



# Older Refugees in the UK: A literature review

## A Refugee Council Working Paper for the Older Refugees Programme

The Older Refugees Programme is a partnership project between Age Concern England, the Refugee Council, Age Concern London and the Association of Greater London Women (AGLOW)

### Writers/Researchers

Naomi Connelly  
Lora A. Forsythe  
Guy Njike  
Anja Rudiger

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## Introduction

Relevant, effective and sustainable practical and policy interventions require knowledge of the experiences, needs and views of their targeted beneficiary groups. Therefore, practitioners, services providers and policymakers need to take account of the many different backgrounds beneficiaries and users have. This can be achieved, for example, by listening to the concerns of beneficiaries and users and by involving them as partners.

The Older Refugees Programme brings together organisations working with refugees, older people and women, to explore the perspectives of older refugees and to improve practical and policy initiatives for older refugees. This is based on a recognition that neither refugees nor older people constitute homogenous groups with uniform needs and concerns, but that a range of factors shape their experiences and perspectives. Not enough is known about how intersecting factors, such as age, migration status, gender and ethnicity impact on people's experiences and needs, and how these can best be taken into account when devising services and policies.

The Older Refugees Programme seeks to develop and identify good practice for and with older refugees, especially older women refugees, rather than merely 'older people' in general, or 'refugees' as a group. It will explore the intersection of migration status, age and gender. This means analysing the specific needs of 'older refugees', male and female, beyond the needs of older people more generally, or even older people from black and minority ethnic groups. It assumes that refugee/asylum seeking status and gender add new and different dimensions to the experiences and needs of older people, which must be identified to make practical and policy interventions for older refugees effective and sustainable. The complex patterns in which people live their lives – e.g. as a refugee who is also a woman and also an older person – shape people's experiences and give rise to specific needs which practice and policy interventions must take into account in order to be successful.

This literature review examines what is known about older refugees' views, experiences and needs, what gaps exist in the knowledge and evidence base, and how these gaps are relevant to policy and practice. It also identifies examples of current policies and practices that either target or include older refugees, as well as key policies that maintain a general focus on older people which could be relevant for refugees. Where appropriate, it draws on literature, policy and practice that takes the needs of black and minority ethnic older people into account. Over the past two decades, there has been a growing body of knowledge and practice looking at the intersection of age and race/ethnicity, which is relevant to refugees in so far as the majority of refugees can be identified as belonging to minority ethnic groups. At the same time, the Older Refugees Programme considers experiences of forced migration to be different from other migration and settlement patterns, and therefore explores how the distinctive experiences of refugees are taken into account when devising policies and practices for older people in general and minority ethnic older people in particular.

The review maps existing evidence, and gaps in evidence, of the needs of older refugees and how these are being met. This forms a basis for identifying questions for qualitative research with older refugees, which lies at the heart of the Older Refugees Programme. The review's first priority was to find academic literature, policy documents and grey literature specifically on older refugees. As the scope of available information under this category proved limited, the search was extended to literature on older minority ethnic

people, on refugees in general and women refugees in particular. No attempt was made to survey academic literature on older people or on women more generally. However, policy documents and practical initiatives relevant to older people have been included, as the Programme seeks to inform policy and practice in this area. Materials were accessed through library and internet searches, and through Refugee Council resource files including conference documentation, annual reports and leaflets. A small number of informational interviews with RCOs and voluntary sector service providers were also carried out.

## 1. Definitions

A scoping report produced for the Refugee Council in 1999 pointed to the difficulty of summarising intersecting factors such as migration status and age in the category of "older refugees". Coombes et al (1999:2) referred to the "lack of a shared view" as to what was meant by "older refugees", and said that this "obviously impedes understanding, researching or developing services to meet needs". Both 'older' and 'refugees' have a range of meanings, separate and combined, in addition to their gender dimension.

### **'Older'**

In the UK, older people are often defined in a labour market context: they are equated with 'pensioners' or people of pensionable age, i.e. currently 60+ (for women) or 65+ (for men). However, these definitions are likely to become more flexible, as new legislation against age discrimination in employment will come into effect in October 2006. An alternative context is provided by social care services, whose target group has increasingly been seen as those who are 75+ or even 85+. However, in 2001 the *National Service Framework for Older People* set out as Standard One "Rooting out age discrimination": "NHS services will be provided, regardless of age, on the basis of clinical need alone. Social care services will not use age in their eligibility criteria or policies, to restrict access to available services" (Department of Health, 2001:16). As a result, some social services departments and primary care trusts have been restructured so that older people are included within adult services. The Social Exclusion Unit's 2006 report on age inequalities defines 'older people' as those over 50. However, age 60 or 65 remains the criterion across many aspects of life, including eligibility for free prescriptions and free or reduced travel charges, and within the social security system.

Among practitioners in the refugee sector, an implicit recognition prevails that a base age of 60 or 65 is too high when considering older refugees, and that 50 or 55 might be more appropriate. Among the reasons given is the likelihood that refugees may become physically and/or mentally frail at an earlier chronological age due to experiences in their country of origin, en route to the UK or after arrival. While no sound evidence appears to exist, these assumptions are based on the experiences of people working with refugees.

With regard to using a set age range as a criterion for receipt of benefits or services, a further problem exists for people with a forced migration background. Refugees may come from societies where exact date of birth is not considered important, or where an individual's documents show an older or younger age through inaccurate, lost or altered records.

Coombes et al proposed that for the work of refugee agencies "the only practical option" was to use self-definition of age (1999:4-5). This approach was also taken by the

Refugee Women's Association in an issue of their newsletter focused on older women (RWA, 2004). Similarly, ECRE's Good Practice Guide relating to older refugees argued for a flexible approach to age, although at a pragmatic level it was suggested to consider those refugees as older who are over the age of 50, on the grounds that in Europe 50 was the age "when finding a job generally becomes difficult, but nearly impossible for refugees and migrants who arrive in EU countries at that age" (Knapp and Kremla, 2002:7-8).

**Possible research questions:**

→ What are older refugees' perceptions of ageing?

**'Refugees'**

Refugee agencies in the UK define as refugees those who have fled persecution in their country of origin, regardless of whether they have been granted refugee status, other forms of leave to remain or whether they are still in the asylum process. The Older Refugees Programme will therefore explore the experiences of asylum seekers as well as people with refugee status.

For asylum seekers, issues are likely to be somewhat different, as government policies treat people differently according to their legal status. For example, asylum seekers are not considered a target group for the government's refugee integration strategy. The practical impact of such policy distinctions remains to be assessed.

Experiences and needs are also bound to be different for recently arrived older refugees and/or their dependants, compared to refugees who have grown old in the UK. All older people who originally came to the UK seeking refuge could be described as "older refugees", yet in practical and policy terms it is relevant whether they arrived 50 years ago or last year. Evidence relating to accessing and using public services, for example (described below), shows that newcomers face particular difficulties, which need to be further examined in relation to age and gender.

At the same time, there is evidence that the "refugee experience" can be "a process with lifetime effects" (Baker, 1983:5). As they age, refugees may re-experience the traumas of their earlier experiences (Finlay and Reynolds, 1987:160), sometimes with feelings of shame, or of guilt at surviving (Scott and Bolzman, 1999:173). An established, if not extensive body of research exists on these psycho-social issues.

Another complexity arises in relation to distinguishing migrants from refugees. For people from countries such as Sri Lanka, the Tamils' long experience of discrimination or persecution means that those who came as migrants may have similar experiences as those who came as refugees (Coombes et al, 1999:5-6). Such considerations may also apply, for example, to older Yemenis in Sheffield and older Latin Americans in London.

Therefore, definitions of "older refugees" may be most useful as pragmatic, contextual ones, which could be different for different purposes or for people from different countries. For example, in research about the needs of older people carried out by the Sierra Leone Women's Forum UK, respondents approached were those who had arrived in the UK since the start of the civil war in 1991 (SLWF, 2003:7).

For policy and practical purposes, the exploration of life histories appears less relevant than an examination of needs and concerns. This suggests that qualitative research should pay particular attention to refugees over 50 who arrived in the UK over the past

decade, and who have gone through the asylum process, either as applicant or dependant, rather than via a resettlement or migration programme.

**Possible research questions:**

→ What are the specific issues faced by newly arrived older asylum seekers? What issues do older men and women face in the asylum process?

## **2. Demographics**

While it is not possible to quantify the UK's population of refugees who are over 50 years of age, some figures are available through the Home Office's asylum statistics. In 2004, 3% of all asylum applicants were aged 50 +. This included more women than men: 4% of female applicants were over 50, amounting to a total of 680 female applicants, and 2% of males were over 50 (a total of 445). Older people also submit applications as dependants, with around 2% of dependants' applications coming from people over 50. More than twice as many dependants' applications from this age group are submitted by women (90 female and 30 male dependants' applications).

The Refugee Council's client database (containing mainly asylum seekers) shows that only a small number of its clients, around 1%, are over 60 years of age.

Hence, while the percentage of older asylum seekers is small, and presumably considerably smaller than the number of older refugees with status, there appears to be a sizeable presence of older asylum seekers. This has not yet been fully analysed for practical or policy purposes.

As the overall majority of asylum seekers are male, the dominant presence of women in the older age cohort is notable. Informed by these figures, as well as the Refugee Council's Women's Strategy, the Older Refugees Programme seeks to pay particular attention to how the needs and experiences of older refugee women are identified and addressed in literature, policy and practice. There is a widespread consensus in social science literature that, until fairly recently, both analyses and policies relating to the welfare state have systematically excluded women. They have failed to identify women's political, economic or civic agency, to assess the family as an institutional domain, to take account of women's unpaid labour within the family and social networks, and to assess the gendered effects and outcomes of social policies, particularly social benefit regimes (e.g. Daly 2000). When looking at multiple identity factors such as migration status, ethnicity and age, it is important to understand how gender interacts with these factors, and how it compounds experiences of exclusion.

Women refugees in particular have long been largely absent from many mainstream refugee and migration policies, as well as analyses of exclusion and racism (e.g. Kofman, 1999). With regard to refugee law, Oswin (2001) stated that the view of refugee women as legal subjects who are passive, dependent and vulnerable victims has begun to be challenged, and that refugee women's agency and the specific modes of persecution they face, are increasingly taken into account. Recent policy and practical initiatives that incorporate a gender perspective primarily focus on gendered causes of forced migration, as well as women's access to and treatment within the asylum process, informed by research on the difficulties that women face when claiming refugee status in their own right (Kofman 1999, Asylum Aid/BID 2005). Some recent studies have included gender

issues when analysing government policy towards refugees (Sales 2002, Schuster 2003, Squire 2005). Bloch (2002) and Dale (2002) undertook case studies that focused on refugee and migrant women's social exclusion, identifying women's experiences beyond the private and reproductive sphere, including their situation in employment, education, language services and the effects of status on their participation in these spheres. A first comprehensive overview of refugee women's experiences in the UK was carried out in 2002 (Dumper 2002a), and strategic guidance for supporting refugee women was developed by the Refugee Council in 2005 (*Making Women Visible*). However, neither includes a focus on older women.

The Refugee Council's guidance, based on consultation with women refugees, set out a strategy for addressing women's issues, acknowledging that refugee women face specific difficulties. This document provided a benchmark for understanding refugee women's needs and improving policies and practical responses to them (Refugee Council 2005: 5). However, the specific experiences of older women refugees were not included within the scope of the analysis. In that regard, the report showed that knowledge gaps on multiple disadvantage remain, such as on the intersection of gender, age and refugee/asylum status.

**Possible research questions:**

→ What are older refugee women's perspectives and needs (especially recent arrivals)?

## Policy and service provision areas

This literature review examines the available knowledge and evidence on older refugees in relation to a number of key integration indicators used by the Home Office (Ager and Strang, 2004), from legal security to functional inclusion in health, housing, education, employment, to refugees' social connections. While some issues (such as safety) are not addressed in separate sections, the review endeavours to cover them as they arise in relation to service provision.

### **1. The legal framework: immigration and asylum law and processes**

While there is a substantial body of literature on recent immigration and asylum laws, their implementation and implications (e.g. Castles 2004, Bloch 2002a, Dale 2002, Oswin 2001), the impact on specific groups of asylum seekers and refugees, such as older people, remains underexplored. While newer literature and policy documents now tend to point to the gender impact of legal and policy measures (Refugee Women's Resource Project 2003, Refugee Council 2005), an increasing awareness of diverse needs among refugees has not yet extended to a focus on older refugees.

As more older refugee women than men enter the asylum system as dependants, they are likely to be particularly affected by the relationship of dependency entailed in this process. The age dimension of this relationship remains to be explored. Some research has been carried out into refugee women's access to independent legal advice (e.g. Refugee Council 2005, Refugee Women's Resource Project 2003), and documentation and initiatives include older women refugees (Refugee Women's Association 2001, Latin American Elderly Project). Asylum Aid's Refugee Women's Resource Project provides free representation and legal advice to refugee women of all ages to help them overcome gender-specific procedural and evidential obstacles in the asylum process. The Sierra Leone Women's Forum drew attention to the considerable stress caused to women by

uncertainties about status and lack of appropriate legal advice (SLWF, 2003: 40, 46). At a Haringey Housing and Social Services workshop on services for older refugees, Williams (2000) noted the issue of poor legal advice and suggested training volunteer advocates from older West Africans' own communities.

Recent changes to immigration and asylum legislation have had a significant impact on asylum seekers and refugees, making the asylum process more challenging, support provisions more limited and the refugee status less secure. Among the measures that are likely to affect older refugees are restrictions to access to health services and stricter family reunion policies. However, no evidence of impact exists at this stage.

**Possible research questions:**

→ How do new immigration and asylum policies impact on older asylum seekers?

## **2. Health, mobility and social care**

There is a vast body of literature on both refugees' and older people's health, including some research specifically on older refugees, and on refugees as a sub-group of black and minority ethnic people. A few references to older refugee women were found in research on refugee women more generally.

Most literature on refugee health discusses problems of access to health care and the significant role that refugee organisations play in assisting refugees to register with a GP (Cowen 2001, Ager and Strang 2004: 13). One of the problems in defining an 'older' refugee in terms of healthcare is that they may be experiencing ageing faster, due to possible traumatic experiences (Ditscheid 2004). Some literature on refugees' health problems therefore contextualises illnesses found among refugees, such as high blood pressure and strokes (Ditscheid 2004), which are assumed to be caused by both past experiences as well as specific difficulties faced in the UK, such as language barriers and racism.

### **Health services and access**

The Department of Health and the Refugee Council produced *Caring for Dispersed Asylum Seekers: A resource pack* in 2003, which included guidance to health services applicable to all dispersed asylum seekers, without specifically addressing the needs of older people. The pack remains available on the DoH's website, though it has not been updated since. Materials such as these indicate that some progress has been made in identifying and addressing health access needs of refugees. Over a decade ago, Bhui (1991: 148) argued that "refugees are rarely included in any ethnic monitoring exercise so little attempt is made to plan for their potential needs" (cited in Wilson 2001: 46). However, recent restrictions of health service provision to asylum seekers suggest that an enhanced knowledge base does not necessarily correlate with policy improvements.

Much of the literature on health services for older refugees and asylum seekers relates to problems of access, particularly regarding language barriers. A report by South London and Maudsley NHS Trust on services for asylum seekers and refugees noted that older patients with post traumatic stress disorder "would benefit from psychotherapy but language problems prohibit this from being provided" (SLAM, 2001:23). The BME Health Forum and the Migrant & Refugees Communities Forum in Kensington & Chelsea and Westminster (2003:16) held a consultation exercise including older refugees and asylum seekers, and reported that "many participants did not know about other services they

could approach, besides their GPs ... An elderly Eritrean man explained that 'People needing health treatment are not aware of the system – they cry at home, and then give up'. Research by the Sierra Leone Women's Forum noted that some respondents were "unaware that pharmacies can help or that they are entitled to free eye checks at opticians. They were also unaware that they could visit ... NHS drop in centres" (SLWF, 2003:35). In Harrow, Wasp et al (2004) found that although language support appeared to be good for older Iranians, older Somalis and Afghanis had little understanding of health services after years in the UK and had not attended appointments due to negative experiences. When Fountain et al (2004: 22, 47) explored knowledge of drugs (other than qat) and drug services among Somali and Turkish Kurdish communities in London through focus groups, including people from their early 20s to late 60s, the Somalis stressed that their culture was an oral one, and this needed to be taken into account when disseminating information about drugs.

Burnett and Peel (2001) discussed the healthcare needs of refugee women. They argued that because women are less likely to be proficient in English or to be literate, it is important to speak to them directly using an independent interpreter (rather than a family member). Screening and health promotion programmes tend to have a low uptake among refugee women. In one study only 5% of refugee women aged over 50 (compared to around 75% of the overall female population in that age group) had gone for breast screening. Trained advocates can enable women to discuss their health more easily, and health workers need to be aware of specific health problems such as genital mutilation. Women need to be offered sexual health care, family planning and maternity care that is sensitive to their cultures. Cultural backgrounds may influence specific health concerns of women, including how women experience menopause. Montgomery (2006: 143) stated that "culture and ethnicity are reflected in a person's beliefs, traditions, language, and social structure; therefore, ethnicity may influence woman's attitudes and acceptance of menopausal symptoms as well as her adherence to and expectations for treatment." The Refugee Council's (2005: 12) strategy for women discussed the health problems that women faced due to experiences of sexual abuse and violence, trafficking and prostitution. It noted the difficulties women encounter in accessing appropriate services to meet their healthcare needs (also Cowen 2001).

Saunders (2004) reported that older refugees, and especially older women refugees, faced particular problems in accessing health services. Older refugees may be "resistant to approaching public authorities for assistance due to their experiences in exile, or of discrimination in their country of settlement" (Saunders 2004). They may also feel insecure due to a loss of social status, difficulty in contributing financially and lacking social networks. This can lead to their dependence on younger generations, and in extreme cases, to violence against older refugees, triggered by dependency and isolation and mostly affecting women (Saunders 2004). This analysis was informed by Pritchard's (2000) report on the prevalence of abuse against older people.

Some positive experiences are noted with regard to targeted service provision. Messele (2001) reported that a focus group discussing an East London Refugees' Health Access Clinic considered the clinic especially useful for older refugees. One participant said "As an elderly woman I feel like I'm safe here and I get all help from this clinic and am happy with all staff". Particularly appreciated were rapid response, time to discuss problems, and shared culture and language with paid and voluntary clinic workers.

### **Physical and mental health states**

Among the health issues mentioned in the literature on refugees are:

- problems deriving from unsettled conditions and absence of health services in the country of origin (e.g. malnutrition, starvation, lack of diagnosis and/or treatment of diabetes and HIV/Aids)
- trauma (including rape, torture) from experience in country of origin or en route to the UK
- stress in the UK due to uncertainties about status, dispersal, racial harassment, poor living conditions, etc.
- susceptibility to conditions such as glaucoma and sickle cell, and loss of limbs
- reliance on traditional healers (Gebrehiwot, 2000) or use of khat (qat) (Patel and Murray, 2005; Patel, Wright and Gammampila, 2005)
- anxieties due to loss of family, role and "loss of their social worlds" (Derges and Henderson, 2003:96)
- culture shock, especially for "those people without much prior knowledge or experience of urban life in industrialized societies" (Scott and Bolzman, 1999:169)
- 'ordinary' ageing including e.g. arthritis and hypertension (SLWF, 2003:32).
- ageing faster due to experiences and high stress, specifically causing high blood pressure and strokes amongst older refugee women (Ditscheid 2004).
- lower uptake of breast and cervical cancer screening, specifically amongst refugee women over 50 years (Burnett & Peel 2001).

Despite an identified set of common health issues, some researchers stress the importance of considering each older refugee as an individual. Roberts and Harris (2002:26) found that there was limited data on the prevalence of impairments and chronic illness amongst refugees in Britain. They argued that "assumptions regarding the course of impairments should not be made. Chronic ill health and conditions related to ageing and diabetes also appeared to be important causes of impairment" among the older disabled refugees and asylum seekers in their study. Derges and Henderson (2003) cautioned against marginalising "cultural bereavement" in light of more drastic trauma experiences.

Insufficient provision has been noted for disabled refugees. This may also be an issue relevant to some older refugees. Focusing on disability among refugees, Roberts and Harris (2002) found that personal care needs, unsuitable housing and lack of aids were among the most prevalent problems for the 38 disabled refugees interviewed. The study also indicated that in responding to disability issues there was a lack of coherence between institutions, such as reception centres, local authorities and NASS. Such issues are among those addressed by more recent guidance published by the National Information Forum (*How to Access Disability Services: A guide for organisations in contact with refugees and asylum seekers*, 2005).

In the field of mental health, substantial evidence exists on the failure of mental health services to meet the needs of black and minority ethnic groups. The Department of Health (2005) developed an action plan for the reform of mental health services which specifically mentioned the needs of refugees when "delivering race equality in mental health care". The plan acknowledged the "particular barriers in accessing and using mental health services" and the circumstances that influence poor mental health conditions (section 3.75). It also stated the need for service delivery to recognise the barriers that are "specific to older people with mental health problems, and other particular circumstances of minority groups" (sections 3.78 to 3.82). Specific gender concerns, however, were not mentioned.

Wilson's (2001) study of mental health care and BME groups looked at how different communities experience mental health issues, including older people, refugees and women. It mirrored findings by Burnett and Peel (2001) that women are more likely than men to report poor health and depression due to isolation. Greater needs of women refugees for mental health services were found regarding disorders such as depression, suicide and post traumatic stress disorder; for example, one third of refugees (but 44% of women refugees) in the London Borough of Newham stated they were depressed (Wilson 2001). Mental health differences between women and men in some minority ethnic communities have long been evident; for example, Asian women were found to have a suicide rate 20% above the national average for women (Bhui 1991, cited in Wilson 2001: 37).

There appears to be a consensus in the literature that refugees, women and older people are all especially negatively affected by the problem of isolation, which is in turn linked to health problems. With regard to older minority ethnic people, Wilson (2001: 45) noted that they were particularly affected by isolation due to the stereotype that BME communities "look after their own", and that older people are "invisible among a growing number of older black people in Britain". Ager and Strang (2004: 13) stressed that mental health problems in older people reduce their capacity to be actively involved in the community.

### **Mobility**

Isolation is also a consequence of restricted physical mobility, which tends to affect particularly older people and women. Therefore, transport services have been recognised as important for supporting older people's mobility, but problems regularly raised in consultation exercises are cost, accessibility, attitudes of bus drivers and other passengers, and safety. These are likely to affect older refugees as well, and there may be additional problems such as anxiety about speaking English and lack of neighbourhood networks, especially for refugee women. The 1994 General Household Survey showed that older women in general were more likely to experience restrictions of mobility, self-care and ability to perform household tasks than older men (cited in Acheson 1998). The SLWF identified a "lack of knowledge of public transport" as an aspect of isolation (2003:49). Gebrehiwot (2000) found that lack of transport to church and social functions was a problem for older Somalis.

### **Social care**

Literature on health and social care provision for BME groups is extensive, and policy and services for older people in black and minority ethnic communities have developed considerably over the past two decades. While little evidence is available on care services for older refugees, much valuable experience exists which could inform support for older refugees.

Social care provision is highly sensitive to demographic profiles and changes. Both refugee and BME groups tend to have a younger age profile than the general population, although at least for BME groups this is undergoing a process of change. For more than a decade, literature has pointed to the growing BME population who will need formal and informal care and may put increasing pressure on BME families (Atkin and Rollings 1992: 406-407). When examining informal care provision, it is important to look at those providing informal care as well as those being cared for. It is well evidenced that caregiving is a highly gendered activity, as women generally take on the responsibility of care (Atkin and Rollings 1992: 407). Atkin and Rollings found that most of the literature on informal care discussed the 'invisibility' of care needs and informal caregiving amongst

BME groups. They noted a common assumption amongst service agencies that BME groups have a greater commitment to care because of strong family networks, but that this assumption may be misguided as many BME older people were found to live alone (Baxter 1989, Atkin et. al. 1989). Coombe (1981) and Cameron et. al. (1989) discussed how absence of family care, especially in the context of social expectations, caused depression in older people.

Some of the literature on BME groups describes practical care interventions developed over the past decades (e.g. *Experiments in Health Advocacy*, Winkler, 1988, and *Working towards Racial Equality in Health Care – the Haringey Experience*, Constantinides, 1989). The weekly magazine *Community Care* ([www.communitycare.co.uk](http://www.communitycare.co.uk)) has reported on many such initiatives in social care, for example on the Apna Ghar day centre in Birmingham, “a lively multi-faith social club where the emphasis is on self-help” (Ogden 1992).

For older people in general, assessment is a key gateway to social care provision. As assessment arrangements have become more systematic and also more rigid, there has been concern about their adequacy in meeting diverse needs. The Chief Inspector of Social Services reported in 2000 that “Assessment procedures may miss or over-emphasise certain aspects of black people's lives and so lead to unhelpful care plans” (Platt, 2000, para.6.11). Banton and Hirsch (2000:40) found that some older Asian people felt that following religious practices could be more important than meeting daily physical needs, but community care assessments and service planning were insufficiently culturally sensitive to take this into account. The development of 'direct payments' (following assessment, funds are made available for the person concerned to purchase their own support services) may ease some aspects of this problem for older people in BME and refugee communities (although perhaps creating other problems in managing finances).

Howarth and Jones, reviewing research published during the 1990s in the *British Journal of Occupational Therapy*, referred to “a startling lack of direct consultation with service users themselves” (1999:456); the single exception was a study of the self-care needs of 19 older Hindu men and women (Gibbs and Barnitt, 1999:101). However, direct consultation has become much more frequent across health and social care, as it is increasingly recognised that the assumption of the automatic availability of informal care in BME communities is neither correct nor compatible with race equality objectives. For example, in 2001 Help the Aged held a conference on health and social care issues for older Chinese people in London, discussing issues such as interpreting, attitudes and transport.

An important issue in social care provision in recent years has been support for carers; some of the literature looks specifically at the role of black and minority ethnic carers. For example, McCalman (1990) explored the experience of carers of older people in Afro-Caribbean, Asian and Vietnamese communities in Southwark (the Vietnamese had come as refugees). In another study, Gunaratnam (1997) considered stereotypes, myths and support for Asian carers, and a more recent project examined need for and provision of respite services for Asian families in Leicester (Jewson et al, 2003). Both McCalman and Gunaratnam noted that informal caring provision in BME communities was affected by poverty, poor housing conditions and racial harassment.

Examples of good practice regarding BME older people include drop-in centres and other community facilities, stretching back 20 years or more, which highlight the role of such

centres as springboards for building confidence and capacity, developing networks, and accessing information, advice and support.

Such practical initiatives can and have been replicated for refugees. Informal resources for older refugees are for example provided by the Latin American Elderly Project (Dadzie, 1993; RWA, 2004). The literature increasingly notes calls for such informal facilities (e.g. Williams, 2000, and Nur, 2000). An evaluation of the impact of Community Fund grants on refugee communities commended organisations for arranging clubs where older people could meet, receive advice, meals, opportunities to learn English, etc (Ball and Griffin, 2001:39-41). Coombes et al suggested that older refugees might prefer such 'open access' services because they might fear "losing everything a second time" if they gave personal details to authorities in order to access more formal services (1999:17).

Community led initiatives exist that supplement informal open access care with more structured provision for individuals. For example, the International Somali Community Trust has set up a Home Share Day Care scheme for older Somalis in Hackney, in conjunction with Hackney Social Services: one or two days a week an older person is looked after by a voluntary carer in the carer's own home (RWA, 2004).

With regard to older people more generally, the health and social welfare policy environment has altered significantly over recent years, in ways which should provide a helpful context for older refugees. The emphasis now is on supporting older people to maintain their independence and autonomy, even when they become frail; and on systems to ensure that older people's voices are heard both in relation to their own support and in relation to needs and services more generally. There have been important policy documents, such as the Department of Health *National Service Framework for Older People* (2001), the Social Exclusion Unit's report on excluded older people (2006), the social care white paper, *Our health, our care, our say: a new direction for community services* (DoH 2006) and initiatives such as Better Government for Older People. In addition, the Supporting People initiative, which provides support services for vulnerable people in the community, includes older people among its potential beneficiaries. These policy plans and initiatives all make at least brief mention of black and minority ethnic older people, although none addresses older refugees specifically. A tighter fiscal environment may place constraints on including health and social care for older refugees within mainstream provision, despite the learning obtained from working with BME groups, while targeted services may be limited by restrictive immigration and asylum policies.

**Possible research questions:**

→ What are older refugees' specific access and care needs? What targeted provision exists currently? To what extent is special provision needed in addition to implementation of good practice developed with BME groups? What are the needs of informal caregivers?

### **3. Housing**

There is significant literature on refugee housing, with clear recognition of its critical role for refugee integration, e.g. the Refugee and Housing Network's *Summary of Findings and Recommendations* (2003) and *Refugee Housing and Neighbourhood Issues: A scoping review* by Quilgars et al (2004). Peckham's et al (2004) analysis of Home Office funded services for refugees indicated that the primary concern amongst refugees was

adequate housing provision. However, most references to older refugees and asylum seekers in the literature are limited to suggestions that attention be paid to their possible needs. For example, Zetter and Pearl's report (2005:53) on the role of Registered Social Landlords (RSLs) does not mention older refugees, although an appendix lists the recommendations of their 1999 report, including the need for RSLs "to be aware of the current and future housing requirements of elderly refugees. The need for additional support mechanisms must be recognised and resourced".

Another missed opportunity as far as older refugees and asylum seekers are concerned is the recent publication *Housing and Support Services for Asylum Seekers and Refugees: A good practice guide* (Perry 2005). Intended "to assist housing organisations across the UK to develop housing and support services" for refugees, and based on an identified failure of most housing associations to develop refugee housing strategies, the needs of older refugees are not specifically addressed.

Notable exceptions in relation to evidence of older refugees' housing needs include Coombes et al (1999: 11-16), who raised issues about the availability of family housing large enough for three generations, the balance between this and independent accommodation for older refugees, and the types of sheltered and residential accommodation which might be appropriate. Williams (2000) notes that older West Africans were often housed in inappropriate accommodation, particularly by NASS, but that local providers' awareness appeared to be improving. Nur (2000) stressed the needs of older Somali refugees for sheltered housing.

While accommodation of asylum seekers has been recognised as a long-standing problem, not much literature is available, and none considers the needs of older asylum seekers. Zetter and Pearl (1999) reported on examples of poor co-operation between housing associations and local authorities with regard to asylum seekers, noting the inconsistent practices between different areas and concerning refugees' inclusion in local race equality policies. Many problems have emerged with regard to the dispersal of asylum seekers to sites across the country with inadequate housing provision. Perry (2003) discussed the private rented sector and NASS, where there has been evidence of exploitation, poor conditions and ignorance of the needs of refugees. The study found that there was "organisational inefficiency, poor policy, and inadequate training and resources at the local level" (2003: 4) and problems in meeting accommodation needs satisfactorily. No information seems to be available on the specific impact of NASS accommodation arrangements on older asylum seekers.

There is substantial literature on minority ethnic people and housing, including some evidence on BME older people, e.g. a survey by Help the Aged (2004). The literature indicates that refugees and BME groups share many housing problems, including discrimination, segregation, overcrowding, and poor housing and maintenance conditions. Both groups were found to have problems in dealing with private landlords as well as housing associations, ranging from communication difficulties to racist intimidation (Perry 2003, Help the Aged 2004, Easterbrook 2002). Therefore, refugees and BME groups tend to rely on informal support or cultural organisations that are trusted, speak the language, and where no stigma is attached to services (Help the Aged 2004: 87). However, these often lack resources and specialist workers. In contrast, there appears to be a reluctance to use local authority services due to experiences of discrimination. A lack of understanding of cultural needs, and lack of capacity to address those, has been interpreted as emanating from institutional racism (Ratcliffe 1999, Help the Aged 2004: 27). Difficulties arising from this are likely to be compounded for older

refugees, as organisations appear ill-equipped to address either cultural or ageing needs. In its survey of housing advice organisations, Help the Aged (2004: 30) found that few had strategies for dealing with housing for older people, age was not monitored routinely, training on age issues received no dissemination and outreach was low. The study concluded that the provision of housing services to BME older people was impeded by a lack of institutional capacity to inform and represent older BME people, a mistrust of mainstream organisations and feelings of abandonment among BME older people, and limited interaction between the older people, mainstream advice providers, communities and faith based organisations (Help the Aged 2004:8).

Especially in dispersal areas, where housing is assigned by NASS, refugees' homes are often found in deprived locations which suffer from a lack of jobs and services and from high crime. This may affect refugee women in particular. A study of BME woman found that living in deprived areas further marginalizes and isolates them (Dale 2002).

Social isolation can be mitigated by family networks, although these can also increase isolation from the community, especially for women. Refugee and BME households tend to be larger, with people of different generations living in a single dwelling (Help the Aged 2004: 16). Older people's independence and mobility are affected by this, as they are often dependent on support and care provided by, or given to, family members, and as there are limited independent housing options for them (Help the Aged 2004: 21).

Poor housing conditions of BME and refugee groups are well evidenced in the literature (e.g. Zetter and Pearl 1999, Perry 2003, Dale 2002). Refugees and ethnic minorities are disproportionately represented in poor housing due to lower income and poverty. As the older population in general suffers from unsatisfactory housing conditions, older refugees are likely to be doubly disadvantaged (Help the Aged 2004: 16, English House Conditions Survey). Refugee and BME groups tend to live in unfit, poor and overcrowded conditions, in high density areas and multi-occupancy dwellings (Perry 2003, Acheson 1998, Help the Aged 2004, Zetter and Pearl 1999, Ratcliffe 1999).

There appears to be a link between poor housing conditions and health problems among minority ethnic people (Help the Aged 2004, Easterbrook 2002, Cowen, 2001, Acheson 1998). Housing related health issues include winter deaths due to hypothermia (cold and damp housing, fuel poverty), and mental well-being problems, for example with regard to outstanding substantial home repairs (Easterbrook 2002).

Poor housing stock exacerbates problems faced by BME older people in relation to maintenance and adaptation of their homes. Maintenance services were found to be unreliable and subject to long delays (Help the Aged 2004). Lack of adaptation for older people compounds mobility difficulties around the home and is related to health problems. Half of all the serious injuries experienced by older people who fall are hip fractures (Dowswell et.al. 1999, Help the Aged 2004: 23), which seriously impede their mobility. The provision of housing repairs for older BME people can be hindered by problems regarding language, outreach and co-ordination of services (Help the Aged 2004).

Where appropriate, measures to improve practical support could be linked to the government's intention of increasing the number of older care recipients who remain in their own homes. For example, the public service agreement target relating to older people's services was to increase the "number of those supported intensively to live at home to 30% of the total being supported by social services by March, 2006, at home or

in residential care" (HM Treasury 2004). If this target is to be met, however, it is essential that homes are in acceptable conditions for older people, adapted to their needs. This does not yet appear to be the case for many BME and refugee older people.

Thomson et. al (2001) and Popay (2001) described how improvement to housing conditions can enhance people's physical, mental and emotional health, as well as reduce demand on health services (cited in Easterbrook et al, 2001). For example, a study of Shepherds Bush Housing Association tenants found that new decorations were linked to a reduction in depression and psychological problems amongst tenants (Popay, 2001 cited in Easterbrook et al, 2001). Care & Repair is a Housing Improvement Agency that supports older people and BME groups to gain access to housing repairs, thus helping to promote independent living for older BME people.

Older people from minority ethnic groups are over-represented among the homeless population (Help the Aged 2004: 26). This is likely to include refugees. A London Housing Federation snapshot survey prepared for the Refugee Council in 2004 found that 20% of London's hostel beds were occupied by refugees (2004). 3% of these homeless refugees were over 46 years of age. 'Supporting People', a government programme relevant to older people which started in April 2003, requires local authority housing departments to work with health and other social services departments to prevent people from losing their homes. It addresses services for older people but makes no specific reference to refugees.

The literature is sparse on the housing needs of older BME or refugee women specifically. However, there is evidence of a higher prevalence of isolation among refugee women, and of housing in areas with higher crime rates, leading to women fearing for their safety, reducing their mobility and increasing their health problems (D'Onofrio & Munk 2004, Ager 2004, Refugee Council 2005).

### **Refugee housing practice**

Since the early 1980s, with growing awareness of an ageing black and minority ethnic population, provision to BME older people has been developed by local authority housing departments and social services' sheltered and residential care. Issues such as racial harassment, cultural and language isolation, integration or targeted provision, cultural sensitivity in relation to ageing and dying, were debated and a number of specialist organisations were formed at that time, for example to provide accommodation for older Asian men in East London, older Chinese people in Liverpool and older Asians in Leicester.

As early as 1987, Finlay and Reynolds' *Social Work and Refugees* drew attention to a number of special schemes for older refugees: a dwelling in Liverpool adapted to meet the needs of three older Somalis, with daily support; a housing project for Vietnamese refugees (including older people) in Greenwich; and a group of older Vietnamese people meeting once a week at the sheltered accommodation of an otherwise isolated Vietnamese woman. They pointed to the importance of imaginative solutions such as these if the needs of older refugees were to be met effectively.

For almost two decades the Housing Associations Charitable Trust (Hact) has been a major supporter of housing provision for refugees, funding and providing strategic development to specialist refugee housing groups and others. Hact's current work ([www.hact.org.uk](http://www.hact.org.uk)) includes an older people's programme, a supported living programme

and a refugee housing integration programme: all three are likely to be relevant to older refugees.

Given the development of other specialist refugee housing providers and provision of housing advice by RCOs (Quilgars et al, 2004), these targeted services remain to be explored more fully with regard to their relevance for older refugees and older refugee women.

**Possible research questions:**

→ What are the living conditions and needs specifically of older asylum seekers? To what extent do women feel dependent and/or isolated? To what extent are older refugees' housing needs addressed by provision for minority ethnic groups, including measures under the Race Relations Act? How do older refugees interact with housing associations and landlords?

**4. Education and Training**

While there appears to be no specific research on education provision and older refugees, literature on older refugees agrees on lack of English language as a barrier to information, services and, ultimately, integration. Ability to communicate in English enables older refugees to avoid dependence on younger family members and to be more self-confident in using public services, transport and public space. It reduces isolation as interaction with other people, such as neighbours, becomes easier.

Little information is available on other educational needs of older refugees. The Sierra Leone Women's Forum (SLWF, 2003) reported a need to develop older refugee women's computer literacy.

Literature on the education needs of refugee women mainly focuses on younger women with children. It is emphasised that refugee women have experienced unequal access to education on the basis of gender stereotyping in some countries of origin, which denies women access to education, especially further education, equipping them with little skills, and sometimes poor literacy, for their start in the UK (Ditscheid 2003). The Refugee Women's Association (2001) has aimed to address such disadvantages through offering ESOL classes, an employment mentoring programme and facilitating access to further education and education funding. The African Refugee Women's Access to Education and Training Project (2005), through the Africa Educational Trust, provides free educational and vocational training advice for unemployed African women refugees and asylum seekers.

There is anecdotal evidence that older refugees meet special barriers to accessing education. These range from general assumptions about older people difficulties in learning new languages and skills, to a lack of availability of classes if priority is given to people of 'working age'. Other barriers include domestic caring responsibilities, lack of literacy in their first language, speaking a first language which is found infrequently in the UK (whereas younger family members may speak a colonial language such as French or English), insufficient confidence to attend classes with younger learners and restrictions to mobility. ECRE's Good Practice guide on older refugees also refers to families' impatience when older people are slow to learn the new language (Knapp and Kremla, 2002:13).

According to the ECRE guide, these barriers can be addressed, for example, through designing courses especially to meet older refugees' needs, as in a one-to-one project in Sweden using computers (2002:22, 28, 29). To circumvent gender stereotyping and imposed restrictions on women's education, some initiatives in the 1980s offered classes such as dressmaking, which proved to be acceptable but also provided a springboard for networking, English language acquisition and other skills.

An array of education initiatives exists for older people more generally. For example, the New Deal for 50+ assists older people in obtaining both training and employment. It also provides training for employers designed to increase their readiness to hire older people. However, it is unclear whether older refugees have benefited from this or similar programmes, while asylum seekers have been explicitly excluded from any work-related training initiative (Yai et al 2005). NIACE offers programmes that support the particular learning needs of BME communities, and include also subgroups such as older people, refugees and women ([www.niace.org.uk](http://www.niace.org.uk)).

**Possible research questions:**

→ To what extent do older refugees initiate, access and participate in education and training? What should provision consist of to overcome barriers they face?

## **5. Employment, benefits and pensions**

### **Employment and unemployment**

There is a large body of research demonstrating refugees' barriers to finding full and suitable employment in line with their skills and experience. There is also evidence of the detrimental impact on integration of the policy to deny the right to work to asylum seekers. However, the literature on the employment situation of refugees does not usually consider older age as a separate factor. While employability is analysed for special groups within the refugee population, including the highly skilled, the young and women, older refugees are not included in statistics or analysis.

For example, the Refugee Council's report on employment (Yai et al 2005) did not contain findings on refugees over 45. The Skills Audit by ASSET UK (Waddington 2005) included 17 out of 592 people that were over 50 years (only five of whom were older women); however, none of the statistics were broken down by gender or age. In Dumper's (2002) skills audit of refugee women in London from the teaching, nursing and medical professions, 90% of the 222 respondents were aged 45 or younger, and only 2 women were 55+. The Refugee Council's (2003) report on work and pensions did not distinguish between age groups or gender. Bloch's (2002) study did not include an age breakdown of the 400 people interviewed.

While age is generally considered a barrier to accessing employment, there is a significant knowledge gap on whether and how this barrier might affect refugees in particular. Some anecdotal evidence exists, for example on refugee women's employment. According to Sargeant et al, "Age is seen to be a significant barrier to employment of women refugees. Jobs are seen to go to the younger people". Age was cited as a particular problem by a group from Sri Lanka, several of whom had been teachers prior to coming to the UK. One person in the group summed up their feelings on this topic: "A woman who is aged 45 to 50 years old is finished as a teacher – unemployable" (Sargeant et al 1999:22-23). Bradstock and Trotman (2003:50) quoted a

Colombian woman as saying "Being a woman over 50 here is a nightmare. I don't know why age here is so important".

With regard to older people more generally, important developments have taken place that address employment discrimination based on older age. New Age Discrimination Regulations will come into force in 2006, which prohibit discriminatory treatment of older job applicants and employees. This has been accompanied by encouraging later and flexible retirement provisions, raising awareness amongst employers, providing guidance and training for older workers, and employment incentive schemes (Taylor 2002). It would need to be ensured that older refugees have access to this guidance and benefit from new regulations as much as other older workers.

The Social Exclusion Unit reported in 2005 that older people remain underemployed. While the over 50s age group represents 30% of working age people, only 20% of those are in work and less than 10% in training (SEU 2005: 51). There are government schemes such as "Pathways to Work" and "New Deal 50+", but asylum seekers are not eligible for these programmes and refugees are not specifically targeted (Yai et al 2005).

There are no official refugee unemployment statistics. However, evidence suggests the rate is far above the national average, and above that of other disadvantaged groups in the UK (Refugee Council 2003). Bloch's (2002) study of 400 refugees found that only "29% of respondents were working at the time of the study compared with 60% ethnic minority population". The report puts unemployment among refugees at 36%. However, previous research suggested refugee unemployment rates between 60-90%, and higher unemployment rates among refugee women compared to refugee men (Dumper 2002, Refugee Council 1999, Shiferaw and Hagos 2002 cited in Refugee Council 2003). According to Bloch's study, refugees are "the most disadvantaged group" in the UK labour market. There was no specific mention of older refugees.

Refugees' barriers to employment have been examined for age ranges up to 45 years, and many of these barriers are likely to be similar, albeit more pronounced, for older refugees. Human capital barriers include a lack of appropriate skills including language, cultural differences and the "psychology of being a refugee" (Shiferaw and Hagos 2002: 14-15, in Refugee Council 2003). External barriers include legal status, non-recognition of overseas qualifications, lack of information and childcare facilities, discrimination and racism (op cit. 9, 15). Racial discrimination might also be a factor in labour market segmentation, as research has shown little correlation between training, skills and sector or level of employment. Bloch found that many refugees have high skills which were not recognised or were mismatched in relation to the labour market sector, with many refugees accepting "occupational down adjustment" (Bloch 2002: 178, 180-181). Length of residence and legal status were also found to be significant barriers to appropriate employment.

Refugee women were found to face even higher barriers to suitable employment than men (Refugee Council 2003). They tend to work in the informal economy and hold low skilled jobs, especially those who are older (Kofman 1999, Shiferaw and Hagos 2002: 25). Ditscheid (2003) argued that due to low literacy levels among refugee women, it could take at least seven years before refugee women are ready to enter the job market with up-to-date skills. Bloch (2002) found caring responsibilities to be a barrier to taking up employment, with 37% of those not in employment giving childcare as a reason. Dumper (2002) pointed to the problems of professional women in getting their skills in teaching, nursing and medical professions recognised.

**Possible research questions:**

- There is a lack of evidence regarding the situation of older refugees in labour market – what skills do they have, are they in employment, what barriers do they face?
- What kind of community or voluntary work do they do, or would want to do?
- What has been the social and psychological impact of moving from employment (in country of origin) to unemployment or lower skilled work, or to retirement?

*EXAMPLE OF PRACTICE***Opening mainstream support to refugees:  
Connexions For Over 45s**

CO45s was an outreach project run by Next Step London North and Age Concern Enfield between March 2002 and March 2005, designed to help older people into employment and co-financed by the Learning and Skills Council-London North and the European Social Fund.

**Target groups and services**

The project supported 348 clients from 47 nationalities, including 11% refugees and 84% people aged over 45. Clients facing multiple barriers included those with low skill levels, no qualifications, low literacy levels, English as a second language, as well as carers, disabled people and those recovering from mental health problems, and ex-offenders.

Co-ordinated by four guidance workers, each client received up to 18 hours one-on-one advice on getting back into work or education and increasing their employability. This included help with job search and applications, assessing skills, and understanding the labour market and education system. The project also included a mapping of local provision, and culminated in a report for Department for Education and Skills with policy recommendations.

**Achievements**

- 88 out of 122 clients found employment (including 15 in voluntary positions) or enrolled in education (34 in further and 6 in higher education).
- Clients reported increased self-esteem and confidence through encouragement received from guidance workers.
- The project was able to reach older people who might have otherwise found it difficult to take initiative when sidelined by employers or services providers.

**Challenges**

- This type of project could be extended to include more refugees while remaining a mainstream initiative. The focus on specific refugee needs, such as transfer of overseas qualifications, could be strengthened.
- While this type of project can build confidence, it may also raise expectations that cannot be met. In this case there were no supporting job schemes in the area, and no local co-ordination body that could have worked with local employers and helped identify and secure paid jobs.

### **Benefits, pensions and other financial support**

The Social Exclusion Unit (2005: 51) report suggested that age discrimination remains widespread in society. In general "older people are at a high risk for poverty... there are a range of sources of income for excluded older people, but accessing them can be complicated" (Social Exclusion Unit 2005: 45). Barriers to accessing benefits included means testing, lack of access to information and advice, stigma, low income adding to poor health, and lack of money (Social Exclusion Unit 2005: 49).

Financial arrangements, including pensions, benefits, savings, family and charitable support, constitute an under-researched area that is likely to be of great significance when assessing older refugees' support needs.

The SLWF needs assessment found that "financial uncertainty and independence are of concern" to older refugee women (2003:45) but noted that not all respondents were willing to disclose their financial arrangements. Coombes et al pointed out that difficulties might arise for older refugees when their financial position was assessed for community care services; their finances might be "entwined with those of other relatives" or they "may have complex obligations to support others in and outside the UK" (1999:14-15). The Refugee Women's Association (RWA 2004) pointed to the risk of families collecting and using older refugees' pensions.

### **Possible research questions:**

→ How do older refugees access financial support, including pensions? What are their needs? Are they aware of their rights? What financial responsibilities do they feel they have and do they feel able to manage those?

## **6. Information and communication**

Literature on older refugees' needs in relation to service provision, as reviewed in the sections above, points to significant information deficits due to missing or inappropriate communication by service providers and unmet interpretation and translation needs. Interpretation issues seem to be particularly pressing in relation to the health service, while contributing to the perceived tendency among older refugees to pursue access routes through RCOs rather than mainstream providers. Challenges include availability of interpreters, effectiveness of language matching, possibilities of gender matching, quality of interpreting (including difficulties caused by specialist health or other terminology, or lack of equivalent words or concepts), interpreting/advocacy boundaries, and problems of using family or friends as interpreters. While providers can draw on a long history of developing interpretation services, additional challenges are caused by the greater diversity of languages among recent refugees, with older refugees more likely to lack knowledge of colonial languages.

Apart from language barriers, service providers are often found to fail in their basic provision and dissemination of information about rights and services. This may have a negative impact on older refugees in particular. A study of disabled refugees and asylum seekers quoted a 72-year-old Somali woman as saying "I do not ask for any services. I would like to, but I don't know what to request or how to initiate a request. I do not know who the service-providing agencies are. I'm disabled and sitting at home" (Joseph Rowntree Foundation, 2002; Roberts and Harris, 2002:18). SLWF noted a "general lack of adequate information disseminated to elderly refugees around health, housing and welfare entitlements" (2003:8). As reported above, some groups of older refugees appeared to "still have little understanding of health services after years in the UK" (Wasp, 2004). SLWF found that "most respondents tended to rely on getting information

by word of mouth or informally which might sometimes prove to be unreliable" (2003: 30, 44); all respondents wished for more information and advice on safety issues.

ECRE argues that access "is to be understood in a wider sense than mere legal entitlement – people also have to know about their rights" (Knapp and Kremla, 2002: 24, 38). Many RCOs aim to raise awareness of rights; for example the Latin American Women's Rights Service "operates an advice and support service for older women, focusing on housing, welfare rights, personal finance and issues such as abuse and domestic violence" (Perry, 2005: 64).

Refugee women appear to be particularly affected by poor availability and dissemination of information, as they are less likely to speak the language of the receiving country, be literate or educated (Burnett and Peel 2001, Ditscheid 2003). One study found Somalis to be especially isolated, with many lacking language skills and displaying a low level of community participation (Bloch 2002). The International Somali Community Trust have set up a Somali Women's Encouraging Group for social activities, sewing classes and arts and crafts to help address the women's feeling of isolation (Ditscheid 2004).

#### **Possible research questions:**

→ What measures could increase levels of awareness of rights and services among older refugees?

## Social connections: communities and families

### **1. Community networks**

Family and community networks are a central aspect of older refugees' lives, but the scope and roles of these networks cannot be generalised. Gender as well as ethnic and national background and faith are key variables in the formation and maintenance of family and social bonds. Bloch (2002) found the role of family and social networks different in each community analysed. In Tamil communities, social bonds appeared to play a vital role, due to colonial ties and established social networks in the UK. In contrast, the Congolese community did not rely much on community networks as their presence in Britain does not have a long history. Somalis were found to have the lowest levels of community bonds. Bloch noted that community bonds played an important role in the decision of where to live within Britain.

According to UNHCR (2002), the needs of older refugees are "met most effectively within the context of family and the community", so "the capacity of families and community to meet their own needs and incorporate older people within them should be strengthened".

There is much discussion in the literature about the role of RCOs in developing community networks, especially with regard to addressing gaps in service provision and meeting the diverse needs of refugees. For example, Quilgars et al referred to the essential and valued role of RCOs, but pointed out limitations of training, resources and lack of collaboration within and between refugee communities (2004: 35-6). These and other issues were also extensively explored in Zetter's analysis of RCOs (2005). Service provision appears to remain a focus of most RCO activities, as opposed to civic and political participation and advocacy. Levels of capacity and provision vary considerably between London and the regions. Although older refugees' needs, and their level of participation in RCOs, are not explicitly mentioned in these discussions, the question of

reliance on RCOs, and on the voluntary sector more generally, is critical when assessing the infrastructure support needs of older refugees.

*EXAMPLE OF PRACTICE*

**Opening community based support to other groups:  
The Latin American Golden Years Day Centre**

The LAGYDC in Lambeth, South London, was founded 17 years ago to support Chilean refugees aged 55+. In 2005, the centre's founder, Amada Vergara, was awarded Best Community Worker prize by Latin Americans in London ("Excelencia Latina 2005").

**Target groups and services**

Initially set up for Chilean refugees, the centre now works mostly with economic migrants from Latin America. Its 120 users are members who participate in running the services, guided by 3 paid staff. Many members have been with the centre for more than 8 years. Over recent years the centre secured funding from Lambeth Social Services, the Primary Care Trust and the Big Lottery Fund.

The principal aim of the centre is to combat isolation among older Latin Americans, and to support those with mental health problems. The centre receives referrals from local GPs and hospitals, and also provides outreach work for people with mobility problems. Its activities focus on using arts and crafts as therapeutic tools, in addition to offering day trips to museums and gardens, plus English and IT classes.

**Achievements**

- The involvement of users (as members) in the day to day running of the centre has contributed to making older people feel valued and needed.
- The therapeutic focus on art activities has proved effective in two ways: it helps members increase their mental wellbeing and develops their skills in new areas.

**Challenges**

- While the predominant use of the Spanish language within the centre makes members feel welcome and comfortable, it also creates a barrier for the use of services by people from non-Spanish speaking communities.
- The centre has extended its target group from refugees to migrants, while maintaining a particular national and cultural focus.
- In the face of growing demand for its services, a planned restructuring of the organisation (including seeking new funding sources, more staff and accessible premises), which is to be based on a consultation exercise, will consider the expansion of services to other communities.

## **2. Family networks**

Family networks form a central aspect of, and important resource for, many older refugees' lives. ECRE suggests that service providers work with families and encourage them to allow older family members to take on responsibilities (Knapp and Kremla 2002: 13). However, the role of family networks has increasingly been challenged in literature

on refugee communities, on grounds ranging from changing family structures over time to intergenerational conflicts and the oppressive role of family bonds for women. With regards to BME communities, many authors have argued that the role of family networks is often overstated and over-dependant on in place of much needed statutory services (especially in health care amongst BME groups, Wilson 2001, Coombe 1981, Cameron et al 1989, Baxter 1989, Atkin et al 1989). The emphasis and reliance on family support can also have a detrimental impact on those individuals that do not receive it, causing depression as their expectations are thwarted (Coombe 1981, Cameron et al 1989).

Osman (1999: 16) pointed out that in Turkish and Cypriot communities the extended family was in a process of dissolution, with more older people now living alone. This proved a social challenge, as older refugees may speak little English, be in poor health, feel isolated and insecure. Moreover, due to clearly differentiated gender roles, older widowed men may be unable or unwilling to perform basic household tasks. Osman suggested a focus on recruiting more Turkish-speaking home care workers. An increased use of care volunteers has been explored as another option. McCarthy's (1995) research in Sheffield among Vietnamese, Somali and Yemeni communities looked into developing volunteer support for older people, but interest appeared low as all three cultures stressed that support was expected from the family or the community.

Intergenerational conflicts, especially concerning gender relations, have been researched with regard to both white and minority ethnic communities, although many case studies did not take place in the UK (e.g. Zaidi and Shuraydi 2002, Darvishpour 1999). Tensions are often reported to be caused by differences of 'norms' and expectations between younger and older family members. This tends to be explained in terms of 'clashing cultural norms' between the 'norms' of the country of origin and the 'norms' of British society. In Dale's (2002) study of Pakistani and Bangladeshi women, generations had different attitudes towards employment, as the younger women sought more "independence and wanted to balance family with work". A similar tension was found in a Canadian study, where different perceptions of marriage caused conflicts between generations (Zaidi and Shuraydi 2002).

With regard to older refugee women, it is important to note that family networks can be a site of oppression, serving to restrict women's independence and mobility (Okin, 1999). While family networks can support the process of settling or feeling settled in a new country, they can also obstruct women's awareness of and access to information, services and rights, especially if gender roles are perceived as different from those in the country of origin. Tensions between different models of gender relations have been identified as a particular source of family conflicts in a Swedish study with Iranian immigrants (Darvishpour 1999).

Gender role expectations as well as intergenerational tensions can in some cases lead to the abuse and exploitation of older family members (Coombes et al 1999:10-11). Discussing 'Elder Abuse' Saunders (RWA, 2004) noted that the changing power dynamics in families could give rise to abuse, yet reporting of this was likely to be inhibited by older refugees' "lack of knowledge of the local way of life" or "lack of time or opportunity to develop social networks with their community". Williams (2000) argued that as older West African refugees lacked English skills they had to rely on younger people, leading to a loss of respect. She recommended addressing older people's isolation and anxieties around status change by making better use of their skills and time. Elmaz (2000) noted that most older Turkish asylum seekers came as dependants with their family and were required to rely on younger family members to access support. This meant that the

needs of younger family members were addressed first. Griffiths (2002:123-4) drew attention to the intersection of changing gender and generational roles: "an implicit association is made between an erosion in the position of the elders and the decline of male authority in the home – i.e. a 're-working of identities'".

**Possible research questions:**

- How do older refugees access and use RCOs? Are their expectations met? Are they involved in setting up and running RCOs? Do they engage with organisations for purposes other than service provision? Do older refugee women have different access and participation routes than men? What is the role of faith-based networks?
- What contacts do older refugees have with British-born people (the receiving community, e.g. neighbours, colleagues, friends)?
- To what extent are older refugees embedded in family networks? What kind of support to these provide? What impact does this have on their independence? How do individuals experience and negotiate their role in the family?

## Addressing gaps in knowledge and evidence

This review identified significant gaps in knowledge and evidence relating to the perceptions, needs and experiences of older refugees. These are partly due to a lack of data on refugees' diverse backgrounds and profiles. Not only are there few statistics kept on the overall refugee and asylum seeker population, as migration status is not usually a monitoring category, but these statistics often fail to disaggregate information based on refugees' age, gender, ethnicity, nationality etc. Special qualitative studies can help to fill some of these gaps, especially in a context of insufficient qualitative and quantitative data, as is the case for older refugees.

When conducting qualitative research with older refugees, and particularly groups that may be more vulnerable, it is important to draw on good practice of conducting research with refugees and older people, and to learn from the experience of other researchers. For example, research by the Sierra Leone Women's Forum resulted in four methodological lessons (SLWF: 22):

- Studies with newly arrived older refugees take a long time to set up and need a lot of trust building.
- Cultural differences between groups, even within the same nationality, may impact on the willingness or ability of some to participate, and this may depend on gender and family structure.
- When research is undertaken there is a great need for follow up in terms of the implementation of the findings.
- Researchers must identify ways in which research can benefit communities.

These last two points gain particular importance in light of a study of 'Black and minority ethnic older people's views on research findings' (JRF, 2004): "They did not want yet more research for its own sake. They wanted action that would bring about change and to be involved in decisions that affected their own lives – locally and nationally".

To improve local service provision, small-scale studies can sometimes provide useful information. Messele (2001), for example, obtained useful insights into the role played by

an East London refugee health clinic in meeting needs of older women, based on only one focus group with eight women meeting for half a day. ECRE's Good Practice guide pointed to the need to find out the views of older refugees by asking them directly, but suggested that this should not be in a single interview but through a series of conversations with each individual in order to build up trust (Knapp and Kremla, 2002: 12).

Such qualitative studies can also contribute to assessing options for improving service provision. More evidence is needed on the respective roles of mainstream or targeted, statutory or community sector service provision.

UNHCR (2002) proposes to focus on mainstream provision in its international work: "Although older refugees may have specific needs, UNHCR has found that they can best be assisted within overall protection and assistance programmes rather than through the establishment of separate services". A question for research and development is whether this conclusion applies to working with older refugees in the UK. An older study that discussed day centres (Finlay and Reynolds 1987:168) reported that older refugees "do not wish to be separated out from their community as 'elderly'", and "may prefer to combine in activities with young people and others". However, after over twenty years of refugee support services, the specific needs of older refugees still appear to be largely unmet, and most good practice relates to targeted services.

The type of provider most suited to meet older refugees' needs may vary. Research could examine under which circumstances RCOs, Age Concerns or statutory agencies are best placed to provide services to older refugees.

Any provision must ensure flexibility and pay attention to diversity. Coombes et al (1999:15) noted that "refugees' needs change over time, and new waves of refugees produce new service needs". Moreover, most instances of unmet needs appear to be caused by service providers' assumption that refugees constitute a uniform group with similar needs, leading to the invisibility of the needs of older refugees and older women refugees. Qualitative research could help to identify how services can be responsive to changing and diverse needs in a cost-effective way.

## Proposals for empirical research areas and questions

- **Definitions and demographics**

→ What are older refugees' perceptions of ageing? What are the specific issues faced by newly arrived older asylum seekers? What issues do older men and women face in the asylum process? What are older refugee women's perspectives and needs (especially recent arrivals)?

- **Legal security**

→ How do new immigration and asylum policies impact on older asylum seekers?

- **Health and social care**

→ What are older refugees' specific access and care needs? What targeted provision exists currently? To what extent is special provision needed in addition to implementation of good practice developed with BME groups? What are the needs of informal caregivers?

- **Housing**

→ What are the living conditions and needs specifically of older asylum seekers? To what extent do women feel dependent and/or isolated? To what extent are older refugees' housing needs addressed by provision for minority ethnic groups, including measures under the Race Relations Act? How do older refugees interact with housing associations and landlords?

- **Education**

→ To what extent do older refugees initiate, access and participate in education and training? What should provision consist of to overcome barriers they face?

- **Employment**

→ There is a lack of evidence regarding the situation of older refugees in labour market – what skills do they have, are they in employment, what barriers do they face?

→ What kind of community or voluntary work do they do, or would want to do?

→ What has been the social and psychological impact of moving from employment (in country of origin) to unemployment or lower skilled work, or to retirement?

- **Financial support**

→ How do older refugees access financial support and pensions? What are their needs? Are they aware of their rights? What financial responsibilities do they feel they have and do they feel able to manage those?

- **Information**

→ What measures could increase the awareness of rights and services among older refugees?

- **Community and family networks**

→ How do older refugees access and use RCOs? Are their expectations met? Are they involved in setting up and running RCOs? Do they engage with organisations for purposes other than service provision? Do older refugee women have different access and participation routes than men? What is the role of faith-based networks?

→ What contacts do older refugees have with British-born people (the receiving community, e.g. neighbours, colleagues, friends)?

→ To what extent are older refugees embedded in family networks? What kind of support do these provide? What impact does this have on their independence? How do individuals experience and negotiate their role in the family?

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