F I N A L T R A N S C R I P T

LEGISLATIVE ASSEMBLY LEGAL AND SOCIAL ISSUES COMMITTEE

Inquiry into Support for Older Victorians from Migrant and Refugee Backgrounds

Melbourne—Monday, 31 January 2022

MEMBERS

Ms Natalie Suleyman—Chair
Mr Brad Battin—Deputy Chair
Mr Neil Angus
Ms Christine Couzens
Ms Emma Kealy
Ms Michaela Settle
Mr Meng Heang Tak

WITNESSES *(via videoconference)*

Mr Christopher Turner, Acting Chief Executive,

Ms Robyn Wilmshurst, Healthy Ageing Leader, and

Ms Margaret Yung, Acting Program Facilitator, Aged, Residential and Outreach, cohealth.

The CHAIR: I declare open the Legislative Assembly Legal and Social Issues Committee's public hearing for the Inquiry into Support for Older Victorians from Migrant and Refugee Backgrounds.

I acknowledge the traditional owners of the land on which we are meeting. I pay my respects to their elders past and present and the Aboriginal elders of other communities who may be here today.

I welcome here today, to present, Christopher Turner, Acting Chief Executive; Robyn Wilmshurst, Healthy Ageing Leader; and Margaret Yung, Acting Program Facilitator, Aged, Residential and Outreach, from cohealth.

I also would like to acknowledge my colleagues participating today: Christine Couzens, the Member for Geelong; Neil Angus, the Member for Forest Hill; and Meng Heang Tak, the Member for Clarinda. I am Natalie Suleyman, the Member for St Albans.

Please ensure that mobile phones have been switched to silent and background noise is minimised.

All evidence taken here today is protected by parliamentary privilege. Therefore you are protected against any action for what you say here today, but if you repeat some of the things outside, including on social media, you may not be protected by this privilege.

All evidence given today is being recorded by Hansard and broadcast live on Parliament's website. Please note that footage can only be rebroadcast in accordance with conditions set out in standing order 234. You will be provided with a proof version of the transcript of today and then the transcript will be made public and posted on the committee's website.

Could I please remind members and witnesses to mute their microphones when not speaking, again to minimise interference. If you have any technical difficulties at any stage, please disconnect and contact committee staff using the contacts you have been provided with.

I invite you to proceed with a brief opening statement to the committee, which will be followed by questions from the members. Thank you. Who will we begin with?

Mr TURNER: That would be me, Chair. I am Chris Turner, the Acting Chief Executive.

The CHAIR: Thanks, Chris.

Mr TURNER: Thank you, Chair, and thank you, committee members, for the opportunity to appear before you today. As you noted, I am accompanied by my colleagues Robyn Wilmshurst and Margaret Yung.

I would also like to acknowledge the traditional custodians of the lands which we meet from today and to pay my respects to their elders past, present and emerging.

I would also like to acknowledge the immense contribution of older people from migrant and refugee backgrounds and the contribution they make not just to families and communities but also to our society and economy more broadly. Despite this contribution, there are many barriers to participation, and I am pleased that the committee provided many different avenues for older people to be involved in this inquiry, including the provision of translated materials, a translated community survey and accepting submissions in preferred languages and various formats.

I will keep my opening remarks brief as I am sure you have many questions for us.

We are a large not-for-profit community health organisation working in the inner and northern suburbs of western Melbourne. In addition to providing general physical and mental health and social support programs, cohealth also provides a range of services specifically for older people. More than 25% of our clients are over the age of 65 and more than a third of those are from culturally and linguistically diverse backgrounds. Many of those clients also experience socio-economic disadvantage, though at the same time have made considerable contributions to the development of our services.

We recognise the strength and diversity of older people from migrant backgrounds and recognise that that then creates a very specific set of needs and experiences depending on many factors, and this might include a person's length of time in Australia, their experience of coming to Australia, their income, their wealth, where they live and even things such as their age, sexuality, physical health and mental health at the time of their need. The majority of older people are engaged with family and friends in their communities, and as their support needs increase they will be able to access a range of supports via their family and communities, but some people do need significantly more support and do face barriers.

By far and away the biggest theme from our consultation in the lead-up to making our submission was the importance of providing services in relevant language, as well as ensuring that there is cultural understanding in the way that a service is provided, and doing so through the use of bicultural and bilingual workers is something we have great experience in at cohealth. If that is not possible, we also recognise the need to ensure that there is adequate investment in accessible and professional language services and to also make sure that where English is not a person's first language we ensure that as much as possible people do not face barriers to receiving the information and care they are entitled to. Thank you.

The CHAIR: Thank you. Any further evidence? No? Okay, we will move on to questions from members. The first question is from Chris.

Ms COUZENS: Thanks, Chair, and thanks, Christopher, Robyn and Margaret, for your time today and for your participation. We really appreciate it. You talk about a lot of recommendations in your submission. How do you believe we can roll them out, and what sort of partnerships need to be established to do that?

Mr TURNER: Thanks, Chris. I might start, and then I will hand to Robyn and Margaret to speak to practical examples. In the work that we do at cohealth one example that I could reference is that during the COVID pandemic we worked in partnership with the Department of Health as well as the Department of Families, Fairness and Housing to establish a bicultural workforce. This had a really strong focus on employing people from communities, not just investing in supplying resources to local community leaders but also looking at leveraging from those local community leader infrastructures, supporting people into employment pathways and having people from certain communities with a depth of understanding of not just the potential clinical or social needs we were working with in the COVID landscape but that depth of cultural understanding as well as part of workforces. That saw a range of bicultural workers working in place at housing estates. It also saw people join testing and vaccination clinic teams. Part of this, for me, is also about not just looking at a set of recommendations to improve the existing workforce but supporting the transformation of the existing workforce by creating meaningful employment participation pathways for people.

The second example I will draw on is our health justice partnership that we have with Justice Connect, which looks at the opportunity to strengthen and leverage existing relationships rather than just creating new relationships. We support the use of our clinics to allow access for lawyers to work in partnership with our aged-care and community health nurses, which allows for there to be a depth of connection between the workers, which can be leveraged, but also a health clinic might already be a welcoming place for someone. They might already have a strength of relationship with a nurse or another provider at that clinic, so by bringing the partner agency into the same location it can break down some of those access barriers that also make it a much more viable partnership opportunity. I might hand over to Robyn and Margaret to augment that. But thank you for your question.

Ms YUNG: Okay, yes. It is Margaret here. I would just like to follow what Chris mentioned about particularly during the COVID period of time. On a practical level I think there are lots of CALD community members. We do a lot for the Chinese community, and also Vietnamese—there are some from the Vietnamese community in our team, and some Africans as well. We can see that even though I think cohealth has a good COVID response team, still some of the community members, because we have been linked together for a long time, also have trust in us. That is why I think it is really crucial for bilingual workers such as us to be the first point of contact, just to reduce anxiety. What is happening is that the community, if they are close contacts, they do not know what to do. Even if they have the numbers to call, sometimes it is quite difficult for them to have a first point of contact. I think for the reliable, trusted bilingual workers in the community, particularly for those refugees and the CALD communities, it is really crucial for them to have the starting points, to have contacts.

The other thing I would like to emphasise are just our legal partnerships for us, and they come up with quite a number of elder abuse clients. If we are just handballing and referring to those services, they might feel anxious and it might even put a lot of extra pressure on them to engage with those services. I think because we are the workers, or the staff, we are very trusted and speak the language and also provide not only the legal parts but emotional support and also other case management as well. So I found that with the cases we referred to Justice Connect it is really helpful to have the partnership with working with the legal service. That means that they will focus on legal, but at the same time we will do a bit of other psychosocial parts to encourage the clients to move forward and advocate for them. This kind of more holistic approach is not only language itself or the legal part. Because we see the clients as holistic, we need to support that as a whole, not only with the single part of the issue there. So that is why I think how to build up the partnership it is really crucial. We can see that bilingual staff and also with appropriate interpreting services or translation services it all needs to come as a whole to support our vulnerable CALD and refugee communities, particularly the old people.

Ms COUZENS: Thank you for that, and thanks for all the work that you are doing. It is great to hear what you have been doing, particularly over the last couple of years. And given that, are there some specific learnings—and I know, Margaret, you talked about the partnerships and things like that—that could be rolled out across the state as one of the recommendations from this inquiry? Have you got any learnings that you could share with us?

Ms YUNG: I understand that it is really crucial to have bilingual staff in the community, but we just cannot rely on that. I think we need to work together and work collaboratively and cooperatively. I think in our recommendation we also see that the language services and also the translation services really need to be more culturally sensitive or culturally appropriate. We can see some examples that we shared with the team. And even for those language lines, when we called the line—13 14 50, yes?—in the first phone call they use English to ask people to press the button. It is really, really unrealistic for those older seniors, particularly those who do not know what is going on with those language lines, to press the button for their own language. So I think some really basic things or more practical ways to encourage those seniors to use the language service are really important. I can see that if we learn from that it is something that system or technology things also need to think about. I cannot really say how in practice to do it but just say something that we can consider or something that probably we can improve in future.

Mr TURNER: If I may, Member. During the early phase of the pandemic there was often a lot of conversation about the community transmission of disease and not a lot of conversation about the community transmission of information. I think one of the things we can take from the pandemic as a learning and carry forward in the recommendations is that recognition that Margaret is speaking to: that not all cultures communicate, not all individuals receive information, in the same way. And if we take forward a recommendation that is only the need to invest in the translation of written material, we are not necessarily thinking about how it is that individuals best have information provided to them for them to understand and interpret, and in an aged-care system which increasingly relies upon a person's ability to make choices and to have control we need to engage in ways that allow them to understand that agency—and just the translation of written materials is not enough. There needs to be a recognition of the individual within their social and cultural context and ensure that the way in which that investment is made supports people to be able to fully engage with the things that they need to know to make the choices that are best for them.

Ms COUZENS: Great. And can you tell us a bit more about your aged-care hub at the cohealth Collingwood site?

Mr TURNER: Robyn, would you like to talk to that?

Ms WILMSHURST: I can jump in there. If I can just add onto what Chris was saying earlier, just a minute ago, in terms of the access to aged-care systems, I think there is a lot of work that can be done in having that direct communication with people in their own language rather than relying on interpreters coming through the My Aged Care system. If they could actually, as Margaret said, pick up a phone and call someone and talk to someone in their first language and get an immediate response, that would be so advantageous in opening up those access barriers that we know are preventing people from accessing the systems. And in terms of the written materials that are coming out, I 100% agree with Chris in that they are not appropriate for the services and the clients that are receiving them. So we really, I guess, want to make a point in terms of advocating to the Commonwealth to change the way that they are communicating with older people, whether that is done by

video or done by direct communication, and not relying on a letter to tell them they have got a package and it is waiting there for them in their language.

In terms of the aged-care hub, look, it is a fantastic program that has been set up, and it is really supporting people who are disadvantaged, living in the community, who are just struggling to access the system and services. It is building that trust and rapport with one aged-care worker and building that network. And we know that many people from migrant and refugee backgrounds do not have a huge amount of trust in their healthcare system. To develop trust with a worker, as they do with our aged-care nurse—she has been able to open up so many pathways. It is a program that I would love to see across all of our community health centres across the state. I would love to have one at my site. It would be amazing to have somebody who really is there and very specifically detailed for that group—who knows the systems really well, who can get to know families, uses the interpreters really well, just knows the intricacies and the barriers that are faced. And I think the other thing that they can do really well is that social prescription side of things, and we miss out on that an awful lot when we just do a generic community health nurse. The aged-care nurse really can look at what are those other social connections we can be making for those individuals and help them to link into those really important issues of isolation.

Ms COUZENS: Great, thank you.

Mr TURNER: Just included in what Robyn is saying, the strength and value of the aged-care nurses' approach is one which takes the family and social context into account as well—so the opportunity to look at the needs of carers, look at the needs of family as they relate to the care of the individual I think is a real strength separate to standalone responses, where it may just be looking at the individual as they present, not thinking about that broader support system that sits around the older person.

The CHAIR: Neil, go ahead. Thank you.

Mr ANGUS: Thank you very much, Chair, and thank you to Christopher, Robyn and Margaret for your evidence today as well as your written submission. Probably my question would be to you I think, Christopher, in relation to a matter identified in your written submission, and that is the issue of oral health. I am particularly interested given the obvious adverse impacts for everyone, and certainly for older members of the community, probably disproportionately so. I am interested to know: what sort of a deterioration have you seen in that provision of service over recent times?

Mr TURNER: Thank you for the question. Specifically, what we have great concern about is the length of time it takes an individual to get access to oral health care. In Victoria at the moment there are a range of ways in which people can access oral health care. Some of that is through private providers, and then we have the public oral health system, including the dental hospital in Melbourne as well. For a lot of our clients, access to private care is not an option, and therefore they are reliant upon that public dental health system. As it stands at the moment we have seen over the last year, for say something like access to general dental care for adults, which all of our over-65-year-olds would fit into, an increase from about 15 months to 43 months, just to wait for an appointment for care—recognising, within that, if an individual has a need for emergency service they can access emergency care quicker than that. But again, that comes to a lot of the things we have just discussed. The individual needs to be able to know that emergency care is available to them, and you need to be able to make a decision that their issue relates to an emergency rather than general dental care. They also need to be able to navigate the system and access that care within their own community as required.

So some of the adverse impacts we have seen: there is definitely that increase in waiting time; I also think about things such as the need for priority denture care. We have waitlists in Victoria of about 20 months at the moment, so that is still a significant amount of time for someone to get an appointment, even before the prosthodontic work can be done. Particularly what we are hoping for is an investment in the public dental system in a way that sees a reduction in those wait times and also allows for some of the other recommendations that we have made being implemented as well: seeing the most appropriate dissemination of information; and the inclusion of bilingual and bicultural workforces in the way in which people can engage with the public dental health system. But most specifically we are really wanting to see a reduction in the time that it takes for someone to access care, because something like a gum disease or some of the issues associated with diabetic mouth care can really deteriorate in that two-year period that people are waiting for care.

Mr ANGUS: That is great, Chris. Thanks very much for that. Further to that, would you have any idea in terms of numbers or percentages of your clients or whatever that would be affected by that?

Mr TURNER: I do not have those numbers on hand, but I am happy to take that question on notice and return to the committee with some information.

Mr ANGUS: Look, thanks. That would be very helpful, because I think it is a significant issue in the broader community and certainly in the multicultural community as well. I am sure all the members here have had it arise in their local areas as well. So that would be most helpful. Thank you. Thanks, Chair.

The CHAIR: Thank you, Neil. I take it there are no further questions. Can I take this opportunity on behalf of the committee to thank you, Christopher, Robyn and Margaret, for your submission and taking the time to participate and give evidence to the committee but also for all the work that you are doing and that cohealth is doing. I know it has been extremely challenging in the last couple of years, so thank you very much on behalf of the committee.

Our next steps will be that a report will be tabled with our recommendations, hopefully before June of this year, and you can keep up to date on the progress of our inquiry on our webpage. Again, thank you so much for being here and taking the time to present to us. All the very best.

Mr TURNER: Thank you so much for the opportunity.

Witnesses withdrew.