Submission No 67

INQUIRY INTO SUPPORT FOR OLDER VICTORIANS FROM MIGRANT AND REFUGEE BACKGROUNDS

Organisation: John Richards Centre for Rural Ageing Research

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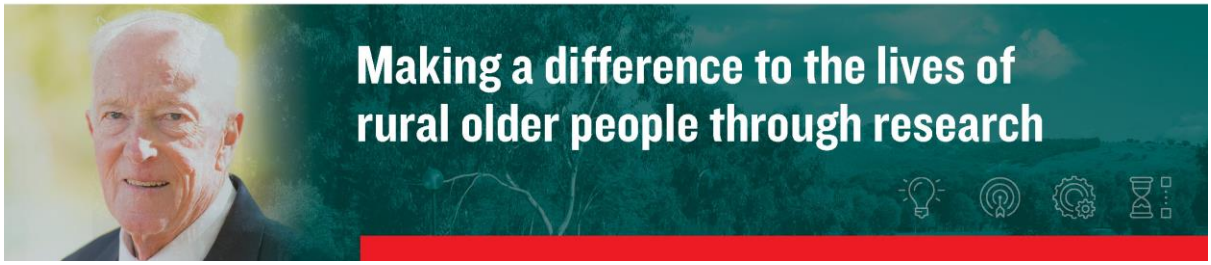


INQUIRY INTO SUPPORT FOR OLDER VICTORIANS FROM MIGRANT AND REFUGEE BACKGROUNDS
https://www.parliament.vic.gov.au/lsic-la/article/4778

30 November 2021

Committee Secretariat
Legislative Assembly, Legal and Social Issues Committee
Parliament of Victoria
Parliament House, Spring Street
EAST MELBOURNE VIC 3002

Submission to the Committee's inquiry into support for older Victorians from migrant and refugee backgrounds

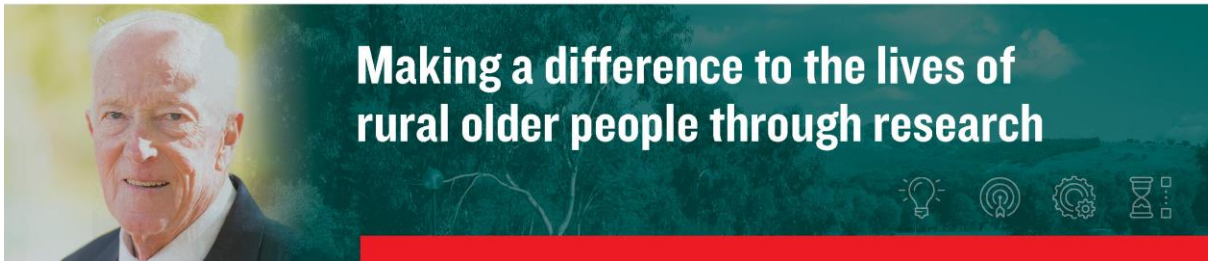
by the John Richards Centre for Rural Ageing Research

The John Richards Centre (JRC) for Rural Ageing Research initiative hosts internationally renowned researchers specialising in ageing and rural research and seeks to develop and implement programs of research that make a difference to the wellbeing of a diverse range of older people living in rural communities.

As experts in rural ageing, the JRC welcomes the Legislative Assembly, Legal and Social Issues Committee inquiry into support for older Victorians from migrant and refugee backgrounds. Specifically, the committee has been asked to consider the needs of older Victorians from migrant and refugee backgrounds including, but not limited to, an examination of the:

a) adequacy of services for older Victorians from migrant and refugee backgrounds;
b) unique challenges faced by this cohort, including, but not limited to, social isolation, civic participation; digital literacy, elder abuse and access to culturally appropriate aged care and home care services; and
c) ideas to advance the physical and mental health and wellbeing of Victoria's multicultural seniors including global best practices.

Australia boasts an increasingly multicultural society, and as such the needs of the Australian ageing population are becoming increasingly diverse (Howe, 2006). In 2017, two thirds of older Australians were born overseas, and one in three were born in non-English speaking countries (ABS, 2017; Australian Government, 2017). This constitutes a significant proportion of older adults considered culturally and linguistically diverse (CALD). This proportion is expected to increase at a disproportionately higher rate compared to their Anglo-Celtic counterparts (ABS, 2014). By 2026, it is estimated that Victoria will host the highest number of the CALD older population compared to other states. with nearly a third of Victorian older adults from CALD backgrounds (Gibson, Braun, Benham, 2001). Whilst there is little by the way of modelling that focuses on older adults from CALD backgrounds in rural and regional areas specifically, the higher proportion of older adults in rural regions compared to urban locations may suggest that an increase in older adults from CALD backgrounds, in line with the anticipated increase in the older population in general, will be experienced disproportionately as well. Older adults from CALD backgrounds can have more complex health needs and combined with the structural disadvantages of rural and



remote healthcare and service provision, the challenge of providing services to this subgroup of the population is particularly challenging in this setting. Previous work has identified some of these challenges to include language barriers, racism and/or discrimination, a lack of culturally appropriate support or services, and, particularly exacerbated by rural locations, limited numbers threatening program sustainability (Rao et al. 2006; Ward et al. 2005).

We welcome this opportunity to discuss some of the key challenges to the provision of healthcare and services to older people from CALD backgrounds, based on research we have undertaken with older people and key stakeholders in rural and regional areas of Victoria. Whilst our insights are based on findings that are predominantly within samples of older people from rural and regional locations, they are not exclusive of the experiences of older migrants and refugees in Metropolitan regions of the state. We present this information as a series of key insights, followed by specific recommendations that relate to each respective finding.

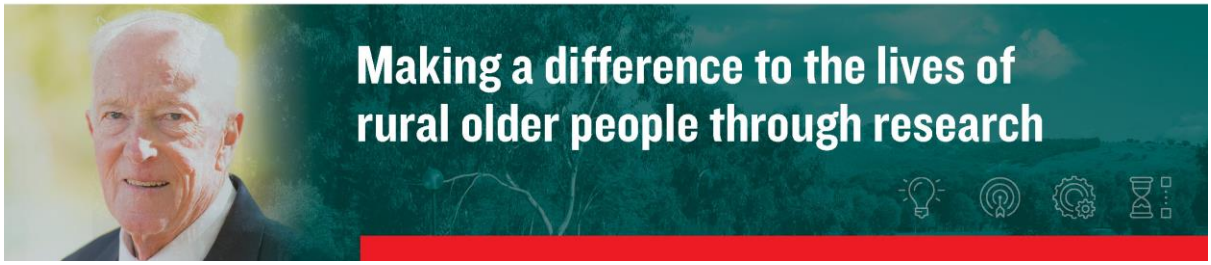
Key finding 1: Divergent understandings of health and failings to accommodate these under the standard biomedical model of healthcare delivery.

Older people from CALD backgrounds may have different beliefs and understandings regarding health. Indeed, among the Karen community in Bendigo, health is perceived as holistic, including physical, mental and emotional health, and beliefs about health are multifaceted and encompass the absence of pain, feeling happy, feeling like one is able to participate in activities of daily life, feeling strong and energetic, looking fresh with clear eyes and skin, having no worries or pressure and being optimistic about the future. Barriers to good health are also multidimensional and consider not only physical conditions and illness, but also other aspects such as access to good food, weather extremes, and 'belonging'. This extends beyond the standard biomedical model of health upon which most healthcare services are delivered, which is based on 'normal' functioning of the body. As such, it is not surprising that many older CALD people feel that that their symptoms were not well understood by doctors, that medicines prescribed are not effective, and that social emotional issues are still not properly addressed. This highlights a significant gap in healthcare provision, being the culturally embedded understanding of health versus the biomedical system in which treatment is sought and provided [1], and the need for a cultural shift in which we move beyond viewing age negatively as a decline in health and accrual of disease, to instead focus on health, longevity, and connection, for better integration of service provision with family, country, culture, and community.

When asked about pragmatic strategies to address the gaps in traditional biomedical models of service provision to better accommodate cultural beliefs and understanding of health, people from the Karen community communicated a strong desire for health care providers to understand what it means to be Karen and from a refugee background, as well as be willing to actively engage with the healthcare concerns raised in a culturally appropriate way. Recommendations to achieve this include [2]:

- Longer consultations;
- Competent and confident interpreters;
- Culturally significant and welcoming symbols and practices displayed in the service location;
- Having healthcare providers from the same ethnic background;
- The provision of cultural literacy and refugee awareness programs for healthcare providers [1].

These findings highlight the need for a service provision framework that allows for working with older people from a diverse range of backgrounds. One such framework is 'cultural safety', which promotes an environment safe for all people, free of assault, acknowledging and accepting of their identify, of who they are, and what they need. The framework is underpinned by values of mutual respect, shared meaning and knowledge, truly listening, and collaborative learning with dignity. Cultural safety extends the notion of cultural competence beyond simply learning



about a different culture, to also acknowledge that service providers and stakeholders also bear their own culture, that culture is diverse and dynamic, and plays a role in creating the unequal power distribution and potential discrimination that exists in our healthcare system. In doing so, a culturally safe framework provides opportunity to engage with the challenges of varied understandings of health, communication barriers, power dynamics and discrimination [1].

Recommendations based on Key Finding 1:

1. Healthcare services need to move from the standard biomedical model of service delivery, to include a 'cultural safety' model of service delivery.
2. Cultural safety training and awareness programs need be developed and provided to all healthcare staff, particularly in areas servicing ethnically diverse populations.
3. Revision of typical aspects of service delivery to enhance cultural safety, including appointment times/durations and opportunities to incorporate translators.
4. Cultural safety needs to be incorporated in tertiary healthcare degrees, for future healthcare professionals.
5. Recommendations for staffing and funding as described below.

Key finding 2: Older CALD people face a variety of barriers to accessing existing healthcare services.

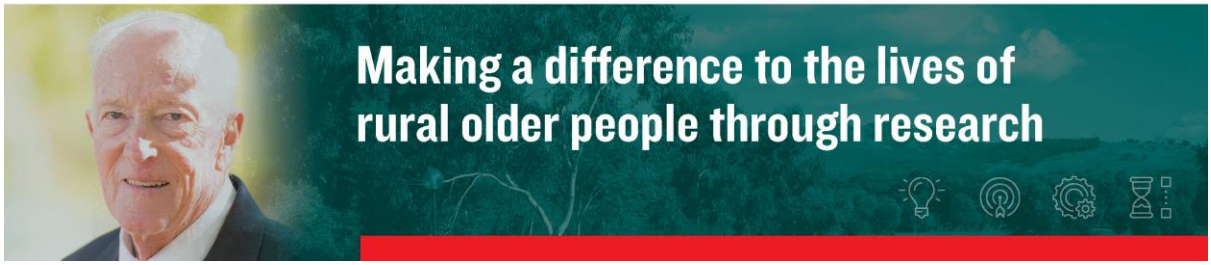
In addition to key finding 1, older CALD groups face other specific barriers to accessing healthcare service, including a sense of not belonging, language barriers and difficulties with communication. The barriers that arise through language and communication are well acknowledged, and our findings among ethnic subgroups in regional Victoria are not new, but rather reinforce what is already known. In our experience, these barriers give rise to difficulties understanding referral letters, and difficulty navigating telephone booking systems or locating services in unfamiliar parts of the city or within large buildings [1]. Additionally, a lack of transport (both private, and in rural areas, public) coupled with large and potentially isolated geographic regions, is a potential barrier to accessing services in rural areas, and the cost of providing transport is a significant impost to funded or subsidised programs and activities [3]. The 'professional' demeanour adopted by healthcare staff can also serve to broaden perceived disproportionate for some ethnic groups, who may have experienced decades of mistreatment by authorities in their country of origin, resulting in deep seeded fear and mistrust of those perceived as authority figures and significant fear and anxiety when attempting to access healthcare services.

Recommendations based on Key Finding 2:

1. Include resources and visual signs in languages of CALD groups often accessing health services and programs.
2. Reorientation of or support for using and navigating booking systems and communication
3. Warm and friendly demeanour of health staff in place of a typical 'professional' or impartial approach to communicating with people, to minimise fear and anxiety associated with accessing services.
4. Adopt cultural safety training for service staff, and cultural safety frameworks for service delivery, as per recommendations for key finding 1.

Key finding 3: Strong interorganisational networks and relationships can be leveraged to engage with CALD seniors for healthcare and health-related programs.

Traditional biomedical services are just one part of an interrelated, complex network of resources and services that older CALD people draw on to manage their health. Professional care is in fact only accessed for persistent or severe symptoms, whilst general health and well-being is typically managed through more commonly accessed pharmacies and over the counter treatments, self-care (exercising, sleeping well), traditional/cultural medications



and herbs, and religious practices [1]. Overwhelmingly, the community (including family, friends, and the religious community) are a key source of advice, assistance and support, reflecting the strong cultural networks that people establish and rely on, and a potential source for contact, communication and collaboration. Rural settings may be particularly beneficial for the development of such networks, due to the small small-scale, highly networked services, and strong culture of volunteerism and community-mindedness [1]. Certainly, during interviews with service providers of programs that engaged older ethnic people in rural areas, smaller communities and centres were identified as being beneficial to identifying and accessing isolated ethnic seniors, for which face-to-face contact and networking within communities were essential to build trust and rapport. Smaller settings also provide better opportunity to circulate information, and better engagement and rapport between organisations, to enhance contact and recruitment into programs [3]. These findings echo those from other research endeavours by the JRC, in which strong inter-organisational relationships and networks underpinned the successful adoption of cognitive screening for older people in rural and regional Victoria, and reinforces the importance of a well networked health and community service sector in addressing the needs of its community.

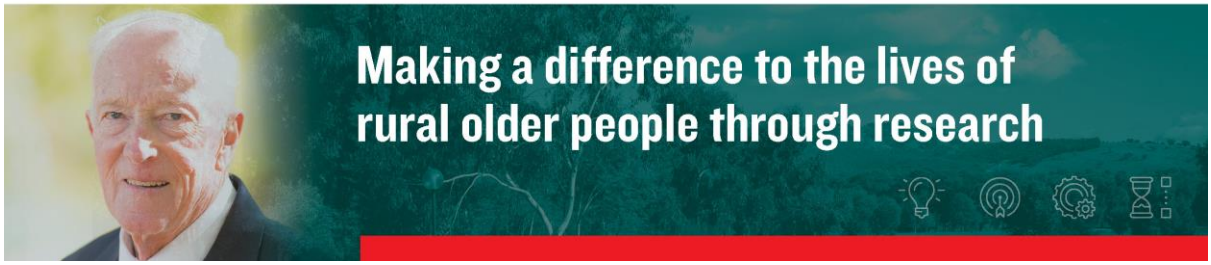
Recommendations based on Key Finding 3:

1. Interorganisational relationships (between organisations servicing older ethnic people) should be promoted. This may be enhanced through the development of a coalition or council for community organisations in regional areas who service older CALD people.
2. Staff from organisations servicing older ethnic people need to be involved with the community, and particularly seek opportunities for face-to-face contact.

Key Finding 4: Maintaining cultural identify and social connectedness is very important to older CALD people.

A well-known challenge of ageing is a loss of social roles, within both work and family contexts. This can have significant consequences for the mental health of older CALD people [4]. As inferred to earlier, cultural identity and a sense of belonging are important to older people from CALD backgrounds, and in some cultures are an inherent component of health and wellbeing. As such, it is unsurprising that in some instances, older adults from CALD backgrounds have been reluctant to participate in activities that do not have other people from the same/similar background in attendance. Congregation during programs and activities provides opportunity to interact and is seen as an important part of maintaining cultural identity, reinforcing the importance of providing structured opportunities targeted at specific ethnic groups. Cultural and religious conflicts may also act as barriers to participation in services and programs, and significant effort is required to consult with communities to resolve potential issues. This should be coupled with appropriate training, and as mentioned earlier, the adoption of a cultural safety framework through which service provision can occur [3]. Our research with service providers suggests that projects successfully able to enhance structured opportunities for ethnic groups whilst managing and maintaining opportunities for cultural practice are more successful in terms of retention [3]. Stemming from this, older adults from CALD backgrounds may be particularly prone to loneliness and social isolation, reflective of resettlement issues that are life stage specific, and the provision of culturally specific services and programs may serve to reduce this. However, there appears to be a gap in addressing these factors in rural and regional Victoria, as externally funded programmes targeting CALD populations are often oriented towards readiness for work, rather than social connectedness [3], and aged care facilities that specifically target ethnic and/or CALD populations rarely exist in rural contexts, unlike in urban Melbourne. We base this on findings from Bendigo, in which out of aged care facilities none are ethnic, cultural or linguistic-specific.

Volunteering may also provide opportunity to enhance social roles and connectedness, and mental health, for older CALD people, as well as partially addressing the deficit in human capacity currently experienced in rural and



regional locations. Our research has previously highlighted the potentially beneficial role for older people from CALD backgrounds, however prevailing social and cultural norms can result in hesitancy to volunteer, inhibition for locating volunteer roles, and family conflict. We recommend the provision of culturally-safe support to facilitate older CALD people filling volunteer positions through education of older and their families as to the potential benefits of volunteering, policy and programs that target older CALD people, and the social inclusion of culturally appropriate volunteer roles for those wishing to volunteer [4].

Recommendations based on Key Finding 4:

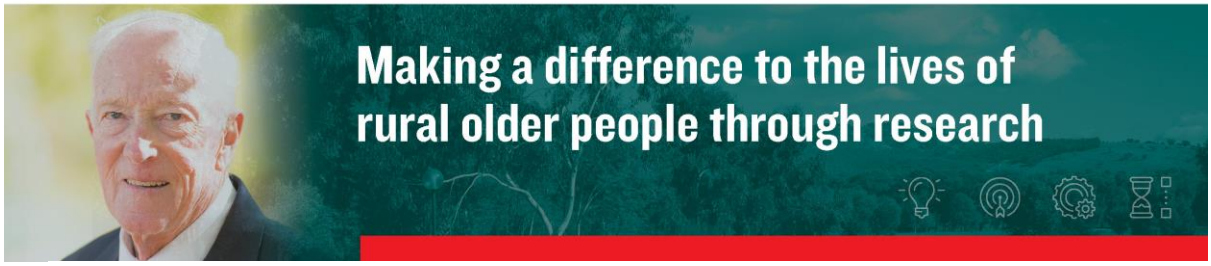
1. Co-design programmes and services that specifically target older CALD people (with direct consultation and input from older ethnic groups), with a focus on incorporating structured congregation/social opportunities for cultural groups, and social connectedness.
2. Macro-level funding structures designed to support flexible pathways for social participation beyond current programs.
3. Adoption of cultural safety framework to guide service and program provision, as recommended under key finding 1.
4. Investigate opportunities for CALD specific aged care facilities in rural and regional Victoria, to align with services offered in metropolitan Melbourne.
5. Social inclusion of culturally appropriate volunteer roles, and policy and programs targeted at older CALD people, including education of the benefits of volunteering.

Key Finding 5: Insufficient funding structures

Appropriate staffing within organisations is crucial for service delivery and sustainability, however a disconnect between federal and state government responsibilities for the aged care and health systems has resulted in confusion, a lack of responsibility, blame, and cost-shifting. The resulting tenuous, finite, and insufficient funding of programs is significant limitation to service delivery; programs and services are understaffed, often temporary, and problematic from the perspective of staff continuity, which in turn threatens retention and therefore sustainability [3]. The tenuous nature of funding is in part contributed to by macro-level funding constraints and regulations, arising from the preference to fund community organisations instead of local government organisations, due to the high cost of local government workers. This has substantially impacted on opportunities to continue to fund existing projects. Also at the local government level, changes to health promotion models, and high level restructuring which has seen local government withdraw from Home and Community Care services, has also affected the sustainability of programs targeting older ethnic people in regional Victoria [3]. Funding relating to the additional costs of providing services in rural areas, and the embedding of interpreters within programs, has also been identified as insufficient. In regard to the latter, high level funding for interpreters is too expensive to be covered internally by organisations, and priority for interpreters is given to health and settlement services over social programmes [3], which poses a threat to programmes targeting social connectedness, which has previously been identified as an important area of focus for older CALD people. Relating to the additional costs of service provision in rural areas, transport costs in particular have been identified as significant and threaten program sustainability [3].

Recommendations based on Key finding 5:

1. State governments ought to assume responsibility for health care and hospitalisation needs of older people, with greater funding commitments by federal government.
2. Stable and permanent funding solutions, which also incorporate local government staff and programs, are required in recognition of the resource constraints associated with targeting, attracting, and retaining older ethnic people, and the additional costs associated with rural delivery of such programs.



3. High level funding to better include provisions for interpreters in social programs, as well as health and settlement programs.

Key Finding 6: Shortages in human capacity for healthcare service and program staffing, and/or appropriately skilled and experienced workers

Human capacity has been identified as a barrier to service and program provision or sustainability. As identified earlier, service and program funding can be tenuous resulting in part-time and transient staff roles, or reliant on other core program funding resulting in limited time allocated to programs and services for older CALD people. This contributes to poor consistency and sustainability of programs and services, which has implications for developing trust between service providers and older CALD people, as well as encouraging continued attendance or use of services [3]. This is particularly exacerbated in rural areas where shortages in available health and program staff prevail. Particularly relevant to his was the recent Australia's Aged Care Workforce Strategy Taskforce [5] finding that the aged care employment crisis in particular is more severe in regional and rural areas, likely contributed to by driven by fewer qualified individuals, low remuneration for aged care workers, and negative profile of aged care careers. Along with a shortage of staff in general is a lack of ethno-specific workers embedded within services and programs, who would serve to enhance cultural appropriateness. In the absence of additional funding, the procurement of such positions requires strategic planning of hiring patterns, and/or the formation of partnerships with local organisations [3]. This finding reinforces several of our previous points, including service workers who have an understanding of what it means to be part of a specific cultural minority, and the need to foster interorganisational relationships between service providers to pool resources and enhance service reach. It stands to reason that the former may be achieved through the targeted training/education and recruitment of CALD people into services and programs aimed at older people, which simultaneously would serve to overcome human capacity shortages in the aged care sector. Despite a growing number of migrants working in the aged care sector, we have previously identified a number of concerns relating to the vulnerable employment status and barriers to career development for CALD people employed in the aged care sector, which contribute to high staff turnover and skill shortages. These include [6]:

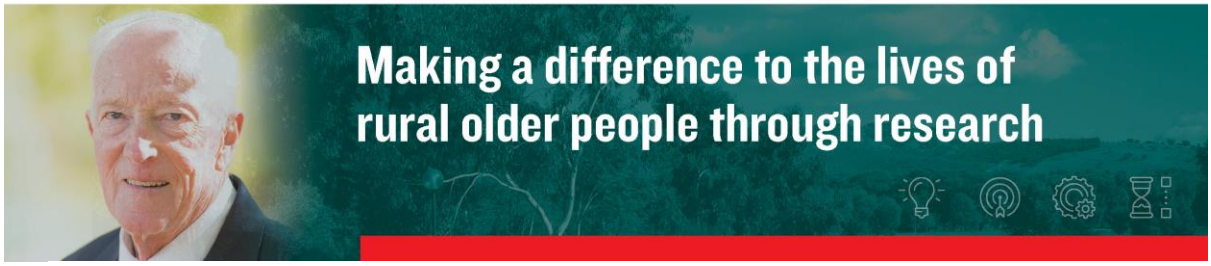
- Lack of support for further training, or to enable caregivers to gain qualifications as enrolled or registered nurses;
- Discrimination, racism, and/or lack of intercultural understanding from colleagues, supervisors, and clients;
- Geographical barriers to networking in regional and rural locations;
- Language barriers and/or lack of English proficiency;
- Difficulty in addressing workplace issues for fear of creating additional problems that impact on well-being.

Based on our findings, enablers of recruitment and retention of CALD people into aged care services and programs include:

- Availability of support services at work and in the community;
- Professional development opportunities for gaining further qualifications;
- Fostering reciprocity and mutual respect, specifically from other migrant care workers and older mentors.

Recommendations based on Key Finding 6:

1. Stable and long-term funding arrangements, as identified under Key Finding 5.
2. Adoption of cultural safety frameworks within workplaces for staff well-being (i.e. not solely for service delivery).
3. Mandated minimum staff-to-resident ratios for aged care facilities.



4. A social change campaign to reframe caring and promote people to take up careers in aged care services and programs.
5. Appropriate remuneration for employees in the aged care sector.
6. Reframing of qualification and skills framework, addressing current and future competencies and skills requirements.
7. Define new career pathways including accreditation.
8. A focus on training/ education, ongoing professional development, and networking opportunities for people from CALD backgrounds, particularly those from rural and regional areas.

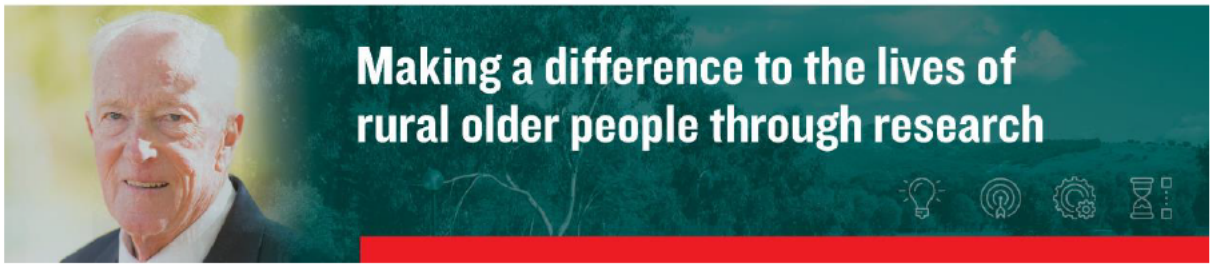
Key Finding 7: A strong digital divide exists for older people from CALD backgrounds, and this is exacerbated for those living in rural and regional areas

The lack of digital literacy exhibited by older adults is well acknowledged, and among older CALD people lower levels of education, low incomes, and limited English skills can intersect to further increase the digital divide created by low levels of digital literacy. This is further exacerbated by low incomes or living in poverty (more likely among migrants and refugees) and in rural areas in which internet connectivity continues to be extremely limited in some locations [7]. Many older people from CALD backgrounds rely on family and friends to assist them in navigating information and services that require internet for access, thus limiting the autonomy and privacy and creating a dependency on support to access relevant services. This approach may be effective when older CALD people are part of multigenerational households, or sufficiently socially connected within their community and cultural group. However, those that may live alone or be socially isolated are at risk for further isolation and digital exclusion [7]. Digital resources provide a means of improving social connection, remaining connected with families and communities, and improving access to services, particularly for those in regional and rural locations. Our findings highlight the importance of social networks in enhancing older people's access to and ability to navigate digital mediums, or in the absence of such networks, the provision of support services to assist older people in better engaging with technology. Indeed, other research recently undertaken by the JRC among more general older adult populations in regional Victoria highlighted the benefits of providing individualised support to assist older people in accessing programs online via Skype, Zoom or Facebook [8], and improvements in acceptance and confidence in the use of technology based on increased exposure and assistance [9].

Recommendations based on Key Finding 7:

1. Further advocacy for better internet connectivity in regional and rural Australia.
2. Incorporation of support for digital literacy and use of digital mediums into programs and services for older CALD people.

In summary, key considerations relating to the challenges in supporting older adult from CALD backgrounds include the delivery or services in alignment with traditional biomedical models of care, which fail to account for diverse understanding and belief of health, as well as unique challenges to accessing programs and services, often driven by language barriers and/or a lack of English proficiency. In rural and regional areas barriers access may further include limited transportation options, shortages in healthcare staff (particularly experienced, qualified and/or CALD staff), as well as poorer internet connectivity and lower digital participation. Additionally, a disconnect between federal and state government responsibilities for the aged care and health systems has resulted in confusion, a lack of responsibility, blame, and cost sifting, leading to insufficient and tenuous funding structures which have ongoing implications for continuity and sustainability of programs and services for older CALD people. Interorganisational relationships between organisations servicing older ethnic people should be promoted to allow for pooling and sharing of resources and service referrals, which may be enhanced through the development of a



coalition or council for community organisations in regional areas who service older CALD people. Finally, social connectedness and cultural identity and belonging have been identified as important to older CALD people and essential for mental health, and opportunities for these should be incorporated into existing programs and services, and in turn may encourage ongoing access and participation.

The JRC team thank you for this opportunity to provide insight into considerations regarding the needs of older Victorians from migrant and refugee backgrounds, and welcome future opportunities to work together to improve the health and wellbeing of older CALD people, and particularly welcome efforts aimed at improving services and opportunities in rural and regional Victoria.

Sincerely,

[redacted]

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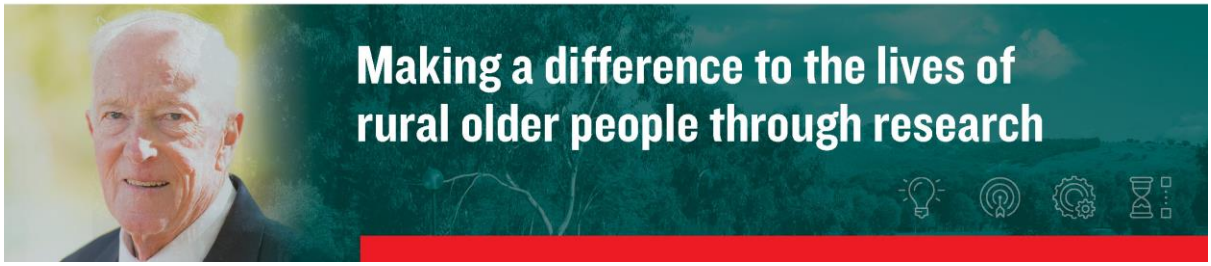
On behalf of the JRC team



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