of refugee women. In many cultures, rape brings shame on the victim and their family and is unlikely to be readily disclosed, particularly within families. Consequently, some families may ostracise rape survivors. For some women, rape may result in pregnancy.

Other issues for refugee women in NSW include:

- untreated reproductive health problems
- physical/ psychological impact of female genital mutilation (FGM)
- limited education and training
- unemployment, underemployment and related financial insecurity
- lack of parenting advice from an extended family
- domestic violence.

The refugee and settlement experience can also affect women's identity. They may be particularly devastated by the loss of home - the place of their traditional authority. A woman's role in Australia may be vastly different to their own, and therefore quite challenging. While some refugee women enjoy improved status in Australia, this change can also put pressure on their relationships.

TIP: Working with survivors of sexual violence

Be very sensitive in cases of suspected sexual violence – e.g., it may be more helpful to offer suspected rape survivors general trauma counselling, and allow any sexual assault issues to emerge as trust develops in a confidential setting.

3.3 Refugee men

Just over 50% of refugees arriving in Australia every year are male. They come under several migration streams. They are usually young: approximately half of males arriving as part of the Refugee and Humanitarian Program in 2002-03 were under 20. Health issues of male refugees tend to be similar to male health issues generally, but are compounded by the refugee experience, combat trauma and exposure to torture i.e. a combination of:

- poor nutrition and dental health, PTSD, musculoskeletal problems, anxiety related to migration status, etc; and
- higher mortality rates, respiratory problems, some cancers, substance abuse, etc associated with men in general.

The most significant underreported and undiagnosed health problem for refugee men may relate to physical and psychological effects of sexual torture, which research suggests is common. Other male refugee groups at particular risk of health problems include boy soldiers, elderly men, and men separated from their families.

Because many have been soldiers, male refugees are generally exposed to different types of traumatic events as compared to women. However, their rates of PTSD

and most other mental illnesses are lower, perhaps because men believe they have more control over their circumstances, and tend to somatise emotional problems - e.g., by speaking of “heat”, “tiredness” or non-specific aches and pains.

While men generally access health services less frequently than women, this is not always true for refugee men, who form a majority of clients at some torture and trauma services.

Of the subjective factors affecting refugee men's health, the most important is loss of identity associated with resettlement. This usually involves loss of traditional male roles and exposure to a culture where women's and children's rights are different and challenge their traditional male roles. This loss of identity may be associated with chronic depression, long-term unemployment, substance abuse, domestic violence or family breakdown.

As with women, the protective factors for refugee men's health in Australia are not spending long periods in detention centres, obtaining permanent residency and secure employment, learning English, and maintaining family and community links.

3.4 Refugee families

There are many ways in which torture and refugee trauma impact on both individuals (see 4.6) and families:

- ▶ family members may have been separated in flight or exile, or killed in their country of origin
- ▶ family roles are often dramatically altered: children may assume the role of interpreters for the family; experiences of trauma can undermine parents' ability to find work
- ▶ Refugee families have little or no understanding of Australian parenting expectations and child protection systems, and those systems may not have had experience in working with refugee families.
- ▶ traumatised parents may be less able to support their children emotionally
- ▶ financial difficulties and generational conflict can cause additional problems in families
- ▶ the family continues to feel traumatised if there is bad news from the home country
- ▶ dislocation from culture and tradition, as well as language barriers, can add enormous pressure
- ▶ children may be taught not to trust anyone

- ▶ guilt associated with leaving family members behind can disrupt the emotional recovery of the remaining family
- ▶ separation from extended family can leave parents unsupported; this is particularly hard when they are facing challenges
- ▶ survivors may act out aspects of their experience at home, for example with their partners whom they experience as abusive, rejecting or betraying.

These pressures can create conflict in families. People from cultures where family conflicts are traditionally dealt with by family or tribal elders need to learn new skills to resolve conflict. If not, these pressures can increase the risk of family breakdown and/or domestic violence.

Refugees may have difficulty accessing services that support parents and spouses, because of language difficulties and unfamiliarity with such services. Additionally, these services are often unfamiliar with the needs of refugee families.

3.5 Refugee children and young people

Some 40% of refugees coming to Australia are under 25. While most arrive with a parent, some arrive alone as unaccompanied minors. These children and young people may have witnessed or experienced torture, been forced into labour or military service, or had family members murdered.

In Australia, these experiences may continue to affect their development. If their parents are traumatised themselves, they may not be able to help their children resolve these issues.

People often assume children are naturally resilient, but this is not always true. Possible effects of exposure to war and organised violence on children include:

- ▶ delayed development or regression
- ▶ acting older/younger than is appropriate for their age
- ▶ variety of post-trauma related symptoms including: nightmares, withdrawal, difficulties with impulse control, concentration problems
- ▶ difficulties establishing trust and friendships
- ▶ anxiety in general, and separation anxiety in particular
- ▶ low self esteem

Education has usually been disrupted. Children may have suffered from malnutrition and a lack of immunisation.

There are also the stresses of settlement. At a time when young people are forming their identities, they may be faced with conflicting value systems of their home country and of their new Australian peers. Often young people become socialised into Australian society faster than their parents and this can create tension in families. As children pick up English faster than adults, their role in the family can change, particularly if service providers inappropriately use them as interpreters.

Recommended readings:

Corner Youth Health Service, STARTTS, NSW Refugee Health Service & Bankstown City Council (2003) *Beyond Survival: Working with Young People from a Refugee Background: A Guide to Getting you Started*, Sydney.

Victorian Child & Adolescent Mental Health Promotion Officers & Christine Farnan (2001) 'Refugee Young People' in *STEP Manual*, <http://www.youthmentalhealth.org/pdfs/07.pdf>, Melbourne.

NSW Refugee Health Service, *Working with Refugee Families and Children*, Sydney 2004

3.6 Older refugees

The two groups of older refugees living in NSW are:

- those who arrived in the past as refugees and have grown older in Australia (the largest group);
- those who arrive in Australia as elderly refugees.

Older refugees face additional challenges to those of the Australian-born and migrant elderly population, including:

- ▶ Post-traumatic symptoms which can remain long after repeated war trauma and may develop years after the trauma occurred. Stress-related psychosomatic illnesses are not uncommon.
- ▶ Disruptions to memory, such as dementia, can trigger painful suppressed memories - e.g. torture or time spent in concentration camps. This is distressing for clients and can lead to challenging behaviour.
- ▶ Activities in aged care facilities may be confused with experiences in concentration camps or in prison - e.g. staff may be mistaken for guards/torturers when doing security checks at night.
- ▶ Loss of status is a major issue. Instead of being a respected member of the community, some older refugees find their skills and opinions are not valued in Australia. This cultural change may lead to depression, anxiety or conflict with the family.
- ▶ Social isolation is common among older refugees, who may find it difficult to develop the trust needed to build supportive social networks. Additional risks include: lack of family; the small size of their community in Australia making it difficult to link with people of similar age and background; lack of bilingual workers; financial hardship; and loss of English language skills if memory is disrupted.



Case Study 3:

MRS C

AGED CARE AND MENTAL HEALTH SETTING

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

History at the Time of Referral:

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

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

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

Assessment

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

Action

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

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

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

Outcome

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



Chapter 4:

Skills for Working with Refugees

4.1 Identifying refugee clients

Determining if a client is from a refugee background helps you assess their needs, and identify appropriate interventions. Refugees are not identified in standard assessment tools, but these pointers will help you determine if your client is a refugee or comes from a refugee-like background:

- ▶ Just ask: “Did you arrive as a refugee?” This is better than asking if they are a refugee - some people will not identify with this description.
- ▶ If you have details of your client’s country of origin and year of arrival, this will help. They are likely to have a refugee background if they have come from the countries listed at 2.4 during the periods described.
- ▶ Consider their migration status e.g. refugee (including Temporary Protection Visa holders), humanitarian, family reunion, student from place of civil unrest, or asylum seeker.

4.2 Minimising re-traumatisation

It’s impossible to anticipate all the circumstances that could re-traumatise your client, but you can minimise the risk by avoiding settings or behaviour that could remind them of interrogation or torture experiences.

- ▶ **Prepare for the interview:** Meet the client at the door with a friendly welcome. If there are security guards at your office, avoid making clients wait for extended periods (being made to wait is often used by torturers). Create a friendly waiting area.
- ▶ **Think about your surroundings:** avoid interview rooms with closed-in spaces or barred windows - they may trigger flashbacks and fearful reactions. Consider allowing trusted persons to be present at the interview, or doing the interview outside an office.
- ▶ **Make it clear you’re there to help:** some refugees may fear government officials or workers. Explain confidentiality (In some cases the information is not confidential, eg child protection matters, so not all information can be kept entirely confidential)
- ▶ **Watch your interview style:** avoid any behaviour that could be interpreted as interrogatory. Let the client control the process - many torture and trauma survivors feel helpless as a result of experiences of torture and settlement.
- ▶ **Avoid asking refugees to repeat traumatic stories:** make thorough case notes and, with the client’s consent, inform referral services of their background so the client does not have to repeat their stories to each service or worker.

4.3 Ensuring confidentiality

Some refugee clients are unfamiliar with the concept of confidentiality, and reluctant to trust interpreters and service providers, particularly those from their own community.

Ensuring confidentiality is also a safety issue: publicly identifying refugees can endanger them, or their families. The Refugee Council of Australia reports that there are people in Australia who pass information back to foreign governments. Identifying a refugee could put family members at home in danger or cause problems for refugees returning to their country.

- ▶ Explain the concept of confidentiality and your obligations whenever you see a new refugee client
- ▶ Tell them of the interpreter’s obligations to keep information confidential
- ▶ Explain that they can make a complaint if they feel confidentiality is breached
- ▶ Never publish any details without their permission. ***Changing details such as gender or using a false name may not be enough to protect identity.***

4.4 Cross-cultural communication

Social workers do not have to be cultural experts, but do need to try to understand their client and to communicate effectively with them. The following will help you negotiate many cultural differences:

- ▶ Ask the client what their expectations are and how things were done in their country
- ▶ Acknowledge and respect differences that may exist between your beliefs, values, and ways of thinking and that of your client. Talking about the differences may help give your client a framework for understanding Australian culture, for example discussing grieving rituals
- ▶ Make an effort: even showing a basic knowledge and an interest in their culture can be invaluable to clients trying to adjust to the Australian system
- ▶ Avoid generalisations about cultural groups: there is variety within each culture that’s influenced by urban or rural background, education, ethnicity, age, gender, social group, family and personality
- ▶ Get advice from community leaders or community workers. ***Confidentiality, however, must be kept at all times.***

4.4 Cross-cultural communication [continued]

Useful tips for communicating well with clients with low levels of English skills include:

- checking that you understand each other
- using open questions
- clarifying questions or statements
- asking questions clearly
- avoiding jargon and slang.

4.5 Working with interpreters

A reliable assessment of a client with little or no English language cannot be made without a professional interpreter. Family or friends should not be used as interpreters, because their personal relationship with the client influences what is said and not said for various reasons.

The client may not have used an interpreter before and will need guidance from you about the interpreting process. Explain that the interpreter's main task is to enable the two of you to communicate accurately, and that he/she must do so with integrity, impartiality and confidentiality.

Tips for using interpreters:

- Ask if the client has any preferences - e.g. a particular ethnicity, religion or gender
- If you work for the health service, you will have Health Care Interpreters available. Otherwise, use the Translating and Interpreting Service (TIS): **Tel. 131 450**
- Organise the interpreter as early as possible to allow time to organise a suitable person
- Contact the interpreter beforehand to discuss the case. Brief them on the type of interview, and how you would

4.5 Working with interpreters [continued]

like the interpretation done (i.e. simultaneous or consecutive). Explain any special needs - e.g., if a client has a thought disorder, the interpreter should interpret exactly, rather than trying to make sense of what is being said

- Build a trusting, respectful working relationship with the interpreter
- Let the interpreter know the sessions could be distressing, and that you'll meet them afterwards to see how they are. Normalise the idea of vicarious trauma of professionals - that trauma affects everyone, including yourself
- Explain interviewing techniques such as open-ended questions, paraphrasing, summarising, reflection of feelings and so on
- Speak directly to the client, using the first person
- Explain your and the interpreter's role to the patient
- Explain confidentiality, and make sure the client understands
- Use clear language and short sentences
- Allow the interpreter to clarify information
- Avoid private conversations with the interpreter in front of the client

After the interview

- Ask the interpreter's opinion of any cultural or political issues in the case, or developments in the country of origin that could affect the client or their family
- Ask the interpreter how the session was for them
- Request the same interpreter for any follow up meetings if possible and appropriate.

If you have a problem with an interpreter's conduct, complain to the relevant service.

Tip: supporting your interpreter

Interpreters are not just a 'voice box', but a third person in the counselling triad. They need support and space to process vicarious traumatic reactions arising from working with refugees.

4.6 Exploring issues around torture and trauma

While a refugee may present with common problems such as grief, trauma symptoms, depression, anxiety, emotional stress or suicidality, the underlying problem may be their experiences of torture and/or trauma.

As talking about these issues can be very distressing, it is important that the client feels safe enough to do so. There is no need to open up these issues with the client unless there is a clear benefit for them. If the social worker is not in a counselling role, it is appropriate to refer the client (if they wish) to a social worker or professional counsellor who can provide a structure for these issues to be worked through safely.

If it is necessary to ask the client about their trauma history, they may be reluctant/ unable to talk about these experiences because of:

- ▶ their need to avoid re-living their experiences
- ▶ mistrust of other people
- ▶ fear of reprisals to themselves or their family
- ▶ avoidance of humiliation or stigma; and/or
- ▶ believing it's inappropriate to discuss these experiences with strangers

- ▶ the effect of trauma on memory and cognition - e.g. traumatic experiences may come and go from consciousness; recall of experiences may not always follow a storyline; memories may be confused.

Clients with PTSD may fall silent, lapsing into a dissociative state to avoid the memory. Those with strong numbing symptoms may present as withdrawn, unresponsive and difficult to engage with. They may avoid the trauma story altogether or refer to it vaguely, then change topics. They may focus on current problems rather than the past, and when the past is discussed, may have difficulty remembering traumatic aspects.

While some people will be unable to discuss their experiences, others may pour out their memories and emotions in a way that can be overwhelming and distressing.

4.6 Exploring issues around torture and trauma [continued]

If disclosure of traumatic events is necessary and/or potentially therapeutic, here are some 'opening lines' to initiate a discussion of your client's experiences and current difficulties:

1. "I understand that some people from your country had a lot of difficult situations before you came here? Was your family affected in this way?"
2. "Sometimes people expect others to 'get over' bad experiences quickly. This is often not the case."
3. "Sometimes when people have been through war situations, the reason they can't sleep is because they have strong memories about what happened."

TIP: Working with Traumatized People

The possibility of re-traumatizing people is real. Even asking simple questions can evoke strong emotions and destabilize those who experienced interrogation and torture.

Do not encourage disclosure unless there's a clear therapeutic benefit to the client.

Help the client maintain control over what they wish to tell you, and allow enough time to close the interview.

4.7 'Normalising' reactions

Many survivors of torture and trauma don't realise their symptoms are common responses to extremely distressing events. Many fear they are 'going mad'. You can help by:

- ▶ explaining that their symptoms are normal reactions to extreme stress
- ▶ pointing out the different ways people react to traumatic events
- ▶ explaining the link between physical and psychological effects of torture and trauma

- ▶ acknowledging the client's distress
- ▶ identifying the major issues the client may have to deal with or may seek help for
- ▶ helping the client build his/her confidence and recover a sense of control.

The Victorian Foundation for Survivors of Torture's (VFST) Recovery Framework below may help you identify the skills and strategies you need to contribute to recovery. The framework identifies four recovery goals based on four components of the trauma reaction. The strategies are an example only and you may be able to identify others. Sometimes a strategy will contribute to two or more goals - e.g. assisting someone to access services helps reduce anxiety and enhances control over the person's environment (Recovery Goal A) but also helps them feel more connected to people who can provide support and care (Recovery Goal B).

A. Trauma reaction component: Anxiety, feelings of helplessness, perceived loss of control

Recovery goal: restore safety and enhance control and reduce the disabling effects of fear and anxiety.

Strategies:

- ▶ Provide basic needs - e.g. health, welfare, education, accommodation
- ▶ Identify causes of anxiety; accommodate the effects of anxiety
- ▶ Restore safety
- ▶ Provide information about the trauma reaction
- ▶ Introduce relaxation exercises

B. Trauma reaction: loss of relationships with parents, family, community, religion and culture; grief; depression

Recovery goal: restore attachment and connections to others who can offer emotional support and care, and overcoming grief and loss.

Strategies:

- ▶ Foster a trusting continuing connection with an available caring person
- ▶ Group participation to reduce social isolation
- ▶ Promote belonging by overcoming settlement problems

- ▶ Link to supportive groups and agencies
- ▶ Provide opportunities for social/political action that may be valued and restore a sense of purpose.

C. Trauma reaction: shattering of assumptions about humanity: trust, dignity and meaning destroyed.

Recovery goal: to restore meaning and purpose to life.

Strategies:

- ▶ Group programs to promote communication, reduce isolation and enhance self esteem
- ▶ Integrate past, present and future through art, story telling and drama
- ▶ Create opportunities to facilitate a view of the future
- ▶ Explore concepts of self, others and the community
- ▶ Validate the cultural differences in values
- ▶ Provide human rights education; explore political background to violence

D. Trauma Reaction: guilt and shame

Recovery goal: to restore dignity and value, including reducing excessive shame and guilt

Strategies:

- ▶ Facilitate expression of guilt and shame
- ▶ Reflect that it's normal for them to wish they could have done more to protect others from harm
- ▶ Allow the telling and retelling of events and stories
- ▶ Assist with developing ways to reduce guilt
- ▶ Community acknowledgment of human rights violations and the need for redress.

Source: VFST (1998) Rebuilding Shattered Lives, VFST: Melbourne.

TIP: Get the skills you need

STARTTTS can provide consultation, supervision and training for working with refugee survivors of torture and trauma. Contact the Training Officer at STARTTTS for more information: 02 9794 1900.

For training on physical health and access issues, contact the Training Officer at the NSW Refugee Health Service: 02 8778 0770.

Asylum seekers in the community often have additional needs arising from their insecure migration status. The refugee determination process can take years. If a serious medical problem arises, asylum seekers may be unable to access health services without help from social workers and others.

Tips for working with asylum seekers living in the community:

- ▶ Clarify your role when you first contact the client. Be sure to differentiate your service from the Department of Immigration. Explain client confidentiality.
- ▶ Be realistic and specific when discussing what help you can offer.
- ▶ Focus on establishing rapport. It may take a number of sessions to identify the real issue.
- ▶ Don't assume you understand the client's problem - clarify it with them.
- ▶ Expect asylum seekers to be anxious, mistrusting, and afraid that seeking assistance from a government service may affect their asylum claims.
- ▶ Be prepared for conflicting or fragmented information - it may be the result of trauma symptoms or lack of trust.
- ▶ Don't be surprised if your client denies that they have already seen any other services.

- ▶ If they need health services but are Medicare ineligible, gently explore their financial status. Stress that you are interested in their ability to access health care, not their immigration status - clients may be tempted to conceal their financial status if they are working without permission.
- ▶ Don't focus on trying to understand different visa categories - your client will know what their visa means. You just need to know:
 - are they Medicare eligible?
 - do they have work rights?
- ▶ If there's extreme financial hardship, consider referrals to agencies that might be able to help, e.g. the Asylum Seekers Assistance Scheme through the Australian Red Cross, or the local Asylum Seekers' Centre. Explore other social networks that might help, such as churches and ethno-specific organisations.
- ▶ If they can't pay for medical care up front, arrange for them to see the hospital revenue department as soon as possible to negotiate payment options.

If your client needs to negotiate with revenue departments at public hospitals:

- ▶ Help them make an agreement with revenue departments. They are unlikely to be able to negotiate this alone.

- ▶ Avoid giving false hopes of the outcome.
- ▶ Before the appointment, help the patient estimate how much they can pay per week/per month. At the interview they may be tempted to overcommit and risk defaulting. Bring copies of their income as proof they can pay.
- ▶ Explain your client's hardship in detail to revenue departments. Not all revenue staff understands the hardships faced by asylum seekers who aren't allowed to work or access social welfare - dealing with senior staff may be more helpful.
- ▶ Ensure your client understands their obligations, and their right to know what they are signing.
- ▶ Stress to the client the importance of maintaining contact with revenue departments if their details or circumstances change. This shows their willingness to make repayments, even when things are difficult.
- ▶ Explain that default of payment can result in debt collection, legal action, or refusal of services in the future.
- ▶ Refusal to complete the negotiation process with hospitals may be caused by lack of comprehension, not necessarily reluctance to pay.

Medicare eligibility

Most people with a humanitarian visa are Medicare eligible, although a small number of people with temporary visas are not. The period of eligibility may differ, depending on their visa. Some asylum seekers living in the community have access to Medicare, but approximately a third does not. Options for asylum seekers living in NSW without Medicare who can't afford health care but need medical treatment include:

- the Asylum Seekers Assistance Scheme: contact the Australian Red Cross for eligibility criteria
- the NSW Refugee Health Service: clinics in Auburn, Blacktown and Liverpool don't

require Medicare cards, although referral options for Medicare ineligible people are limited. Contact RHS for details

- the Asylum Seekers Centre clinic in Surry Hills.
- certain General Practitioners (GPs) are willing to see people without Medicare
- certain health services (e.g. STARTTS, chest clinics, sexual health clinics) do not require a Medicare card
- some hospitals are willing to negotiate regular payments from Medicare ineligible patients who need treatment.

4.10 Making effective referrals

- ▶ **Get client's consent for referral first.**
This gives clients a sense of control. You also need their permission to divulge sensitive information, e.g. their emotional and physical difficulties. Explain to the client why this information is needed.
- ▶ **Refer to professional reputable services:** because of their experiences of state oppression, it may be difficult for refugees to trust service providers and feel confident that their information will remain confidential.
- ▶ **Give clear instructions:** write down the address, phone number of the service, and contact person. You may need to go through the details of how to get there or arrange a volunteer to take your client to an appointment. Torture and trauma experiences may affect memory, making it difficult to remember details. Clients with PTSD may get confused about appointments or 'forget' them.
- ▶ **Explain what services are:**
Some people come from countries with no equivalent services. If you make a referral for counselling, for instance, explain the purpose of counselling in simple terms and in a way that normalises the need for help with psychological and emotional issues.
- ▶ **Ensure the client understands:**
 - a] the type of service they're being referred to and what to expect
 - b] the type of intervention they will receive (e.g., one-to-one; group)
 - c] special procedures for referral and/or eligibility
 - d] if there are waiting lists, including how and when they will be contacted.
- ▶ **Try to match the client to the service provider:** where possible, refer them to services that share or have experience with their culture, gender, language, religion and/or political affiliation.
- ▶ **Keep expectations realistic:** services can only do so much - e.g. if the client is referred for counselling, explain that this may not provide a 'quick fix' for problems, and that healing may take considerable time.

4.10 Making effective referrals [continued]

- ▶ **Remember the financial limitations:**
Refer people to bulk-billing specialists or public hospital clinics where possible. If you make multiple appointments, try to make them all on one day to save transport costs.

Section 5.1 has a list of specialist services that are useful referral options.

TIP: When common sense isn't enough

Avoid giving advice about areas you know little about - especially those related to processing of asylum seeker's application. Not only is it illegal to give immigration advice unless you're a registered migration agent, but you can raise false hopes. Instead, refer people to an appropriate legal service (see section 5.1).

4.11 Keeping up with current events

Social workers can't ignore the political nature of the refugee experience - this denies the cause of a client's persecution. Keeping up with current events also helps you anticipate their needs. If conflict escalates, your client's anxiety for family at home may increase. Media coverage of events can often trigger painful memories.

It helps to be aware of:

- ▶ the political and/or social history of the country or region the client is from
- ▶ the reasons for conflict in the region
- ▶ the ethnic make-up of the region
- ▶ the level of persecution that exists there
- ▶ cross-cultural issues
- ▶ the effects of state terror on persecuted people

Websites providing a background to refugee movements:

- ▶ **Amnesty International:**
www.amnesty.org.au
- ▶ **Refugee Council of Australia:**
www.refugeecouncil.org.au
- ▶ **Forced Migration Review:**
www.fmreview.org
- ▶ **International Rescue Committee:**
www.intrescom.org
- ▶ **One World Network:**
www.oneworld.net
- ▶ **Refugee Studies Centre (University of Oxford):** www.rsc.ox.ac.uk
- ▶ **United Nations High Commissioner for Refugees:** www.unhcr.ch
- ▶ **US Committee for Refugees:**
www.refugees.org

Hearing stories of torture and trauma can produce strong reactions in health professionals. This is normal - it is not a personal inadequacy. Be aware of your own reactions so you can use them to improve your work and your understanding of the clients, rather than let them interfere with your effectiveness. This is explored further below in ideas for coping.

Some common responses when listening to traumatic stories are:

- ▶ embarrassment due to not knowing how to respond to atypical client behaviours
- ▶ feelings of inadequacy in addressing issues raised by the client
- ▶ intense emotional distress - eg anger, fear, grief, anxiety
- ▶ avoidance of the issues
- ▶ non-acceptance, disbelief and denial
- ▶ 'blaming' the client for the feelings and emotions triggered by their stories
- ▶ compassion fatigue
- ▶ physical and psychological responses - e.g. nightmares and insomnia
- ▶ over-identification with the client.

Ideas for coping:

- ▶ It's important to have a trusted clinical person with whom you can discuss your work, including stressful aspects and vicarious trauma/ counter-transference reactions. You can also network with social workers in other agencies with expertise in refugee work, including STARTTS, the NSW Refugee Health Service, the Transcultural Mental Health Centre and Multicultural Health Services/Units.
- ▶ To manage stress and prevent burnout, workers must be aware of their own needs and find appropriate ways of coping with feelings and responses to a client's situation.
- ▶ Ensure you have a balanced life by doing non-refugee related things and activities you enjoy; avoid using alcohol, sleeping pills or tranquillisers as a crutch.

This is an amended version of the NSW Advocates Kit prepared by the Refugee Council of Australia. Each service has different eligibility criteria

Refugee Health and Counselling

NSW Refugee Health Service

This statewide service, funded by the NSW Department of Health, aims to protect and promote the health of people from a refugee background in NSW. Services include clinical consultations, provision of health care information and education to refugees, training in refugee health issues, facilitating and conducting research, advocating for health equity for refugees, and a variety of projects. Many RHS activities are conducted through partnerships with specialist agencies, mainstream health services and community organisations. Health clinics are located in Auburn, Blacktown and Liverpool.

Level 2, 157-161 George St
Liverpool, NSW 2170
www.refugeehealth.org.au

Tel: 02 8778 0770
Fax: 02 8778 0790
refugeehealth@swsahs.nsw.gov.au

Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS)

This state-wide service specialises in assessment and interventions for refugee survivors of torture and trauma. STARTTS provides free psychosocial health assessment, individual and family psychotherapy and counselling, psychiatric assessments and follow-up, physiotherapy and bodywork to people from a refugee background. Complementary services include a youth program, the Families in Cultural Transition Program, a group program, a volunteer program, community development initiatives, community training and education, and a specialist library.

There is an early intervention program for newly arrived refugees that provides psychosocial assessment and assistance with resettlement.

STARTTS has offices in Carramar, Auburn and Liverpool, and operates from a number of different outreach locations including Newcastle and Wollongong.

PO Box 203
Fairfield NSW 2165
www.startts.org

Tel: 02 9794 1900 (Intake)
Fax: 02 9794 1910

Transcultural Mental Health Centre

This state-wide service promotes access to mental health services for people of non-English speaking background (NESB) in general. The Centre also works with consumers, carers, health professionals and the community to encourage positive attitudes to mental health.

<http://www.tmhc.nsw.gov.au/>
Tel: 02 9840 3800 or 1800 648 911
Fax: 02 9840 3755

Community Support for Refugees and Asylum Seekers

In addition to the services below, some ethno-specific and smaller services can be found on the Department of Immigration and Multicultural and Indigenous Affairs' website (www.immi.gov.au).

The Asylum Seekers Centre (ASC)

The Centre provides a safe place for asylum seekers living in the community to gather while waiting for the Australian Government to make a decision about their status. Activities include a range of classes, social activities, referral and case management. ASC is funded by the non-government sector. ASC has four social workers. A doctor and nurse hold a weekly health clinic.

38 Nobbs Street
Surry Hills 2010 NSW
asc_inc@bigpond.net.au

Tel: 02 9361 5606
Fax: 02 9331 6670
www.asylumseekerscentre.org.au

Australian Red Cross - Asylum Seekers Assistance Scheme (ASAS)

A Commonwealth Government funded program administered by the Australian Red Cross. Assists eligible asylum seekers in the community to meet some basic financial and health care needs if in extreme financial hardship.

Level 6, 159 Clarence Street
Sydney NSW 2000

Tel: 02 9229 4246 or 02 9229 4111

Integrated Humanitarian Strategy Services (IHSS)

IHSS funds intensive initial settlement services to newly arrived humanitarian entrants through a national network of contractors, assisted by volunteers. Support is usually provided for six months. Services include: Initial Orientation Assistance, Accommodation Support, Household Formation Support, Early Health Assessment and Intervention, Proposer Support and Service Support.

Integrated Humanitarian Strategy Services (IHSS) [continued]

Eligibility differs for each service, but many are not available to asylum seekers. Contact the Department of Immigration and Multicultural and Indigenous Affairs for details on the provider in your area: www.immi.gov.au.

The House of Welcome

The House of Welcome helps Temporary Protection Visa holders with no family or community links, to make the transition into the community. The House provides limited emergency accommodation and a drop-in centre where people can get help and support, enhance their computer skills and attend English classes. English courses are also run in the Fairfield, Cabramatta and Carramar areas.

140 Wattle Street
Carramar NSW 2163
Tel/Fax: 02 9727 9290

Mercy Refugee Service (MRS)

Recruits, trains and coordinates volunteers to assist refugees and their families, through the MRS Volunteer Community Links Project. Trained volunteers provide whatever assistance is needed - finding accommodation, gaining employment, offering social support or starting school. MRS is also involved in education and advocacy on behalf of asylum seekers and refugees.

1 Thomas Street
Lewisham NSW 2049
www.mercy.org.au/refugees
Tel: 02 9564 1911
Fax: 02 9550 9683

Migrant Resource Centres (MRCs)

Situated throughout NSW, these centres are non-profit, community-based organisations, established to promote the wellbeing of migrants, refugees and humanitarian entrants of non-English speaking backgrounds living in the local area around each centre. Services can include bilingual settlement casework services, information, advice and referral, English classes, immigration advice, free use of computers, telephones, faxes and photocopiers for job-seekers, and information sessions on settlement issues - health, education, immigration, housing and social security.

The following MRCs/Migrant Service Agencies, operate in NSW:

▶ Auburn MRC	02 9649 6955	▶ Blacktown MRC	02 9621 6633
▶ Baulkham Hills/Holroyd/Parramatta MRC	02 9687 9901	▶ Canterbury/Bankstown MRC	02 9789 3744

▶ Fairfield MRC	02 9727 0477	▶ Newcastle and the Hunter Region MRC	02 4969 3399
▶ Illawarra MRC	02 4229 6855	▶ St George MRC	02 9597 5455
▶ Liverpool MRC	02 9601 3788	▶ Sydney Multicultural Community Services	02 9663 3922
▶ Macarthur MRC	02 4627 1188		
▶ Migrant Network Services (Northern Sydney)	02 9987 2333		

*Legal Assistance***Refugee Advice and Casework Service (RACS)**

Free community legal service specialising in refugee law. Offers a variety of services including legal advice and casework for people applying for a Protection Visa (refugee status), referrals, and training.

Suite 8C, 46-56 Kippax Street
Surry Hills NSW 2010
Tel: 02 9211 4001
Fax: 02 9281 8078

Immigration Advice and Rights Centre (IARC)

Provides free legal advice on migration and citizen law to clients, by telephone and in person. IARC does not give advice about Protection visas or RRT applications, or advise on permanent employer nomination visas, business visas and independent points tested visas.

4th Floor, 414-418 Elizabeth Street
Surry Hills NSW 2010
www.iarc.asn.au
Tel: 02 9281 1609
Fax: 02 9281 1638

*Tracing Lost Family Members***Australian Red Cross Tracing Agency and Refugee Service**

Assists asylum seekers and refugees locate and contact family overseas where contact has been lost through war, internal conflict or natural disaster. In some countries, messages can be sent between family members, and family reunion (particularly between children and parents) can be facilitated. Red Cross can also provide information to families and individuals on a broad range of services, as well as referrals to other public and private agencies. These services are free.

159 Clarence Street
Sydney NSW 2000
Tel: 02 9229 4143

5.2 Refugee networks

Asylum Seekers' Interagency (ASI)

Meets bimonthly in Sydney to discuss issues relevant to agencies working with asylum seekers. Open to agency representatives working with or for asylum seekers. There are working groups on detention, welfare/housing and on legal issues around temporary protection/asylum issues.

Contact: Amnesty International 02 9217 7600

Ethnic Minorities Action Group (EMAG)

A group of representatives from small, or new and emerging communities (many of them refugee communities) living in Sydney who come together to share information, resources and advocacy strategies.

Contact: Anglicare Migrant Services 02 9560 8622

Greater Murray and Riverina Regional Refugee Health Services Network

A group of GPs, health professionals and community supporters from Wagga, Albury/Wodonga, Young, Griffith, Sydney and the ACT who come together to share information, expertise and resources about refugees living in the Greater Murray and Riverina regions.

Contact: Companion House 02 6247 7227

NSW Refugee Health Improvement Network (RHIN)

A forum of health workers working with refugees in NSW. RHIN raises refugee health issues and works collaboratively to develop strategies to protect and improve the health of refugees. Membership is open to individuals working in the health field. Meetings are held bimonthly in Parramatta, Sydney.

Contact: NSW Refugee Health Service 02 8778 0770

Refugee Support Network (RSN)

The main NSW forum of agencies and service providers working with refugees in Sydney. Meets every two months to improve coordination in services, to exchange information and discuss important policy issues affecting settlement of refugees and humanitarian entrants in NSW.

Contact: Refugee Advice and Casework Service 02 9211 4001

Temporary Protection Visa Support Group

Offers TPV service providers the opportunity to share information and problems concerning the provision of services to TPV holders.

For more information contact the Convenor.

Contact: Refugee Council of Australia 02 9660 5300

5.3 Recommended websites

Refugee Health - Australia

- ▶ NSW Refugee Health Service:
www.refugeehealth.org.au
- ▶ Service for the Treatment & Rehabilitation of Torture & Trauma Survivors (STARTTS): **www.startts.org**
- ▶ Forum of Australian Services for Survivors of Torture & Trauma:
www.fasstt.org.au
- ▶ Refugee & Asylum Seeker Health Resource Centre, Royal Australian College of GPs:
www.racgp.org.au/folder.asp?id+694
- ▶ Brisbane Refugee & Asylum Seekers Health Network (QLD):
www.brashn.org
- ▶ Refugee & Asylum Seeker Health Network (VIC):
www.rashmelb.org

Refugee Health - International

- ▶ Doctors Without Borders/Médecins Sans Frontières International:
www.msf.org
- ▶ Health for Asylum Seekers & Refugees Portal (UK):
www.harpweb.org.uk
- ▶ Reproductive Health for Refugees Consortium:
www.rhrc.org
- ▶ Boston Centre for Refugee Health and Human Rights:
www.glphr.org/refugee
- ▶ World Organisation Against Torture:
www.omct.org

5.4 Recommended readings

Aroche J & Coello M (1994) *'Toward a systemic approach for the treatment and rehabilitation of torture and trauma survivors in exile: the experience of STARTTS in Australia'*, paper presented at the 4th International Conference for the Centres, Institutions and Individuals Concerned with Caring for Victims of Organised Violence: *'Caring for and Empowering Victims of Human Rights Violations'*, 5 - 9 December, DAP, Philippines.

Becker R & Bowles R (2001) *'Interpreters' experience of working in a triadic psychotherapy relationship with survivors of torture and trauma: some thoughts on the impact on psychotherapy'* in B Raphael & A Malak (eds) *Current Issues in Transcultural Mental Health Diversity: Mental Health in Challenging Times, Monograph 8*, NSW Transcultural Mental Health Centre, Sydney.

Blackwell, D. (1993) "Disruption and Reconstitution of Family, Network, and Community Systems Following Torture, Organized Violence, and Exile". In P. Wilson & B. Raphael (eds), *International Handbook of Traumatic Stress Syndromes*, Plenum Press, New York, pp. 733 - 741.

Bowles R (2001) *'Social work with refugee survivors of torture and trauma'* in M Alston & J McKinnon (eds) *Social Work Fields of Practice*, Oxford University Press: Oxford, pp220 - 235.

Bowles R, Haidary Z & Becker R (1995) *'Family therapy with survivors of torture and trauma: Issues for women in an Afghan case study'*, paper presented at the Third National Women's Health Conference: Changing Society for Women's Health, ANU: Canberra.

Bruce A (2003) *'Australia's refugee and humanitarian program'* in Barnes D (ed) *Asylum Seekers and Refugees in Australia: Issues of Mental Health and Wellbeing*, Monograph 9, NSW Transcultural Mental Health Centre: Sydney.

Centre for Population Mental Health Research at the University of New South Wales (2004) Media Release: *'Temporary protection visas compromise refugees' health: new research'*, http://www.unsw.edu.au/news/pad/articles/2004/jan/TPV_Health.html, 30 January 2004.

Cunningham M & Silove D (1993) *'Principles of treatment and service development for torture and trauma survivors'*, in JP Wilson & B Raphael (eds) *The International Handbook of Traumatic Stress Syndromes*, Plenum Press: New York.

Ferguson B & Pittaway E (1999) *Nobody Wants to Talk About It: Refugee Women's Mental Health*, NSW Transcultural Mental Health Centre: Sydney.

Herman J (1992) *Trauma and Recovery*, Harper Collins: New York.

Jupp, J. (1994) *Exile or Refuge: The Settlement of Refugee, Humanitarian and Displaced Immigrants*, Bureau of Immigration and Population Research, Australian Government Publishing Service, Canberra.

Kordon, D.R. et al (1988) *Psychological Effects of Political Repression*, Sudamericana/ Planeta Publishing, Buenos Aires.

Martín-Baró, I. (1989) *'The psychological consequences of political terrorism'*, paper presented at the *Symposium on the Psychological Consequences of Political Terrorism, 17 January*. Committee for Health Rights in Central America: Berkeley, California.

Martín-Baró, I. (1994) *Writings for a Liberation Psychology*, Aron, A. & Corne, S. (eds), Harvard University Press: Cambridge.

Nguyen T & Bowles R (1998) *'Counselling Vietnamese refugee survivors of trauma: points of entry for developing trust and rapport'* *Australian Social Work*, 51, 2: 41-47.

Pittaway E (1991) *Refugee Women - Still At Risk in Australia*, Australian Government Publication Service: Canberra.

Reid, J. & Strong, T. (1987) *Torture and Trauma: The Health Care Needs of Refugee Victims in New South Wales*, Cumberland College of Health Sciences, Sydney.

Silove D, Tarn R, Bowles R & Reid J (1991) *'Psychosocial needs of torture survivors'*, *ANZJ Psychiatry*, 25: 481-90.

Asylum seeker	Someone who has applied for asylum or refugee status and has not yet received a decision
DIMIA	Department of Immigration and Multicultural and Indigenous Affairs
FGM	Female Genital Mutilation
Humanitarian entrant	A term used to describe refugees and other people who are at risk of serious human rights violations.
MRC	Migrant Resource Centre
PTSD	Post Traumatic Stress Disorder
Refugee	A person who is outside his/her country of nationality or usual residence, and is unable or unwilling to return because of a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group, or political opinion
STARTTS	NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors
TPV	Temporary Protection Visa: three-year visa given to people who, after arriving in Australia without authorisation, have been found to be genuine refugees
Torture	Deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of an authority, to force another person to yield information, make a confession, or for any other reason

This guide was designed to provide essential background information and practical suggestions to assist social workers provide quality care to people from a refugee background.

Practical hints in a variety of social work contexts are provided, along with a number of useful resources. Examples of social work interventions are scattered throughout.

This resource was produced by the NSW Refugee Health Service and STARTTS, under the guidance of a Steering Committee and the support of social workers and multicultural health staff from the Bankstown, Fairfield and Liverpool Health Services.

The following people deserve a special acknowledgment, as without them this guide would not have been possible: B-Ann Echevarria, Claudia Graham, Cathy Preston-Thomas, Marisa Salem and Robin Bowles.

Steering Committee:

Alison Pryor, Katina Varelis, Yvonne Santalucia, Nada Damcevaska, Jolanta Swierczynski, Diana Milosevic, Marisa Salem, and Robin Bowles

Thank you also to the staff of STARTTS and NSW Refugee Health Service for their comments; contributions were made specifically by:

Jennifer Taylor, Lucy Marin, Patrick Morris, Mark Byrne, Rise Becker, and Diana Milosevic.

Grateful acknowledgement also to the Social Work Departments of Liverpool Health Service for their financial contribution.

Acknowledgement to Paula Goodyer for editorial advice.

Design and printed by KMD Design & Print.



NSW Refugee Health Service



S.T.A.R.T.T.S

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of Torture and Trauma Survivors**