TRANSCRIPT

LEGISLATIVE ASSEMBLY LEGAL AND SOCIAL ISSUES COMMITTEE

Inquiry into Early Childhood Engagement of CALD Communities

Bendigo—Wednesday, 23 October 2019

MEMBERS

Ms Natalie Suleyman—Chair
Mr James Newbury—Deputy Chair
Ms Christine Couzens
Ms Emma Kealy
Ms Michaela Settle
Mr Meng Heang Tak
Mr Bill Tilley

WITNESSES

Ms Martine Street, Manager, Settlement Services, and

Ms Sue Ghalayini, Humanitarian Settlement Program Case Manager, Bendigo Community Health Services.

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The CHAIR: I declare open the public hearing for the Legal and Social Issues Committee Inquiry into Early Childhood Engagement of CALD Communities. All mobile phones should be on silent at this stage. I welcome Martine Street, Manager, Settlement Services, and Sue Ghalayini, Humanitarian Settlement Program Case Manager, from Bendigo Community Health Services. All evidence taken by this Committee is protected by parliamentary privilege, therefore you are protected against any action for what you say here today, but if you do go outside and repeat the same things, including on social media, those comments may not be protected by privilege. All evidence given today is being recorded by Hansard, to my right. You will be provided with a proof version of the transcript for you to check as soon as it is available. Verified transcripts, PowerPoint presentations or any handouts will be placed on the Committee's website as soon as possible. I now invite you to proceed with a brief, 5- to 10-minute opening statement, and that will be followed by the Committee asking some questions.

Ms STREET: Great. Thank you very much for the invitation. I would just like to start briefly. I am a team manager of settlement services, having worked in AOD, family therapy and young people. In this space of settlement, I have been in this space for 10 years. I think it is important to note that Bendigo is actually not recognised as a settlement location. We do not have the status of being designated, so our actual new arrival numbers fall in under Shepparton. We actually work with the brand-new-arrival ladies who get off the plane at Tullamarine and are brought up the Calder Highway to Sue and her team. We can work with people for up to a five-year period. They exit from Sue's program into another program. It is a beautiful, seamless transition. We are situated in a large mainstream service. Our clients might not be coming to see us; they may be coming to see a plethora of other health professionals or social services. We are unique in that settlement services are located in a community health setting.

We currently have 31 children aged under eight in Sue's program, and it is a perfect setting to pilot any pilots or projects for access if you are wanting to affect any change or implement anything and measure it. And we are dreadfully underfunded. This is going to be something you commonly hear: we are dreadfully underfunded.

Nearly all our arrivals to Bendigo are for family reunification. They are either Karen or Karenni, having come out of Thai refugee camps, and they often come in large families, so we are dealing with children in this age group often. Many people have never been to school. They have never held a pen and cannot read or write in their own language. It is not uncommon now for new arrivals, including children and infants, to come with significant health issues or profound disabilities. This can impact their settlement journey as their focus is on attending numerous health appointments and trying to navigate systems. It can impede enrolments into school, for example.

Our program literally walks with people. It shows them the route to their local primary school or kindergarten. It literally gets on the bus to show them how to top up a Myki card and get to a doctor's appointment or how to use utilities. Having come from a refugee camp, there is no electricity, gas or flushing toilets, so we literally show them safety around utilities.

It is repetitive work because we have observed very poor health literacy and low uptake of information and knowledge and retention of that. It is not unusual for Sue to exit someone at 18 months and they cannot remember her name. Many clients, even our staff with a lived experience, will tell you they do not recall their first 12 months in Australia. They are often dissociated and overwhelmed. They are not service users. We have very sophisticated systems that allow children in particular and our primary caregivers to fall through gaps.

Many services are not sensitive to our client group in particular, but there are positives here. Just to acknowledge them: one innovative practice was young children under the age of three were having to attend the Royal Children's Hospital for their Mantoux test, which is a TB-related test. That is a 5-hour round trip for people who have only just arrived, sometimes with many children in tow, sometimes sick, to attend the hospital

and then attend three days later for the result of the test. So working with Sue and the refugee health nurse in Bendigo Health that is now done locally, so it is so much less of an impost on families.

Despite the challenges that you are going to hear and that you have read, this is amazing work. We are really humbled with this work and my team are fierce advocates. They are tigresses and tigers around their clients and daily they battle the systems that deny our clients fairness and equity. With that, I cannot think of anyone better placed to introduce to you than Sue, my client, who is a senior case manager at the coalface. It is her bread and butter. Go for it, Sue.

Ms GHALAYINI: Thanks, Marti, and thank you for giving us this opportunity. My name is Sue Ghalayini. Both my parents are from non-English-speaking countries and so I am a first-generation Australian. I have a master of social work and I also have a postgraduate qualification in Australian immigration law. The reason I decided to study further in immigration law was that I saw a gap in providing immigration assistance here in Bendigo for many of our clients. So I provide free legal advice and migration law advice and assist families with their applications for humanitarian visas. I listen to their stories and I hear their stories of displacement and torture. I carry that with me, but I have not experienced that. They are the ones that have experienced that.

I have got an understanding of some of the experiences they have had pre-arrival to Australia. I have been to some of the Karenni and Karen refugee camps in northern Thailand on numerous occasions so I have witnessed firsthand the environments which these families are coming from and the lack of resources, whether they be medical resources or educational resources. So I have a good understanding, and I have been working as a case manager in this field now at Bendigo community health for nearly seven years. I have continually tried to improve my knowledge and understanding of the shoes these people are walking in. I just wanted to give you a bit of background, not to big-note myself but to give you an understanding that I really am passionate about the work I do and I want to know more about who they are and where they come from. That gives me a better focus of how I can deal with service providers, when I am saying to them, 'This is my experience' or 'This is what you need to change or how you need to improve your practice'.

I did some googling last night because I was curious about any research into this particular area here in Australia, and unfortunately Australia is really lacking in research. I found one Australian study that was conducted in 2014. It was in a paediatric journal and it was on the educational, developmental and psychological outcomes of resettled refugee children in Western Australia. It did not give an age group. At refugee health clinics they interviewed the GPs and refugee health nurses at these clinics in Western Australia and the sample size was 332 children who attended that health clinic. They reported on the prevalence of sensory impairment, being vision, hearing and developmental delays. There were 7.5 per cent with visual impairment, 3.3 per cent with hearing impairments and 6.9 per cent with developmental delays.

So this kind of leads me into some of the work I have been trying to do with, or the advocacy I have been trying to do with, our GPs. We actually were approached—my colleague and I—a couple of years ago by a couple of GPs from our own clinics who felt that they lacked the training to work with our clients. These GPs are time-poor. We are seeing the advent of these super clinics that have absolutely no training in working with our clients.

There are many refugees here in Australia but there are lots of different cohorts, and from our experience—we have worked with families from Sudanese background, Afghan background, some Middle Eastern—the majority of clients we work with are Karen, and they have had virtually no experience with any of our systems. Where they live is remote. It is jungle. They still live in huts, and there are no services, basically. There is nothing there.

So what I have observed is that many of the families that come from other countries, such as Sudan, Afghanistan or Iraq, actually have a familiarity with these services. It does not take them long to adapt and understand what they need to do, but we have observed with our Karen families that it takes them a lot longer to understand all of our services and the systems and the referral processes and what they have access to. So building the capacity of GPs in their knowledge and understanding of a particular cohort even—what their lived experience is—is really important to outcomes for these children. Quite often, as Marti said, the complexities that children are coming with are vast—whether it be physical, emotional or intellectual. They have a number of very complex health needs, these children. I do not know whether a lot of GPs have the time to be putting

their energy into understanding or knowing or picking up when a child is not thriving. Many of the Karen children are very shy. They do not speak the language, so if a child has got a developmental delay where they may not be speaking—they may be three years old and still not speaking—we are not finding these things out until later, and sometimes it is not even a health professional that is picking this up. It might be someone in a playgroup—a volunteer in a playgroup. It might be me, thinking, 'There's something not quite right', but still they are not being detected—they go under the radar—because of, often, that shyness and their lack of ability to speak.

There are also, I have observed, a lot of assumptions made. We are all guilty of making assumptions. I make assumptions myself. But I think there are a lot of assumptions being made by health professionals and education professionals about a child's capacity and that a child has not been a witness to trauma or torture. We have to assume in many cases the worst for these children—that they have experienced these things.

All service providers working with children of this age group need to be aware of the signs of when a child is not thriving and not make assumptions that a child is shy because they do not speak the language. Like Marti said, it can be the retention of information. In the first few weeks after my clients arrive I do a case management plan with them and we work on their needs and their goals. I know that they have done the AUSCO training, as they call it, which the international organisation for migration put on for a week prior to their departure from Thailand. They learn about Australian culture. They learn a lot of things. It is a lot of information over five days, and it is the whole family, even the children. Probably not that toddler age group, but certainly children, maybe from five to eight, are participants in the AUSCO program. When I ask them what they remember about that, they do not remember anything, and that is only two weeks prior. So issues with the retention of information are experienced by all family members, not just the adults; it is the children as well.

They come with no health history at all. It takes so much time to build a history, for us to get referrals to paediatrics or assessments done by Assessments Australia for a child that has got an intellectual disability. Sometimes it can take months for that child to start school because they have to create a history for themselves, basically, in order to have those assessments done, created, and be referred to the appropriate school.

The other thing that I have found too is with interpreters. In pretty much any appointment that I have attended with a client, whether it be a health appointment, education or a kinder enrolment, the service provider is often of the assumption that whatever they say the interpreter is able to interpret. What they do not understand is that the Karen language actually does not have as many letters in its alphabet. They do not have as many words in their vocabulary. They do not have a word for 'counselling'. There are many words that they do not have, and I find often that the professional service provider is not asking the interpreter if they actually understand what is being asked of them to interpret, so what worries me is that a lot of things get missed. Karen people are traditionally very passive. They will say 'Yes' a lot when they actually do not know what is being asked of them or being explained to them.

A lot of school material is still in English. Everything seems to be moving online, which further disadvantages these families. It was so fitting that today I received an email from the YMCA. They provide some early childhood learning here in Bendigo, and I do not know how I came to be a 'Dear parent or guardian', but they obviously have my email address, and they were doing a parent opinion survey. I was intrigued, seeing I was coming here today, and I went into the online survey to see what languages it was available in. Still nothing is available in Karen, even though the Karen have now been settled here for 20 years. We are still using the migration patterns from the 50s and 60s and it is still the same languages that keep coming up as being interpreted. There were 10 different languages, but not one of them was Karen. I actually do not know how our parents navigate these systems, because we only case manage them for 18 months, and in 18 months they are still a long way from being ready. But we often do not have a choice but to exit them, as long as we know that there is family member that can possibly help them. But they have still got a long way to go. They have got a huge journey ahead of them, but they do not get case management forever and they are kind of left on their own. Enrolment forms are really difficult, especially with a lack of immunisation material. The Medicare system, to get all your immunisation details, is never up-to-date, so often it can take time before kids can start school or go into kindergarten or child care—because the immunisation details are not there. Even though they start an immunisation process basically from the minute they start their refugee health checks, within the first four weeks after arrival, those immunisations are not updated on the system for many months.

Child care options are limited to generally just a few places where children of that particular ethnicity are already attending, which puts further pressure on those service providers. There are some playgroups around Bendigo, but again they are operated by mainstream organisations. I do not know why, because we have had settlement here now for 10 years. I do not understand why. This will probably be the next, maybe, research—as to why these women are not choosing to start their own playgroups. I do not know whether we are building some kind of dependency. I find that a bit of a worrying trend. Many kindergartens are still not supported with language support, despite having a number of Karen children attending. I do not know how parents are able to attend meetings and information evenings that I know all kindergartens have. I know there is no language support provided. So they are obviously just taking family members. I think we need to acknowledge and recognise that we actually need to provide some professional assistance and employ people who can speak the language.

Teachers, child care providers and kindergarten workers have probably had no training in the lived experience of these clients. They probably would jump at the chance of having some training, but I do not think it is even offered. I am not aware of any training being offered to this service industry, but they certainly need it. They need to understand the lived experience of the children that they are dealing with.

I will finish off. So we know the major risk factors for learning problems, which include: parent misunderstanding the education systems; parental expectations of the child's academic achievements—and we have experienced that with the community, where the expectations of the parents can sometimes be higher than the child is capable of achieving; bullying because of race; and low expectations of teaching staff is another one that we are kind of aware of. But we also know the factors for success, which are: parental involvement in education, supportive home environments, family cohesion and accurate educational assessment and grade placement. That has been something that has cropped up and community members—community leaders—have actually brought that to our attention, worried that children are not actually being placed in the correct grading. I am often asked by teachers when we enrol children, 'What grade you think they should go in?'. I am not qualified to say that. Clearly there is a lack of training there and a lack of expertise around that and supportive peer relationships.

Ms STREET: I think for Bendigo it is really important to note that there is a large cohort here; it is like an oasis. I think it is the second-largest Karen cohort in Australia outside of Werribee, we have been told. They have created their own migratory pattern. We have no annual indicative arrival numbers for Bendigo, so we staff on a lick and a promise that we might get this many clients. But because they are all family reunifications and they are getting help with documents they have created their own migration pattern here. We punch above our weight for sure.

There are some real positives here though. We did some focus groups and spoke to a lot of parents and tried to disseminate the survey, which was great by the way; it was in quite easy English. So we sent that out because we wanted their voices heard—not so much services'. So from asking them, one of the standouts there for sure was maternal and child health. But what we wanted to know is when they drop off, because that is the key funded service picking up developmental issues. We were talking about how many people are taking up the three-year-old eye check, for example—we were wondering. Hopefully you have got Andie West coming from City of Greater Bendigo, or their maternal and child health person; they may have some more information on figures for when the parents stop coming. We pick up developmental delays and try to get in early. We notice that fine motor skills are not working or they are still in nappies. Most of our clients understand when their child should be, probably, walking or eating solids, but in terms of other developmental issues it is all around teaching and education. So ask questions—pick our brains.

The CHAIR: Thank you very much for your presentation, and thank you for all the work that you do. I can only imagine that at times it is extremely challenging. In the last 10 years there has been an increase of refugees here. It has been positive, and I have read your report where you talk about the social impact that it has had and how economically it has been relatively positive, but then I have just heard your submission in relation to a simple thing such as interpreter services that do not include Karen, when this city has close to 3000, and probably more, families here. There continues to be a massive gap in relation to the most basic service, which is interpreting services; your key languages; also navigating the system; and fourthly, the workforce. In the last 10 years there does not seem to have been the mentoring or the encouragement for the Karen community or the

Sudanese community or the Afghan community to take the steps to having their own facility or child care or to working in council or anywhere. So there are probably three or four questions in there. We have the stats here, so what is the challenge and what is the barrier here?

Ms STREET: I think there are some examples: we have got someone who is about to do their traineeship in pharmacy, for example; we have got a Karen caseworker at justice; we have got diverse staff with us; and Bendigo has just put on two Karen. But, I think, that even though population has increased here, services have not kept up, and it is not an excuse anymore. It is much more than a decade. We have been in it a decade, but it was happening a little earlier than then.

I think English is very difficult to learn and I think possibly communities' young people have not had good opportunities at school. I think a number of high school students end up in these Karen or Afghan VCAL classes. We have had a lot of people migrate to the Catholic college because they have a higher expectation and the kids are in the mainstream classes and they are excelling. We do not have a language school here. We feel a language school would be a really good start for the first 12 months. We have had a different system here: a cluster system, where they have put resources into individual schools and encouraged us to settle people in those areas.

I do not know if it is an evolutionary thing here. I think it is just slow to happen with the community themselves becoming—we have got the dental hospital, and we have got Karen dental technicians. That is a brilliant model you will hear about. The city uses a Karen clinic. I know we want to get away from ethnospecific services—I am not a fan of them; I am much more around integration, not having specific hubs where people gather—but I think we have missed the mark with the language school.

The CHAIR: Just in your notes it does note that the Karen community does have a language school at the mosque and it is hopeful that there will be an Afghan language school in the future.

Ms STREET: They have not even got an association yet. They have got their own challenges. The Karen are more advanced. They have got some funding and we have worked really closely with them, with a number of different community leaders on their committee, to get that language school going on a Saturday, and they continue to then practise cultural traditions—as in song, dance and weaving. So there are some exceptions here, and it is just slower. I just feel like we constantly need to be reminded that the one blanket does not fit all. The life experience of the Karen is so different. They are not urbanised. They are not service users. They recycle, re-use—they are the classic recycler and re-user because they were lucky to get rations. Maybe more scholarships might help. Evaluation of the programs they are teaching. Do they evaluate success? How do they measure? Is VCAL the best option? Is it evidence based?

The CHAIR: They are really important points, and that is what I am trying to actually just gauge.

Ms GHALAYINI: And some of the feedback we get from mostly high school students is that the students all kind of get put together in the one ethnic group. So I do not know—and some of the students felt that they wanted to be part of the mainstream, yet they kept being diverted into their own ethnic groups.

Ms STREET: So many of those guys will leave VCAL and they will go to foundation English at the adult migrant English program.

Ms GHALAYINI: Yes, because they just continue to speak their own language.

Ms STREET: So this is where these missed opportunities have happened. It should not be for these young people's grandchildren. The future for every migrant who comes here is their children, and some of these children have been denied that through some of the systems. So leaving four years of high school to then go into level 1 or foundation English is a crime. I hope somewhere here you guys might be able to look at those systems and why they are failing young people. It is not our bread and butter.

The CHAIR: I have just got one more question in relation to the value of early childhood care. Coming from very challenging backgrounds and settling here, do you think that they do value early childhood development, or is that not a priority?

Ms STREET: I do not think it is necessarily in their paradigm. I know that Karen parents have said a lot of them want their children with them until they are four. We know that a lot of mums were really anxious about being separated from their children and handing them to strangers. They are on the poverty line, so there are the fiscal restraints, but if they had people in there who looked like them and sounded like them, that would be a pathway of comfort.

Ms GHALAYINI: And that is what they are asking for.

Ms STREET: And the separation strategies that Australian women are offered or white women are offered are not necessarily offered to our clients, and they are anxious to leave their children. So then we have got the situation in our women's group of kids going to prep without having any structured environments pre that. We go in there and we teach them about play and eye contact and getting on the ground with their littlies, but it is not their parenting experience. So they will often hand over the parenting duties to whoever is in the vicinity. So education is key, but I think the next step is having the workforce reflect the community. That is where we are up to. We need more of that. They want to be great parents. They are actually great parents.

The CHAIR: It is just ensuring that they will be okay.

Ms STREET: They just have not quite made the step into that mainstream. We do not want to create a Karen kinder. We want those kids in there with other Aussie kids. Havilah Road kinder? Great. They teach Karen and English in that kinder. They have got a great, probably, critical mass in there and I think they have Karen staff, so they have positive outcomes and for the wider participants in that kinder. And I am sure you going to hear more about some of the innovative things. It is all about integration and it is about the city stepping up and starting to employ some of the younger ones that are more than competent—so more traineeships. They learn experientially.

The CHAIR: My final question: in your submission you refer to parenting in the Western world. My question is: when we talk about diversity in culture and faith, and what we are today, how do you talk about parenting in the Western world when you have such diversity, interfaith and cultural mix?

Ms STREET: We might answer that separately. I can just say from an operational area, when we have organised parenting groups and the parents have helped us co-design the modules, we have gone in with something off-the-shelf, like raising great kids or raising boys or whatever, but we find the parents just want to talk, they just want to ask questions. They want to know how do you have such great kids or how do you sort out the tantrum at the cash register? So I think it is about having welcoming, safe spaces where parents can come to talk and just normalise things—have a safe environment where they can ask some questions about maybe not feeling so bad because their kids are not behaving or they have started to introduce a digital nanny to the kids and the kids cut up rough when they take the device off them, or they are locked into the processed food. I think it is education. I think it is safe spaces. It is us having the time to be with people. We are locked into these systems where you are locked on computers. These guys provide a service and then you have to go in and claim it and find the evidence. Our clients are seen more by volunteers and students then our caseworkers, so we have got some fundamental models wrong. The HSP model—working with the most vulnerable.

Ms GHALAYINI: They are also quite fearful of our laws around family violence and smacking their children. They do not quite understand what is permissible and what is not permissible. What we are also seeing is, because now they have access to money and this plethora of sweets and processed foods, a lot of children eating a lot of sugar, a lot of highly processed foods, in their diet.

The CHAIR: I think that is all children.

Ms STREET: Food is seen as a reward, and sometimes big is beautiful.

Ms GHALAYINI: They do not have the knowledge. They do not have that history to understand its impacts on their teeth. There are a number of Karen adults with diabetes, and we will probably see an influx of grandchildren with diabetes as well—type 2 diabetes.

Ms STREET: They do not have the body type traditionally, but there is a high incidence of diabetes. I think food security was such an issue as well that for a parent to have food and deny their child the food is a big deal—the most basic. Yes, so there is a little bit of work.

Ms COUZENS: Thank you both very much for your presentation and also the comprehensive submission that was put in. That was really interesting reading, so I thank you both. Do you think that regional Victoria has more challenges than perhaps the metro areas?

Ms GHALAYINI: Yes and no. I think it has its own challenges that are very different from the metro challenges.

Ms COUZENS: Is that access to services or what—

Ms GHALAYINI: Access to services. Housing is more affordable. It feels more like a community. I know I have heard that many times. I do not know what the challenges are in metro. I can only kind of imagine what they would be like, but I think regional settlement, from what we hear from our clients, has been really successful.

Ms STREET: And it really warrants attention. I have been hearing for a decade about regional settlement, and I was so excited. Then I learned that was for Pacific settlement—of the region. Now we hear that it will be slower to unroll but people are getting on board, finding out what is on the ground. I think if people just asked locally it would eliminate some of the barriers. We have got great resources. Geelong is almost a suburb of Melbourne. We are the second-largest—

Ms COUZENS: Not quite. We have got an hour between us.

Ms STREET: But I think we are the second-largest inland city in Australia next to Toowoomba. There is a new hospital. I know the city is saturated. We hear from our peers in settlement services that there are many weeks on a waiting list to get a child into school. We do not have that. A lot of our clients are home owners. We have a high rate of home owners. Like every migrant, they are doing what they do. They are pooling their money. One kid gets the house or mum gets the house and the kids get the house. It is a great place to raise a family, and I hope there is more attention on it and that services pick up. I think sometimes when people make decisions in Melbourne they forget the impost of the travel. That Royal Children's Hospital thing, for example—no-one thought that that would be 10 hours of public transport for a sick child or a caregiver. The more removed you are from the coalface, sometimes the less you—

Ms COUZENS: It is the same with a lot of things.

Ms STREET: Yes, the nuances of the difficulties to access services.

Ms COUZENS: So you would say that the regional focus is very positive?

Ms STREET: Very positive. And I think they are voting with their feet, guys. I think that is evidenced by people moving here every month from around this country. They are leaving Canberra because it is cold and it has expensive rent. They are leaving Sydney for the same reasons—high rent. They are coming from Ringwood—

Ms GHALAYINI: Adelaide, Tasmania.

Ms STREET: Nhill, Werribee. It is a bit of cross-fertilisation to Nhill. There are people travelling from Werribee, Hoppers Crossing and Laverton to work at Castlemaine bacon. They have bought a house here and eventually will move into their houses here. The Karen in particular are here to stay. This is home.

Ms COUZENS: You talked earlier about the feedback from GPs and their inability, I suppose, to address some of the issues that they are seeing in those communities. What do you see as the answer to that issue? Obviously communities are going to go and see GPs. How do we solve that problem?

Ms STREET: Do you know how GPs have to do training every year to get ticks?

Ms COUZENS: Yes.

Ms STREET: There need to be some around working with the CALD community, torture trauma and working with interpreters.

Ms COUZENS: Good.

Ms STREET: Absolutely. That is one way—to keep it enclosed into them keeping credentialled, working through PHNs, because they are the ones that have access to that pathway of teaching.

Ms COUZENS: Yes, great. The community leader role—I know, not just in my community but in communities across regional Victoria, the community leaders are leaned on a lot, not only by their community but by services—

Ms GHALAYINI: Services. Yes, we are aware of that.

Ms COUZENS: service providers, workers; everybody is putting pressure on them. What is your view on how we start to change that? I know that earlier you talked about employing more people from community in some of those key roles. How do we do that and how do we take pressure off community leaders to be the place that everybody goes to to get a message across to community, for example?

Ms STREET: It is very interesting, because I have worked very closely with one in particular, encouraging that person to surround himself with a committee that could speak English and take the weight off. But I think sometimes, like a lot of people, maybe people really enjoy being the focus and the gateway, but they create bottlenecks and actually they do not refer out. They do not ever refer to us, which is unfortunate. Some do, but some do not. Some work better. It is a hard one; it is a really hard one. I think sometimes it is in people's pathology to keep the power and the information and not share it, and it is a bottleneck for us often, sharing information.

Ms COUZENS: Should we be providing resources to community and their leaders to be able to provide that information internally in their community? Is that a way of dealing with that?

Ms GHALAYINI: The other problem is some of the service providers who have access to free interpreting are not using it and instead they are ringing community leaders. Real estate agents are just renowned for doing that. We offer to build the capacity of real estate agents, show them how to use interpreters, because they have access to free interpreting, but we just cannot seem to get that message through and they still just rely on community leaders. If they need to do a house inspection, they will contact the community leader or they will contact me to ask the clients to be home or to make sure that they know that the agent is coming. There is still a lot of work to do in that space.

Ms COUZENS: You mentioned earlier about issues with the interpreters and how that is reinterpreted to community members. What are some of the solutions that could be put in place to help deal with that, do you think?

Ms STREET: We just try and work with them to build their confidence to be able to say, 'No, ring this person'.

Ms GHALAYINI: Service providers needed to be trained how to speak with interpreters. It is actually specific. It is specific to a particular cohort. Because not many people would know that in the Karen language there are a lot of words that mean nothing to them—'mental health', for example. What doctor knows that? What service provider knows that? Very few. So 'counselling' is one word that keeps getting used and used and used. Yet there is no word for counselling in Karen. I do not know how they are navigating that. I do not know how they are negotiating that. As I said, it is those clients who are lucky enough to receive case management for that 18 months, that we can keep track of, keep an eye on and keep working with, but what do all the people do without case management? I do not know. It worries me. I think there are a lot of people slipping through the gaps.

Ms STREET: So with leaders, we have had leadership courses, but I think with the funding models—you know, you have to apply for a little project here and a little project there; nothing is embedded with that mainstream area that has got the access. Maybe something very specific, only to be applied for by community leaders? There are also all those other natural leaders. We have got a community guide. She has three phones; we work with her not to burn out. She is just like an Indigenous elder. We have got people who will not ring ambulances; they cannot navigate the phone system. If you have got a child having an asthma attack, you are trying to find someone to ring an ambulance; there are a lot of risks out there.

I do not quite have the answers, but we have actually helped organise a community consultation with the current Karen leader cohort, so that could be a good avenue to talk about their capacity building. I will put that on their agenda.

Ms COUZENS: That would be great.

Ms STREET: It is about the leaders working a bit more collaboratively. Because another dynamic playing out here to be aware of is that interpreters that are used locally become the vessels of incredible knowledge and power.

Ms COUZENS: And just one last question—you talked about supporting people for 18 months.

Ms STREET: In Sue's program?

Ms COUZENS: Yes. I am interested to know what happens after that 18 months, particularly where they have got young children. How does that all play out? Are they totally reliant on their own community? How does that all work?

Ms GHALAYINI: They are offered a referral. We have got a program that can work with families for up to five years. We offer them a referral into the Settlement Engagement and Transition Support program—SETS—and it is up to them whether they want to continue with that. That is more around capacity building. There is a bit of case work in there, but it is still building the capacity of the community—community development.

Ms STREET: That is advocacy, information provision. We are trying to have that access to information start from Sue's group up to the five-year period. Everyone in that program has a lived experience. They are all credentialled with a lived experience. But often by the time Sue is exiting, they are engaged in mainstream services and they come and go from us. So it is when they need something—document help—otherwise they are off doing it. But we can also re-refer back in to the specialised intensive service that is reserved for complex clients. There are many kids with profound illness and disabilities that sit in this program over here as well.

Ms COUZENS: I am interested in how you engage those families where there are preschool kids who clearly need to access services but are not.

Ms STREET: Information, help with filling out forms, literally walking them to the referral, and they are all warm referrals here. All warm referrals—it is a policy of the organisation for anyone vulnerable. It is that hands-on walk-in with an introduction; we help to set up the appointment and step back. It is just juggling the dependence all the time.

Ms GHALAYINI: And if I notice a gap, say for example if I notice that there are a lot of parents who are still struggling with child restraints, not putting their kids correctly into child restraints, then I will talk to the SETS team and say, 'Look, I think we need to get some information out there to the parents about this particular area'.

Ms STREET: And the way we recruit to that information is literally pound the pavement and get on the phone. Flyers do not work. You have got to personally engage with people to get them to come along.

The CHAIR: Just one final point: as a Government we have emphasised AA for women's participation, making sure that we have strong representation in the corporate and board sector and across government. This is something that I am very passionate about and I would like your opinion on this. We have just talked about the workplace and I suppose the real gap in diversity in workplaces, whether it is in government agencies,

mainstream services and so on. What I am getting at is we have had AA quotas in board appointments through government. How do you feel about it, and what is your opinion on having quotas for diversity—actually setting them?

Ms STREET: I love it, and I think it is a good step around inclusion and welcome, and mentoring and teaching. I think it is a really good thing to consider.

Ms GHALAYINI: I agree with Marty. I think it is worth considering.

The CHAIR: Thank you. That is excellent.

Ms STREET: We have extended it to our Indigenous, our First Australians.

The CHAIR: Absolutely.

Ms STREET: I really think it is worth considering.

The CHAIR: Today we were talking about having that, similar to the AA quotas—having a cultural quota that incorporates our diverse communities, our multicultural communities—

Ms STREET: Love it!

The CHAIR: and of course our Indigenous communities as well. So I think that is a step that is something that, as I said, I am passionate about, and I wanted to seek your opinion. So thank you, so, so much.

Ms GHALAYINI: Even within our team, our quota is more—we would have more people from a different cultural background in our team than we actually do from the general Aussie population, and it is great to work in a team that is so diverse.

The CHAIR: That reflects Victoria.

Ms STREET: Yes.

Ms GHALAYINI: I love to see our organisation reflecting that as well.

Ms STREET: We are either first-generation migrants or we are migrants,

The CHAIR: Absolutely, and so am I. I always say, 'You can't be what you can't see'. On that note I thank you so, so much for the work that you do in your community and for presenting to us today. We have really been able to exchange and dialogue today. We will be able to keep up with the Inquiry updates hopefully, and some great recommendations will be put forward early next year.

Ms STREET: Terrific. Thank you, and we really hope you get some good information around maternal and child health, because it is our key funded service in this area. Go, early childhood services! Very important.

Ms GHALAYINI: I do not know whether it is worth mentioning all the different subcommittees we are part of as well, like the refugee health and wellbeing network, where we liaise with child and maternal health, with kindergarten.

The CHAIR: Yes. Is that part of the submission?

Ms STREET: Kate will fill you in.

The CHAIR: Lovely, thank you. Have a lovely day.

Witnesses withdrew.