DutchCare Ltd

SENATE COMMUNITY AFFAIRS REFERENCES COMMITTEE INQUIRY INTO AGED CARE

SUBMISSION FROM FRONDITHA CARE INC AND DUTCHCARE LTD JANUARY 2005

1. Introduction:

This submission is from Fronditha Care Inc. and DutchCare Ltd. Fronditha Care Inc. and DutchCare Ltd are charitable, community organisations, providing a range of community based and residential care services to elders of Greek speaking (Fronditha) and Dutch speaking (DutchCare) background.

This submission will not repeat the analysis and recommendations of the plethora of issues relating to the funding, administration workforce and standard monitoring of the aged care service system. These have been adequately addressed by a number of submissions received by the Senate Enquiry. Rather the submission will address the specific issues confronting Culturally and Linguistically Diverse (CALD) elderly and the critical importance of language and cultural identity in determining effective service delivery and ability to exercise fundamental rights.

2. Importance of Cultural Identity and Language:

Cultural identity and language can ultimately determine:

- The quality of life in residential care;
- The extent to which community based services effectively meet needs;
- Access to services; and
- The right to choose, be informed of options and participate in care planning.

Cultural identity is important, because it allows and provides for:

- A sense of belonging, affinity and connectedness to others;
- Affirmation of who one is; and
- Meaning to social existence.

Cultural identity has an important part to play in the well being of all persons, particularly in the life of elders. As people become older there is a corresponding growth in the need to reflect and share with others their life experiences, celebrations, rites, language, music, history and all those thing which gave meaning and continue to give meaning to life. Cultural Identity in this sense is what binds people together, the social glue which connects us to each other.

Language is even more important because common language is the only means through which an elderly person (or any one for that matter) may exercise a basic human right and meet a basic human need to engage and be engaged by the rest of the world.

Understanding and communication between the care or service provider and the care or service recipient is the precondition to:

- Assessing needs;
- Collaboratively developing intervention strategies to meet needs;
- Obtaining and giving feedback; and
- Allowing the service recipient to exercise the fundamental right to be informed and the right to choose.

For a large percentage of CALD elders who struggle with cultural isolation and the English language these basic elements are missing from the way they may experience services delivered to meet their needs. The most poignant example of this is residential aged care service which for all intent and purposes provides the total and all encompassing social environment for an elderly person 24 hours a day 365 days a year. The ability to relate to carers, other residents, volunteers, family members, visitors, and to reminisce with others, participate in group activities, enjoy food and music, is absent if the elderly person does not share the language and cultural identify of the dominant group. CALD elderly persons in a mainstream nursing home are in social solitary confinement, existing in isolation which manifests in depression and withdrawal.

3. Victoria – The most culturally diverse state:

According to the Australian Institute of Health & Welfare[1], Victoria has the most diverse older population in terms of cultural and linguistic backgrounds of any Australian state:

- In 1996 older CALD persons (65 + year olds) constituted 23.1% of the state population of elders. By 2001 this figure increased by 71% reaching 31.8% of the total population of elders. It is clear that those who migrated to Victoria during the 1950's and 1960's are now entering the older age group.
- Within the broad CALD population the demographics for particular ethnic groups demonstrate large growth in numbers. The growth of elders in the Greek and Dutch communities are presented in the following table.

70 PLUS YEAR OLDS

	1996	2001	2006	2011	2016	2021	2026
Greek	5,557	10,044	16,874	24,172	29,296	30,879	28,931
% Increase over 1996 census		81%	204%	335%	427%	456%	421%
Dutch	4,754	6,132	7,039	7,780	9,009	10,538	10,360
% Increase over 1996 census		29%	48%	64%	90%	122%	118%

Based o Table 7.2: Persons aged 70 and over from culturally and linguistically diverse backgrounds, Commonwealth Planning Region by country of birth, Victoria, 1996 to 2026, Braun, AIHW.

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Australian Institute of Health and Welfare (2001) *Projections of older immigrants. People from culturally and linguistically diverse backgrounds, 1996-2026, Australia.* Australian Institute of Health and Welfare

The above demonstrated very clearly that the waive of migrants of the late 40's, 50's and 60's are growing older at a much faster rate than the general community.

Persons who were born in Greece and the Netherlands are projected to remain relatively large groups among older immigrants from Culturally and Linguistically Diverse Backgrounds. Greek speaking elders were ranked the second largest group and Dutch speaking elders were ranked the fifth largest group in 1996. Their relative ranking will continue well into the 2020's.

The census of 2004 shows that in relation to Greek speaking elders over the age of 70, more than 70% were not able to speak English well or not well. Although the figure for Dutch speakers is lower it is important to note that self-assessment of English competency at a younger age does not provide a reliable projection for the same cohorts, in later life.

Both research and the experience of DutchCare and Fronditha Care clearly shows that language reversion in later life is very common particularly in the 75 plus age group.

4. Response to terms of reference:

The adequacy of current proposals including those in the 2004 budget in overcoming aged care workforce shortage and training.

Fronditha Care Inc and DutchCare Ltd endorse the Aged & Community Services Australia and the Ethnic Communities Council of Victoria submissions in relation to aged care workforce shortages and training. However, we would also like to add the following comments:

Shortage of bilingual staff

Both organisations are experiencing difficulties in recruiting bilingual staff. The first generation migrants who constitute the major source of workforce supply are becoming older and are progressively moving out of the workforce.

Cross Cultural Training.

The problem of cultural gap between carers and service recipients needs to be addressed with continued emphasis on cross cultural training. However, "short" "sharp" courses in cross cultural training are inadequate because such an approach reduces cultural identity to simplistic rules of "do's" and "don'ts". Cultures are within themselves complex and diverse. Concurrently cross cultural training should incorporate greater emphasis on attitude, beliefs and notions of "normality" that carers bring to the caring task.

To address the problem of language and cultural sensitivity it is recommended that:

a) Gerontic Nursing courses provide specialised training in working with elders from CALD background with particular emphasis on the positive aspects of such work;
b) Cross cultural training be incorporated in all curriculums for carer training;
c) Cross cultural training places greater emphasis on the carers' attitude and the need for an "open mind"; and
d) Appropriate incentives are made available to service organisation to provide language classes for staff and in particular to enhance community language skills of second and third generation immigrants.

<u>The performance and effectiveness of the Aged Care Standards and Accreditation Agency in:</u>

- ***i)*** ***<u>assessing and monitoring care, health and safety,</u>***
- ***ii)*** ***<u>identifying best practice and providing information, education and training to aged care facilities, and</u>***
- ***iii)*** ***<u>implementing and monitoring accreditation in a manner which reduces the administrative and paperwork demands on staff.</u>***

- The current regulatory framework relating to the Accreditation process, is deafening in its silence on the importance of language and cultural identity, to service delivery and the experience of CALD elders. Only 1 out of 44 accreditation outcomes makes reference to cultural identity whilst there is no mention of performance benchmarks at all in relation to language and the importance of communication.
- The fundamental problem with the accreditation standards is the manner in which the concept of culture is applied within standard outcomes. Standard outcome 3.8 refers to "individual interests, custom beliefs and culture are valued and fostered" and forms part of standard 3 relating to residents lifestyle.

  The overall structure of the standard outcomes are based on a wide range of residents needs: food, medication, personal support to be related with dignity, need for hygiene, activities etc. "Spiritual" and "cultural needs" are separated from and treated differently to all other needs. This approach is fundamentally flawed. "Cultural needs" cannot be separated from all the other outcome standards. It is not possible to separate beliefs, values, perceptions, (all the cultural influences) from leisure and activities, from privacy and dignity from notions of independence from emotional support from palliative care and all the other outcome standards. Yet this is exactly how the standards are structured.

- On the other hand the ability to communicate with the resident in a language they understand, does not receive any mention or attention at all. Yet the standards assert the residents' right to be involved in their assessment, in developing care plans and in exercising their right to choose between options. Further the Accreditation Agency often does not use interpreters when assessing facilities and hence cannot obtain adequate feedback from residents on whether their needs are met.

We recommend that:

a) The outcome standards are reviewed and that specific outcomes are introduced relating to language and communication needs of CALD elders.
b) A 10th outcome standard is included in the overarching standard 1 relating to management systems. Such an outcome should relate to cultural sensitivity across all relevant outcomes in standard 2, 3 and 4.
c) A clearly designated position to represent and advocate on behalf of CALD elders be created on the Board of Directors of the Accreditation Agency.

<u>The appropriateness of young people with disabilities being accommodated in residential aged care facilities and the extent to which residents with special needs, such as dementia, mental illness or specific conditions are met under current funding arrangements.</u>

The Aged Care Act 1997 clearly identifies CALD elders as a special needs category (section 11.3).

Younger People with Disabilities:

There is a growing body of anecdotal evidence that second generation younger persons with intellectual disability can be as culturally and linguistically isolated as their older first generation parents. The limited capacity of this group to integrate and adapt to the broader community, coupled with the fact that their care and support has been the total responsibility of their parents, has meant that they also have fully adopted the language and cultural identity of their parents. Both DutchCare and Fronditha Care have been approached by older parents who are concerned about care of their intellectually disabled offspring following their death. Their concern is always expressed in terms of the linguistic and cultural isolation of their offspring. In these circumstances an ethno specific residential care service may be optimum care for "younger" intellectually disabled second generation CALD persons.

Service Models

The current funding arrangements of the residential Aged Care system supports 4 models of service delivery to elders of CALD background:

- Ethno specific – providing residential care to a particular CALD community, with a significant percentage of staff sharing the residents' cultural and linguistic background;
- Cluster – providing residential care to a small number of CALD communities within one facility with staffing arrangements reflect the particular linguistic and cultural background of residents;
- Multicultural model –providing care to a large number of CALD communities with diverse language and cultural identity. Staff also may have a wide range of languages, but the staff languages do not reflect the language of residents; and
- Generalist – This model provides general residential care without specific targeting of particular cultural and linguistic groups. In these facilities English is the common language. Bilingual staff are coincidental rather than the result of targeted recruitment.

Allocation of government funding to service providers is built on broad considerations and the relative competitive merit of proposals. (Section 14.2 of Aged Care Act). Although mention is made of the provision of care for care recipients who are people with special needs, there is:

a) No public details or benchmarks against which the relative capacity of the service provider to care for CALD elders is assessed;
b) No acknowledgement of the relative merits of the different service models mentioned above, and the inherent capacity of the ethno specific model to provide care to elders who struggle with English or do not have or have lost their English language skills; and
c) No monitoring of service development after allocation of resources. In many instances service providers who have been allocated beds for "CALD elders" will in fact provide a generalist service.

As a consequence there is a very large and widening gap between the demand for cultural specific services (as evidenced by the large number of CALD elders on waiting lists) and the service system capacity to respond.

Waiting Lists as at 30th December 2004.

Agency	**Residential Care**	**Community Care**
DutchCare	140	593
Fronditha Care	242	83[2] *

Many CALD elders who do not have language skill are placed in generic nursing homes where they exist in social isolation.

An additional factor which continues to inhibit cultural specific service responses to CALD communities is the view that ethno specific service models can only be provided or should only be provided by ethno specific organisations. Because of this perception many mainstream community organisations which have the skills and expertise to provide residential care self select out of providing cultural specific service to CALD communities. The role of large experienced community agencies can be particularly important for emerging CALD communities which do not have the financial resources to cover the large capital expenditure involved in aged residential care.

Such a role for mainstream organisations should be undertaken through partnership arrangements, which incorporate the relative strengths of ethno specific organisations. These strengths include:

- Strong, established links within their communities;
- A broader approach to service provision including community education; and
- Stronger position to marshal CALD community resources (volunteers, fundraising, CALD media).

Dementia Care and CALD Elders.

This submission argues that cultural specific care is critical to the well being of CALD elders in residential care. The argument takes on a paramount scale in instances of CALD elders who have dementia because of:

- Language and cultural differences can and do amplify challenging behaviours;
- The inability to be understood actively and directly contributes to a range of responses by the CALD elder from challenging behaviours through to severe withdrawal and isolation;
- Studies have demonstrated that CALD elders with dementia in generic residential facilities are over medicated with sedatives. The same studies show that elders in ethno specific services have minimum medication;
- Lack of language and cultural sensitivity lead to misdiagnosis and assessments with instances of CALD elders being placed in psycho geriatric facilities when, in fact, their condition does not warrant such extreme measures; and
- The onset and progress of dementia is associated with the progressive loss of English skills and the regression to first language and early socialisation experiences.

In this context the cultural specific service model is the most appropriate service response to CALD elders who have dementia. It is recognised however that for a number of reasons this

[2] This figure is lower for Fronditha Care Inc because it does not provide the range of community services offered by DutchCare

may not always be possible and that generic facilities are the only available options. Even in these circumstances the critical role of language remains and so does the need to provide appropriate funding to service providers to meet the additional demands generated by the needs of CALD elders.

We recommend that:

a) As a matter of policy the Department of Ageing provide clear preference to ethno specific and cluster models of care for CALD elders;
b) That mainstream organisations are actively encouraged to enter into partnerships with ethno specific organisations to provide cultural specific services to CALD communities particularly new and emerging CALD communities;
c) As a matter of policy, the Department of Ageing acknowledge the broader inherent benefits resulting from resourcing ethno specific organisations; and
d) The Department of Ageing closely monitor all service providers who have been allocated special needs beds, to ensure that they continue to target elders from CALD communities and provide culturally appropriate and language services.

The adequacy of Home and Community Care programs in meeting the current and projected needs of the elderly.

HACC Program Objectives

The objective of the HACC program is to provide home based care to frail elderly as a means of avoiding premature admission to residential care. The strategies to achieve this objective takes the form of a range of services delivered to frail elders in their home. These services include meals on wheels, adult day care, home help etc.

In Victoria, HACC services are essentially delivered through local government and frail older people may only choose from the existing menu of services.

For frail elders of CALD background some of these services are culturally alien. For example, meals on wheels as a service may not be used not only because the food delivered is not consistent with the cuisine style to which an elderly has been accustomed all their lives, but also because the entire notion of food being delivered to one's home, is, in itself, culturally foreign. Further the cultural significance of food can be quite different. For example in the Greek cultural context eating is strongly linked to social events. In this context the strategy of delivering meals to frail elders is not perceived to be an appropriate strategy of keeping and maintaining elders in their own home.

However other types of assistance which could play a crucial role in supporting an elderly CALD person at home are excluded from the menu of services offered by the HACC services.

For example a case coordination service aimed at assisting elders to negotiate service systems would be more relevant in supporting CALD elders who are culturally isolated and struggle with the English language.

We recommend that some of the resources currently dedicated to the menu of HACC services be redirected to provide a more flexible response to frail CALD elders who are culturally isolated and struggle with the English language.

Underutilisation of HACC Services.

Underutilisation of HACC services by elders of CALD background has been extensively documented. The broad reasons for this are because the service system has failed to:

a) Provide a flexible service response to the needs of CALD elders (refer above);
b) Effectively inform the community of CALD elders and increase their awareness of service availability;
c) Provide a "user friendly" point of entry to the service system. At a minimum the point of enquiry and where necessary a referral should be conducted in the preferred language of the frail elder; and
d) Provide a "user friendly" service response incorporating culturally sensitive assessment, service planning and delivery. Social planners and program developers continue to ignore the importance of cultural identify and language for certain services. For example although by their very nature planned activities program rely on social interaction for their effectiveness, planners continue to bring together elders of CALD backgrounds, ignoring the absence of a common language and cultural identity, the fundamental preconditions to any meaningful sustained social activities and interaction. On the other hand in services such as home maintenance the question of language or cultural identify are not crucial (cutting the lawn or cleaning the spouting). Yet the National Standards, and the service system fails to clearly differentiate between the two services and the critical role of culture and language that is inherent in one but not the other.

We recommend that:

a) The HACC National Service Standards develop explicit performance stands and benchmarks for culturally sensitive and culturally appropriate responses to increasing CALD elders awareness of HACC services and providing a "user friendly" service response;
b) All HACC services develop strategies for providing a "user friendly" point of entry to the service system;
c) The task of assessment of need and eligibility for HACC services, wherever possible be undertaken through a cultural specific service model; and
d) All services within the HACC program be assessed to determine which are the most effective service delivery models for each service.

The effectiveness of current arrangements for the transition of the elderly from acute hospital settings to aged care settings or back to the community.

The current arrangements for the transition of the elderly from acute hospital settings to aged care settings or back to the community are ineffective and require further improvement. The Victorian Government (page 12) and the Aged & Community Services Australia submission have outlined the key issues for older people. Some of these issues include:

- Long hospital stays for older people due to the lack of available high care beds;
- Older people leaving hospital prematurely; and
- Poor discharge planning.

For older people from CALD backgrounds these issues are further exacerbated due to cultural and language barriers. When older people from CALD backgrounds are admitted to acute care, from residential care or those older people in acute care, awaiting residential care

placement, the experience is daunting. For example, older people and family member's face pressure of early discharge and need to make quick decisions about placements to residential care, yet, ethno specific residential facilities have large waiting lists. Current access to government funding is restricted. There is a need for the establishment of appropriate and sufficient interim care arrangements for older people of CALD backgrounds to allow investigation of longer term care options.

Conclusion:
Fronditha and DutchCare argue that the large and very rapidly increasing older population from CALD backgrounds have special needs. It is unfortunate that recent policy initiatives[3] give scant and cursory attention to these needs. What is needed is a strong commitment by all levels of government to ensure there is a genuine response to cultural sensitivity and language issues. The task will require a whole policy approach with clear analysis of need, setting objectives implementation and monitoring. Improvements in service delivery in many instances does not require additional sources. Benefits for CALD elders can be achieved by a commitment to change policy and the way in which current resources are deployed.

[3] This figure is lower for Fronditha Care Inc because it does not provide the range of community services offered by DutchCare