
Social work with older people from culturally and linguistically diverse backgrounds: Using research to inform practice

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Abstract

This research investigated the views of older culturally and linguistically diverse (CALD) people, their families and paid workers about experiences of giving and receiving care services in the Barwon region of Victoria, Australia. The project was conducted in collaboration with Diversitat, Geelong. While the research process incorporated a range of qualitative techniques this article is confined to reporting selected findings from the individual interviews and a focus group discussion. These findings demonstrated that particular caregiver personal attributes strengthened the relationship between older people and caregivers; differing interpretations were offered up about the use of time; multiple barriers for older CALD people using health and social services were identified; and that experiences of ageism within the health services were reported along with infrequent use of interpreter services. The article concludes with a discussion about the implications for social work practice and education with older CALD people.

Introduction

There is no shortage of literature and media attention raising awareness about the implications of an ageing population in Australia or New Zealand (Boston & Davey, 2006; O'Connell & Ostaszkiwicz, 2005; Coory, 2004; Teese, 2002). This article reports research findings on the identified needs of a particular subgroup of the Australian aged, those from culturally and linguistically diverse backgrounds (CALD) living in Geelong, Victoria.

Using the 2001 census data for the Barwon region in Victoria, it was identified that approximately 37% of the population of the City of Greater Geelong aged 65 + (10,246 individuals) were made up of people born outside Australia and other main English speaking countries (GECC, 2004:10). Even so, recent analysis of the Home and Community Care funding in this region demonstrated that older people from CALD backgrounds are under-represented in accessing home and community care assistance (HACC Barwon-South Regional Plan, 2003, p.9).

Together, these trends prompted this research to identify how CALD people in the region experienced working with local health and social services, to provide clues about why existing resources and support services were not being fully utilised by this group of older people and their family caregivers. In their capacity as service providers and trainers in the field of cross cultural service delivery, Diversitat, a large non-government social service agency in the region, were also interested to document how older people from CALD backgrounds experienced health and social services. Diversitat aged care services hosted the research project. The research incorporated three specific aims. These were to:

- Identify the barriers for older CALD persons in accessing community and residential care services in Geelong.
- Identify areas of difficulty and sensitivity for both clients and workers in this field of practice.
- Develop ways to improve cross-cultural communication and the process of providing personal care to older people from CALD backgrounds.

The findings have implications for how future social work services might be planned and delivered. In particular the need for ongoing professional development and education focused on cross-cultural communication and service delivery was identified.

As Anglo-Saxon Australian women conducting this research, we were mindful that we first needed to learn more about the conceptual dimensions of cultural diversity to understand how these factors might influence the research process and design. In the literature review that follows, we outline some of the paradigms that informed and shaped our thinking in relation to the research process.

Literature overview

The following brief review of the literature examines typologies for understanding difference and diversity, explores barriers to effective cross-cultural communication and care, briefly discusses the influence of ageism in service delivery and provides a critique of recent literature related to cross-cultural social work practice.

Typologies for understanding difference and diversity

Recent publications focusing specifically on education and training for cross-cultural communication and understanding incorporate a range of typologies setting out characteristics that differ between cultural groups (Gannon, 2000). A broad understanding of difference in terms of *personal values*, *worldview* and the impact of *social organisations* (such as family and governance structures) are considered integral to examining difference from a cross-cultural perspective (Samovar & Porter, 2003). These dimensions in turn are further distilled into 'cultural syndromes' where the nature of living is examined in relation to the way people make decisions, communicate, behave, govern, express feelings and perceive attributes in others (Triandis, 2003, pp. 20-22). A number of models for understanding cross-cultural communication in particular have been promoted in the literature (Kagawa-Singer & Blackhall, 2002; Hogan-Garcia, 2003; Gannon, 2000), each of which have notions of cultural sensitivity and cultural competence, as their foundation.

While these paradigms provide background for understanding the socio-political contexts and phases in which studies on cross cultural living and communication have been

located, on their own they do not provide predictors for how intercultural communication and helping relationships can be enhanced. In particular the current prescriptive nature of the cross-cultural training fails to incorporate a structural analysis of the impact racism, class and gender have on cross-cultural relationships (Nipress, 2001). The approaches tend to be based on a binary model which contrasts the dominant with the 'other' (Ganguly, 2001) and rarely acknowledge the socio-political and economic contexts of people's lives. Not surprisingly much of the literature in this field explores the notion of 'diversity'.

What is diversity? It became clear during the course of the research that cultural diversity can be understood in a range of different ways. Two of the most common typologies to aid understanding of diversity are outlined below. The first analyses cultural diversity based on the way communities and the people living within them are organised and shaped by the following determinants:

- Universalism vs. Particularism (rules vs. relationships)
- Collectivism vs. Individualism (the group vs. the individual)
- Neutral vs. Emotional (the range of feelings expressed)
- Diffuse vs. Specific (the range of involvement)
- Achievement vs. Ascription (how status is accorded) (Trompenaars, 1993, p.29)

A second typology for conceptualising diversity is outlined by Parekh (2000), where diversity is understood more from a position of life choices, values and corresponding behaviours. Parekh identifies the following categories within this typology as:

- *Subcultural diversity*: Where members share a broadly common culture but some prescribe to different beliefs and practices that impact on their way of life (gay & lesbian community; miners; fishers).
- *Perspectival diversity*: Members of a society that seek to radically change the central principles and values (ie, feminists; environmentalists).
- *Communal diversity*: Where a range of groups live within the same geographical proximity by their own sets of different systems of beliefs and practices.

Using this frame of reference the term 'multicultural society' generally refers to a society that exhibits all three types of diversity (Parekh, 2000, pp. 2-4).

Both of the typologies above afforded us as researchers the opportunity to expand our own understanding of the range of ways in which the lived experience of diversity could differ both within and between cultural groups. The distinctions drawn out from each of the typologies also signalled to us areas of knowledge and understanding that appear to receive minimal attention in current social work curricula.

Meanwhile, clear definitions of the term 'diversity' are hard to find. A recent explanation notes 'The concept of 'diversity' has come to represent cultural, ethnic, racial and religious differences between the 'dominant group' and immigrant and indigenous populations' (D'Cruz, 2007, p.35).

Barriers to effective cross-cultural communication and care

Specific barriers to effective cross-cultural communication and care have been documented in the literature and include a number of concerns ranging from significant language dif-

ferences between workers and the clients (McDonagh, 2000), staff lack of knowledge and respect for traditional beliefs and practices (Ngo-metzger, Massangli, Carridge et al., 2003); nonverbal misinterpretations, along with an over reliance on preconceptions and stereotypes (Matsumoto & Juang, 2004).

While several of the above barriers to effective cross-cultural communication and care were evident in the focus group and individual interviews conducted during the course of this research, the practice of *ageism* within health and care systems was also identified by several participants.

What is ageism? The term ageism emerged during the 1960s (Butler, 1969) in response to the prejudicial views of older people promoted in Western youth-oriented cultures. Ageist attitudes can be understood as a constellation of feelings, stereotypes and differential treatment directed towards older persons due to their age (Kite & Wagner, 2002, p. 131).

There has been a great deal of research both overseas and in Australia attesting to the presence of ageist attitudes, practices and policy in relation to the delivery of health care services to older people (Wells, Foreman, Gething & Petralia, 2004; Robb, Chen & Haley, 2002). Older people and their caregivers interviewed in this pilot research reported what they believed to be instances of negative attitudes and treatment of older people by staff, including social workers, from local health care services. Before conducting the research we also examined the literature related to cross-cultural social work.

Cross-cultural social work

While there is no argument in the social work literature about the need for practitioners to be able to work effectively with clients who come from a range of differing cultural backgrounds, there is not agreement about how this practice objective might best be met. The notion of educating practitioners to demonstrate 'cultural competence' has been widely canvassed and supported in the social work literature (Furness, 2005; Jong Won Min, 2005; Williams, 2006). Factors necessary for developing cultural competence are diverse and have been summarised by Weaver (1999) as including the following: critically reflecting upon one's own bias and beliefs; recognising the impact of devastating colonial histories; increasing knowledge about differing cultural groups; understanding and valuing the notion of diversity; recognising the level of historical or contemporary distrust between various groups; appreciating the significance of difference in the helping relationship, including the impact of power dynamics. (Weaver, 1999, p. 218). However, Dean (2001) argues that one person cannot ever be competent in understanding the constantly evolving and emergent culture of another, but instead suggests that practitioners accept their ongoing lack of competence in cross-cultural matters. She notes that such acceptance does not in any way imply an abdication of responsibility for continuing to improve knowledge skills and understanding of cross-cultural practice.

Methodology

This discussion outlining the method for conducting the research documents the ethics approval process; data collection procedures; constraints and limitations of the research method.

Ethics approval. This research was conducted in partnership between Diversitat, Geelong Victoria and two academic researchers. The research was guided by a reference committee made up of staff and representatives from Diversitat, the City of Greater Geelong Council and Barwon Health. The method for conducting the research was developed in consultation with the reference group, and ethics approval for the research was sought and gained from the Central Queensland University Ethics Committee. The reference group played a central role in conducting the research. Being made up of people from a range of ethnic backgrounds, the group participated through auditing the research process for cultural sensitivity, including advising on individual interview formats and recording protocols.

Data collection. Nine individual interviews were conducted during July 2004. This article reports the findings from these discussions. Two of the individual interviews were with qualified cultural consultants employed by the agency, three were with older agency clients, and four were with family caregivers. This was a small sample due to the fact that this research was exploratory in nature, and participation by older clients and family caregivers (most of whom were older themselves) needed to be carefully negotiated over time due to the sensitive nature of the topics being discussed. It was decided that interviews would be best conducted at Diversitat rather than in people's own homes. The process of organising the interviews was rather complex, due to co-ordinating participant transport to the agency, accessing interpreting services and overcoming communication difficulties in making these meeting arrangements. These dynamics provided us with a great deal of experiential learning about conducting cross-cultural research with older people.

Prior to conducting this research we had been advised by the reference group that discussions with this particular cohort of older people could be expected to take a great deal of time, and it did. Transcriptions from the individual interviews were analysed to discover emerging themes using open coding (Strauss & Corbin, 1990). Two researchers coded each transcription independently. Coding results were then compared to form the basis for an agreed cluster of themes.

Constraints and limitations of the research methodology. There were two main limitations within this research process. The first is that the participant population for this research was small, with just nine individual interviews being conducted. This method of data collection was supplemented with an audit and review of existing training material, and an examination of existing literature and research related to cross-cultural communication.

The second limitation is that while the research involved engaging with people from diverse cultural backgrounds, the interviews and analysis were carried out by three women from predominately white Anglo-Saxon backgrounds. As such the issues identified may reflect more of an Anglo-centric interpretation of what appeared to be of most significance in the findings. To help address this limitation the data gathering process and subsequent analysis were carried out in close consultation with a research reference group.

Findings from the individual interviews

The following discussion provides an overview of selected findings from the individual interviews with older people and their caregivers. While a schedule of questions was used to guide the individual interviews, the discussion with participants about use of services

was for the most part free-ranging. Questions were open-ended and participants were encouraged to elaborate when describing their personal experiences. Some common themes were evident in these interviews and these are discussed below.

Personal attributes. While there is a great deal of focus in the literature on the notion of difference, and understanding the unique features of various cultures, during the research process we found much in common between what caregivers and care recipients perceived as being most important in terms of the delivery of practical and health services. Irrespective of the different cultural perspectives, the nature of the relationship between older clients and their workers appeared to be as important as knowledge of the first language in terms of shaping satisfaction with care services. There were several situations discussed in the interviews where difficulties with language existed between clients and workers, but these were outweighed by the personable manner in which the service was provided. This finding suggested that for the older people and caregivers we interviewed, the demonstration of respect, empathy, genuine interest and giving time were in some cases more important in the interaction, than knowing the details of the particular cultural background, although this too was very helpful. These findings are consistent with those of Dean (2001) who states:

It is not so much 'knowledge' but rather 'understanding' that is basic to successful clinical work across cultural divides. When we work toward understanding we are engaged in building a relationship. These two ongoing processes of understanding and relationship building are mutual and intertwined and at the heart of successful cross-cultural work (Dean, 2001, p.628).

During the interviews several instances were cited where staff were unable to speak the same language as the older person, but were highly regarded by the older person and/or their family carer because of the quality and process of care provided. Listed below are the particular personal attributes that older people and family caregivers identified as being important in providing care for older people:

- Demonstrating active listening skills.
- Showing acceptance and tolerance for difference.
- Being patient especially in situations where interactions may be time consuming due to communication difficulties.
- Combining honesty with compassion and care.

...and have a little compassion, because they don't know from one day to the other, nobody knows what's coming ... that's the only thing - honesty and dignity, because it doesn't matter about languages... (Grethe, Client).

...and she said to me you know one of the most important ingredients for anybody who is working with the elderly is compassion, and she said in all of their efforts to help me I didn't experience a sense of the person who is here to help me has any compassion for me, they were happy to come in and tell me that if I rearranged my house and had it in a different way so that it wasn't an occupational hazard for their workers, then they could help me, but it's my house ... (Will, cultural consultant).

Demonstrating acceptance and establishing a meaningful connection with clients was most significant to the older person and/or their family caregivers where staff demonstration of care, respect and compassion transcended other qualities including speaking the same language as the older person.

Messages conveyed through use of time

Discussions in several of the interviews focused on the messages conveyed to older people and caregivers through use of time. This recurring theme around the issue of care professionals needing to take the time to deliver a meaningful and quality service runs counter to the neo-liberal market economy where effectiveness is measured by outputs rather than process-oriented outcomes.

Discussions around use of time could be categorised in different ways:

Spending time conveys care...

I see time more as how effectively you use the time that you do have, and it's connected to that issue of respect, that you demonstrate to people that the time that you have got for them, that's all you're doing, you're focusing on them ... and that's so easy to do, it's nothing amazing, like you turn off your mobile phone, you turn up on time, you turn up when you say, you don't cancel wherever possible, and I think that if you have demonstrated to a client that you are interested in them, you are respectful of them, when you can't they will understand. And people know whether you care or you don't care and if you're interested, everyone can pick it up ... (Colette, family caregiver).

... in a case like somebody with a problem with language like myself, to speak slowly and clearly so the other person could understand what I want, then there's almost no problems (Peter, family caregiver).

Being left waiting conveys a lack of care and generates anxiety and uncertainty for the older person and their caregiver. In the case of Anna, 12 hours passed in Accident and Emergency before a decision was made about her grandmother's care.

Our whole day we stayed in hospital, close to midnight, from when they took her in around lunch time 'til somewhere near midnight they finally got her into a bed, and it's not their fault, I'm saying this whole system is wrong, there's something very wrong about our system...we were there that long without eating, just in that emergency area, trying to help my grandmother through the pain that she was experiencing and going over the story over and over again with the medical staff, coming in to do checks on her and asking questions on her behalf (Anna, family caregiver speaking about her grandmother).

The need for practitioners to respect and acknowledge the amount of time that informal caregivers spend with the client was highlighted, particularly in relation to consulting with family and/or caregivers when conducting an assessment with an older person from a CALD background.

... because time is very important in these cases. When one person is at home with family or friends or with the carers they have 24 hours time to see what he or she is doing, and the professional people see only that patient for a few minutes, and they have no idea what goes on in the other parts of the day (Peter, family caregiver).

Barriers to using services

As noted above, previous research with CALD client groups has revealed numerous barriers impacting upon service access and use. Findings from our research concur with these earlier studies. All of the participants we spoke to had difficulties with accessing and/or

using services for differing reasons. Obstacles to utilising existing services were identified from a number of perspectives. These included:

Reluctance to access services due to feelings of familial loyalty and responsibility combined with community pressure

I know some people are not using any services, they just try to do their best, I mean family members, some children are sort of proud that they don't want anybody to help, they want to do their jobs to the end with their parents (Peter, family caregiver).

... my Mum and Dad had a real issue about using any services ... so I assisted them through all of those processes, but in terms of taking anything from a council or anywhere else, no, it won't work, no, we're here, 'what sort of a person would I be' would be Mum's classic response, 'that I can't do that for my mother and brother'. Respite – totally foreign – not just to her but to the entire community, and they come from a very close-knit community... they would all look after their own, and if you did tap into services there was something very wrong, and the community would talk about it, and then that pressure... people don't want to even take up services sometimes because they don't want to go there, they don't want the community talking about it (Anna, family caregiver).

Lack of information about services and financial support available

And some people, they are caring for really sick people and they don't even know that the government pays carers allowance, they don't know that even (Peter, family caregiver).

I mean for an English-speaking person it's still a maze to find your way through the system, but for a person from a non-English background with a minimal amount of education it's daunting and frightening (Will, cultural consultant).

Services not being provided in ways that suited the client

...they call this home help, one hour of home help once a fortnight, it's not help, plus you've got to fill in forms, plus you've got to purchase from a list of chemicals that they tell you, plus there's occupational health and safety where they can't step on a ladder to change a light bulb, a whole lot of things that they find difficult to understand because their notion of what help at home is not a western notion (Will, cultural consultant).

Unwillingness on the part of agency workers to respond to requests for help

Interviewer – so you specifically asked for some help?

Grethe – yes, and that young doctor said what do you want, he's old (Grethe, client and caregiver to her husband).

At this stage Grethe's request for help was unheeded. Three months later the situation with her husband had deteriorated to the point where she could no longer look after him at home and he was admitted to long-term hospital care.

Workers in the formal system not explaining how the services work

But in hospital they have plenty of information but for example when a patient is not understanding the social worker who came with a lot of brochures and information, so the social worker has no other choice but to leave the information beside the patient's bed and go, and after I would not know if they had called in the interpreter or not, because I came to see him, so I looked at a lot of stuff and I found out that they wanted to shift him to a different place (Peter, family caregiver).

Emphasis on attitudes of resilience and need for self help within the older person's own cultural community

We can't expect help for everything ... you've got to do something yourself. You get nothing for nothing (Elmo, client).

Older people wishing to maintain their independence

... she wants to cook for herself, it's just like taking a piece of her own liberty and independence. She wants to cook for herself, she wants to do everything she can, although she's not aware so much of her status, she wants to do everything by herself (Agnieszka, family caregiver).

Expectations

Throughout the discussion with older people and family caregivers it was evident that intergenerational social changes and expectations relating to cultural and care issues had potential to cause very real problems within and between families. Intergenerational differences related to:

Cultural expectations

We lost my grandmother in May this year, but up until the time that she died she would have been quietly the head of the household, she was the one who sort of had to know everything, so there was a bit of a challenge always there between Mum, Dad and Gran, because Gran was stuck in the old ways, the old family structures, whereas Mum and Dad had migrated to Australia and had their children here ... So they were at a cross roads between cultures. So to teach Nan different ways of doing things was very hard, to get her to use services was even more hard, I would put that almost in the impossible basket (Anna, family caregiver).

Expectations older people had of their families

...but the majority of the mistakes as I see it (in the health system) are made because the person goes there by themselves, especially new Australians, and they can't express themselves and they might say one thing for another, or it is interpreted by the doctor in a different way ... he might give them the wrong medicine or the wrong ointment for pain or whatever. So to me I blame the family of that person (Elmo, client).

For example, that time when we were looking after my grandmother and we got meals, my grandmother told me that I should be ashamed of myself doing this and bringing these services in to the house, when there are people here (Anna, family caregiver).

Family caregiver expectations of themselves, including a sense of duty and responsibility

The expectation has been that the oldies stay with me, and they stayed with us (Hans, family caregiver).

Not knowing the parents' first language

... some people don't know where to look for help when they need help, even when they are really pure Australians, and they don't know even their parents' language, only the Australian English (Peter, family caregiver).

Use of interpreters in service delivery

Not surprisingly, issues of communication and language were discussed in-depth. Difficulties with language and communication were identified in the health care services in

particular. From the older people and caregivers we spoke to it appeared that interpreters were infrequently used, even when significant discussions regarding assessment, treatment and discharge took place.

... they'd talked to my Mum about the options, like a pin or a replacement, and even there I felt like one minute they're talking about replacement then later on after the operation they say well when we got in there we realised that it was more appropriate to do a pin so we went with a pin. Well you know, do I translate this back to my grandmother or do I just tell that to my mother, and explain to my mother the difference between and the complications ... I mean the doctors didn't have an interpreter there for any of that, we did that, I did that (Anna, family caregiver).

Interviewer - when your husband was in hospital did staff make special efforts to understand (your language).

Grethe – I don't think so, they think you're not very normal...

Ageism

During the interviews several of the participants identified ageist attitudes amongst staff within the health care system

Interviewer – you were telling me how they treat the old people...

Grethe – like dirt, like they don't exist, you're nothing, you're just a number...(Grethe, client and caregiver)

I'm there, and they took him in all the time into hospital, but the elderly for some reason are on the bottom rung, I think there's more important people to look after, like these people are in their 80s and 90s, they're not going to get any better, let's just give them an average... where there's other people higher up that really need the care... that sort of attitude (Gunter, family caregiver).

Multi-layered complex nature of presenting issues

It was evident that many older CALD clients presented to health and care services with a complex mix of health, cultural, familial and language issues to be addressed.

... she's never been in an ambulance before apart from after the fall, she's never been to hospital in her life before, so we're talking about someone who is almost like a child going to the hospital, she's never ever been there, it was a totally different culture. So on top of not knowing the language, there's a culture shock about all of this too ... but Nanna didn't just have a broken hip, Nanna was 96, Nanna had memory loss, Nanna didn't speak any English, Nanna ended up having a pacemaker, Nanna had chronic constipation before she went in, so you've got to look at all that in combination, so if you're giving drugs or injections for pain and they're chronically constipating her even more, please prepare us, tell us what it's all about, tell us what to expect so we can tell her what to expect (Anna, family caregiver).

Implications for social work practice and education

While the participants in these interviews raised concerns about the assistance they had received from a range of health and care professionals including social workers, medical

personnel, nurses and home help staff, their stories related to universal skills and qualities needed to work with older people from CALD backgrounds. These messages were about the need for workers to demonstrate aspects of care and respect, ensuring trustworthy communication and not discriminating access to services on the basis of age.

The data from these interviews suggest the need to develop practitioner skills and understanding in how to communicate cross culturally and provide ethnically sensitive models of service delivery. For social work this means making available education and ongoing professional development opportunities for students and workers to learn more about working with people from diverse ethnic backgrounds.

In particular, social workers encountering CALD clients need to be open to learning about the cultural dimensions that impact upon this group of older people and their family caregivers. This includes having some appreciation of the cultural expectations embedded within family decision making about use of community support services and accessing residential care, along with a sound knowledge of how to engage and work effectively with an interpreter. Interview and assessment processes with older CALD clients are likely to be more time consuming where English is a second language, even when an interpreter is present.

Given that only a small fraction of the meaning people get from interaction is derived from words that are spoken, most communication is of a nonverbal nature (Matsumoto & Juang, 2004, 280). This phenomenon explains how workers can demonstrate genuine empathy and respect even when they are not able to converse in the client's first language. Even so, to communicate these attributes effectively and with authenticity workers will need to spend unhurried time with their client/s, learning about their story and their place in the world before moving into any form of intervention.

Practical strategies for addressing the above areas in social work education could include incorporating, when possible, older CALD consumers into classroom and field teaching; use of case study material focused on issues from this client group perspective; including sociological theory about notions of interlocking oppression (Yeatman, 1995) and intersectionality (Mullings & Schulz, 2006), where social marginalisation based on multiple dimensions such as gender, age and ethnicity might be more fully explored.

At a more macro level, social work students and workers need to name and actively address ageism in policy and practice when it is encountered. Finding ways to strategically advocate for older people to receive ready access to adequate health, housing and income maintenance needs to remain a practice priority. Unfortunately, participating in this level of intervention often becomes subsumed by the daily demands of practice. Yet it is at the macro level of policy intervention that lasting changes for the status of older people can be made.

Other methods for ensuring the voices of older CALD clients are heard are to advocate for participation from individuals and groups in this community on aged care service planning, development and evaluation forums. Together with seeking out research and education opportunities so that older people might tell their own stories and contribute to the knowledge and professional development of workers, these strategies will challenge

the dominant discourses embedded within current service planning, delivery and professional training.

Conclusion

In this article we have sought to explore and make public the double jeopardy experienced from ageing and being from a CALD background in Australia, while also requiring formal or informal care of some kind. The findings from this inquiry highlight how work with this group of clients might be enhanced through the development of particular worker attitudes and attributes, while also noting the stark existence of ageist practice within current health and social service organisations. The implications for social work delivery and education is discussed, outlining micro and macro level strategies for addressing how practice with older CALD people might be developed further.

Acknowledgement. We wish to thank clients and staff from Diversitat, Geelong, Victoria for the invaluable input and time generously given to the above research.

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