



The Spiritual Imperative in Multicultural Aged Care - Multiculturalism, Mainstreaming and Marginalism

Ron Mitchell, August 2011

Introduction

As the Director of the Multicultural Council of the Northern Territory (MCNT) I welcome the opportunity to be here today at the 4th International Unity in Diversity Conference. The MCNT based in Darwin is a peak body for multiculturalism and service provider for individuals and families from culturally and linguistically diverse (CALD) communities.

The MCNT is a hybrid organisation in that it functions as both an EEC (ethnic community council) and a MRC (migrant resource centre). The MCNT is funded by the NT and Federal Governments to address settlement barriers and encourage the participation and self-reliance for recently-arrived migrant and humanitarian communities in our society.

The MCNT has a philosophy of providing access for older CALD background people to innovative social interaction activities to provide a positive and productive ageing experience. In 2010 the MCNT with two other Darwin based NGOs the Council on the Ageing NT (COTA NT) and Carers NT, have formed the Multicultural Aged Care Network focussed on CALD community seniors and with the aim of strengthening bonds and creating partnerships between CALD communities and local aged care service providers.

Australia can be described as a nation of migrants; almost one in four of Australia's residents was born outside of Australia. Migrants have arrived and settled in Australia for the past 200 years. Australia is one of the most culturally diverse nations in the world and will maintain that distinction for generations to come.

The multicultural nature and inherent cultural diversity of Australia's population creates a unique identity and spirit but also presents barriers to social inclusion and economic participation for many new settlers. It is these barriers to settlement that our NGO (and our counterparts in other states) addresses through funded projects.

Background of the demographics of Australia's ageing CALD population

Australia's population is ageing and this presents a major demographic challenge. The major contributors to population ageing in Australia are: large numbers of ageing 'baby boomers', increased life expectancy, and declining fertility rates.

Migration has been a particularly significant factor contributing to the growth and cultural diversity of Australia's population since the Second World War. As a consequence of this post-war migration wave the ageing population from CALD backgrounds is growing at a proportionately faster rate than for the mainstream population.

The older CALD community comprises people who arrived to Australia as refugees and skilled migrants when they were young and have aged in Australia, as well as those who have migrated in older age for reasons of family reunion or retirement. Over the decades longevity has increased for Australians because of improvements in living standards and advances in preventative and curative health care.

Demographic projections indicate that the proportion of Australians from CALD backgrounds over 80 years of age has increased from one in eight in 1996 to one in five by 2011 and is estimated to be one in four by 2026. The experience of ageing in mainstream society is now very positive with dramatic increases in recent years in health and well-being. However for older people in CALD communities there remain a number of societal, economic, and health consequences of ageing and significant service gaps with intrinsic cultural isolation, disadvantage and marginalisation.

It can be argued that not only is the CALD community ageing faster than the mainstream community in Australia, it is also ageing younger than the mainstream community. In particular older CALD background seniors who arrived in Australia as refugees face accelerated ageing from the combination of pre-arrival experiences, post-arrival resettlement issues and the usual challenges of ageing in a new country.

The challenges of multicultural aged care - identification of a special needs group

Under the *Aged Care Act 1997* older people CALD backgrounds are identified as a special needs group for aged care programs whether in residential and community settings. As a group, older people from CALD backgrounds share with other Australians the range of needs that arise from the ageing process but also have additional needs and challenges.

For various cultural reasons residential care has traditionally not generally been considered an option by CALD communities. There has been the traditional expectation that that elderly CALD background parents will be cared for and supported by families and communities. In many CALD cultures there is stigma and a sense of shame associated with residential care options. Typically to date the use of community aged care services by older Australians from CALD backgrounds has been relatively under-represented in residential settings but over-represented in formal community care settings.

However within CALD communities kinship based extended family caring structures and intergenerational reciprocity are changing and because of economic and social pressures, family tensions and interstate migration there are less options for long-term family based care and stable accommodation with a sense of belonging for elderly parents. As a consequence in future years there will be an unprecedented demand for culturally appropriate residential aged care services for older CALD people.

Multicultural aged care has many challenges. CALD communities prefer facilities and services that identify strongly with their own cultural background. Multiculturalism as a policy celebrates diversity and promotes mainstream services as the means to deliver aged care services for CALD recipients across a range of cultural backgrounds. Culturally competent mainstream aged care results in cost-effective use of resources and effectively links older CALD people to the wider community.

Older Australians from CALD backgrounds are increasingly requiring access to mainstream aged care services. Mainstream service providers are required to deliver culturally appropriate and responsive aged care services to CALD recipients to meet accreditation standards. Mainstream services alone do not currently meet the special needs of older CALD people. In certain residential settings clustering of services for CALD seniors from specific cultural backgrounds has been a successful model for mainstream aged care services but is not widely applicable because of economic pressures.

For some larger CALD communities from non-English speaking backgrounds in specific locations, ethno-specific aged care services provide a high standard of care and are in high demand. The needs and preferences of smaller and dispersed CALD communities however are not usually well targeted and can be overlooked with low numbers in multicultural or mainstream aged care services and this can accentuate marginalisation for CALD seniors.

Characteristics of the Northern Territory's CALD community demographics

The Northern Territory by area comprises 17% of the land mass of Australia, but only 1% of Australia's population. These two factors (large land mass and small population) present challenges as well as opportunities to the community services sector who have the task of identifying issues and developing strategies to assist and address issues of concern in ethnic communities.

The Top End of the Northern Territory is situated adjacent to the most culturally, religiously and ethnically diverse region in the world - a region of conflict, change and continuity where various cultures and faiths meet. As well a quarter of the population of the Northern Territory is Indigenous, and Indigenous communities manage about half of the land area.

Within the Northern Territory's ageing population, the number of people from CALD backgrounds is growing faster than for other Territorians. Within a few years it is expected that one-third of local older residents will be from CALD backgrounds. According to the 2006 Census, the Northern Territory had the youngest population of all states and territories, with a median age of 31 years. Yet paradoxically, the Northern Territory's population is also ageing, and faster than the national average.

Darwin has the fastest growth rate of the CALD population projected for any capital city in Australia, although that projection is from a very low numerical base. By 2011, it is expected that one-third of Darwin's older residents are expected to be from CALD backgrounds and the three most common countries of birth in the older CALD population are projected to be Greece, Indonesia and Germany.

Darwin has always been culturally diverse and provides an example a relatively successful multicultural society. What is perhaps unique about Darwin is that there are a large number of small interacting ethnic and faith communities. None of these communities is large enough to operate independently and exclusively of other communities in the neighbourhood, the school or in the workplace.

The cultural diversity in Darwin's older population is also increasing with changing migration patterns from interstate and overseas; more so than in the other capital cities. Another demographic factor to take into account in assessment of the ageing population in Darwin is that Darwin's proximity to Asia accounts for differences in its migration pattern and structure of the CALD community. There are four ethnic groups unique to the Top Ten of the Northern Territory's source countries of migration intake - Indonesia, Sri Lanka, The Philippines and Malaysia - that do not occur in demographic data elsewhere in Australia.

Apart from the recent demographic trends, there are social factors impacting on the decision of more seniors than before to plan to remain the Territory for their retirement and not move interstate, apparently because of advances in lifestyle, social infrastructure and access to services. This factor in addition to the rapidly ageing population of the Northern Territory and the common practice of younger CALD families to move interstate will place demands on the availability of aged care accommodation in future years.

However for the CALD population because of current low numbers, there are no ethno-specific aged care facilities or clustering of CALD communities of interest within mainstream institutions. There is a clearly defined need for the provision of culturally appropriate and empathetic aged care training in Darwin to ensure that the special needs of seniors from CALD communities are incorporated into care provision.

The current situation of the lack of culturally appropriate and ethno-specific CALD background seniors accommodation will not change dramatically in the near future because of the numerically low numbers of the various CALD communities. In addition, there is a lack of availability of cultural competency and commitment by staff to ensuring that the special needs of CALD communities are identified and addressed. The exception to this maxim would be the availability of culturally appropriate residential aged care homes for Indigenous people in the Northern Territory.

Culturally competent multicultural aged care in principle and practice

Migrants and refugees have the right to culturally appropriate and responsive services. Cultural competency refers to an ability to interact effectively with people of different cultures and implies responsiveness, accountability and reciprocity.

As Australia's cultural diversity increases, cultural misunderstandings resulting in the provision of inappropriate end-of-life care to people from CALD backgrounds has the potential to escalate. The consequences of culturally inappropriate residential aged care include psychological distress and unnecessary suffering for the recipient, family, carers and community.

Culturally competent aged care maintains individualised quality care for older Australians from CALD backgrounds through supporting individual cultural, linguistic and spiritual needs and preferences. It is always important to identify and support individual needs and preferences and not assume that all people from the same culture or religion practice the same rituals or share the same beliefs. The degree to which culture is absorbed and expressed is different for every individual, family, community and society.

While culture contributes to shaping an individual's beliefs, values and attitudes, people of the same or similar cultural backgrounds do not necessarily share the same needs or preferences in residential aged care. Differences in the cultural identity of seniors in the CALD population also occur because of other factors such as the time of arrival in Australia, socioeconomic status, educational background and life experiences.

Cultural competence is a two way learning process. Mainstream health care professionals should resist the temptation to categorise and stereotype. Culture is not absolute; for any person culture is cumulative, evolving and dynamic. Many long-term migrants in Australia have adopted values and a way of life that are different and distinct from their home country while not having dismissed past beliefs, values and practices.

It should be recognised that mainstream health care professionals hold strong culturally determined beliefs about ageing dying and death and these inform their practices in caring for older people from CALD backgrounds. It is crucial that health care professionals should seek to understand their own spirituality but not seek to impose their own values and belief systems on to aged care recipients.

The spiritual imperative of multicultural aged care and end of life perspectives

The western perspective of 'ageing and decline' and fears about ageing, death and dementia promotes stereotypical attitudes and has influenced public attitudes and service provision in the multicultural aged care sector. Mainstream community attitudes in Australia in effect are barriers to the provision of culturally sensitive aged care.

Death and dying are among the most significant and sacred events of all societies and cultures. The western trend for medicalisation and institutionalisation of aged care has removed ageing and death from everyday western experience. On the other hand, the traditional migrant family has members age die at home, surrounded by family.

Cultural and religious factors often assume greater significance for aged care recipients and their families. Ageing can be described as a spiritual journey as people confront and review their own mortality and take account of their lives past, present and future. The maintenance of integrity, wisdom, acceptance, and peace of mind requires a supportive environment that supports the spiritual dimension of the ageing person.

Holistic culturally competent aged care necessitates an understanding of ageing, death, dying and bereavement from different cultural and spiritual perspectives. Spiritual care for aged care recipients improves the quality of care in the later years of their lives and is a way of helping older people in their search for hope and meaning in their lives as they face issues of grief, loss and uncertainty. At this time for older people spirituality and religion become more pervasive and confronting to the individual and family.

Engaging in spiritual awareness is an important element in the ageing process. For this reason, health care professionals should nurture the spiritual dimension and be aware of and learn to tap into this valuable resource. Aged care services should respect and support the customs, beliefs, rituals and practices of culture, religion and spirituality that can provide meaning and comfort to aged care recipients and their families.

The interaction between culture, religion and spirituality in spiritual care

While spirituality and religion have much in common and are intertwined, they are not synonymous. Spirituality is much broader and more personal than religious affiliation and is about the search for the meaning of life, our relationships with family, friends and God and our connectedness to humanity and the universe. Religion is a component of spirituality and can be defined as the public expression and practice of an organised system of beliefs and worship that are shared with a community of believers.

There is complex interaction between spirituality and religion. Spirituality and religion are obviously not mutually exclusive but do have much in common in terms of being shaped by where and when people were born and their life experiences and choices. Spirituality and religion also share an interest in personal beliefs and feelings, the sacred and divine dimensions of life and how to transcend life's inevitable challenges.

Spirituality does not necessarily include a belief in a God or a faith or religious affiliation. While spirituality may be influenced by religious beliefs, it is also shaped through many non-religious influences. Religious practice may be an expression of an individual's spirituality but conversely people can be religious in the shared public sense but may not feel that are spiritual or in touch with their personal spirituality.

Providing for spiritual needs and preferences for recipients in multicultural aged care

Each person has a spiritual dimension and involves personal relationships and transcendent capacity becoming more intense with the ageing process. In residential aged care each individual is a spiritual being and entitled to support and care of their spiritual needs.

One aspect of many religious and philosophical traditions in CALD communities is the affirmation of the value and status of older people within the faith community and beyond in the wider community. This affirmation is at times at odds with a western secular tradition that appears to offer limited respect to older people and the ageing process. We live in a society that values people at the height of their powers and abilities.

Awareness and identification of current and preferred spiritual practices and beliefs assists with the meeting spiritual needs of aged care recipients from CALD backgrounds. The understanding of particular religious practices and beliefs assists with the provision of culturally appropriate spiritual support but simply asking an aged care recipient to which religion they belong however does not adequately determine their spiritual needs.

Aged care recipients and their carers and families report conflicting times of loss of faith and despair and at other times of growth and even inner peace. Culturally appropriate spiritual care support assists care recipients to express their unique spirituality in an open and non-judgemental environment and helping them to maintain important spiritual practices, beliefs and networks.

For some CALD communities the spiritual and religious beliefs of aged care recipients may require strict adherence to ritual and influence all aspects of their daily lives. The spiritual needs of aged care recipients may also change over time; some older CALD people become more aware of and interested in spiritual and religious matters while in residential aged care, perhaps for the first time in their lives.

Regular reviews of aged care recipients' spiritual needs and preferences will ensure the support provided is relevant to their needs. While spiritual care requires the identification of individual needs and preferences, the tendency to assume that all people who speak the same language practice the same religion, or that all people following the same religion practice the same rituals or share the same beliefs should be avoided.

In CALD communities, religions have varying degrees of adherence and influence among communities of believers. Mainstream health care professionals and spiritual carers should be aware of and provide facilities for religious and spiritual observances such as Holy Days, facilitate excursions to places of worship, assist aged care recipients to maintain existing religious networks and provide access to chaplains or pastoral care workers.

Interpreters and bilingual workers may also be needed. Often when many people of CALD backgrounds age, develop dementia or become terminally ill, they revert to their first language. This is a spiritual 'comfort zone'; even though the person may be quite fluent in English at this time it may be important to understand that there is a preference for communication in their first language and so interpreters are important if not essential.

The availability of qualified and medically informed and culturally appropriate translators and interpreters who can honestly relay information in spite of the own cultural beliefs and spirituality ensures effective, efficient and reliable communication between health professionals and aged care recipients, their families and spiritual carers.

Conclusion

In these recent times of secularisation and the search for meaning outside of traditional religion there has been increasing attention focused on spirituality and the role it plays in physical health and mental well being of aged care recipients. In residential aged care the need of an individual for spiritual care is not confined to those who have religious beliefs and practices but extends to all. Specific spiritual needs should be identified and not confined to those residents who have nominated that they belong to a particular religion.

It is recognised that the provision of quality aged care within a multicultural framework is more successful when it is 'patient centred' and designed around the unique needs of individual. There is the imperative for mainstream health care professionals to take into account the beliefs and values that CALD aged care recipients bring to residential settings and should be aware of and understand their spiritual needs, resources and preferences.

The provision of culturally appropriate spiritual care in residential aged care settings is a holistic team effort and benefits not just the CALD aged care recipients but society as a whole. The MCNT is working to address inherent access and issues in multicultural aged care in Darwin to ensure that the spiritual dimension is embraced and nurtured for the benefit of carers, care recipients and their families and communities.