AUSTRALIAN ASSOCIATION OF

GERONTOLOGY

NSW Notes

AUTUMN **SEPTEMBER 2003**

Ageing in a Multicultural Society:

moving forward together

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AAG (NSW) held a very successful seminar at the Educational Centre Liverpool Hospital on August 29 2003. The topic was Ageing in a Multicultural Society, moving forward together. 230 delegates attended and this was a very positive indication of the interest in this topic. The opening keynote speakers discussed cultural competence in ageing and aged care and ageing and aged care agendas, policy, research and practice. The following sessions gave services the opportunity to showcase models of care, which illustrated a range of approaches to providing quality care, which meets the needs of ageing Australians in a multicultural society. The afternoon keynote speaker discussed ageing in a multicultural society from a consumer perspective. The seminar concluded with discussion and questions from the delegates to the three keynote speakers.

COMMITTEE MEMBERS

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Summaries of the speakers' papers begin on page 2 with the keynote speakers.

Professor Clare Ungerson RM Gibson Travelling Fellow

Our final event for 2003 will be hosting the Gibson Travelling Fellow Clare Ungerson. Prof Ungerson studied Politics, Philosophy and Economics at Oxford and Social Administration at the London School of Economics and is Professor of Social Policy Southampton University, United Kingdom.

Professor Ungerson will be in Sydney from Monday November 17 to Wednesday 20 November. The NSW Division has organised an afternoon seminar in conjunction with Aged and Community Services NSW & ACT. This will be held at the Carlton Hotel, Parramatta where Professor Ungerson will be speaking on *"Funding Care Users to employ their own care labour: A cross National European perspective."*

Use the form on page 11 to register This is a great opportunity to hear an international speaker talking on ageing issues.

On Wednesday and Thursday 19 and 20 November, the Hunter Chapter will be hosting Prof Ungerson.

Plans for the rural conference for 2004 in conjunction with the Hunter Chapter and Hunter Ageing Research are underway. The closing date for the call for papers has been extended to 1 November 2003.

NEWS FLASH!

AAG Hunter Valley Conference closing date for papers extended to 1 November 2003.

Called '*Beyond the Boundaries*' this conference is being held 11-12 March 2004 at the Kurri Kurri Tafe and aims to explore the emerging issues and identify the ways to overcome the various boundaries, which impact on the support for our ageing population.

The conference is expected to attract up to 200 delegates and will feature substantial current information on the study of ageing in the relaxed environment offered by the Hunter Valley location.

See page 10 for information about submitting a paper and registering your interest in attending the conference.

AAG (NSW) thanks the South West Sydney Commonwealth Carer Respite Centre and the Transcultural Mental Health Centre for their generous sponsorship support of this seminar.

Key note speakers

Towards Cultural Competence in Aged and Community Care

Prof Maurice Eisenbruch, Director, Centre for Culture and Health, UNSW
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The time has come to ensure that all health and human services in Australia are culturally competent. 'Cultural Competence is a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals that enables effective communication in cross-cultural situations' (Cross et al., 1989).

- All health professionals in Australia need to be culturally competent in aged care.
- This training needs to be lifelong – with continuity from undergraduate education, postgraduate and specialist training, and continuing education The Centre is developing such training at the University of New South Wales.
- The emphasis should be on the ' diversity dividend', which implies that cultural competence helps aged and community care of all people living in Australia, not just those from ethnic or language minority groups.
- The workforce population is itself culturally diverse, an asset to be drawn upon in education.
- Promotion and education on cultural competence occurs at four levels: individual, professional, organisation, and systemic (whole of Government, NGO sector and diverse communities).

The aged and community care sector, to ensure competency when dealing with CALD clients or staff, needs a framework that encompasses (a) professionals and (b) other workers who, though not necessarily be tertiary educated, are a key to delivery of services.

The Department of Health and Ageing has issued HACC National standards, and also Residential Care Standards. Such standards tend to address diversity using labels such as 'culturally appropriate' but these are not defined or operationalised, and seldom audited, but who defines 'culturally appropriate' aged and community care.

The onus, in the case of HACC, is on external consultants, and in the case of residential care, upon Aged Care Standards Accreditation quality assessors. These organisations must act as monitors but, in the case of diversity, without necessarily knowing what they are monitoring. The Commonwealth and State government policy-makers are not involving culturally diverse consumers in standards development. Crossing the bridge is essential, by which the system, through an informed and culturally competent consumer focus (not merely token community consultations and needs analysis surveys and basic data analysis) can ensure that it meets client needs. Support is needed through education and research and evaluation from the university sector.

Looking over the horizon, there are two pathways. In one, the government would fund culturally diverse communities to define and deal with their own concerns and to let the people decide what they want for themselves. For this to work, a mutual and culturally competent understanding between policy makers and these communities would be essential. In the second, the mainstream aged and community care sector would become transformed and more culturally competent and, in this way, better able to meet the needs of the community. These approaches, rather than being seen as independent or mutually exclusive, should be carried out to reinforce one another..

There appears to be a growing body of international research on ageing and cultural diversity, with the identification of centres of excellence, and such strategic developments are urgently needed in Australia. The Australian research needs to be more culturally competent – to overcome sampling errors that bias against the inclusion of aged care and disability groups that speak languages other than English. Much of the data are about easy-to-measure outputs such as 'access' while a outcome such as culturally competent service delivery is not measured. There are no tools, research frameworks, or a body of researchers trained in culturally competent methodology. The agenda should build on anthropologically-informed qualitatively sound work..

It is no wonder that policy development, in the absence of a culturally competent evidence base, occurs in a vacuum, possibly accounting for the disjunction between standards and delivery – a recipe for disaster in an ageing and culturally diverse Australia.

'Research' is often oriented towards generating knowledge for improving some discreet aspects of local service provision. As a result this is more 'needs assessment' rather than research which investigates how the whole program's conceptual framework or implementation policies are affecting the community. At the same time the development of guidelines is needed for smaller service delivery organisations (such as for nursing homes, respite care, HACC services and disability services) at the local level whilst a larger program of research and policy is going on. Both a short term and long term focus is vital. The NGO sector (such as ECC, Council of the Ageing, Aged and Community Care Services Association, NCOSS), because of their familiarity with the issues on the ground, is perfectly positioned to partner with the tertiary sector in this sort of research.

The review of the Ethnic Aged Care Framework (EACF) is under way and as a result any discussion on cultural issues is timely. Greater integration at the broad policy level between EACF and community care will be on the agenda of this review. This will be an important opportunity to raise issues that affect CALD aged. The connection with indigenous issues should be fostered as it has the great synergy with CALD issues.

The Australian Association of Gerontology conference is the right starting point to advance in agenda in promoting knowledge, research and education cultural competence in aged and community care, and particular reference to health and well-being. It is essential that the group emerges from the culturally diverse communities (not just token representatives) who will guide, shape, and keep it honest.

Agendas in ageing and aged care policy, research and practice

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What is the "big picture" of ageing? Where are we heading, and what are likely to be the major developments in ageing and aged care in the next ten to twenty years?

Ageing is on Australia's agenda as never before. The "Intergenerational Report" prepared by Treasury before the 2002 Budget pointed out the potential financial impact of the ageing of the baby boomer generation. Unfortunately, the report had a rather "doom and gloom" tone, but it did focus popular attention on what Australia needs to do to prepare for 2040, when the peak of the baby boomer generation is likely to need support and care.

Our plans and preparation need to be based on evidence of what works and what doesn't. This is why you will be hearing a lot more about research in ageing. As evidence based medicine is now taken for granted, we are moving into evidence based policy and evidence based service provision. Research provides evidence and builds knowledge. This is what the AAG is all about: expanding knowledge of ageing through the cycle of research – education - policy – practice. Practice generates new issues and new questions, starting the cycle again.

There are some major trends emerging in ageing and aged care:
- the average lifespan is likely to continue to increase and many older people will enjoy more years of active life (the "third age");
- more older people will stay in work, either by choice or through financial need, and there will be fewer younger people to be employed;
- community care will continue to grow, both because more older people would prefer to stay in their own homes, and residential care is becoming more costly to provide;
- the provision of housing and the provision of care will increasingly be seen as two separate issues, not a "package deal";
- dementia is likely to be with us for some time yet, although early diagnosis and more effective medication may slow the progress of symptoms;
- very old people (in their 80s, 90s and even over 100) are likely to develop neurological problems and frailty, even without Alzheimer's disease (the "fourth age");
- good social networks are being increasingly shown to have a positive impact on health and well being, so we will need to look at the context in which older people live and try to enrich that.

Those of us who are practitioners or service providers have many opportunities to interact with older people and their families. We cannot all be researchers, but we can all observe, think, and reflect on what works (what seems to help older people do better and be happier) and on what doesn't work (what seems to make things worse). "Reflective practitioners" who question, who think, who discuss issues, who try new things, are all part of generating the questions that need to be answered by research. In this way we play our part in the research-education-policy-practice cycle, and help to improve the experience of ageing for all..

The situation of people from a non-English speaking background

Dorothy Buckland-Fuller, Sociologst and Social Activist
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Ageing people of non-English speaking background, NESB, have the same basic needs and difficulties as their Anglo-Australian counterparts.

Apart from their everyday needs for food, shelter and company,
- they need acknowledgement (acceptance and respect);
- sufficient health and other social services to keep them in their own home for as long as possible;
- appropriate services to cater for any special needs or disabilities they have;
- Those with children and grandchildren also need to see them regularly and to spend time with them.

Ageing NESB people of have two major handicaps:
- the language problem and
- the '*us and them*' attitude (the fear of others who look different)

The foregoing, together with :
- the demise of the Multicultural Policy
- the continuing erosion of Community Services and the paucity of Government funding to NGOs
- the assumption that the older and longer established communities are able to take care of their Elders
- the continuing divisions in our society
- the greed of some and the apathy of many are causing much pain and trauma to our ageing population in general and to those of NESB in particular.

Our Elders, whether born in Australia, or overseas, grew up in a poorer and simpler world. Many of them, rightly or wrongly, believe that theirs was a better world; a kinder world, a world where integrity, family and friendships counted and politicians could be trusted. They are concerned about: the growing cost of living; growing unemployment; the long hours their children have to work out of fear of losing their jobs; divorces; youth attachment to a '*dolce vita'*; youth suicide; their own failing health; the shortage of hospital beds.

A great number of them, are concerned about the increasing racism in our society; the future of Medicare; doctors, resistance to bulk billing; our involvement with the United States of America and its effect on our society. It is therefore obvious that this rapidly changing society worries them, upsets them, frightens them.

- Is this the type of society into which they wish to grow old gracefully?
- Is this the type of society in which we wish to spend the rest of our lives?
- Is this the type of society we wish our children and grand children to inherit?

These and several other questions are posed in this paper. I do not profess to understand the cultures of so many ethnic groups. I am aware that one cannot generalise even when talking about one single ethnic group, let alone when talking about nearly 200. All I plan to do today is to pass on to you some of the insights and experiences I obtained during 35 years of active involvement with members of our society in all areas and at all levels of the social ladder. and to mention a couple of successful projects.

SESSION ONE:
Assessment and Referral issues

A Medical and ACAT Perspective

Dr Jeffrey Rowland, Director of Aged Care, Liverpool Health Service
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Caring for the aged in a multicultural society is affected by demographics. Already the population aged 65 and over from a non-English speaking background is greater than those from an English speaking background and it has still not reached peak demand.

Barriers to Access/Equity include:
Language Barrier
Myth of lack of perceived need
Knowledge of Services
Understanding of Service
Lack of knowledge re rights (interpreters)
Medication related problems
Different views on health
Resistance from staff
Isolation / Mobility difficulties
Socio-economic factors
Elderly communities

Further variable factors are:
Language is not equivalent to culture. ie Spain vs Argentina.
There is heterogeneity within cultures. ie North vs South Italy
Migration history also affects culture.
Education can limit communication. ie the degree of literacy vs the illiterate
Social support supplied by family, friends and community.

Individual beliefs have to be considered
Dietary preference,
Family values and customs,
Religion
Alternative Medicine
Nursing Home
Death & Dying
Illness
Dementia

Risks
The risks associated with aged care for people of non-English speaking background are greater for those most recently arrived, without close relatives and living alone. Rented accommodation, low income and limited formal education also add to risk. These people are more likely to visit a doctor and less likely to use preventative services or go to a hospital. Based on census data, they have a lower rate of referral to ACAT.

Standard ACAT assessment tools used need to incorporate:
Content equivalence, Semantic equivalence (Translated meaning), Technical equivalence (Method ie pencil/ paper), Criterion equivalence (Interpretation of measurement vs norm) and Conceptual equivalence (Same theoretical construction)

Responsibilities of ACATS are:
- Perform culturally appropriate assessments
- Collect accurate / relevant data
- Disseminate information in a relevant form
- Assess local needs/demographics for planning
- Involve Ethnic communities
- Enhance access to services/facilities
- Identify/address Health needs
- Collect and use resources
- Use experienced interpreters (language and culture)

A HACC Perspective

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In summary the article will address the issues of cultural bias in screening tools, the impact that clients using the HACC program without case management has on assessment and referral, purpose of assessment and the integration of cultural needs into the assessment process.

Each will be explored within the confines of the Home and Community Care program with a view to highlight the diversity within the program which offers clients benefits yet complicates the streamlining of assessment and referral.

One proposed amendment to the current assessment process is that service providers only have the information needed in order to effectively provide the particular type of service that they are funded for. The underlying philosophy is that the only justifiable purpose for the collection of information from a client is if that information is for the bettering of service design and delivery.

A Psychogeriatric Perspective

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In the 1996 Australian census, people named nearly 200 countries of birth with over 100 languages spoken 23% of the population were born overseas and 16% had a non English speaking background. Older people born in NESB countries constitute 18% of the Australian population aged 60 years and over. and 20% of this NESB population group live in NSW. This segment is growing at a much faster growth rate (79%) as compared to Australian-born older population (29%).

Barriers to Mental Health Service Utilization by Culturally & Linguistically Diversified Groups:
- Insufficient coordination between services.
- Language barriers to access.
- Lack of cultural awareness and sensitivity by service providers.
- Delay in diagnosis and detection.
- Use of indigenous healers.
- GP's lack of resources and skills.
- Lack of information.
- * Exposure to trauma in the past.

Strategic Direction for Mental Health Care in a Multicultural Society
- Provide information on mental health and mental health services to the people of CALD background in a culturally sensitive manner.
- Improve coordination of and access to mental health services by people of CALD background.
- Enhance skills of mental health professionals to provide timely and appropriate mental health services to people from culturally diverse background.
- Promote culturally appropriate assessments, diagnosis and treatment.
- Promote partnerships between mental health service and various stake holders.
- Provide a supportive role to primary carers.
- Ongoing research and evaluation of mental health needs for people of culturally diverse background.

Key Issues in Caring for Older People's Mental Health
- Better mental health care: Diagnosis & care; Caring strategies for diverse population; Caring in in-patient community and residential setting.
- Partnerships: Consumers, carers, GPs, aged care services, & NGOs.
- Promotion, prevention, early intervention: Strategies for depression, suicide prevention etc.
- Quality and effectiveness: Outcome measurement Assessment & Evaluation tools (MH-OAT)

Community Aged Care Psychiatric Services (WSAHS): Sources of Referrals Psychogeriatric Services Model (WSAHS)
- Referral, assessment and treatment in in-patient unit.
- Referral, assessment, reviews and treatment in out-patient Clinics.

• Day patient program in in-patient unit to promote early discharge and/or to provide continuity of care.
• Therapeutic groups in CHC and aged care facilities.
• Psychiatric reviews and case management in the Community and in aged care facilities.
• Ongoing consultation & liaison: - Aged care & primary health care services. - Mainstream services.

Outreach Care By Psychogeriatric Service (WSAHS):
• Early intervention to prevent hospitalisation: Acute & urgent assessment and treatment in least restricted environment (in community and aged care facilities).
• Ongoing culturally sensitive psychiatric assessment and reviews.
• Case management and networking with stake holders involved in the care.
• Provision of services under Mental Health Act and Guardianship Board.
• Ongoing liaison with primary carers, aged care services and other community services.

Multicultural Resources
• Availability of written and audio material on mental health issues.
• Culturally & linguistically appropriate assessment tools.
• Interpreter service.
• Transcultural Mental Health Service
• Multicultural support groups for carers and consumers.
• Use of depression and suicide prevention strategies targeting older people from NESB
• Multicultural Aged Care Service Packages for older adults.
• Ethno-specific Aged Care facilities

Recommendations
• Assessment must incorporate culturally sensitive issues and problem areas.
• Use of multicultural resources is critical for effective/quality/speedy assessment, diagnosis & treatment.
• The key is the appreciation and timely utilization of the above resources.
• Understanding their perception and knowledge about mental health issues such as causes, treatment patterns etc is crucial to effective service delivery

Research
• Focus group research covering 15 cultural groups to explore their perception, knowledge, and understanding about mental health issues was carried out by - by TMHC (1999 on the following:
• Mental Health Problems As Perceived by Older People,
• Older People's opinion about Cause of Mental Illness,
• Older people's Expressions about Mental Illness
• Treatment Seeking Pattern of Older People
• Opinion About Hiding
• Opinion About the Type of Information Needed
• Public Health Models of Mental Health Care for Elderly Population(Martin G Cole, Canada)
• Identification of a population at risk and implementation of a population based intervention.
• Screening of a population at risk, identification of individuals at risk, and implementation of risk factor abatement program for these individuals.
• Screening of a population at risk, identification of individuals with symptoms or disorders, and implementation of treatment program for these individuals.

SESSION TWO: Mental health issues

'Help me to understand'

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The main messages of this paper are twofold. Firstly, the need to further develop the understanding in the aged care and mental health system of the complexities and the diversity of experiences and cultural, linguistic, religious and social needs of our ageing population. Secondly, that government jurisdictions continue to imbed in their core business the principle of servicing the needs of this diverse population group as integral to all policy and program developments.

It is well known that the population of Australia is ageing and that it is projected to age significantly. Similarly, a number of our ethnic communities are experiencing rapid ageing. Twenty percent of the total 65+ yrs population in NSW is of non English speaking background (NESB) and fifteen percent of the NESB population in NSW is 65yrs and over.

There will be an increased proportion of the population living longer and being healthier. With increased longevity there is often an associated increase in complex mental health problems such as dementia or mental illness. As a result of this, there is an increased awareness in government that this population group represents an emerging area of need that will present with special mental health and aged care requirements. These changes will place extra demands on the acute health and aged care infrastructures and on families, carers and residential service providers. Policy and services need to be responsive to a range of diverse needs and the specific life experiences that have impacted on the ageing process for people of culturally and linguistically diverse backgrounds (CALD).

The paper has been written on the basic understanding that our multicultural ageing population is heterogenous in its migratory patterns, composition and needs. As a result of this, the ageing experience and the specific needs of this population group may vary according to years of residency in Australia, immigration status, reasons for migration, pre and post migration experiences, level of English proficiency, cultural and religious issues, financial independence and level of social support networks. These factors can all have an adverse impact on one's mental health and pose difficulties in accessing services.

The paper addresses the main mental health related needs experienced by our ageing population of CALD, the patterns of service use and the broader implications of this for policy development and service provision. The paper concludes with an overview of key NSW Health initiatives in the aged care and mental health sector that have implications for the ageing population of people from CALD.

Responding to the mental health needs of the NESB older person

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Transcultural Mental Health Centre (TMHC)
The TMHC is a state-wide specialist mental health service for people with a non-English speaking background (NESB). Services include resource development, publications, mental health promotion, specialist projects (eg. consumers, carers, children, adolescents, older people, suicide prevention) and a specialist Clinical Service Clinical services provided include consultation, assessment, counselling, psychoeducation and group intervention.

TMHC Clinical Service
This is available to all people of NESB, who live in NSW, and who experience mental health problems It is available to those people regardless of age, gender, and migration status. Clinical intervention is provided through 118 sessional workers, who are qualified and experienced clinicians, enabling direct client contact to be made within 5 to 7 working days Short-term intervention is provided. Their bilingual sessional workers are qualified in psychology, social work, mental health nursing, occupational therapy, counseling and psychiatry
.

Profile of Older People of NESB
820 people aged 60 years and over were provided with clinical intervention between 1995 and 2003, 62.2% female and 37.8% male. 15.8% were refugees, 72.7% speak poor English and 16.1% speak no English at all Older people make up 16.6% of all clients seen by TMHC. The men and women (from all areas of Sydney and some from the outer metropolitan area) were born in over 50 different countries and speak over 60 different languages.

Referral Source

Self/Relative/Friend	29.5%
Mental Health Service	21.5%
General Hospital	12.7%
NGOs	10%
Community Health Service	6.6%
General Practitioner	5.2%
Other	14.5%

Mental Health Problem

Depression	33.5%
Anxiety	13%
Grief	8%
Post Traumatic Stress	6.8%
Psychotic Illness	5.8%
Lack of Diagnosis	5.8%
Adjustment Disorder	4.1%
Social/Family Problem	3.5%
Bipolar Disorder	2.8%
Other	16.7%

Case Example: An 85-year-old female diagnosed with depression. She responded well to treatment for depression, however, once discharged she became withdrawn, cried a lot, and spent most of her day in bed in a foetal position. She has flashbacks of the war in Vietnam and the faces dislocation with her family and business. She used to be a competent businesswoman, mother and wife and it seems to trouble her that she no longer is. She is supported by her husband and daughter, as well as the other family members. The referrer requests she be assessed alone, as the husband tends to speak on her behalf.

Case Example: A 73-year-old man has a history of chronic schizophrenia. He may have managed on herbal medications in China. He is now on Respiradon and is settled. He has persecutory beliefs. He speaks about being wanted in the 'cultural revolution'. A cultural assessment and provision of psychoeducation to the client and his family are requested. The client is noted to speak Mandarin with a Shanghainese dialect.

Case Example: A 75-year-old is experiencing depression. She has had 2 admissions and appears well in hospital only to regress once discharged. The client has difficulties in the relationship with her daughter and family. The family are minimising her condition and even refer to her as 'mental'. The family problems have been associated with the client having increasing suicidal ideation. An assessment with regards to social & family issues is requested.

Case Example: A 69-year-old man is suffering from various health problems. He also has sleep disturbance, constant headaches, keeps losing weight despite having a good appetite, and has started to withdraw from normal activities. His wife died four years ago and he lives with his son, who is getting married in a few months. He will then need to move to live with other family members. His GP has prescribed anti depressants but the medication has not helped.

Summary Comments
- TMHC needs to have continued focus on the specific needs of NESB older people.
- TMHC needs to be involved in providing education and training to service providers re mental health and older people.
- TMHC needs to continue with mental health promotion and appropriate resource development, to work with other services and the community to reduce stigma and isolation and to focus on initiatives which enhance resilience and well-being; We need to continue to work effectively with consumers, carers, GPs, Govt and NGO sectors, and the community.

How to make a referral to the TMHC?
Contact 1800 648911 or 9840 3899
Ask for Intake Officer
Information and advice regarding cultural issues, resources and clinical intervention is supplied through TMHC sessional workers. Or visit www.tmhc.nsw.gov.au

SESSION THREE: Showcasing models of care

A Whole of Community Approach

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Co.As.It. offers a range of community services through individual case work, group work or community development initiatives to meet the needs of the Italian community in Sydney. It could be argued that these needs have been exacerbated by the migration experience, lack of culturally and linguistically appropriate support services or lack of on-arrival settlement infrastructure. However, what we do know is that these factors are now having a significant impact on the way in which the Italian community is ageing. The strength of Co.As.It. is not only in seeking funding or in providing a range of services to assist the Italian community. It has also been the ability of the organisation to change and adapt over time to meet the needs of the community as they have changed and diversified. A further strength is the ability to see a person through many crises throughout their lives, be it an intergenerational conflict, a settlement issue, an aged care issue or via direct service provision for the frail aged.

The Co.As.It. Community Service team is currently comprised of the following:
- Community Settlement Services Worker
- 2 Aged Project Officers
- Welfare Worker for the Frail Aged
- Community Visitors Scheme Coordinator
- 2 psychologists providing Mental Health Program
- Drug And Alcohol Worker
- Youth Worker
- 4 Respite Day Care Coordinators who manage 9 Italian specific day care groups throughout Sydney
- 4 Community Aged Care Packages Coordinators and a CACP training officer managing 148 funded packages and 45 field staff
- Carer's project which produces a quarterly newsletter
- Administration and support staff

Co.As.It. (Italian Association of Assistance) was first established in Sydney in 1967 at a time of mass Italian migration.

The role of Co.As.It. has changed and developed considerably since this time in

an attempt to continue to meet the needs of the community. Over the years, Co.As.It. has lobbied State and Federal Government to be able to meet such needs as they have arisen. For example, in the early 1980's a huge gap around mental health services for the Italian community was detected which as a result of constant lobbying to the Health Department funding for 2 positions was granted in 1983.

It is important to note that many Italians migrated out of necessity rather than choice which has had a huge impact on the migration process and the experience of settlement. The group with whom we are mostly dealing with are facing issues around language and age.

Socialisation which is both culturally and linguistically appropriate is vitally important to healthy ageing. Co.As.It. has developed a string of social groups in the last 20 years as well as frail aged and dementia specific day care groups to attempt to meet this need.

Since the mid 1990's Co.As.It. has noted a substantial increase in the number of referrals from people suffering dementia. For a long time the Italian community experienced these difficulties and a great deal of work and education has had to be carried out by Co.As.It. in order to de-stigmatise dementia as well as mental illness in general.

A view to the future would reveal that the Italian born community will obviously continue to age and that more work and research will need to be invested in the area of aged care. In 'Projections of Older Immigrants' issued by the Institute of Health and Welfare for the Department of Aged Care, Italy is highlighted as remaining the most common country of birth for older people from a CALD background. It is estimated that Italian born in 2011 will represent 3.2% of older persons in the state. By 2026, the number of older people from a CALD background is expected to continue to increase by up to 56% however the number of older Italians is expected to decline by 17%. Italian born in the 80+ age bracket are projected to increase by 68% in the period from 2011-2026.

A whole of community approach requires more than direct services. It requires a significant understanding of the cultural issues of the target group as well as the ability to meet the needs of the community as they change and diversify.

The Chinese Helpline

A Partnership between Alzheimer's Australia (NSW) and the Chinese Advisory Group

Sallyanne Aarons and Lin Hong Ye
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Alzheimer's Australia (NSW) aims to provide a service to customers requiring information and support in an accessible and equitable manner. Alzheimer's Australia (NSW) presently operates a Dementia Helpline between 9.00am and 5.00pm from Monday to Friday which provides a service to people living with dementia, people concerned about their memory loss, carers, professionals and students. During the time from 2000 to 2002, Chinese callers were the largest culturally and linguistically diverse (CALD) group to make contact with the Dementia Helpline.

An advisory committee consisting of Alzheimer's Australia (NSW) management staff and delegates from Cabramatta Community Centre, The Australian Chinese Community Association (NSW), the Chinese Australian Services Society Coop Ltd and an ethnic Aged Health advisor was set up to establish services for Chinese dementia sufferers.

It was decided to pilot a tri-lingual Helpline for 12 months from April 2003. The line would be staffed by two trained Mandarin/Cantonese and English-speaking volunteers with the aim of extending the existing dementia Helpline service to the Chinese Community. The dedicated helpline would operate on the third Thursday of each month from 9.00am to 5.00pm. There is a voicemail service for out of hours callers or callers who call while the line is busy. The voicemail message includes information about how to contact the Chinese Australian Services Society and the Australian Chinese Community Association (NSW).

The main subjects about which callers wanted assistance ranged from information about dementia, Chinese doctors, respite care, behaviors of concern, ACAT information and nursing homes.

Some of the logistical challenges to be met in this service include, maintaining a regular presence in the Chinese Community, the limited service (once a month is too limited) and finding specialized bi or tri-lingual counselors. Cultural barriers also provide challenges; Chinese people are generally hesitant about talking about their feelings. Dementia is considered a mental illness and carries a stigma. There is thus not a lot of information about dementia in the community. Also there is a strong commitment to keep the elderly at home with strong guilt about relinquishing care.

A clustering approach

Alex Paska, Bankstown Multicultural Aged Care Facility
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I currently work for the Kennedy Health Care Group, which operates 7, Nursing Homes and a Hostel and have been asked to speak to you about clustering in residential aged care facilities.

There are numerous Residential Aged Care Facilities in NSW which cater for specific (NESB) non-English speaking background people including St. Sergius at Cabramatta – Russian, St. Hedwig at Blacktown – German and Elizabeth at Dean Park – Hungarian..

There are also numerous general facilities that have clusters of a specific language group of residents. A cluster is nothing more than a group of residents within a Facility with common language and/or social and cultural background. Clusters can be based on language (most common) or on religious or cultural similarity.

One of these, Merrylands Nursing Home, is currently in the process of setting up a Spanish and Maltese cluster. . Clusters can be planned, as is the case at Merrylands Nursing Home where Spanish and Maltese speaking clusters are being established or the cluster can establish itself almost by accident.

For example, by one or two residents of from (say) a Chinese speaking background are living in the facility. To provide care for these, staff may be recruited who have Chinese as a second language. The Social Workers in the hospitals when seeking a place will ask if the facility can care for a Chinese speaking person. If the answer is "Yes" then word quickly spreads throughout the system that such and such a facility can accommodate a particular type of residents. Relatives looking for a suitable place may also be influenced by the fact that the facility already has some residents who speak the language of the prospective resident.

This process tends to "snowball" and if this trend continues, pretty soon a sizable group of residents needing similar care will be accommodated at the facility. This then causes the facility to put in place more

services for these residents such as special meals and social activities and it goes on.

Our Bankstown (Multicultural) Aged Care Facility is new (approx 2 years old), having 105 beds in 1 & 2 bedrooms all with private toilets and bathrooms. Bankstown also has a 22-bed dementia specific wing. Stage 2, which is expected to be completed by mid 2004, will house an additional 45 "Low Care" beds. Low care beds are hostel type accommodation. It costs no more to live at Bankstown than at any other Nursing Home.

Bankstown is an innovation in multicultural care for the aged. It is unique in NSW because it caters exclusicvely for people not born in Australia. Unlike the other facilities limited to caring for a single language, Bankstown caters for 7 different communities. These are: Polish, Arabic, Mauritius (French speaking), Macedonian, Ukrainian, Vietnamese and Chinese. It is acknowledged that even within these 7 groups there are many cultural differences. So a much greater cross section of cultural differences is being catered for at Bankstown. The reality is that people who may speak one language may come from widely different parts of the country, or even from several different countries, and have different religions and customs. If there are not sufficient people from these target groups, then people from other non-Australian born communities may be accepted at Bankstown.

Here we provide a variety of services, which cater for the diverse needs of our residents. Staff are provided who can speak the languages of these residents and great care and attention is paid to the cultural and spiritual needs of the residents. Visitors from organisations as well as religious persons are encouraged to visit regularly. National Days are celebrated and special days of importance are recognised. Cultural groups are invited to perform dances and recitals and videos are provided in the resident's own native languages. Special meals are provided wherever possible.

While most other facilities only cater for a single language group or a single cluster within a larger Australian resident group, Bankstown caters for 7 clusters with other non-targeted NESB residents being accepted from time to time The challenges of administering such a facility are much greater than managing a general or one language facility.

As Bankstown is unique at this time, the management is on a very steep learning curve and we are all very mindful that this model may be the way to go for the future so we are very keen to succeed.

There are many communities in NSW which do not have the numbers or are financially unable to support a stand-alone facility to cater exclusively for their community. Or existing facilities are too far away for relatives to access easily. As a result, residents who have no English language skills are placed into general-purpose aged care facilities. This must be an extremely stressful situation for them.

The model now operating at Bankstown may fill a need that in the past has not been possible. All of us a the Kennedy Health Care Group are excited at the progress being made at our Bankstown Facility in meeting the needs of our senior citizens.

Promoting more accessible mainstream services

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Migrant Resource Centre
napcoord@sgmrc.org.au

History The NESB Access Project was initiated by the St George Migrant Resource Centre in 1999. The broad aim of the project is to improve access to mainstream Home and Community Care (HACC) services by people of culturally and linguistically diverse backgrounds (CALD) who reside in the St George district and the Sutherland Shire. I was employed to manage the project and provide advice and support to HACC service providers regarding the planning and delivering of culturally appropriate services. I am also responsible for implementing outreach strategies for the small and isolated communities.

For the HACC population from CALD backgrounds we have employed a group of bilingual workers covering the five major language communities (Arabic, Chinese, Greek, Italian, Macedonian and other former Yugoslavain languages) whose primary role is to link potential CALD HACC clients with local mainstream HACC services and to guide and support these clients through this process until they are confident with the service/s they are being provided with.

The other side of our work is to educate the mainstream HACC service providers about the issues and needs of the CALD communities and to resource them to effectively meet the needs of CALD - customers. During this two-prong approach of service provision we review clients' uses of services and feed this information back to the HACC service providers and other relevant government bodies.

We use a number of conventional as well as innovative mechanisms to reach and recruit potential clients and improve the cultural appropriateness of the services provided by the mainstream HACC services.

These strategies include:

- Translate service information into community languages and print into pamphlet form, which is distributed widely to individuals, service providers, community groups and other key outlets. Each pamphlet contains the information in English on one side and the community language on the other. This is important for the CALD elderly people, as their children often cannot read their parents' language.

- Use of the media both ethnic and local; and all forms including print and radio. We prepare and send them Media Releases and we also hold live interviews. In addition to this, we utilise various newsletters of local mainstream, ethno-specific organisations and religious groups.

- Running of the Multilingual Information Line with a different bilingual worker each working day to improve access for potential CALD clients to information in their languages. We promote the days and languages to the community so that they call on the days that their language-specific worker is on duty. E.G. Mondays = Italian, Tuesday = Arabic, Wednesday = Macedonian, Thursday = Chinese and Friday = Greek.

- Maintain regular contacts with relevant ethnic or aged-specific organisations and groups, workers and community leaders by visiting them, attending common forums/ meetings, or supporting them through membership of their advisory, management or steering committees etc.

- Utilise funds on a brokerage arrangement for one-off projects to meet specific needs. We employ relevant bilingual staff on a short term basis and target small and isolated communities E.g, the Muslim Men's project came about from us finding out through our regular HACC Access Project work that they were poor users of HACC services. We employed a Muslim-Arabic speaking man for 6 months P/T to find out the reasons for this group's lack of use of services. We will use the findings from this project to address the

to Interpreters delivering these sessions. Similar sessions delivered by interpreters was not passed on as effectively.due to the time delay between relaying information from the facilitator to the interpreter and back to the audience.

- Utilising interpreter services for initial home assessments, using medical consultations.

- Linkages to the existing Dementia Carers Support Group (Macarthur), Liverpool & Bankstown and Linkages to the Day Care and Respite Services Case Conference (Macarthur) held monthly.

Main challenges

- In many cultures there is not a clear understanding of dementia
- For many people the concept of respite is unfamiliar and may go against cultural norms
- Aboriginal communities. Linking with key workers eg. Wollondilly
- Lack of bi-lingual male workers in SWS
- Lack of trained staff to work with people who have dementia
- Greater community awareness of dementia issues

Conclusion

Our aim for the future is to expand the Reslink and Transcultural Programs to minority ethnic groups in the community. We intend to do this by forming greater relationships with key workers in the community.

Formalising the partnerships between community service providers will streamline the services we are providing to family carers and the people they care for.

Providing Transcultural Respite

Adele Lubiana, Macarthur Reslink Program
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The Reslink Program is funded by the Commonwealth Department of Health and Ageing under the National Respite for Carers Program. The aim of the Reslink program is to assist carers of people with dementia who have challenging behaviour.

The service was set up after consultations with service providers, forming a steering committee and establishing a working party to explore the way respite and support services could be effectively provided to people of (CALD) culturally and linguistically diverse and ATSI communities The Working Party targeted dementia education programs for the Vietnamese and Spanish communities in the Fairfield area. These were identified as 2 of the major language groups in SWS. Education sessions were provided by bi-lingual workers.

An evaluation of the Reslink Program was carried out in 2002. Carers made the following recommendations:
1. More centre based respite was needed to allow longer respite periods.
2. Increased group respite for CALD people
3. Greater respite usage of bi-lingual workers having an understanding of language, culture, traditions and beliefs.
4. Greater access to leisure and recreation activities during respite.
5. Greater access for carers in organising residential care services.

As a result of the growing needs expressed by our carers and the Reslink Program evaluation, Macarthur Health Service was able to submit an Expression of interest to the Commonwealth Department of Health and Ageing (under the National Respite for Carers Program) to establish the Transcultural Respite Service. It became operational as of July 2003. The Transcultural Respite Service is now available to both carers of people with dementia and people who are frail aged and for people who are self carers.

Key features of the program

- The Transcultural Respite Service has formed links with key workers from Ethnic and Aboriginal services to gain their support and insights into the way respite services can be planned and implemented in the community. In some cases workers and volunteers from these organisations have assisted in the direct provision of respite services.

- Provision of leisure/recreation activities in and outside of the home. This involves learning from the carer and care recipient what interests, hobbies the person (being cared for) has currently and has had in the past. An activities box is set up for workers who are providing in home respite. This includes music, cooking items, hand cream, craft items, paints, dried flowers and woodwork tools. Leisure activities reflect the cultural and gender needs of the care recipient. For clients with challenging behaviour the Reslink/Transcultural programs implement activities such as soft music and outings to quiet, non crowded environments such as parks, coffee shops and libraries.

- Clustering models allows the Program Co-ordinator to bring together people of the same of similar cultural background within a day centre or community facility. This model allows for the expansion of leisure/ recreational activities to reflect cultural background. Blending clients from various cultures allows for the learning and sharing of various customs. For people with dementia, clusters are located within day centres that have secured environments. For people who are frail aged small groups have been formed in church halls and other community halls.

Indian Cluster (Dementia Specific): Lurnea Day Care
Greek Cluster (Dementia Specific): Lurnea Day Care
Cantonese Cluster (Early Stages Dementia): MMRC
Assyrian Cluster (Frail Aged): Camden District Activity Centre
Spanish Cluster (Frail Aged): Stocklands Mall Community Hall (Wetherill Park)
Greek Cluster (Frail Aged): Greek Orthodox Church Hall (Liverpool)
German/Austrian (Frail Aged): German/ Austrian Social Club (Cabramatta)
Aboriginal & Torres Strait Cluster (Frail Aged): Tharawal Local Aboriginal Land Council. Thirlmere

- The brokerage model is used allowing for bi-lingual workers to be contracted from commercial and community organisations to work with small groups within the centre based settings. This model has allowed greater flexibility in the following ways:
1. Providing a worker with the same cultural background and language as the client/carer.
2. Providing a worker who has an understanding of the local area
3. Providing a worker of the gender preferred by the client

- Service Agreements have been developed with various agencies such as Home Care, CACP Providers, Ethnic Specific Services, MRC, Aboriginal Services and private nursing agencies. The Service Agreements list the term of the Agreement, job specifications, OH&S issues, Insurances and the scheduled rates for payments.

- Bi-lingual information sessions involving family carers, service providers and volunteers. Utilising trained bi-lingual workers to deliver the sessions as opposed to Interpreters delivering these sessions. Similar sessions delivered by interpreters was not passed on as effectively.due to the time delay between relaying information

from the facilitator to the interpreter and back to the audience.

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AAG Hunter Valley Conference

1 Nov '03 closing date for papers

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- Geographical Boundaries
- Inter-sectoral Boundaries
- Personal Resource & Care Boundaries
- Limits to Imagination and Innovation
- Professional Boundaries
- Partnerships
- Boundaries of Self (achievement and self limitations)
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Email your 250 word abstract to Adelaide Bornmann abaust@smartchat.net.au

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The full conference brochure, along with special rates for accommodation options, will be available by the end of December.

Hunter Chapter

RM Gibson Oration

Sixty two participants were welcomed by our Chapter's President Dr. Andrew Scane to this year's R.M. Gibson Oration. These participants joined with good fellowship and interaction to make the evening's Oration the success it was.

Dr. Diane Gibson, Head of the Welfare Division at the Australian Institute of Health and Welfare, Canberra who was to be the Orator, presenting 'Residential Aged Care – current patterns & future directions", suddenly took ill and was not able to attend

Luckily Assoc. Prof. Julie Byles, stepped into the breach with her 'hot off the press' interesting data from the Australian Longitudinal Study of Women's Health: "Women in an Ageing Australian Population". At short notice, Julie was able to obtain special permission from her Study Supervisor to present this data. It was interesting that the study showed many women were satisfied with their existing quality of life.

RM Gibson Travelling Fellow

Clare Ungerson's will be visitung the Hunter Chapter visit on 20th November 2003. There is to be an afternoon presentation at The Casuarina Room, Warabrook Centre for Aged Care, Warabrook and an evening presentation at The Friendship Room, Club Nova Panthers, King & Union Streets, Newcastle. During the afternoon, Clare will speak on *Current issues in the supply and demad of longtime care: a UK perspective*. In the evening she will speak on *Funding care users to employ their own care labour: cross national European perspective.*

Diary Dates 2003

27-29 October **SYDNEY**
Diversity in Health 2003
Innovation..Creativity..Harmony
Multicultural Health and Wellbeing
Sydney Convention Centre
Phone: 02 9280 0533
diversity2003@pharmaevents.com.au

17-19 Nov (tbc) **SYDNEY**
RM Gibson Fellow,
Clare Ungerson, Sociologist,
Southampton University
Carers, formal and Informal
Phone: 02 9523 1715
abaust@smartchat.net.au

12-14 November **HOBART**
36th Annual Conference
Australian Association of Gerontology
Expanding Knowledge of Ageing
Wrest Point, Hobart
Phone: 08 8302 1051
aag.conf@flinders.edu.au

8-12 December **CANBERRA**
International Conference on Population Ageing and Health
Modelling our Future
conference@natsem.canberra.edu.au

2004

11-12 March KURRI KURRI
AAG Hunter Valley Conference
Beyond the boundaries; Ageing in rural areas, the future and the imagination
Phone: 1300 368 783 or
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