RACGP
Royal Australian College *of* General Practitioners

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Part B. Multiculturalism in aged care

General principles

- Culture, religion and the settlement experience influence perceptions of healthcare and outcomes.
- Multicultural aged care is to be approached with a curious mind; the patient is always the best source of information.
- Working with trained interpreters greatly enhances outcomes; Translating and Interpreting Service (1300 131 450) is a free phone or face-to-face service available for general practitioners (GPs).
- An increased index of suspicion for post-traumatic stress disorder (PTSD), anxiety and depression, particularly comorbid with dementia, is needed.
- For important decisions, a family collectivist approach is common, and residential aged care facilities (RACFs) may be a last resort.
- All states and territories have dedicated migrant services.

Introduction

The demographics of Australia's culturally and linguistically diverse (CALD) people aged ≥65 years have changed markedly since the turn of the 21st century.[1]

More than 300 languages are spoken in homes around Australia (excluding Aboriginal and Torres Strait Islander languages). This reflects Australia's humanitarian entrant program, which has resettled refugees from dozens of countries across Europe, Africa, the Middle East and Asia.

While many excellent migrant-specific services have evolved, our knowledge of demographic shifts and the emerging evidence base has not been matched by health policy development and service delivery.[1]

Access by older CALD people to many important mainstream services is hampered by factors that include use of interpreter services and cultural awareness training for staff. Given more than 30% of people aged ≥65 years will be CALD by 2020, more work is needed to cater for this vulnerable population group.[2] This chapter will aim to provide general background information and specific practice points for general practitioners (GPs), residential aged care facility (RACF) staff, and the wider multidisciplinary care team.

For some older CALD Australians, acculturation often seems beyond their reach, their reliance on family absolute, and language a major barrier. The gains for which migrants leave their country of origin – financial security, safety and good healthcare – are accompanied by profound losses, including loss of language, social status and supports, homes and natural environment.

Often, traditional family structures change rapidly after migrants arrive in Australia. Principal carers need to study, meet Centrelink requirements, financially assist distant family and sponsor distant family to Australia, all of which affect their ability to provide the care expected.

Younger family members adopt the values and ways of their new country and lose their birth language proficiency; the 'digital divide' further affects this population group.

Older people from a refugee background often have increased vulnerabilities, and:[3]

- neglected health conditions and sequelae
- language barriers and sensory impairments
- higher levels of disadvantage and trauma
- low levels of formal education and literacy.

Principles for good multicultural healthcare

In order to provide appropriate and effective healthcare to older people with a CALD background, it is important to develop an understanding of the migration experience, including refugee and asylum seeker journeys. Equally important is the recognition that individual experiences and backgrounds affect health.

While it is impossible to know about every culture, it is a mark of respect to be curious and take individual or collective preferences into account. It is particularly important to ask about beliefs and fears. There are surprisingly few taboos in the context of a conversation with a trusted health professional.

As with all patient groups, there are no shortcuts; the time spent investing in building a therapeutic relationship based on good communication with a trained interpreter is vital.

Among CALD communities, there is a prevalent belief that treatment with medication, injections and surgery are superior to lifestyle or non-drug interventions. It is the role of the GP to carefully explain the basis for decisions. The 'partnership' model of Australian healthcare may generate confusion and even discomfort among this patient population.

Residential care is not a favoured option among CALD communities as older people are highly valued and looked after at home for as long as possible. However, in many cases, competing demands on younger family members affect the feasibility of this ideal.

Language and communication

It is a myth that providing care for people from different cultures who do not speak English requires skills that only specially trained GPs possess.

Interpreters will often be needed for the whole, or part of the, consultation. If possible, the aim would be to work with professional interpreters face to face so important non-verbal cues are not missed.

If an older patient, particularly someone with hearing impairment or dementia, strongly prefers a family member to act as the interpreter, it is important to proceed with respect and care:

- Explain that the role of interpreters is to interpret all that is said, not to add their own opinion.
- Check that the family member is comfortable and competent; note information is rarely withheld among close family from CALD communities.
- Have an agreed back-up plan to default to a professional interpreter if issues arise.

There is no guide to what to expect in a conversation about illness, dying or death with someone from another culture, and the basic rules are a lively curiosity, sensitive enquiry, active listening and the avoidance of any assumption. Once this is grasped, 'cross-cultural' communication skills are well within the remit of every GP.

Working with interpreters

Bilingual and multilingual GPs need to carefully assess their own ability to consult in their second or third language.

It is important to note that while it may be time consuming to engage an interpreter, the reality is that taking a history and conveying instructions via sign language is even more time consuming.

Translating and Interpreting Service (TIS) is available onsite and via the telephone for no cost within RACFs and community aged care services. TIS is also available cost-free for all medical practitioners in private practice, including radiologists and community pharmacists (not available for Home Medicines Reviews [HMRs]).

The Doctors' Priority Line is available 24/7 at 1300 131 450; however, significant underuse of this service leaves patients and GPs exposed to risk.

Phone interpreters will be more acceptable than a face-to-face, onsite consultation if confidentiality is a strong concern; however, barriers include hearing and technical considerations (eg speaker phones). Many important or complex healthcare conversations will need to be done slowly and over several sittings.[4]

The use of translated written materials helps if the older CALD patient is literate.[5]

In the RACF setting, it is important to be aware that bilingual care staff may have varying English proficiency; particular issues arise when the staff member and resident speak different languages, neither of which is English.

Clinical considerations

Many older people from a refugee background have had poor or no prior access to healthcare before arriving in Australia, and undiagnosed and undertreated chronic illnesses are common (eg diabetes, hypertension, osteoarthritis, chronic obstructive pulmonary disease [COPD]).

High rates of post-traumatic stress disorder (PTSD) are seen in those who have experienced war, imprisonment, torture and dislocation (refer to Part A. Mental health and Part B. Care of older veterans).

The gender of the treating professional and interpreter may be very important for CALD patients; it is important to check and not to make any assumptions.

The age stated in a medical file is often based on 'assigned date of birth' on the patient's arrival visa documents, which can be wildly inaccurate. This has implications for health (eg age-based screening and Pharmaceutical Benefits Scheme [PBS] requirements) and wider determinants of health (eg aged pension entitlement).

It is impossible to overestimate the sense of dislocation experienced by someone migrating in the last couple of decades of their life. Providing comfort and reassurance and building a lasting therapeutic relationship is vital for this patient population group.

Medication management

Health literacy and language factors have a large effect in the area of medication management. To avoid differing degrees of mayhem, the 'golden rules' of geriatric prescribing serve well:[6]

- Keep regime as simple as possible.
- Commence one medication at a time, and use the 'start low, go slow' approach.
- Review promptly for efficacy and adverse effects.
- Use one pharmacy that must keep all scripts.

- Encourage same brand and consider Webster packs.
- Explain 'novel' concepts (eg no 'sharing' of medications, long-term use of many medications).
- Check use of traditional medicines and informal importing of medicines.

Metabolic profiles (pharmacogenomics) may affect patients differently (eg Asian skin reaction to carbamazepine).[6]

Refer to Part A. Medication management for more information.

Dementia

Dementia may be viewed more as a normal part of ageing than a medical condition among CALD communities. There are instances where if cognitive impairment predates migration, the older patient may never know they are in Australia.

The standard 'Western-centric' Mini-Mental State Examination (MMSE) can be unproductive in people who have no recorded date of birth or formal education. The use of the Rowland Universal Dementia Assessment Scale (RUDAS) has been validated for use in CALD populations.[7]

Managing advancing dementia and its sequelae, particularly in an RACF setting, may require a flexible solution, and families and carers can advise staff on specific approaches. For example, underwear is not worn in many cultures, which would make continence pants in continence management unacceptable.

Refer to Part A. Dementia for more information.

Screening and immunisation

New entrants to Australia will need comprehensive screening for infectious and chronic diseases, and also a full catch-up on immunisation. The following resources are useful:

- Refugee Health Guide's *Recommended initial screening investigations for people from refugee backgrounds*
- Department of Health's *Factsheet: Free catch-up vaccines for refugees and humanitarian entrants aged 20 years and older*

Recrudescence of previously treated infections (eg tuberculosis,[8] schistosomiasis) can prove diagnostically elusive and require specialist referral.

Nutritional and bone health

Dietary preferences are often well catered for within the homes of older CALD people; however, this can often be unmet in hospitals and RACFs.

Edentulism is prevalent where access to healthcare has been scant.

Vitamin D, iron and B12 deficiencies are common in CALD people, and screening is advised.[9]

The use of unsafe footwear (eg sandals, thongs) is often common and, combined with sensory and balance loss, increases falls risk (refer to Part A. Falls).

Substance use

Ongoing tobacco use is common in this population group, and alcohol use may be hidden. Betel (areca palm) nuts, which are popular in South Asia, East Africa and the Pacific, combined with tobacco in a 'quid' placed in the user's cheek for hours (producing a mild stimulant effect) can lead to oral cancers.[10] When taking a smoking history, it is important to specifically ask about chewing tobacco.

More information on smoking cessation is available in the RACGP's *Supporting smoking cessation: A guide for health professionals*.

Kava is popular among CALD communities from the Pacific, and has been implicated in acute hepatitis.

Psychological

The incidence of PTSD in survivors of torture and trauma exceeds 50%, but will not present in a way congruent with the *Diagnostic and statistical manual of mental disorders*, fifth edition, (DSM-5).[11] Stigma surrounding mental illness in many communities may strongly affect the older person's engagement with assessment and treatment.[8]

Along with the effect of social isolation, onset of dementia and associated communication deficits, depression can emerge and may respond to both drug and non-drug interventions. Finding out what was important to the person in their country of origin can be informative for the patient and their family. Each state and territory has its own organisation to which GPs can refer people affected by trauma (refer to 'Resources' below).

The use of the Translated Geriatric Depression Score can assist GPs in the management of older CALD patients with mental health issues.

Abuse of older people

The abuse of older people is often a complex issue that is under-reported, and carries more stigma in CALD communities. Particularly be aware of financial abuse, psychological abuse and extension of spouse violence into old age.

Gastrointestinal

Clinical and medical histories are difficult to obtain in older CALD people, and constipation is a very common cause of elusive abdominal pain; an abdominal plain X-ray is often illuminating.

Helicobacter pylori should be treated and cure tested. A common reason for representation with reflux symptoms is patient discontinuation of proton pump inhibitors (PPIs). Festivals often involve spicy foods and 'mini epidemics' of gastro-oesophageal reflux disease (GORD).

Preventive health

Preventive health screening (eg cervical or bowel cancer screening) may not have been conducted for older CALD people.

More information on preventive health is available in the RACGP's *Guidelines for preventive activities in general practice*.

Culture, family, religion and refugee journey

An older CALD person's position within their family underpins healthcare discussions and decisions, especially if conversations are about serious illness or dying. Initial information gathering to delineate family structure, roles and dynamics will be vital, and will include consideration of additional angles (eg the older family member's pension contributing to the family finances) and position in the home ownership or rental market.

This is often complex terrain; open questions at regular intervals will give the GP the best chance to establish optimal lines of communication to allow planning.

The refugee journey, combined with the events that precipitated it, leads to factors influencing communication and decision making. These include the effect of trauma on trust, ability to process and retain information, and very individualised resilience patterns. A low threshold for suspecting trauma and considering referral is indicated in older people from a refugee background.

Social isolation among older migrants has many faces. The transition from rural, village and/or camp life, played out in close-knit communities and from large families all living under one roof where the elders played a central role, is abrupt.

Fasting for cultural or religious reasons is common and varied, and it is important to ask the patient about this. People who are frail or unwell are usually exempted, even though they may still wish to fast. Diabetes medication may need careful management during these periods (refer to the RACGP's *General practice management of type 2 diabetes*).

Carers

Carer stress may be difficult to assess among CALD people, often not emerging through direct questions, but observations over time (refer to Part B. Families and carers). The effect on education, employment and health for carers – with unequal burden for females – coupled with a theme of 'self-care is seen as selfish' is often hidden.

Information and support regarding Centrelink's carer payment, in-home respite and care packages, and carer support may need to come from the GP. Centrelink's Multicultural Service Officers in each state and territory are extremely accessible and a mine of information.

Death, dying and rituals

Patients from a CALD background experience delays in receiving comfort care, higher ventilation rates and lower rates of advance care planning.[12]

Assessing competency, good interpreting, allowing time for family consultation and questions, and practical assistance to link with a social worker (eg appointment of enduring guardian) are important.

Palliative care

Palliative care starts with careful exploration of expectations, wishes, beliefs and fears, particularly in relation to choices around home, hospital or hospice care (refer to Part A. Palliative and end-of-life care).

As the patient's conditions worsen, the clinical care team widens to include palliative care clinicians and community nursing services, who may need 'orientation' and support.

End-of-life care, discussions around a diagnosis of dementia or a transition to in-home care or an RACF will be facilitated by a case conference or care plan, which can include an interpreter.

Rituals

Many ethnic and religious groups will have very specific rituals that surround the phases of preparing to die, death, funeral/burial rites and mourning. Large numbers of community members often fill the home, and religious or cultural expectations for burial timing may conflict with coroners' examinations.

Family members overseas will play a large role; the final illness of an older person can act as a catalyst for family reunions if these are possible. Funeral arrangements may be delayed for travel, and certification for compassionate leave emailed to close family.

Navigating the aged care journey

Navigating the complex tiers of aged care services can prove particularly challenging for CALD patients and their families.

Support from a GP, even to put the patient in touch with the relevant agencies, can be helpful for patients. Some organisations will lack policy frameworks, cross-cultural training for staff and a budget that allows for use of interpreters.

Each state and territory has a key organisation that offers different types of support for refugees and other migrants. These are an excellent first port of call – they often offer a 'walk in' time each week where initial contact can be made. Specific aged care programs are funded within these agencies.[13]

Additional information

For permanent residents who reach 60 years of age, citizenship can be conferred without sitting the citizenship test. Citizenship ceremonies are opportunities for celebration. Many older people are thrilled to get a passport and organise joyful overseas reunion trips, either back to their country of origin or to other resettlement countries.

Issues to forecast and deal with as early as possible include:

- health insurance, especially for travel to the US
- immunisation and preventive advice
- providing a health summary and medication lists
- enough medications to last the trip
- in-flight health.

Racism and discrimination are under-reported among older CALD people; asking and offering support and advocacy can make a difference.

Practice systems should be set up:

- Update contact details at every encounter as they are likely to change frequently.
- Include next-of-kin and case worker details.
- Consider the use of text messages for recalling patients.
- Build a base of 'CALD friendly' medical/allied specialists, and indicate on each referral if an interpreter is required, including language and gender.

Most medical software packages include ethnic demographic information fields, and should ideally be completed during the first appointment.

Resources

- GP guide to using TIS
- RACGP endorsed: Migrant and Refugee Women's Health Partnership's *Guide for clinicians working with interpreters in healthcare settings*
- Easidose prescribing aid
- State-based services for survivors of torture and trauma (Forum of Australian Services for Survivors of Torture and Trauma)
- Palliative Care Australia's *Multicultural palliative care guidelines*
- Agencies with assistance for CALD patients:
  - My Aged Care: 1800 200 422
  - Older Persons Advocacy Network: 1800 700 600

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