

Delivery of
Community Aged Care Services
to Ethnic Groups

MAINSTREAM *versus* ETHNO-SPECIFIC SERVICES

it's not an
'EITHER \ OR'

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GLOSSARY AND ACRONYMS

ACCS	Australian Croatian Community Services
ACSA	Aged Care Services Australia
APCS	Australian-Polish Community Services
CACPs	Aged Care Packages
CALD	Culturally and Linguistically Diverse
CEGS	Culturally Equitable Gateways Strategy
ECCV	Ethnic Communities' Council of Victoria
ESAs	Ethno-specific Agencies
FECCA	Federation of Ethnic Communities' Councils of Australia
HACC	Home and Community Care
PAGs	Planned Activity Groups
PICAC	Partners in Culturally Appropriate Care
VAHEC	Victorian Association of Health and Extended Care (now Aged and Community Care Victoria)
Grey literature	Literature that has not been coded with ISBN under a nationally recognised database system

EXECUTIVE SUMMARY

Project purpose and background

The purpose of this project was to review the literature concerning the delivery of community aged care services to people from culturally and linguistically diverse (CALD) backgrounds. This document presents the findings of the review.

The Ethnic Communities' Council of Victoria (ECCV), in collaboration with the Healthy Ageing Research Unit at Monash University, identified the need for such a review in order to inform their organisational strategy in relation to the future direction of community aged care service delivery. While there is a wealth of experience and anecdotal evidence in the multicultural sector on this topic, the purpose of this review was to consolidate the academic literature published nationally and internationally.

Project methods

The following activities were undertaken as part of the literature review:

1. Consultation with the advisory group to devise a description of the content to be included in the review;
2. A systematic search of the key databases to obtain a preliminary list of relevant literature;
3. Consultations with key informants to identify further literature (including internal agency policies and reports) and to highlight key themes;
4. Review of the draft report by the advisory group;
5. Development of key findings of the review and key points for consideration; and
6. Production of the final report.

Key findings of the review

Needs and experiences of older CALD people

- Due to variations in reasons for immigration, length of time in Australia and English language proficiency, together with the common factors that contribute to individual differences (such as age, gender, religion, income, socio-economic status, geographic location), the experiences and needs of older people from CALD backgrounds are dynamic and diverse.
- Language barriers and lack of accessible information about services to older people and their families, continue to emerge as the key barriers to service provision for older people from CALD backgrounds.

Models of service delivery and partnerships

- A fundamental principle for service delivery is that a blanket approach, or single model of service delivery, may be inappropriate to meet the diversity and dynamic nature of CALD people's needs.
- While multiple service systems and agencies do enhance consumer choice, they may also present challenges to the ease of access to services and administrative challenges.
- Mainstream services alone do not currently meet many older CALD people's needs.
- Ethno-specific services are a vital component of service delivery models but may not be able to meet the diversity of smaller CALD groups' needs.
- It's not an 'either or': Ethno-specific, multicultural and mainstream services are all required to work in partnership to deliver a responsive and effective community aged care system.

Policy: A whole-of-government approach

- Despite a substantial body of policy work in the area of cultural diversity and responsive multicultural aged care services, a consistent and coherent policy direction remains to be developed.
- The concepts of multiculturalism and diversity have become open to a multitude of interpretations which are being used to justify the gamut of service provision models.
- Insufficient funding and inadequate resource allocation are hindering effective service provision.
- Potential exists for a whole-of-government approach that will reduce gaps in service provision for CALD older people.

Quality research and dissemination

- Academic and evidence-based research and publications in this field are scarce.
- The grey literature appears to predominate, but is difficult to access and may lack scientific rigour.
- An increase in published research, together with evaluation of programs and service delivery models are required in order to inform evidence-based policy making.

Key points for ECCV and its constituencies' future consideration

Models of service delivery and partnerships

- Continue to explore alternative and flexible models of service delivery to meet the needs of a diverse older population.
- Review the implications of adopting a macro (e.g. based on broad service provision principles such as equity, access and social justice) versus a micro, 'person-centred' (e.g. individual differences and needs) approach to aged care service delivery.
- Consider how to balance the 'trade off' between meeting CALD-specific needs, as well as providing a flexible, cohesive, and accessible service system.
- Consider how best to develop partnerships between mainstream and Ethno-specific Agencies (ESAs), and identify the key principles upon which these partnerships should be based.
- Promote the development of appropriate practice guidelines to build and foster effective and equitable partnerships and relationships between government, peak bodies, mainstream, multicultural and ethno-specific services.
- Develop strategies that capitalise on the knowledge and experience of ESAs and bilingual/bicultural workers, ensuring that their contributions are valued by mainstream agencies in order to promote effective partnerships.

Policy: A whole-of-government approach

- Promote existing efforts to strengthen a whole-of-government approach that takes into account the needs of Australia's increasingly diverse older population.
- Continue to lobby government to devise more comprehensive and coherent policy directions and guidelines to better serve the needs of CALD older people, including the promotion of partnership models.
- Increase awareness of the implications of promoting policy directions around multiculturalism, cultural difference and social inclusion, and the potential tensions that exist.
- Encourage the development of evidence-based policy and practice.

Workforce and training

- Ensure that increasing the numbers of accredited interpreters and bilingual staff in mainstream organisations remains high on the policy agenda to promote ongoing improvement of mainstream service provision.
- Increase training opportunities for bilingual staff in both mainstream and ESAs to increase their language capacity to meet CALD clients' needs and the ability to influence higher-level organisational decision making.

Quality research and dissemination

- Improve channels of communication between ESAs and government to ensure dissemination of relevant grey literature and avoid unnecessary duplication of research. This may be through existing networks, an ongoing program of forums, and/or accessible via a central database allocated with an ISBN.
- Increase awareness and recognition of the knowledge, expertise and experience of and within the multicultural sector, as well as the value of the literature produced.
- Bridge the gap between the grey literature and the academic and evidence-based research to ensure that the grey literature informs more formal research.
- Encourage the development of partnerships between research institutions and ESAs to create opportunities for developing rigorous and empirical research which will address any gaps in the literature.
- Encourage sustained research to investigate not only needs but also availability, access and effectiveness of CALD-specific initiatives to improve health outcomes in ethnic communities and to inform policy development.

Planning for the future

- Continue to identify channels for improving access to information about services for older CALD people and their families.
- Facilitate access to knowledge, experience and resources of larger, more established ethnic groups, by smaller emerging groups.
- Encourage ongoing monitoring of Home and Community Care (HACC) service use and packaged community aged care service use, in relation to population demographics and projections.
- Promote efforts to involve and include older CALD people in setting their own research agendas, planning and policy.

REPORT OVERVIEW

This review was undertaken within the context of a demographic phenomenon, both internationally and within Australia, in relation to the increasing numbers of older people from CALD backgrounds.

The Ethnic Communities' Council of Victoria (ECCV), in collaboration with the Healthy Ageing Research Unit at Monash University, identified the need for a comprehensive literature review on the delivery of community aged care services to people from CALD backgrounds.

The central purpose of this review is to inform ECCV's organisational and policy strategies in relation to future direction of community aged care service delivery.

Following a brief outline of the methodology, this report sets the scene for the research within the context of the contemporary Australian aged care and multicultural sectors. The report provides an overview of relevant literature in relation to the delivery of community aged care services for older people from CALD backgrounds.

In the executive summary, this report draws together the main findings of the literature, and establishes key considerations for service policy and planning.

PROJECT METHODOLOGY

Funding for the project was provided jointly by ECCV, several ESAs and the Victorian State Government. Representatives from these organisations formed an advisory group to oversee and guide the development of the review. The research team met regularly with the advisory group who provided insights and expertise to the project.

A comprehensive literature search incorporating the relevant published and unpublished (grey) national and international literature was undertaken. Electronic database searches included Ageline, Ageing Research Online, ProQuest, CINAHL, Informat, HSTAT, Web of Science, and Embase. Google and Google Scholar were also searched to identify literature that may not have been readily available via other databases. Key funding and service organisations websites (e.g. Department of Human Services, Joseph Rowntree Foundation, ECCV, Federation of Ethnic Communities' Councils of Australia (FECCA), Department of Health and Ageing, Council on the Ageing, and Centre for Culture Ethnicity and Health) were also accessed. Several key journals (e.g. Journal of Cross-Cultural Gerontology, Health Services Research, Health and Social Care in the Community, Ethnicity and Health) were also separately searched, and the key reference lists were also scanned for relevant documents. Literature accessible in the English language from 1980 was included in the review. The key search terms included: ethnic; CALD; cultural; ethno-specific; ethno; ageing; aged care; services; community; and service delivery.

A small number of key informants nominated by the advisory group were consulted as an additional strategy to elicit information about the key grey material, as well as to identify current issues and key themes in this area. Key informants included members of the advisory group, state government and members of ethnic communities.

Limitations of review

Traditionally, a systematic academic review categorises literature according to various 'levels' of evidence depending on how the research was conducted and what methodology was employed. In the field of delivery of community aged care services to people from CALD backgrounds, however, traditional scientific literature that can be rated in this way is scarce.

The majority of the evidence on this topic is located in the grey literature, which is less accessible and therefore less likely to be included in rigorous academic reviews. Furthermore, unpublished literature is

often regarded by the academic world as less scientifically sound, as it is often based on experiential or anecdotal evidence and not empirical research. It is also unlikely to have been peer reviewed, resulting in insufficient quality control during the dissemination process. Peer review provides some measure of quality of control in the evaluation of particular propositions.

The authors of this report acknowledge the importance of the grey literature for informing the findings of this review, as it is predominantly grounded in the opinions and experiences of planners, policy makers or service providers who have direct contact with aged care services or multicultural and ethno-specific agencies (ESAs). Much of this grey literature reports on the significant needs of its clients, the experiences of older people themselves, and is therefore a valuable source of information. References to the grey literature will primarily be contained within the first section of the review (Australian Context).

It must be emphasised that literature of all kinds is produced in a social and political context. It is not surprising therefore that the findings of this review in the main may align with current government funding, policy and political frameworks. In addition, there is also the likelihood that many of the planning and policy documents written by agencies are never released into the public domain. Indeed, it was suggested by a number of key informants interviewed that these unpublished documents may be 'controversial' or 'challenge current political directions'.

INTERNATIONAL CONTEXT

The ageing of populations is an important demographic phenomenon that has created significant challenges for many countries including Australia. Internationally, maintaining health and wellbeing and minimising disability for older people are now major goals for researchers, health professionals and policy makers alike (Andrews, 2002; Browning & Kendig, 2003, 2004; Secretary of State for Work and Pensions, 2005; Yang, Browning, & Thomas, 2006). It is recognised that ageing well can have major impacts on individuals, families and communities, in addition to the economic costs of services provided to older people. Supporting older people to maintain the best possible state of health and wellbeing is therefore in everyone's interests.

Unfortunately, there is overwhelming evidence to indicate the inequalities in health of minority and ethnic groups. In response, the World Health Organisation (WHO) continue to disseminate frameworks and guidelines to promote health for all (World Health Organisation (WHO), 1978). Inequalities in health care and reporting of people from CALD backgrounds is also of concern to researchers who advocate for more useful data collection that reflects the diversity of the population (Siegel, Regenstein, & Jones, 2007).

AUSTRALIAN CONTEXT

Defining the CALD Population

In addition to an ageing society, Australia has the added challenge of a multicultural society, which is likely to have diverse health needs and require diverse responses accordingly. In 2006, the number of overseas-born Australians reached five million, representing almost a quarter (24%) of the total population. The proportion of persons 65 years and over is greater amongst the overseas born population (17.7%) than for the Australian-born population (10.9%), reflecting past immigration trends and policies (Australian Bureau of Statistics, 2008).

CALD communities vary according to how and when individuals arrived in Australia, particularly in relation to specific immigration programs, or whether they arrived as refugees or skilled migrants. The older CALD community is a heterogeneous group, currently comprising people who came to Australia when they were young and have now turned 65 years, as well as those people who have come in older age for family reunion or retirement (Ip, Lui, & Chui, 2007). These factors have implications for service development and delivery that is responsive to particular community and individual needs.

To date, defining cultural and linguistic diversity has been a challenge, primarily because it is comprised of many different factors. The Australian Bureau of Statistics identified a set of variables in order to develop consistency across data collection (McLennan, 1999). The core variables included Country of Birth of Person, Main Language Other Than English Spoken at Home, and Proficiency in Spoken English. The full standard set also includes Ancestry, Country of Birth of Father, Country of Birth of Mother, First Language Spoken, Languages Spoken at Home, Main Language Spoken at Home, Religious Affiliation, and Year of Arrival in Australia. Howe (2006) suggests that languages spoken at home and English language proficiency are the most useful indicators for the purpose of identifying the needs of CALD older people in relation to the provision of HACC services.

Policy context

This review revealed that over the past 30 years, a number of important government and non-government documents addressing policy, funding and service delivery strategies for ethnic communities have been developed. It is these documents that have, in no small way, assisted in shaping the direction and provision of aged care services within a multicultural Australia. In short, these documents have guided strategies for reform in the provision of community care within a multicultural framework (see Appendix 1, for timelines of key events and reports).

Immigrants form the majority of Australia's population. Their numbers have been determined according to evolving immigration policies over the last 200 years. In the last 20 years or so, the social consciousness of government has moved from assimilation, to integration to multiculturalism (Garrett & Lin, 1990). Multiculturalism is now the prevailing policy direction, used by the governments to promote a society that values and celebrates diversity (Thomas, 2007) which has, in many respects, paralleled international experiences (Garrett & Lin, 1990).

This predominant policy framework has resulted in the stagnation of ethno-specific aged care services, and the promotion of mainstream services as the best way to cater for the needs of CALD older people (Aged and Community Services, 2006; Allotey, Manderson, & Reidpath, 2002). However, due to the plethora of ways in which the concept of multiculturalism has been interpreted, it has justified the development of both mainstream and ethno-specific services. This particular observation provides a critical context for the findings of this review.

Aged care system

The Australian aged care system is funded and managed by a combination of local, state and federal government, non-government and private agencies. The aged care system can be broken down into four tiers (ECCV, 2008):

- **Residential Care** and related support services for very frail older people;
- **Respite** services for frail older people living in the community and their carers;
- **Community Care** for frail older people living in the community; and
- Services and groups that promote social interaction and active and **Positive Ageing** for older people.

These services are classified as 'formal' care, which is separate to the 'informal' care and support provided by family, friends and neighbours. For the purposes of this review, consideration is primarily given to the middle two tiers: specifically respite and community care for frail older CALD people and their carers living in the community.

There is strong preference internationally for CALD older people and their families to remain in the community rather than seek institutional care (Barnett, 1988; Multicultural Council of Tasmania, 2006; PRIAE, 2004). Up to one million Australians used community care services in 2004-2005 (The Allen Consulting Group, 2007). However, it is estimated that more than 400,000 older Australians living at home have unmet care needs: some of these are existing clients, but many others may not be aware of, or accessing the service options available to them (The Allen Consulting Group, 2007, p. vii). Clearly, there will continue to be an ever-increasing demand for an accessible and efficient community aged care service system.

Victorian ageing initiatives and programs

The *Home and Community Care* (HACC) program is cost-shared between the Commonwealth and State governments. In Victoria, approximately \$480 million is currently allocated to the HACC program. In 2003-2004, over 216,000 Victorians received a service from this program, which included 21% from 85 nations classified as non-English speaking countries and 12% who speak languages other than English at home (Aged Care Branch, 2006).

Over 500 agencies provide HACC services in Victoria, 50 of which are ethno-specific. Seventy-five per cent of HACC funding goes directly to local government authorities (LGAs) which is the State Government's preferred model of resource distribution (as opposed to a multiple service system). In this way, a key informant suggested that the model aims to ensure all geographic locations are covered, reducing potential gaps in service eligibility and for ease of planning. A number of ESAs are funded directly to provide a more discrete set of HACC services (namely social support related, such as Planned Activity Groups (PAGs) and Volunteer Coordination services – as opposed to 'core' HACC services). The state government's vision is that HACC is a needs-based service, is fair and equitable, and not simply for those people who are familiar with the service system.

The *Culturally Equitable Gateways Strategy* (CEGS) was launched in Victoria in December 2003. The aim of CEGS was to expand the use of core HACC services provided by local government to people aged 65 and over from CALD backgrounds (Australian Healthcare Associates, 2007). \$2.1 million per annum (over three years) was allocated to 19 councils, 17 ethno-specific agencies, three Migrant Resource Centres, the Municipal Association of Victoria and ECCV. In addition to increasing service usage, the aim of the strategy was to build and strengthen partnerships between agencies. The strategy has now been evaluated and the draft report highlights the many achievements and challenges of the strategy, and offers recommendations for the roles of LGAs and ESAs in the future delivery of HACC services (Australian Healthcare Associates, 2007).

The *Victorian Cultural Planning Strategy* (CPS), implemented in 1997 and evaluated in 2006-07 (Brooke, 1996; Keating & Barrow, 2007; Loughnan, 2002), focused at the systemic level to address capacity for organisations to deliver culturally appropriate services (i.e. cultural competence). The CPS incorporates the use of the Cultural Planning Tool (CPT) and promotes developing a HACC Cultural Action Plan (CAP) as an annual requirement for services. Evaluation of the strategy indicated that it was not well designed, implemented, or integrated within existing strategies and frameworks and recommended that it requires substantial reworking. The lack of formal links between the CPS and CEGS was also highlighted in the CEGS evaluation (Australian Healthcare Associates, 2007).

The *Active Service Model* is a recent policy initiative introduced by the Victorian State Government, and is based on the vision that HACC services should be provided to 'supplement' clients' functional abilities, rather than reinforce their dependency (Department of Human Services, 2008). Underlying this initiative is the view that by adopting preventive or early intervention approaches to care – as opposed to being crisis-driven – the demand for, and cost of, future services will be significantly reduced. The introduction of this initiative, without any specific reference to people from CALD backgrounds, is an indication that current government continues to adopt a mainstreaming approach to community aged care services delivery. However, the 'Supported Access' program, a pilot program launched at the beginning of 2008 involving eight ESAs, implies that there is still a role for ESAs and scope for improving CALD people's access to HACC services.

The Victorian approach is similar to that of Queensland in its Multicultural Services Development Strategy. The focus of this service planning strategy is on the provision of generic services which, according to Queensland Health, is not at the expense of growth and development of existing ethno-specific service provision (Queensland Government Queensland Health, 2006). The Queensland Government has clearly articulated that the most effective long-term approach is to deliver services to older CALD clients through mainstream HACC services. The report however, acknowledges

ESAs as a key component to service provision, and agencies are encouraged to apply for funding to expand their capacity. The report also outlines how new ESAs, which can demonstrate need, will also be eligible for funding. Interestingly, a range of new and existing initiatives were highlighted as targets for ongoing development, in order to support the vision of Queensland HACC program in developing the capacity of mainstream HACC providers to deliver services to CALD people. These initiatives included: information, education and training services; HACC workforce Skills Development Strategy; HACC Multicultural Information Strategy; enhancing planning and purchasing process; promoting communication; and enhanced client care co-ordination.

Current Victorian community aged care service use by CALD clients

While there is evidence to suggest under-utilisation of HACC services by CALD communities, a recent evaluation of the CEGS strategy indicates that the rate of use of HACC basic services by CALD people across metropolitan Melbourne is rising (Australian Healthcare Associates, 2007). Similarly, a review of HACC social support services for CALD people found services to be well attended and provided important opportunities for socialisation, physical activity and access to support (Haralambous, Moore, & Tate, 2007).

The pattern of HACC service usage by people from CALD backgrounds in rural areas differs, however, from those with Anglo-Celtic backgrounds. Ward et al. (2005) investigated the use of HACC services by CALD people compared to Australian-born in rural areas of Victoria. Whilst they found that the proportion of CALD people who were HACC users was consistent with the demographic profiles, this was not the case for their extent of service usage (they received 35% less hours than Australian-born counterparts).

As part of the CEGS strategy, Howe (2006) undertook a comprehensive investigation to map the trends, profiles, and distribution of Victoria's CALD population with a view to informing future service planning and delivery of HACC services. Howe concluded that the dynamic and dispersed CALD population across Victoria requires a flexible strategy to address the diversity of CALD people's needs.

Overview of peak body and service provider perspectives

The following section presents a selection of peak body and service provider perspectives, specifically relating to future models of community aged care service delivery. These are illustrative examples and are by no means a comprehensive list. The perspectives presented are primarily based on printed materials produced by the respective agencies. The authors would like to acknowledge that many key service providers and agencies do not have the resource capacity to produce such documentation. Unfortunately, therefore, their perspectives have not been included in this overview. However, this section does incorporate some views and perspectives of key informants where appropriate.

Australia's peak bodies involved in ageing, aged care and multicultural issues, together with direct service providers, have a wealth of expertise and experience from which to draw upon, in the circumstances and service needs of the older population. Between them, they continue to produce a plethora of reports documenting client needs and barriers to services, and prepare submissions to government, outlining planning and strategic directions, and offer policy recommendations. Accordingly, this documentation is grounded in direct contact with clients and communities, and the experience of delivering community-based services. This provides an invaluable body of knowledge directly informed and influenced by funding bodies and the changing political climate. Often this documentation is not published, which not only makes it widely inaccessible, but also brings into question the quality of the evidence base provided in these reports. The authors of this report acknowledge the importance of this particular body of work in informing this literature review, but also acknowledge its limitations.

Aged and Community Services Australia (ACSA)

ACSA (Aged and Community Services, 2006) maintains that a mixed service system that accommodates a range of needs, cultural and geographical differences is the appropriate policy response. Ethno-specific and multicultural models are important and legitimate components of a culturally competent system. A cultural competency model needs to be embraced and strategies identified, in order to develop a culturally competent workforce, such as developing partnerships between industry and the education sector. Future considerations include the notion of a 'cultural pool' of funds to assist with meeting cultural norms and standards as well as the production of high quality research. Underpinning this policy position, is the belief that cultural diversity is a mainstream issue (Mundy, 2007).

Aged and Community Care Victoria (ACCV, formerly VAHEC)

VAHEC (Victorian Association of Health and Extended Care, 2005) produced a comprehensive report documenting the issues relating to the provision of aged and community care services to people from CALD backgrounds. It listed 37 recommendations which Gerard Mansour (2007), of ACCV, stated as being even more relevant today than in the past. Recommendations for the provision of services fall under eight categories (including government, industry, providers, planning, benchmarking, etc). Generally, there is support for a multi-pronged approach, with roles for ESAs, cluster, multicultural and generalist services discussed. Specifically, ESAs are recommended in the case of larger ethnic communities, with other service types offering alternative solutions in the cases of small or dispersed ethnic communities. The proposed approach assumes a model of care that: (1) provides for the 'whole' person; (2) focuses on the individual and specific care needs; (3) places culture at the centre of service planning; (4) engages the client in decision making; and (5) engages family and community in provision of care.

Federation of Ethnic Communities' Councils of Australia (FECCA)

FECCA (2007, p. 6), in its most recent ageing policy statement, supported the position that "... ethno-specific and multicultural service providers must have the opportunity to provide aged care services on an equal footing to mainstream service providers where they can demonstrate capacity and scale. This includes in the area of HACC services which are often managed by state governments with significant federal funding". The statement also emphasised the need to build the capacity of mainstream services, and adopt a non-discriminatory approach to aged care.

Ethnic Communities' Council of Victoria (ECCV)

ECCV (2007), in their CEGS services guide, supported multicultural and ESAs in ensuring culturally competent service provision. ECCV called upon the Government to increase funding to multicultural and ESAs to support their work and allow for greater choice of services and service providers by CALD older people. ECCV (2006) reported that, in reality, mainstream services are increasingly turning to multicultural and ESAs for advice on how to deliver culturally appropriate care, which further supports their claim for increasing the capacity of multicultural and ESAs directly. Key policy directions include allocating sufficient funds for cultural and linguistic-specific services, ensuring that organisations can demonstrate cultural competence and associated respect/regard for the expertise of multicultural and ESAs, and the use of brokerage funding models (Kukanja, 2007). Brokerage models, in this instance, are those where smaller ESAs are engaged by larger generic organisations, such as local governments, and are financially compensated for their specialist knowledge and services.

Australian-Polish Community Services (APCS)

In a recently released 10-year Aged Care Plan, APCS highlighted advocacy, partnerships, adequate service system resourcing and direct service delivery, as key strategies to deal with this community's current aged care issues (Ashby J. and Associates Pty Ltd, 2001). This plan flags access to services as critical. Partnerships were identified specifically with the aim of improving the relationship between Polish elderly and mainstream services and facilities. The document pictorially illustrates the current services supplied by APCS (e.g., Community Aged Care Packages (CACPs), PAGs, Social Support), as well as those services most in demand which include more CACPs (due to increasingly older profile of Polish clients), Linkages (nursing home level care at home), linking to HACC, dementia care, and support for carers.

In addition, APCS's Health Promotion Plan identified systemic and service issues as a key health issue (Butera, 2007). More specifically, the Plan identified the importance of having "a 'service system' where ethno-specific and multicultural services complement and add value to mainstream service providers and support them to develop inclusive practices and strategies which ensure health needs are met and health inequalities are effectively addressed" (p.19). Samplawski (2000) outlined six key points in relation to providing culturally appropriate PAGS for older Polish clients including: delivery of programs in Polish; establishment of links for clients within the wider Polish community; a holistic approach; acknowledgement of the Polish character and migrant experience; acknowledgement of Polish history; and how these considerations provide a sense of belonging. Samplawski (2000) identifies the APCS service as being a model of best practice through employing expert and responsible staff as well as providing services that are sensitive, responsive, coordinated, timely and thorough. In addition, service provision can be improved for Polish elders by employing bilingual staff, training culturally competent staff, and through implementing effective information strategies (Drozd, 2002).

Froniditha (Australian Greek Society for Care of the Elderly)

Froniditha undertook a demographic and needs analysis of Victoria's Greek elders. Recommendations highlighted that governments should fund ESAs as the preferred model of service delivery, where cost effectiveness is proven (Tsingas, 1998).

Australian Croatian Community Services (ACCS)

In its 10-year aged care plan, ACCS identified its key role in the provision of direct services, information and education to its target communities. Furthermore, in response to the Croatian community's lack of current access to mainstream aged care services, the plan also highlighted the organisation's role in providing advice to mainstream service providers (Dimitriadis & Freidin, 2004).

South Australian Multicultural and Ethnic Affairs Commission (SAMEAC)

The role of SAMEAC (Le, 2006) is to advise the Government and public authorities on the extent to which services and programs meet the needs of CALD people. Aged care issues have long been a concern for this Commission and Le argues that mainstream service providers need to build their capacity to better engage with community organisations to empower the latter in the provision of aged care services to their respective communities. This position supports the partnership model approach, which will be discussed later in the review of the literature.

Ethnic Link Services, South Australia

Funded by the HACC program, Ethnic Link Services, in Adelaide, has been in existence for over 20 years, working towards building equity of access to HACC services for CALD people. Bilingual workers provide language assistance, advocacy and linkage to mainstream service providers for clients in over 24 languages, liaise with ethnic communities and address cultural awareness issues in mainstream services (Brock, 2002).

Key Informants

As one key informant summarised, the demand for basic community care is common across all older people. Addressing needs related to food, social life and lifestyle, however, requires more specific attention. Another informant highlighted the need to account for the fact that older people from CALD backgrounds often want to re-establish links with their cultural roots, particularly as they age. Client needs are dynamic, and service models need to be flexible to cater for these changing needs (on a daily basis). This informant also noted that the administrative shackles inherent within a government department are not conducive to serving the diverse and dynamic needs of CALD clients. Nor does a stringent or restrictive geographically located funding model necessarily have clients' best interests in mind. CALD clients' needs go deeper than just addressing language needs, but their values also change over time. While there is a need to build a responsive service 'system', by its very nature, a 'system' cannot cater for individual need.

Summary

Generally, the evidence indicates the need for an increasingly culturally responsive and accessible aged care service system in Victoria, underpinned by the coexistence of multicultural, ethno-specific, and generic aged care and support services (Kukanja, 2007). Together they offer a range of vital services to clients, and a much needed choice of service options. Over the past 15 years, much progress has been made in improving the quality of service provision to older CALD people (Drozd, 2002). Overall, there appears to be support for developing a national framework and strategy for ensuring a culturally competent health and aged care system. Whilst multicultural and ESAs recognise their own vital role in service provision, there exists an underlying assumption and expectation that mainstream services will always be part of the picture of service provision. For this reason, multicultural and ESAs regard advising and supporting mainstream service provision for older CALD people as one of their key roles.

REVIEW OF THE LITERATURE

The literature presented in this section comprises national and international peer reviewed journal articles, public opinion pieces, project reports and other research. The majority of this literature is published and widely available via formal research databases (see p.7). The following review presents a summary of this literature. More detail about specific literature cited in the review is available (Appendix 3). It must be noted, that a number of papers reviewed in this section is in direct contrast to the views, practices and policies of the multicultural sector.

The international literature offered important insights and lessons in relation to the delivery of community aged care services in Australia. Due to the different demographic, geographic, and political context however, it must be recognised that the applicability of this literature to service delivery models in Australia may be somewhat limited. It is therefore recommended that the findings from international sources be read with this perspective in mind.

Older people from CALD backgrounds have been identified in the literature as a group with 'special' and diverse needs. An overview of the literature identifies this group's needs and experiences of community support services and provides the context for a summary of different service delivery models. This discussion is then followed by an outline of the literature focusing on service delivery for smaller target groups.

Overview of CALD needs

CALD as a 'special' needs group

Older people from CALD communities share many of the same support needs as other older Australians. However, they have also been identified as being a special needs group, due to the following factors (Barnett, 1988; Barnett & Associates, 1997):

1. Being separated from their place of birth;
2. Speaking a language other than English, or having English as their second language;
3. The need to adapt to a culture which is different from their own, and having their own culture not appreciated or acknowledged by others;
4. Having to cope with intolerant or racist attitudes, or with cultural stereotyping; and
5. Difficulties experienced in accessing aged care services due to these and other factors.

Rowland (1999), however, highlighted that only about a third of older CALD people will have special needs that require ethno-specific services. His analysis was based on the assumption that it was those new arrivals and settlers with little or no English who are likely to be the most in need of ethno-specific services. Obviously English proficiency does not mean that older CALD do not require ethno-specific services, it simply means that they will come up against less barriers and challenges on account of being able to communicate. This analysis supports Howe's (2006) assertion that the CALD population, in the context of HACC services, should be defined according to levels of English proficiency.

Heterogeneity of CALD people

Rowland's (1999) distinction between different levels of need amongst CALD older people supports the widely held assertion that older CALD people are not a homogenous group. Indeed, the majority of the literature highlights the heterogeneity of experience and needs amongst people from different ethnic groups (e.g. Mackenzie, 1999; Matsuoka & Sorenson, 1991; Patel, 1999). Heterogeneity has obvious implications and challenges for developing effective service delivery models.

The health concerns and expectations of older Australians from Anglo-Celtic backgrounds differ from those of older people from other ethnic groups (Quine, 1999). However, the findings by Quine indicate

that there is equivalent variation across different ethnic groups. She cautions against using a blanket approach to developing policies and planning services for CALD older people (Quine, 1999). As an example, ethno-specific needs of those with greater English language proficiency are likely to be more amenable to management within mainstream provision (Rowland, 1999).

Overview of needs and barriers to services

The range of physical, social and support needs of CALD communities in Australia has been comprehensively documented (e.g. Nimri, 2007; Orb, 2002; Rao, Warburton, & Bartlett, 2006). In Orb's review of the literature, three areas of concern for ageing ethnic migrants were identified: physical health; mental and psychological wellbeing; and socioeconomic welfare (Orb, 2002). A Queensland scoping project identified the major categories of issues as: economic and financial aspects; social needs, social isolation and quality of life; transport; housing; health needs; and aged care (Bartlett, Rao, & Warburton, 2006).

These issues faced by older people in general may become exacerbated by cultural and language barriers, migration circumstances, age at the time of migration, gender, and geographic location, along with age-friendly housing, transport and infrastructure facilities (Bartlett et al., 2006). While the circumstances of CALD older people may vary according to age on arrival and reason for immigration, certain common demographic factors have been identified as sources of stress (e.g. existing community support, marital status, rural or urban backgrounds, English competency, and dispersion of children) (Thomas, 2007). There is also anecdotal evidence to suggest that as people age, they seek more social interactions with those from similar CALD backgrounds (Nimri, 2007; Rao et al., 2006).

Perceived barriers for CALD groups accessing respite services include either not having knowledge about services, cultural inappropriateness of services, language barriers, cultural barriers (e.g. food/religious requirements), lack of links between organisations and CALD groups, as well as a lack of available bilingual staff (Gallagher & Truglio-Londrigan, 2004; Kruger, Tennant, Smith, & Peachey, 2007; Migrant Information Centre and Yooralla, 2006). Above all, language and communication consistently emerge as the primary barrier to accessing services (Bartlett et al., 2006; Thomas, 2007).

One study highlighted how the needs of older Australian refugees often get subsumed within those of refugees or CALD older people more generally (Hugman, Bartolomei, & Pittaway, 2004). The impact of trauma for this group was found to be a common experience, which researchers suggest can lead to a range of mental health problems (Mackiewicz, 1996).

A study in Hong Kong revealed that Chinese elders are often passive in expressing their community care needs, and as such, may demand more awareness on the part of professionals around non-verbal cues (Lui, Lee, & MacKenzie, 2000). Another study of older Chinese migrants in Australia, identified lack of English proficiency, difficulties accessing language support and interpreter services, transport, and dependency on children, as key issues, especially for women (Ip et al., 2007). The authors suggested that a common belief, held by non-Chinese, that Chinese older parents are usually well looked after by their families, had the potential for feelings of loneliness and isolation to go unnoticed. A British study of black and minority older people confirmed that assuming the extended family of people from CALD backgrounds will look after their elders may be a myth (Butt & O'Neil, 2004). While older people from CALD backgrounds may be more likely to live with their families for a range of reasons (family reunification schemes, financial hardship, cultural inappropriateness of public care, etc.), it appears that the support they receive from their families may be more about containment rather than care.

Other writers suggest that racism in the health and social service system may also lead to unmet need (Blakemore, 2000). Racism in this context includes how individuals from different CALD backgrounds face more barriers to accessing healthcare than individuals from the dominant group. A British study

revealed that older people regard mainstream services and society as being both ageist and racist (Butt & O'Neil, 2004). It is evident that some minority communities are in a much better position than others to overcome the challenges of a system that caters to the mainstream to meet the care needs of their older people (Blakemore, 2000). "In this way existing research has tended to racialise the debate about minority needs, focusing on problems in community care as if they affect all black people equally" (Blakemore, 2000, p. 30).

In the UK, Brotman (2003) highlights how the barriers to care for CALD older people have been focused at the individual and relational level, without attention being given to systemic barriers. Brotman makes the point that while multicultural initiatives have erased racism from the agenda, racist attitudes still need to be challenged by gerontological policymakers and practitioners (Brotman, 2003).

Thus, while the literature indicates there is a substantial degree of unmet need which may be exacerbated by being from a CALD background, it is important to emphasise that unmet need may be temporary and best predicted by a lack of an 'engaged', not necessarily unavailable, caregiving system (Tennstedt, McKinlay, & Kasten, 1994). The following issues were identified as particularly important in relation to aged care policy and the CALD community: linguistically appropriate services; culturally appropriate services; appropriate information strategies; appropriate consultative and participatory processes; appropriate training strategies; improved coordination strategies; and appropriate planning and data collection processes (Barnett, 1988). "The diversity of the ethnic population and its range of needs can encourage fragmentation of resources, duplication of some services and gaps in others" (Barnett, 1988, p. 11). Still pertinent today, this sentiment highlights the fact that coordination of services is critical. The next section examines the literature regarding service system models in more detail.

Models of service delivery

Overview

Developing culturally appropriate services is challenging, as indicated by the range of different models that have evolved over the last thirty years or so. The responses to this challenge range from the provision of ethno-specific services, to increasing the capacity of mainstream services, to become more culturally sensitive and inclusive (Barnett & Associates, 1997).

While mainstream services appear to be the current prevailing model of community aged care service delivery, the evidence indicates that these services are still not able to meet the needs of older CALD people.

The literature offers abundant evidence to support the value and effectiveness of ethno-specific services for CALD older people. However, it also provides evidence that it is not feasible for ESAs alone to respond to the needs of all Australia's ethnic communities.

Reviewing the literature highlighted that the critical question to be asked is not about the comparative efficacy of ethno-specific versus mainstream services, but rather how the various different models can best complement each other. Consequently, it is not a question of an 'either or' approach.

Both the published and unpublished literature indicates that the future of community aged care service delivery lies in the coexistence of mainstream, multicultural and ethno-specific services working together and in partnership. However, anecdotal evidence cautions that a partnership model can also be time-consuming, ineffective and frustrating when incorrectly implemented.

Range of models

Review of both the Australian and international literature indicates that no single model of aged care service delivery can meet the needs of all older people from CALD communities (Barnett, 1988; Barnett & Associates, 1997; Garrett & Lin, 1990; Howe, 2006; Matsuoka & Sorenson, 1991; Rowland, 2007; Watt & MacGaughey, 2006). There is widespread support for the roles of ethno-specific, multicultural, and mainstream services, working independently and in partnership. Some models of care may be more suitable to some locations and communities than others, depending on many factors, such as ethnic population profile and dispersion and geographic characteristics (Howe, 2006). While there is a demand for greater flexibility of service models to enhance choice for clients, there is also a need to reduce fragmentation and confusion and increase ease of access to the system (Craw & Gilchrist, 1998).

A study in the UK highlighted mainstreaming, targeting, engagement and benchmarking as the four key elements of effective service provision for CALD groups (Watt & MacGaughey, 2006). This supports Hanen's (1986) proposal that if the core functions of aged care services are identified and implemented into practice then the need to ask an 'either or' question about models of service delivery becomes less pertinent.

Ethno-specific services

During the 1970s in Australia, several groups lobbied for the development of ethno-specific health services (Garrett & Lin, 1990). In 1978, the Galbally report, *Review of Post-Arrival Programs and Services for Migrants*, recommended funding by the Commonwealth Government to ESAs. It argued that immigrant settlement should be based on self-help, subsidised by the state through ESAs run by immigrants themselves (Doyle, 1992).

The advantages and disadvantages of an ethno-specific service model have been outlined by Barnett et al. (1988) (Appendix 2). Despite being written two decades ago, the issues are still relevant today. High rates of service utilisation and satisfaction are associated with culturally specific and relevant services (Koseki, 1996). An American study sought to investigate why people from CALD backgrounds used ethno-specific services, and concluded that ESAs were critical components of multicultural service delivery systems (Holley, 2003). Indeed, "... no matter how much some generalist (mainstream) organisations adapt, people may want to be served by ethno-specific organisations where they feel more comfortable and can easily communicate, and where their needs may be understood in a more favourable cultural or racial context" (Doyle, 1992, p. 50).

Providing services based on cultural background, however, can be problematic as it may obscure other factors that determine a person's preferences and care needs (Sciegaj, Capitman, & Kyriacou, 2004). Furthermore, a service delivery model that only focuses on ESAs is unrealistic and unfeasible, due to the heterogeneity within ethnic groups and ethnic identity (Matsuoka & Sorenson, 1991). Assumptions that ESAs share the same ideologies as their clients can also be problematic (Sakamoto, 2007).

People from CALD backgrounds have been identified as a special needs group, but 'antiracism' advocates warn against cultural approaches to difference, as they are in danger of homogenising people and their needs (James, 1998). Some writers believe that funding ethno-specific service provision will simply serve to continue to allow ESAs to be poorly resourced, perpetuating marginalisation and endorsing 'de facto racism' in modern society (Jayasuriya, 1985; Doyle, 1992, p. 51; Patel, 1999; Patel, Bhutta, Davies, & Bandopadhyay, no date). Thus, the key question that remains is: do the benefits of categorisation according to cultural background (e.g. culturally specific and appropriate care) outweigh the disadvantages (e.g. potential segregation and exclusion) for providing community care to older CALD people?

Mainstream services

Cost effective use of resources, linking older CALD communities to the wider community, and having the potential to provide a longer term response to the changing need of the CALD older people over time, are just some of the advantages of a mainstream model (Barnett, 1988). An Australian study also revealed a much higher level of satisfaction for mainstream services by older CALD people than was conveyed by the existing literature from ethnic lobby groups at the time (Legge & Westbrook, 1994). In the UK, Patni identified culturally competent mainstream teams as the best option for future service delivery systems, although she notes that they are not currently in operation. Nor are there clear policy guidelines about the appropriate way to provide services to diverse groups (Patni, 2006).

The literature indicates that while ESAs have been criticised for their potential to marginalise ethnic groups, so too has mainstreaming, but for different reasons. Xynias (2002), for example, has cautioned that mainstreaming can marginalise CALD people due to their relatively small numbers and their specific needs being overlooked. Furthermore, Fuller (1997) identified how a mainstream service system, whilst appealing, simply serves to advantage those whose values most closely fit with the dominant social norms.

Importantly, Fuller (1997) proposes that if people from CALD backgrounds participate in health system processes, it is more likely they will be better served under a mainstream model. Similarly, there is a considerable drive in the UK to support the involvement and engagement of older people themselves in the research, policy and service development (Butt & O'Neil, 2004; Cordingley, Hughes, & Challis, 2001; Patel et al., no date; Watt & MacGaughey, 2006).

Cultural competence

Shortfalls in efficacy and accessibility of mainstream services for CALD people has resulted in the production of guidelines for delivering culturally competent care (National Health and Medical Research Council, 2006). While cultural competence has demonstrated an increase in access to health care for at-risk older people in the US (Mackenzie, 1999), problems have arisen, as no universally agreed definition of cultural competence exists (Stewart et al., 2006). Despite the need to inform services of cultural differences, ethnic groups have expressed frustration with the stereotypic and essentialising tone of many of the guidelines (Allotey et al., 2002).

Evidence suggests that cultural competence needs to be addressed at several levels (individual, professional, organisational and systemic) for mainstream services to be effective (National Health and Medical Research Council, 2006; Stewart et al., 2006).

Partnership model

The need for cooperation and partnership between mainstream, multicultural and ethno-specific agencies has been recognised for at least two decades. Through experiencing the limitations of a mainstream system, particularly for meeting the needs of refugees and recently arrived migrants, the importance of a combined approach became evident (Kunst, 1992). Doyle (1992) emphasised the potential for partnerships to better meet the needs of a constantly changing, dynamic population. However, developing effective protocols for effective networking between mainstream, multicultural and ESAs, which includes valuing one another's contributions, are vital (Doyle, 1992; Sivadurai & Rivera, no date).

To maximise the advantages of both of these models Barnett (1988, p. 21) called for a balance between the two options, with the ultimate objective being "the promotion of an integrated care system, rather than a dual system involving a central and a peripheral system of aged care". Barnett (1988) demonstrated that the balance between the two approaches may not always be the same for all service types – for example, food services may be enhanced by an ethno-specific approach, and respite may

be better delivered through a combination of approaches. Barnett et al.'s 'Linkages' model mirrors the partnership model discussed by Rowland (2007), and provides a viable option for smaller ethnic communities, as do Migrant Resource Centres (Barnett & Associates, 1997).

In the same vein as Sakamoto's Canadian study (2007), Patni in the UK cautions against assuming that ESAs can provide the most effective services to ethnic groups (Patni, 2006). "Race-specificity does not equal cultural competence, just as mainstream teams do not equal culturally incompetent teams" (Patni, 2006, p. 166). Like Sakamoto, Patni promotes an anti-oppressive approach, emphasising the importance of dialogue, co-existence, and partnerships between professionals and users/carers.

In Canada, Matsuoka and Sorenson (1991) identified several advantages of a 'bridging' model (i.e. partnership) over a mainstream, ethno-specific, or multicultural approach. However, core issues raised regarding the implementation of the model included workforce recruitment and training, and allocation of government resources.

In the UK, the Policy Research Institute on Ageing and Ethnicity (PRIAE) has conducted and coordinated a considerable body of Europe-wide research around the long-term care needs of black and minority ethnic older people. An analysis of empirical studies in the 1980s concluded that minority ethnic organisations were central in the supply of care and were actually acting as primary providers in place of mainstream providers, as opposed to being complementary providers (Patel, 1990, 1999). The inadequacies and 'patchiness' of mainstream services were noted to have continued on into the late 1990s (Patel, 1990), which strongly aligns with the Australian literature. Recent recommendations have included working in partnership to recognise the importance of ESAs, and to direct more funding to strengthen the infrastructure of the multicultural voluntary sector (PRIAE, 2004).

Other literature to inform the review

In the previous section, the literature reviewed directly relates to community aged care services for older CALD groups. However, there are other pockets of literature that may also inform understanding about service delivery models, particularly in relation to refugees and smaller immigrant groups, caregivers of CALD people, residential aged care accommodation and mental health services. This literature will be summarised below.

Refugees and other small immigrant groups

It is estimated that 13,000 refugees and humanitarian entrants settle annually in Australia (NSW Refugee Health Service, 2006). The majority of older refugees have arrived as humanitarian entrants, often having fled persecution, while others have come via family reunification programs. In 2003, the Department of Immigration, Multicultural and Indigenous Affairs (DIMIA, 2003) reviewed the settlement services available to migrants and humanitarian entrants and, despite the array of components comprising the ethnic aged care framework, concluded that there remains substantial dissatisfaction with mainstream aged care services. Indeed, the review indicated that there was an increasing reliance of older migrants, especially those not proficient in English or frail, on bilingual staff and ethno-specific agencies. Establishing flexible funding models and partnerships between government funding bodies was flagged as having the potential to improve access to health and aged care services. Importantly, the review highlighted that the full reality of providing social services in a culturally and linguistically diverse society is not accurately reflected in agency budget allocations.

Older refugees in Australia, like other immigrants, are a highly heterogeneous group whose needs are significantly different from their younger counterparts (Atwell, Correa-Velez, & Gifford, 2007). While a number have lived in Australia for many decades, others are recent arrivals. For the latter, the existence of established social support structures is scarce. The key issues for older newly arrived refugees were isolation (and the loss of social networks), family conflict and mental illness (Atwell, Correa-Velez, &

Gifford, 2005; Atwell et al., 2007). As is the reported experience of other more established immigrants, new arrivals experience similar barriers to service use, such as lack of knowledge and information about aged care services and cultural barriers. Refugees also face specific barriers on account of their often traumatic experiences prior to migration in their home countries, which impacts on their levels of trust in government services and fear of revealing personal information (Atwell et al., 2007). Among the recommendations for addressing the needs of this cohort, is the need for building better links between resettlement agencies and the aged care sector, which supports the partnership model of service delivery. The authors also recommend expanding volunteer visiting programs and ethno-specific senior citizens groups to supplement family care, which not only offer opportunities for social interaction but increase the visibility and capacity of refugee communities (Atwell et al., 2007). Additionally, refugees may require aged care services at a younger age than other populations and this needs to be accounted for in future service model planning.

Developing a policy on partnerships between settlement services, aged care providers and health services was a recommendation of researchers in Sydney (NSW Refugee Health Service, 2006). Hugman et al. (2004) also explored the experiences of older Australian refugees and found that the effects of trauma and forced migration significantly impact on the experience of growing old. The authors highlighted that current ageing policy and practice has failed to account for the fact these people are not 'ageing in place' and that these people do not have access to their 'ordinary' communities (Hugman et al., 2004). Migration has also severely impacted on family roles and relationships, presenting yet another significant challenge to service provision, and health promotion.

A study conducted in Sydney over a decade ago concluded that the key to meeting needs of newly arrived refugees was through the development of specific national refugee settlement policy, and the effective coordination and consultation between government and non-government organisations, including members of different ethnic communities (Waxman, 1998). The findings of subsequent research also reports that current ageing policy still fails to acknowledge the specific issues facing refugees, in particular older refugees (NSW Refugee Health Service, 2006).

Canadian 'newcomers'¹

Canada is one of only a few countries that actively recruits immigrants, in addition to having an immigration program that accepts immigrants and refugees. Canada has a similar immigration history to Australia, for example in the preference for white Europeans prior to 1960s (George, 2002). Canada is also experiencing similar migration trends, in that the top source countries are non-European (Asian). It is therefore not surprising that there is a body of literature emerging from Canada that may be useful within an Australian context.

Literature on settlement service delivery models for newcomers constitute both theoretical and practice-based models (George, 2002). Theoretical models include cultural competence, anti-racist, ecological and empowerment approaches. There are also theoretical models that acknowledge and respond to the different stages of immigrant adaptation, from the pre-movement phase through to integration. Practice based models are concerned with how services are delivered, be it by ESAs or mainstream services, or a combination of both. George (2002) noted that, in reviewing the literature, it is evident that settlement service models have focused primarily on theoretical concerns or the interests of service providers. Furthermore, George (2002) proposes a needs-based model of service delivery that brings newcomer needs to the forefront to drive service planning.

In addition to the different models of service provision, Beyene (2000) suggests that placing variable emphases on one or a combination of the following types of service provision may assist in providing appropriate care for specific groups of new arrivals: (1) needs focused; (2) specialised based; or (3) case management. Beyene (2000) further recognises that within each particular service there are various levels pertaining to the newcomers' duration of stay and the point at which they are in the

settlement process. The needs of newcomers in Canada are unique and significantly restricted by resource and organisational capabilities (Beyene, 2000). George's (2002) model draws on Beyene's (2000) distinction of different types of service provision, and the various levels within each type.

In Canada, a study that investigated the views of service providers and policy makers on social support for immigrants and newcomers concluded that systemic issues are the key challenge to future service provision (Simich, Beiser, Stewart, & Mwakarimba, 2005). Thus, rather than deliberate about who should be delivering services, the authors highlight a more fundamental problem. The systemic issues include limited resources, lack of integration of policies and programs and narrow service mandates. The authors suggest that changes in public discourse about immigrants' contributions, improved governance and service coordination, and a holistic long-term perspective are vital elements in providing more effective support (Simich et al., 2005).

Caregivers

An Australian study investigated the perceptions of (mainstream) respite care amongst three different ethnic groups as well as respite service providers. Respite providers reported that an average of 16% of clients was from CALD backgrounds and that the most common strategies for catering for CALD peoples' needs included: use of interpreting services; translating; and cultural awareness training. Perceived barriers to services for CALD clients included not knowing about services, not being culturally appropriate, language barriers, lack of links with ESAs, insufficient bilingual staff and cultural barriers, e.g. special food (Migrant Information Centre and Yooralla, 2006). Another Australian study of Russian speaking female family caregivers found that these women were not accessing their welfare entitlements or existing resources due both to poor referral procedures by professionals, and/or the influence of previous social policies in their country of origin (Team, Markovic, & Manderson, 2007). These findings mirror those of CALD service users themselves.

In the UK, a study investigating the needs of Bangladeshi caregivers revealed that carers received limited support from health and social care providers which was not indicative of their need (Merrell, Kinsella, Murphy, Philpin, & Ali, 2006). Communication barriers and lack of knowledge of services were highlighted as key reasons for inequitable access to services. The perception that services were unable to meet cultural and religious needs also influenced the accessibility and uptake of services, which has implications for cultural diversity training.

In Canada, a qualitative study identified that immigrant female family caregivers avoided certain formal services for a range of reasons, including a lack of cultural sensitivity. These women's challenges were compounded by language, immigration and separation from family in their home countries (Stewart et al., 2006). The authors concluded that intersectoral collaboration between agencies is essential to reduce the challenges identified and to establish services which are both culturally and linguistically sensitive.

Residential accommodation

Runci has conducted a considerable body of work in relation to residential aged care facilities for CALD older people (Runci, 2004; Runci, O'Connor, & Redman, 2005; Runci, Redman, & O'Connor, 2005). These studies highlight the urgent need for widespread use of language-appropriate services, especially given the fast growing ageing CALD population. Communication and language issues also feature prominently in a recent report that reviewed the experiences of Commonwealth funded residential aged care CALD residents (Hughes, 2008). The report identified a range of views from satisfaction to inappropriate and poor quality care. The Aged Care Standards and Accreditation Agency assesses homes' compliance with the Accreditation Standards. Cultural identity is included in one standard, however, ideally it needs to be assessed against all the standards (Aged and Community Services, 2006; Hughes, 2008).

In addition to ethno-specific and cluster models, Petrov (1997) promotes St. George's as a viable alternative, which as a mainstream service provider delivers culturally appropriate residential care. Of key importance in this model, is the capacity of the current workforce, particularly with regard to staff recruitment, management and attitudes. Petrov also emphasised the importance of providing individualised quality care within a multicultural context.

The *Power and Powerlessness* project (Multicultural Council of Tasmania, 2006) investigated the experiences of aged care facilities for CALD older people in Tasmania. Language, food and culture, spirituality and isolation emerged as the greatest issues of concern. Many participants raised the possibility of having ethno-specific facilities. In Tasmania, however, even the largest CALD group is too small in numbers to make this a viable option. This is unfortunate considering that, in one study, both residents and carers were more satisfied with ethno-specific residential homes, particularly relating to the food, companionship and relationships with staff (Westbrook & Legge, 1991).

Mental health services

As with health and social care services, general mainstream mental health services are used less by CALD older people than by "white-dominant" communities (Klimidis & Minas, 1999). Many risk factors contribute to the manifestation of mental illness amongst CALD older people. Further examination of this complex conglomeration of issues is required in order to inform the development of appropriate programs and services (Klimidis & Minas, 1999).

A qualitative study in Canada identified several key barriers for CALD older people in accessing mental health services. These included inadequate numbers of trained and acceptable mental health workers, lack of information, disturbance of family support structures, reliance on ESAs that are not designed or funded for formal mental health care, and stigma in seeking help (Sadavoy, Meier, & Ong, 2004). The researchers noted that clearly there is a need for more mental health workers from CALD backgrounds, and for building the capacity of mainstream mental health services via training and core funding. Specifically, mainstream services require acceptable and appropriate entry points, and adequate flexibility in order to respond to the diverse and changing needs of its potential users. An Australian study also found that beliefs about stigma and shame contributed to the reluctance of people from Asian communities to access help from mainstream services (Wynaden et al., 2005).

In debating whether there should be separate psychiatric services for ethnic minority groups, Bhui and Sashidharan (UK) succinctly summarise the arguments for and against respectively (Bhui & Sashidharan, 2003). The points raised are very relevant to this review. Bhui's argument for separate services highlights the many shortfalls in mainstream delivery, particularly the inability to address institutional cultural issues, and the clear need for an alternative model of care. However, there is a sparse evidence base for the effectiveness of ethno-specific services, and Bhui highlights the need for more comprehensive evaluations of services that can guide future service delivery. Sashidharan, on the other hand, emphasises the importance of delivering services via a mainstream model, as it has the potential to address the underlying issue of ethnic inequalities. Sashidharan asserts that there is limited evidence to support the view that CALD people have different needs, and that reinforcing differences based on culture perpetuates the myth that culture is a problem. Further, by creating specialised services, it allows mainstream services to turn a blind eye and fail to take responsibility for providing culturally appropriate care.

Sashidharan clearly demonstrates how the issue of service delivery for CALD people may be framed through a rights and equality focus and how subsequently, the emphasis for policy development must be on ensuring mainstream providers can provide care within this framework. If, alternatively, the focus is on individual need and differences of need, then the resulting policy development is around the provision of ethno-specific services. The issue for the latter is that individuals have many needs not just relating to ethnicity and culture, but also to gender, age, education, etc. In conclusion, if services were

delivered according to each of these particular approaches, then service provision has the potential to become even more fragmented and unfeasible in the longer term.

CONCLUSION

Considering the worldwide demographic phenomenon of increasing numbers of older people from CALD backgrounds, it is most timely to reflect upon the delivery and planning of community aged care services.

This review of the relevant literature indicates that, in Australia, developing culturally appropriate and responsive services has been on the agenda for the last thirty years. The literature reports on a range of models for the provision of services to older people from CALD backgrounds, including ethno-specific, multicultural and mainstream services.

While mainstream services appear to be the preferred model of community aged care service delivery, the literature indicates that these services are currently not able to meet all the needs of older CALD people.

The literature offers abundant evidence to support the value and effectiveness of ethno-specific services for CALD older people, while at the same time emphasising the inability for ESAs alone to respond to the needs of all of Australia's ethnic communities, and particularly smaller groups. Review of the literature also highlighted that a critical factor is how the various models can best complement each other, as opposed to making comparisons between them.

Consequently, the prevailing wisdom indicates that it is not a question of an 'either or' approach. Both the published and unpublished literature indicates that the future of community aged care service delivery for people from CALD backgrounds lies in the coexistence of mainstream, multicultural and ethno-specific services working together and in partnership.

In summary, there remains very little systematic, published evidence-based research that has as its focus the delivery of community aged care services to people from CALD backgrounds. The outcome of this review demands further research and investigation

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APPENDICES

Appendix 1. Timeline of key events relating to cultural diversity in community aged care services

DATE	TYPE OF EVENT	DETAILS
1978	Report	Review of Post-Arrival Programs and Services for Migrants (Galbally, Canberra)
1985	Commonwealth Act	Commonwealth Home and Community Care Act – CALD identified as one of five special needs groups
1985	Program	Joint Commonwealth/State HACC program launch
1986	Commonwealth Policy	Commonwealth adopted 'mainstreaming' as an ideology to strengthen the base of multiculturalism
1992	Commonwealth Strategy	National Integrated Settlement Strategy (NISS)
1992	Commonwealth Standards	HACC National Service Standards
1995	Commonwealth Policy	The Ethnic Older Persons Strategy (now subsumed by PICAC and CPP)
1997	Commonwealth Act	Aged Care Act – People from non-English speaking backgrounds identified as one of five special needs groups
1997	Strategy	Victorian HACC Cultural Planning Strategy. Evaluation in 2006.
1997	Commonwealth Initiative	Partners in Culturally Appropriate Care (PICAC)
1998	Charter	Charter of Public Service in a Culturally Diverse Society that committed all government service providers to integrate 7 principles into their strategic planning, policy and corporate reporting processes (access; equity; communication; responsiveness; effectiveness; efficiency; and accountability).
1999	Commonwealth Policy Document	A New Agenda for Multicultural Australia
1999	Commonwealth Report	National Stocktake of HACC Policy and Service Provision for People with a Diverse Cultural and Linguistic Background (Dept of Health and Aged Care)
2000	Commonwealth Framework	Draft National Framework for the Development of Culturally Inclusive HACC Services (Dept of Health and Ageing – based on National Stocktake above)
2001	Policy Document	Growing Victoria Together
2002	Commonwealth Guidelines	HACC National Program Guidelines – identifies CALD clients as a special needs group

DATE	TYPE OF EVENT	DETAILS
2002	Summit	Culturally appropriate aged care summit, Australian Multicultural Foundation
2003	Report	Access, Services, Support, Respect – Local Governments' Response to Cultural Diversity in Victoria, VMC
2003	Commonwealth Policy Document	Multicultural Australia: United in Diversity – Updating the 1999 New Agenda for Multicultural Australia: Strategic Directions for 2003-2006
2003-2006	Strategy Launch	Culturally Equitable Gateways Strategy (CEGS), Victoria
2004	Act	Multicultural Victoria Act
2004	Commonwealth Policy Document	A New Strategy for Community Care – The Way Forward
2005	Report	Strategic Directions in Assessment, Victorian HACC program, DHS
2005	Report	Language Services Policy, Department of Human Services, Victoria
2005	Policy Document	A Fairer Victoria
2006	Act	Victorian Charter of Human Rights and Responsibilities Act
2006	Policy Document	Valuing Cultural Diversity – Cultural diversity guide – planning and delivering culturally appropriate human services, DHS, Victoria
2005	Commonwealth Initiative	The Community Partners Program (CPP)
2008	State Program	Supported Access Pilot Project, Victoria (HACC)

Appendix 2. Extract from Barnett et al. (1988)

Advantages and Disadvantages of Each Approach

ADVANTAGES:

- (a) **ethno-specific approach**
- enables linguistic and cultural appropriateness of provision;
 - encourages ethnic communities' participation in key decision-making processes;
 - increases ethnic communities' skills and abilities to develop and control their provisions for their elderly members;
 - reduces current imbalance in provisions for the aged generally and the ethnic aged in particular;
 - provides a readily identifiable allocation to ethnic groups;
 - proven level of satisfaction among ethnic communities with this approach (AIMA, 1986).
- (b) **modified generalist approach**
- increases generalist providers' sensitivity to needs of special groups;
 - allows users to draw on wide experience and infrastructure of generalist providers;
 - cost-effective use of resources;
 - links the ethnic aged to other elderly groups in the community;
 - has the potential to provide a long-term response to the changing needs of the ethnic aged over time.

DISADVANTAGES:

- (a) **ethno-specific approach**
- encourages marginalisation of ethnic aged from wider community – a 'second tier of aged care';
 - removes pressure from generalist providers to adapt to a multicultural society and to share their resources;
 - is not usually applicable to small size and geographically dispersed ethnic groups;
 - ethnic communities may not possess the full range of skills needed to develop and provide certain facilities;
 - may not be as cost-effective as modifying generalist services
 - encourages ethnic groups to compete with each other for limited resources.
- (b) **modified generalist approach**
- does not have credibility (at present) with most ethnic community groups;
 - takes time and effort to educate generalist providers about the special needs of the ethnic aged and appropriate methods of responses to those needs;
 - requires clear lines of accountability and built-in monitoring processes to ensure that the needs of the ethnic aged are being addressed;
 - generalist providers are less able than ethnic groups to respond to the special needs of the ethnic aged.

Appendix 3. Annotated bibliography of the key literature

PRO ETHNO-SPECIFIC SERVICES	
Koseki (1996) US	Koseki investigated utilisation and satisfaction with a service program designed specifically for Native Hawaiian elders. There were considerably high rates of utilisation and satisfaction with this culturally specific and relevant service. The researchers concluded that changes in federal policy would ensure programs and services better meet the needs of ethnic minorities. Services need to be more flexible and responsive to the needs of ethnic minorities and one way in which to do so is to involve ethnic minorities themselves in program design (generate sense of ownership and self-responsibility). Interestingly the importance of networking and outreach for this group, instead of brochures and mass media, was emphasised to better disseminate information about services.
Holley (2003) US	This research study sought to investigate why people from CALD backgrounds used ethno-specific services. It raised the usual issues regarding clients being able to speak in their own language, feeling valued and respected by staff, distrust of non-ESAs and also less likely to experience racism. Holley concluded that ethnic agencies are critical components of multicultural service delivery systems.
DISADVANTAGES OF ETHNO-SPECIFIC SERVICES	
Sakamoto (2007) Canada	This Canadian study raised awareness about the dangers of assuming that ESAs share the same ideologies as their clients. While this study focused on the perspectives of Chinese skilled immigrants whose main concerns were employment related, it raises an important issue that may be relevant to other CALD migrants. Specifically, that the presence of ESAs may not necessarily result in improved social services for specific immigrant groups. This is partly due to some immigrant service providers actively promoting the assimilation of peer immigrants into mainstream society, and becoming a part of the system that has served to oppress minority groups. The author notes that the literature lacks coherent theoretical and ideological frameworks necessary to inform effective models of service delivery. However, an anti-oppressive approach has the potential to fill this void.
ADVANTAGES OF MAINSTREAM SERVICES	
Legge & Westbrook (1994) Australia	This Australian study surveyed 371 community health workers from 5 different ethnic groups about satisfaction of their clients with mainstream and ethno-specific health services. The study found significant differences in the evaluation of 15 of the 18 aspects of health services examined. Interestingly, mainstream services (which included home care services) attained higher ratings than services specifically for non-English speaking patients (such as availability of interpreter services, provision of ethnic workers, availability of health literature in ethnic language). The researchers concluded that no clear guidelines could be provided on the basis of these results to inform government or health care providers about the most effective models of health care. However, it did indicate a much higher level of satisfaction for mainstream services than was conveyed by the existing literature from ethnic lobby groups at the time.

<p>Patni (2006) UK</p>	<p>Patni cautions against assuming that ESAs can provide the most effective services to CALD groups. "Race-specificity does not equal cultural competences, just as mainstream teams do not equal culturally incompetent teams" (p.166). Like Sakamoto, Patni promotes an anti-oppressive approach, emphasising the importance of dialogue, co-existence, and partnerships between professionals and users/carers. In concluding, Patni identifies culturally competent mainstream teams as the best option for future service delivery systems, although notes that they are not currently in operation. Nor are there clear policy guidelines about the appropriate way to provide services to diverse groups.</p>
<p>DISADVANTAGES OF MAINSTREAM SERVICES</p>	
<p>Fuller (1997) Australia</p>	<p>Fuller identified how a mainstream service system, while appealing, simply serves to advantage those whose values most closely fit with the dominant social norms. If this is the case, then we can expect that mainstream services will be most effective for Anglo Australians. Fuller proposes that if people from CALD backgrounds participate in health system processes, then it is more likely that they will be better served under a mainstream model.</p>
<p>Xynias (2002) Australia</p>	<p>Xynias highlights how the concept and service delivery policy of mainstream or mainstreaming has been an integral part of the HACC program since the mid 1980s, and as such has meant the use of existing service structures rather than the development of different service structures. Alternative services would be provided if mainstream services were not capable of delivering appropriate services, but problems have arisen in measuring performance of existing services in terms of cultural diversity. Mainstreaming has been challenged in that it reinforces marginalisation of ethnic groups and their access.</p>
<p>MODELS OF SERVICE DELIVERY</p>	
<p>Garrett & Lin (1990) Australia</p>	<p>Policy development has been, and continues to be, influenced by ethnic relations ideology. So depending on how Australia regards ethnic relations, this perspective will influence current policy and practice. Cultural identity and multiculturalism, that emphasises cultural difference and encourages individual cultural expression, has led to development of ethno-specific services. Regarding ethnic relations as a social equality issue has led to the belief that mainstream services need to develop the capacity to respond to the needs of people from all backgrounds. Garrett and Lin noted that multiculturalism has so far been predominant, and that Australia's policy debates have in many respects paralleled international experiences. During the 1970s in Australia, several groups lobbied for the development of ethno-specific health services. The degree to which ethno-specific services are needed and the extent to which mainstream services can become accessible and responsive has been a subject of debate for over two decades. Garrett and Lin outlined five possible options: providing ethno-specific services; providing cultural awareness training for mainstream health professionals; use of bilingual staff; employment of ethnic health workers; recognition of overseas qualifications. Garrett and Lin also identified another question about whether services should be of a specialised nature, or whether needs can be met adequately by generalist services.</p>

<p>Watt & MacGaughey (2006) UK</p>	<p>Watt and MacGaughey developed a template to highlight four key elements essential for effective service provision to ethnic groups. The four elements are: mainstreaming; targeting; benchmarking; and engagement. 'Mainstreaming' and 'targeting' correspond to what is referred to as a mainstream and ethno-specific approach in this report. Benchmarking refers to the need to gather service usage data and conduct evaluations. Engagement refers to the need to engage ethnic people in all stages of planning and delivery. It is interesting how they have all been highlighted and used as a framework to evaluate service delivery to ethnic minority groups in the UK.</p>
<p>Rowland (1999, 2007) Australia</p>	<p>Rowland (1999) highlighted that only about a third of older CALD people will have special needs that require ethno-specific services. His analysis was based on the assumption that those new arrivals and settlers with little or no English are likely to be the most in need of ethno-specific services. Obviously English proficiency does not mean that older CALD do not require ethno-specific services, it just means that they will come up against less barriers and challenges on account of being able to communicate. Ethno-specific needs of those with greater English language proficiency are likely to be more amenable to management within mainstream provision (Rowland, 1999). Rowland (2007) identified the potential of three models: (1) ethno-specific; (2) generic/mainstream; and (3) partnership.</p>
<p>Howe (2006) Australia</p>	<p>Howe indicated the need for a mix and match of roles for ethno-specific, multicultural and mainstream agencies. In her report to DHS, Howe emphasised how the distribution and dispersion of CALD populations is both dynamic and not uniform. Therefore service needs are likely to reflect this. This means that some models of care may be more suited to some areas than others, and will need to be very flexible. But because of the wide dispersion, it is an issue of relevance to all LGAs.</p>
<p>Craw & Gilchrist (1998) Australia</p>	<p>Craw and Gilchrist highlight the need for increased flexibility of service models to enhance choices for clients. However it must be noted that the diverse range of services and agencies is already confusing and should not necessarily become further fragmented. There is a need to balance trade off between flexibility and easy access/information about system. The issue is possibly about how much control/autonomy ESAs can have to provide services, and whether they are just complementary to mainstream or whether they have a discrete role. This is considerably determined by funding and resource allocation.</p>

PRO PARTNERSHIP MODELS	
Barnett (1988; et al, 1997) Australia	Barnett et al emphasise that no single model can be expected to meet the needs of all ethnic communities (1997). Four models are listed: Ethno-specific, partnership or 'multicultural' model, clustering (residential-specific), and 'Linkages'. 'Linkages' provides a viable option for smaller ethnic communities, as do migrant resource centres. Barnett suggests that a partnership strategy can bring about the necessary balance between ethno-specific and modified generalist provisions, which can respond to individual circumstances (1988). To maximise the advantages, Barnett (1988) calls for a balance between the two options – "the ultimate objective should be the promotion of an integrated care system, rather than a dual system involving a central and a peripheral system of aged care" (p.21). Barnett (1988) demonstrates that the balance between the two approaches may not always be the same for all service types – for example food services may be enhanced by an ethno-specific approach, and respite may be better delivered through a combination. Barnett et al (1997) created a resource to assist aged care service providers to link and work with small ethnic communities to develop aged care facilities and services which provide high quality and culturally sensitive care. A Linkages model of service recognises the contribution of both parties, creating a dynamic and balanced association. Barnett et al recognise that individually each partner cannot deliver the complete product, but in combination their individual expertise is magnified – the whole is more than the sum of its parts.
Matsuoka & Sorenson (1991) Canada	Matsuoka and Sorensen report that a service delivery model that just focuses on ESAs is unrealistic and unfeasible due to the heterogeneity found amongst ethnic groups and ethnic identity. In reflecting upon social service delivery in Canada, four models were identified: mainstream, ethno-specific, multicultural and bridging. These models were examined in relation to immigrants and refugees from Ethiopia and the authors identified several advantages of the bridging model (i.e. partnership) over the other approaches. For example, it prevents ethnic communities from becoming peripheral, it complements the policy of multiculturalism (by maintaining ethnic identity), and provides a point of entry into mainstream services for CALD people. Core issues raised regarding the implementation of the model included workforce recruitment and training, and allocation of government resources. It must be noted that the elements of this model (being 17 years old) are quite rudimentary.
Sivadori & Rivera (no date) Australia	Sivadorai and Rivera conducted a pilot project in Queensland to improve access to mainstream HACC services for CALD people. They highlighted the tendency for monocultural values of service providers to inform service delivery which hinders access to CALD. The challenge for mainstream services to develop flexible structures and adaptable models of service delivery to meet the needs of CALD clients. Researchers recommend development of protocols for effective networking between mainstream services and ethno-specific service providers. <i>There are no known publications from this study.</i>

Patel (1990, 1999) UK	<p>Patel heads up the European Minority Elderly Care Project at PRIAE (Policy Research Institute on Ageing and Ethnicity, UK). Patel and colleagues in the UK have conducted a considerable body of research around the long-term care needs of black and minority ethnic elderly. An analysis of empirical studies in the 1980s resulted in the conclusion that minority ethnic organisations were central in the supply of care and acted as primary providers in place of mainstream providers, as opposed to being complementary providers (Patel, 1990, 1999). The inadequacies and 'patchiness' of mainstream services were noted to have continued on into the late 1990s (Patel, 1990). In the late 1990s, the group at PRIAE conducted a study which asked participants to respond to a discussion document and attend a seminar, in order to investigate perspectives on long-term care in relation to black and minority ethnic older people. Discussion focused around four questions: the appropriateness of current models of care; accessing services; planning and paying for long-term care; and reducing dependency. Findings resonated with the literature in Australia, such that current mainstream models of care are inadequate both with regards to a lack of supply and being culturally inappropriate. ESAs, in contrast, were regarded as critical providers of basic needs in the absence of other mainstream care providers, and that they were fundamental to making CALD issues visible. In relation to 'access' to services, limited choice, poor information, cultural and language barriers and underlying presence of discrimination were all emphasised. As a result, the PRIAE introduced the 'Pomegranate' model of care which was envisioned to cater for all minority ethnic groups 'under one roof' with the capacity also to cater to specific person-centred requirements. It serves to promote unity in diversity, much the same as how multiculturalism (and mainstreaming) has been promoted in Australia, specifically encouraging people to exercise their rights to maintain their diversity, yet living and working in unity. Clearly there are common issues between the UK and Australian experiences, and Australia may be able to learn from international developments in this area.</p>
PRIAE (2004, 2005) UK	<p>PRIAE (2005) extended their research at the beginning of this century to incorporate the perspective of other European countries. The specific aim of which was to generate knowledge to provide practical policy responses on how best to meet the health and social care needs of minority elders from different ethnic and cultural backgrounds. The three year mixed methods study involved 10 countries, 3277 minority ethnic elders from 26 ethnic minority backgrounds, 901 health and social care professionals, and 312 voluntary organisations. It sought the views of ethnic older people first and foremost, to be supplemented by other practitioners and workers in the field. One of the key research questions was about whether care provision should be ethnically separate and specialist or integrated into mainstream existing health and social care provision. The findings indicate that the needs of ethnic older people are not currently being met by mainstream service providers, and that various strategies need to be implemented to address this issue. This includes working in partnership to recognise the importance of ESAs, and to direct more funding to strengthen the infrastructure of the ethnic voluntary sector (PRIAE, 2004).</p>

<p>Patel et al (no date) UK</p>	<p>Patel et al advocated for the importance of a tripartite approach to research into ethnicity and ageing involving service users, mainstream service suppliers and voluntary/minority ethnic organisations. As is the case in Australia, ethnic minority users in Europe do not access available services due to cultural, linguistic and socio-economic barriers that “remain stubbornly in place at the present time”. The ethnic sector “suffers from fragmentation and consequent difficulty in coordination of activities and targeting of funds” and community organisations ultimately compete for the same funding, with little or no mainstream funding.</p>
<p>Doyle (1992) Australia</p>	<p>Doyle identified that “no matter how much some generalist (mainstream) organisations adapt, people may want to be served by ethno-specific organisations where they feel more comfortable and can easily communicate, and where their needs may be understood in a more favourable cultural or racial context” (p. 50). Doyle noted that the “roles and terms of compliance cannot be dictated solely on the basis of who has the most power and resources in the system, but on the basis of what are the needs of the clientele/consumer population, and how these needs can be met, through what kind of organisational forms” (p.50). He emphasised the need for flexibility, and that service provision needs to be able to respond to the constantly changing, dynamic, population and needs. Furthermore, he highlighted that partners need to value one another.</p>

