Please note: this is an automated transcription

The Care Matters podcast is brought to you by the ESRC Centre for Care and CIRCLE, the Centre for International Research on Care, Labour and Equalities.

In this series, our researchers welcome experts in the field and those giving or receiving care to discuss crucial issues in social care. As we collectively attempt to make a positive difference to how care is experienced and provided.

How Language Matters in Transnational Care: In conversation with Professor Loretta Baldassar

Jayanthi Lingham:

I am, Jayanthi Lingham and I'm a research associate here in the Centre for Care, Sheffield. I'm really pleased to be here today with Professor Loretta Baldassar. Loretta, I wonder if you could introduce yourself.

Loretta Baldassar:

Thank you. I'm really delighted to be here. I'm a visiting fellow in the Department of Sociological Studies at Sheffield University. But I'm also affiliated with the centre for care, particular working with Majella Kilkey on the migration aspects. The bordering, everyday bordering stream. And I am from Edith Cowan University. I have a new role at Edith Cowan University in Perth, Western Australia, where I am Vice-Chancellor, Professorial Research Fellow and I head up, research lab called the Sage Lab Social Ageing Futures and also a tracks migration research network.

Jayanthi Lingham:

And the reason that we have come together in this podcast is because, I work with Majella Kilkenny within a research group that is called Care Trajectories and Constraints. And within that I work on a research strand called Borders in Care, which is looking at the care needs and experiences of people who have cross borders, and as part of that, quite often may not have, English as a first language.

And in the co-production work, it's become apparent that it's really important for us to think about the language that we use, not just in relation to the Borders and care study, but more broadly around care when we're communicating our research and when we're talking with potential research participants, and that this is the reason why we we've decided to have this podcast mini series called How Language Matters, which is part of the centre for care Care Matters podcast series.

And this is the first episode in the mini series. And we thought and it was a fantastic opportunity to think, much more about how language matters when we're talking about

research and associated policy with in relation to ageing and care and migration. And so actually, I think I wanted to start by asking you some of the background, because your research is Australia based. The research that we're doing here, and the centre is in the UK, and it would be really useful to know what the relationships between migration and ageing and care in Australia.

Loretta Baldassar:

Thanks, Jay. And those issues are really pertinent to, the research I'm doing as well. In fact, I think that language matters and language issues can provide a really interesting lens on helping us to understand the migration process for settlement process service delivery and transnational issues. But to answer your specific question about the relationship between migration and care in Australia, I suppose a couple of things I could start with to set the stage a bit.

1 in 3 older people in Australia was born overseas. So by older people I mean people over the age of 65 years. And so that's a huge proportion of our population. So diversity and migration in ageing is a big and growing issue in Australia. So waves of migration can really clearly be seen in the ageing profile. So the big post-war influx, which was a major influx of non-English-speaking migrants from southern Europe, primarily Italy, Greece, the former Yugoslavia, Malta, these people are all now, you know, something like 75% of the southern European born are over 75 years of age.

So that's a big ageing issue. And then in the 70s, we had the began to have the influx from South Asia, Southeast Asia. These populations, you know, in their 50s and heading towards ageing really quickly. So ageing and diversity is a big issue for us. And it's up front and centre in our discussions about ageing. The other point to make is that our care workforce is also a migration issue.

So migration is a care. She cares a migration issue. And something like 40% of our care workforce are migrants. And that percentage increases as the skills level decreases. So our lower skilled care workers are often the most recent migrants. And these are very vulnerable, groups who are in precarious jobs in the care workforce. And all the issues that I know are relevant to the UK are relevant to Australia as well.

But what we have is a situation where that care workforce, a very vulnerable population, is paired with the older migrant population in the care setting, who are also a vulnerable population, but they're from different migrant backgrounds with different languages, and everyone is speaking English as a second language. So here we have two vulnerable populations in that setting. So language matters a big deal actually for the care worker and for the care recipient.

Jayanthi Lingham:

It's really interesting and useful to hear that background in in the UK. I mean people have always migrated obviously with that with the history of the British Empire especially. But after World War two, there was active recruitment from across the old empire for former colonies of people to fill the labour force gaps. And so people came as part of the the empire as citizens and came here.

And in Sheffield in particular, for example, came to work in the heavy industries. And then later in the 70s came to work in the service sector, setting up, you know, the takeaways, restaurants and everything. You know, people always migrate, obviously for multiple complex reasons. But then they've also been people fleeing post-colonial conflict, political situations and much more now, climate crisis, economic crisis.

And so we also have a very diverse population in Sheffield across the UK. And that's, part of the population that came many years ago are also obviously it's similar to Australia, in that situation with differing language needs. So people, while they were part of the British Empire, will have learned English very much and, and, and come here speaking very good English, albeit in accents different from what people might have expected.

But there are language needs, but also the needs of a diverse population. More broadly in the UK, some of those relate to what you might have expected in terms of your care arrangements. Moving from one place to another place and, and perhaps, having to navigate different families, structures and setups and having family that, are in different places overseas and, and you'll hear so all of those matters is still relevant. And I think in the UK.

Loretta Baldassar:

That that's another dimension I could have added. Actually, you're absolutely right. There's also the case of migrants living across borders, transnational families and migrants working out how to care for family members who are distant, living in another place. And all of the, issues that that are relevant there. But going going back to the language issue, you know, why does language matter, I suppose is the question here.

And, what we know very clearly from Australian data is that migrant groups are more likely to access services later. And in poorer states of health, so they access them later in terms of their health trajectories. And we know that one of the barriers is language and another barrier is cultural, he said. You know, where expectations about care.

So, broadly speaking, it can be helpful to say, you know, families, cultures that are used to relying on the family for care, you know, tend to leave it later to access services provided by the state. And we're seeing that in, in, in the care stats and the health stats for El Davis ageing populations. So that's one way that we can see language really does matter.

And actually there's some really interesting work that's informed my research anyway by, Elisabetta Santini and Tracy Reynolds in the UK on those groups that you were describing.

He arrived in the post-war period. And what they showed in their work was that those groups that have what they called, I still I'm not sure now what terminology they use.

They might have used the term cultural broker, those communities that have people within them who are proficient in both languages, both the language, the host country language, if you like, and the the languages of the sending areas, and also proficient in the literacy of the health service landscape, you know, and that today also includes digital literacy, right?

Because a lot of our services have gone online. So there's another kind of language literacy we need to to think about, health literacy and health online literacy. Those communities that are well embedded and integrated usually have members within them, often that what we call in migration studies, the second generation or the 1.5 generation. These are the members of the community who were born in the host country.

So they are really proficient in the host country language, but also in the service landscape. Whereas new and emerging communities or communities that might be more marginalised for other reasons, for other barriers, who don't have that kind of member, who has that cultural competency set of competencies, are even less likely to access services in a timely way.

Jayanthi Lingham:

I was just going to this chicken, actually, because it's so interesting hearing about the situation in Australia. And obviously you've referred to research on the UK, and it was making me think about the, some research that I was involved with when I was at Warwick University working with, Professor Sharon Rye, and we were working on a study looking at the experiences of unpaid carers and unpaid carers and older people who need care, specifically during Covid, but that the matter of brokers, if you like, came up and exactly as you said quite often second generation or younger generation who were mostly literate, so could speak fluent, can speak fluently in English,

but also navigate the health system and also digitally literate end up having to help not just their family members, but across the community. And one of the things that came up was that while that ends up being kind of a linchpin, because that those resources are not there when they need to be within the social care and health care system.

But also there were risks of power dynamics and difficulties and challenging household dynamics, kin dynamics, as we all have across all of our communities and issues of people maybe being taken advantage of and being charged to use particular language support. And so there's an extra layer of kind of vulnerability that that comes in there when those matters of language aren't addressed.

The other thing I wanted to bring up was that you were saying, with newer waves of migrant communities in Australia, there is, research that shows that people reach health services or don't access health services until much later. And I think here in the UK, there

was some research actually, from quite a long time ago by the Joseph Rowntree Foundation in 2007.

I think that was looking specifically at the post 2004 migration that had happened after and countries and joined the EU and when the UK was still in the EU. So people came a lot of people came as working migrants from, places like Poland and, were working in much more precarious sectors and also didn't have English and didn't access.

And, and now coming to the point where they really need to access health services but never thought to access them and that presenters or that did present as much more urgent issues when they did eventually reach those services. Which is an issue for those peoples in those communities, health and needs and an issue for that system as well.

Loretta Baldassar:

It's those, people that had access services later in poorer states of health that increased the cost of health care as well, and also the impact on their lifestyle and the, you know, their capacity to live meaningful lives in their later ages is also diminished. So it costs the health care system and the individual and the family and the community when that's happening.

So it's something we really need to address. And your earlier point two links, both points together. I think around what both countries are now are grappling with in terms of interpreter and translation services. So, you know, we've put a lot of effort in Australia into developing a national translation interpreter service, which can be online or on the phone to avoid those informal arrangements which were happening certainly before the service was available, where a family member does the translating and interpreting and all those issues about power and gender and the appropriateness, come into play.

And so we know that that's not best practice. We know that that should be avoided. Of course, it still happens informally. And, you know, I remember because I've been working in the field for 30 years, you know, the cleaners were brought in because back in the post-war period, the cleaners had a set of language competencies that matched these groups, not the care staff.

And they were brought in to, to be informal interpreters and translators. What you find now with the smaller groups, even when you use the formal, service, is that sometimes because of political and religious fractions, they might not be the right person either. So it's a really complex matters in that language. It really matters. And it's a really complex.

Jayanthi Lingham:

Yeah. There's two things that I was thinking as you were saying that, and I'm going to say the first and I have to remember the successes, and the first is when you were describing were you were saying that in Australia that there's the National Translation Interpretation Service. In theory there is that in the UK also. So if you go to use the NHS, you have the

right to request an interpreter that's going to be there, that because of underfunding under resourcing it doesn't.

I don't think it necessarily always happens or happens to the extent that it's needed. And the other thing is that even when English is your first language and you are supporting or and you are going to the health service or social care service, and you have particular care needs or emerging care needs, the system is again, so under resourced now that the likelihood is you'll only get your needs met if you have a relative shouting about your needs and articulating your needs, forget the language, you need that.

So in a way on top of that, then it need be used. Even if you can manage the interpreter and the translation issues, you still need that relative there. So that's a really, difficult thing.

Loretta Baldassar:

I mean, advocacy definitely is critical, isn't it? In in accessing quality care. That's very clear to me from my graphic research in the sector, advocacy matters. And if you've got the additional barrier of language, it's an additional burden. And there's some really troubling research, isn't there? Especially from the US, about everyday forms of racism, creating barriers where, you know, they actually advise black people to take a white person with them to the hospital.

You know, you're actually going to be considered more seriously and listened to more seriously. If you just have a white person with you. I mean, this is clearly visible in their, research. And I think we have shades of that in both our countries as well. And, and the cost that that's, that's another barrier that's hard to quantifies.

And it, it's those everyday experiences of marginalisation which impact our wellbeing and our health and hard to pinpoint. And the other reason that people access services later in, in poorer states of health, which is related to language, is that they're not in their languages and they're not appropriate to their cultural expectations and understandings of care. So we don't have services that meet their needs easily.

You're describing a situation in perpetual crisis. I've heard people talk about it of, you know, everyone experiencing, and requiring, advocacy to get any sort of care. So, yeah, we're talking about compounding, aren't we? Barriers.

Jayanthi Lingham:

After, what, over a decade of of economic austerity and funding cuts, severe funding cuts to local services where social care is, is, is resourced, where in a profound state of crisis, as you were talking there, I was thinking about what I think my second point was, which was that, the needs of people who don't have English is the first language on, related language, but relates to more complex things than just language, so particular care arrangements and things.

And you describe that as cultural needs. I, I always have, as we talked at, kind of be in my bonnet about what we mean by culture and, and perhaps we can think about this a little bit more because we have different acronyms to refer to different groups, in Australia and in the UK. And I think in Australia, you use this acronym called Kaldi, which is cultural and.

Loretta Baldassar:

Culturally and linguistically diverse. So we do we could talk about called groups and in the UK but had been.

Jayanthi Lingham:

Yeah, in the UK there's a host of as if inadequate descriptors or acronyms, but I suppose the most common one that people might have heard is the, which gets shortens to Bame, which throws up a whole other set of issues, but which stands for black and minority ethnic communities. And I mean, we could tell a whole other podcast talking about the issues with that, but I guess straight off you can say that that kind of collapses together a whole set of needs and, trying to bring it back to language, for example.

I mean, we're talking about anyone who is being me is probably kind of a majority in the world. And so how do you how do you how do you encapsulate the needs, let alone the language and the uses of, people, those people, these people, because that includes me, in that one acronym. But on top of that, when you're navigating the system, there are so many other social hierarchies as well.

If you can talk in the right, if you can talk the language, if you can navigate to social care or health care language. But on top of that, if you can talk a certain kind of language, and this is where I say class issues come into it, if you if you can talk with a certain kind of authority, if you can, you know, if if you're from a certain backgrounds and people will take you more seriously and.

Loretta Baldassar:

Age is another dimension, all of these are, intersecting that may very rose.

Jayanthi Lingham:

But to. So I guess I was just thinking neither of those acronyms encapsulate though. Yeah. I wondered what that's you know, what the benefits are of cold. And if you are having that there in the first place. And maybe if there are other particular pitfalls.

Loretta Baldassar:

Look, I think that's a really interesting question. Why do we have these categories and other useful and so that sort of leads me back to one of the first points I made at the start actually, was that language is an interesting lens on understanding the migration process,

the settlement process and more contemporary kind of conceptions of transnational social fields and transnational ties.

And, and that's where this language, it needs to be contextually in, in Australian, migration history. So if I can give a little potted history and see what, see if that helps. In general you could divide Australian migration history. And it has been by many commentators into a number of broad periods. And for simplicity, I'll just talk about some main ones.

The first one is usually called assimilationist or assimilation ism, and that was from 1900 to about the 1950s. So this is the period of the formation of the Australian nation state. 1901 was the Federation of Australian States. We had landmark policies like the Immigration Restriction Act, which is colloquially known as the White Australia Policy. And this was, you know, a period in Australian history which is extremely formative and the impacts of which are still being felt today, where the charter group or the group against which all others were defined was the the British Protestant colonialists.

And interestingly, the Irish Catholics joined that group eventually in that period, through their advocacy and work in the Australian Labour Party and the private school system. That's a history we could, I'll just break it out. But we talk about the charter group in the assimilationist period as being Anglo Celtic, from which all other identities are defined, in particular indigenous and ethnic groups, because we had two people, what was considered a terra nullius, an, people land.

And that was only debunked, you know, really quite recently with native title, indigenous people didn't get citizenship up until the late 60s, and the Immigration Restriction Act was not disbanded until the early 70s. So this is a significant history. And in that period, we were peopling Australia with a very carefully designed immigration policy, which we continue to have very carefully designed policies that work because we are an island nation.

So you can determine who gets in and who doesn't. Anyway, let me get back to assimilation ism. This period. If we look at language and, social policy, it was about becoming Australian, a straight line thesis that, you know, we wanted people to come, but they had to become Australian. And what Australian was, nobody really defined. But it was this Anglo Celtic centre and it was English speaking and so all policy was geared to assimilation ism.

And my grandmother, who arrived before the war, remembers this as everyone needing to become a new Australian, and you were admonished publicly if you were heard speaking your first language. It was not, thought to be a positive thing to maintain the languages from the sending areas. It was considered to, limit the capacity of someone to integrate and settle and to become a new Australian.

And it was considered to not help them, learn English. Now that all fell apart in the 50s, 60s and 70s. And, sociolinguistics was particularly useful in helping us understand that if

you support L1 learning, that is your first language, you will have better outcomes in L2, which is your second language, your new language in the host country.

So that revolutionised our thinking. Unfortunately, that message is still not out there in some areas, and I know even in Europe I lived in Italy. So three years, about a decade ago, and they were still talking about how L1 impacts negatively on L2, which is actually wrongheaded. It's wrong thinking.

Jayanthi Lingham:

But in the UK, if you didn't speak English as a first language at home, you were assumed when you started school to be backwards. And so in a similar kind of practice prevailed where you would have, you know, parents desperate for their children to not be seems to be backwards. And actually, I was just thinking a little bit earlier, you you referred to, host country in sending country.

And we don't use those terms in the UK. And I think it relates to the language and, and the assumptions from that simulations, period. And I wondered if you could just explain.

Loretta Baldassar:

Well, I talk about sending areas instead of home country to avoid some of the essential izing that can happen. This is methodological nationalism, right? This is Werner's critique of of talking about peoples as national groups, because we know they're very heterogeneous. So language matters also in the way we conceptualise, write and think about things. And that's another layer that we need to be really mindful of.

Yeah. But during the assimilationist period, it was very much a straight line thesis. And home countries were thought to be homogenous cultures, and the host country was thought to be a and a homogenous culture that you could assimilate into. And so we were cold calling new arrivals new Australians. That's, it's it's emblematic in the language. The language really is a window on the social policy of the time.

And the conceptualisation and migration itself was conceptualised as a, as a process where you left your homeland and you, you know, you forgot it. And you then settled in the new country. And we had a migration of settlement policy for most people, not all. And that was reflected also in our social policy. So migration policy, social policy, language policy, all of these aligned, and they were revised in the 50s, 60s and 70s with a more integrationist stance, which was beginning to recognise that, no, people don't magically forget their homeland cultures and they don't forget their language.

And these are really central. And if you support them, you have, you know, healthier people. And sociolinguistics was really central to that work. So we started to build the building blocks we needed for the very progressive policies of multiculturalism, which

came in the 1970s. And I look back at those times as really the heyday that the they were my formative years.

I went to university in those years, and really it was very progressive. We were even talking about structural forms of pluralism, where we would deliver services in language for different groups. We had language schools, we had schools, for different communities. We had health services for different communities geared in language and attentive to all of the intersections that make up cultural ways of being.

Jayanthi Lingham:

And did it by then, did that, did that period recognise and accept that Australia hadn't been a terror nucleus? That and so were those where those services being designed to also support the people whose land had been stolen occupied.

Loretta Baldassar:

That's a really good question. It's very interesting to look at the policy and even research. There have been very two distinct, distinct, separate silos of work, one on Indigenous Australian histories and one on white settler histories. And the white settler histories is the migration stream, which is the one I've been in, and the indigenous is a separate stream.

More recently they've been coming together and people have been asking questions, about their intersections because, you know, migrants and indigenous people are also, mixed families as well. And mixed histories and, and points of intersection in those histories, especially in regional Australia. But for good policy reasons, actually, they were kept separate because there were they did have a different set of needs.

And this brings us to the point about called, you know, this is a debate, an ongoing debate. On the one hand, we it's useful to have a name to talk about diversity, like cultural linguistic diversity, because this is based on the fundamental philosophy which informs multiculturalism, which is to treat people equally. We need to be aware and recognise their differences.

Whereas if we have the counterpoint philosophy, which is to treat people equitably, we have to treat them all the same. We're missing those differences. The other side of that argument is that it's inherently othering, racialised. Another thing. Yeah. So where and interestingly, cultural and linguistic diversity in the Australian context and the policy context doesn't refer to English speakers, it just refers to non-English speakers.

And an earlier acronym was NSL, NASB, if I remember correctly, non-English speaking language background or something like that. Then we moved to called and you could do an analysis of the acronyms, and it would be a window onto this shifting understanding of culture and language, different understanding about what's involved in the settlement process and different understandings about migration.

But what multiculturalism allowed us to consider was multiple identities, intersections. This these were the building blocks for trans nationalism that came later, which was to say, well, actually, and that became more visible with, social uses of new technologies and the revolution in poly media environments. We can now talk about transnational social fields when we talk about families existing across distance, in ways that really confound and critique the straight line thesis that you leave your homeland and you don't, you know, you forget about it and you settle in a new country with transnational frames of reference. We talk about people inhabiting both places simultaneously.

Jayanthi Lingham:

And that also seems to account much better for the fact that now there are, later generations of people who are still connected to wherever it was that their parents and grandparents, travel from and also connects to here, but in different ways from how you might be connected, if you don't have that journey, that history of migration and your family background.

Loretta Baldassar:

And that is something I'm really interesting interested in, actually, is we still have research silos about service delivery, which is really a settlement focus and fraying. And then transnational issues. Yeah, be good to bring them a bit together. And and for understandable reasons they've been a bit siloed. But now's the time I think to to start talking about service delivery that embraces a transnational frame because they have been quite separate in our even in our research.

So I tend to be a transnational families research scholar now, but I did start out my career as a more service provision person. And I think language and these issues help us again, are a window onto this. Unfortunately, with 911 and the financial crisis and you know, those things, if we remember back, we had in Australia a very pointed dismantling of multicultural, certainly structural pluralism in service provision and whether in fact it was more costly.

I don't know, we've ever done the homework on that. I don't think it was because it had better outcomes. If you think about prevention and how we're living longer and in poorer states of health, but that work wasn't done when we moved to post multiculturalism, sometimes called mainstreaming, where the thesis is that all our services deal with the diversity of our population, but in reality it becomes a form of mainstream, which is monocultural.

And I wonder if that's actually also what's happening in the UK in these sort of post-racial Britain contexts. I wonder where all that work from the Birmingham school in, you know, there ain't node black in the Union Jack, which was very informative for Australia and the development of cultural studies and identity, identifying identity politics in a where's that all gone to in this moment when we look at service delivery and diversity, as you say, you

know, people have said to me here, there's so many issues that it just gets lower down the list. But really I think it's integral, isn't it?

Jayanthi Lingham:

And it seems very peculiar to even entertain the thought that we're post-racial in the UK. When you think about all the kind of ongoing political issues that have come up and, and the activism in the resistance against the racism that that has been kind of uncovered in our institutions and is ongoing.

Loretta Baldassar:

At the same time, it's not a centralising isn't it, because we're saying we are we are diverse, we are super diverse, we are multicultural, and we deal with it in our primary services, in our, you know, one service. So that tension really needs some unpacking doesn't it? And it's that but it's back to that philosophical point. Do we do we need to recognise difference in order to deliver equitable services or not? And how do we unpack that?

Jayanthi Lingham:

And bringing that to the question of service delivery and service provision in care? We had in the centre for care a seminar by one of our, one of the professors working with the Catherine Needham and Patrick Hall, who presented on their book Social Care in the UK for Nations Between Two Paradigms, published by Bristol University Press. And those two paradigms, I think, which I was not at the seminar, but yeah, it.

Loretta Baldassar:

Was a really great seminar. I was so pleased to be there. It really gave me a understanding of UK history. And, you know, it's interesting. The title says Four Nations, but those four nations are the four nations of the United Kingdom. And within that it sort of implicitly shows heterogeneity, right? Doesn't it? And there's language issues in those four nations with Welsh and, Gaelic and so on.

But the other diversities of the migrant histories, just seem to disappear a bit. And we talked about that at the end of the seminar, and I think people are really interested. And because I have come with an Australian frame, where we've had a Royal commission into aged care quality, health and standards. And even in that, I have to say, diversity issues were not key, but, you know, they were mentioned using the nomenclature of called and indigenous culture and linguistic diversity.

And there were mentions of it. And we have had as a result, recommendations about how to provide ethno specific services. And this brings me to, the seminar and, and this work. So should we support ethno specific services, which are a form of structural pluralism, where we're using service delivery and language and recognising cultural needs.

And I suppose if we map that onto the two, the tensions between the two paradigms in, Catherine Needham and Patrick Hall's work, they called the two paradigms, I think, differentiated and standardised. So the standardised is that approach which is regulated, consistent, you know, considers safety issues, institutionalised, centralised, tries to treat everyone equally.

Jayanthi Lingham:

So this is standardised care. On the one hand, the one paradigm. And those are the kind of, the benefits or advantages of standardising that care. So you have a certain level of at security, of knowing that you, you have the right to get access to all of that. Schenker.

Loretta Baldassar:

Exactly, exactly. Whereas the other paradigm was, I think they called it differentiated, which was person centred, micro commissioned, asset based, more flexible, responsive to individual needs. And this could be more like where you would find ethno specific. But what happens there is that with all that flexibility, are we, sort of sacrificing consistency. And are we then challenging safety and standards and, and so the royal Commission in Australia kind of said looked at ethno specific, which is from that differentiated, paradigm and said, well, yes, it is the best care for to deal with cultural differences and language differences, but we need to standardise it so that we meet certain standards.

And so now you need to employ at least this many language speakers, and you need to do this, this and this, which is good at one level. But what it's resulted in is a lot of ethno specific providers have said we just can't meet that. So we've sort of sacrificed the really good programs that I could see were continuing that really did try and manage those things.

And where you sort of see it, and my work is mainly qualitative and micro. Okay. So I'm going to go to some of my more micro studies is in is in dementia care. You know, you've got someone who's lived in Australia for 50 years. They're now in their 80s. They've got progressive cognitive decline. It days Apache. They're reverting to their first language, which is something that happens with cognitive decline.

Maybe no one in their family speaks that language fluently because it's really their first language, like a dialect from their home country. People might still, in their family have standardised forms of the language but not know that dialect. So they become increasingly socially isolated. Their personhood is at risk because it's difficult to co narrate their life. And I think narrative methodologies are really helpful to understand dementia because you find in couples, for example, that the spouse without dementia will co narrate the person's life and ability to participate and in social engagements by kind of filling in the gaps in their attempts to speak.

It's a beautiful kind of theory and method. And what happens in care settings, institutional care settings in particular, if there's no one that has that language or even those cultural

understandings about touch and, what the care ways, that person can become very shut down and isolated. And I've seen it, I've seen the person very withdrawn.

And then it's very difficult to interpret their care needs. And, and there's, you know, increasing use of chemical restraint because of problematic behaviours. And sometimes what's the root of this is communication issues sometimes. And I'm not an expert on dementia, but I had seen these things unfold. And I think we need more research and we need to look at this.

And I think language matters here. So I think the Royal Commission is right to say language is a key here. And let's have some standards around care delivery and language in language. But then I think if we make the standards too high to achieve, we're also undermining what's possible. And maybe we need to think more creatively about how to deliver those needs.

As I said at an earlier point in our conversation, the migrant care workers have different language backgrounds to the older population. At some point, these are going to line up better, and so I'm hopeful about, the future as well. But at the moment, that's an area that needs more research.

Jayanthi Lingham:

It's really useful to hear some of the complexities that came out in, in the research that you were describing, with people with dementia as well, because I was thinking then that's an added layer of complexity, where because of the condition of dementia and the progressive nature of dementia, communication is so, so key. And then when then you also need to take into account people's language needs.

When English or the dominant language of wherever they are, is not the first language. In addition and I think when we outside of this podcast talked about this, I was quite fixated on the fact that, anyway, there are lots of issues with meeting people's communication needs and dementia and lots of, there's lots of pre judgements or, inaccurate judgements and understandings about dementia that we need much more.

We need to become much better at in, in service delivery and just in meeting the care needs of people with dementia. However, I then went and looked back at, at a WhatsApp conversation that I'd had with the family member about supporting a family member who, had dementia and had gone back to their first language. And I realised that the the exchange that I'd had with this family member was about respite care for this person.

And, and I had put in that, I'm so relieved that there's someone there that is going to be speaking that that first language. So it's, it it is a really significant thing. And you're absolutely right. It's it's about being able to hear the language, understanding how you might communicate in, in, in whatever that language is, regardless of whether there's a perfect understanding of dementia by the person that is providing that care.

Loretta Baldassar:

So and it's even more subtle, I think, in those really, intimate moments in, in, in, in meaningful living in, in institutional settings where, you know, I've seen this many times where the person living with dementia is finding it difficult to communicate in any language, really. But the if their carer has familiarity with the cultural ways and ways of being and they can often more easily predict or interpret what language that is offered or is available.

And often this is around simple things like food. Food is so powerful. I mean, really? And why? I mean, the Royal Commission in Australia uncovered just some desperately inadequate situations where, you know, for, too little was being spent on food, and food was being used as medicine, where everybody was just given laxatives because they weren't moving enough.

So we'll just start giving them anyway. And, you know, people becoming incontinent after a respite period because they're not getting the mobility they need and they're getting laxatives in their food. I mean, all this stuff is critically important, and I can't even remember where I began because I've got a funny side track now.

Jayanthi Lingham:

That I was, I was absorbed in your very, rich and disturbing but very important description about it.

Loretta Baldassar:

Food. So, you know, I've had, Italian residents in aged care just say we don't really want much. We just want fresh ingredients and ingredients that we recognise as our food. You know, could we have some pasta and some good parmesan cheese and some fresh tomatoes and basil? It's not hard and it's not expensive. And, and the other thing they say is could we prepare it?

But, you know, it's this whole dignity of risk issue about standards and safety. And this is all about culture and language as well. And when we get down to the nitty gritty in those micro ethnographic encounters that I do my research on, it is about what matters and what's meaningful. And this is often around food, language and ways of being touch these kinds of, aspects of communication more broadly.

Jayanthi Lingham:

Is, is about meeting people's just human social happiness, you know, and I guess thinking back to thinking back to Catherine and Patrick's book and those the tensions between that standardised care and their differentiated care, which I think is also called person centred care. I can absolutely see the and potentially the importance of being able to meet, you know, diverse needs, lots of different needs and to also, well, send to the person

and send to the person's the person, family or community and say, you know what it is that you need.

And it might be something like food, it might be particular communication and in particular languages, I guess I also in the UK at least worry that the risk is that then takes the kind of onus off the state and local authorities to even think about those things and just say, okay, the family knows best, the hassle knows best or that person knows best, and then it kind of becomes cost cutting, or corner cutting exercise where costs can be saved.

And, and that's not a bad thing, but the actual costs are still there and they just fall much more heavily on unpaid carers and on households who are already so under resourced.

Loretta Baldassar:

It's fraught isn't it. And, and I did like the conclusion actually which was we made something like clumsy and good enough solutions that promote learning and feedback. And I think, I think that's a really positive note to, to mention, which was the conclusion of their work. And I think it is about that. It's about now moving forward and and naming the tensions between those paradigms and working through them.

And I think part of the answer is messy ness and what you're describing there about the inherent risks of the person centred, which I would call, relation centred. I think that's a better word because you immediately added community. And I think the person centred model is quite medicalized and looks at the possessed person as the disease.

Whereas I think if we talk about relationship centred, we have a broader perspective that social relational, which is what is essentially the best definition of care, I think, and personhood. And if we think about those risks, we're also sort of tending to see what happens in Australia. Is the migrant community as a deficit model. But actually there's enormous resources there as well.

If we can facilitate them and support them and not take advantage of them. So I think there's something about an answer there as well. How can we facilitate community as resource rich models without further burdening the care burden dimension which you've raised? I think there is some answers there that we need to work out, and I think that's where my research is heading. And, I think this book kind of points to that direction as well.

Jayanthi Lingham:

It sounds like they're saying that we need to be having these conversations, which is the starting point, which is absolutely true.

Loretta Baldassar:

And I'd also like the next chapter of the book to bring diversity in and to do a bit of what we've been doing today in our podcast, which is what is the history of language policy and

migration and settlement policy in service delivery, and where have we got to and why has this point of diversity seemingly disappeared a bit? And how do we bring it back?

Jayanthi Lingham:

And how does that history map on to the care needs and the care experiences of people who have lived that history and are here? And, and, and where does that take us in terms of policy? Where does that take us in terms of what we need.

Loretta Baldassar:

For this policy? Addressing the challenge that the book ends with, you know, clumsy and good enough solutions that promote learning and feedback. You know, I think I think there's something in that direction.

Jayanthi Lingham:

Yeah, we've ended up doing quite a good mini review of the book.

Loretta Baldassar:

And I think, I think your language matters. Podcasts really does matter. And part of it is trying to work out what the questions are actually. But I think you're on to something really important.

Jayanthi Lingham:

Yeah. Because as you were saying earlier on there social level, there's the level that we've talked about language and care needs of people who, who, who we're thinking about within the centre for care. And then there's always how also how we talk about masses and care and issues of care. And that also matters. So I think as hopefully as we go through the podcast series will untangle, untangle, some of that matters.

Loretta Baldassar:

A bit more and I wish you well, more power to you.

Jayanthi Lingham:

Thank you very much.