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

Coburg—Tuesday, 1 March 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

Ms Carla Wilkie, Elder Abuse Prevention and Response Liaison Officer, Western Health, and

Ms Della Robb, Team Leader, Healthy Ageing, Merri Health, North and West Metropolitan Elder Abuse Prevention Networks.

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

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

I also acknowledge my colleagues—to my right, Michaela Settle MP, the Member for Buninyong, and Meng Heang Tak MP, the Member for Clarinda.

All mobile phones should be turned to silent at this point.

All evidence taken by the committee is protected by parliamentary privilege. Therefore you are protected for anything you say here today, but if you say the same things outside, you may not be protected by this privilege.

All evidence given today is being recorded by Hansard, and you will be provided with a proof version of the transcript for you to check, and once that is complete the transcripts will be posted on the committee's website.

I now invite you to make a brief opening statement to the committee, which will be followed by questions. I invite Ms Carla Wilkie, the Elder Abuse Prevention and Response Liaison Officer for Western Health. Also we have Della Robb, the Team Leader of Healthy Ageing from Merri Health. Thank you very much, Carla.

Ms WILKIE: Thank you for inviting us to briefly present and discuss the concerns we have about elder abuse as it relates to older migrants and refugees in Victoria. My name is Carla Wilkie. I am the Elder Abuse Prevention and Response Liaison Officer at Western Health, working on the integrated model of care project for the prevention and response to elder abuse, which is a DFFH project. I sit within the Western aged care assessment service at Footscray Hospital, and today I am joined by my colleague Della Robb—we had expected Grace as well. Amongst many other hats they wear in their job roles, they also coordinate the northern and western elder abuse prevention networks on an alarmingly small budget given the scale of elder abuse in Melbourne's northern and western regions. The northern and western elder abuse prevention networks combined have 79 member agencies and are led by Merri Health.

The key social driver of elder abuse is ageism, and ageism is everywhere. It is in our communities, our institutions and in ourselves. The western and the northern elder abuse prevention networks seek to influence social change by envisioning that older people will be respected and valued in their homes, their communities and when accessing services and supports. We do this by undertaking ageism and elder abuse awareness raising activities directly with community and also by supporting professionals who work with older people, most often from diverse backgrounds, to promote networking opportunities between services, to build their capacity and to promote access to helpful resources, amongst other things.

Because this is quite a sensitive area within elder abuse we are unable to, I guess, articulate lived experience patient stories in a live capacity, but we would like to share a de-identified older migrant's story about an experience of elder abuse to add to context of this discussion. M—not her real initial—had previously lived abroad independently in her own home. She lived in the town where she was born, grew up and later married and had her own family. M had family and friends living nearby, but she missed her son, so she came to Victoria for an extended visit with him, her daughter-in-law and her grandchildren. M's son told her she needed to live with them ongoing and sold her home overseas against her wishes. The proceeds of the sale went towards applying for permanent residency and building a new family home, which M would live in with her son's family. M undertook all the domestic tasks, including cooking, cleaning and grandchild care, whilst her son and daughter-in-law went out to work. M did not have access to her own money, and she desperately wished to return to her home country. M's first contact with someone who safely inquired about her wishes came after she had become very unwell and required ongoing regular healthcare review and aged care service supports at home. M's experience is not unique, and various versions of the same narrative are heard across health care, aged care and social services regularly.

A reminder that elder abuse is a form of family violence that disproportionately affects diverse populations inclusive of migrant and refugee cohorts. Older people from culturally and linguistically diverse communities may face additional risks of abuse due to increased social isolation, language barriers and greater dependence on family members.

It is important to know that elder abuse is about a person or multiple people having power and control over an older person. Elder abuse is a single or repeated act or a lack of appropriate action, which occurs where there is a relationship with an expectation of trust, which causes harm or distress to the older person. It may be intentional, involving deliberate mistreatment, as in M's case, or it might be unintentional, resulting from a lack of information, support or ability. The impacts of elder abuse are serious and wide-ranging, from psychological distress across the spectrum to serious injury, permanent disability, premature admission into residential aged care facilities and premature mortality. So elder abuse for sure creates a significant public health burden both now and in the future, when elder abuse is expected to rise in accordance with our ageing population.

Perpetrators of elder abuse are most often trusted family members and caregivers, so where services have inadequate training or supports to meet the needs of older migrants and refugees, family members may be utilised as interpreters or conduits of important information, which can lead to service providers unintentionally colluding with perpetrators of elder abuse. Two-thirds of elder abuse victims do not seek assistance, so elder abuse remains largely hidden, and even more so in migrant and refugee communities. There may be cultural variations in understanding of abuse inclusive of differences in expectations of caring roles within families or attitudes towards reporting abuse and seeking assistance.

Many older migrant and refugee community members may not identify what they are experiencing as abusive. They may not know they are entitled to better treatment or may not believe they deserve to be treated in a better manner. Additionally, migrant and refugee communities may be small, and there may be a great deal of shame or fear of social exclusion or disruption of family relationships attached to speaking up about abuse. They may have a past history of trauma that leads them to distrust health, social and law enforcement professionals. As such, culturally safe opportunities to disclose their concerns are essential, and early, accessible and culturally relatable provision of information around their rights, the law and available supports is important in elder abuse prevention.

We cannot have a discussion about elder abuse without acknowledging the escalated suffering of older Victorians experiencing abuse under the COVID pandemic. Elder abuse has increased during the pandemic by an estimated 99% and is being called 'the second shadow pandemic', only behind violence against women and girls. Additionally, in Melbourne's metropolitan region during 2020–21 we experienced an increase in secondary consultations for elder abuse of between 76 to 400% month on month compared to previous years. This was combined with heightened severity and poorer outcomes during a time when elder abuse went further underground and services were increasingly scarce.

Broadly speaking, elder abuse in Victoria is under-researched, under-reported and under-responded to across health care, social services, aged care services and the legal sector. The causes of elder abuse and the barriers to seeking support are considerably more complex, nuanced and challenging for those from migrant and refugee backgrounds. The challenges are compounded by public health and social services being less equipped to respond to elder abuse in diverse populations. We need a greater understanding of elder abuse experienced by migrant and refugee populations and the implementation of effective elder abuse prevention and culturally sound service responses.

On behalf of the north and west metro elder abuse prevention networks members, thanks for inviting us and for your important consideration of the impact of ageism and elder abuse on older Victorians from migrant and refugee backgrounds.

The CHAIR: Thank you, Carla. Della, did you have anything?

Ms ROBB: I want to reinforce what my colleague Carla has said in that arguably diversity is one of Victoria's strengths, and where we enable diversity to participate we achieve enormous outcomes. I run the north and the west elder abuse prevention networks, and I am really startled by the difference in those two networks. In the northern region I have a much more rich tapestry of service provision and involvement by services and community members from backgrounds, and I find that the Northern Elder Abuse Prevention network is productive and exciting and innovative. I am finding quite a different situation in the west. I know that government policy aims to empower communities to address these issues. What I am finding in the west is that something is missing. I know we have privilege here. I just want to say that I am struggling to get local councils to accept the mandate by state government to raise awareness of elder abuse, and I do not really

understand why that is a problem—it is not in the north but it is in the west. I am getting very polite refusals to attend meetings time after time from arms of government. That seems strange to me.

The other thing that I would like to just highlight—and again, this is what Carla has been saying over and over again—is that where we allow diversity to participate in society we achieve greatness, and the ability for elders from CALD backgrounds to contribute and have a voice, particularly in the west, is missing. We know from looking at COVID that COVID unearthed a lot of things that we now cannot unsee. The patterns of high numbers of COVID positives in the metropolitan area were largely in the north and the west, where the working poor reside, and therefore you might say there are pools of working disadvantage. And yet in the west we have this strange reluctance of local government to be involved in raising awareness of elder abuse and opportunities for elders from CALD backgrounds to have a voice. So that could be a real hotspot for us going forward.

Ms WILKIE: I think what Della is speaking to is around equity. It usually takes twice the amount of effort to get half the amount of traction when working with services, with clients and with leadership at services, and this has been a consistent challenge for us. My feeling is that if we are seeking to create equity here, we would be building more resources into communities where there is more intersectionality and subsequent need. We know that the western suburbs have a higher degree of community members who have living circumstances that are low socio-economic, lower education levels. We know through health services that there is a high degree of comorbidities—more unwellness more broadly—yet if I use the immediate example, the elder abuse initiatives are the same at all five trial sites. In fact in some respects some of the funding is less in the west.

Another example would be that Victoria Police have rolled out an elder abuse financial abuse project in the eastern suburbs, and it has been there for a couple of years. We have been advocating with them very politely and relentlessly to roll it out in the west, and we might be getting some traction now, but I am mindful about the decision to roll that sort of initiative out initially potentially in a space that has need but maybe not necessarily the greatest need.

The CHAIR: Thank you very much for presenting that evidence and in particular for the west. Being the Member for St Albans I know all too well in relation to some of the services and in particular the west versus in a sense the north that it is not equally spread, and I think that is a real, real challenge. How do you actually get local government to participate and activate those local communities and in particular where there are seniors or elderly groups? That continues to be a challenge. Just before I go to a question, in the west we continue to face massive hurdles in relation to service. I have particular constituents who have been approved for services but because they are in the municipality of Brimbank and there is no service provider they have been sitting on a list for over a year now with no options.

My question is: what more does government need to do where you have a situation of inequity between municipalities? How do we in a sense create that equity across Victoria? So it would not matter if you lived in St Albans or in Ballarat or in Dandenong, you would get the same level of service and support. What does government need to do to get it to that par with local government?

Ms WILKIE: The west has difficulties with retention of quality clinical staff, with retention of quality health service leadership, with retention of talent in the space. They often move to other areas. I would come back to the notion of inequity. I think where there is a greater degree of intersectionality it requires more funding, more bodies on board and more supports. We need a higher box to stand on in the west, because we simply have more challenges.

Ms ROBB: I have worked in the west for around 20 years, and I think what I am taking from what Carla is saying is that sometimes it is really hard to collaborate; you are so busy defending your patch. More awareness, more research, more resourcing is obviously essential, but sometimes as well it is about breaking down that defensiveness, making it very clear from government what the expectations are of people already on the ground reaching out—not being so defensive of their patch, such as councils making offices available for meetings and councils being really aware that 'We are expected to do something in this elder abuse space. Let's advertise what the local initiatives are on our website'. That actually does not take money, it takes will.

Ms WILKIE: These are really difficult things to talk about. People often do not think that elder abuse occurs. They cannot believe that there are, I guess, job titles that have the term 'elder abuse' in them. So we are

working with well-intentioned workforces who maybe are not necessarily appreciating how hidden elder abuse is and how hidden the suffering of older people across that spectrum can be. I guess we have been trying since 2017 to get traction in a very polite and proactive manner. My feeling is: I wonder if we need a bit more direction coming from the leadership within council, within key services that work with our more vulnerable older people, to participate in the existing training and supports and to engage with us.

Our goal is always to make things easier. We will do the heavy lifting for our colleagues so that they can then bring elder abuse prevention initiatives forth to their communities, but it is that first thing of getting in the door and convincing our colleagues of the need.

The CHAIR: Just going back to local government, we have a situation where local government more and more are actually removing themselves out of the space, let us be quite honest, especially in the west, where they are no longer providing service and referring on to other agencies. Where you do have councils no longer wanting to be in this space, how do you, I suppose, try and engage and get the councils back on board? Because whether it is financial or whatever the burdens on councils, they are exiting this space very, very quickly.

Ms WILKIE: The main concern with councils exiting the space around aged care supports and the like is it then becomes more privatised, and what we have is some providers who have tremendous rhetoric around support and what have you but in practice really struggle—and struggle not only to recognise the importance of educating their staff and supporting their staff, but we are actually in a position where these providers will often be led not by industry leaders, they will be led by people with business backgrounds. So you have a whole workforce of well-meaning people who go higher for support because they are really confused and confronted by some of the things they are seeing when they go out to visit older people, and because there is not an expert there to be able to help them balance that or to be able to direct them to services like our own, then the older people suffer under those conditions. I have certainly encountered some really seriously concerning situations over the years where it was really about those services not having the information. My feeling is that you have that sense of community responsibility that is not necessarily borne out with private industry.

The CHAIR: I see.

Ms ROBB: We know that the outsourcing model can work when it is coupled with a comprehensive reporting framework or accountability framework. If you look at the example of home care packages that have been outsourced to people alongside a significant framework of quality, we do not necessarily have that with elder abuse. Let us take, for example, Hobsons Bay council, which has outsourced a lot of its community services. It is not alongside an accountability framework and an expectation and a will to drive the agenda of looking after all of the members of the community, because often elders from CALD backgrounds are silent. So we need that leadership of expecting accountability and helping to raise that awareness from our community's leaders.

The CHAIR: Any other questions?

Ms SETTLE: I guess the emphasis has been more from the provision. We have heard a lot from other people around elders from CALD backgrounds being less comfortable with accessing services and so forth, and I was interested in your submission talking about expansion of bilingual peer education initiatives. I would just like to hear a little bit about that.

Ms WILKIE: We think it is absolutely essential if we put on our elder abuse lens, that for older people to disclose that they are experiencing disrespectful behaviour or to disclose things that are challenging, like abuse, they need to have trust and rapport and feel culturally safe to do so and understood. The concern with home care package services and providers that do not have same language, that do not understand those nuances when they are going in and providing the care, is that it is simply not going to be culturally sound. We have had situations where really well meaning caregivers have ultimately ended up in deep neglect with their well-loved family member because they simply did not feel safe and as though the services that were available could meet their needs. So I think it is imperative—and I know this comes from the commonwealth government—that we advocate with them to prioritise the need to preferentially provide these services so that we are having bilingual care seeker support, that we are having bilingual people going in and doing the showering and dressing and cleaning, because often they are the first people that observe the concerning behaviour. They are also people that can provide social anchors as to what is not appropriate. So if these people understand abuse and

understand what an older person's rights are and they are also speaking the same language and have this rapport and trust, the likelihood of the older person disclosing their concerns and seeking help is much higher.

Ms SETTLE: That is a sort of language issue. But do you talk about the peer programs? I am kind of interested in that. So that is a bit more about someone else's—

Ms WILKIE: Sure. Sorry, I went off on a tangent.

Ms SETTLE: No, not at all. That was great, but I was just interested in the peer thing because I think there is such a move towards that peer provision.

Ms WILKIE: Yes. We have a few north and west metro elder abuse prevention networks members who are running these discrete, small, co-designed projects with specific communities, and I am thinking about Sarah Choong at MiCare, which are a home care package provider. They provide care to the Karen community. She was able to secure a small amount of funding to do an elder abuse prevention program, which was very much geared towards the cultural needs of Karen elders. Part of this is to work with older community leaders around expert clinicians having an understanding of their communities and then also to work with Karen community leaders to upskill them with information so that they are then providing social anchors to their broader communities. So I guess, co-design intervention projects that are about promoting respect for older people, are at their root really elder abuse prevention interventions. They would aim to use culturally relatable language, as many cultural groups don't have language for abuse or family violence.

There are a number of co-designed financial projects that Medha Gunawardana and her group have done out of Australian Multicultural Community Services, and they have partnered with Financial Counselling Victoria to do similar co-design projects with older culturally and linguistically diverse clients. So one of the things we do is try to put on record what it is they are doing so that that wisdom is not lost, so it can be replicated elsewhere, and to support our community partners to seek that funding and to participate in that. Again, it is a tricky construct to get traction for that.

I am also aware of some co-design work that the National Ageing Research Institute have done in the realm of intergenerational relationships and support. We know that when we enhance intergenerational relationships and respect we can go some way to mitigating the risk of elder abuse. From our perspective, we think the relationship between these co-designed projects and research and really recording all of our learnings and making sure that they are accessible and reproducible elsewhere is absolutely essential. But we are very early on in that.

Ms SETTLE: Thank you.

The CHAIR: Heang.

Mr TAK: Thank you. I thought I had more questions, but most of the questions have already been answered. But in terms of non-legal intervention, if I can just ask again, do you think that it would work? What kind of service could promote awareness and also intervene but in a non-legal intervention way for elder abuse?

Ms WILKIE: Least restrictive models are best practice in elder abuse response. We know that elder abuse victim-survivors do not connect well with traditional family violence services and supports, and in fact the language does not connect well with older people more broadly. We have worked very hard and I think the DFFH have worked hard to place a role like the role that I fill within health care, but also to have it sit alongside ACAS, the Aged Care Assessment Service. So aged care pathways can be really helpful pathways that can mitigate risk for people experiencing elder abuse, but when it comes to migrant and refugee populations, making sure that those pathways are culturally safe is key, because our big issue is getting participation. And my most concerning client group is older migrant and refugee populations who have cognitive decline or dementia and are hidden; they would be the group of most concern. We will often see end-stage situations in health care that are very confronting, but opportunities might have been missed along the way.

Della and I were talking earlier about the importance of first responders to elder abuse in community situations—so GPs, churches and other ethno-specific community groups where older people and their caregivers are already engaged and where they are already participating and already have trust and rapport—and the notion of these groups being effective first responders is an area that I think needs further exploration.

We would certainly like to see GPs doing training in elder abuse and, I guess, GPs more explicitly understanding creating a safe space for older people to disclose their concerns, the importance of engaging a separate interpreter and seeing the older person by themselves without a family caregiver, the importance of seeing that person repetitively by themselves with an interpreter and sensitively asking those elder abuse screening questions and then responding in a sensitive and supportive manner and not unintentionally presuming that the caregiver will have a friendly response to those complaints by the older person. I get very few consults with GPs each year, yet I am aware that older people experiencing long standing abuse will often say that they have been to their GP 30 times in a year. I feel like it is a missed opportunity for early identification and intervention with older people. Broadly, there is so much respect for doctors within culturally and linguistically diverse communities, which can be drawn on.

Ms ROBB: This is something that I have heard from two separate networks, two separate cultural groups, in the space of one week, whereby somebody from a Greek background and somebody from a Tibetan background said the same thing to me, and that is in their culture the role of a social worker is unknown or they do not have a traditional framework of understanding for or language to describe a social worker as being someone that you trust and you tell things to. They do for a health worker, which is why embedding those responses and awareness in the health services is so important. Health and legal, yes, but not social workers.

The CHAIR: That makes sense.

Mr TAK: Yes, that makes sense. Thank you, Chair. Thank you.

The CHAIR: Well, thank you very much. We could continue on and on, but we will conclude at this point.

Ms WILKIE: We will if you let us.

Ms ROBB: We really appreciate this opportunity. Thank you so much.

The CHAIR: Thank you very much to Carla and Della for your evidence today, which will form part of our deliberations. The committee will table a report back to the government in the Parliament of Victoria in the coming months, and we will keep you updated on our website and through our secretariat. But thank you so much for all the work that you do—I know it is challenging, and in particular in the west—and the work that Western Health has done during the last two years. Everyone has been impacted by the pandemic. So thank you very much for all the work that you are doing.

Ms WILKIE: Thank you for the work you are doing too. We appreciate it.

The CHAIR: We will have to have a conversation offline about the west.

Witnesses withdrew.