EMERGING NEEDS SCOPING STUDY

REGIONAL REPORT

PRESENTED TO THE OFFICE FOR THE AGEING, SOUTH AUSTRALIA BY

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1 EXECUTIVE SUMMARY

Office for the Ageing (OFTA) identified 5 groups of communities with older and frail people from CALD backgrounds who have, or will have ageing populations within the next two to three decades. The Department established the Emerging Needs Scoping Study (ENSS) project to examine the needs of these groups.

This project which was undertaken over 2009 and 2010 aims to:

- assist OFTA gain a comprehensive understanding of the current and future community-based aged care needs of some of the main emerging CALD communities in South Australia;
- develop OFTA's knowledge base so that it will be sufficient to inform the development of culturally appropriate service models and equitable allocation of Home and Community Care (HACC) funding to these communities; and
- provide communities new to South Australia with information on Home and Community Care (HACC) services.

The five groups studied in this project are:

- Middle Eastern and North African group
- Spanish Speaking group
- South East Asian group
- Southeastern European group
- African group.

OFTA selected countries of birth to be included in each group on the basis of their ageing demographic profile.

The project being undertaken by the HOKJOK team (refer Appendix 1 for project team) is confined to the following four groups:

- Country of birth is Lebanon, Syria or Egypt and/or ancestry is Lebanese, Syrian or Egyptian and/or main language spoken at home is Arabic.
- Country of birth is either Vietnam, Cambodia, Indonesia, Malaysia or Philippines and/or ancestry is Vietnamese, Khmer, Indonesian, Malay or Filipino and/or main language spoken at home is Vietnamese, Khmer, Indonesian, Malay, Filipino or Tagalog.
- Country of birth is either Bosnia and Herzegovina, Croatia, Serbia, Former Yugoslav Republic of Macedonia (FYROM) or Bulgaria and/or ancestry is Bosnian, Croatian, Serbian, Macedonian or Bulgarian and/or main language spoken at home is Bosnian, Croatian, Serbian, Serbo-Croatian/Yugoslav (so described), Macedonian or Bulgarian.
- Country of birth is either Spain, El Salvador, Argentina, Bolivia, Chile, Colombia, Ecuador, Paraguay, Peru, Uruguay or Venezuela and/or ancestry is Spanish,

Salvadoran, Argentinean, Bolivian, Chilean, Colombian, Ecuadorian, Paraguayan, Peruvian, Uruguayan or Venezuelan and/or main language spoken at home is Spanish.

An extensive regional consultation process was undertaken. This included:

- 10 regional community meetings in Coober Pedy, the Riverland, Mt. Gambier, Murray Bridge, Port Lincoln and Whyalla plus a meeting in outer metropolitan Virginia. Some of these were ethno specific and some were multicultural.
- 10 stakeholder meetings with representatives from various community and Government organisations
- a 24 item community questionnaire
- an organisational stakeholder questionnaire completed by 21 stakeholders.

144 people attended the community meetings and 155 people completed the community questionnaire either at the meetings or outside of the meetings. Responses which met the Emerging Study Scoping Needs criteria were considered if they were over 50 years of age or if they were under 50 years of age and identified themselves as a carer.

Eighty eight (88) questionnaire responses (of the 155) met the ENSS criteria and of these 29 people were carers. In total, 56 organisational and community stakeholders were spoken to directly.

There have been a number of project benefits to date including the following:

- briefing members of all four steering committees on the regional consultation findings has helped to build awareness amongst metropolitan workers of the needs of regional communities and has identified a need for outreach work
- Croatian Care for the Aged Inc. have applied for HACC funding to commence an outreach program
- the consultative process found discrepancies between Census data and community and stakeholder views of their population particularly in Coober Pedy.

Funding Issues

In the past a broad range of ethno-specific, multi-ethnic and generalist organisations in South Australia received funding under the Commonwealth Government's settlement schemes including:

- Pt. Lincoln Multicultural Council
- Coober Pedy Multicultural Forum
- Whyalla Multicultural Forum.

At the time, the Department of Immigration and Citizenship anticipated that the majority of migrants receiving services under Settlement Grants Program (SGP) would transit into mainstream services within a five year period. In reality, some migrants are not self-reliant within five, ten or fifteen years and required ongoing assistance. The cessation of SGP funding left a significant gap in providing assistance to older people in established ethnic

communities and placed a greater reliance on State government-funded human services, and on Commonwealth Department of Health and Ageing services (such as Community Aged Care Packages).

In South Australia, bodies such as the Pt. Lincoln Multicultural Council, Coober Pedy Multicultural Forum and the Whyalla Multicultural Forum all lost their funding.

In regional areas there has been a reliance on community goodwill to assist frail elderly people from culturally and linguistically diverse backgrounds with the spectrum of their ageing needs.

In many instances the elderly have been forced to leave their homes of decades and move to Adelaide for support. Whilst the funding has disappeared real community needs still exist and in some communities such as Coober Pedy, which has a very diverse multicultural population and a high percentage of single elderly, are struggling.

The consultants found a belief in communities, that help is not forthcoming and that they are consulted for the sake of being consulted. It is the consultants' view, based on a number of community consultations and stakeholder discussions, that regional CALD communities will be unwilling to participate in future discussions, unless tangible support is provided as a result of this study.

Demographic data

1355 people aged 50 and over born in the ENSS designated countries of birth lived in regional South Australia at the last Census and 323 of these lived alone. 600 were aged 65 and over and 178 of these lived alone. The three largest regional groups were born in Croatia (377), Southeastern European nfd. (247) and the Philippines (264). The group from the Philippines is younger than those from Croatia or Southeastern Europe. 21% of those who lived alone were based in Whyalla and 17% in Coober Pedy. Those who live alone and lack family members living locally may face difficulties accessing services because of language and/or cultural issues and are at risk of not accessing the services they need.

Many of the people born in these ENSS countries are scattered in small groups across a number of local government areas. Only 12 regional Local Government Areas had 40 or more people aged 50 and over from the ENSS countries of birth. The five largest concentrations were in Whyalla, Coober Pedy, Port Lincoln, Berri and Bamera (DC) and Mount Gambier. These five Local Government Areas contained 45% of all people born in the designated ENSS countries aged 50 and over living in regional South Australia at the 2006 Census.

The analysis was complicated by the fact that in some instances the Census data appears to be an underestimate.

The Coober Pedy community stood out as having issues with the ABS Census figures.

This came out both through the consultation process and at a consultation meeting in Adelaide of current and past workers from Coober Pedy with staff from OFTA. Based on our consultation we believe that the Coober Pedy census data is substantially lower than actual resident numbers.

For this reason the demographic data for Coober Pedy should be used with caution.

Questionnaire responses

Some questionnaire respondents misinterpreted the question on whether or not they needed assistance with various activities. They indicated that they are currently receiving help but did not indicate that they needed a particular type of help. This led to both underestimates of the levels of need for particular services and levels of unmet need. For this reason data should be taken as indicative of trends rather than precise levels of need.

67% of the ENSS questionnaire respondents were female and 32% were male.

The largest group of respondents was born in the Philippines and this group comprised over 44% of the respondents meeting the ENSS criteria. In total, including the Filipino questionnaires which were discounted because they were younger and not carers, 74 Filipinos responded to the regional surveys and they were also the largest group represented at community meetings.

As the Filipino community ages it may need outreach work from a metropolitan based Filipino worker.

The four largest groups of questionnaire respondents who met the ENSS criteria were born in the Philippines, Croatia, Spain and Lebanon. 59% of all carers who responded were born in the Philippines and 62% of all carers who responded said that they were caring 24/7.

Over 30% of all respondents and 27% of those who were carers said that their health was poor or quite poor. High blood pressure, arthritis, diabetes and back or neck problems were an issue for all age groups aged 50 and over with 42% of all respondents reporting that they have high blood pressure and 37% that they have arthritis.

The average number of health complaints increased with age with people aged 50-64 having an average of 2.6 health complaints, 65-79 years averaging 3.4 health complaints and those 80 and over having an average of 4 health complaints. One third of all respondents aged 50 and over said that they had four or more health complaints. Fifty percent of those born in Croatia sixty percent of those born in Spain had four or more health complaints. A significant percentage of carers i.e. over 50% had high blood pressure and 40% had back or neck problems.

The level of need for different types of assistance varies with age. For respondents aged 50-64 years the three highest areas of unmet need are for house repairs, help to use Government or other services and assistance to understand how to help the person they are caring for. The top three areas of unmet need for respondents aged 65-79 years are assistance with information about services and other help, paperwork and transport.

There were nine areas in which 15% of respondents aged 80 and over indicated that they had unmet needs namely:

- house cleaning
- dishwashing
- gardening
- rubbish removal
- bathing
- dressing
- getting in and out of bed
- nursing care and taking medication.

This age group had higher needs for personal care than the other age groups. Carers top three unmet needs were for: assistance to understand how to help the person they are caring for, podiatry and counseling.

Due to distances and availability of resources in regional South Australia transport is a real problem both for individuals and for Agencies delivering services to elderly people. There is quite a high reliance on friends and family for transport assistance amongst respondents aged 65 and over. Nearly half of the carers relied quite heavily on family and friends to get about and some indicated that they had no means of getting about.

A very low number of the total respondents said that they use respite services. Whilst both carers and the total group of respondents both put multicultural community based care as one of their top two respite preferences, individuals wanted a carer at home who spoke the same language and carers wanted an English speaking carer at home. This may reflect carers immediate needs and their view of their likely options.

Across all regions surveyed a very high percentage of all questionnaire respondents wanted a community visitor and to attend a community group meeting (between 49% and 100%).

At the community consultations people indicated that they were prepared to pay a contribution for services particularly at current HACC contribution rates.

Regional summary

The regional areas varied quite considerably and whilst the numbers were relatively low the level of need particularly in Coober Pedy was high with multiple barriers to service access.

Coober Pedy

Overall Coober Pedy stood out as a regional area which lacked services and programs suitable for the CALD sector even though it had a far higher percentage of people born in other countries than other regional centres. It was looked at in more detail than the other regional centres because it has very high levels of need. 40% of the residents aged 50 and

over in Coober Pedy were born in predominantly non English speaking countries. At least 32% of Coober Pedy residents aged 50 and over live alone.

A very significant percentage of Coober Pedy residents between the ages of 65 and 79 indicated that they spoke a language other than English at home as their main language i.e. 65-69 years 42%, 70-74 years 50% and 75-79 years 59%. This has implications for service provision as language can create an additional barrier to accessing services.

The Coober Pedy Multicultural Communities Forum is the best placed organisation in Coober Pedy to auspice a CALD Ageing HACC worker.

Mt. Gambier

In Mt. Gambier there were 64 people aged 50 and over who met the ENSS criteria and of these 15 were living alone. HOKJOK has attempted on two occasions to reach consumers in Mt Gambier firstly, with the Carer's Report in 2007 and then in 2009 with the current project and have found it difficult on both occasions to access community people. Local stakeholders indicated at both consultations that they also find it hard connecting with CALD communities. Many stakeholders consulted noted that they were servicing only a very small number of CALD clients. Some agencies said that they struggled to get CALD people attending their groups either because the groups were not perceived as culturally or linguistically appropriate or because simply people were not aware of the services being offered.

Murray Bridge

Currently the majority of the CALD population in Murray Bridge is under 40 years of age. Murray Bridge had 44 people from the designated ENSS countries at the 2006 Census and the majority of these were under 65 years of age and from a Filipino background.

Pt. Lincoln

At the 2006 Census there were 103 people aged 50 and over from the designated ENSS countries of birth living in Pt. Lincoln and 15 of these lived alone. Over 50% were aged under 65 at the Census. The Eyre Peninsula experiences a high degree of isolation and levels of socioeconomic disadvantage range from very high to moderate. According to ABS 2006 Census data there are 16 languages other than English spoken at home by residents aged 50 and over. 70 people spoke one of the designated ENSS languages as their main language at home with the majority of these speaking Croatian. More recently the Filipino community is showing a strong presence in the area, but this community is relatively young and currently not dependant on HACC services.

Agencies within Pt. Lincoln service a region well beyond the city boundaries. Many indicated that they find it difficult to capture CALD clients in their services and that while they know they need to be more proactive in reaching out to ethnic communities this is difficult with resource constraints. All local agencies work across each other to ensure that a client receives the best possible service. Community members, the Pt. Lincoln Multicultural Communities Council and local agency workers all indicated that the local community would

benefit by having a dedicated CALD ageing position based in Pt. Lincoln who would also service the periphery areas.

Riverland

Australian-born people comprise 84% of the population of the Riverland, well above the State average of 74 %. Whilst this CALD population is relatively small, culturally and linguistically appropriate services are vital to communities in this area as many people have lived isolated lives on their farms and have never learnt English. There is a strong reliance on family to support elderly parents. However, many children have moved for economic reasons and people are left on their own without immediate supports. Whilst there are currently some services provided by Ethnic Link these are not the full range of a multicultural ageing worker.

Whyalla

Whyalla has a very diverse cultural mix of people aged 50 and over speaking 24 languages at home. There were 238 people living in Whyalla aged 50 and over from ENSS designated countries of birth at the 2006 Census. 54 % of these were aged 65 and over and 29% lived alone.

There were over 1200 families from Spanish and Croatian background in Whyalla in the 1970s and 1980s. These numbers have since dwindled with families moving to Adelaide and other States for economic reason. Those who remained are now very frail and aged and in need of great support and assistance to meet their daily needs. Many rely on their families for this support but numerous people have no local support structures and live quite isolated lives. Spanish community members indicated that they would like assistance to meet as a community. This would require travel assistance and facilitation of program.

Both the Spanish speaking and Croatian community members indicated that they need language support either locally or from Adelaide. Currently Uniting Care Wesley, Port Adelaide auspice two Ethnic Link workers in Whyalla however the need is beyond current Ethnic Link funding scope. This may need to be addressed by the Department of Office for the Ageing. Many residents felt very isolated and lonely in their local community and did not know where to go for support. This message was conveyed to the consultants several times by both the community and mainstream stakeholders.

Recommendations

The top three regional priorities are: Coober Pedy, Whyalla and Port Lincoln. We believe workers could also work with the surrounding area as they become established.

1. It is recommended that a multicultural ageing worker is auspiced by Cooper Pedy Multicultural Forum for Coober Pedy. As this worker becomes established outreach work with surrounding towns is recommended.

2. It is recommended that a part-time multicultural ageing worker is auspiced by Country Health SA for Port Lincoln. As this worker becomes established outreach work with surrounding towns is recommended.

3. It is recommended that a multicultural ageing worker is auspiced by Uniting Care Wesley Port Adelaide for Whyalla.

4. It is recommended that the multicultural ageing workers be provided with support and peer training and advice and that the workers are part of:
    a. a Multicultural Ageing HACC Workers Regional Network supported by OFTA
    b. the Office for the Ageing Multicultural HACC Workers Forum.

5. It is recommended that sufficient resources are provided for travel and that each worker is provided with a lap top with inbuilt camera to support Skype, and GIS hand held equipment that enables them to plan their travel within the region as efficiently as possible.

6. It is recommended that Croatian Care for the Aged Inc. undertake outreach work for the Croatian community in Cooper Pedy, Port Lincoln, Whyalla, Mt Gambier and the Riverland.

7. It is recommended that OFTA coordinate and fund cultural competency training for HACC service providers in regional South Australia.

8. It is recommended that OFTA review the role of the Multicultural Forum and Ethnic Links role in this region to clarify the most effective way to meet future needs for the whole CALD ageing community.

9. It is recommended that a future project be established to:
    a. facilitate the establishment of partnerships both within the regions and between regional workers and metropolitan agencies for the whole CALD sector in Regional SA
    b. identify other outreach programs which are needed.

10. It is recommended that a whole of Government approach be taken to funding the needs of migrant groups over the continuum of their settlement and ageing process and that a specific State/Federal reference group be established to address this.

2 PROJECT OVERVIEW

2.1 PROJECT OUTLINE

The current Australian and South Australian Government HACC review agreement is underpinned by the *Improving with Age* Ageing Plan for South Australia; the Commonwealth's ageing agenda *The Way Forward* and the report by the Commonwealth Parliament's Senate Standing Committee on Community Affairs *Quality and Equity in Aged Care* (2005). It reflects the findings of these reports and specifically targets special needs groups including older and frail people from CALD backgrounds.

Office for the Ageing (OFTA) identified 5 groups of communities with older and frail people from CALD backgrounds who have, or will have ageing populations within the next two to three decades. The Department established the Emerging Needs Scoping Study project to examine the needs of these groups.

This project which was undertaken over 2009 and 2010 aims to**:**

- assist OFTA gain a comprehensive understanding of the current and future community - based aged care needs of some of the main emerging CALD communities in South Australia;
- develop OFTA's knowledge base so that it will be sufficient to inform the development of culturally appropriate service models and equitable allocation of Home and Community Care (HACC) funding to these communities; and
- provide communities new to South Australia with information on Home and Community Care (HACC) services.

The five groups studied in this project are:

- Middle Eastern and North African group
- Spanish Speaking group
- South East Asian group
- Southeastern European group
- African group.

OFTA selected countries of birth to be included in each group on the basis of their ageing demographic profile.

It is likely that the findings from this project will lead to more equitable funding and service arrangements for these communities.

The project being undertaken by the HOKJOK team (refer Appendix 1 for project team) is confined to the first four groups: Middle Eastern and North African group; Spanish Speaking group; South East Asian group and Southeastern European group. These four groups included the following people:

- Country of birth is Lebanon, Syria or Egypt and/or ancestry is Lebanese, Syrian or Egyptian and/or main language spoken at home is Arabic.
- Country of birth is either Vietnam, Cambodia, Indonesia, Malaysia or Philippines and/or ancestry is Vietnamese, Khmer, Indonesian, Malay or Filipino and/or main language spoken at home is Vietnamese, Khmer, Indonesian, Malay, Filipino or Tagalog.
- Country of birth is either Bosnia and Herzegovina, Croatia, Serbia, Former Yugoslav Republic of Macedonia (FYROM) or Bulgaria and/or ancestry is Bosnian, Croatian, Serbian, Macedonian or Bulgarian and/or main language spoken at home is Bosnian, Croatian, Serbian, Serbo-Croatian/Yugoslav (so described), Macedonian or Bulgarian.
- Country of birth is either Spain, El Salvador, Argentina, Bolivia, Chile, Colombia, Ecuador, Paraguay, Peru, Uruguay or Venezuela and/or ancestry is Spanish, Salvadoran, Argentinean, Bolivian, Chilean, Colombian, Ecuadorian, Paraguayan, Peruvian, Uruguayan or Venezuelan and/or main language spoken at home is Spanish.

Responses who met these criteria were considered if they were over 50 years of age or over or, if they were under 50 years of age but identified themselves as a carer.

2.2 METHODOLOGY

The project methodology was based on a community development model which empowers people to effect change in their community. It was vital that communities understood the importance of this project and engaged with it as the outcomes would benefit their current and future ageing populations.

Four steering committees were established and met during the project to assist and guide the process. They assisted with:

- linking consultants with regional communities
- advice on factors which may prevent the establishment of viable services
- advice on service providers and key community people committed to the implementation of culturally appropriate Home and Community Care services
- advice on possible synergies with other service providers and other communities
- input into the development of community profiles
- advice on service gaps in their community.

Desktop research focused on demographic data, interstate models, previous reports which focused on these communities and background briefing material prior to the community meetings. OFTA provided base demographic data which was analyzed by the consultants.

An extensive regional consultation process was undertaken. This included:

- 10 regional community meetings in Coober Pedy, the Riverland, Mt. Gambier, Murray Bridge, Port Lincoln and Whyalla. Some of these were ethno specific and some were multicultural
- 10 stakeholder meetings with representatives from various community and Government organisations (see Appendix 2)
- a 24 item community questionnaire
- individual surveys from people who could not attend meetings
- an organisational stakeholder questionnaire
- regular meetings with the Office for the Ageing.

In addition a further meeting was arranged between the consultants, Office for the Ageing and community representatives from Coober Pedy.

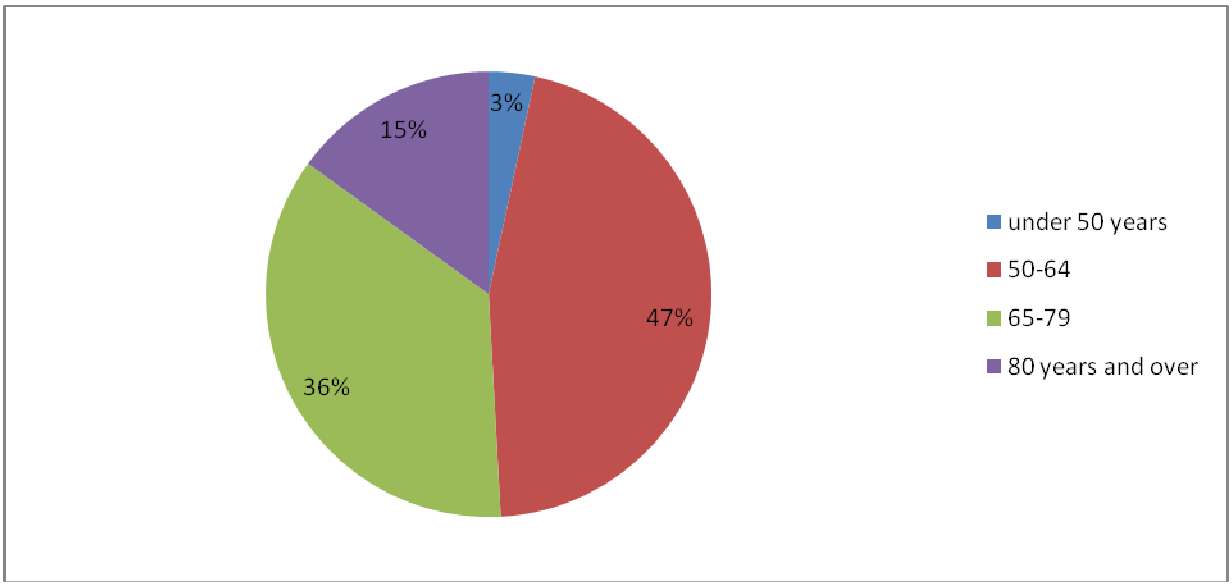
144 people attended the community meetings and 155 people completed the community questionnaire either at the meetings or outside of the meetings.

Of these 32 fell outside the target group because they were outside the designated target group. An additional 35 responses which were from the designated countries or identified with these countries, fell outside the target group because they were under 50 years old, did not identify as carers and would not be meeting the frail aged criterion within the next 15 years. Many younger Filipinos attended the regional consultations and 32 of the 37

questionnaires of those aged under 50 years were born in the Philippines, spoke Filipino and/or identified as Filipino. Other respondents who were excluded were born in Australia, Burma, Czechoslovakia, England, Germany, Greece, Italy, Latvia, Netherlands, Poland or Switzerland.

The community questionnaire analysis is based on 88 questionnaires from respondents who met the project criteria.

FIGURE 1: AGE DISTRIBUTION OF ENSS RESPONDENTS



In order not to identify individuals and maintain confidentiality as promised during the consultations, the questionnaire analysis has been cumulated to the age group level and separate results are not given for individual regional areas or ethno specific groups. Results for carers are included both in the age specific responses and in the cumulated carer responses.

In total 56 organisational and community stakeholders were spoken to directly (refer to Appendix 2). Further input was also received from steering committee members, key community members, community stakeholders and a stakeholder survey which was completed by 20 HACC stakeholders.

The project was also required to provide briefings to communities on Home and Community Care programs. In most instances it was the first time individuals had received any information on State Government programs which could assist them to stay in their communities. These briefings were undertaken as part of the community meetings.

2.3 COMMUNITY ASSISTANCE

The community consultation phase in the regional areas relied heavily on the support and assistance offered by a number of people in the facilitation of community gatherings, completion of questionnaires and/or the provision of valuable information about their respective communities. The consultants would like to thank the following people:

- Talal Andary, Riverland Druze Community
- Amal Al- Halabi, BASMA
- Graham McNoughton, Riverland MALSSA
- Tina Doulgeris, Chairperson, Coober Pedy Multicultural Forum
- Maria Gigos, Multicultural Communities Council SA
- Steve Baines, Mayor, Coober Pedy Regional Council
- John Day, Country Health SA, Coober Pedy Hospital and Health Service
- Joe Morrison, Country Health SA, Community Health Pt. Lincoln
- Petar Zdravkovski, Chairperson, Pt. Lincoln Multicultural Forum
- Josel Bautista, Chairperson, Club Filipino Inc. of Port Lincoln
- Edgar Detoya, Filipino Community of Murray Bridge
- Jenny Leibich, South East MALSSA
- Meg Hanley, Uniting Care Wesley, Port Adelaide (Whyalla)
- Juan Diaz, Spanish Community Whyalla
- Anne Garrett, Our Wellbeing Place, Murray Bridge
- Beatrice Evans, Filipino Community of Whyalla
- Jan Cowie, Multicultural, Bethel Christian Church, Whyalla
- Heather Muirhead, MRC Mt Gambier
- Nora Thiele, Filipino Community, Barmera, Berri and Loxton
- Jennie Liebich, SEDAS (South East Disability Advocacy Service)
- Marj Hately ACAT, Mt Gambier
- Helen Warhurst, Boandik Lodge, Mt. Gambier
- Trish Patzel, Boandik Lodge, Mt. Gambier
- Galhan McGirty, Boandik Lodge, Mt. Gambier
- Chris Stephenson, Community Health, Mt. Gambier
- Colleen Moore, Carers SA, Mt. Gambier
- Krys Howard, Home Care Plus
- Sister Slavica, Croatian Care for the Aged Inc..

2.4 KEY COMMUNITY PEOPLE

A list of key community members of the ENSS communities and multicultural sector is provided below:

- Talal Andary, Riverland Druze Community
- Amal Al- Halabi, BASMA
- Tina Doulgeris, Chairperson, Coober Pedy Multicultural Forum
- Maria Gigos, Multicultural Communities Council SA
- Steve Baines, Mayor, Coober Pedy Regional Council
- Petar Zdravkovski, Chairperson, Pt. Lincoln Multicultural Forum
- Josel Bautista, Chairperson, Club Filipino Inc. of Port Lincoln
- Edgar Detoya, Filipino Community of Murray Bridge
- Juan Diaz, Spanish Community Whyalla
- Beatrice Evans, Filipino Community of Whyalla
- Nora Thiele, Filipino Community, Barmera, Berri and Loxton.

In addition please consult Appendices 2, 3 and 4 for lists of stakeholders consulted, HACC stakeholders and community stakeholders surveyed.

2.5 DATA INTEGRITY ISSUES

2.5.1 ABS 2006 CENSUS DATA

Random numbers are allocated in small cell responses in ABS Census data and this may lead to some variance in total responses in the various tables utilising ABS Census data contained below.

ABS Census data for people listed as born in South Eastern Europe nfd. was also included for the Southeastern European group because some steering committee representatives indicated that their Census data was greatly underrepresented and some of them may be included in this more generic listing for country of birth. This was the only Census listing for nfd. which had significant numbers in it.

The Coober Pedy community stood out as having issues with the ABS Census figures. This came out both through the consultation process and at a consultation meeting in Adelaide of current and past workers from Coober Pedy with staff from OFTA. Based on our consultation we believe that the Coober Pedy Census data is substantially lower than actual resident numbers.

2.5.2 QUESTIONNAIRE RESPONSES

Some questionnaire respondents misinterpreted the question on whether or not they needed assistance with various activities. They indicated that they are currently receiving help but did not indicate that they needed a particular type of help.

This led to both underestimates of the levels of need for particular services and levels of unmet need and for this reason data should be taken as indicative of trends rather than precise levels of need.

We have not analyzed individual questionnaires to gauge the extent of this underestimate.

Some questionnaire respondents did not identify as carers when they were undertaking a caring role. For some respondents the term ‘carer’ is still a poorly understood term. The carer responses may be higher than indicated.

It was clear from community consultations in both metropolitan and regional South Australia that communities vary in their expectation of receiving help. Some communities are more self reliant and have low expectations of receiving help and some want any help to come from their families. People who fall into these two categories may have

underestimated their need for help as they are unaware of the value of small amounts of regular help in helping them maintain their life at home.

Some are reluctant to identify their need for help because they do not want to go into residential care. It is our view that the lack of any identifying data on questionnaires kept this issue to a minimum.

People's self-reported perception of their health varied greatly with some people who had major health complaints and/or multiple health complaints still indicating that their health was quite good.

2.6 PROJECT BENEFITS TO DATE

- The Croatian Care for the Aged Inc. identified a need for outreach work through the consultation process and information provided at the steering committee meetings on demographic data. They have applied for HACC funding to commence an outreach program.

- The briefing of members of all four steering committees on the regional consultation findings has helped to build awareness amongst metropolitan communities of their needs.

- Community groups in Coober Pedy, Whyalla and Port Lincoln all identified the need for a local multicultural community worker.

- A consultation meeting which included OFTA staff and current and past workers from Coober Pedy helped provide OFTA with a clearer overview of the complex issues faced by Coober Pedy residents and the multiple challenges which they are confronted with.

- Regional community members from a diverse range of cultural backgrounds (including the target group of the Emerging Needs Scoping Study) were made aware of HACC services at community meetings and community organisations which may be able to assist them.

- Discrepancies in ABS 2006 Census data for Coober Pedy were identified.

- The Coober Pedy consultation meeting with current and past workers identified a possible model of linking school children to the Coober Pedy Multicultural forum to teach CALD seniors computer skills.

3 COMMUNITY OVERVIEW

3.1 REGIONAL DISTRIBUTION OF ENSS COUNTRIES

1355 South Australians living in regional South Australia and aged 50 years and over were born in the Emerging Needs Scoping Study (ENSS) designated countries of birth (Middle Eastern and North African Group : Egypt, Lebanon and Syria; Spanish Speaking Group : Spain, Argentina, Bolivia, Chile, Colombia, Ecuador, El Salvador, Paraguay, Peru, Uruguay and Venezuela; Southeastern European Group: Bosnia and Herzegovina, Croatia, Serbia, Former Yugoslav Republic of Macedonia (FYROM) and Bulgaria and South East Asian Group: Vietnam, Cambodia, Indonesia, Malaysia and Philippines) at the last Census. Census data from South Eastern Europe nfd. was also included for the Southeastern European group because some steering committee representatives from this group indicated that their Census data was greatly underrepresented and some of them may be included in this more generic listing for country of birth. This was the only census listing for nfd. which had significant numbers in it which is why the same process has not been followed for the Middle East and North African group which also indicated that their Census data is too low. Six hundred of these people were aged 65 and over at the 2006 Census with the largest group located in Whyalla.

Many of the people born in these countries are scattered in small groups across a number of local government areas. The 2006 Census did not list any people aged 50 and over born in Syria, Paraguay, Peru, Venezuela, Ecuador living in regional SA and there were low numbers from Lebanon and Egypt with the largest grouping of Lebanese in Berri Bamera LGA. The largest group of people born in Spain was in Whyalla (i.e. 48 people aged 50 and over, 36 aged 65 and over). Whyalla also has people born in Chile and Argentina.

The three largest regional groups are from Croatia (377), Southeastern European nfd. (247) and the Philippines (264). The group from the Philippines is younger than those from Croatia or Southeastern European nfd.

Of the 1355 people in the Emerging Needs Scoping Study living in regional SA at the 2006 Census the group from Southeastern European with 751 people is the largest group and represents 55% of all those aged 50 and over in these four groups living in regional SA – see Table 1.

Some of those from Indonesia may be Dutch speaking and as there has recently been a study of the ageing needs of the Dutch community OFTA made a decision during the project to exclude these from the study.

TABLE 1 COUNTRY OF BIRTH AND AGE DISTRIBUTION OF SOUTH AUSTRALIANS BORN IN DESIGNATED ENSS COUNTRIES AND LIVING IN REGIONAL SOUTH AUSTRALIA 2006 CENSUS DATA

Country of Birth	50-54 years	55-59 years	60-64 years	65-69 years	70-74 years	75-79 years	80-84 years	85-89 years	90 and over	50-64 years	65-79 years	80 and over	Total 50 years and over
Middle Eastern and North African													
Egypt	6	6	6	7	7	3	0	4	0	18	17	4	39
Lebanon	3	0	0	0	9	4	0	0	0	3	13	0	16
Syria	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	9	6	6	7	16	7	0	4	0	21	30	4	55
Spanish Speaking Group													
Spain	12	6	15	21	18	9	3	0	0	33	48	3	84
Argentina	3	9	3	9	0	0	0	0	0	15	9	0	24
Bolivia	3	0	0	0	0	0	0	0	0	3	0	0	3
Chile	3	9	3	3	0	0	0	0	0	15	3	0	18
Colombia	3	0	0	0	0	0	0	0	0	3	0	0	3
Ecuador	0	0	0	0	0	0	0	0	0	0	0	0	0
El Salvador	3	0	0	0	0	0	0	0	0	3	0	0	3
Paraguay	0	0	0	0	0	0	0	0	0	0	0	0	0
Peru	0	0	0	0	0	0	0	0	0	0	0	0	0
Uruguay	0	0	6	0	0	0	0	0	0	6	0	0	6
Venezuela	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	27	24	27	33	18	9	3	0	0	72	60	9	141
South East European Group													
South East European nfd.	40	30	26	53	38	38	18	4	0	96	129	22	247
Bosnia and Herzegovina	6	9	12	6	3	3	0	0	0	27	12	0	39
Croatia	42	53	77	115	52	23	12	3	0	172	190	15	377
Serbia	12	15	6	12	6	3	0	0	0	33	21	0	54
Former Yugoslav Republic of Macedonia (FYROM)	6	3	3	0	6	0	0	0	0	12	6	0	18
Bulgaria	0	0	12	0	0	4	0	0	0	12	4	0	16
Total	106	110	136	186	105	71	30	7	0	352	362	37	751
South East Asian Group													
Vietnam	8	23	3	4	0	0	0	0	0	34	4	0	38
Cambodia	3	0	0	0	0	0	0	0	0	3	0	0	3
Indonesia	14	3	0	6	11	0	3	0	0	17	17	3	37
Malaysia	19	11	7	16	4	6	0	3	0	37	26	3	66
Philippines	106	73	34	35	6	0	4	3	3	213	41	10	264
Total	150	110	44	61	21	6	7	6	3	304	88	16	408
All 4 groups	292	250	213	287	160	93	40	17	3	755	540	60	1355

3.2 LOCAL GOVERNMENT AREA

Only 12 regional Local Government areas had 40 or more people aged 50 and over from the ENSS countries of birth. The five largest concentrations were in Whyalla, Coober Pedy, Port Lincoln, Berri and Bamera (DC) and Mount Gambier. These five Local Government Areas accounted for 45% of all people born in the designated countries aged 50 and over at the 2006 Census living in regional South Australia –see Table 2. There were only 3 people aged 90 years and over at the 2006 Census.

ABS 2006 data did not indicate that anyone aged 50 and over born in any of the designated ENSS countries lived in the following Local Government Areas: Elliston (DC); Flinders Ranges (DC); Kimba (DC); Maralinga Tjarutja (AC); Naracoorte and Lucindale (DC); Orroroo/Carrieton (DC); Streaky Bay (DC) or Tumby Bay (DC).

TABLE 2: LOCAL GOVERNMENT DISTRIBUTION OF SOUTH AUSTRALIANS BORN IN DESIGNATED ENSS COUNTRIES 2006 CENSUS DATA

Local Government Areas	50-54 years	55-59 years	60-64 years	65-69 years	70-74 years	75-79 years	80-84 years	85-89 years	90 years and over	50-64 years	65-79 years	80 years and over	Total 50 years and over
Alexandrina DC)	17	6	6	10	3	3	3	4	0	29	16	7	52
Anangu Pitjantjatjara (AC)	0	0	3	4	0	0	0	0	0	3	4	0	7
Barossa (DC)	3	3	4	0	9	0	3	0	0	10	9	3	22
Barunga West (DC)	4	0	0	3	0	0	0	0	0	4	3	0	7
Berri and Barmera (DC)	8	15	3	15	24	17	6	0	0	26	56	6	88
Ceduna (DC)	3	3	0	0	3	3	0	0	0	6	6	0	12
Clare and Gilbert Valleys (DC)	8	3	0	0	0	3	0	0	0	11	3	0	14
Cleve (DC)	0	3	3	0	0	0	0	0	0	6	0	0	6
Coober Pedy (DC)	14	25	37	22	11	3	3	0	0	76	36	3	115
Copper Coast (DC)	0	3	3	3	0	3	3	0	0	6	6	3	15
Franklin Harbour DC)	0	0	0	0	4	0	0	0	0	0	4	0	4
Goyder (DC)	0	0	0	7	0	0	0	0	0	0	7	0	7
Grant (DC)	6	0	3	3	0	0	0	0	0	9	3	0	12
Kangaroo Island (DC)	0	3	3	0	0	0	0	0	0	6	0	0	6
Karoonda East Murray (DC)	4	0	0	0	0	0	0	0	0	4	0	0	4
Kingston (DC)	0	0	0	3	0	0	0	0	0	0	3	0	3
Le Hunte (DC)	0	0	0	4	0	0	0	0	0	0	4	0	4
Light (RegC)	9	6	0	10	0	3	0	0	0	15	13	0	28
Lower Eyre Peninsula (DC)	0	3	0	0	0	0	3	0	0	3	0	3	6

Table 2 continued													
Local Government Areas	50-54 years	55-59 years	60-64 years	65-69 years	70-74 years	75-79 years	80-84 years	85-89 years	90 years and over	50-64 years	65-79 years	80 years and over	Total 50 years and over
Loxton Waikerie (DC)	6	7	3	5	0	0	0	0	0	16	5	0	21
Mallala (DC)	15	4	6	3	6	3	0	3	0	25	12	3	40
Mid Murray (DC)	3	7	0	3	0	0	0	0	0	10	3	0	13
Mount Barker (DC)	17	16	6	3	12	3	3	0	0	39	18	3	60
Mount Gambier (C)	16	12	11	15	4	6	0	0	0	39	25	0	64
Mount Remarkable (DC)	0	3	0	0	3	0	0	0	0	3	3	0	6
Murray Bridge (RC)	8	10	16	6	0	0	4	0	0	34	6	4	44
Northern Areas (DC)	3	0	3	3	0	3	0	0	0	6	6	0	12
Peterborough (DC)	3	0	0	6	0	0	0	0	3	3	6	3	12
Port Augusta (C)	6	3	7	12	7	0	0	0	0	16	19	0	35
Port Lincoln (C)	22	17	19	15	18	6	3	3	0	58	39	6	103
Port Pirie City and Dists (M)	13	0	3	23	3	0	0	0	0	16	26	0	42
Renmark Paringa (DC)	12	19	6	5	3	3	0	0	0	37	11	0	48
Robe (DC)	0	0	0	0	4	0	0	0	0	0	4	0	4
Roxby Downs (M)	7	0	0	0	0	0	0	0	0	7	0	0	7
Southern Mallee (DC)	0	0	3	3	0	0	0	0	0	3	3	0	6
Tatiara (DC)	3	5	0	3	0	0	0	3	0	8	3	3	14
The Coorong (DC)	9	5	0	0	0	0	0	0	0	14	0	0	14
Victor Harbor (C)	15	9	3	0	3	7	0	0	0	27	10	0	37
Wakefield (DC)	0	7	0	3	0	0	0	0	0	7	3	0	10
Wattle Range (DC)	3	3	6	11	0	7	0	0	0	12	18	0	30
Whyalla (C)	44	29	37	65	33	17	9	4	0	110	115	13	238
Yankalilla (DC)	0	0	3	0	4	0	0	0	0	3	4	0	7
Yorke Peninsula (DC)	18	12	9	10	0	3	0	0	0	19	13	0	42
SA Unincorporated	3	9	7	9	6	0	0	0	0	19	15	0	34
Total	292	250	213	287	160	93	40	17	3	755	540	60	1355

3.3 LIVING ALONE

There were 323 people aged 50 and over born in the ENSS designated countries of birth who lived alone in regional South Australia at the last Census – see Table 3. 178 of these people were aged 65 and over at the 2006 Census. The largest concentration is located in Whyalla which had 21% and Coober Pedy with 17%. Based on feedback in Coober Pedy during the consultations there may be additional people who have chosen not to complete the Census form consequently, those living alone may be greater than what the Census figures indicate.

TABLE 3: LOCAL GOVERNMENT DISTRIBUTION OF SOUTH AUSTRALIANS BORN IN DESIGNATED ENSS COUNTRIES WHO LIVED ALONE IN REGIONAL SA 2006 CENSUS DATA

Local Government Areas	50-64 years	65-79 years	80 years and over	Total 50 years and over	Local Government Areas	50-64 years	65-79 years	80 years and over	Total 50 years and over
Alexandrina (DC)	0	3	0	3	Murray Bridge (RC)	6	0	0	6
Anangu Pitjantjatjara (AC)	0	3	0	3	Northern Areas (DC)	0	3	0	3
Barossa (DC)	0	4	3	7	Peterborough (DC)	0	6	0	6
Barunga West (DC)	0	3	0	3	Port Augusta (C)	3	3	0	6
Berri and Barmera (DC)	0	15	3	18	Port Lincoln (C)	6	6	3	15
Ceduna (DC)	3	3	0	6	Port Pirie City and Districts (M)	3	6	0	9
Clare and Gilbert Valleys (DC)	3	0	0	3	Renmark Paringa (DC)	3	6	0	9
Cleve (DC)	6	0	0	6	Southern Mallee (DC)	3	3	0	6
Coober Pedy (DC)	35	21	0	56	The Coorong (DC)	6	0	0	6
Copper Coast (DC)	0	3	0	3	Victor Harbor (C)	3	0	0	3
Kangaroo Island (DC)	3	0	0	3	Wakefield (DC)	3	0	0	3
Lower Eyre Peninsula (DC)	0	0	3	3	Wattle Range (DC)	3	0	0	3
Mallala (DC)	3	0	0	3	Whyalla (C)	23	42	3	68
Mid Murray (DC)	3	3	0	6	Yorke Peninsula (DC)	7	3	0	10
Mount Barker (DC)	12	12	0	24	SA Unincorporated	8	6	0	14
Mount Gambier	3	12	0	15	Total	145	163	15	323

166 of those living alone were aged between 65 and 79 years and only 15 were aged 80 years and over – see Table 4. It is likely that as the cohort aged 65-79 years ages that demand for services from this group will increase. The 3 largest groups of those meeting the ENSS criteria living alone in regional South Australia were from Croatia, the Philippines and Southeastern Europe.

The 2006 ABS Census data did not identify anyone living alone in regional SA aged 50 years and over who was born in Syria, Bolivia, Colombia, Ecuador, El Salvador, Paraguay, Peru, Venezuela, Vietnam or Cambodia.

TABLE 4: COUNTRY OF BIRTH AND AGE DISTRIBUTION OF SOUTH AUSTRALIANS LIVING ALONE IN REGIONAL SA BORN IN DESIGNATED ENSS COUNTRIES 2006 CENSUS DATA

Country of Birth	50-64 years	65-79 years	80 years and over	50 years and over
Egypt	6	6	0	12
Lebanon	0	6	0	6
Total Middle East and North African group	6	12	0	18
Spain	6	11	0	17
Argentina	0	3	0	3
Chile	6	3	0	9
Uruguay	3	0	0	3
Total Spanish Speaking Group	12	20	0	32
Southeast European nfd.	27	40	6	73
Bosnia and Herzegovina	6	3	0	9
Croatia	31	52	6	89
Serbia	9	9	0	18
Former Yugoslav Republic of Macedonia (FYROM)	3	0	0	3
Bulgaria	6	3	0	9
Total Southeast European Group	82	107	12	201
Indonesia	3	3	3	9
Malaysia	9	3	0	12
Philippines	30	21	0	51
Total South East Asian Group	42	27	3	72
Total all 4 groups	145	163	15	323

Older South Australians living alone who may also face difficulties accessing services because of language and/or cultural issues are at risk of not accessing the services they need and may need extra assistance to do so particularly, if as in Coober Pedy, they lack family members living locally.

4 COMMUNITY RESPONSES

4.1 QUESTIONNAIRE RESPONDENTS

In total 155 community members completed questionnaires in regional South Australia. 67 of these were excluded from the sample because they did not meet the criteria for the Emerging Needs Scoping Study.

This left 88 core respondents who formed the basis of the following analysis – see Table 5. 5). In order not to identify individuals and maintain confidentiality as promised during the consultation, the questionnaire analysis has been cumulated to the age group level and separate results are not given for individual regional areas or ethno specific groups. Data for the 29 carers who responded has been cumulated to two age brackets. In some instances carers' results are reported on twice, both in the general table and in the notes on carers.

TABLE 5: OVERVIEW OF ALL QUESTIONNAIRE RESPONDENTS

Age in years	ENSS carers	ENSS non carers	Respondents outside of study parameters	Total questionnaire respondents
25-49 years	3		37	40
50-64 years	18	23	13	54
65-79 years	24	7	11	42
80 years and over	1	12	6	19
Total	46	42	67	155

95% of those aged under 50 years (i.e. 35 people) who were excluded because they were not carers came from the Philippines. The respondents over 50 years who were excluded from the analysis because they did not meet the criteria for this study came from Australia, Austria, England, Germany, Poland, Switzerland, Netherlands, Greece, Italy, Montenegro, Burma, Greece, Latvia and Czechoslovakia.

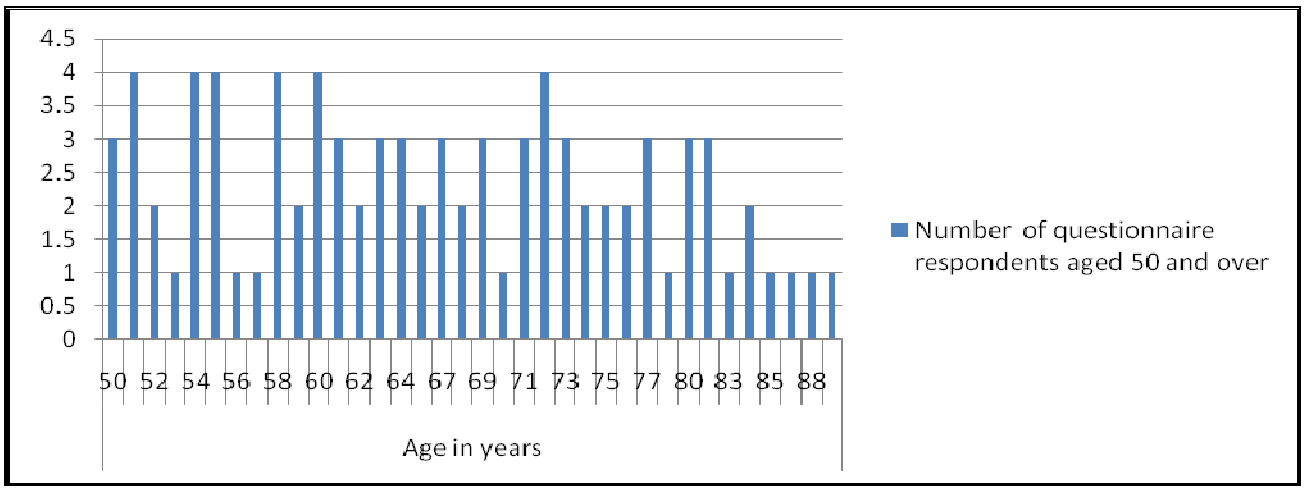
The largest group of results came from Whyalla which also had 18% of those born in ENSS designated countries aged 50 and over in regional South Australia according to 2006 Census data – see Table 6.

TABLE 6: GEOGRAPHIC LOCATION

Age in years	Coober Pedy	Mt Gambier	Murray Bridge	Port Lincoln	Riverland	Whyalla	Total
25-49 years	1		1		1		3
50-64 years	5	2	6	8	8	12	41
65-79 years	4	3	2	9	3	10	31
80 years and over	5	1	0	0	3	4	13
Total	14	6	8	17	14	26	88

As Figure 2 shows quite a lot of younger community members participated in this survey. This reflects the nature of CALD or multicultural community groups which have a wider age distribution.

FIGURE 2: AGE DISTRIBUTION



87% of the questionnaires were completed by the person themselves – see Table 7.

TABLE 7: STATUS OF PERSON COMPLETING QUESTIONNAIRES

	25-49 years	50-64 years	65-79 years	80 years and over	Total
Answering for self	2	34	29	10	75
Answering for family member	0	7	2	3	12
No answer	1	0	0	0	1
Total	3	41	31	13	88

67% of respondents were female and 32% were male. This is skewed however, by the high percentage of female respondents aged under 65. This trend was more pronounced amongst the carers who responded with 72% of carers being female. In the age bracket 65-79 the gender split was more even – see Table 8.

TABLE 8: GENDER

	25-49 years	50-64 years	65-79 years	80 years and over	Total
Male		10	14	4	28
Female	3	31	16	9	59
No answer		0	1	0	1
Total	3	41	31	13	88

Quite a number of carers and younger respondents were on a pension - see Table 9. At every community meeting people indicated that they were prepared to pay a contribution for services particularly at current HACC contribution rates.

TABLE 9: PERCENTAGE OF RESPONDENTS ON A PENSION

25 -49 years	50-64 years	65-79 years	80 years and over
55%	39%	94%	100%

The largest group of respondents was born in the Philippines and this group comprised over 44% of the core respondents –see Table 10. In total, including the Filipino questionnaires which were discounted because they were younger and not carers, 74 Filipinos responded to the regional surveys and they were also the largest group represented at community meetings. At a later stage as the Filipino community ages it may need outreach work from a metropolitan based Filipino worker.

The four largest groups of questionnaire respondents who met the ENSS criteria were born in the Philippines, Croatia, Spain and Lebanon – see Table 10.

TABLE 10: COUNTRY OF BIRTH

Country of birth	25-49 years	50-64 years	65-79 years	80 years and over	Total
Philippines	3	27	8	1	39
Croatia		4	10	4	18
Spain		2	5	3	10
Lebanon		2	2	3	7
Serbia		2	1	1	4
Macedonia		0	2	0	2
Ecuador		1	0	0	1
Macedonia		1	0	0	1
Bosnia		1	0	0	1
Holland		1	0	0	1
Chile		0	1	0	1
Yugoslavia		0	1	0	1
Austria		0	0	1	1
No answer		0	1	0	1
Total	3	41	31	13	88

Respondents primarily identified themselves by their country of birth however 10% did identify as Australian, Croatian Australian or Filipino Australian. Some Filipinos speak Spanish as one also identified as Filipino Spanish – see Table 11.

TABLE 11: HOW QUESTIONNAIRE RESPONDENTS IDENTIFY THEMSELVES

	25-49 years	50-64 years	65-79 years	80 years and over	Total
Australian		3	2	0	5
Chilean		0	1	0	1
Croatian		4	7	1	12
Croatian Australian		0	1	1	2
Croatian Italian		0	0	1	1
Ecuadorian		1	0	0	1
Filipino	3	24	8	1	36
Filipino Australian		2	0	0	2
Filipino Spanish		1	0	0	1
Lebanese		0	2	2	4
Macedonian		0	2	0	2
Serbian		3	0	2	5
Spanish		2	4	3	9
No answer		1	4	2	7
Total	3	41	31	13	88

4.1.1 CARERS

29 carers (i.e. one third of respondents) responded to the questionnaire. Their ages ranged from 38 years to 83 years of age. 21 were under 65 years of age and 8 were aged 65 years or over. 21 of the carers were female and 8 were males - see Table 12.

59% of all carers who responded were born in the Philippines.

TABLE 12: AGE PROFILE OF CARERS

	25-49 years	50-64 years	65-79 years	80 years and over
Percentage of carers responding in this age category	10%	62%	21%	7%

62% of all carers who responded said that they were caring 24/7 and over one third of these carers were aged 50 to 64 years of age – see Table 13.

TABLE 13: HOURS SPENT CARING

Hours spent caring	Percentage of carers in age group				
	25-49 years	50-64 years	65-79 years	80 years and over	Total
1-10 hours		10%		3%	13%
11-20 hours		0%	7%		7%
21-30 hours		5%			5%
31-40 hours					
24/7	10%	34%	14%	3%	62%
No answer		3%			3%

4.2 COMMUNICATION ISSUES

17% of questionnaire respondents had low functional spoken English - see Table 14 and 22% had problems reading English - see Table 15.

TABLE 14: ABILITY TO SPEAK ENGLISH

	25-49 years	50-64 years	65-79 years	80 years and over	Total
Not at all		1	0	2	3
A little		1	7	4	12
Well	2	18	20	4	44
Very well	1	19	4	3	27
No answer		1	0	0	1

TABLE 15: ABILITY TO READ ENGLISH

	25-49 years	50-64 years	65-79 years	80 years and over	Total
Not at all		0	2	5	7
A little		1	10	1	12
Well	2	15	17	3	37
Very well	1	23	1	4	29
No answer		0	0	0	0

63 % of questionnaire respondents said that they spoke English at home. 75% said that they spoke another language at home, with 44% speaking only one of the designated ENSS languages and nearly one third speaking two languages - see Table 16.

Communication issues did emerge as an issue in meetings where the need for interpreters was evident and in questionnaire responses where people needed assistance with communication, letter writing and dealing with Government Agencies. It may be that whilst people's English skills are adequate for tasks such as shopping for complex issues such as legal issues or important medical issues they need the assistance of an interpreter or a family member.

TABLE 16: LANGUAGES SPOKEN AT HOME

Language spoken at home	25-49 years	50-64 years	65-79 years	80 years and over	Total
English	3	32	14	7	56
Croatian		3	11	2	16
Filipino	2	8	2	1	13
Spanish		2	6	3	11
Serbian		3	2	2	7
Arabic		2	2	2	6
Tagalog		4	2	0	6
Macedonian		1	2	0	3
Ilokano (Filipino dialect)		2	0	0	2
Dutch		1	0	0	1
Visaya (Filipino dialect)		1	0	0	1

Communities utilised a variety of sources for information including the radio and word of mouth followed by family members, Centrelink, Doctors and Community Health Centres - see Table 17. During the regional consultations many communities indicated that they relied on their children both locally and intra state to support them with information. In both Pt. Lincoln and Coober Pedy the Multicultural Forums were utilised for information support.

In Whyalla many people who attended the consultations were unsure of where to go for help Ethnic Link was not known by the Spanish or Filipino communities in the region. The Spanish community who attended the consultation used to get information from the Spanish club or the Multicultural Forum worker. Both of these options are no longer available to the community.

TABLE 17: CURRENT SOURCES OF INFORMATION

	Coober Pedy	Mt. Gambier	Murray Bridge	Pt. Lincoln	Riverland	Whyalla
Radio	√		√	√	√	
Television	√				√	
Internet	√		√		√	
Local newspaper	√		√			
Satellite television	√					
Druze directory				√		
Telephone directory						√
Centrelink newsletters	√				√	
Newsletters					√	
Information sessions			√			
Family	√		√	√[1]		
Friends				√		√
Word of mouth	√		√	√		√
Community groups		√				
Coober Pedy Multicultural Forum	√					
Pt. Lincoln Multicultural Communities Council				√		
Centrelink			√	√		√
Families SA	√					√
Doctor			√	√		√
Council					√	√
Police				√		
Hospital				√		√
West Coast Community Service				√		
Community Health Centre	√		√	√		
Flinders Lodge				√		
Flinders Home for the Aged				√		
Not for profit Agencies		√				
Counselling service						√

Communities indicated that they preferred to receive information in two languages English and their home language, as many children were not fluent in their home language - see Table 18. They also preferred to receive information in brochures/pamphlets and most communities highlighted the value of the Centrelink newsletter - see Table 18. In Coober Pedy, Pt. Lincoln and Whyalla communities mentioned that when the Forums were staffed they had regularly organised information sessions for the community to attend. In every community there were some people who were happy to have information in English.

[1] It was a problem for people in the area who no longer had children or family members

TABLE 18: PREFERRED SOURCES FOR INFORMATION

Preferred sources	Coober Pedy	Mt. Gambier	Murray Bridge	Pt. Lincoln	Riverland	Whyalla
Telephone	√					
Word of mouth	√					
Radio				√		√
Verbally as reading can be a problem	√					
Pamphlets/ brochures	√	√		√[2]	√[3]	
Mail	√		√			
COTA seniors newsletter	√					
Centrelink newsletter	√	√		√		
Doctors		√		√		√
Centrelink						√
Diabetes Australia		√				
Carers SA		√				
Newspapers		√		√		
Ethno specific outreach worker		√		√		
Post office				√		
Council				√		
English and other language spoken (bi-lingual)	√	√		√	√[4]	√
Multicultural Forum	√			√	√	√
Internet					√	
Filipino Club			√			
Probus				√		
Hospital				√		
Community Health				√		
Television				√		
Newsletter				√		

[2] Community groups in Pt. Lincoln wanted information sent to Pt. Lincoln MCC, Croatian Club, Hellenic Club, Filipino Club and Women's Monthly group.
[3] The Lebanese community wanted information forwarded to key Druze contact for distribution to their community
[4] The Lebanese community wanted information in Arabic and English even though they said that most of the community speaks English

4.3 HEALTH ISSUES

Over 30% of all respondents said that their health was poor or quite poor - see Table 19.

TABLE 19: SELF REPORTED HEALTH STATUS

	50-64 years	65-79 years	80 years and over	Total
Very poor	1	0	4	5
Quite poor	8	9	5	22
Quite good	22	20	4	46
Very good	6	2	0	8
Cannot say	4	0	0	4
No answer	0	0	0	0
Total	41	31	13	85

27% of carers said that there health was quite poor with the majority of those aged 65 or over reporting that there health was quite poor. Due to the low number of carers aged 25-49 years who responded to the questionnaire their health issues are not reported on separately but are part of the cumulated date for carers aged 25-64 years see Table 20.

TABLE 20: SELF REPORTED HEALTH STATUS OF CARERS

	Carers aged 25 - 64	Carers aged 65 and over	Total
Very poor	0	0	0
Quite poor	3	5	8
Quite good	10	2	12
Very good	5	1	6
Cannot say	3	0	3
Total	21	8	29

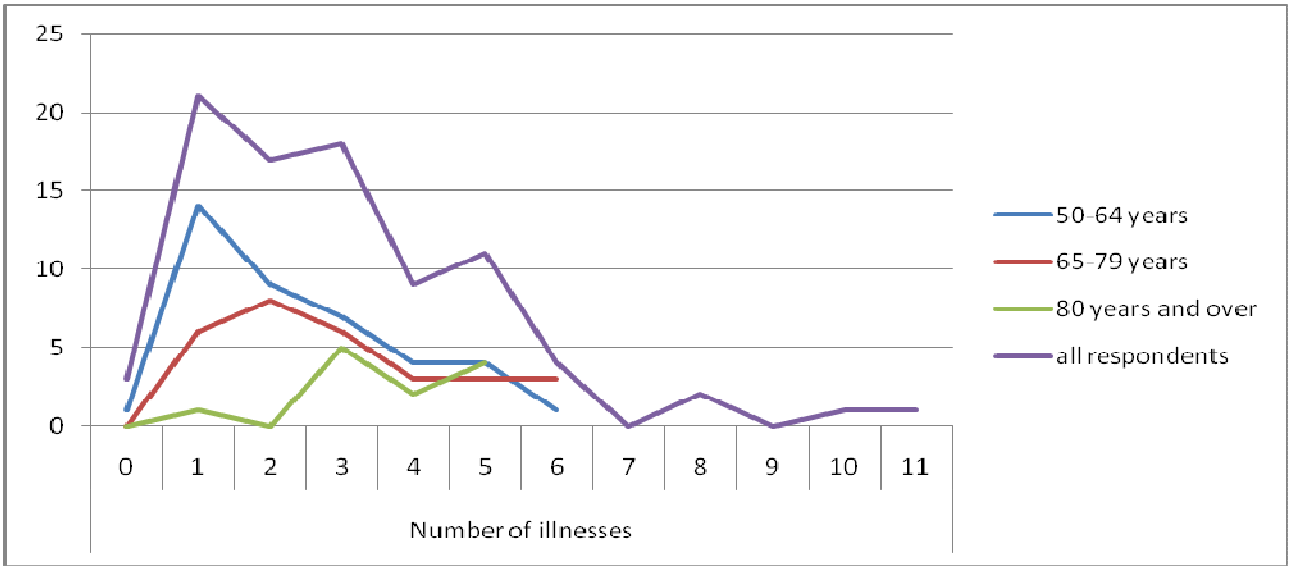
High blood pressure, arthritis, diabetes and back or neck problems were an issue for all age groups aged 50 years and over, with 42% of respondents reporting that they have high blood pressure and 37% that they have arthritis – see Table 21.

TABLE 21: SELF REPORTED HEALTH COMPLAINTS

Health complaint	50-64 years	65-79 years	80 years and over	Total
High blood pressure	14	19	4	37
Arthritis	11	13	9	33
Diabetes	12	8	5	25
Back or neck	13	9	2	24
Vision	6	9	3	18
Hearing	7	5	5	17
Fatigue	8	7	1	16
Mobility	2	4	6	12
Heart	5	6	0	11
Memory	5	1	3	9
Stress	6	2	1	9
Osteoporosis	2	2	3	7
Depression	2	4	0	6
Cancer	2	2	1	5
Anxiety	1	1	1	3
Stroke	0	0	3	3
Other- asthma	0	3	0	3
Physical impairment	1	1	0	2
Other- Kidney	0	2	0	2
Other-lungs	0	2	0	2
Other- hips	0	1	1	2
Dementia	0	0	1	1
Other psychological	0	0	1	1
Other -liver	1	0	0	1
Other- coughs	0	1	0	1
Other-spinal	0	0	1	1
Other-ulcer	0	0	1	1
Multiple sclerosis	0	0	0	0
Parkinson's disease	0	0	0	0
Post Traumatic Stress Disorder	0	0	0	0
Other	2	1	0	3
No answer	6	1	0	7

33% of all respondents aged 50 years and over said that they had four or more health complaints - see Figure 3.

FIGURE 3: NUMBER OF HEALTH COMPLAINTS



50 % of those born in Croatia had four or more health complaints as did 60% of those born in Spain –see Table 22.

TABLE 22: COUNTRY OF BIRTH OF RESPONDENTS REPORTING FOUR OR MORE HEALTH COMPLAINTS

Country of Birth	50-64 years	65-79 years	80 years and over	Total
Croatia	4	5		9
Philippines	4	2		6
Spain		3	3	6
Serbia	1			1
Yugoslavia		1		1
Ecuador	1			1
Holland	1			1
Lebanon			1	1
Austria			1	1
Total	11	11	5	27

The average number of health complaints increased with age with people aged 80 years and over having an average of 4 health complaints - see Table 23.

TABLE 23: AVERAGE NUMBER OF HEALTH COMPLAINTS

	50-64 years	65-79 years	80 years and over
Average number of health complaints	2.6	3.4	4

Over 50% of carers reported that they had high blood pressure. Back or neck problems which were the fourth highest health complaint of all respondents aged 50 years and over

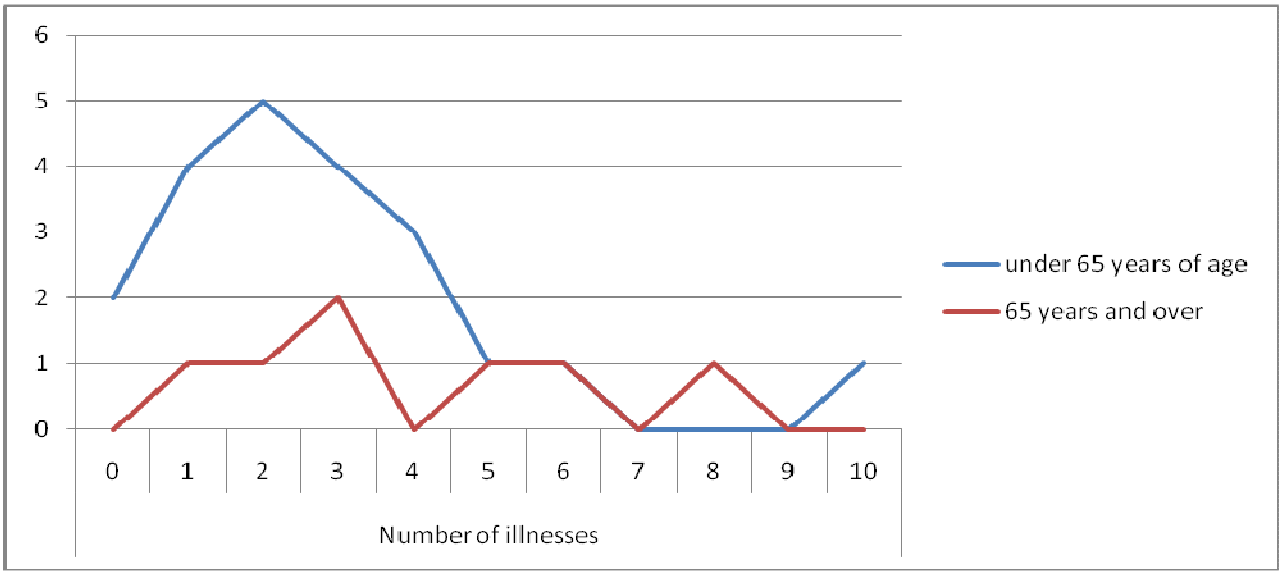
(27%) was the second highest health complaint reported by carers with 38% indicating that they had problems – see Table 24.

TABLE 24: SELF REPORTED HEALTH COMPLAINTS OF CARERS

	Carers aged 25-64	Carers aged 65 and over	Total
High blood pressure	10	5	15
Back or neck	8	3	11
Arthritis	5	4	9
Diabetes	4	2	6
Fatigue	5	1	6
Hearing	3	2	5
Heart	3	1	4
Memory	3	1	4
Mobility	1	3	4
Stress	4	0	4
Vision	3	1	4
Depression	3	0	3
Osteoporosis	2	1	3
Anxiety	2	0	2
Physical Impairment	1	1	2
Other asthma	2	0	2
Stroke	0	1	1
Other hips	0	1	1
Other ulcer	0	1	1

The average number of health complaints for all carers was 3 however 21 % of carers had five or more health complaints – see Figure 4.

FIGURE 4: NUMBER OF HEALTH COMPLAINTS OF CARERS



4.4 HELP NEEDED AND LEVEL OF UNMET NEED

The level of need for different types of assistance varies with age.

Out of the 41 respondents aged 50-64 years, 17 did not indicate that they needed any help and 27 respondents did not indicate that they were getting any help. 29% indicated that they needed help with house cleaning and house repairs. This was followed by 17% who needed help to use Government or other services and 12% who needed help with paperwork. This may be an indication of English language skills being sufficient for everyday use but not for more complex issues.

15% wanted someone to ring and check that they are ok and 12% wanted assistance to understand how to help the person they are caring for. Many respondents did indicate that they are getting assistance at present either formally or informally.

For respondents aged 50-64 years the three highest areas of unmet need are for house repairs, help to use Government or other services and assistance to understand how to help the person they are caring for – see Table 25.

Of the 31 respondents aged 65-79 years the top four areas of assistance needed are transport, house cleaning, paperwork and going to medical appointments. These were then followed by needing assistance going to other appointments, communication/language assistance and information about services and other help. This indicates that while many respondents have indicated that their English is reasonable they are still need assistance for more complex issues.

The top three areas of unmet need for respondents aged 65-79 years are assistance with information about services and other help, paperwork and transport - see Table 26.

Respondents aged 80 years and over had far higher levels of need and there were 12 areas in which over 30% of respondents indicated that they needed help. These were as follows: 77% required help with house cleaning; 46% required help to go to medical appointments; 38% required help with paperwork, transport and going to other appointments and 31% required help with gardening, taking medication, changing light bulbs banking, washing and ironing, lawn mowing and podiatry.

There were nine areas in which 15% of respondents aged 80 years and over indicated that they had unmet needs namely:

- house cleaning
- dishwashing
- gardening
- rubbish removal
- bathing
- dressing
- getting in and out of bed
- nursing care
- taking medication.

This age group had higher needs for personal care than the other age groups - see Table 27.

Some questionnaire respondents misinterpreted the question which asked whether or not they needed assistance with various activities. They indicated that they are currently receiving help but did not indicate that they needed a particular type of help.

This led to both underestimates of the levels of need for particular services and levels of unmet need and for this reason data should be taken as indicative of trends rather than precise levels of need.

TABLE 25: NEEDS ANALYSIS RESPONDENTS AGED 50 - 64 YEARS

Type of assistance needed	Need help	Receive help	Unmet need	% needing help	% unmet need
House repairs	12	6	6	29%	15%
Help to use government or other services	7	3	4	17%	10%
Understanding how to help person I am caring for	5	1	4	12%	10%
Someone ringing to check that I am ok	6	3	3	15%	7%
Paperwork	5	2	3	12%	7%
Podiatry	4	1	3	10%	7%
Counselling	4	1	3	10%	7%
Help to get to community activities	4	2	2	10%	5%
House cleaning	12	11	1	29%	2%
Occupational therapy	2	1	1	5%	2%
Going to medical appointments	5	4	1	12%	2%

Table 25 continued Type of assistance needed	Need help	Receive help	Unmet need	% needing help	% unmet need
Paying bills	4	3	1	10%	2%
Help to visit family	3	2	1	7%	2%
Home meal deliveries	3	2	1	7%	2%
Meal preparation	2	1	1	5%	2%
Wood chopping	1	0	1	2%	2%
Lawn mowing	5	5	0	12%	0%
Transport	5	5	0	12%	0%
Physiotherapy	3	3	0	7%	0%
Handyman work	2	2	0	5%	0%
Letter writing	2	2	0	5%	0%
Bathing	2	2	0	5%	0%
Moving about house	2	2	0	5%	0%
Toileting	1	1	0	2%	0%
Grooming	1	1	0	2%	0%
Advice on nutrition, food storage and preparation	1	1	0	2%	0%
Washing & ironing	4	5	-1	10%	-2%
Information about services and other help I can get	4	5	-1	10%	-2%
Rubbish removal	3	4	-1	7%	-2%
Shopping	3	4	-1	7%	-2%
Dishwashing	2	3	-1	5%	-2%
Changing light bulbs	2	3	-1	5%	-2%
Taking medication	2	3	-1	5%	-2%
Banking	1	2	-1	2%	-2%
Communication/language assistance	1	2	-1	2%	-2%
Dressing	1	2	-1	2%	-2%
Help to visit friends and neighbours	1	2	-1	2%	-2%
Eating	0	1	-1	0%	-2%
Speech therapy	0	1	-1	0%	-2%
Help with gardening	4	6	-2	10%	-5%
A nurse to help me change dressings, manage incontinence etc	1	3	-2	2%	-5%
Getting in and out of bed	0	2	-2	0%	-5%
Going to other appointments	2	6	-4	5%	-10%

TABLE 26: NEEDS ANALYSIS RESPONDENTS AGED 65 - 74 YEARS

Type of assistance needed	Need help	Receive help	Unmet need	% needing help	% unmet need
Information about services and other help I can get	8	1	7	26%	23%
Paperwork	10	4	6	32%	19%
Transport	14	8	6	45%	19%
House cleaning	12	7	5	39%	16%
Changing light bulbs	6	1	5	19%	16%
Handyman work	7	2	5	23%	16%
Letter writing	7	2	5	23%	16%
Communication/language assistance	8	3	5	26%	16%
Going to other appointments	8	4	4	26%	13%
Podiatry	6	2	4	19%	13%
Counseling	4	0	4	13%	13%
Help to use government or other services	6	2	4	19%	13%
Help to get to community activities	6	2	4	19%	13%
Home meal deliveries	5	1	4	16%	13%
Help with gardening	6	3	3	19%	10%
Going to medical appointments	10	7	3	32%	10%
Someone ringing to check I am ok	5	2	3	16%	10%
Physiotherapy	4	1	3	13%	10%
Understanding how to help person I am caring for	3	0	3	10%	10%
Washing &ironing	5	3	2	16%	6%
Paying bills	6	4	2	19%	6%
Shopping	6	4	2	19%	6%
Taking medication	4	3	1	13%	3%
Help to visit friends and neighbours	4	2	2	13%	6%
Lawn mowing	5	4	1	16%	3%
Rubbish removal	3	2	1	10%	3%
House repairs	6	5	1	19%	3%
Getting in and out of bed	1	0	1	3%	3%
Moving about house	1	0	1	3%	3%
A nurse to help me change dressings, manage incontinence etc	1	0	1	3%	3%
Help to visit family	3	2	1	10%	3%
Meal preparation	2	1	1	6%	3%
Advice on nutrition, food storage and preparation	1	0	1	3%	3%
Wood chopping	2	2	0	6%	0%
Eating	0	0	0	0%	0%

Table 26 continued Type of assistance needed	Need help	Receive help	Unmet need	% needing help	% unmet need
Bathing	3	3	0	10%	0%
Toileting	2	2	0	6%	0%
Dressing	2	2	0	6%	0%
Grooming	3	3	0	10%	0%
Speech therapy	0	0	0	0%	0%
Occupational therapy	0	0	0	0%	0%
Dishwashing	1	2	-1	3%	-3%
Banking	3	4	-1	10%	-3%

TABLE 27: NEEDS ANALYSIS RESPONDENTS AGED 80 YEARS AND OVER

Type of assistance needed	Need help	Receive help	Unmet need	% needing help	% unmet need
House cleaning	10	8	2	77%	15%
Dishwashing	2	0	2	15%	15%
Help with gardening	4	2	2	31%	15%
Rubbish removal	3	1	2	23%	15%
Bathing	3	1	2	23%	15%
Dressing	2	0	2	15%	15%
Getting in and out of bed	2	0	2	15%	15%
A nurse to help me change dressings, manage incontinence etc	3	1	2	23%	15%
Taking medication	4	2	2	31%	15%
Changing light bulbs	4	3	1	31%	8%
House repairs	2	1	1	15%	8%
Paperwork	5	4	1	38%	8%
Banking	4	3	1	31%	8%
Going to medical appointments	6	5	1	46%	8%
Going to other appointments	5	4	1	38%	8%
Toileting	1	0	1	8%	8%
Grooming	1	0	1	8%	8%
Physiotherapy	1	0	1	8%	8%
Counselling	1	0	1	8%	8%
Meal preparation	2	1	1	15%	8%
Washing & ironing	4	4	0	31%	0%
Lawn mowing	4	4	0	31%	0%
Wood chopping	0	0	0	0%	0%
Handyman work	2	2	0	15%	0%
Paying bills	3	3	0	23%	0%
Shopping	3	3	0	23%	0%
Someone ringing to check I am ok	2	2	0	15%	0%
Eating	1	1	0	8%	0%

Table 27 continued Type of assistance needed	Need help	Receive help	Unmet need	% needing help	% unmet need
Moving about house	0	0	0	0%	0%
Podiatry	4	4	0	31%	0%
Speech therapy	0	0	0	0%	0%
Occupational therapy	1	1	0	8%	0%
Transport	5	5	0	38%	0%
Help to visit friends and neighbours	1	1	0	8%	0%
Understanding how to help person I am caring for	0	0	0	0%	0%
Home meal deliveries	1	1	0	8%	0%
Advice on nutrition, food storage and preparation	0	0	0	0%	0%
Information about services and other help I can get	2	3	-1	15%	-8%
Letter writing	0	2	-2	0%	-15%
Help to use government or other services	1	3	-2	8%	-15%
Help to visit family	0	2	-2	0%	-15%
Communication/language assistance	1	4	-3	8%	-23%
Help to get to community activities	0	3	-3	0%	-23%

Carers had different priorities to the other respondents. 41% percent needed help with house cleaning, 28%with using Government or other services and transport and 24% with paperwork, house repairs and going to medical appointments.

Carers top three unmet needs were for: assistance to understand how to help the person they are caring for, podiatry and counselling see Table 28.

TABLE 28: CARERS UNMET NEEDS

Type of assistance needed	% of unmet need
Understanding how to help person I am caring for	17%
Podiatry	14%
Counseling	14%
House cleaning	10%
Paperwork	10%
Help to use Government or other services	10%
Home meal deliveries	10%
Physiotherapy	7%
Wood chopping	3%
Help going to medical appointments	3%
Occupational therapy	3%
Transport	3%
Help to get to community activities	3%

4.5 CHANGES TO HOME

38% of all respondents said that they needed some modifications to their home to make it safer or more accessible for them to live in.

The type of assistance needed varied by age. The highest priority for respondents aged 50-64 years was for hand rails and shower rails. The highest priority for respondents aged 65-79 years was for emergency alarms and for those aged 80 years and over it was for ramps - see Table 29.

Carers required more assistance with 48% of carers indicated that they needed modifications.

TABLE 29: HOME MODIFICATIONS REQUIRED

Home modification	50-64 years	65-79 years	80 years and over
Hand rails	22%	29%	23%
Ramps	7%	13%	31%
Shower rails	22%	19%	15%
Emergency alarms	20%	32%	15%
Other	2%	3%	0%

The most popular modification required by carers was handrails followed by shower rails and then emergency alarms. 17% indicated that they needed ramps - see Table 30.

TABLE 30: HOME MODIFICATIONS REQUIRED BY CARERS

	Carer aged 25-64 years	Carers aged 65 years and over	All carers
Hand rails	28%	50%	41%
Ramps	10%	25%	17%
Shower rails	24%	25%	31%
Emergency alarms	21%	25%	28%

4.6 PERSONAL CARE

One third of all respondents required assistance with transport and respondents in all age groups required assistance with the cleaning of linen (a service which is still offered in regional South Australia). Mobility is an issue with nearly a quarter of respondents aged 80 years and over needing a walking frame and 15% requiring a wheel chair - see Table 31.

TABLE 31: PERSONAL CARE REQUIRED

Type of assistance needed	50-64 years	65-79 years	80 years and over	50 years and over
Transport	20%	42%	54%	33%
Cleaning of linen	17%	10%	15%	14%
Meal deliveries to home	12%	10%	8%	11%
Walking frame	7%	10%	23%	11%
Wheelchair	7%	3%	15%	7%
Aids	12%	3%	0%	7%
Incontinence pads	7%	3%	8%	6%

The two highest needs for carers were for transport assistance and cleaning of linen. 10% of carers required meal deliveries and mobility aids - see Table 32.

TABLE 32: PERSONAL CARE REQUIRED BY CARERS

Type of assistance needed	Carers 25-64 years	Carers 65 years and over	All carers
Transport	6	4	34%
Cleaning of linen	7	2	31%
Walking frame	5	1	21%
Meal deliveries to home	5	1	21%
Wheelchair	4	0	14%
Incontinence pads	3	0	10%
Aids	3	0	10%

4.7 TRANSPORT

There is quite a high reliance on friends and family for transport assistance amongst respondents aged 65 years and over.

People in all age groups indicated that they had no means of getting about – see Table 33.

TABLE 33: TRANSPORT USED

Mode of transport	50-64 years	65-79 years	80 years and over
Drive yourself	73%	45%	23%
Bus/train	2%	23%	0%
Taxi/access cab	10%	16%	23%
Friends/family	22%	39%	38%
Council bus	2%	10%	0%
No means of getting about	7%	6%	31%
No answer	7%	10%	8%

Nearly half of the carers relied quite heavily on family and friends to get about and some indicated that they had no means of getting about - see Table 34.

TABLE 34: TRANSPORT USED BY CARERS

Mode of transport	Carers 25-64 years	Carers 65 years and over	%
Drive yourself	12	2	48%
Friends/family	9	5	48%
Bus/train	1	2	10%
Taxi/access cab	2	1	10%
Council bus	1	1	7%
No means of getting about	1	1	7%
No answer	2	0	7%

4.8 RESPITE SERVICES

A very low number of people said that they use respite services – see Table 35. 21% of carers said that they use respite services.

TABLE 35: USE OF RESPITE

	25-49 years	50-64 years	65-79 years	80 years and over
% using respite	0%	10%	6%	0%

Even though a low percentage of all respondents said that they use respite, 43% did have a view on what form of respite they would like to use. The top two preferences were a carer at home who spoke the same language and multicultural community based care followed by activity based respite. Only one respondent wanted residential respite - see Table 36.

TABLE 36: RESPITE PREFERENCES

Type of respite	25-49 years	50-64 years	65-79 years	80 years and over	Total
Carer at home (speaks same language)		4	9	3	16
Community based (multicultural)	1	8	5	2	16
Activity based care (eg exercise classes, cards, cooking)	1	3	2	3	9
Carer at home (English speaking)	1	3	3	1	8
Community based care (English speaking)		2	2	2	6
Community based care (speaks same language)		0	2	1	3
All day care		3			3
Overnight care		2			2
Residential		1			1
Other		1	1		2
No answer		24	19	7	50

The top two preferences of carers were for community based multicultural care and an English speaking carer at home. This may indicate that they are aware of the difficulty of getting care assistance in the same language. It may also reflect marriages between different cultures and the fact that many Filipino female carers are married to men from a different cultural background and need a carer that they can communicate with – see Table 37.

TABLE 37: RESPITE OPTIONS PREFERRED BY CARERS

Type of respite	Carers 25-64 years	Carers 65 years and over	Total
Community based (multicultural)	7	2	9
Carer at home (English speaking)	4	2	6
Carer at home (speaks same language)	2	3	5
Community based care (English speaking)	3	2	5
Activity based care (eg exercise classes, cards, cooking)	3	1	4
All day care	3	0	3
Other	2	1	3
Community based care (speaks same language)	1	1	2
Overnight care	2	0	2
Residential	1	0	1
No answer	6	4	10

4.9 COMMUNITY ACTIVITIES

A very high percentage of all questionnaire respondents wanted a community visitor and to attend a community group meeting - see Table 38.

Over two thirds of all carers wanted a community visitor and to attend a community group meeting - see Table 39. This trend occurred in all regions. As children have left the regions for employment elsewhere, the reliance on community groups has increased to alleviate loneliness and provide support.

TABLE 38: COMMUNITY VISITORS AND GROUP MEETINGS

Type of Activity	25-49 years	50-64 years	65-79 years	80 years and over
% wanting community visitor	100%	49%	55%	54%
% wanting community group meeting	66%	56%	68%	69%

TABLE 39: CARERS WHO WANTED COMMUNITY VISITORS AND GROUP MEETINGS

Type of activity	Carer 25-64 years	Carers 65 years and over	Total	% of carers who want this assistance
Community visitor	16	4	20	69%
Community group meeting	13	6	19	66%

At the community consultations people indicated that they were prepared to pay a contribution for services particularly at current HACC contribution rates.

5 SERVICE PROVISION OVERVIEW

5.1 HISTORICAL OVERVIEW

Prior to World War 11, Australia's migrant intake was relatively small and the United Kingdom and Ireland were the main source countries of migrants. Migrant intake increased dramatically from 1949 to the early 1960s with more than two million people immigrating to Australia from Europe as permanent residents.

The majority of post war immigrants have historically preferred settling in the larger cities of Australia, namely Sydney, Melbourne and Brisbane. As indicated in Table 40 below the largest numbers of migrants in regional areas settled in NSW and Queensland.

TABLE 40: ABS CENSUS DATA 2006 PEOPLE FROM NON ENGLISH SPEAKING BACKGROUND IN REGIONAL AUSTRALIA

State/Territory	Total number of people from non-English speaking background all ages living in regional Australia
New South Wales	83 000
Queensland	83 000
Victoria	51 000
Western Australia	15 000
South Australia	12 000
Tasmania	6000
Northern Territory	2000
Australian Capital Territory	Nil

The governments of the time strongly advocated for assimilation. This changed in the late 1960s when ethnic groups started to focus on how they could provide support to individual members, families and groups of their respective communities by developing and establishing ethnic, social, religious, cultural, educational and sporting clubs themselves. As they did so, Governments began to recognize and acknowledge the legitimate concerns of the ethnic communities and migrants in general, accepting responsibility for their welfare and well-being. In 1968 the Commonwealth Department for Immigration established the Grant in Aid scheme to provide welfare services to migrants, with an emphasis on individual casework.

The Grant-in-Aid (GIA) scheme was followed by the Migrant Project Subsidy Scheme (MPSS) 1978; the Migrant Access Projects Scheme (MAPS) 1988 and the Community Settlement Services Scheme 1997.

The recommendations in the 1978 Galbally Report led to ethnic groups receiving services through three main streams in Australia both regionally and in the metropolitan areas: Migrant Resource Centres, Ethnic Communities Councils and ethno specific agencies (such as Greek, Italian and Hungarian communities). These agencies were initially supported by grants from the Australian Government followed by State Governments. Table 41 gives an overview of the number of Migrant Resource Centres and Ethnic Communities Councils in each State and Territory.

TABLE 41: TOTAL NUMBER OF MIGRANT RESOURCE CENTRES AND ETHNIC COMMUNITIES COUNCILS' IN EACH STATE AND TERRITORY.

State/Territory	Migrant Resource Centres (MRC)	Ethnic Communities Councils (ECC)
New South Wales	9	5
Queensland	3	5
Victoria	11	8
Western Australia	4	1
South Australia	1	1
Tasmania	2	2
Northern Territory	-	1
Australian Capital Territory	1	1

For many ethnic communities within the metropolitan and regional areas, their needs transitioned from settlement issues to health, social and geographic isolation and ageing needs. A review in 2003 of the CSSS-funded services noted that many services which were being provided to groups who had been settled for some time were not specifically related to settlement needs. These included services for:

- the frail aged;
- migrants with physical and mental disabilities;
- respite care;
- women's health;
- migrants experiencing social and geographic isolation;
- migrants with deteriorating English language skills due to age and inability to communicate with health professionals and carers; and
- home-visiting services to hostels and nursing homes.

Consequently, the Department of Immigration Multicultural and Indigenous Affairs ceased funding many communities who once received funding under the settlement schemes as they no longer met the funding criteria for settlement issues. The change of focus on supporting recent arrivals left a significant gap in providing assistance to older people in established ethnic communities.

The current Settlement Grants Program (SGP) which was introduced in July 2006 and superseded earlier schemes focuses on services which assist eligible clients to become self-reliant and participate equitably in Australian society as soon as possible after arrival.

The program funds service providers to manage projects which offer orientation, community development and/or integration services to specific groups of new migrants.

In the past a broad range of ethno-specific, multi-ethnic and generalist organisations in South Australia received funding under the Commonwealth Government's settlement schemes detailed above including:

- Vietnamese Community in South Australia SA Chapter Inc.
- Croatian Welfare Services
- Macedonian Welfare Services
- Serbian Welfare Services
- Previous Yugoslav Welfare services
- Pt. Lincoln Multicultural Council
- Coober Pedy Multicultural Forum
- Whyalla Multicultural Forum
- some of the more older established communities such as the Greek, Italian, German, Polish, Ukrainian and Hungarian communities.

It was anticipated by the Department of Immigration and Citizenship that over time the majority of migrants receiving services under SGP would transit into mainstream services within a five year period.

In reality, some migrants are not self-reliant within five, ten or fifteen years and require ongoing assistance.

As clients fell outside the SGP target group, staff in some Agencies continued to work outside their funding brief to assist people in need who had been in Australia for longer than five years.

The ongoing settlement challenges faced by most of the current generation of older culturally and linguistically diverse (CALD) people and their need for continuing support placed a greater reliance on State government funded human services, and on Commonwealth Department of Health and Ageing services (such as, Community Aged Care Packages).

In New South Wales, Victoria, Queensland and Western Australia, many of the generic peak multicultural agencies such as the Migrant Resource Centres and Ethnic Communities Councils have taken on the role of advocating on behalf of the multicultural communities to ensure that their needs are raised at all levels. These agencies have been able to sustain themselves following the reduction of immigration funding by attracting new financial resources such as HACC and other government grants. As they have done so their client base has transitioned from migrant/refugee status to HACC client.

These agencies have auspiced a range of HACC and aged services including day care, dementia day care, multicultural home support programs, community aged care programs, carer support, multicultural aged and disability services, community visitors programs,

meals services, access services and referral to HACC services. In regional areas of New South Wales, Victoria, Queensland, Western Australia these services are provided either by the agencies themselves or in collaboration with other mainstream bodies.

In South Australia whilst some politically savvy ethnic communities in metropolitan Adelaide were able to secure alternative funding to meet the needs of their ageing community others, particularly in the regional areas were not successful. Bodies such as the Pt. Lincoln Multicultural Council, Coober Pedy Multicultural Forum and the Whyalla Multicultural Forum lost their funding.

In these regional areas there has been a reliance on community goodwill to assist frail elderly people with the spectrum of their needs.

In many instances the elderly have been forced to leave their homes of decades and move to Adelaide for support. As the regional summaries in Section 7 demonstrates whilst the funding has disappeared real community needs still exist and some communities such as Coober Pedy with a very diverse population and a high percentage of single elderly are struggling.

As of July 2010, the Migrant Resource Centre of SA provides minimal outreach to regional South Australia and the Multicultural Communities Council has limited capacity to provide services regionally. Historically the Multicultural Communities Council of SA has received limited HACC funding to provide transport services and carer support, for the metropolitan region only. The voices of multicultural communities in regional South Australia have slowly disappeared as communities which lost immigration funding lacked the capacity to secure alternative funding for their ageing communities.

The consultants found a belief in communities that help is not forthcoming and that they are consulted for the sake of being consulted. It is the consultants' view (based on a number of community consultations and stakeholder discussions) that regional CALD communities will be unwilling to participate in future discussions unless tangible support is provided as a result of this study.

5.2 REGIONAL CHALLENGES

The provision of accessible and culturally appropriate services for older people living in regional Australia faces multiple challenges including:

- Overcoming issues of distance, and time spent in travel for service providers and consumers.

- Developing an appropriately skilled and available workforce, in the face of wider workforce ageing (which is more pronounced in regional Australia), the reducing availability of aged care workers, and reduced access to training and development opportunities. In addition, staff turnover is higher than in metropolitan locations, and many health and community aged care professionals work alone with little or no administrative or professional support.

- There is a need to balance the demand for resource efficiencies and viable service delivery against the relatively small and often dispersed numbers of CALD background people. Many regionally based aged care services are small in size and with limited financial and staff resources, making it difficult to achieve economies of scale, compounded by the higher costs of delivering care (compared with metropolitan services).

- Service boundaries created by government funding programs do not necessarily reflect local need and lack the flexibility required to do so. There are a range of services that support older people in regional Australia but it is difficult to plan and coordinate these in a way that can achieve synergy and resource efficiencies (ACSA: NRHA, 2004; Sappey Bone & Duncan, 2007).

- Rural regions have average incomes that are 30 % lower than inner metropolitan levels and 36 of Australia's 40 poorest areas are classified as rural or remote (ACSA:NHRA, 2004: 4).

Although these challenges are significant, the research literature and examples of innovative practice offer possible strategies that are of relevance in meeting the needs of CALD background communities living in regional South Australia. These are discussed in Sections 5.3 and 5.4.

5.3 ONGOING COMMUNITY ISSUES

In September 2005, the SA Office for the Ageing, through Multicultural Communities' Council SA, commissioned a project which consulted with CALD communities in two regional locations (the Riverland and Whyalla) about the then draft SA Ageing Strategy. Findings from the consultation process in both regional locations reinforce those of this current OFTA project, including the following:

- coordination is a major issue with CALD communities dispersed across regional South Australia
- community intermediaries or key workers are critical in providing information to older people, and in linking communities to 'mainstream' service providers and organisations. These workers are critical in ensuring that older CALD people make use of available services and know that they exist
- there is value in establishing a coordination position in some regions which provides a central point of information for CALD communities and assists with integrating services being received by different agencies
- the waiting lists for GPs prevent access to choice of GP, and therefore, to continuity of care
- there is a significant need for bilingual, bicultural health professionals. There is also a need to build stronger relationships with GPs and other health professionals
- there is significant scope to develop innovative service models that build on current community and spiritual centres (e.g. in Coober Pedy). By using places that are familiar to people, it is possible to provide effective health prevention and other services for CALD older people. This also enables the involvement of people at earlier ages to educate them about health and to prepare them for older age (Kate Barnett and Associates, 2005)

5.4 POSSIBLE EFFICIENCIES THROUGH TECHNOLOGY

There may be scope for rurally located community aged care providers to pool their workforce resources, and with the use of spatial technologies adopt a planned approach that streamlines care in the home and enables a sharing of travel related costs.

Technology to assist in the support of older people involves a continuum ranging from simple assistive aids to more complex and high-tech solutions like robotics. These have significant potential both for enabling independent living and for efficient resource usage. Assistive technologies can also reduce injury among both formal and informal carers (Productivity Commission, 2008: 184-186; Brown *et al*, 2004: 2-3).

As new wireless and mobile technologies become more widely available, and speed and bandwidth barriers in regional Australia are overcome, their potential to enhance the delivery of aged care is growing. Increased access to 3G mobile phone services, online interactive video, and location based GIS (geographical information systems) services are all expected to be of particular value to aged care providers, particularly those delivering care in the community.

New technologies such as GPS tracking, video conferencing or virtual link-ups to provide remotely delivered support, and GIS modelling of service provision and transport, offer largely untapped opportunities for rural service providers to deliver services across large areas and remote populations in more efficient ways.

There is a small, but growing body of literature that demonstrates how the application of geographic information systems (GIS) can more efficiently schedule community based care services and contain transport costs (Productivity Commission: 2008). Analysis by Howie (2008) found that these costs can be reduced by more than one-third through using GIS.

For instance, in 2006, the Murray Mallee Aged Care Group (MMACG) began to explore the use of a GPS system to map the locations of their clients and independent contractors in order to determine the distances being travelled and the most efficient client-contractor linkages. The MMACG mapped all clients and independent contractors to set up a database, and trained staff in the use of equipment.

Funding for this initiative involved $637, a once-off outlay that achieved savings of $25,086 in a single year. The savings achieved were attributed by the service to more efficient and effective management of travel and care arrangements. For example, the GPS mapping enables visits to several clients to be consolidated into a single trip and contractors are able to be matched with clients on the distances between them. In addition, being able to visualise the spatial distribution of clients and contractors enabled the MMACG to identify growth areas in service provision and areas where new contractors needed to be sourced.

Building on the foundations set by the MMACG, funding has been provided for a three year study by the Department of Health and Ageing in collaboration with the MMACG. The *'Linking Rural Older People to Community through Technology'* project exemplifies how the application of GIS technology can enhance the delivery of aged care services in the Murray Mallee region.

5.5 A REGIONAL MODEL

While the configuration and coordination of aged care services in regional areas is out of scope of this report for OFTA, the lessons emerging from the research point to the importance of locating Multicultural Ageing Workers (MAWs) within a wider regional health, ageing and community services workforce. It will be critical that the MAWs are not employed in isolation, but are part of two levels of networks:

- with other MAWs in regional and metropolitan South Australia, and
- with local health, aged care and community services workers.

Multicultural workers who are not part of an ethno-specific service and are employed within a 'mainstream' service provider organization need access to a supporting and learning peer network. For those in regional settings, the isolation of distance is compounded by professional isolation. For this reason, structured networks that provide both peer learning and support become a vital link for them.

If several regional workers are appointed it is proposed that:

- they are linked into a *Multicultural Ageing HACC Workers Regional Network* supported by OFTA, which would be structured around one face to face meeting annually (rotated across the sites) and the use of information communications technology (videoconferencing, Skype, email) for ongoing interaction
- each of the Regional MAWs is provided with a lap top with inbuilt camera to support Skype, and GIS hand held equipment that enables them to plan their travel within the region as efficiently as possible
- they attend the Office for the Ageing Multicultural HACC Workers Forum
- adequate funding is allocated to support these measures.

This will provide the workers with cost-effective support, peer training and advice.

The model proposed also promotes partnerships between MAWs (and through them, the ethnic communities receiving their support) and local health and aged care service providers and metropolitan ethnic communities and peak ethnic agencies. The research literature reviewed shows support for collaborative service delivery and workforce development, sharing costs for workforce training and resources involved in service provision. If technologies such as GIS are used appropriately, then shared transport and other services can be planned, resulting in more effective use of scarce resources.

6 STAKEHOLDER CONSULTATIONS

In South Australia there are one hundred and fifty (150) agencies which receive HACC funding for the provision of community aged care services.

25 HACC funded agencies in regional South Australia were asked to complete a questionnaire and 21 agencies responded. The responses were a snap shot for the month of May 2010 and their client base may have since altered. The agencies were providing a range of community aged care services to people from a diverse group of culturally and linguistically diverse backgrounds. Responses for each regional area are provided in the regional summaries in Section 7.

- ACH Group, Murray Bridge
- Boandik Lodge
- Berri Barmera Council
- Carers SA, Eyre Carers
- Carers SA, Murray Bridge
- Carers SA, Mt Gambier
- Carers SA, Northern Country Carers
- Carers SA, South East
- Country Health SA, Coober Pedy
- Community Health SA Domiciliary Care, Whyalla
- Community Health SA, Renmark Community Care Services
- Country Health SA , South East Regional Health Service
- Country Health SA, Waikerie Community Service
- Country Health SA, Pt. Lincoln Heath Services
- Mathew Flinders Home Inc.
- Murray Mallee Aged Car Group Inc.
- Murray Mallee Community health Service
- Rural City of Murray Bridge
- Uniting Care Wesley Port Adelaide Ethnic Link Services
- Whyalla Aged Care Inc.
- West Coast Home Care.

In some of the regional areas the numbers of people serviced from a culturally and linguistically diverse background were small as predominately the client base in regional South Australia is people who speak English. However, this does not imply that people from

a CALD background were not living in the regional areas but rather they are not seeking HACC services either because they are not aware of them or the service they require is not culturally or linguistically appropriate.

Most HACC services sought after were domestic assistance (cleaning), home maintenance (gardening, home repairs), support services for carers (counseling, information referral, support groups), transport, used for shopping, medical appointments, social activities, allied health and community nursing.

Some of the issues that Agencies faced in servicing CALD clients in the regional areas were:

- not having multicultural workers in regions to advocate for clients and community needs, to act as “link worker”
- limited knowledge of HACC services by CALD communities
- lack of interpreter services, resorting to family, friends, employees (agencies understand that this is not ideal but need to resort to this as there may not be any alternative)
- communities believing that family should be providing the service thus avoiding community options
- having appropriate language specific staff to meet community needs
- transport issues as regional distances can be great
- some areas did not have transport available after office hours and on weekends
- a lack of cultural competency training for mainstream agencies
- inability to advertise services to the ethnic communities in community languages
- using the phone for interpreting is not accepted by the elderly
- ethnic communities not accessing services until crisis point
- clients having unrealistic expectations of what services can be provided
- limited translated information, cost involved in translating information and in using interpreters
- translations can be poor and difficult for people to understand
- it takes longer to respond to/link with CALD clients as they are not as forthcoming into accepting services and can be suspicious of agencies
- the provision of culturally appropriate meals services in regional SA is difficult to address
- some people are not willing to accept services from a mainstream agency
- most CALD clients do not like speaking over the phone
- no after hour services for carer support, respite, evening or weekend
- not having appropriate skilled staff to address post war trauma counseling in regional SA.

Carers SA indicated that they had a strategy for working with CALD communities and generally most regional agencies try to build on community relationships. West Coast Home Care in Pt. Lincoln earlier this year engaged a consultant to conduct a cultural diversity needs survey.

Some agencies have built strong relationships with local regional and metropolitan groups and developed positive working relationships namely:

- Boandik Lodge (South East) has a strong relationship with the Italian Pensioners group and they are developing a relationship with the Limestone Coast Migrant Resource Centre. As part of their Business Plan, Boandik Lodge have identified a need to meet minority needs
- Country Health SA South East Regional Health Service and Carers SA South East are developing a relationship with the Limestone Coast Migrant Resource Centre to assist refugee communities being relocated to the South East
- Ethnic Link Services, auspiced by Uniting Care Wesley, Port Adelaide provide regional support to the Riverland and Whyalla regions
- Country Health SA, Renmark Community Care Services participates in the Greek Welfare Centre's Community Partners Project.

In addition, some metropolitan ethnic communities are undertaking outreach work in the regional areas where their communities are located i.e. Croatian Care for the Aged Inc in Pt. Lincoln and Coober Pedy.

7 REGIONAL SUMMARIES

7.1 COOBER PEDY

Coober Pedy was looked at in more detail because it has a very ethnically diverse population and high levels of need.

Coober Pedy is a town 846 kilometers north of Adelaide on the Stuart Highway. It is known as the opal capital of the world because of the quantity of precious opals that are mined there. During the 1960s and 1970s the mining industry expanded rapidly as many European migrants came to seek their fortunes. Many of them have aged in Coober Pedy and want to remain there for the remainder of their lives.

Coober Pedy has a very culturally and linguistically diverse population for its size with over 45 different ethnic groups. At the 2006 ABS Census its population was 1916. The Mayor of Coober Pedy challenges this figure. He believes that there are over 3500 people living in the town. The Post Office has a register of over 4000 people who live in and about Coober Pedy. The official ABS statistics are also disputed by the community.

This creates problems because as the figures are not a true indication of those who live in Coober Pedy, Agencies (who are funded on the basis of official data) are receiving insufficient funding to provide an appropriate response to community need.

The 2006 Census data indicates that there were 784 people aged over 50 in Coober Pedy. Of these 280 were born in Australia and 504 stated they were born elsewhere.

40% of the residents aged 50 and over in Coober Pedy were born in predominantly non English speaking countries - see Table 42.

115 of these were born in the designated ENSS countries with 39 of these aged 50 and over living alone at the 2006 Census.

TABLE 42: COUNTRY OF BIRTH OF COOBER PEDY RESIDENTS AGED 50 AND OVER AT ABS 2006 CENSUS DATA

Country of Birth	People aged 50 and over	Country of birth	People aged 50 and over
Greece	85	Australia	280
Croatia	46	England	32
Germany	33	New Zealand	12
Southeastern Europe, nfd.	33	Ireland	7
Hungary	21	United States of America	6
Italy	16	Scotland	5
Bosnia and Herzegovina	15	Wales	3
Serbia	15	Not stated	114
Netherlands	7	Total	459
Austria	6		
Cyprus	6		
Slovenia	6		
Eastern Europe, nfd.	6		
Czech Republic	6		
Poland	6		
Bulgaria	3		
Romania	3		
Philippines	3		
China (excludes SARs and Taiwan Province)	3		
India	3		
Zambia	3		
Total	325		

In the Far North Region encompassing Coober Pedy 520 people aged 50 and over at 2006 Census spoke a language other than English or an indigenous language as their main language at home. This figure excludes those who did not state which language they spoke and may well be an underestimate because of lower Census participation in Coober Pedy (and possibly other Far North areas).

In Coober Pedy itself there were 255 people aged 50 and over who spoke a language other than English or an indigenous language as their main language at home at the 2006 Census. The top five languages were Greek, Croatian, Serbian, German and Hungarian – see Table 43. Of these 96 people spoke one of the designated ENSS languages. In addition we found Filipino speakers aged 50 and over in our consultation.

A significant percentage of Coober Pedy residents between the ages of 65 and 79 indicated that they spoke a language other than English at home as their main language i.e. ages 65-69 years - 42%, ages 70-74 years - 50% and ages 75-79 years - 59%. These percentages are significantly higher than for Metropolitan Adelaide and have implications for service provision as they can create an additional barrier to accessing services.

TABLE 43: MAIN LANGUAGE SPOKEN AT HOME IN COOBER PEDY LGA AT ABS 2006 CENSUS DATA

Language spoken at home	50-54 years	55-59 years	60-64 years	65-69 years	70-74 years	75-79 years	80-84 years	85-89 years	90-94 years	95-99 years	100 years and over	Total
English	96	99	104	63	21	11	3	0	3	0	0	400
Pitjantjatjara	3	4	0	0	4	0	3	0	0	0	0	14
Not stated	26	22	21	18	9	5	6	0	0	0	0	107
Greek	4	14	23	19	15	8	0	0	0	0	0	83
Croatian	3	9	9	9	8	3	0	0	0	0	0	41
Serbian	8	5	7	8	3	0	0	0	0	0	0	31
German	3	3	3	8	5	3	0	0	0	0	0	25
Hungarian	3	3	10	3	3	0	0	0	0	0	0	22
Italian	0	7	4	3	0	3	0	0	0	0	0	17
Serbo-Croatian /Yugoslavian, so described	0	0	3	3	0	3	3	0	0	0	0	12
Czech	0	0	0	6	0	0	0	0	0	0	0	6
Dutch	3	0	3	0	0	0	0	0	0	0	0	6
Slovak	3	0	0	0	0	3	0	0	0	0	0	6
Mandarin	3	3	0	0	0	0	0	0	0	0	0	6
Polish	4	0	0	0	0	0	0	0	0	0	0	4
Bosnian	0	0	3	0	0	0	0	0	0	0	0	3
all people	155	169	187	140	68	39	15	0	3	0	0	776
non English speaking	30	44	62	59	34	23	3	0	0	0	0	255
% speaking a language other than English or an indigenous language												
	19%	26%	33%	42%	50%	59%	20%	0%	0%	0%	0%	33%

The nature of the local industry has led to many single men living in the community, who never married or had a family and are currently ageing. Loneliness, isolation and poverty are very real in Coober Pedy and there are no social activities coordinated for people unless they are linked into the local health service program which has limited capacity. 56 of those aged 50 and over living alone were born in the designated Emerging Needs Scoping Study countries – see Table 3. As local information indicates this may well be an underestimate.

At least 32% of Coober Pedy residents aged 50 and over live alone.

Coober Pedy has only one HACC funded service within the town, Coober Pedy Hospital and Health services, and due to resource constraints this service only provides limited services for a small part of the community. They provide a range of HACC programs for the local community, namely domestic assistance, personal care, meals, support services for carers, limited transport and social support, Community Aged Care Packages, Extended Aged Care Packages and Extended Aged Care Dementia Packages. Some outreach assistance to the region is provided once a month by Country Health SA Pt. Augusta-Domiciliary Care. There can be a wait time for these services.

No service providers surveyed at Coober Pedy indicated that they provide home maintenance, home modification, community nursing, respite care or centre based day respite to ENSS clients.

At the time of the survey the Coober Pedy Hospital and Health services was providing limited services to a very small number of Croatian, Serbian, Bosnian, Filipino and Montenegrin community members and a small number people from other CALD backgrounds. Their client base from the CALD community was small.

As the community is small the agency has tried to link into the Coober Pedy Multicultural Forum to ensure that they were connected into local community needs.

Stakeholders identified the following gaps in services for the Coober Pedy community:

- no dementia specific services
- no public transport
- no information available in other languages
- no HACC transport outside of office hours
- no local interpreter services (there is a reliance on family and friends)
- no specialised health services residents are required to travel to Pt. Augusta or Adelaide
- no local allied health services (they come in from Pt. Augusta on a monthly basis)
- no suitable social workers or counselors to address post traumatic stress disorder (PTSD)
- no culturally appropriate meals services
- no Day Centre
- no CALD specific worker, just a financial worker based at the Coober Pedy Multicultural Forum who by default acts as community worker
- no after hours services for current HACC programs
- no social activity programs for the aged
- no community bus

- no community centre where activities could be run for the elderly
- no low care facilities
- no formal links into ethnic communities based in Adelaide other than Croatian Care for the Aged Inc and the Serbian priest from the Serbian Orthodox Church of St Sava, Woodville Park
- no appropriate footpaths (it is difficult for the elderly to negotiate streets as footpaths are uneven or not available and generally conditions are unsafe for the elderly).

Many residents within Coober Pedy are happy to receive support from ethnic workers based in Adelaide i.e. the Croatian Care for the Aged Inc. based in Adelaide supports residents of the Croatian community in Coober Pedy, Pt. Lincoln and Mt. Gambier**.** Peak ethnic community organisations should be encouraged to support their members in regional areas by undertaking outreach work. For many people living in Coober Pedy these workers are their lifeline as they do not have family or friends and live a very isolated existence.

For over 25 years the local ethnic community relied on the Coober Pedy Multicultural Forum's, GIA/ CSS worker or their children to assist them with their paper work. However, many of the children have moved into the city for work and the CSS position was defunded over 5 years ago and since then the communities have struggled to find the appropriate support.

The elderly use family living in Adelaide or intra state for support, local friends, Community Health Centre staff, bank staff, Families SA staff, Coober Pedy Multicultural Forum staff (financial worker) or the local post office staff for language assistance. Telephone interpreters are not trusted and as a result people are reluctant to use them.

The communities prefer to have information provided in both English and in their home language for those who are able to read. Many elderly are illiterate in their own language and those require the information in English for others to be able to explain it to them. Information is disseminated by word of mouth, satellite TV, Centrelink newsletter, their children and where available ethnic agencies visiting the local community i.e. Croatian Care for the Aged Inc.

As the local community has always been multicultural they are happy to receive multicultural services where appropriate, and some would be happy to pay a nominal fee.

Service providers need to be aware that many of the elderly who have remained in Coober Pedy live on the poverty line and may not be able to afford to pay for services but will not openly state this, preferring to go without.

Communities want to age and remain in Coober Pedy but current services are not adequate this situation needs to be redressed. Their greatest desire is for there to be a worker based at the Coober Pedy Multicultural Forum (CPMCF) who can assist them with their ageing needs.

CPMCF is a not for profit, incorporated organisation which was established in 1994 and has remained operational since that time. It was able to attract Grant in Aid (GIA) funding for a settlement worker from the Department of Immigration and Ethnic Affairs which then converted to the Community Settlement Scheme. Both Schemes aimed at assisting migrants with settlement issues. This funding ended in 2005/6 when the Commonwealth deemed that Coober Pedy was no longer receiving immigrants. In 2006, they obtained Commonwealth funding for a financial counselor position. The Forum's offices (CPMCF) have also been used by the Family Day Centre and the Health Survey Project Officer. The Coober Pedy Multicultural Community Forum has retained its town offices and has been able to attract sub tenants. They currently have the Regional Development Australia Far North Officer and the Arid land Officer on site and this diversification of their income has enabled them to maintain a strong financial position.

Their committee is committed to the local ethnic communities and the region and has employed several workers in the past. CPMCF has proven flexible in their approach to assisting the Coober Pedy community and at times have extended their services to meeting community needs. At present, some outreach work is done by their financial counselor to nearby towns and they have also co-auspiced a training scheme with the local TAFE.

The office location in the centre of town is ideally placed for the local CALD community as they are located directly across from the town's Post Office, shops and it is easily accessible. People can usually get a 'lift into town' to their offices. The town has no public transport and when the elderly lose their ability to operate and drive a car they become dependent on neighbours for local transport so this centrality and accessibility is very important for service provision.

Over the years CPMCF has provided independent 'one stop shop' assistance to many of the CALD population. They are still being approached by CALD ageing people for assistance but are unable to assist as their needs fall outside their funding scope and subsequently they refer them on. The Coober Pedy Multicultural Communities Forum has strong links with all mainstream stakeholders in the region, such as Country Health SA, Families SA, local industries, banks and the Local Council.

The Coober Pedy Multicultural Communities Forum is the best placed organisation in Coober Pedy to auspice a CALD Ageing HACC worker.

7.2 MT. GAMBIER

At the 2006 Census almost 65 000 people live in the Limestone Coast which includes Mt. Gambier Bordertown, Millicent, Beachport, Robe, Kingston, Penola, Tantanoola, Cape Jaffa, Keith, Lucindale, Meningie, Port MacDonnell and Tantanoola.

The industries for Mount Gambier and the Limestone Coast are primarily transport, construction, agriculture, forestry, horticulture, dairy, viticulture, fishing, engineering and tourism. Mt Gambier and the South East is considered to be one of the more affluent regional areas of South Australia as a result of its local industries.

The city of Mount Gambier with approximately 24 000 people at the 2006 Census is South Australia's largest regional city outside of Adelaide, the regional centre of the Limestone Coast in the South East of South Australia with well over a third of people living in the region residing in and around Mount Gambier local government area and the 50th largest urban area in Australia. Approximately 85% of people are Australian-born, and 1.6% is Indigenous. Overall, approximately 70% of people live in the lower part of the region.

The regional city of Mt Gambier has a very diverse population base as a result of earlier migration in the 1950s and 1960s to work in the timber, agricultural and fishing industries or more recently migration for broader industries such as the wine industry and meat works in the area. There is a regional office of the Migrant Resource Centre which supports new arrivals such as the Sudanese who have settled around the periphery of Mt. Gambier. While the newer migrant groups are entering the area, some of the older groups are relocating to Adelaide and Melbourne to be close to their children and services.

There were 64 people aged 50 and over from the designated ENSS countries of birth and of these 15 were living alone.

HOKJOK has attempted on several occasions to access consumers in Mt Gambier firstly, with the Carer's Report in 2007 and then in 2009 with the current Emerging Needs Scoping Study and have found it difficult on both occasions to access community people. Local stakeholders indicated at both consultations that they also found it difficult to access CALD communities, and many stakeholders consulted noted that they were servicing only a very small number of CALD clients.

Some agencies said that they struggled to get CALD people attending their groups either because the groups were not perceived as culturally or linguistically appropriate or simply people were not aware of the services being offered.

Agencies within the region have good working relationship amongst one another and are happy to refer clients on if they are unable to meet their needs.

Whilst there are a range of agencies delivering HACC programs in the region many of them indicated that the ethnic communities were reluctant to take on services as they perceived it a role for the family. Agencies were aware that they needed to be more proactive in working with ethnic communities but found it difficult with limited resources.

Agencies such as Boandik Lodge and Carers SA which have taken steps to ensure that access and equity is embedded into their business plans should be commended.

The following agencies responded to the stakeholder survey:

- Boandik Lodge
- Carers SA South East, services cover the upper and lower south east
- Country Health SA, South East Regional Health Service (services cover the regions of Mt Gambier, Bordertown, Naracorte, Keith and Millicent).

Combined these agencies deliver the full range of HACC services for the South East regional community. At the time of the survey the agencies indicated that they were servicing a small number of people, possibly one or two from the Serbian, Croatian, Montenegrin, Bosnian and Herzegovina, Cambodian, Indonesian, Malaysian, Filipino and Spanish communities. It should be noted that the ethnic client list for Country Health SA, South East Regional Health Service is quite extensive with over 50 ethnic communities represented. For additional information please refer to the MDS HACC data from the Department.

Some agencies have developed strong relationships with ethnic communities and agencies in the region, namely Country Health SA, South East Regional Health Service and Boandik Lodge connecting with the Limestone Coast Migrant Resource Centre and also working with the Italian Pensioners Association.

Some of the Croatian residents indicated that they contact Croatian Care for the Aged Inc. in Adelaide to seek culturally and linguistically appropriate support. Most of the information comes from Adelaide and not locally, as many of them do not trust the locals. This may be an area where Adelaide based ethnic agencies could work alongside regional agencies to support the local community.

Stakeholders and community identified the following gaps in service provision for the CALD communities in Mt Gambier:

- no language specific services, other than Italian community
- no culturally appropriate food, Meals on Wheels
- limited financial resources to provide a specialised CALD programs
- limited to no CALD staff to undertake service delivery
- limited translated information available
- no suitable social workers or counselors to address Post Traumatic Stress Disorder
- no on-site interpreters available (individuals rely on family, friends, volunteers which is inappropriate)
- communities are suspicious of interpreters used
- limited transport service
- no public transport in certain areas of the city
- no community bus

- no after hour or weekend services available for carer support or respite
- the diversity of ethnic groups in the region makes it difficult to respond appropriately
- limited access to doctors
- lack of trauma counselling.

Croatian community members have requested that additional outreach work be undertaken in the region to ensure that older community member's needs are addressed. Language is important for the community as many are isolated because of language difficulties.

There is a great expectation from ethnic communities that services will be delivered in the relevant language however this is extremely difficult within regional SA.

It has been difficult for the project to gather sufficient evidence of need. The priority is for cultural competency training of mainstream Agencies dealing with ageing issues.

7.3 MURRAY BRIDGE

Murray Bridge located approximately 78 kilometers from Adelaide on the Murray River is the largest town in the Murraylands group of towns. It has a sprawling rural centre, grain silos, vegetable gardens, hothouses and light industry around the town centre. The rural city is the centre of a major agricultural district which is driven by dairying, chicken raising, pig breeding, tomato and snow pea growing.

At the 2006 Census, Murray Bridge had a population of 14 048, up from 12 998 at the 2001 Census. 10.4% were born overseas, and 4.5% were Indigenous Australians. The area has a very small number of older ethnic residents predominantly Greeks, Italians and a small number of Germans as most of the elderly have moved to Adelaide to be closer to their families.

Currently the majority of the CALD population in Murray Bridge is under 40 years of age.

Due to the nature of its local industry the area has been actively seeking newer migrants to support its growth. Murraylands now has a diverse cultural pool with migrants from Afghanistan, Africa, Europe, China and the Philippines. By far the largest groups of migrants since 2005 are from China.

The Murraylands Regional Development Board, Department of Trade & Economic Development (DTED), T&R Pastoral and the Rural City of Murray Bridge funded the Murraylands Multicultural Project in 2006 to support the settlement of all new migrants, irrespective of visa class. New arrivals include settlers from mainland China, Afghanistan and Africa.

In addition Lutheran Community Care is funded by the Department of Immigration and Citizenship to support the settlement of refugee (humanitarian entrants) in Murray Bridge.

Local agencies are committed to supporting ethnic communities coming into the region and work with each other and metropolitan groups to ensure that new migrants remain in the area.

Local and metropolitan agencies (for example the Overseas Chinese Association and the Filipino Women's Association) should be commended for being proactive in supporting and reaching out to ethnic groups in the area.

However, some agencies are still struggling to service CALD clients due to not being able to respond in a culturally and linguistically appropriate manner.

Although Murray Bridge is approximately 80km from Adelaide, transport within the town and back to Adelaide is very poor and expensive; this prohibits people from attending programs locally or in Adelaide.

Murray Bridge had 44 people from the designated ENSS countries at the 2006 Census and the majority of these were under 65 years of age and from a Filipino background.

The following agencies responded to the stakeholder survey:

- The Rural City of Murray Bridge
- Carers SA
- Murray Mallee Aged care Group
- Murray Mallee Community Health Centre.

These agencies combined delivered a range of HACC services for the Murraylands regional community. Some of the services provided were: domestic assistance, home maintenance, home modification, social support, support services for carers, transport assistance, centre base day care, personal care, community nursing, Community Aged Care Packages and Extended Aged Care Packages. At the time of the survey the agencies indicated that they were servicing a very small number of people from the Croatian, Filipino and Vietnamese communities. For additional information please refer to the MDS HACC data from the Department. For this region, ethnic communities were not strongly represented on the HACC data.

Gaps in service provision as identified by stakeholders and community include:

- limited local public transport
- limited local taxi service
- no local interpreting services
- cost prohibits the hire of interpreters from Adelaide
- no cultural competency training
- no CALD workers to provide HACC services.

As the CALD community in Murray Bridge is still relatively young the priority is for cultural competency training of mainstream agencies dealing with ageing issues.

7.4 PORT LINCOLN

Port Lincoln is the major service centre to the Eyre Peninsula and with burgeoning aquaculture activity and services it is the home of aquaculture. Port Lincoln's primary industries include the production of lambs, wool and beef and cereal crops (including wheat, oats, barley, canola and lupins). Port Lincoln is perhaps the nation's biggest combined agricultural and fishing centre. Tuna, prawns, lobster, abalone and scale fish are the major fishing and aquaculture industries.

Located on the Eyre Peninsula, Port Lincoln is situated approximately 650kms from Adelaide, South Australia.

The Eyre Peninsula experiences a high degree of isolation and levels of socioeconomic disadvantage range from very high to moderate.

The Port Lincoln local government area had a population of 14 245 in the 2006 Census. 7.2% are from a CALD background and 5.4% are from an Aboriginal background. At the 2006 Census there were 103 people aged 50 and over from the designated ENSS countries of birth living in Pt. Lincoln and 15 of these lived alone. Over 50% were aged under 65 at the 2006 Census.

According to ABS 2006 Census data there are 16 languages other than English spoken at amongst residents aged 50 and over. 70 people spoke one of the designated ENSS languages as their main language at home with the majority of these speaking Croatian. More recently the Filipino community is showing a strong presence in the area, but this community is relatively young and currently not dependant on HACC services.

Post World War II there was an influx of migrants and the community boasted a diverse population including communities from the former Yugoslavian region, Greece, Italy and Poland. These communities established themselves within the fishing, agricultural and ship building industries in and around Pt. Lincoln.

When the greatest CALD population was at its peak between 1950 and 1990 the Pt. Lincoln Multicultural Council (PLMC) was established and this body received Department of Immigration funding to assist new immigrants settling into Pt. Lincoln. However, as the number of new immigrants diminished the Pt. Lincoln Multicultural Council lost its immigration funding. It has slowly wound down its operations and is no longer as prominent as it once was. This situation is similar to that of other multicultural agencies in regional South Australia. When Government departments withdrew funding from specific regional programs they did not support the local groups in seeking other more appropriate sources of funding and this has led to ongoing issues for some CALD communities.

Where once CALD people relied on Pt. Lincoln Multicultural Council to support them the elderly now rely on their families and friends. In many instances their immediate family members have moved to Adelaide or other States for economic reasons and this can create difficulties.

Ethnic communities do not have an identified worker to assist them and advocate on their behalf. This gap in service provision in the region still exists and even though the number of people from a culturally and diverse background has diminished it has become more prominent now that the ethnic community is ageing.

Agencies within Pt. Lincoln service a region well beyond the city boundaries and many indicated that they find it difficult to capture CALD clients in their services.

Recently, some agencies have approached the Pt. Lincoln Multicultural Council committee members to assist them with connecting into the local CALD community.

Local agencies indicated that they needed to be more proactive in reaching out to ethnic communities, but due to resource constraints this was not possible. All local agencies work across each other to ensure that a client receives the best possible service.

There is no formal means of disseminating information into the community. The local paper is in English and all community groups are run in English. People with language difficulties are not accessing services; they prefer culturally and linguistically appropriate service provision, however this is not possible in Pt. Lincoln. CALD residents contact ethnic community agencies or family in Adelaide for support and information.

Community members, the Pt. Lincoln Multicultural Council and local agency workers all indicated that the local community would benefit by having a dedicated CALD ageing position located in Pt. Lincoln who would also service the periphery areas.

The following agencies responded to the stakeholder survey:

- Country Health SA, Pt. Lincoln Health Services
- West Coast Home care
- Mathew Flinders Day Care
- Carers SA.

These agencies combined deliver a range of HACC services for the West Coast regional community. Some of the services provided were: domestic assistance, home maintenance, home modification, support services for carers, transport assistance, centre base day care, personal care, allied health services, social support and community nursing. Other services included Community Aged Care Packages, Extended Aged Care Packages and Extended Aged Care Packages Dementia. At the time of the survey agencies indicated that they were servicing a small number of people from the Croatian and Serbian communities. For additional information please refer to the MDS HACC data from the Department.

Mathew Flinders Day Care, West Coast Home Care and Country Health SA, Pt. Lincoln Health Services have over the years developed a working relationship with the Pt. Lincoln Multicultural Council to meet the needs of the CALD communities in Pt. Lincoln and surrounding areas.

For this region, ethnic communities were not strongly represented on the HACC data.

Stakeholders and community identified the following gaps in service provision for the CALD communities in Pt. Lincoln:

- no CALD specific ageing worker
- no ethnic meals
- limited transport options
- interpreting and translating undertaken by family and friends
- phone interpreter not utilised as people are wary
- agencies do not know their CALD client base
- lack of cultural competency training for workers
- no local ethnic media
- limited to no specialist services
- shortage of doctors in the region
- lack of CALD mental health support
- lack of culturally and linguistically appropriate workers
- literacy issues in reading translated information.

Additional research in the area which may complement OFTA's ENSS and identify further gaps which need addressing is currently being undertaken by the University of Adelaide, NHMRC study, *The Physiology of health Systems: Port Lincoln as a case study*, commenced November 2009 and will run over two years. "The Research is to capture and describe comprehensively all health system activity relating to a sizeable and carefully-defined Australian population (that of Port Lincoln, in western South Australia, population ~14 000) and, simultaneously, to undertake a person-based, population-wide assessment of health in the same community. Together, these activities will form a unique basis for the introduction and careful evaluation of a series of changes to the health system that have been mooted at State and National level, providing, for the first time ever, a proper foundation of evidence for abandoning those initiatives or rolling them out across the rest of the country"[5].

The key agency delivering HACC services (including CACPs packages and domiciliary care) in the region is Pt. Lincoln Community Centre, Country Health SA which provides the whole range of HACC services. The catchment area for the Port Lincoln Health Service extends throughout the Eyre Peninsula to the Western Australian border including the townships Tumby Bay, Coffin Bay, Elliston, Wudinna, Cummins, Lock, Streaky Bay, Ceduna and Yalata. The Service has numerous partnership and networking arrangements including:

- Options Co-ordination
- Uniting Care Wesley

[5] NHMRC 2010 Project Grants http://www.nhmrc.gov.au/research/index.htm; http://sgrhs.unisa.edu.au/SGRHSProjects/project.asp?Project=317

- Port Lincoln Aboriginal Health
- West Coast Home Care
- Mathew Flinders Residential High Care
- Pt. Lincoln Multicultural Council.

Country Health SA - Pt. Lincoln is well placed to auspice a CALD Ageing position and is committed to working in partnership with all ethnic community groups in the region to meet the needs of the diverse ethnic ageing population for the region. The service data for clients of Pt. Lincoln Community Health indicates that 190 CALD individuals currently access Community Health Services which is approximately 39% of all CALD individuals in the Pt. Lincoln area. The HACC program currently services 117 of those clients which represent approximately 24% of the Pt. Lincoln CALD population.

7.5 RIVERLAND

The Riverland covers the area near the Murray River from where it flows into South Australia downstream to Blanchetown. The major town centres are Renmark, Berri, Barmera, Loxton and Waikerie. The Riverland region is approximately 220 kilometers from Adelaide. The area is primarily known for the cultivation of grapes, citrus fruits, tomatoes, vegetables, wheat and wool.

The Riverland region's population in 2006 was 33 460 people (2.1 % of the State's population). The Loxton Waikerie District Council area has the largest population in the region, with just over 12 000 people, or 36 % of the region's total population. Berri & Barmera District Council has a population of approximately 11 370 (34 % of the region's total), and there are just over 9,860 people in Renmark Paringa (30 % of the total). Renmark is the multicultural centre for the Riverland area.

Australian-born people comprise 84% of the population of the Riverland, well above the State average of 74.0 %.

The cultural diversity of the region is based primarily on older migrants from Croatia, Macedonia, Lebanon, Vietnam, Greece, Italy, Turkey, India and some more recent arrivals from Afghanistan and the Middle East on Temporary Protection Visas to work in the region. There were 88 people aged 50 and over at the 2006 Census in Berri and Bamera and 48 in Renmark Paringa from ENSS designated countries of birth. 27 of these were living alone.

Due to the distances between towns that make up the Riverland region, limited transport services and programs and the scattered location of diverse ethnic communities it is difficult to meet the needs of the CALD community in this region. These groups, particularly the Croatian community, were difficult to access.

Culturally and linguistically appropriate services are vital to communities in this area as many people have lived isolated lives on their farms and never learnt English. There is a strong reliance on family to support elderly parents however, many children have moved for economic reasons and people are left on their own without immediate supports.

The Croatian Care for the Aged Inc provides outreach work to the Riverland region as communities have requested their support. It must be noted that there are some ethnic communities with Community Partners Program (CPP) funding that are also reaching out in this region. Such a response is vital for isolated community members to receive culturally and linguistically appropriate support.

Stakeholders indicated that CALD clients do not access services early, waiting until crisis point and this can be difficult in a region which has limited resources. Agencies acknowledge that they do not undertake community development work with ethnic communities "they are happy to support CALD clients if they are approached but do not actively go out looking for them".

Like so many other regional areas the Riverland Multicultural Forum had a position funded through the Department of Immigrant to support new immigrants settling into the region. They also lost their funding but managed to keep their office going through other funding sources.

The Forum which is a focal point for the multicultural community in the region advocates on CALD issues, supports the community as required and acts as a multicultural information source for agencies but it does not deal with aged issues itself because of a lack of funding.

Currently multicultural HACC services are provided by Ethic Link Services who have regional offices in both Renmark and Whyalla. They provide a valuable service to the Riverland multicultural community but in some instances are unable to provide a language specific response to some of the CALD groups in the region. During the consultation it became evident that some of the local community members and agencies were not aware of Ethnic Link, and appreciated this project alerting them to this service.

The following agencies responded to the stakeholder survey:

- Country Health SA Waikerie Community Service
- Country Health SA, Renmark Community Care Services
- Country Health SA, Renmark Community Care Services
- Uniting Care Wesley, Port Adelaide (Ethnic Link Services)

These agencies combined delivered the broad range of HACC services for the Riverland community. Some of the services provided were: domestic assistance, home maintenance, home modification, support services for carers, transport assistance, centre based day care, personal care, social support and community nursing. Other services included Community Aged Care Packages, Extended Aged Care Packages and the National Respite for Carers Program. At the time of the survey agencies indicated that they were servicing a number of people from the Croatian and Macedonian communities. They also provided services for a number of other ethnic communities. For additional information please refer to the MDS HACC data from the Department.

Communities and stakeholders identified the following gaps in services for the Riverland community:

- limited transport for the region (there are many buses in the region but there is a lack of coordination)
- no public transport on weekends or evenings

- no generic ethnic community worker in the region
- services are not using interpreters
- no local interpreters
- people are wary of phone interpreters
- doctor shortages and people unable to see own local doctor.

OFTA may benefit from reviewing the role of the Multicultural Forum and Ethnic Links role in this region to clarify the most effective way to meet future needs for the whole CALD ageing community.

7.6 WHYALLA

Whyalla is the third most populous city in South Australia after Adelaide and Mount Gambier. It was established initially as a mining town by BHP but came to prominence in World War II when ship building became the main industry for the area. In 1948 displaced persons began arriving from Europe to the region to provide the labour for the ship building industry. Shortly after the war a solar salt industry was added to its already powerful industrial base.

To satisfy the continuous demands for labour both the Commonwealth Government and BHP placed advertisements in overseas newspapers for many years to attract fitters, turners and machinists. The population boom of Whyalla peaked in 1976 when it settled at just over 33 000 with the largest shipyards in Australia. A slump in ship building around the world in the mid 1970s resulted in the closing of the shipyards in 1978 and a decline in the BHP iron and steel industry since 1981 also impacted employment.

Whyalla in its peak economic period had a very diverse community predominately from European backgrounds as a result of post war migration. More recently, the community has seen the influx of people from the Philippines, some through skilled migration, family reunions and students. The Filipino community in the area is much younger and appears more organised as a group. The community is also accepting newer refugee groups.

There were over 1200 families from Spanish and Croatian background in Whyalla in the 1970s and 1980s. These numbers have since dwindled with families moving to Adelaide and other States for economic reason. Those who remained are now very frail and aged and in need of great support and require assistance to meet their daily needs. Many rely on their families for this support but many have no local support structures and live quite isolated lives.

Since 2004 the city has experienced an economic upturn as a result of the mining boom with the population slowly increasing and the unemployment rate falling to a more typical level. According to the 2006 Census the population of the Whyalla census area was 21 122 people, making it the second largest urban area behind Mt Gambier in the State outside of Adelaide. Approximately 73% are Australian-born, and only 3.6% were Indigenous people. Whyalla has a very diverse cultural mix of people speaking 24 languages at home aged 50 and over.

There were 238 people living in Whyalla aged 50 and over from ENSS designated countries of birth at the 2006 Census. 54 % of these were aged 65 and over and 29% lived alone.

Whyalla Multicultural Communities Centre received Grant in Aid funding from the Department of Immigration to assist new migrants from CALD communities to successfully settle in the regional areas of SA. When the funding ended the Centre was unable to

continue and has now closed. This issue was raised during the Carers consultation which HOKJOK undertook and again during this consultation. Community members indicated that they need a specific aged care worker who understands their cultural and language needs. The community would like to see an ethnic aged position similar to that which was run by the Whyalla Multicultural Communities Centre some years ago.

Spanish community members indicated that they would like assistance to meet as a community. This would require travel assistance and facilitation of program. Both the Spanish speaking and Croatian community members indicated that they need language support either locally or from Adelaide.

This need could be addressed by Adelaide-based peak ethnic agencies such as Croatian Care for the Aged Inc. undertaking outreach work.

The stakeholders interviewed as part of the consultation indicated that there were gaps in community cohesiveness and that agencies have not been able to respond to the cultural diversity in the region.

Currently Uniting Care Wesley Port Adelaide auspice two Ethnic Link workers in Whyalla however, the need is beyond current Ethnic Link funding scope. This may need to be addressed by Office for the Ageing.

Disseminating information within the local ethnic community was difficult as there is no formal way of getting information out and there was a reliance on word of mouth. Many have satellite television and ethnic papers come from Sydney but this is not local information. Interstate papers contain limited to no information related to Adelaide and the regional areas.

Many residents felt very isolated and lonely in their local community and did not know where to go for support. This message was conveyed to the consultants several times by both the community and mainstream stakeholders.

The following agencies responded to the stakeholder survey:

- Country Health SA, Domiciliary Care, services are also provided to the community at Iron knob
- Uniting Care Wesley, Port Adelaide (Ethnic Link Services)
- Whyalla Aged Care.

These agencies combined delivered the broad range of HACC services for the Whyalla and surrounding areas. Some of the services provided were: domestic assistance, home maintenance, home modification, support services for carers, transport assistance, centre base day care, respite care, allied health services, personal care, social support and

community nursing. Other services included, Community Aged Care Packages, Extended Aged Care Packages and Extended Aged Care Packages Dementia. At the time of the survey agencies indicated that they were servicing a small number of people from the Croatian, Bosnian, Serbian, Macedonian, Filipino, Egyptian, Spanish and Uruguayan communities and that combined, they catered for over 30 ethnic communities. For additional information please refer to the MDS HACC data from the Department.

Stakeholders and community identified the following gaps in service provision for the CALD communities in Whyalla:

- no activity based programs for people with mental health issues, multicultural communities and youth
- no local specialists
- limited resources for local agencies to keep up with fluctuating community needs
- limited availability of local doctors
- no social support programs unless linked into Ethnic Link services
- no transport after hours
- lack of a community bus
- lack of local interpreters
- reluctance to use telephone interpreters due to confidentiality issue
- limited translated information
- no Multicultural Forum or Multicultural Centre to act as a recognizable focus point for service access.

Community members consulted identified that they required cultural and language specific support for the CALD frail and elderly.

Uniting Care Wesley Port Adelaide is best placed to auspice a CALD position as the Whyalla office supports two Ethnic Link employees who have invaluable knowledge around Whyalla's CALD communities and who currently work within these communities. The Whyalla Ethnic Link staff have worked with a diverse range of ethnic communities and have been involved in the local ethnic community for over 40 years.

Uniting Care Wesley also has the Joan Gibbons Neighborhood Centre under its umbrella of programs. This centre runs activities and programs such as numeracy and literacy which is utilized by consumers who have English as a second language.

Uniting Care Wesley Port Adelaide is well known and respected in the community. They have strong links with various organizations and agencies such as Nunyara, SAPOL, Domiciliary Care, Commonwealth Respite and Carelink Centre, Whyalla Community Health and have a formal partnership with Housing SA, Families SA, Community Mental Health, CAMHS, and Disability SA.

8 GAPS IN SERVICE PROVISION

Table 44 summarizes gaps in service provision raised by both stakeholders and community members. It is a detailed snapshot from Spring 2009. It may be that some communities have gaps which are not included here simply because they were more focused on other issues. Some of these issues may have been addressed in the interim period.

Coober Pedy stood out as a regional area which lacked services and programs suitable for the CALD sector even though it had a far higher percentage of people born in other countries than other regional centres.

Some Agencies have tried to undertake outreach work into Coober Pedy but have not been able to maintain this on a regular basis because of funding issues.

TABLE 44: SUMMARY OF GAPS IN SERVICE PROVISON RAISED BY STAKEHOLDERS AND COMMUNITY MEMBERS

Gaps in service provision	Coober Pedy	Mt. Gambier	Murray Bridge	Pt. Lincoln	Riverland	Whyalla
Health issues						
Shortage of doctors in region	√		√	√	√	√
No specialised health services,	√			√		√
No local allied health services	√					
No dementia specific services	√					
No suitable social workers or counsellors to address Post Traumatic Stress Disorder or mental health issues	√	√		√		
Communication issues						
No local interpreter services, relying on family and friends	√	√	√	√	√	√
No information available in other languages	√					
Limited translated information available		√				√
Cost of hiring interpreters from the city			√			
Communities suspicious of telephone interpreters	√	√	√	√	√	√
No local ethnic media				√		

Table 44 Gaps in service provision continued	Coober Pedy	Mt. Gambier	Murray Bridge	Pt. Lincoln	Riverland	Whyalla
Transport Issues						
Public transport limited – no weekend services or after hours	√ No public transport	√	√	√	√ No coordination of existing buses	√
Limited local taxis			√			
No community bus	√	√				√
No public transport	√	√				
No HACC transport outside of office hours	√					
CALD workers and programs						
No CALD Ageing worker	√		√	√	√	√
No language specific programs	√	√				
No cultural meals services	√	√		√	√	√
No CALD staff to provide service delivery		√		√		
No cultural competency training	√		√	√		
Limited financial resources to provide specialised CALD programs	√	√		√		√
Limited formal links into ethnic communities based in Adelaide	√ Croatian Care for the Aged Inc and Serbian Orthodox Church of St Sava, Woodville Park					
No day centre	√					
No after hours services for current HACC programs	√	√				
Diversity of ethnic groups in the region, makes it difficult to respond appropriately		√		√		
No social activity programs for the aged	√					√ unless linked to Ethnic link programs

Table 44 Gaps in service provision continued	Coober Pedy	Mt. Gambier	Murray Bridge	Pt. Lincoln	Riverland	Whyalla
Infrastructure						
No community centre where activities could be run for the elderly	√					
No low care facilities	√					
No appropriate town infrastructure	√					

9 RECOMMENDATIONS

The top three regional priorities are: Coober Pedy, Whyalla and Port Lincoln with workers servicing surrounding areas as they become established.

1. It is recommended that a multicultural ageing worker is auspiced by Cooper Pedy Multicultural Forum for Coober Pedy. As this worker becomes established outreach work with surrounding towns is recommended.

2. It is recommended that a part-time multicultural ageing worker is auspiced by Country Health SA for Port Lincoln. As this worker becomes established outreach work with surrounding towns is recommended.

3. It is recommended that a multicultural ageing worker is auspiced by Uniting Care Wesley Port Adelaide for Whyalla.

4. It is recommended that the multicultural ageing workers be provided with support and peer training and advice and that the workers are part of:
    a. a Multicultural Ageing HACC Workers Regional Network supported by OFTA
    b. the Office for the Ageing Multicultural HACC Workers Forum

5. It is recommended that sufficient resources are provided for travel, lap tops with inbuilt cameras to support Skype, and GIS hand held equipment (to enable workers to plan their travel within the region as efficiently as possible).

6. It is recommended that Croatian Care for the Aged Inc. undertake outreach work for the Croatian community in Cooper Pedy, Port Lincoln, Whyalla, Mt Gambier and the Riverland.

7. It is recommended that OFTA coordinate and fund cultural competency training for HACC service providers in regional South Australia.

8. It is recommended that OFTA review the role of the Multicultural Forum and Ethnic Links role in this region to clarify the most effective way to meet future needs for the whole CALD ageing community.

9. It is recommended that a future project be established to:
    a. facilitate the establishment of partnerships both within the regions and between regional workers and metropolitan agencies for the whole CALD sector in Regional SA
    b. identify other outreach programs which are needed.

10. It is recommended that a whole of Government approach be taken to funding the needs of migrant groups over the continuum of their settlement and ageing process and that a specific State/Federal reference group be established to address this.

10 APPENDIX

APPENDIX 1: PROJECT TEAM

The Project Team is a consortium comprising of:

HOKJOK	Ms. Helena Kyriazopoulos
	Ms. Kristin Johansson
	Project Officer, Mrs. Amanda McInnes
The University of Adelaide, The Australian Institute for Social Research	Dr. Kate Barnett
Seniors Information Service	Mrs. Miriam Cocking

Hokjok is the lead consultant and the project manager for the Emerging Needs Scoping Study.

As a team, the consortium has over 50 years collective experience in the ageing sector and well over 80 years combined experience working with CALD communities at a local, national and international level. The members of the consortium are based in South Australia and as a group have extensive local knowledge and networks.

APPENDIX 2: STAKEHOLDERS CONSULTED

Coober Pedy	
Steve Baines	Mayor of Coober Pedy Council
Tina Doulgeris	Chairperson, Coober Pedy Multicultural Forum
Krystal Hauri	Vice Chair, Coober Pedy Multicultural Forum
Maria Novosel	Families SA
Gai Di Donna	Manager Community Health
John Day	Coordinator Community Services
Martine Brooks	Health Promotions Officer
Maria Gigos	Former resident and former Chair of Coober Pedy Multicultural Forum.
Sasha Dragovelic	Former resident, worked for Centrelink in Coober Pedy
Adriana Beltrame	Formerly worked in Coober Pedy region
Sister Slavica	Croatian Care for the Aged Inc.
Mt. Gambier	
Jennie Liebich	SEDAS South East Disability Advocacy Service
Marj Hately	ACAT
Helen Warhurst	Boandik Lodge
Trish Patzel	Boandik Lodge
Galhan McGirty	Boandik Lodge
Chris Stephensen	Community Health
Colleen Moore	Carers SA
Krys Howard	Home Carers Plus
Murray Bridge	
Ailene Lawson	Murray Mallee Community Health Service
Nayano Taylor- Neumann	Lutheran Community Care
Carla Vicary	Murray Mallee Community Health Service
Gary Sawyer	Murray Mallee Ageing Taskforce, Rural City of Murray Bridge
Kylie Cornish	Community Care, Rural City of Murray Bridge
Helen March	Community Care, Rural City of Murray Bridge

Ann Marie Garrett	Coordinator Our Well Being Place
Port Lincoln	
Joe Morrison	Country Health SA, Community Health Pt. Lincoln
Michelle Lydeamore	Port Lincoln Health Service (PLHS) ACAT
Jan Bebbington	Port Lincoln Health Service (PLHS) Dom Care
Julie Elliot	Matthew Flinders Home
Christai Shery	Australian Red Cross
Michelle Schilling	Port Lincoln Health Services
Caitlin Parker	Port Lincoln Health Services
Peter Zdravkovski	Chairperson, Pt Lincoln Multicultural Forum
Josel Bautista	Chairperson, Club Filipino Inc of Port Lincoln
Riverland	
Robyn Blight	Carers SA River Murray & Mallee Carers
Graham McNaughton	Riverland Advocacy Service
Andrew Haigh	Berri Bamera Council
Cathy Perre	Riverland Multicultural Forum, South Australian Multicultural Ethnic Affairs Commission, MADEC
Kathy Rosenthal	O' Briens Solicitors (Croatian background)
Sandra Karayannis	Ethnic Link Services
Rita Lobban	Ethnic Link Services
Julie Brand	Riverland Carer Respite Program, Ethnic Link Acting Coordinator
Michele Garrett	Renmark Community Care HACC Coordinator
Carol-Ann Zimmerman	Riverland Community Health Service, Aged Care Team Leader
David Ward	District Council of Loxton Waikerie
Andrew Talbot	Disability SA
Virginia	
Pat Cole	Amalgamated Playford Council
Whyalla	
Jodie Chadwick	Joan Gibbons Neighborhood Centre
Sandra Brabon	Domiciliary Care
Branimir Kevin Sprajcer	Croatian community

Juan Diaz	Spanish speaking community
Beatrice Evans,	Filipino Community of Whyalla
Jan Cowie,	Multicultural, Bethel Christian Church, Whyalla
Marijka Kowalzuk	Ethnic Link Services
Lillian Shaw	Uniting Care Wesley Port Adelaide (UCWPA)
Meg Hanley	Uniting Care Wesley Port Adelaide (UCWPA)

APPENDIX 3: HACC STAKEHOLDERS

HACC Stakeholders
ACH Group, Murray Bridge
Boandik Lodge Inc.
Carers SA - Eyre Carers
Carers SA River Murray & Mallee Carers
Carers SA South East Carers
Community Health SA Dom Care -Whyalla
Country Health SA Coober Pedy
Country Health SA Hospital Inc.
Country Health SA Pt. Lincoln
Country Health SA Renmark Community Care Services
Mathew Flinders Day Care
Murray Mallee Aged Care Group
Murray Mallee Community Health Centre
Pt. Lincoln Health Services
Rural City of Murray Bridge
South East Regional Community Health Service
Uniting Care Wesley Port Adelaide Inc.
Waikerie Community Health Service
West Coast Community Services
Whyalla Aged Care

APPENDIX 4: COMMUNITY STAKEHOLDERS

Community Stakeholders
Coober Pedy Multicultural Community Forum
Croatian Community Whyalla
Club Filipino Inc. of Port Lincoln
Filipino Community, Barmera, Berri and Loxton
Filipino Community of Murray Bridge
Filipino Community of Whyalla
Pt. Lincoln Multicultural Council
Riverland Druze Community
Spanish Community Whyalla

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