ANSWERS TO QUESTIONS ON NOTICE

Unmet Need Data

COTA NSW would like to shed light on other matters that represent unmet need for older people. Service responsiveness to a range of population groups is essential to better understand the extent of unmet need in the community. COTA NSW would like to highlight some areas for consideration.

A recent report by the University of Western Sydney *"Older men and Home and Community Care Services: Barriers to access and effective models of care"* found that while older men make up 45% of the population in NSW, they only represent a third of HACC users. The report also suggests that there is a need for further research around culturally and linguistically diverse men and Aboriginal and Torres Strait Islander men.

Older Carers are in need of respite care, particularly those who have not tapped into support services. There is some concern for older carers from culturally and linguistically diverse (CALD) backgrounds, who for cultural reasons have taken on the full care of their children with a disability without accessing necessary support, or who feel that existing support does not meet their cultural needs. Many older CALD carers have expressed the desire to have family members provide respite care as more appropriate than "strangers". Provision of adequate and culturally sensitive respite is essential for older carers to be supported in their role and to ensure that their health needs are being met.

COTA NSW is also very concerned about the lack of support available to grandparent carers in NSW, many of whom have a disability themselves, who are unable to receive respite care. While we understand respite care is for those children who have a disability, it is imperative that unmet need in this area is documented for further dialogue and action through the Commonwealth.

COTA NSW supports the view that better data collected on unmet need is a duty of care of any department. It is imperative that agencies work across jurisdictions and boundaries to address unmet need in a holistic way to ensure that people do not fall through the gaps.

Ageing Population and Telecare Initiatives

a) The potential contribution of Telecare

COTA NSW supports Carers NSW recommendation on Telecare, as stated in their submission to this inquiry, Carers NSW notes:

Telecare has been defined by the Scottish Government as:
"the remote or enhanced delivery of health and social services to people in their own home by means of telecommunications and computerised systems. Telecare usually refers to equipment and detectors that provide continuous, automatic and remote monitoring of care needs, emergencies and lifestyle changes, using information and communication technology to trigger human responses, or shut down equipment to prevent hazards."'

A growing body of international evidence suggests that Telecare can also have considerable benefits for the sustainability of the disability and community care systems. Telecare has been found to:

- *enable people to stay in their homes for longer*
- *reduce the need for acute home care*
- *delay admissions to residential care*
- *reduce the number of unplanned hospital admissions*
- *reduce the number of delayed discharges from hospital.*

COTA NSW supports any initiative that supports people to age in place, this initiative is especially important for those people who are in remote, regional and rural locations, those people who are not in close proximity of family and other supports.

COTA NSW will be very concerned with the cost to clients. The main concern will be the impact of such technology on energy consumption and cost. In NSW we have seen many older people struggling to pay basic energy bills, let alone dealing with paying for hardware set up, maintenance and repair of technology.

The other issue will be ensuring that appropriate support and capacity building for those clients that may overwhelmed by technology.

b) Innovative service models

The most innovative service model for an ageing population is a one stop shop Community Care Model including allied health. The Women's Health Centre model of health and well being doctor, nurse practioner/educator, allied/alternative health practitioners, health education, referral to other services, such as counseling, domestic violence and other community support. It is essential that such a model also includes outreach and home visit services.

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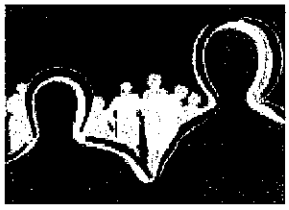
Attachment 1

No place for our loved ones to go

Tuesday, 03 November 2009 01:00

There is a great and growing crisis in Australia that few people know about and even less are talking about, says Sydney mother and working carer Estelle Shields.



Estelle is the mother to 32-year-old Daniel, who has high support needs and a severe intellectual disability. Aged 58, Estelle lives in Ryde and works as a piano teacher, giving lessons during the time when Daniel is at work, in a supported employment establishment.

Estelle says she feels a deep sense of despair and panic as the years race past with little hope of her being able to secure independent living accommodation for her son before she and her 65-year-old husband themselves become dependent on support services, or pass away.

The fear of what will happen when she and her husband die, or can no longer care for their son, fills her with dread and motivates her year in and year out to seek a solution to the problem - not just for her own family, but for the hundreds of other carers in a similar position.

While there are support projects which offer respite and future planning, such as the Ageing, Disability and Home Care (ADHC*) Older Carer program, you must be aged over 60 and maintain your primary care role to be eligible. For those under this age or unable to continue as primary carer, it is almost impossible to access funded 'supported accommodation'.

"There is nowhere in the 'lucky country' for its citizens with severe dependent disabilities to live - except staying at home with their parents," said Estelle.

"Daniel has seen his three younger brothers all stretch their wings and move out and desperately wants to leave home and live with his friends, but with a severe intellectual disability, he cannot just 'move out'. He needs in-home support, some supervision and help with many of the daily living tasks we all take for granted.

"Around the developed world, governments have come to terms with this issue and have taken responsibility for their citizens with an intellectual disability. Here in Australia, we trail far behind other first world countries. The solution that our governments are suggesting, that is, that we pass our disabled adult children on to their siblings, is a third world one and unworthy of this wealthy nation," Estelle said.

"You have probably heard an expectant parent say that he or she has no preference about the gender of the child, as long as the baby is 'OK'. But what happens to those parents who randomly receive into their hearts and homes the child who is 'not OK'?"

Estelle said the average Australian believes that things are improving for people with a disability, because they see wheelchair-accessible buildings and transport. "The reality is that waiting lists for early intervention are longer than they have ever been, disability education is in crisis and the costs involved in raising a disabled child are often crippling," she said.

"Families like ours have been on an ADHC accommodation register for many years - but this is NOT a waiting list for supported accommodation. We have been told by ADHC that there are no waiting lists in NSW anymore.
"We know from the Shadow Minister for Disability Services, Andrew Constance, that last year there were 1700 requests from carers already in crisis seeking supported accommodation for their loved one with a disability. Only 112 places were available.

"And each year about 90 supported accommodation places go to people with a disability who have been in foster care but now, at 18, need to be housed in the community. Other places need to go to people with a disability who have wrongly been placed in prison. The need for accommodation far outstrips availability. People like us are way, way down the list.

"There is a disability system in each state but it is beyond the capacity of the states to deliver what is needed. Currently, the disability system in NSW is boasting extra funding under Stronger Together. But they are meeting the need of only approximately seven per cent of the families that apply for supported accommodation.

"Imagine the outrage in our society if we had an education system or a health system that could meet the needs of only seven per cent of the population. Yet this is what we have in the disability sector and very few people mention it."

Not one to sit idly on her hands and whinge, Estelle has spent the past six years lobbying various government departments to support a concept plan she and a number of other families in a similar situation have proposed. Their group is called RASAID (Ryde Area Supported Accommodation for Intellectually Disabled). Their dream is to develop a residential cluster housing development in their local area.

"We have seen our people grow up together over decades and witnessed how much they enjoy each other's company and we want to make an intentional community for them with a pioneering model that will set a precedent for housing people with an intellectual disability and be emulated across the country," she said.

"Today, after six years of garnering support for our project from politicians (including the past three State Disability Ministers and Deputy Premier), ADHC and Health Department bureaucrats, we are as far from achieving our dream as we ever were, despite having found a suitable building site and having been given repeated assurances and promises that the project would be funded.

"In fact at the last meeting with ADHC earlier this year we were told that if the proposal went ahead, our sons and daughters might not be the ones to benefit anyway – the government would have to allocate any new supported accommodation places to those most in need.

"So we are back at square one after many years of hard work. But it's not just about bricks and mortar. Some of the families in our group have the ability to borrow funds to build their son or daughter independent accommodation, but they need an assurance from the State Government that if they do this, a recurrent service will be provided to support their child. The Government refuses to give that assurance.

"In some cases families I know have even offered to gift their entire house to ADHC to operate as a group home, on the condition that their child will be supported with a service. In all of these cases, the families have been refused.

"What on earth are we supposed to do? Just hand our children over to the State and walk away? One of my friends in her late 70s was forced to do just that after she became unable to care for her son. She was broken-hearted and her son, who has an intellectual disability, was bewildered, frightened and confused, wanting to know where his mother was.

"In one day he lost his mother and primary carer, his home, his social network, his job - all the stability and comfort he ever had in his life was demolished. They found a place for him 20 kilometres from his home and it is very, very difficult for his elderly mum to visit him there. The trauma and grief this family suffered was horrendous. It is unconscionable that our society can let this happen.

"Yet this is how the disability system works in Australia: it is dependent on the fact that we love our sons and daughters too much to relinquish them. But in our state last year, 65 families who were pushed to the edge did have to relinquish care of their loved one. Because no gradual transition out of home and into supported accommodation is possible under these crisis circumstances, the wrench is total and it is inhumane."

Far from being in a better position at the beginning of the 21st Century, Estelle said that she had seen a major decline of services and supports for people with a disability compared to when her son was born three decades ago.

"We could get immediate early intervention services like occupational therapy, physiotherapy, and speech pathology, and there were great special schools for our children to attend. There were accommodation options available, too," Estelle said.

"Some of these places were highly inappropriate but many were family instigated and family run and were caring village-style residences. They have all been branded with the label of 'institution' and closed, but very little has been done to replace them. A report released recently says that for many years people with disabilities found themselves shut in, but now they find themselves shut out - shut out of the way of life the rest of us take for granted.

"My son, Daniel, has a significant disability. He has the cognitive age of a three or four-year-old and needs a lot of assistance with his daily living. Yet he is strong and well, active and happy, a valued member of the team at his workplace, a loyal friend and an integral part of our family. Everything he has achieved over the years has come with great effort and this qualifies him to be called an 'Aussie Battler'. At the age of 32, he has earned the right to leave home and we have earned the right to retire.

"There are thousands like us and we look to our governments to provide what we must have. We are told that as Australia ages, there are measures in place to accommodate the needs of the changing demographics. We, the carers, are also ageing, and there are no plans in place for our precious sons and daughters - no place for them to go when we are not here."

* With the merger of several NSW government departments from July 1st, the former Department of Ageing, Disability and Homecare (DADHC) is now known as ADHC (Ageing, Disability and Home Care, Department of Human Services NSW)

HANSARD TRANSCRIPTS

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Ms McALPINE: During this calendar year we have introduced the new vacancy management policy, which allows people to flag future need for accommodation. We have been adjusting the service registers to separate the need for accommodation soon versus future need. We have 1,076 people indicating a need for accommodation soon. In the past 12 months, there were 178 vacancies, 118 individuals were placed and a further 26 individuals have been identified for an available vacancy but have not yet been placed.
CHAIR: How were they distributed across the regions?
Ms McALPINE: The 178 vacancies were: Hunter region, 18; metro north, 42; metro south, 57; northern, 33; southern, 11; and western 17.
CHAIR: How many families relinquished responsibility to the department for their children, including adult children, because they found themselves in crisis in the past 12 months?
Ms McALPINE: In 2008-09, a total 63 people were relinquished to the care of the department. Of them, 40 were adults, 15 were children and eight were young people aged 16 to 17 years.
The Hon. MELINDA PAVEY: How does that figure of 63 for the past financial year compare with previous years?
Ms McALPINE: I will have to take that on notice.
The Hon. MELINDA PAVEY: Is it a substantial increase?
Ms McALPINE: I do not know off the top of my head.
The Hon. MELINDA PAVEY: Was it not around 30 the previous year? My understanding is that it has almost doubled in one year.
Ms McALPINE: I am sorry, I will have to take that on notice.
The Hon. MELINDA PAVEY: Mr Lynch, would you know, as the Minister?
Mr PAUL LYNCH: We will take that question on notice.
The Hon. MELINDA PAVEY: You do not know?
Mr PAUL LYNCH: I said we will take that on notice.
The Hon. GREG DONNELLY: Point of order: I think I have heard the words "take on notice" four times yet the Hon. Melinda Pavey continues to ask the same question and, rather sarcastically, directs the question to the Minister in a way that I think is inappropriate. The questions should be addressed in a proper way, and we can do without the sarcasm.
CHAIR: The question has been taken on notice. I think the Hon. Melinda Pavey is just surprised that the Minister and staff are unable to provide that information. Further to supported accommodation, when you said how many people had applied and you broke down the numbers to "soon" and other definitions of vacancies, you are talking about more than 2,000 people. Is that correct?
Ms McALPINE: There are 1,076 indicating a need in the near future. There was a large number last estimates—I think about 1,700—and that included future need

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The Hon. MELINDA PAVEY: The number of people who were denied supported accommodation is 1,771 minus 64, is that right?
Ms McALPINE: And the 45 that are in train.
The Hon. MELINDA PAVEY: The level of unmet need for supported accommodation in New South Wales is around 1,700. How does that compare as per the percentage of population with Victoria, Queensland and Western Australia?
Ms McALPINE: I do not have that off the top of my head. I will take it on notice.
The Hon. MELINDA PAVEY: How many clients in New South Wales have been accommodated under Stronger Together?
Ms McALPINE: Three hundred and fifteen have moved on the first phase and that is broken down into 77 people in the Criminal Justice program, 125 in the general specialist places and 113 young people who have been transitioned from the Young People Living in Care Program.
The Hon. MELINDA PAVEY: How many clients with disabilities in New South Wales are entitled under the Commonwealth State and Territory Disability Agreement criteria to be considered for accommodation supports who currently do not have access to them? Is that the 1,700 figure?
Ms McALPINE: Is that the people who say they need a group home?
The Hon. MELINDA PAVEY: Yes. How many?
Ms McALPINE: Out of the total population, I need to take that on notice.
The Hon. MELINDA PAVEY: How many clients accommodated in supported accommodation services in 2007-08 across New South Wales were accommodated straight from the family home? Do you keep such a statistic?
Ms McALPINE: No. I would have to take it on notice.
The Hon. MELINDA PAVEY: How many people have met the urgent need criteria for supported accommodation and are waiting on the list? Is that the 1,700 or so?
Ms McALPINE: Yes.
The Hon. MELINDA PAVEY: Do you agree with the Australian Institute of Health and Welfare data that unmet need stands at 8,500?
Ms McALPINE: In New South Wales?
The Hon. MELINDA PAVEY: Yes.
Ms McALPINE: We do not have 8,000 putting up their hand right now.

Attachment 2

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Raising pension age 'will not work'

Adele Horin **Source:** **The Sydney Morning Herald**

August 19, 2010

RAISING the pension age from 65 to 67 will have only a limited impact on the employment rates of older workers, a leading economist says. This is because many Australians leave the workforce in their 50s and 60s and receive a disability pension or other government payment.

Bob Gregory, professor of economics at the Australian National University, said 90 per cent of single people who take up the age pension at 65 had previously received another payment - the disability pension, carer payment or Newstart Allowance, on average for six years.

A high proportion of married couples also followed this path from dependence on a government payment in their late 50s or early 60s to reliance on the age pension, he said.

"If I go on the disability pension at 63, I move seamlessly to the age pension at 65," he said. "If eligibility for the age pension moves to 67 I just spend the extra years on the disability pension, so nothing is gained for workforce participation."

Professor Gregory will address "The Silver Century" forum today at the Salvation Army headquarters in Sydney. The forum, examining prospects and problems of an ageing society, is being organised by Council on the Ageing NSW and the Australian Association of Gerontology (NSW).

Professor Gregory said policies to increase workforce participation had to start much earlier than 65. In the past decade there had been improvements in keeping older workers. But it was the 55-65 age group who were moving out of the labour market. In 2007 the average age of retirement was 59.

Professor Gregory said contrary to myth it was less well-off Australians who left early or lost their jobs and moved on to a payment. Last year the government announced that in 2017 the qualifying age for the age pension would gradually start to increase, reaching 67 for men and women by 2023.

Higher retirement ages are intended to moderate the long-term costs of providing age pensions to an ever-growing proportion of the population.

Roger Wilkins, principal research fellow at the Melbourne Institute, said raising the pension age to 67 was important in shifting norms about retirement. But governments were constrained in their influence over early retirement not only because people could get other payments, but because increasing numbers would have adequate superannuation they could access at 60, or earlier if born before 1964.

"What will matter more than pension age will be the age people can access their super, the tax treatment of super and the rules about how quickly they can deplete it," he said.

University of Western Sydney
Bringing knowledge to life

2009

Older men and Home and Community Care Services: Barriers to access and effective models of care.

mhirc

This study was undertaken by Professor John Macdonald, Mr Anthony Brown and Dr Anni Gethin of the Men's Health Information and Resource Centre, University of Western Sydney.

This research has been undertaken with assistance from Ageing, Disability and Home Care (ADHC). However, the information and views contained in this study do not necessarily, or at all, reflect the views or information held by ADHC or the NSW Government.

TABLE OF CONTENTS

1 STUDY BACKGROUND

1.1 Introduction

This study is about older men who are physically frail or have a disability, and their access to home and community care (HACC) services in NSW. The aims of the study were to find out:

- The social and support needs of older men with physical limitations
- Attitudes to services and barriers to access: why older men with physical limitations are not accessing home support services, centre based respite, transport and social activities to the extent expected, and
- Effective models of care: ways of successfully engaging with older men to increase their utilisation of services and involvement in centre based and supported activities.

Service providers across NSW have expressed concern about the relatively low numbers of older men using HACC services. Part of the response to the issue has been to seek to better understand the problem. As such, Ageing, Disability and Home Care (ADHC) commissioned this study with HACC Program funding. The study was undertaken by researchers from the Men's Health and Information Resource Centre (MHIRC) at the University of Western Sydney (UWS).

The focus of this report is on the challenges older men face in accessing community aged care. However, it in no way detracts from the challenges older women face in similar situations. It is important to acknowledge that each gender faces differing challenges as we age[1]. This report does not seek therefore to determine if older men are better or worse off in regard to community aged care than older women.

1.1.1 What we researched: the study parameters

The focus of the study was on men aged 65 and over who require some assistance to remain living independently in their home and community. As a HACC target group these men would be considered 'frail older people'. However, our research found that the term 'frail' is not generally acceptable to older men, nor is it acceptable to many service providers. Accordingly, we have referred to the study population simply as 'older men' throughout this report – with the implication that our discussion relates to older men who would be eligible for community aged care services on the basis of their physical limitations.

Community aged care services are delivered by a wide number of government and non government agencies (NGOs) in NSW. The terminology 'Home and Community Care' (HACC) refers to services jointly funded by ADHC and the Commonwealth Department of Health and Ageing (DoHA). These services are provided in accordance with the *Home and Community Care Act 1985* and the legal agreements between DoHA and the Australian states and territories[2].

The great majority of community aged care services delivered in NSW are HACC funded services. The balance of community aged care is provided under a wide range of funding arrangements (for example, Veterans' Home Care [VHC], funded by the Commonwealth Department of Veterans Affairs). It is common for an NGO to receive service funding from ADHC and one or more other sources.

For the purposes of this research we took the view that barriers to access and successful engagement strategies for older men were likely to be similar whatever the source of funding. Thus the research did not seek to exclude the views of individuals (clients and service providers) across the diversity of funding arrangements.

1.2 Methodology

1.2.1 Overview

This study used a mixed methodology incorporating:

- Analysis of the HACC minimum data set (HACC MDS)
- An online survey to service providers
- Focus groups of service providers
- Interviews with individual service providers
- Interviews with older men eligible for HACC services (both users and non users of services)
- Interviews with carers of older men

1.2.2 Analysis of the HACC minimum data set

"The HACC Minimum Data Set (MDS) is a collection of data about HACC clients (such as their age and living arrangements) and the amount and types of assistance being provided to them through the HACC Program".[3] Providers of HACC funded services in NSW are required to regularly report on the services they deliver. The analysis of this data set was undertaken by the research company, WESTIR, with the guidance of the UWS researchers. The aim was to determine the level of HACC services being provided to men aged 65 and over, and to determine if differences in service delivery by location and service type could be ascertained.

1.2.3 Online survey

The survey was undertaken to obtain information from service providers. It included questions both about the barriers older men face in accessing services and activities and about models that had been used to successfully engage with this population group. The survey provided a range of insights into the issues faced by older men and service providers to this group; these issues were also further explored in the focus groups.

The survey was delivered via the online survey host, Survey Monkey. A survey link was distributed electronically to providers of community services across NSW (both ADHC and non-ADHC funded) through HACC Development Officers, the project reference group and the Council of Social Service of NSW (NCOSS). Managers of services or programs were invited to complete the survey.

In total, 126 surveys were completed. It is not possible to assess the response rate as it is unknown how many individual services and service outlets received the survey. However, there were sufficient surveys completed to indicate both the significant barriers to service access, and the characteristics of programs that had successfully engaged older men.

1.2.4 Focus groups with service providers

Three focus groups were held with community aged care service providers. These were held at:

- Parkes (central Western NSW)
- Windsor (regional NSW)
- Manly/Warringah (urban Sydney)

A total of 37 service providers participated in the focus groups. Three focus group participants were men, 34 were women: proportions which accurately reflect those of the community aged care workforce[4].

The focus groups were used to further explore the access barriers that had emerged in the survey and to ask survey providers how they had managed to overcome these barriers. Elements of successful programs and services were also discussed.

Data from the focus groups was transcribed then analysed according to the central themes of the research (barriers and effective models of care), with additional issues (e.g. rural services, CALD issues) included if they emerged.

1.2.5 Interviews with individual service providers

Eleven service providers were interviewed by phone or face to face interviews. These were individuals who had a particular professional interest in the client group but who were unavailable to participate in the focus groups. Issues around barriers to accessing services and ways of successfully engaging with older men were explored.

1.2.6 Interviews with older men and carers

Ten older men and three female carers were interviewed for the research. These people were recruited through referral by services and by responding to notices placed in community settings across NSW.

Recruiting older men and carers for the study proved quite difficult, even with the offer of a $50 voucher to cover costs. The most effective means of recruitment was the direct approach through service providers.

1.3 Ethical aspects

The research was undertaken with careful attention to proper ethical conduct: informed consent was obtained from each research participant and appropriate measures were taken to ensure that participant identities remained confidential.

Each part of the research was approved by the Human Ethics Committee at the University of Western Sydney – with separate ethics applications completed and approved for the each component, namely:

- Analysis of the HACC MDS
- Focus group and interviews with service providers
- Interviews with older men
- Interviews with carers

1.4 Data limitations

The participants in the study were all self selecting and most had a particular interest in older male use of HACC services. Many of the service providers had sought to engage with older men and reflected on their own practice; they reported examples of successful programs and engagement strategies. Whilst this provided rich data, the study did not include service providers who may have had negative or 'male deficit' understandings in relation to service provision.

There were difficulties recruiting men who did not use HACC services. We were able to recruit two men who did not use services, however, most of the male interviewees were users of HACC services or other community aged care services. Interviewing more non users may have added greater depth to the analysis of why men sometimes choose not to use services. However, service providers did offer many of their observations as to why older men reject services.

During the study particular issues relating to older men from CALD backgrounds and who reside in rural or remote areas emerged; these are highlighted as appropriate.

1.4.1 Groups not included in the study

The study did not examine issues relating to a number of groups of older men. Those specifically excluded were men with significant cognitive impairment (including dementia) and men residing in residential care.

In addition, we did not examine issues relating specifically to Aboriginal older men, as this was considered to be more properly the subject of a separate study. Similarly, issues relating to older men of diverse sexualities were not specifically examined. It was also beyond the scope of the study to consider issues relating to socio-economic background. However, we acknowledge that wealth and social status can impact on patterns of service usage.

1.5 Project reference group

The researchers were advised and guided by the project reference group, which included the following members:

- Ms Noreen Byrne – A/Manager Research and Evaluation, Evidence Base Development, Business Improvement, ADHC
- Ms Lucy Moore – Senior Policy Officer, Strategic Policy and Planning, ADHC
- Ms Pauline Armour – Community Care Development Manager, UnitingCare Ageing
- Ms Maja Frölich – Multicultural Policy and Development Officer
  Policy, Strategy, Communication and Education Unit, Carers NSW
- Professor John Macdonald – Director, MHIRC, UWS
- Dr Anni Gethin – Research Project Coordinator, MHIRC, UWS
- Mr Anthony Brown – Project Officer, MHIRC, UWS

2 DATA AND LITERATURE

2.1 Introduction

Understanding the use of HACC services by older men requires examining existing information about older men, levels of need and service provision. It also requires understanding older men in Australia: who they are, their values, and their strengths and vulnerabilities. In the sections that follow we examine relevant data and provide a discussion of the literature about the nature of older men and how they access services.

2.2 Data: the potential demand for HACC services by older men

'There are fewer older men than older women' is one possible explanation for why older men do not use HACC services than older women. That is, assuming an equal need for services by both genders, lower male life expectancy will equate with lower male service usage.

In the case of HACC services, fewer men could explain some of the difference in levels of service use, however, it cannot explain it all: about 45% of the older population is male, but males are only one third of older HACC service users[2]. In addition, there are certain HACC services that reportedly have a very low uptake by men, for example, centre based respite (see Part 3: Findings).

We examined various data sources to see if it was possible to determine the true level of service underutilisation for older males eligible for HACC services in NSW.

2.2.1 Age distribution by sex

Age distribution for people aged 65 years and over in NSW is shown at Table 1. Proportions of men decline for each successive age grouping, from close to half for those aged between 65 and 69, to less than a quarter for those aged over 95 years. Although it should be noted that, overall, men comprise around 45% of the NSW population aged 65 years and over.

Table 1. Persons aged 65 years and over by sex - NSW

Age Range (years)	Males	Females	Total	% Male
65-69	124,959	129,465	254,424	49.1
70-74	100,549	110,352	210,901	47.7
75-79	85,126	102,965	188,091	45.3
80-84	57,086	83,618	140,704	40.6
85-89	26,162	48,365	74,527	35.1
90-94	8,198	21,267	29,465	27.8
95-99	1,426	5,180	6,606	21.6
100 and over	248	809	1,057	23.5
TOTAL	**403,754**	**502,021**	**905,775**	**44.6**

Source: ABS Census of Population and Housing (2006).

2.2.2 Ageing and CALD backgrounds

Around one in five Australians aged 65 and over are from non English speaking countries[5], meaning that people from culturally and linguistically diverse (CALD) background form a sizable proportion of the older population. A comparatively high proportion of CALD older people are men: 49% as compared with 43% of those born in Australia. In the 65-74 age group of CALD people this pattern is marked, with men outnumbering women[5].

2.2.3 Need for assistance with daily activities

In the 2006 Census, NSW residents were asked if they had a need for assistance with various daily living activities. Between the ages of 65 and 74, there are a slightly higher proportion of women as compared to men identifying a need for assistance. In the older age groups the proportion of men and women needing assistance differs markedly, with much higher proportions of women as compared to men[6].

Table 2. Core activity need for assistance by sex - NSW

Age Range (years)	Males	Females	TOTAL	%Male
65-74	17,524	19,368	36,892	47%
75-84	25,115	41,938	67,053	37%
85 years and over	13,927	39,389	53,316	26%
TOTAL	**56,566**	**100,695**	**157,261**	**36%**

Source: ABS Census of Population and Housing (2006).

2.2.4 Are older men underserviced by HACC services?

Given that lower proportions of men identify a need for assistance, the question arises of whether they are receiving an appropriate level of services. Examining the patterns of HACC service delivery can provide some insight into this question.

HACC services can be used by people who need help to live independently, regardless of age. In practice, the great majority of HACC clients are older people aged 65 years and above; in NSW 79% of HACC clients are in this age group[2].

There is a marked disparity in HACC service use by sex. In NSW, males are just over one third of all HACC clients (see Table 3).

Table 3. HACC Clients by Sex, NSW (%)

Sex	%
Male	35
Female	65
TOTAL	**100**

Source: HACC MDS Bulletin 2007-2008

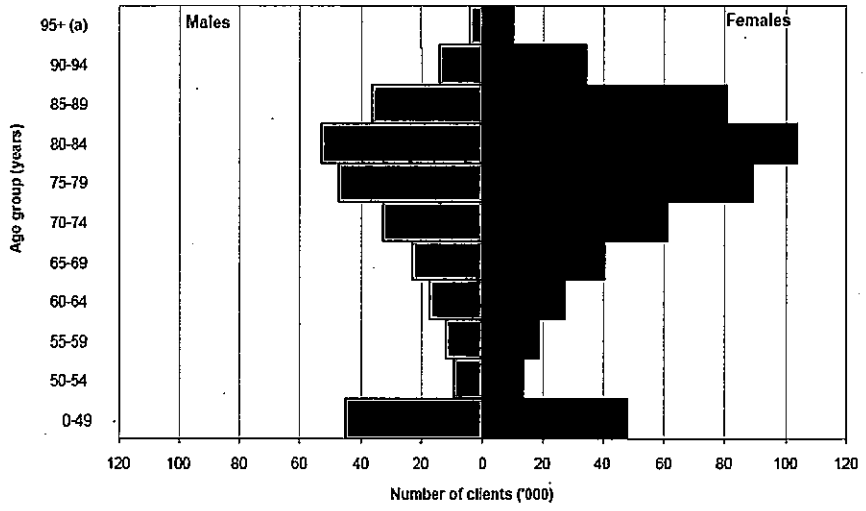
And, as has been shown (Table 2, above) 36% of the persons identifying a need for assistance are men. On immediate face value, this could look like a good match of services to need. However, there are a number of issues to consider. These include:

- The provision of HACC services by age group (i.e. men in particular age groupings may be underserviced)
- Levels of unmet demand for assistance (See section 2.2.5)
- Males are less likely than females to state that they need assistance (see Part 3: Study Findings)

HACC service use by age

The service use imbalance by sex is particularly marked in older age groups (see Figure 1). It can be seen that for all age groups over 64 years, female clients substantially outnumber male clients. In the age groups 65 to 74 years the proportion of men using HACC services is around 35%. This compares with the 47% of males who identified as needing assistance in these age groups (see Table 2). So, at the very least, it is possible to see that males in these age groups are not receiving HACC services in proportion to their stated need for assistance (although their need for assistance may be being met in other ways – see sections below).

Figure 1. Age and sex distribution of HACC clients, 2007-08



Source: HACC MDS Bulletin 2007-2008 (a) (The 95+ age group is over estimated)

The disparity between need for assistance and HACC services by sex appears to decrease with age, so that in the oldest age groups, HACC service delivery by sex is close to the stated need for assistance.

2.2.5 Unmet demand for assistance

Not everyone who identifies that they need assistance receives assistance. In NSW, 36% of men and 33% of women aged over 60 who have identified a need for assistance feel that their needs for assistance are not being met[7]. For people receiving partial or no assistance for identified needs, it is apparent that males have particular unmet needs in regard to self care, health care, transport and property maintenance[7].

2.2.6 Are men receiving assistance from non HACC providers?

It is possible that men are not using HACC services as much as demand would suggest because they access support from another source, such as that offered through Veteran's Home Care (VHC), and national aged care programs such as Community Aged Care Packages (CACP) or Extended Aged Care at Home (EACH).

Veterans Home Care (VHC) services are allocated evenly between men and women, with 51% male clients[5]. However, VHC is offered to a very small proportion of older Australians, accounting for around 8% of community aged care services to people aged 65 years and older[5].Therefore the existence of this service does not account for the substantial differences by sex in HACC service use.

Whilst the other services CACP and EACH offer proportionately more services to women than men, they also provide relatively small proportions of overall community aged care[5].

2.2.7 Are men receiving the assistance they need from carers?

Carers are an important source of assistance for both older men and older women. Whether informal carers are 'filling the gap' in meeting the assistance needs of older men is an important question. Informal care can be provided by partners, or other family and friends. In terms of partner care, male and female partners over 60 offer similar proportions of all informal care, at 23% and 25% respectively[6]; the balance of informal care being provided by non partners.

Essentially, it is not possible to accurately determine from existing data sets the extent to which informal care is meeting the needs of older men which are not being met by HACC services. It is a complex question, because 'needing assistance' and 'having that need met' involve many variables – both for the person needing assistance and the person or agency providing that assistance.

Some of the issues include:

- A person receiving informal care often also uses community aged care: around 73% of Australians using community aged care also use informal unpaid care[5].
- A person's need for assistance may only be partially met, e.g. they may receive the help they need with personal care, but not transport.
- Carers often need assistance themselves, e.g. with respite or home support services.
- In older age, men and women are fairly equally likely to be a carer, and in the oldest age group (85+) men are more likely to be carers than women[8].

2.2.8 Analysis of the HACC minimum data set

To further explore the questions around older male utilisation of HACC services, an analysis was undertaken of the HACC MDS for NSW[1]. This data set includes reported episodes of HACC service delivery to clients in a given year.

The analysis of the HACC MDS was able to confirm that episodes of HACC service delivery by sex to people aged 65 years and over, are proportionately one third to men, two thirds to women. This correlates with other analyses of the HACC MDS for NSW[2].

2.3 Literature: the social context of service delivery

2.3.1 Introduction

Ageing is a gendered process. The experience of growing older differs between men and women; events of old age, such as illness or bereavement can have a differential impact depending on a person's gender[9]. Understanding the interaction between gender and ageing can help us to better comprehend how older men interact with services, and work out more effective ways of providing services to this population.

The challenges to masculinity created by ageing is a relatively recent area of research interest[10]. It offers a number of useful insights for those working with older men, for instance in analysing how older men maintain a sense of 'manliness' when confronted with the process of becoming older. In the sections that follow, some of the key aspects of masculinity and ageing are discussed. It must be stressed that the gendered aspects of ageing create both strengths and vulnerabilities for men.

2.3.2 Generational factors

The notion of what it means to be a man differs between cultures and environments – including historical eras. Ideals of being a successful man change over time; the men who are now aged 65 and over grew up and were adults in very different times to the present.

The age cohort of men in our study contains two distinct generations 'The Oldest' and 'The Lucky Generation'[11]. Men of 'The Oldest' generation were born before 1927, and in 2009 are aged 82 years and over. Many men in this generation served in World War II and experienced the Great Depression of the 1930s.

The Lucky Generation are so termed because they consider themselves more fortunate than their parents. They experienced the benefits of the post war economic boom and full employment, but were still substantially influenced by the austere values of their upbringing[11]. They were born between 1926 and 1946, and in 2009 are aged 63 to 81.

These generations have been identified as having values of independence, hard work, stoicism, austerity and resilience[12]; and take "pride in their own prudence and restraint"[13]. They have an aversion to charity and believe that people need to look after themselves and their families. Also, they grew up and worked in an era that was largely pre feminist. Traditional gender role models prevailed, where men were the bread winners and sole providers and women looked after the home[11].

[1] Conducted by the research company, WESTIR – see methodology.

Because of these influences, men of these generations tend to place a very high value on independence and self reliance, see themselves as providers, and to perceive the domestic realm to be the province of women.

2.3.3 Masculinity and cultural diversity

Men born overseas are around one in five of the older male population, and a steadily increasing proportion of older people[6]. Socio-cultural influences affect both ageing and gender – meaning that older men from culturally diverse backgrounds may approach service usage from a different perspective from English speaking and Australian born older men.

Social support is being increasingly recognised as a significant social determinant of health[14]. Older men from cultural minorities can be advantaged in their familial and social relationships[15]. Extended family and closer cultural communities and service organisations often provide CALD older men with a strong support network which can act as a buffer against social isolation and the risk of depression.

Alternatively, it has been observed that there is a prevailing and incorrect belief that CALD communities do not need services, because they will 'look after their own.' Participants in a recent study stated that not only did they have a need for community care services, they were willing to use these services[16].

A CALD background can also create barriers to service usage. Language is an obvious barrier, where lack of English proficiency makes it difficult to negotiate and understand service provision. Cultural expectations about aged care can prevent families from seeking outside support. In many cultures it is considered to be the role of the family to care for elderly people[15]. Other options may not therefore be considered, even if family or partner care is beginning to break down. Similarly, there can be gendered expectations that 'a wife cares for her husband', which may prevent the female partner from seeking support.

2.3.4 The importance of independence

Ageing is often associated with a loss of independence. Maintaining independence is a marker of ageing well for both men and women[17]. Independence is often seen by men as an important part of their masculine identity, and a core value for older men generally[18]. Thus, 'independence' is a critical variable to understand when offering assistance to older men: asking for or accepting help may not be a simple transaction, but may threaten central constructs of an older man's identity. With a largely feminised workforce, careful consideration is needed to work with older men in a way which builds on their strengths and retains their dignity, while finding ways to support them to access services.

Masculine independence should be viewed as a potential strength, and not a problem. For example, in terms of health services, promoting independence has been identified as 'an untapped tool for engaging older men in discussion about their health'[18]. So it can be observed that 'independence' provides an entry point for HACC service providers to older men: the role of services is to support 'masculine independence' in old age. This theme is returned to in our findings, below.

2.3.5 Retirement and the construction of non work related identity

Retirement from work can have a substantial impact on men[19]. It means the loss of a work related identity and the social connections associated with work. For older men, particularly men who have found meaning in their lives outside their home, it can be more difficult to adjust to this new domestic environment. Even in retirement some men still find meaning outside their home, be it in their shed or garden, or in activities away from the house".[20]

Recognising the importance of work and the external world to a man's identity is useful to service providers. For example, an older man can be engaged in conversations about the work he did before retirement, his property, his cars, his garden or his sporting or other achievements. Older men are likely to enjoy activities that have some continuity with the activities they enjoyed in the past.

2.3.6 Older men as carers

Men aged 65 and over are more likely than women of the same age to be carers – for example, in Australia there are 245,000 men and 209,000 women of this age group in carer roles[8]. This imbalance, whilst counterintuitive given different life expectancies, is thought to result from older men being more likely to be living with a partner

than alone, and older surviving men being healthier than older women[8]. A significant proportion of older men are in carer roles, for example, 25% of men aged 75-79 are carers[8]. It is also likely that the number of male carers is underestimated, with some men seeing 'care' as a normal part of a marriage rather than a separate role. Most frequently, older men are caring for their partner. The carer role creates significant responsibilities, and can also create an 'ambivalent situation with respect to masculinity'[21].

Caring is perceived as a traditionally female role, and involves traditionally feminine tasks such as personal care of another and housework. The role can create a difficult situation for an older man's self perception as 'a man.' It also confines him more to the domestic sphere and reduces his opportunities to socialise with other men.

Researchers have observed that older male carers often behave in ways to preserve their sense of masculine self. For instance, they may never describe themselves as a carer, portray caring for a wife as a masculine duty undertaken because of their marriage vows, and emphasise that they are 'in charge'[21]. This should help providers be aware of acting on simple stereotypes of 'masculinity', since the behaviour of this group of older men indicates that masculine identity is capable of changing with circumstances, and in this case demonstrating a development of the caring role.

For service providers working with older male carers, it is useful to be aware of the ambiguities involved with the role. For example, men may prefer to be termed a husband rather than a carer, and to feel like they are the primary decision maker about care related matters (such as respite or additional home support services). Engaging their active participation in such decisions needs to be considered in the training offered to providers.

2.3.7 Health and health behaviours

Patterns of health and health behaviour differ between older men and older women. Compared to women, men over 65 are more physically active, have better self rated health[22] and lower rates of depression[23]. However, older men suffer higher rates of most major diseases as compared to women. Also, in NSW, older men have higher rates of smoking, heavy drinking and lower rates of fruit and vegetable consumption and are less likely to seek medical care[22].

2.3.8 Social connections

Men tend to have smaller social networks and weaker interpersonal connections with family and friends than women[9]. In Australia, male social connections have traditionally been heavily based around work and sporting clubs. As has been pointed out already in the context of social support, older men are therefore more vulnerable to loneliness and isolation than women, particularly if they live alone or have lost a spouse (see below). A lack of social support can also place an older physically frail man at greater risk of institutionalisation – as there are not people to provide assistance and health monitoring.

On the positive side, recent years have witnessed a rapid expansion of the Men's Shed movement , offering older, often retired men, occasions to form new supportive relations with other men[24]; the rapid growth rate is an indication of their positive role in older men's wellbeing.

2.3.9 Bereavement

Bereaved men are more likely to suffer depression, grieve for longer and engage in substance abuse, than women whose partner has died[25]. Loneliness and social isolation are also more prevalent amongst bereaved men. Older men often have less developed social networks than their female partners, and bereavement may mean the loss of a man's main friend and confidant[9].

2.3.10 Older men and service provision

Older men tend to be underserviced in the community, and can be less visible to service providers[9]. A number of reasons have been put forward to explain this disparity; these relate both to factors particular to men and factors relating to the way services are provided. Examining the explanations for why older men do not generally access community services to the same extent as older women helps to understand this phenomenon in relation to HACC services.

The most obvious explanation for older men receiving fewer services is because there are fewer men surviving to old age (see Section 2.2.1). For each older age group there is a declining proportion of men. In the oldest age groups which require the most support and assistance, there are greater numbers of women.

Men are also less likely to be aware of the resources available to them and less likely to seek them out. Some communication methods about services (written brochures, newspaper advertisements) are not particularly effective for men; they are more likely to respond to specific outreach, concrete and practical information and information from peers.

A 'male unfriendly' environment is one of the reasons put forward to explain men not accessing health services as much as would be expected[19]. Similarly, community services are configured in a way that is not exactly 'male friendly'. They tend to be very female centred – with majority female workforces and clients. This 'female domination' is particularly evident in community aged care in Australia: 91% of the workforce[4] and two thirds of the clients are female (see above). A feminised environment in community aged care can potentially put off males from seeking help or participating in activities. This is not because professionals in the field would seek to deter men – but simply because older men may feel uncertainty, or embarrassment in moving into an unfamiliar environment. Also, many older men prefer to deal with men[19]. These issues emerged strongly in our research – and are discussed further below.

2.3.11 Service styles that men prefer

Research with healthy older men living in the community identified that men prefer to interact with programs and services that give men the opportunity to:

- Utilise existing skills or knowledge (or learn new ones)
- Make a contribution to others
- Engage in physical activity
- Be with like minded people[26].

In the absence of similar research with men in community aged care, it is reasonable to assume that men would be attracted to aged care services that offered the same type of opportunities. These issues are addressed in our findings and discussion that follow.

3 STUDY FINDINGS

3.1 Barriers to accessing home support services

Home support services include a wide variety of services such as help with personal care, meals on wheels and home visiting (often delivered through Home Care Service of NSW). Service providers were asked what they considered to be the barriers to eligible older men accessing home support services. The five issues most frequently selected by service providers from the Service Provider Survey are listed below (Table 5).

Table 5. Home support services: main barriers to access

CLIENT ISSUE	RANK
Feels he can manage himself	1
Feels embarrassed to ask for help	2
Unaware of services available	3
Prefers that partner assists him	4
Unaware of eligibility	5

Source: Service Provider Survey. n= 126

The barriers were explored in greater detail with service providers through open ended questions in the survey, focus groups and interviews, and through the interviews with older men and carers. The views expressed are discussed below.

3.1.1 Feels he can manage himself

'I'm just fine, thank you' is an attitude encountered quite often by providers of home support and family members of older men (sometimes expressed more vociferously, e.g.: '*Bugger off!*'). Clearly, if a man believes he is 'doing fine', then there is no impetus for him to accept assistance. For example, as one man said: *"I can't see the dirt, it doesn't worry me."*

However, the rejection of assistance potentially creates a complex situation because a man may subjectively judge that he is coping, whereas service providers and family may have concerns for his well being. Typical concerns include those of social isolation, potential falls, nutrition, and day to day household management.

He can manage himself

One factor recognised by service providers is that some men may be managing quite well by their own estimation. For example, a man might appear to be spending too much time alone, or not to be eating well or to have a house that appears cluttered and unclean – but that is how 'he likes it.' In the view of service providers, if a man has an authentic desire to manage alone and is at no immediate risk, then home assistance is not required – at that point.

To say he is 'not managing' is too confronting

For other men the claim to be 'just fine' can cover a number of other concerns. According to service providers some men fear that if they accept help they will end up in the nursing home. For example, as one manager commented: *"they think it is the first step in the slippery slope to institutional care and death."*

Acknowledging a need for help can also make a man feel old, incapable and emasculated, and ways of working with men who find it difficult to ask for support are discussed in the sections below.

3.1.2 Feels embarrassed to ask for assistance

Many older men are apparently reluctant to ask for assistance even when others believe they need it. Feeling ashamed or embarrassed about asking for assistance is one of the main reasons for this reluctance. Research participants identified a number of underlying issues that contribute to older men not wanting to ask services to assist them.

Generational factors

Independence, self sufficiency, stoicism and resilience are some of the core qualities in generations of men over 65 (The Oldest and The Lucky Generation – see Section 2.3.2). These qualities can make it difficult for men to ask for assistance outside of a serious crisis: 'help seeking' is not a behaviour with which they are comfortable or familiar. One manager made the comment: *"I think the generation of men who are over 65 years of age at present have been brought up to be self sufficient and see asking for help as a weakness."* Another summed up the generational attitude as: *"you look after yourself and your family, you don't ask for anything."* And it often was a case of *"you made do with what you had"* – meaning that people of this generation expect to manage with their own financial and personal resources.

Similarly, men of these generations often have particular expectations about the marriage institution, namely that husband and wife care for each other, literally 'in sickness and in health'. This issue is discussed further below in relation to men preferring their partner to care for them. It can also mean that men will not seek help in their own caring roles, regardless of their own frailty; for example one worker commented: *"he won't ask for help with caring for his wife – when he got married that's what he signed on for."*

It was noted that the qualities of self sufficiency and independence can be even more marked in rural men; living from the land, often in very harsh conditions, meant an even higher level of self reliance was required.

Pride and sense of self

Related to the generational values is the strong sense of pride in many older men. This issue was mentioned above, where older men can be reluctant to ask for assistance, because to do so would confront their sense of who they are as a man and their capabilities. And many older men do not actually consider themselves old! Service providers commented about the issue of pride:

"It's not a 'manly' thing to accept service, it shows signs of weakness."

"I think a lot of it has to do with pride - men of that generation don't seem to ask for help - I went and gave a talk to the local RSL Sub-Branch, spoke to over 100 men, some who live by themselves and none of them rang me later on although all said that the service was worthwhile and a good idea."

Pride is also a factor in accepting certain services. Anything that appears to be charity can be rejected by some men. Also, if a man does not see himself as old, he is unlikely to want services that are 'for old people.' According to one older man, to accept aged care services is tantamount to admitting: *"I am old, I can't do what I could do when I was younger."*

Embarrassed about receiving personal care

Some men are embarrassed about another person providing their personal care, and would normally prefer that their wife or other family member perform these tasks. This can particularly be the case for certain cultural groups, where it is inappropriate for an unrelated woman to touch a man. Alternatively, some men are averse to receiving personal care from men, and would prefer a woman to perform these tasks.

Don't want to deal with women – particularly younger women

Most home and community care workers are women. Some older men can find talking with and accepting services from women difficult – especially much younger women. As one worker observed: *"they find it hard to have younger women coming into their homes and trying to organise them."*

3.1.3 Information: unaware of services available/unaware of eligibility

An information barrier exists when a man is unaware of the services available or unaware of his eligibility for services. In the view of providers, the barrier is not often one of lack of information: community aged care services are widely publicised, for instance through national and local papers, community newsletters, notice boards and

through local information sessions, such as those run by Veteran's Affairs. Information is also readily available through telephone or internet contact with services, for example, by calling the local neighbourhood centre. A number of reasons were identified as to why older men were not accessing this information.

Older male communication styles

Many older men prefer to find out information through direct means, such as through a partner, friend or acquaintance. They are less likely to read written sources of information. In the view of one worker: *"men don't read things on notice boards or in newsletters so much."*

It was also observed that men can also need time to consider information – 'to let it sink in'. Therefore if faced with a choice 'do you want it or not' may feel pressured and default to rejecting a service.

Less likely to seek out information directly

Managers also observed that older men did not appear to independently seek out information about services as much as older women. This was seen to be a result of a number of factors. 'That's women's business' was an attitude observed by service providers, in that anything to do with domestic or personal services can be seen as the province of women; or as one worker noted: *"they will use the services if their wife makes the call and arranges it."*

The realm of human service provision can be confusing and strange for older men, particularly for those who have seldom dealt with such services. There can be a wide array of acronyms and service providers, and unfamiliar territories to negotiate. For example, one manager said: *"it's not like taking his car to the mechanic or getting a tradesman around, where a man feels fine telling the guy what is wrong and what needs to be fixed."*

For CALD older men, the difficulty of seeking services can be exacerbated by language barriers and dealing with an unfamiliar culture. Service providers reported that for CALD men without family or community access points it was very difficult to work out where even to begin in accessing services, or indeed that such services are available.

3.1.4 Prefers that his partner assist him

Many physically frail men prefer that their wife or partner assist them. Understandably, it is usually preferable for a man that intimate tasks such as help with toileting or showering be undertaken by his partner. More generally, a man's partner may have always done the domestic tasks such as cooking, cleaning and washing – so that in essence there is no change in the couple's roles in this regard. One service provider made this comment: *"they've always had a division of labour - she does the cooking and cleaning, there isn't really a change there."* In many cultures, a gendered division is very strongly delineated – for example one worker observed that: *"in Indian culture, it is expected that the spouse needs to look after the husband."*

Service providers did not consider 'partner care' an issue of concern, provided both partners were reasonably happy with the arrangement and the level of care was adequate. Where problems do occur is when a man's partner is no longer able to care for him properly (for example, develops dementia or becomes physically frail themselves) or when the partner becomes physically and mentally exhausted and needs a break.

Elderly wives can become distressed with providing daily care, and may seek respite care service support that is not agreed to by the man. At times, men can view the suggestion of using a respite service as a threat to his remaining at home with his wife. In these situations the couple needs sensitive support to ensure that the needs and concerns of both partners are met.

3.2 Barriers to participating in day programs and activities

Home and community care providers offer a range of day programs and activities for frail older people. As a HACC service type these are termed 'centre-based respite' or 'transport'. They can involve structured centre based programs' or more informal outings or activities. Service providers were asked what they considered to be the main

barriers to men accessing these types of activities. The five most frequently mentioned issues are listed below (see Table 6).

Table 6. Main barriers to participating in day programs and activities

CLIENT ISSUE	RANK
Client does not want to participate in organised activities	1
Client feels activities are not interesting for men	2
Transport	3
Client does not know about activities	4
Client prefers to go to a commercial venue (e.g., pub or club)	5

Source: Service Provider Survey. n= 126

These issues were explored in greater detail with service providers in the survey, focus groups and interviews, and through the interviews with older men and carers. The views expressed are discussed below for each issue:

3.2.1 Client does not want to participate in organised activities

Almost half of survey respondents indicated that not wanting to participate in organised activities was a barrier to older male participation in the day programs and activities offered by home and community care providers. Analysis of this issue showed that there were a number of underlying components to this barrier.

Some men just don't want to do social activities

Some men prefer their own company or that of their partner, or visits with friends. The idea of participating in group activities is simply not appealing. As one worker observed: *"they didn't do social activities before they retired, and they are not interested in them now";* or, as an older man said: *"we don't often do social activities - my wife and I like to do things together."*

Some men prefer unstructured social activities

For many men, meeting in a park, a cafe or casually is far preferable to attending an organised activity. In a parallel to young men 'hanging out', many older men like to socialise informally with other men, for instance, at the pub or club, in the park playing chess or cards, or in cafes smoking and drinking coffee. Ways for services to facilitate unstructured activities are discussed below.

Some men like organised activities, just not the ones on offer

One worker observed that the problem was not so much with 'organised activities' *per se* but the types of organised activities being offered. That is, the available organised activities are sometimes not particularly interesting to men. Also, it was noted that for men who have had professional occupations or positions of high level responsibility, *"attending 'day care' can seem like a step down."*

Some men like organised activities, but don't want to feel like the only man

Whether an activity is perceived as being of masculine interest can also depend on the number of men participating. 'A lunch', for instance, is not an intrinsically gendered activity, but can seem like a 'ladies lunch' if there are no or few men attending. Feeling like the only man or being significantly outnumbered by women was identified as a substantial barrier to male participation in day programs and organised activities. That is, even if a man might enjoy a particular activity, he may feel uncomfortable being with a group of women or being expected to socialise with women. Examples of typical comments made included:

"Most of the men who have been offered to attend day care are not comfortable being in the same setting with a majority of women (for cultural reasons as well)."

"These men didn't socialise directly with women, other than their wives and families."

"We do have a gender segregated society – just like at a BBQ with the men drinking beers, and women talking in the kitchen."

3.2.2 Client feels activities are not interesting to men

"Men generally don't want to do craft or play bingo" and *"they don't want to go to a flower show or see quilts"*; and *"having lunch with a lot of old women is not very appealing."* Service providers observed that day programs and activities have tended to cater for female interests more than masculine interests. Some men do enjoy playing bingo or participating in crafts - including men we interviewed. However, it would appear these men are in the minority.

Older men tend to prefer different activities to older women. This observation is consistent with the gendered leisure patterns of younger people; for example, leisure studies have shown that men tend to prefer sports, physical activities, doing things with their hands and socialising with other men. Most men prefer 'blokey' activities, usually in the company of other men (see below).

3.2.3 Client does not know about activities

Lack of information about activities is a barrier to men accessing day activities and programs (as it is with home support services). Clearly if men do not know about an activity, then they cannot choose to participate.

3.2.4 Transport

Transport can create serious difficulties for physically frail or disabled older men. Service providers identified transport as a significant barrier to men participating in day programs and activities – they also identified a number of components within the 'transport barrier.'

A lack of appropriate transport

At the simplest level, a lack of transport options can prevent older men from getting to activities. If they have no access to a car, then they must use an alternative form of transport. Some older frail men can walk shorter distances or move around with mobility aids or a wheelchair. However, these are only practical options for those living in close proximity to facilities or public transport routes. For others, they are dependent on family, friends, community or volunteer transport.

Service providers indicated that community and volunteer transport is often offered to older men who participate in organised activities. Where there could be an issue is for men wanting to participate in community activities at different times or locations.

Physically accessible transport

For men who are very frail or at risk of falls, getting in and out of some vehicles is difficult or impossible. Whilst some community vehicles are fully accessible, issues were noted with volunteers' cars and with private and public buses.

Self esteem and transport issues

In the view of some service providers, masculine self esteem can be strongly attached to driving and independence, for example, one manager observed that: *"losing the license can be a major psychological blow to a man."* Accordingly, some men who can no longer drive can find it very difficult to become a person who is now collected and driven around.

Rural areas and transport

In rural areas, transport difficulties tend to be exacerbated. Some of the factors identified included: walking to activities is not realistic, a need to travel long distances, lack of family nearby, lack of volunteers, and the cost of petrol. Also, 'sea and tree changers' may move to a rural locality whilst they are still driving – not planning for the time when they no longer have access to a car.

3.2.5 Client prefers to go to a commercial venue: pub or club

Pubs and clubs are venues heavily frequented by older men. Clubs, in particular, often have excellent physical access, their own transport service, and activities older men like to do. They also offer relatively cheap food and

alcohol. Service providers indicated that older men would often prefer to go these kinds of venues, rather than participate in day programs in a community centre or organised activities.

The perception was that these venues offer a valuable resource to older men, and as such, do not create a problematic barrier. In fact many service providers incorporated visits to pubs and clubs in their activities for men.

3.2.6 Other barriers

Other barriers to male participation in day activities identified by service providers and older men, included:

- Health concerns – if a man is feeling unwell he may not want to attend
- 'That's for old people' – men not feeling old or wanting to identify as old
- Man is a carer – he may not want to leave his wife
- Language barrier
- Financial – feeling that the activities or respite are not affordable
- Continence concerns

3.3 Engaging with older men: effective models of care

Many services are using strategies to engage older men to use home support services or participate in community activities, for example, 66% of surveyed services had developed specific strategies.

We asked services, older men and carers what had been particularly effective in encouraging men to accept home support services or to participate in activities.

3.3.1 Directing the approach through the family or friends

It was observed that for some men, the default position can be to reject home support services and say 'I don't need it'. In such instances it can be effective to work with the man's family or friends to talk with him first about home support services. Also effective is having an older man who has successfully used services and can articulate the benefits talk of his experiences, e.g., at Senior's Week talks, or as a peer mentor or volunteer.

Using peer contact can be particularly effective: if one man is using services, it appears more likely that his friends will be open to the prospect.

One of the carers we spoke with expressed frustration that home support services had not worked through the family. This woman's father in law had been very hostile at the prospect of strange people entering his home, but, in the carer's opinion, he would probably have been persuaded by family members to accept care.

"Workers need to be proactive in finding the men in need of services. Men will sit back and wait for someone to help. Once you speak to the men, they are usually keen to receive services."

"Once one man starts using it, the others will. They'll use it if their mates say it's ok."

"I was on crutches and I ran into an old friend at the shops – she told me about 'Caroline's' service. I would not have found out about it otherwise."

"Service operators need to go to where men are in their comfort zone to inform them. e.g. I started in this service as a female men's worker with only one client on books. I went to local pubs and clubs to let them know what we were about and to ask them want they wanted. This approach has worked."

3.3.2 Direct delivery of information

Men often prefer to receive information about services directly. That is, rather than reading about a service on a notice board, or in a newsletter or brochure, they will be more likely to use a service if they receive direct information and encouragement from a service provider, friend or family member (see above).

3.3.3 Taking the time to establish a connection

'You need to take the time to get to know him and to hear his story' was a point made repeatedly by service providers. Developing a connection was seen as highly important in encouraging older men to accept services. Service providers could develop the connection by treating the initial assessment more as a conversation and an opportunity to get to know the man and his history; *"these men have had extraordinary lives,"* was one comment.

In rural areas in particular, a family or social connection with a man, no matter how distant, can reportedly provide a starting point for developing trust, and a man accepting services.

3.3.4 Exploring underlying issues when men reject services

It was observed that older men can sometimes reject services because they feel they are coping well on their own, despite the concerns of others. Exploring the man's perceptions, and his concerns and reasons for giving this response can be useful. These issues can then be addressed in further discussions about his health and well-being, for example, his not noticing deteriorating state of the house due to increasing visual impairment that needs assessment and treatment.

3.3.5 Linking into existing networks

Related to the direct delivery of information is providing information about services in a familiar setting or through an existing network in which the man participates. Some of the networks service providers used to get men to access services included:

- Bowls and other sporting clubs
- Church and religious organisations
- Clubs and pubs
- Gardening and other interest clubs
- Men's Sheds

3.3.6 Emphasising independence

Independence and self reliance are core values of the older generation of men. These are strengths that can be used by service providers to encourage men to accept assistance. Service providers indicated that men will more readily accept assistance if it is framed as enabling 'independently living in his own home' rather than the first step in ever increasing dependency: *"you need to say it is about remaining independent, not losing independence."*

Older men who were successfully using home support services understood the services from this perspective, for example: *"if you can't cook there is something wrong with you, but having Home Care come in once a fortnight and do the cleaning helps my wife and me."*

3.3.7 Language

The language used to communicate with older men is critical. Men do not want to be made to feel weak or needy, nor do they want to feel like they are accepting charity or taking services from someone else 'who needs it more than they do'.

During this study we were repeatedly told that the terms 'frail' and 'day care' should be avoided. Men are unlikely to think of themselves as 'frail aged' or wanting to go to 'day care' (*'that's pre-school'*).

Also, service providers reported that being clear that HACC services were not charity, was reassuring for some men. Informing men that HACC is a government service paid for by taxes' can help overcome this barrier. Similarly, explaining HACC services as similar to Medicare – i.e. clients pay small portion of the service, but the rest is paid for through the taxation system, was useful information for some men.

3.3.8 Asking older men what they want

"Ask the men what they want" was the suggestion of a number of service providers in relation to encouraging older men to participate in activities. Consulting the men was considered an essential way for services to act responsively and organise activities that men wanted to engage with.

3.3.9 Taking a restrained approach

Older men can find accepting services less threatening if they are offered just one service at a time. Several service providers indicated they used this approach, for example: *"you don't offer them everything all at once, you just offer them one service, say some gardening, and then if they like that they are far more likely to think about accepting other services."*

3.3.10 Using male peers and volunteers

Many men prefer to interact with other men. Services which had male volunteers found that older men responded well to this contact, for example: *"they like to talk to another bloke"*, and *"we find that the men want to talk to the bus driver."* And as one older man said: *"I like Barry taking me to the appointments, he comes and gets me and we talk in the car."*

More formal peer support programs can also work well for older men. For example, the DVA has developed a network of peer educators to inform veterans about health and lifestyle issues. This program is effective because the men providing the education have a similar background and risk profile to the men with whom they are working.

Existing models of service delivery do not always take into account men's preferred styles of communication. Men tend to talk side by side rather than face to face, and may be more used to socialising in groups. Programs that encourage one on one relationships (such as visiting programs) may not appeal to some men – or can be more effective if the volunteer does an activity with the man, such as going for a walk or watching sport or a film.

3.4 Day programs and activities: what men prefer

To successfully engage older men in day programs and activities, both a man's interests and physical capabilities need to be taken into account. Nearly half of survey respondents (47%) had organised activities particularly for men. We asked the survey respondents, the focus group participants, older men and carers about the characteristics of activities that are preferred by older men.

3.4.1 Unstructured activities

Many older men prefer unstructured activities and socialising. Popular activities are often those that do not require too much of a commitment from men or much external organisation; although the activities might include a competitive element, such as cards or board games. We asked older men and service providers about the types of unstructured activities older men enjoy, and they gave the following examples:

- Talking / catching up with mates: *"most men like to talk with a mate instead of participating in organised activities."* (Note that men tend to talk side by side rather than face to face)
- Drop in activities – e.g., for a chat and a cup of coffee
- One on one activities – e.g., a walk with someone
- Games – e.g., access to pool tables, bowls and table top games without too much direction so that they can play regularly with local friends
- Access to tools and workshops – 'to potter around and fix things'
- Watching other people play sport (e.g. at the bowls club, then having lunch afterwards)
- Cards
- Fishing
- Gardening
- Watching sport on TV with other men

3.4.2 An informal location

Men often prefer to spend time in community settings rather than in centres. As one worker commented: *"they don't feel comfortable coming into the centre, it's full of women and feels a bit sterile."* Other workers observed that community based socialising can feel more normal to men and more what they were used to doing in their leisure time. Also, for those men who smoke, a more informal or outdoor setting allows this habit. Some of the locations for older men's activities/socialising included:

- A cafe next to a park (where the men could sit outside and smoke)
- Parks (informal chatting, playing chess)
- A man's house (a volunteer held a monthly men's BBQ)
- Pub and club based visits (or having lunch at a pub)
- Men's Sheds

3.4.3 Being with other men / and male workers and volunteers

Older men usually prefer to socialise with other men. Service providers had observed that men are far more likely to participate in day programs or activities if they are either 'men only' or if there are at least a few other men participating, for example: *"most of the men who have been offered day care are not comfortable being in the same setting with a majority of women (for cultural reasons as well), all of the men have given us input that if they had choices they would prefer and enjoy being in all men day care groups."*

Also male workers and volunteers usually get a very good response from men. It was observed that men are more likely to participate in an activity if there is a man involved – either as a worker, or as a volunteer (e.g. the bus driver or the volunteer who transports the man).

3.4.4 Activities that engage with existing interests

Successful models of care are ones which create consistency between current care and the men's life history. This could be through creating environments and/or activities which are similar to individual men's former employment and community engagement.

"They like activities that have anything to do with machinery or the weather," was a comment from a rural community worker. The observation was made that many men prefer activities that have continuity with their existing interests – often established in their younger adult years. When men are not so physically capable, they may still enjoy elements of that activity, for example, watching sport rather than playing it, giving advice on how to fix things rather than operating power tools, or caring for a much smaller garden.

Also, although men may tend to prefer less structured activities (see above), many will enthusiastically engage in organised activities that they find interesting. Some of the activities that had been well received by men, included:

- Visits to:
    - Car museum/Train museum/Dam/Weather station/Ship/Brewery/Factory/Farm
- Practical activities:
    - Fixing things/Cooking classes/Gardening/Computers/ Technology classes

3.4.5 Recognises socio-cultural context

"What they want to do is drink coffee, smoke and boil up a kranksy sausage" was an observation of one project worker of older Polish men. Recognising the socio-cultural context of older men was seen as critical for engaging effectively and facilitating activities and socialising that CALD men preferred.

Supporting older men from a CAALD background could require a degree of flexibility – for example, it may not be appropriate for smoking or drinking alcohol within a community centre, therefore other venues needed be organised (see informal locations – above).

3.4.6 Health information and screening sessions

'Men only' health information and health check sessions have been very well received, according to service providers. These have included sessions on common problems of older males concern such as prostate cancer, heart disease and incontinence. The men's health check 'Pit Stop' sessions have also had an excellent response from older males. Female workers usually did not participate in these sessions - 'leaving the men to it'.

These sessions provide an opportunity for older men to ask questions and discuss health anxieties in a safe supportive environment. They are run by male health professionals, usually in a social and lively manner, in contrast to the clinical setting where health problems are usually discussed. Although not a specifically social activity, the popularity of these health sessions supports the view that in relation to organised activities, men prefer those with a 'purpose'.

For the service providers these sessions can provide an opportunity to promote other health promoting services and activities for frail older men – such as gentle exercise, cooking classes or social groups. Also, in terms of getting men to 'take care of themselves', these sessions are consistent with research findings that men are more likely to be engaged with health promotion if vulnerabilities are discussed in a straightforward manner and with attention to the contexts in which men operate[27].

3.4.7 Men's Sheds

Men's Sheds are a very popular facility for men of all ages; they can be found across NSW towns and suburbs in ever increasing numbers. Many of the service providers we interviewed for this research were involved in or in contact with Men's Sheds. Their clients had been involved to various degrees, including regular participation in their local Men's Shed, day visits to sheds or participated in the Men's Shed Day Program.

For men who have liked working with their hands and fixing things, and still enjoy these activities, a shed can be a place he enjoys visiting. For the physically frail or disabled older man, some Men's Sheds can provide good opportunities to participate in practical activities, socialise and offer advice to younger men. Although it was noted that in order to be effective, a shed's organisers need to be supportive of involving older men and the shed needs to be set up with appropriate safety and access. Some sheds can only accommodate a man who has high support needs if his carer is also present.

Shed activities that work well for older men include:

- Modified carpentry and metalwork (taking account of a man's physical ability)
- Fixing toys and repairing household items
- Mentoring younger men
- Watching activities (and commenting/offering advice)
- Management activities
- Socialising with other men

4 DISCUSSION AND CONCLUSIONS

4.1 Introduction

Older men underutilise home and community care services in NSW. In this report we have investigated the 'barriers to access' experienced by older men, and explored ways in which these barriers can be overcome: 'effective models of care'.

4.2 Underutilisation

HACC service providers in NSW have expressed concerns that older men are not accessing services at a level that reflects their need for assistance. These concerns are reflected in available data and in our research. The proportion of older men accessing HACC services is less than proportionate to their population size. Importantly too, the proportion of older men accessing HACC services is also less than the proportion identifying a need for assistance[7]. Particular access problems appear to be experienced by men under 75, male carers and for men in relation to participation in day programs and activities.

The full extent of underutilisation is probably not reflected in the available statistics. It was observed that men are more likely than women to say 'they can manage', even when they could benefit from services.

Underutilisation is also uneven across services. Although we were unable to determine the extent of gender disparity by service type from the HACC MDS, our survey and interviews indicated that some services had less than 20% male clients. Some organisers of centre based day programs and neighbourhood centre activities reported very low, or no male participation.

4.3 The implications of underutilisation

Service providers expressed serious concerns about older male underutilisation of services. For very frail men or those recovering from falls or strokes, not accessing home support services can be a 'one way ticket to the nursing home'. Men can also be at increased risk of a range of problems, including falls, medication problems, poor nutrition and social isolation. One man we interviewed expressed regret at refusing services: he felt that he could have remained in his own home longer had he accepted assistance.

From an equity perspective, underutilisation of services means that men are not being as adequately supported as women in 'ageing well.' That is, when older men are encouraged to accept home support services they usually find that the services meet their needs and help maintain their independence and quality of life – 'when they try them, they like them'. Similarly, older men enjoy the social contact provided by activities and outings when their participation is encouraged and enabled, as reflected on one older man's comment: *"I like going to the men's BBQ, I have a yarn with the old blokes."*

It does have to be acknowledged that from an older male perspective service underutilisation may not necessarily be a problem. Some older men with physical limitations want to manage independently and in their own way. Their standards of living may differ to external measures, and they may prefer to 'keep to themselves'; if these men are not at particular risk, perhaps they do not actually need assistance. In cases like these, service providers have a number of options aside from leaving the man to his own devices. Sometimes, listening to and exploring a man's concerns about accepting assistance can provide an entry point. Alternatively, information can be left with a man, and, if appropriate, contact made again at later date.

4.3.1 Identifying older men who are likely to experience difficulties accessing services

Not all older men experience barriers to service use. The men least likely to experience difficulties accessing services are those who are already familiar with services and/or have clear access points to services – for example, men who were involved in service provision as workers or volunteers are much more accepting of services, as are

men who access services through their partner, a hospital social worker or other family or friends. There are also older men who will never access services, and will refuse whatever approaches are made to them. Services need to be respectful of the man's decision, and see if there is an appropriate time to re-engage if circumstances change, such as an admission to hospital.

In between these groups of older men are another group of men who experience some barriers to accessing services, but not insurmountable barriers. If services are to improve access to older men, it is the middle group – those who experience moderate barriers to accessing care, who are the optimal target. Drawing from our research, it is possible to show the general characteristics of men by the degree of difficulty they have in accessing services (see Table 7).

Table 7. Degree if difficulties in accessing services by characteristics

Degree of difficulty in accessing services	General Characteristics
None or very little	• Has used and liked services before • Volunteered/worked in community services, church, neighbour aid • Partner or family member organises assistance • Accepts services organised through the hospital
Moderate	• Unfamiliar with community services • CALD background and not connected to CALD organisations • Living alone • Widowed • Small social networks • Unsupportive family • Carer of spouse or other family member • Living in rural area / isolated property • Oldest group – living independently for a long period
High	• No family /or estranged from family • Very private and reserved personality types • Highly independent

4.4 Home support services and older men: towards effective models of care

'Masculine deficiency' is one explanation we expected might arise to explain why men do not access services. This was not the case. Overwhelmingly, the service providers we talked to had reflected on the complexity and socio-cultural factors involved. Older men were not portrayed as deficient, but as independent, self reliant and having lived 'extraordinary lives.' Barriers to access were seen largely as a consequence of an inadequate fit between older men and the way home support services tend to be provided.

The values and formative life experiences of older men are from earlier eras. They are also men with masculine identities shaped by their history, culture and dominant models of masculinity. There is diversity in any group of people. But as a group, older men will put a very high value on independence, managing themselves, competence, privacy, prudence and not asking for help - unless essential. They are probably unfamiliar with the domestic sphere; they are less likely than women to have accessed social support and health services for their families. They usually have little social contact with women apart from their partners and families. Men from minority cultures can have particular difficulties due to languages and the even more marked delineation of gender roles.

HACC services are delivered by a very wide variety of agencies. Overall, it is a highly feminised environment, the vast majority of workers are women, and two thirds of older clients are women. Receiving services is dependent on

self or professional referral and 'an assessment' of an older person's need for services. Workers in the sector can be low paid and very time pressured; not being able to meet the demand for services is a common experience.

Despite the challenges faced by services, agencies are actively working to improve the fit between HACC services and older men. Our research interviewees were skewed towards workers and managers with a strong interest in making services more accessible to men. They were able to offer insights into effectively engaging with older men.

Essentially, successfully working with older men means respecting the fact they grew up in different eras, value being highly independent, are less likely to find out about services by themselves and generally find using services more difficult than women. It also means having some understanding that a sense of masculine self can be particularly threatened by the ageing process; accepting 'help' can be profoundly threatening, especially help from younger women and unfamiliar services, or services that look like charities.

Ways of working around these barriers included developing a personal connection (rather than being an anonymous service), being respectful and non invasive of their privacy. Services had also adapted they way they distributed information about services to be more 'men friendly'. Table 8 summarises the key barriers that older men face, and ways in which services have overcome these barriers.

Table 8: Key barriers to older men accepting services – and effective models of care

BARRIER	MODEL OF CARE (AND EXAMPLES OF PRACTICE)

Information about services	• Direct approach to men, e.g.:
	  o Make an appointment to see him in his home
	  o Through clubs, pubs and cafes
	• Communicate in direct ways, e.g.:
	  o Shake hands
	  o Ensure the man can hear what is being said
	  o Ask what he wants
	  o Answer any questions frankly
	  o Be clear and detailed about the service and costs
	• Ensure written information is clear and straightforward
	• Use telephone follow up where appropriate
	• Provide information through the family
	• Run information sessions on issues of male interest (and provide HACC information at these)
	• Use peer contact and referral ('if one man is using a service, then his mates will')
	• Referrals through GPs and hospitals

Services seeming anonymous and unfamiliar	• Develop a personal connection, rather than being a 'voice on the telephone' • Meet with the man in his home, take the time to talk to him about his experiences during an assessment • Emphasise local connections – e.g. 'I am from service X, based in 'name of town or suburb'

Language that concerns or denigrates older people namely:
• **Assessment**
• **Frail**
• **Client**
• **Day care**
• **Older or Senior**
• **Carer**
	• Use of alternative language and expressions, for example:
	  o Invite a man to register, rather than say 'you are going to have an assessment'
	  o Day club or social club is preferable to 'day care'
	  o Don't describe men as frail
	  o If a man is a carer to his wife, he will probably prefer to be referred to as her husband

Table 8 (cont.): Key barriers to older men accepting services – and effective models of care

BARRIER	MODEL OF CARE (AND EXAMPLES OF PRACTICE)
Concerns about loss of independence, fears of 'ending up in the nursing home'	• Emphasise that services are about supporting independent living and keeping people in their homes longer. Give practical examples of how accepting assistance enhances independence • Explore the man's concerns – e.g. if he rejects services, respectfully ask why he does not want the services • Initially, only offer one service, e.g. 'perhaps you would like someone to do your mowing? • Mention other older men using services or use peer referral • Leave information for the man to review, and follow up later to see if he is interested
Concerns /embarrassment about dealing with women	• Take time to develop a personal connection • If possible locate a male worker or volunteer
Service appears like a charity	• Emphasise that the service is 'government funded' and paid for from taxes, and that some contribution is usually required

4.5 Participation in day programs and activities: towards effective models of care

"Where are all the men?" was one question asked by service providers in relation to day programs and activities. It reflects an awareness of the often very low levels of male participation. Increasing male involvement was seen as an important challenge by service providers, and one that many had addressed or were keen to develop.

Some of the barriers to older men participating in day programs and activities are similar to those that prevent older men from accepting home support services. These barriers included information not being disseminated in male friendly ways and language issues (use of words and terminology that older men can find denigrating or feel that don't describe them).

It must be acknowledged that some older men do not want to do organised activities. They either prefer to socialise in other settings, or prefer their own company or that of close family and friends. For these men, barriers to access are not an issue.

For those older men who might like to do activities, or for whom a day program might be of interest (and provide much needed respite for his carer) our research identified specific barriers to participation. The main barriers were that the offered activities were not very interesting to men, were too structured and that the other participants were mainly women. Lack of transport to venues can also prevent older men from participating in activities – although this is not necessarily a gendered barrier.

Many of the service providers we spoke with had recognised that men and women tend to prefer different activities and had developed men's groups and specific activities for their male clients. Table 9 outlines the barriers to men participating in day activities, and highlights the key principles underlying effective models of care.

Table 9: Key barriers to older men participating in day programs and activities – and effective models of care

BARRIER	MODEL OF CARE (AND EXAMPLES OF PRACTICE)
Activities offered do not appeal	• Consult with men as to what they like to do • Provide activities of more masculine interest, e.g.: o Fixing things / construction o Competitive board games and indoor sports o Visits involving: sport, machinery, weather, fishing, gardening etc o Health information seminars o Cooking classes o Computer skills / technology classes

Table 9 (cont.): Key barriers to older men participating in day programs and activities – and effective models of care

BARRIER	MODEL OF CARE (AND EXAMPLES OF PRACTICE)
Organised activities do not appeal	• Support the development of unstructured activities, e.g.: o Coffee morning in a local cafe o Lunch at a local pub or club o Activities in a park – chess set, boules etc o Develop a 'men's space' in a centre – (with outdoor access for smoking) o BBQs at a centre or volunteer's house o Informal walks with a volunteer or worker
Information	• Provide information about activities in direct, straightforward ways – e.g. o Call the man and remind him o Fliers with very straightforward text (and no clip art or fancy borders) o Put information on a business card o In community languages – as appropriate
Transport	• Adapt vehicles to enable travel by physically frail men • Inform men of the exact nature of the service, its costs, where it will stop, where it will take him • Use male volunteers where possible/preferred • Respect that he probably drove for many years, e.g.: o Ask the man to give directions, advise on parking and negotiating traffic (if he would like to/as appropriate) o Talk about the vehicle, and what he used to drive
Day programs/respite does not appeal	• Provide men only day programs/ or men's days (if possible) • Have men's activities incorporated into day programs • Ensure the environment is male friendly – include magazines of men's interest, newspapers, outdoor areas/gardens

4.6 Conclusion

Supporting people to age well is a key principle of community aged care. Principles of access and equity hold that *all* older people will be able to access this care as needed – that is, the ideal is that all older people can access the support needed to remain living independently in their homes as long as possible, regardless of gender, socioeconomic background or culture. Thus, that a sizable proportion of the older population, *viz* older men, find community aged care services difficult to access, is grounds for concern.

Indeed, people are concerned. ADHC, HACC service providers, other community aged care providers, older men, their carers and families – all can see that HACC services are not always fitting very well with how some older men operate and with what they want.

For the current generations of older men, accessing help can be difficult; it can be threatening, and accepting help can feel like a loss of independence. Community aged care is usually a very unfamiliar concept and involves moving into highly feminised environments. Community social activities for physically frail older people are mostly female dominated, and day programs are often run with few or no men attending.

Quite possibly, the next generation of older 'Baby Boomer' men will not experience the same degree of difficulty, and will be 'demanding every service under the sun' and perhaps setting up their own men's day programs groups and activities. However, the issue now and for coming decades, is the current generations of older men; the

youngest of these generations could still be alive in thirty years or more. Adapting services to their needs is of pressing importance.

Our study has shown that many service providers across NSW are meeting the challenge of opening up HACC services to older men. Many of the people we spoke with had adapted the way they offer services – and in ways that respected men and 'where they are at.' Many providers understand that men respond well to personal contact, respectful direct interactions and framing HACC as 'preserving independence'. Concerns were expressed that moves to centralised service allocation, would create further barriers for older men.

Services are also offering men's activities, and outings for men that interest men, incorporating 'Men's Shed' concepts into day programs, and running seminars on older men's health. Older men have said they like these initiatives and are clearly responding well to having choices.

Services are, however, are under no direct obligation to be more 'men friendly'; it could in fact be construed as yet another demand on a very stressed workforce. Whilst there is an argument for more resources for HACC services to improve access and equity by gender, we argue that services need to look at the gender mix of their clients, particularly the number of men attending day programs and activities.

If a community aged care service has less than thirty five percent older male clients, it is cause for reflection. Services are funded to deliver services to HACC eligible people in their community. Hence services can ask: where are the older men in the potential client population? What efforts need to be made to reach these men? How can the service offer activities of masculine as well as feminine interest? How can the environment for activities be changed (e.g. to a different venue, or to be more male friendly)? How can a centre be made more welcoming to men?

Asking these kinds of questions is what underlies a service becoming more inclusive of men. Then, as service providers have shown, there are effective ways of addressing the issues and engaging well with older men to accept HACC services and to participate in activities.

As men's health researchers, we see a need for regular reporting on older male participation by service type and activity type. This will enable the measurement of progress towards greater gender inclusivity. Most of all, we would like to see the experiences and learning of 'male friendly' services shared across the community aged care sector. We are confident that by sharing the principles and practice of 'effective models of care' for working with older men, combined with encouragement and adequate resourcing, will work well for services, and be welcomed by older men and their families.

4.7 Recommendations

On the basis of this research investigating older men and HACC services in NSW, the following recommendations were developed.

For community aged care service providers, it is recommended that:

- A review is undertaken of the gender balance of clients by each service type. Where less than 35% of clients are male for specific services, then services should develop ways of engaging more older men.
- A review is undertaken of communication strategies and styles to determine if they are inclusive of both genders.
- Male only activities are incorporated by services where appropriate, such as male day programs or special events of male interest.
- Male workers and volunteers are targeted for recruitment.

For Ageing, Disability and Home Care, it is recommended that:

- Services are actively encouraged to improve access to HACC services by older men.
- The document 'Older men and community aged care: models of service delivery' is distributed to community aged care services across NSW.
- Training seminars are developed and offered to services to assist in developing engagement strategies for older men and male friendly models of service delivery.
- Support and encouragement is offered to community aged care services in recruiting more male workers and volunteers.
- Regular monitoring and evaluation is undertaken in relation to issues around older male access to HACC services in NSW.
- Additional research is undertaken to investigate the needs of older men who are carers, given the numbers of older men in carer roles and their particular support requirements.

REFERENCES

1. Russell, C., *Gender and ageing*, in *Longevity and social change in Australia.*, A. Borowski, S. Encel, and E. Ozanne, Editors. 2007, UNSW Press: Sydney. p. 99-116.
2. DoHA, *HACC MDS Annual Bulletin 2007-2008.* 2009, Department of Health and Ageing: Canberra.
3. DoHA. *Governance: HACC minimum data set.* 2009; Available from: http://www.health.gov.au/internet/main/Publishing.nsf/Content/hacc-mds.htm.
4. NILS, *Who cares for older Australians? - A picture of the residential and community-based aged care workforce.* 2007, National Institute of Labour Studies, Flinders University: Adelaide, SA.
5. AIHW, *Australia's welfare: The seventh biennial report of the Australian Institute of Health and Welfare.* 2005, Australian Institute of Health and Welfare: Canberra.
6. ABS, *Census of population and housing: New South Wales (State).* 2006, Australian Bureau of Statistics: Canberra.
7. ABS, *Survey of disability, ageing and carers.* 2003, Australian Bureau of Statistics: Canberra.
8. ABS, *A profile of carers in Australia.* 2008, Australian Bureau of Statistics: Canberra.
9. Kaye, L. and J. Crittenden, *Principles of clinical practice with older men.* Journal of sociology and social welfare, 2005. **32**(1).
10. Arber, S., K. Davidson, and J. Gin, *Changing approaches to gender and later life*, in *Gender and ageing: Changing roles and relationships*, S. Arber, K. Davidson, and J. Ginn, Editors. 2003, Open University Press: Buckingham. p. 1-14.
11. ABS, *A picture of the nation: the statistician's report on the 2006 census.* 2006, Australian Bureau of Statistics: Canberra.
12. Consedine, N.S. and A. Skamai, *Sociocultural considerations in aging men's health: implications and recommendations for the clinician.* Journal of Men's Health, 2009. **6**(3).
13. Mackay, H., *Generations.* 1997, Sydney: Macmillan.
14. Macdonald, J.J., *Environments for health: A salutogenic approach.* 2005, London: Earthscan.
15. Markides, K.S., et al., *Ethnicity and minorities*, in *Encyclopedia of Gerontology.* 2007, Elsevier: New York. p. 532-538.
16. Sedger, R. and D. Boyde, *Project report on the study into the needs of carers from CALD communities in the Nepean area.* 2008, Nepean multicultural access project and Strengthening community links for people with disabilities in the Nepean area: Sydney.
17. Stephenson, P.H., et al., *A methodological discourse on gender, independence, and frailty: Applied dimensions of identity construction in old age.* Journal of Aging Studies, 1999. **13**(4): p. 391-401.
18. Smith, J.A., et al., *"I've been independent for so damn long!": Independence, masculinity and aging in a help seeking context.* Journal of Aging Studies, 2007. **21**(4): p. 325-335.
19. Macdonald, J.J., A.J. Brown, and J. Buchanan, *Keeping the balance: older men and healthy ageing.* 2001, NSW Committee on Ageing: Sydney.
20. Macdonald, J.J., *A population health approach to men's health.* NSW Public Health Bulletin, 2001. **12**(12): p. 313-315.
21. Ribeiro, O., C. Paúl, and C. Nogueira, *Real men, real husbands: Caregiving and masculinities in later life.* Journal of Aging Studies, 2007. **21**(4): p. 302-313.
22. Population Health Division, *The health of the people of NSW: Report of the Chief Health Officer.* 2008, NSW Department of Health: Sydney.
23. Mackinnon, A., A. Jorm, and I. Hickie, *A national depression index for Australia.* Medical Journal of Australia, 2004. **181**(7 Suppl): p. S52-S56.
24. Ballinger, M., L.A. Talbot, and G.K. Verrinder, *More than a place to do woodwork: a case study of a community-based Men's Shed.* Journal of Men's Health and Gender, 2009. **Vol. 6**(1): p. 20-27.
25. Grant, E. and M. Potenza, *Textbook of men's mental health.* 2006, Arlington, Virginia: American Psychiatric Publishing.
26. Hall, C., et al., *Keeping the thread: Older men's social networks in Sydney, Australia.* Quality in Ageing, 2007. **8**(3): p. 10-17.
27. Monaem, A., et al., *Engaging men in the health system: observations from service providers.* Australian Health Review, 2007. **31**(2): p. 211-217.

DIVERSITY & AGEING in ACTION

FORUM PROCEEDINGS

Monday 10 May, 2010 at Parramatta Town Hall

COTA (NSW)
Council on the Ageing (NSW) Inc

Ethnic Communities' Council of NSW Inc.

multicultural communication

TACS

metro migrant resource centre

FOREWORD

The issue of diversity in ageing is the sleeper issue in the overall debate and consideration of population ageing in NSW. Yet the reality of CALD community ageing and the specific communities which have a high proportion of ageing needs to be drawn into the centre of the debate. In this context the Diversity & Ageing in Action forum, which took place on 10 May 2010 in the Parramatta Town Hall is an important and timely event.

The Forum brought together a large number of community representatives, organisations and services providers keen to understand the service delivery and equity issues relevant to CALD older people. The Forum was extremely successful and served to garner energy and clarify policy directions that need to be pursued to better identify and meet the needs of CALD older people.

I commend these proceedings to you and hope that you use the information contained and the policy and advocacy directions which were developed, as a tool to achieve substantial and significant change in the capacity of aged services to meet the needs of CALD older people.

Pino Migliorino

Chair
NSW Ministerial Advisory Committee on Ageing

Chair
Federation of Ethnic Communities Councils of Australia

DIVERSITY & AGEING in ACTION

BACKGROUND

In October 2008 Council on the Ageing (COTA) NSW approached the Multicultural Health Communication, Metro MRC and the NSW Transcultural Aged Care Service (TACS) to discuss issues impacting on older people from culturally and linguistically diverse (CALD) backgrounds. In 2009 COTA NSW invited the Ethnic Communities Council of NSW to join the partnership towards hosting the first Diversity and Ageing in Action Forum in 2010.

The partnership between a range of agencies ensured broad promotion of the Forum to a wide range of peak and ethnic-specific agencies concerned with ageing and aged care.

The aim of the Forum was to connect community workers, community and opinion leaders, consumers, and key departmental staff to openly discuss the needs of CALD older people. The following are the proceedings of the forum, intended as a frank reflection of CALD community needs around ageing and aged care.

FORUM PROCEEDINGS

On the 10 May 2010 COTA NSW, in partnership with the Ethnic Communities Council of NSW, Multicultural Health Communication , Metro MRC and Transcultural Aged Care Service, held the first Diversity and Ageing in Action Forum at Parramatta Town Hall.

The Diversity and Ageing in Action Forum was opened by the Hon. Paul Lynch MP, the then Minister for Ageing, on behalf of the Premier of NSW, The Hon. Kristina Keneally MP. (see Attachment A for news clip)

One hundred and fifty participants representing 120 organisations and around 100 diverse communities (see Appendix B for list of organisations represented) participated in the Forum demonstrating a need for dialogue with the CALD sector about the changing needs of their ageing communities.

The Forum was facilitated by Pino Migliorino, Chair of the NSW Ministerial Advisory Committee on Ageing and Chair of the Federation of Ethnic Communities' Councils of Australia, who brought a great deal of knowledge and skill to managing the diverse range of speakers and participants.

The Forum included six key presentations that canvassed all levels of government and their response to ageing in NSW, as well as specific presentations on CALD older people in NSW.

Presentations delivered were:

Needs Identification of CALD Older People, Pino Migliorino, Chair of the NSW Ministerial Advisory Committee on Ageing and Chair of the Federation of Ethnic Communities' Councils of Australia

Key Issues for NSW, Sigrid Patterson, Director, NSW Office for Ageing, Ageing Disability and Home Care, Department of Human Services

Directions for Aged Care in Australia, Roserina Murace, Manager, Community and Carer Support Section, Aged Care Branch, NSW State Office, Department of Health and Ageing

Health challenges affecting CALD Older People, Professor Brian Draper MBBS MD FRANZCP, Professor (Conjoint), School of Psychiatry, University of NSW

Local Government and Ageing Services, Margaret Kay, Senior Policy Officer, Ageing and Disability, Policy and Communications, Local Government and Shires Association of NSW

Home and Community Care Service Challenges, Karen Connor, Director, Home and Community Care, Ageing Disability and Home Care, Department of Human Services

The presentations were followed by a Panel Discussion that encouraged questions from the floor. Presentations that were made available will reside on the COTA NSW website (http://www.cotansw.com.au/policy-issues.aspx) alongside the report.

The Panel Discussion generated five themes for further discussion, these were:

- **Responsiveness of Mainstream Services**
- **Accessibility to Residential Aged Care and Home and Community Care**
- **Engaging with and Responding to CALD Communities**
- **Fostering Cultural Competency in Aged Care**
- **Social Research and Diversity Needs**

In order to produce a summary of each workshop we have compiled comments under broad headings. Not all individual comments were captured in the summary; however the raw material is attached as recorded in the sessions (Appendix C). The summary outcomes of each group discussion are presented below.

GROUP ONE: RESPONSIVE MAINSTREAM SERVICES

Convener - Maria Lemos, Metro MRC

Responsive Services

In order for mainstream services to be more responsive, they need to embrace person-centred approaches. The principle of person-centred care is about responding to and meeting individual needs. Adopting person-centred approaches would mean responding to the sexuality, cultural, religious and linguistic needs of older people from CALD backgrounds. In a person-centred environment even the complex needs of older migrants and refugees who have experienced war and trauma can be met.

In meeting individual needs, staff and volunteers need to understand the background issues affecting individuals such as sexuality, religion, culture, grief, trauma, refugee and life experiences, as well as the diversity within each community. Advice can be sought and partnerships forged with other services that can provide CALD programs. There are opportunities for CALD programs to act as an entry point to other community services.

While many mainstream services have adopted person-centred approaches, there are still discrepancies and gaps between theory and practice. This can be addressed through commitment to staff and volunteer training. There is a need to highlight good practice examples and transfer knowledge of what works across services.

Needs analysis of CALD older people should be ongoing so that services are adapting to changing requirements. This will require open dialogue with communities.

There are structural and policy barriers to funding services at both state and federal levels.

The Forum advocates:

1. A review of the aged care legal framework to encourage mainstream service providers to adopt more responsive practices in meeting the needs of CALD older persons.
2. A system that will recognise and acknowledge good practice in the provision of culturally appropriate care to all citizens irrespective of their cultural background.
3. A simpler and more streamlined aged care system with improved interfacing across Commonwealth and State funded services and programs and between health and aged care.

Valuing human resources

Mainstream services need to provide staff and volunteers with regular cultural awareness and diversity training.

Recognising the language, cultural and other skills of volunteers and staff that are in-house adds to service culture and helps in meeting the diverse needs of clients.

There is a need for mainstream services to recruit bilingual workers and volunteers to meet the needs of clients.

Mainstream services need to be culturally sensitive and committed to cultural training for all staff e.g. how to approach communities, promotion and participation.

Cultural accreditation of services may provide greater consistency across services and programs in how they respond to CALD clients.

Information and Partnership

"Information on culturally sensitive entry points, good practice, ideas and experiences should be shared through existing networks."

Mainstream services can implement and promote programs about cultural diversity, e.g awards program for residents to strengthen the sense of community. This may include welcoming environments, language, cultural links, such as food and customs to engage the new clients, and maintaining connections with other services the client may use.

Partnerships with CALD and diverse communities are vital to support mainstream services in meeting the individual needs of clients.

Continuity of care from community to residential is important. Family members feel alienated and disempowered once their loved ones enter residential care. They go from a very active, all involving role to complete disengagement. A partnership in care should be developed to allow continuity of care. This is essential for CALD communities.

While integrated services exist as resources, it is believed that they are not being used. There is lack of flexibility in programs within the same service and adaptation to suit the individual needs of clients is often not encouraged. A smooth transfer and migration from program to program should be common practice.

GROUP TWO: ACCESSIBILITY TO RESIDENTIAL AGED CARE AND HOME AND COMMUNITY CARE

Convener: David Atkins, COTA NSW

Valuing Human Resources

There are shortages of services, facilities and workers in the community. A promotion and publicity campaign is needed about how exciting the community sector is to work in.

There are enormous human resources in the community that are not being utilised. This can be addressed by providing incentives for training to work in the community sector. Mature age workers and young people should be encouraged to join the sector through retraining opportunities and career education. Services need to reach out to the community through more education, training and promotion of the community sector in schools, universities and other educational institutions.

"Staffing issues need to be addressed; more workers,

staff ratios and workloads need to be improved."

Lack of staffing is an ongoing issue. The sector needs to be more proactive about recruitment of workers and volunteers. A marketing campaign is needed about how exciting the community sector is to work in, and to promote a positive image of the sector to attract and retain people to the industry.

"There is a big difference between practice and reality."

Teaching needs to be more appropriate and relevant to the sector; it's too out of date. Retention of staff is important. Better pay and conditions are urgently needed to attract people to the sector.

Responsive Services

There is a need to increase flexibility with respect to service delivery and the amount of hours available.

It is also necessary to establish and / or increase the amount of culturally appropriate case management and clarify case manager roles and responsibilities to individuals accessing services.

Consumer-centred care packages can better address needs. People do not want to go into nursing homes. Providing culturally appropriate services and language specific case managers / workers will meet the needs of CALD consumers.

Residential facilities should be a home; they should promote independence and should be available in all areas.

Education

There is a need for financial planning education for older people as they reach retirement and have to make choices about aged care, hostels and other major ageing decisions.

What does a person do if they have no family to assist them with the process as they age?

System improvements

Personal medical history needs to travel with the person so that every service has the same information and duplication can be reduced.

"The health system is not talking to the aged care system."

Integration of both state and federal funded services would be helpful to CALD communities.

"Stop the duplication and streamline the process of access to services."

CALD communities need to have the system simplified and streamlined. Forms should be the same across services, paperwork should be reduced and more organisation is required between health and aged care.

"It should be easy to move from the hospital system into the aged care system and into the community but it is very difficult and complex."

There is no uniformity in the way services are provided. The system is so complicated. Standardisation across the sector is urgently needed.

"The federal and state governments need to be on the same page."

The ongoing assessment of needs of CALD communities and specifically older people is required.

Funding

There is a lack of funding within the community, especially in rural and remote communities; and there is a general lack of awareness of what services are available to people.

There is a need to increase funding to various packages such as EACH, CACPS, etc.

There needs to be more research in best models of culturally appropriate care and a call for less competition and more cooperation between service where funding is concerned.

There is a need for greater flexibility within the services agreement to enable innovative and responsive service delivery.

GROUP THREE : ENGAGING WITH AND RESPONDING TO CALD COMMUNITIES

Convener – Peter Todaro, Multicultural Health Communication

Information and Partnership

The diversity within CALD communities needs to be understood. There are many smaller communities that require recognition and inclusion. There needs to be more research and representation of the smaller emerging communities.

Segmentation of CALD communities would better reflect the diverse needs. Community infrastructures (radio, newspapers, newsletters, forums, etc.) provide access to engage with various communities.

More cultural competency building to teach staff how to engage with communities is needed to understand and respond to the diversity. Brokerage models are working where the service is culturally appropriate and they reach out into the community.

Small and emerging communities require support and leadership so that the needs of smaller CALD communities are advocated. We need to identify agencies that can lead in a more formal way.

COTA should assist communities by providing leadership in the area. COTA is well placed in providing assistance to support small agencies in writing funding submissions. The Community Relations Commission needs to be more active in providing assistance to smaller communities to engage in the sector.

Partnerships and greater cooperation need to be encouraged among ethnic specific and mainstream services.

> *"We need to give back to the communities that we are consulting with, the information needs to return, they are sick of being consulted and no information is given back and nothing happens."*

There was a strong call to ensure that communities receive feedback from consultations (such as this one). It was noted that communities are consulted but rarely get feedback about their contribution and the outcomes.

GROUP FOUR: FOSTERING CULTURAL COMPETENCY IN AGED CARE

Convener:- Maria Stephanou

Responsive Services

There are two levels of cultural competency: staff and organisational. At the organisational level service policies and mission statements need to reflect the importance of culture and cultural diversity.

In defining cultural competency in aged care the following need to be considered:

- The significance of culture and respect for cultural diversity.
- The special needs of older persons from CALD backgrounds.
- Acknowledgement of common needs among people who come from similar backgrounds.
- The importance of culturally sensitive assessment for an individual:
    - Listening to client / family irrespective of whether the assessment is formal / informal.
- The importance of communicating effectively in cross-cultural situations:
    - Non-language indicators are important such as body language.
- The need to adapt services to meet the cultural needs of the individual, that is person-centred care.

Measures of cultural competence include:

- Recognising / identifying needs.
- Communicating respectfully and effectively in cross-cultural situations.
- Knowing about the person and their culture.
- Knowing what is appropriate and what is non-appropriate care.
- Knowing where to get information in the community and finding out what's important to the person – their individual needs.
- Understanding that religious needs are very important with people when their health fails.

Policies need to be supported by the organisation and its management. Service managers and staff need to have strategies on how to respond to cultural needs and rituals around dying.

Service commitment to culturally diverse service delivery needs to be reflected in staff training and orientation on cultural and religious nuances in CALD communities.

Services need to be aware that in some small communities it may not be appropriate to have workers from their own backgrounds for confidentiality reasons.

Sharing information among staff about the cultural needs of an individual can be helpful as long as the client's privacy/confidentiality concerns are respected.

Services should be aware that there may be financial reasons for resisting care particularly residential care.

Information and partnership
Services can benefit from partnership with local community groups and organisations to assist in the promotion of services to specific groups.

The quality and availability of resources varies across the gamut of CALD communities. The more established communities have access to many resources while not much is available for small and emerging ones. The translations of certain words (such as 'respite' and 'care packages') are confusing as those concepts are not familiar to some communities including the established ones. Multicultural resources relevant to aged care can be found on www.culturaldiversity.com.au

Person-centred Care
Group, individual and family needs have to be considered for example some health and religious beliefs are commonly held by a group; other beliefs are specific to the individual understanding about the person and their different cultures is important. Services need to know where to get information in the community in order to find out what is important to the person culturally, spiritually and socially.

Person-centred care is about understanding the importance of culture for an individual in relation to food, health and hygiene, religious, social and emotional needs. It is important to build rapport with families and clients. A solid partnership with carers/family can make a difference in meeting the needs of clients.

GROUP FIVE: SOCIAL RESEARCH AND DIVERSITY NEEDS

Convener – Anne Marie Elias, COTA NSW

Research

The needs of CALD older people now and in the future need to be researched. There is a need to commission research that explores:

- The value of the contribution of older people.
- Next generations attitudes to volunteering.
- Healthy ageing – attitudes to diet and lifestyle.

It is important to highlight best practice in provision of ageing programs and services in local government. Investment in CALD research in the following areas is important in understanding the needs of CALD older people:

- Who are the well aged?
- What are older people's attitudes to ageing?
- What do older people need to age in place?
- What are their lifestyles and attitudes on life and death?

Research is required now to better plan for the future needs of CALD communities: research on younger cohorts about how they will age; what expectations they have of ageing; where they will age, etc.

There is need for positive ageing research and greater investment in positive ageing activities. Gathering comparative research on CALD older people globally may provide interesting insights, for example Greeks in Canada, UK and Australia.

While there is a growing body of research on ageing, there remains a dearth of CALD research. There is a need to connect the existing research on ageing and older people so that we have a more coherent picture of what is emerging.

Responsive Services

There is a need to dispel the cultural myths about caring for CALD older people and families and get to the real question: *What services do people have and what do they need?* In this context, services need to inquire about the barriers to CALD older people accessing their services.

Cultural competencies of service providers are needed at national, international and multi-national levels.

Mainstream services can work in partnership with ethno-specific agencies to provide culturally appropriate services to CALD clients. Capacity building of mainstream services to address the cultural needs of CALD clients is essential, and can be achieved through effective partnerships with CALD agencies.

CONCLUSIONS AND RECOMMENDATIONS

RESPONSIVE SERVICES

From a CALD consumer perspective, responsiveness in aged care service is essentially linked to cultural competence and commitment to person-centred care.

Leadership at the organisational level is essential in building cultural competence in aged care. This can be demonstrated through:

- engaging in dialogue with CALD communities or appropriate agencies for the ongoing assessment of older CALD consumer needs;
- developing an understanding of barriers to accessing services for CALD older persons; and
- adopting inclusive policies and procedures to overcome service delivery challenges in cross-cultural situations.

In practice this will mean providing opportunities for staff and volunteers to attend cross-cultural awareness education, identifying, adopting and promoting good practice, and encouraging the transfer of cultural knowledge across the organisation.

The person-centred care approach is about meeting the individual needs of consumers. This implies an understanding of background issues affecting individuals such as religion, sexuality, grief, trauma, refugee, cultural and life experiences, as well as the diversity within each community.

Mainstream services can seek advice and forge partnerships with ethno-specific providers or agencies. This will enable them to provide culturally appropriate services to CALD clients. Brokerage arrangements seem to be effective in community care. Some CALD projects can act as an entry point to other community services.

For the CALD consumer residential care is a last option. Residential facilities need to have a more pronounced 'home' feel, encouraging independence and flexibility. A need for more flexibility in service delivery and hours was also highlighted for the community sector. The case management aspect was seen as vital but required clear roles and responsibilities in meeting the consumers' cultural needs.

The current system is very complicated. There is no uniformity in the way services are provided. Standardisation across the sectors is urgently needed. CALD communities need a simplified and streamlined system with reduced paperwork, the same forms used across services, and more coordination between health and aged care.

The Forum advocates:

1. A review of the aged care legal framework to encourage mainstream service providers to adopt more responsive practices in meeting the needs of CALD older persons.
2. A system that will recognise and acknowledge good practice in the provision of culturally appropriate care to all citizens irrespective of their cultural background.
3. A simpler and more streamlined aged care system with improved interfacing across Commonwealth and State funded services and programs and between health and aged care.

VALUING HUMAN RESOURCES

Discussions focused on three issues:

- workforce shortages in aged care and suggestions for making the sector more attractive to potential employees,
- recognition of cross-cultural skills among existing staff, and
- the need for ongoing cultural awareness and diversity education.

Strategies for improving aged care recruitment and staff retention include improved pay and conditions, reviewing the training programs for potential aged care workers to reflect new concepts in education, and service providers targeting the right communities as well as schools and universities.

In-house recognition of language, cultural and other skills of volunteers and staff adds to service culture and helps in meeting the diverse needs of clients. Mainstream services need to be culturally sensitive and committed to cultural training for all staff; the training needs to include how to implement strategies for approaching communities, promotion and participation.

Cultural accreditation of services may provide greater consistency across services and programs in how they respond to CALD clients.

The Forum advocates:

1. Mandatory cultural awareness education for all aged care staff and volunteers.
2. Service accreditation taking into consideration the percentage of staff who have attended cross-cultural education either at orientation or at regular intervals.

INFORMATION AND PARTNERSHIP

The diversity within CALD communities needs to be understood by the aged care sector. The segmentation within communities reflects their diverse needs.

Some of the established communities are in a better position to look after the aged care needs of their members. However there are many smaller emerging communities that require recognition and inclusion. There needs to be more research and representation of these communities.

There is a general lack of awareness of what services are available to people. CALD older persons must be provided with more information and financial planning education as they enter retirement to be able to make decisions about choices in aged care and other major ageing issues. A variety of means are available for reaching out to the communities but the approaches and resources used must be culturally appropriate and accessible. Community infrastructures (radio, newspapers, newsletters, forums, etc.) provide access to engage with various communities.

In CALD communities involving families in decision-making about care is essential. This can assist with the gathering of information and avoid feelings of disengagement and disempowerment as loved ones move into formal care.

Partnerships should be encouraged to facilitate the exchange of information and continuity of care as people transfer from service to service and from community care to residential. Information on culturally sensitive entry points, good practice, ideas and experiences should be shared through existing networks. Brokerage models are working where the service is culturally appropriate and they reach out into the community.

Overall there was a strong call to ensure that communities receive feedback from consultations (such as this Forum). It was noted that CALD communities are consulted but rarely get feedback.

The Forum advocates:

1. More emphasis on researching the aged care needs of small emerging communities and establishing mechanisms for their ongoing support on ageing issues.
2. Encouragement of partnerships and networking to enhance sharing of information on good practice and brokerage opportunities.
3. Providing feedback to participants of the Diversity and Ageing in Action Forum.
4. Holding the Diversity and Ageing in Action Forum annually in different locations in NSW.
5. Forum participants continuing to network and engage together to provide greater advocacy and support for CALD older people.

PERSON-CENTRED CARE

Culturally appropriate care can be delivered through the person-centred approach. This involves understanding the importance of culture for an individual in relation to food, health and hygiene, religious, social and emotional needs. It is important to build rapport with families and clients. A solid partnership with carers/family can make a difference in meeting the needs of clients.

Services also need to know where to get information about particular CALD communities in order to find out what is important to the person culturally, spiritually and socially. This should be part of their staff cross-cultural education.

The Forum advocates:

1. More research into person-centred service delivery models to ensure they will be able to deliver culturally appropriate aged care.

RESEARCH

The needs of CALD older people now and in the future should be researched. It is vital to commission research that explores:

- the value of the contribution of older people
- next generations' attitudes to volunteering

- healthy ageing – attitudes to diet and lifestyle.

Research is required now to better plan for the future needs of CALD communities as well as research on younger cohorts about how they will age, what expectations they have of ageing, where they will age, etc.

Investing in positive ageing research and particularly positive ageing activities is imperative. Gathering comparative research on CALD older people globally may provide interesting insights for example, Greeks in Canada, UK and Australia.

While there is a growing body of research on ageing, there remains a dearth of CALD research. It is important to link the existing research on ageing and older people so that we have a more coherent picture of what is emerging.

The Forum advocates:

2. Increased involvement of Forum participating agencies with educational institutions to raise interest in researching CALD aspects of ageing.
3. Government funding support for any existing or new research initiatives focusing on CALD ageing.

FUNDING

Aged care services within the community, especially in rural and remote communities, are not adequately funded. Funding should be increased for various care packages such as EACH and CACPs and greater flexibility exercised within funding service agreements to enable innovative and responsive service delivery. There is a strong call for less competition and more cooperation between services where funding is concerned.

More funding must be made available for programs that aim to increase awareness of aged care services among CALD communities, and for researching best models for culturally appropriate care.

The Forum advocates:

1. More funding for community aged care packages.
2. Flexible service agreements to facilitate collaboration between services and improve responsiveness to CALD aged care needs.
3. More funding for educating CALD communities on aged care options.
4. Positive responses to funding applications for well-planned research initiatives on CALD ageing.

THE FUTURE OF AGED CARE

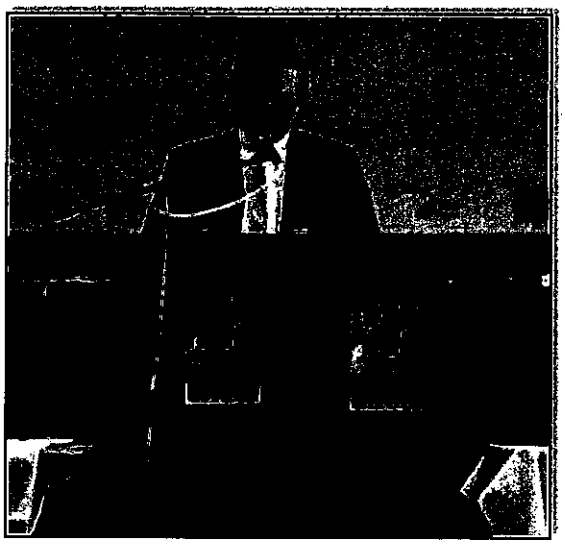
The Productivity Commission Inquiry into aged care provides an opportunity to address models of care for older persons from CALD backgrounds. There are gaps between current policy and practice. Commission members need to know how aged care for CALD works in practice.
http://www.pc.gov.au/projects/inquiry/aged-care

The Forum encourages:

1. Community agencies and consumers to respond with submissions to the Productivity Commission Inquiry on aged care.

APPENDIX A: News Clip

Diversity and Ageing in Action Conference at Parramatta Town Hall



Minister for Ageing Hon Paul Lynch
by Street Corner Staff
11/05/2010

"While our city and State benefits both economically and culturally from this rich diversity, it is also ageing".

"By 2011, nearly 23 percent or more than 1 million Australians aged over 65 years will have come from a culturally and linguistically-diverse background".

Hon Paul Lynch

The NSW Government is planning ahead for the needs of a culturally diverse ageing population, Minister for Ageing Paul Lynch said today.

Speaking at the Diversity and Ageing in Action conference at Parramatta Town Hall, Mr Lynch said the NSW Government understood the need for government services to match the needs of older people from culturally and linguistically diverse backgrounds.

"Sydney and New South Wales are among the most culturally-diverse locations in the world," Mr Lynch said.

"More than one million New South Wales residents speak a language other than English at home and most of those people live in Sydney," he said.

"While our city and State benefits both economically and culturally from this rich diversity, it is also ageing," Mr Lynch said. "By 2011, nearly 23 percent or more than 1 million Australians aged over 65 years will have come from a culturally and linguistically-diverse background," he said.

"That's why the NSW Government is planning ahead through a three-year Cultural Diversity Strategic Framework as part of the Towards 2030 strategy," Mr Lynch said.

The Cultural Diversity Strategic Framework will ensure that gender, culture, language, where people live and their socio-economic circumstances are factored into the delivery of government services.

Mr Lynch said that a series of language services workshops would be held throughout the State at the end of the month and in early June at Penrith, Parramatta, Bankstown, Wollongong, Wagga Wagga, the Hunter, Coffs Harbour and Armidale.

The workshops will primarily target front-line staff from Ageing, Disability and Home Care.

"The workshops aim to improve communication between staff and older people who rely on government services," Mr Lynch said.

Ageing statistics

- In 2006, 12 percent of the NSW population was aged 65 to 84 years
- In 2006, 1.6 percent was aged 85 years and over
- By 2011, nearly 23 percent or more than 1 million Australians aged over 65 years will have come from a culturally and linguistically-diverse background.
- By 2016, it is expected that Australia will have more people aged over 65 years than people aged 15 years or less

Hon Paul Lynch

APPENDIX B: Organisations represented

ADHC_ Gen
ADHC-Metro
AFAO
Aged and Disability Services, Catholic Care (Wollongong)
AIRI ECC Board Member
Anglicare-General
Anglicare - Counselling Support Info and Advocacy
Arab Council Australia
Area Ethnic Aged Health Adviser, SWSAHS
Auburn Community Health Centre
Aust. Hearing
Australian Korean Welfare Association
Bankstown Area Multi cult. Network
Bhutanese community
Blacktown Hospital SWAHS
Blue Mountains Food services
C.A SS
Canada Bay Council
Carers NSW
Catholic Care
Catholic Care Hunter Manning
Cent Coast Disability Network
Central Coast Domestic Violence Advocacy
Centrelink Hornsby
CO.AS.IT, Italian Ass of Aust
Com Respite Carelink Centre
Combined Pensioners (CPSA)
Community Services Manager, Lane Cove Council
CPP Arabic Project Officer, Sydwest Multicultural Services Inc.
CPP- Tamil Project Officer
Cumberland Homecare Services
DADHC
Dementia Respite SWS
Diverse Community Care
ECC Illawarra
ECC of Newcastle
ECC Vice Chairman
Greek Centre
Hawkesbury Council
Hills Shire Council

Holsworthy Community Centre
Hunter Northern Settlement Services
Hunters Hill / Ryde Community Centre
Hurstville Council
Kogarah Council
Law Access
Legal Aid - Nowra
Manager Dementia, Bankstown & Liverpool Teams, Ageing, Dementia & Disability Care Directorate
Migrant Resource Centre Parramatta (Hills-Holroyd)
MS Kogarah
Mt Druitt Ethnic Community Services
Multicultural Health New England
Multicultural Health Service
Nepean CACP
Nepean Multicultural Access
Newcastle/Hunter Community Access
North Shore LAC , NSW Police Force
NSW Comm. Transport
NSW Fair Trading
NSW Health
NSW SLASA
Parramatta Centrelink
Penrith City Council
Prime
Red Cross
Riverwood Community Centre
Schizophrenia Fellowship
SESIAHS
Sikh Kirtan Tracher Mission
Sikh Youth Australia
Sri Om Care
SSWAHS - Liverpool
SSWAHS- Missenden
SSWAHS
St George Migrant Resource Centre Inc
Stanhope Healthcare Services
Summit Care Canley Vale Gardens
Summit Care Head Office
Sydney West Multicultural Services
Sydney Malayalee Association Inc
Sydney Multicultural Community Services
Sydney University Sydney School of Public Health

Sydney West Uniting Care
TARS
Transcultural Mental Health SWAHS
Turramurra Sikh Temple
Ultimo Community Centre, Sydney City Council
Uniting Care- General
Uniting Care Ageing
Uniting Care Ageing South Eastern Region
Western Sydney Community Forum

APPENDIX C: Raw Material – Break out groups

Group One - Convener - Maria Lemos

How can mainstream services be more responsive to diversity?

- Mainstream services need to have person-centred care regardless of culture especially for people who experience war and trauma.
- Mainstream services need to facilitate CALD programs and need to continually educate staff and volunteers and recognise skills that are in-house and not being used.
- Discrepancies and gaps between theory and practice need to be addressed – "practice what you preach".
- Individual needs focused.
- Sharing information through networks.
- More flexible service provision.
- Recognise diversity or needs within the same community.
- Diverse work force and volunteers.
- Emphasis on individual needs in practice.
- Diverse partnerships.
- Cultural sensitive entry points.
- Resourcing workers.
- Promote programs about cultural diversity.
- Integrated services exist as resources but are not being used.
- Training should encompass volunteers.
- More bilingual workers and volunteers in mainstream services.
- Analysis of needs must be ongoing.
- Seeing people with needs as individuals rather than their ethnicity.
- May need to understand the background issues, such as sexuality, etc, knowledge in the work force of specific issue. For example: HIV issue in the Sudanese community; instead of assumptions of their needs there needs to be an understanding of the surrounding issues and the stigma associated with refugee issues.
- Cultural sensitivity and commitment to cultural training for all staff. e.g. Communication in ways to approach communities, promotion and participation.
- Need for structured change – policy change.

- Cultural accreditation and implementation in regards to clients accessing the service.
- Welcoming friendly environment.
- Clinically appropriate services.
- What can they provide: language, cultural links, such as food and customs to engage the new clients, connections with other services the client may use.
- Service needs to be open to dialogue.
- Other service providers.
- Mainstream services must be connected to CALD services.
- Lessons are not transferred to other services.
- Awards program for residents to build community.
- Consistency across services and programs.
- Barriers to funding services at both state and federal levels.
- Continuity of care from community and residential care.
- CALD projects as an entry point to other community services.

Group Two - Convenor – David Atkins

Access to Aged Care – Residential and Home and Community Care?

- Increase flexibility in regards to service delivery and the amount of hours available.
- Establish and / or increase the amount of culturally appropriate case management and clarify their roles and responsibilities to individuals accessing services.
- Consumer-centred care packages.
- Personal medical history needs to travel with the person so that every service has the same information and duplication can be reduced.
- Information needs to be in culturally appropriate formats.
- Lack of staffing is an ongoing issue.
- The health system is not talking to the aged care system.
- What does a person do if they have no family to assist them with the process as they age?
- People do not want to go into nursing homes.
- Within the community there is a lack of funding, especially in rural and remote communities; and there is a general lack of awareness of what services are available to people.
- Increase funding to various packages such as EACH, CACPS, etc.

- Flexibility within the services agreement.
- Integration of both state and federal funded services would be helpful to CALD communities.
- CALD communities need to have the system simplified and streamlined, forms should all be the same for all services, reduce paperwork, more organisation between health and aged care.
- There is no uniformity in the way services are provided.
- Pay and salary needs to be increased across the sector.
- Sector needs to be more proactive about recruitment of workers and volunteers.
- Promotion and publicity about how exciting the community sector is to work in.
- Residential homes in all areas.
- Reaching out into the community more.
- Enormous human resources in the community that are not being utilised, people need to be retrained as community workers.
- Residential facilities should be a home, they should promote independence.
- The system is so complicated.
- Staffing issues need to be addressed; more workers, staff ratios and work loads need to be improved.
- Language specific case managers / workers and services.
- More education, training and promotion of the community sector in schools, universities and other educational institutions.
- Standardisation across the sector.
- It should be easy to move from the hospital system into the aged care system and into the community but it is very difficult and complex.
- Mature aged workers should be encouraged into the sector.
- There is a big difference between practice and reality. Teaching needs to be appropriate and relevant to the sector, it's too out of date.
- The federal and state governments need to be on the same page.
- Financial planning for older people as they get to retirement and have to make choices about aged care, hostels and other major ageing decisions.
- There are shortages in the community of services, facilities and workers.
- Needs to be more assessment of community needs.
- Services must be culturally appropriate.

- Career education for young people, incentives for them to work in the sector, promotion of a positive image of the sector, marketing campaign to get people in to the industry and stay in it. Retention of staff is important.
- Better pay and conditions; people can earn more money working in other sectors.
- There needs to be more research in best models of culturally appropriate care.
- Less competition and more cooperation between service where funding is concerned.
- Stop the duplication and streamline the process of access to services.

Group Three - Convenor – Peter Todaro

Engaging with CALD communities including responding to that engagement.

- Smaller CALD communities needs can be different and there needs to be a system where smaller communities can get some leadership.
- Got to get better at saying who we are and trying to engage and be more specific than just saying CALD or Arabic as these groups have many smaller communities that require recognition and inclusion.
- We need to give back to the communities that we are consulting with, the information needs to return, they are sick of being consulted and no information is given back and nothing happens. They don't receive feedback.
- It's important to segment populations as CALD is too broad a term.
- COTA should assist communities by providing leadership in the area.
- Use community infrastructures to engage with various communities. Such as radio, newspapers, newsletters, forums, etc.
- More cooperation and partnerships, more collaboration.
- We need to identify agencies that can lead in a more formal way.
- More cultural competency building to teach staff how to engage with communities.
- More appropriate streams of information.
- Brokage models are working where the service is culturally appropriate and they reach out into the community.
- COTA should support people in writing funding submissions.
- Community Relations Commission needs to be more active.
- There needs to be more research and representation of the smaller emerging communities.

Group Four - Convenor – Maria Stephanou

Fostering cultural competency in aged care.

- There are two levels of cultural competency – staff and organisational.
- Policies and mission statement need to reflect importance of culture.
- Define cultural competency:
    - Common needs of groups.
    - Specific / special needs.
    - Person-centred care.
    - Understand the importance of cultural for an individual.
    - Listening to client / family and whether the assessment is formal / informal.
    - Non-language indicators are important such as body language.
- Measure of cultural competence:
    - Recognise needs / identified needs.
    - Effective respectful communication.
    - Knowing about the person and their culture.
    - Appropriate and non-appropriate care.
    - Know where to get information in the community and find out what's important to the person – their individual needs.
    - Religious needs are very important with people when their health fails.
- Quality of resources available.
- Whose responsibility is it? It starts at the top. Management and policies.
- Policy needs to be supported by the organisation. Some organisations will do bits when they have accreditation but not at other times.
- Training – giving staff the time and resources to apply what they know and training that is culturally appropriate.
- Food.
- Bilingual staff.
- Partnerships with local community groups and organisations which is good for promotion to specific groups.
- Rapport with families and clients, partnerships with carer / family can make the difference.

- Awareness of small communities not necessarily wanting workers from their own backgrounds – confidentiality.
- Awareness of financial reasons for resisting care / residential care.
- Cost / finances / fees.
- Translations of words are confusing. e.g. packages, respite, etc?
- Strategies of managers and services of how to implement cultural needs and rituals around dying.
- Cultural diversity website: www.culturaldiversity.com.au
- Productivity Commission needs to address models of care. The difference between policy and practice. They need to know how it works in practice.
- Personal care history of client should be retained by client.
- Orientation of new staff.
- The importance of sharing with other staff.

Group Five - Convenor – Anne Marie Elias

Social Research and what we need to know and how we get it?

- The needs of older people now and in the future.
- Looking at local government who have programs on ageing.
- Getting younger people to face the future of intergenerational interaction.
- Who are the well aged?
- What are older people's attitudes to ageing?
- What do older people need to age in place?
- Differences and similarities about older people and children ageing.
- Cultural myths about caring for older people and families need to be removed.
- What services do people have and what do they need?
- Linking the research.
- Research for the future – younger cohort about how they will age, what expectations they have, where will they age, etc.
- Cultural competencies of service providers at national, international and multi-national levels.
- Capacity building in communities.

- Provision of sessional services in partnership and the valuing of ethno-specific services knowledge, ability and skills.
- Research on current 65+ and emerging 65+ on health, attitudes, etc.
- Research on productive ageing to recognise value of older people and their financial contribution to the community.
- Grandparenting.
- CALD older volunteering and the monetary contribution of CALD older volunteers.
- Research into younger CALD volunteers, the next generation and their attitudes.
- Volunteering in schools as part of the curriculum.
- For profit aged care concerns around capacity building as non-profits do a lot of capacity building.
- Lifestyles and attitudes on life and health.
- Positive ageing research.
- Positive ageing activities.
- Service system barriers to CALD older people.
- Cultural and linguistically barriers to services.
- Comparative research CALD globally. Such as Greeks in Canada, UK and Australia.