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)*

Professor Bianca Brijnath, Director, Social Gerontology, National Ageing Research Institute;

Ms Rebecca Edwards, Manager and Principal Lawyer, Seniors Rights Victoria;

Dr Giang Tran, Advocacy and Policy Officer, Multicultural Centre for Women's Health; and

Ms Judith Abbott, Chief Executive Officer, Carers Victoria.

The CHAIR: I declare open the Legislative Assembly Legal and Social Issues Committee 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 also acknowledge my colleagues participating today: Christine Couzens, Member for Geelong; Michaela Settle, Member for Buninyong—she is not here at the moment, but she may join us later on; Neil Angus, Member for Forest Hill; Meng Heang Tak, Member for Clarinda; and my name is Natalie Suleyman, Member for St Albans.

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

I invite you now to proceed with a brief opening statement to the committee, which will be followed by questions from committee members. Before you begin can you please state your name for the record and for Hansard. Thank you. We will begin with Bianca.

Prof. BRIJNATH: Yes, I am happy to go. Thank you.

The CHAIR: Thank you very much, and if you would like to just state your name for the record. Thank you.

Visual presentation.

Prof. BRIJNATH: Wonderful. Thank you. My name is Professor Bianca Brijnath, and I am from the National Ageing Research Institute, NARI. First of all, I am very grateful and welcome the opportunity to present here today with my co-panel members, with whom I am giving a joint presentation and a joint submission. I will just give a very brief overview of my institute, which is the National Ageing Research Institute. We are Australia's only independent medical research institute devoted to research on ageing, and we have a very strong emphasis on translation of evidence into policy and practice across health and community settings. We have been around for a bit over 40-odd years. We have a multidisciplinary team that covers social, clinical and public health aspects of ageing, and we have got networks across the country as well as internationally. Our vision is a world where older people are respected, healthy and included, and to that extent we seek to collaborate and work together with not only policymakers, clinicians and frontline providers but also older people themselves, including those from culturally and linguistically diverse backgrounds. This ensures that our work is properly translated to have maximum meaning and uptake and that everything that we do is ultimately evidence based.

Just a few quick points, I guess, to frame the conversation today: Australia, as you know, is an increasingly ageing and multicultural nation—indeed more multicultural in some ways than the United States, the UK and New Zealand. We are also an ageing country, and by 2056 about 8.5 million people in Australia are going to be over 65. And if you look at this little graph I have got here, what I really want to draw your attention to there is the diminishing orange line, which talks about southern and eastern European born populations, and the growing bands in green, which are populations that are Asian born. And what we have at the moment in this country is a demographic transition underway in the over-65 cohort, where we will have a change in the migrant populations moving from European to Asian born.

The other thing I would also like to draw your attention to is when we frame our discussions around multicultural communities it needs to be more than just a failure to seek formal help, that the system is indeed set up to have many systemic burdens within it and that there are very few culturally appropriate options, often inadequate language support and suboptimal care from health and aged-care services who are not necessarily trained and equipped on how to culturally adapt resources and tools and techniques to work with multicultural communities. There are also several discriminatory visa conditions that inhibit many communities from even accessing help in the first place and force them to seek it privately. These barriers really come over and above current barriers in the system, which everybody faces, which I have drawn your attention to there, and these sit over and above that. So there is a double burden so to speak. We have made recommendations in our submission about how we might reduce these disparities. I provided a bit of a precis there rather than elaborating on all of those recommendations.

The other thing I wanted to draw the committee's attention to is the opportunity that presents itself in terms of digital literacy and digital media and technologies. They offer enormous potential and scope. We are having our session today, for example, on Zoom. They are available 24/7. They offer some opportunities for participant engagement and opportunities to navigate services. Eighty-eight per cent of Australians are already using internet every week. They often spend more than 40 hours a week online, and this figure is actually higher when you talk about younger migrant and refugee communities but lower in older ones. So there is an opportunity there for how we might increase digital literacy for older people from migrant and refugee communities, thinking about some sort of intergenerational programs and opportunities to build health and financial literacy to reduce social isolation and loneliness, obviously of course recognising the caveats that this all needs to be done safely and with the provision of appropriate hardware and software for older people. You cannot really build digital literacy if you do not have a computer or if you do not have stable internet.

And finally I wanted to make a few quick points about data quality before I hand over to others. Really to note that linguistic and cultural information is very inconsistently captured and reported not just in Victoria but in other jurisdictions as well, and several crucial variables such as ancestry and ethnicity are often omitted altogether. So we have a very incomplete picture of what is going on, and if we do not have good data, we really do not know what is happening. We need to have some sort of, in my view, consistently and routinely collected variables about older migrants and refugees so that we can actually compare where we are at, where we are going and how we are doing, and we also need to invest in participatory research methods in order that we actually hear the voices of older migrant and refugee Victorians themselves, so not just what is filled out on the form but what they want to tell us too.

And I believe we are able to do these things—it is quite a unique opportunity that we have here in Victoria—in order to improve the lives of all Victorians. To build on the future, to provide exemplars for other states—certainly Victoria is already leading the way on many of these frontiers—and to share this knowledge with other parts of the world. Indeed many of the research projects that we do here at NARI that involve cultural and linguistically diverse populations have had their genesis in Victoria but then have gone national and indeed international. And organisations such as the WHO want to engage with us to see what we are doing. I believe that this sort of work positions Victoria to really have a high impact, both nationally and internationally, to translate knowledge into practice and to build more fairness and equity. I will leave it at that, and thank you very much for the opportunity to speak today.

The CHAIR: Thank you, Professor Bianca. Who is the next speaker?

Dr TRAN: I am happy to go. I am willing to start.

The CHAIR: Thank you.

Dr TRAN: Good afternoon. My name is Giang Tran from the Multicultural Centre for Women's Health. I am an advocacy and policy officer for MCWH. Before I start I would like to acknowledge the traditional owners of the various lands which we are joining from. I pay my respects to the elders past and present. I acknowledge that as a migrant I benefit from the dispossession and colonisation of the land we now call Australia.

I would like to thank the committee for the opportunity to present at the first public hearing of the parliamentary Inquiry into Support for Older Victorians from Migrant and Refugee Backgrounds. Today I will focus on the issues of older migrant and refugee women's mental health.

About our organisation: the Multicultural Centre for Women's Health is a national, community-based organisation that is run by and for women from migrant and refugee communities. We advance the health and wellbeing of migrants and refugee women through our multicultural and multilingual information and education, research, training and advocacy. As an organisation with a specific focus on migrant women's health and wellbeing, our presentation will discuss the mental health issues of older women from migrant and refugee backgrounds.

Our submission and my presentation today are based on our over 40 years experience of working with migrant and refugee women as well as some of the available research and data on this topic. As we note in our full submission, including the joint one and our own one, older women from migrant and refugee backgrounds are particularly vulnerable to mental health issues. I would like to highlight that older women from migrant and refugee backgrounds experience multiple forms of disadvantage that significantly impact their ability to have positive mental health experiences.

Indeed, one of the main issues leading to the poor mental health of older migrant and refugee women is social isolation and loneliness. Factors that contribute heavily to social isolation are language barriers, social and cultural disconnection, and issues in using advanced technology. Another significant factor that results in mental illness for older women is elder abuse. However, when older women from migrant and refugee backgrounds seek support they often face multiple barriers to accessing mental health and other services at all levels. The system can be complex, difficult to navigate, expensive and inflexible. Many mental health services lack cultural responsiveness and are not tailored to older migrant and refugee women in Victoria. While interpreters are available, they are not often used or there is very little investment in upskilling the interpreter workforce, particularly when it comes to mental health.

As we outline in our full submission, MCWH recommend that it is necessary to adopt an intersectional approach to supporting older women from refugee and migrant backgrounds. This means enacting legislation and policy that supports multilingual and culturally appropriate service delivery, that recognises the impact of systemic inequality, the impact of gender, race and age discrimination and the challenges of social isolation, language barriers and cultural disconnection.

As an organisation that has been working very successfully for over 40 years in delivering bilingual health information and supporting migrant women of all ages, we really believe that bilingual and bicultural support are needed for older migrant women. We need to provide ongoing investment in mental health services to offer culturally and linguistically appropriate support to older migrant and refugee women. Thank you very much for this opportunity.

The CHAIR: Thank you very much.

Ms ABBOTT: Chair, would you like me to go next? It is Judith Abbott from Carers Victoria. It is probably a nice segue from the previous witness. Good afternoon, committee members. My name is Judith Abbott, and I am the Chief Executive Officer of Carers Victoria. Thank you for the invitation to speak at today's hearing. I too would like to acknowledge the traditional owners of the various lands on which we are meeting today and pay my respects to elders past, present and emerging and any Aboriginal people on this meeting today.

Carers Victoria is the peak body for all unpaid carers in Victoria. For about 30 years we have worked with carers, governments and a wide range of partner organisations to make life better for carers. This spans everything from policy development and advocacy on behalf of carers through to participating in research in part with partners such as NARI and delivery of carer support services, primarily in Melbourne's western metropolitan region, where we estimate some 70% of the carers we support are either caring for a person from a refugee or migrant background or are from that background themselves.

I would just like to focus for a few minutes on carers and some of the key considerations in relation to the inquiry's scope. This is important because some older Victorians from migrant and refugee backgrounds are carers themselves, while for many older Victorians the support of an unpaid carer is essential for their continued wellbeing. One of the biggest challenges we have—it is not the first time you have encountered this

in this inquiry, I am sure—is the challenge of counting. It is difficult for us to quantify how many carers are from CALD backgrounds or who might be caring for someone from a CALD background. That is because there are a range of factors that mean that they are in effect hidden. They may not identify as a carer. They may not be recognised as a carer by their communities or professionals. They may face language barriers or cultural influences that mean there is a reluctance to engage with government services or may just not be aware that there are services available for people who identify as a carer that they might be able to access. That means that really when we talk about the size of the caring population in Victoria we have to talk about statewide numbers and then we need to extrapolate them for the refugee and migrant backgrounds.

So just to give you a very broad sense, we estimate there are over 700,000 unpaid carers across the state. About 170,000 of those are over 65, and in that older age group about one-third of those are primary carers of a person with a profound or severe core activity limitation. That means that the care they are providing is equivalent to part- or full-time work hours every week. We do not know how many of those people come from a refugee or migrant background, but we can be certain that quite a number of them do. Around 80% of the care that older people across Victoria with care needs receive is provided by family carers. That means that a lot of older Victorians, including those from migrant and refugee backgrounds, can remain at home because they have got the support of a carer. But even when people from migrant and refugee backgrounds go into residential aged care we know that they still receive significant report from their families and others to communicate in language, advocate and provide culturally appropriate food.

One of the things that we wanted to just raise with the committee is the cost and challenges of caring, because while it is really important it also does come at a cost. A caring role can contribute to financial disadvantage, social isolation, barriers to accessing employment and training, poorer health and wellbeing and neglect of one's own needs and goals. This is so for all carers, but for those who are caring for older people from migrant and refugee backgrounds there can also be additional obligations—for example, being called upon to provide informal translation services or in effect being a cultural navigator for that older person as they seek to work their way through a mainstream service system.

One of the dilemmas, I think, in this space is that we know from our own experience that it can be much harder to get culturally appropriate support services such as respite—the very services that both older people might require and that their carers rely on as well to kind of manage the impact of their caring role. We see this in Melbourne's western metropolitan region where it can be difficult sometimes to get culturally appropriate respite, which has impacts for both the older person and for their carer. So we are keen to see opportunities to enhance these, to build workforce understanding and to strengthen interpreting services, because we know those will deliver benefits for both the older people involved and their carers.

I just wanted to touch briefly on dementia. I know the committee has been particularly interested in dementia as a unique challenge for older Victorians from migrant and refugee backgrounds, and it is great to have NARI involved in this conversation, given their extensive research. I did just want to mention that it is well recognised that caring for someone with dementia can be one of the most demanding forms of care. It can be accompanied by feelings of loss and grief for the relationship and a life once shared. There is research by Dementia Australia from back in 2019 that shows that it can really exacerbate social isolation and loneliness, which is a segue into the mental health of older carers and people supporting older people from migrant and refugee backgrounds. We know there are often grave concerns if there is someone who is an older carer looking after an adult child. They are often very concerned about what will happen if they are no longer able to provide care, and we know that that can really play into the overall mental health of that older person. There is a lot of complexity in the area. I am happy to speak about this a little more, further on, if the committee would like. But we know that most carers experience social isolation and loneliness in much higher rates than the general population. When you consider the information from the previous witness, it really highlights why that intersectional approach is important, because we can think about people's cultural status, we can think about their role as carers and their other obligations, and we can bring a whole lot of factors together in a way that can work best for that person and the system.

I am just going to jump through. I note the committee has been particularly interested in views on the royal commission into mental health. Carers Victoria is a strong supporter of that commission and its recommendations. We think it is fantastic how it has recognised the value of the caring role and supporting role and that it is going to embed that into the future mental health system. We think that is a fantastic thing, but we really do think that all carers, including older people who may come from migrant and refugee backgrounds,

need to have access to those kinds of supports, be recognised in that way and in particular have access to the mental health and wellbeing supports that give them the best chance of being able to remain happy, well and sustained in their role.

We are really looking forward to seeing how the committee goes with its deliberations. We think there are great opportunities through this inquiry. We are keen for the approach outlined in the submission that brings together both the needs of the older person but also the supporters and carers around them, and we look forward to working with you all to achieve a better future for older Victorians from migrant and refugee backgrounds and their carers. Thank you.

The CHAIR: Thank you, Judith. We move on to Rebecca.

Ms EDWARDS: Hi, everyone. I am Rebecca Edwards. I am the Manager and Principal Lawyer at Seniors Rights Victoria—last but not least, I hope.

I would also like to acknowledge the traditional owners. Today I am coming to you from the lands of the Dja Dja Wurrung people of central Victoria.

Thank you for the opportunity to present. Seniors Rights Victoria, which I will call SRV, is a statewide specialist community legal centre focused on elder abuse, and we are also a program of Council on the Ageing Victoria, which has that broader remit of representing the rights and interests of Victorians aged 50-plus.

I Zoomed in this morning and listened to one of our partner organisations, Justice Connect, giving evidence to you, and while Justice Connect's elder abuse work is done via health-justice partnerships, SRV has a slightly different model. Like Justice Connect we also believe that an integrated service involving both lawyers and social workers is the absolute best practice for elder abuse work, and part of the reason for that is that people experiencing elder abuse often have other associated non-legal problems that also need addressing—sometimes before the legal work can begin or sometimes concurrently—and they can be things like housing, health, financial and emotional problems. So rather than embedding ourselves in a health service, we are an independent service which employs both lawyers and social workers, and we work together with the client.

So what do we actually do? Well, we provide older people aged 60 and above or Indigenous Australians aged 45 and above with a helpline service, and that provides information and referrals. Then we can also provide them with specialist legal services, either one-off legal advice or ongoing casework in appropriate cases, so we can provide social work advocacy, including short-term individual support. Via the helpline we also provide information and referrals to friends and families of older people who are concerned about elder abuse, and we do secondary consultations for service providers and professionals.

As a community legal centre SRV also has a role in policy and advocacy, in capacity building and in working collaboratively with relevant sectors to better identify and address and hopefully prevent elder abuse. We have also got a community and professional education project. So we are definitely not a CALD-specific service; we are much more of a mainstream service. But nonetheless we see a considerable number of older people who were born overseas. So, for example, approximately half—50%—of the advices that we do, both legal and social work, are provided to people who were born overseas. There is more detail in our submission, but, consistent with what Bianca was saying earlier, for the older cohort—so the 75 plus—they tend to come from European countries, whereas for the 60 to 75 age group, China and Vietnam, for instance, are much more significant statistically. We use telephone interpreters or in-person interpreters when required, and approximately 14% of our advices are done using an interpreter.

So elder abuse is a form of family violence, as I am sure you know, but unlike intimate partner family violence it has got some unique characteristics. It is not as gendered. Roughly speaking, of older people who experience elder abuse, there is about a one-third, two-thirds split, with older women making up the majority. However, as far as perpetrators go, they can be roughly equal male or female, usually adult children. And elder abuse can be a very difficult subject matter for families to grapple with. The combination of those abusive and distressing behaviours that they are experiencing combined with sometimes fairly catastrophic financial consequences can be overwhelming even for the most well-resourced and supported people, and those difficulties are just enhanced for older people from migrant and refugee backgrounds who are facing the additional barriers—both identifying and accessing services and then of course taking action to address the abuse.

Some of those barriers which are not necessarily unique to our service are that it is likely that older people who do not speak English are going to be reluctant to call a helpline about such a sensitive issue, and they may also be hesitant about their ability to interpret legal advice. It might be the case that people from a non-English-speaking background are less aware of the service and are not familiar with terms like 'seniors rights' or 'elder abuse' or 'powers of attorney'. Some barriers actually apply across populations, so there can be things like not recognising behaviours as abusive, not wanting to speak publicly of what might be seen as a family issue, being ashamed or feeling responsible for the abusive treatment or not wanting negative consequences for the perpetrator. And of course a significant barrier to access for older migrants and refugees is that many might be reliant on family members to provide language interpretation for a range of services, from doctors appointments to discussions with banks and utilities, and if it is the family member who is providing that assistance who is also perpetrating the abuse there is little chance that the older person will be able to access the support.

So, yes, I mean fundamentally we believe it is imperative that older people from migrant and refugee communities are supported with culturally appropriate resources delivered in an inaccessible way. That needs to be done hand in hand with organisations that are properly resourced to deliver and expand their services as well as working with the communities that they are there to support.

I am happy to answer any questions as part of the next part. Thank you.

The CHAIR: Thank you very much, Rebecca. I will move to questions from committee members—for the first question, Chris.

Ms COUZENS: Thanks, Chair, and thank you all for that really valuable contribution and your participation. It is great to hear the amazing work that you are doing, so thank you for that. I am a regional member, along with Michaela, who is on this committee, and obviously we have a strong interest in what happens in the regions. But one of my questions is around the digital challenges around access and affordability—the barriers to language support, health, mental health, family violence, all those things. How do we address them in partnership and who should we be partnering with in a co-design model? I am interested in your thoughts. I know it is a long question.

Ms EDWARDS: Perhaps, Chris, I could just mention a particular project that we are working on at the moment. It is only just starting. I am really passionate about rural and regional too, having spent all of my working life in rural and regional areas except for this current role. Seniors Rights is officially based in Melbourne, although it is a statewide service.

One of the things we have discovered through our casework, and this relates to the dementia discussion earlier, is that there is a need for not just supporting people to put in place things like powers of attorney but also really changing the language around supportive decision-making and encouraging carers to take a role—and it is not just carers, it is professionals too—where they are involving the person with impaired decision-making in the decisions that are being made. So they are not just taking over. As part of that we were lucky enough to get some funding and we are focusing that on regional areas and CALD communities, with the first area that we are going to focus on being Ballarat. But we very strongly do not want to be like a fly-in fly-out service, so we have already spent six months just building partnerships with some of the organisations that are working in Ballarat with the communities that we are trying to target so that we are delivering what they would find useful. We are sort of putting out there a suite of things that we could possibly do and saying, 'Which of these might be appropriate for the communities you are servicing?'. I think that type of service delivery is becoming more common and more accepted, but it has to be working with the communities in the regions and placed-based services, not just metrocentric.

Ms COUZENS: Great. Thank you. And I have got a specific question for Judith. You talked about the data collection for Carers Victoria and the fact that there is no breakdown on how many migrants, refugees, carers and families there might be. Is that something that you would support as a recommendation from this committee?

Ms ABBOTT: I think it would be helpful. Also there is a national carer survey. A second one is going to run later this year, and I am quite keen to see what we might be able to get into that piece as well. But it would certainly help us understand and provide advice about what might be necessary, yes.

Ms COUZENS: Do you know at this point how carers might deal with the language barriers—interpreters and those sorts of things? Are they issues that are confronted by people now?

Ms ABBOTT: They are. I was talking with some of my carer services team today. We have a few bilingual workers on our team, but we do rely on translation services and interpretation services. We anecdotally are finding that sometimes it is not quite as easy to get someone as it used to be and that they are now operating to tighter blocks of time than they might have a few years ago, so what that means sometimes is the discussion with the carer might still be going and the interpreter has to leave. Those are absolutely understandable but are some of the things that the team is working with day in, day out. We will continue to do everything we can to try and build and address that, but it has been a longstanding challenge, hasn't it? There are never quite enough translation services, there are never quite enough specific services, but it is certainly something we do see in our work in Melbourne's west.

Ms COUZENS: Great. Thank you.

The CHAIR: Thanks, Chris. Any further questions? Heng, thank you.

Mr TAK: Thank you, Chair. Neil also put his hand up.

The CHAIR: Sorry. I did not see him on the screen. Neil, you will be next. Thank you.

Mr TAK: I guess this is just a continuation of the question from Chris to Judith: what do you think is the best way in terms of communication going forward? Like you said, even having an onsite interpreter. Would access to an on-call interpreter also help or is there any better way from your point of view?

Ms ABBOTT: Could I take that one on notice? This is the bit where I have to declare that I have been in the role for four months so my knowledge is not as deep as it might be. But I would like to get the views of my carer services folk. So if I can take that on notice, I will get some advice back to you.

Mr TAK: Okay.

Prof. BRIJNATH: Chair, may I jump in?

The CHAIR: Yes, please.

Prof. BRIJNATH: Thank you. We have done some research at NARI, and it was just looking at a cognitive assessment for dementia and to try and understand the difference between an interpreter being face to face with the client and the clinician versus all three of them being removed. There was no major substantive difference we could find. The quality was relatively the same. It saves money; that is a good thing, and interpreters very much appreciate that, because they do not get paid for their travel time when they have to go between jobs. So they can do more jobs sitting at home, and the quality is relatively the same. It is not the gold standard, but it is definitely a viable model. So I would certainly say, especially in rural and regional areas where it is harder to find interpreters, particularly in languages that are less widely spoken, it is a good model that can work.

Mr TAK: All right. Okay. Thank you, Chair.

The CHAIR: Thank you. Any further questions? I will move to Neil. Thank you.

Mr ANGUS: Thank you, Chair, and thank you to all the witnesses for your evidence this afternoon as well as your written submissions. I have got a question in relation to dementia, and I think probably it might go your way, Judith, perhaps with a comment from Bianca. I am just interested if you have got any knowledge or statistics in relation to the incidence of dementia in the multicultural community. Is it any different to the broader community, to the best of your knowledge?

Ms ABBOTT: Neil, I am going to cheekily pass that across to Bianca, because this is such a core part of NARI's research agenda around dementia. So that is a very elegant handball there.

Mr ANGUS: Thank you.

Prof. BRIJNATH: Thanks, Judith. Yes, I can answer that. Look, there is no national prevalence study really on dementia at the moment, so we do not even have a good understanding of how prevalent the issue is in the general Australian community. But what we did do was some modelling. That work is now under review, but we did do some modelling just based on ageing alone. So we were separating all the risk factors that can enhance your risk of dementia from that model just on ageing alone. Yes, there is projected to be a big increase in multicultural communities living with dementia into the future. Part of it is just the ageing cohort, but part of it also, I think, where we need much more research to understand what is happening, is whether the dementia prevention and risk reduction messages are actually filtering into those communities. My sense from the research we are doing and understanding is that it is not. We do a lot of work with multicultural communities. We go out and talk to them about dementia, and I get asked two questions all the time. The first one is, 'What is dementia?', and the second one is, 'How do we prevent it?'. And so a lot of the best evidence is just not being translated and reaching those communities.

Mr ANGUS: Right. Look, thanks, Bianca. I think you are right there. I think that is going to be a big issue for the broader community in years to come, and it will be great to see, perhaps if there is some federally funded work done across the board, where we go with all that.

Chair, I have just got another question for Rebecca, if I can, please. Rebecca, particularly I want to touch on the issue of elder abuse. Effectively, at the end of the day, one of the more common, as I understand it, areas of elder abuse is in the financial area. It is obviously not limited to that, but it certainly is in the financial area. In relation to communicating potential risks, particularly amongst the multicultural communities, to financial institutions, has any thought been given to that, or has any work been done with financial institutions to alert them to the higher risk category of multicultural seniors in Victoria?

Ms EDWARDS: It has not been part of our work specifically. We have worked with banks, and we have done a lot of work on them being aware of elder abuse and what they might be able to do in relation to it, but not multicultural specific. The Australian Banking Association is also pretty heavily interested in elder abuse generally, but again I am not aware of anything specific to people from multicultural communities. Even just last week there was an example with a client who called up for some advice where there had been some fairly appalling behaviour by the bank, where the son, who as it turns out was the perpetrator of abuse, had done all the interpreting for the mother. They had not seen the mother separately at all, and the only time, after some years of using her house as equity for the son's non-existent basic business, they realised was when the son went out for a cigarette break and the mother in her broken English said, 'Please, no more. Stop. No more'. That was a big shock for us, that banks are still behaving like that. So I think there is more work to be done, but I also do not want you to think that there is no work being done, because there is.

Mr ANGUS: Sure. Thank you for that. I certainly concur with you; I think there is a lot more that can be done. Maybe, given the statistics we have seen just in this presentation, with the ageing population coming upon us there is going to be in the financial area a lot more money at stake. I think it will be incumbent upon the financial institutions to inform themselves and not allow matters such as the one you just described—and we have had other similar evidence this afternoon—to occur. I think there is a good piece of work to go there too, so thank you. Thank you, Chair.

The CHAIR: Thank you, Neil. There being no further questions, can I take this opportunity on behalf of the committee to thank you enormously, Bianca, Rebecca, Giang and Judith, for your presentation and your submission to the committee on this inquiry. It has been extremely valuable and again we thank you for participating today live.

Our next step will be that we will table a report to Parliament with some recommendations, hopefully before June. If you would like to keep up to date with the progress of the committee and in particular this inquiry, you can do so via the website.

Before I conclude, I would just like to, as a westie MP, thank you for all the work you have been doing. I know it has been challenging in the last two years, but in particular Carers Victoria and the Multicultural Centre for Women's Health, I know that the work you do for the west is enormous. All the very best in your endeavours, and again thank you very much for being here today.

Committee adjourned.