TRANSCRIPT

LEGISLATIVE ASSEMBLY LEGAL AND SOCIAL ISSUES COMMITTEE

Inquiry into Early Childhood Engagement of CALD Communities

Melbourne—Monday, 28 October 2019

MEMBERS

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WITNESS

Dr Adele Murdolo, Executive Director, Multicultural Centre for Women's Health.

The CHAIR: I declare open the public hearing for the Legal and Social Issues Committee's Inquiry into Early Childhood Engagement of Culturally and Linguistically Diverse Communities. All mobile telephones should now be turned to silent. I welcome Dr Adele Murdolo, the Executive Director of the Multicultural Centre for Women's Health. 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 go outside and repeat the same things, including on social media, these comments may not be protected by privilege. All evidence given today is being recorded by Hansard, and you will provided with a proof version of the transcript for you to check as soon as you can. Verified transcripts, PowerPoint presentations and any handouts will be placed on the Committee's website as soon as possible. I now invite you to proceed to a brief opening statement to the Committee of up to 10 minutes, which will be followed by some questions from Committee members. Thanks, Adele.

Dr MURDOLO: Thank you very much, and thank you for the invitation to be here today. I feel very privileged to have the opportunity. I think what I will be talking about might be just a little bit different to the previous contributions from other members in that our main focus is women, and migrant and refugee women, so I guess we are sitting a little bit outside the system that you are probably mostly looking at.

The CHAIR: That's good. That is what we want to hear.

Dr MURDOLO: What I will be talking about is really some of the work that can happen outside of that system to build the capacity of that system and the capacity of users of that system to use it. I hope that will be of interest and useful.

I am from the Multicultural Centre for Women's Health. We have been going for 40 years. We are a migrant and refugee women's organisation run by and for migrant women. Our main focus is providing the information and education that migrant women need to improve their health and to act on their health in a preventative way. We have a team of about 20 bilingual health educators who are trained. There is an accredited course that they do. They are trained up to deliver key health messages to women in their languages.

We operate in an outreach capacity, so we go out and work with women in their workplaces or in their English language centres. I heard you talking about the hubs earlier. We do also work with women in the hubs. Just as an example, for women who are dropping their children off at primary school, after they have dropped off we will run some sessions within either the school or another room within the hub, and provide them with education within that context. It is great to be able to reach women who are in that stage of life, because there are so many important issues there to do with their health. Our issues range from sexual reproductive health to mental health. We also talk about family violence and preventing or having an early intervention into family violence.

As well as that direct work with women we have an advocacy policy and research role. We are funded both by the State and Federally to take some of that work that we are doing in the state to a national level. If there are issues that are coming up in the sessions that we run with women, we combine that with an evidence base and we use those to advocate for changes in policy or we do the kind of work that I am doing here today. One of the key reasons why we are focusing on migrant and refugee women and access to services is that there is a pattern of service use that we have noticed among migrant and refugee women, and that is that they tend to have very low access at the early intervention and prevention point within those services and then they are over-represented in the acute. So if we are thinking about the issue of domestic violence, for example, they are very unlikely to access family violence services at an early point, and when those issues come to the attention of the authorities it is very often through police at a very crisis end when the woman is really fearing for her life. So there are many years there between first occurrence and when help is sought where the violence escalates. So we see a very crisis end.

In regard to health, I can give the example of antenatal care, where migrant women are much less likely to access antenatal care. So there is 56 per cent in the first trimester compared with about 70 per cent among the

English-speaking population. Then they have a lot more poorer outcomes at birth. So this is the pattern. Within the sector that you are looking into I would suggest that we would see a similar pattern, where there is very low uptake with the optional types of services, and I guess that is where problems build up, and we are seeing some effects at the other end of that system. I think with maternal and child health in particular one of our observations is that attendance drops off. So that is a universal system—all women have access to it—but very often migrant and refugee women tend to go to the earlier appointments but then their attendance drops off over time. So this is an issue that I think definitely could be addressed within the system and would lead to better outcomes.

So why would I be here talking about early childhood? It was great to be invited. Thinking about it as well, we would like to suggest to the Committee that women really need to be considered quite centrally to the considerations of this Committee. You may well already be doing that, thinking more specifically about women as mums and the role that they play in children's lives, but I guess I would support that way of approaching the issue because women are very central to the development of children. They are often the mediators between their early childhood programs and the children. I guess also for a whole range of different reasons—and of course there is a lot of diversity within that—with many of the women who we see, especially where there is low English proficiency, there will not be as much capacity as is needed to actively navigate a complex system, especially when that system is quite different to the one where they have come from. So I think that the other point about that is to not only consider women centrally to the considerations of this Committee but also to think about the role of gender equality within the solutions for the Committee as well. It is very often that combination of gender and race inequality that can prevent migrant women from being active participants in a whole range of different services. So thinking quite holistically, building gender equality and building racial equality within Victoria and more broadly would actually contribute to what I am assuming this Committee would like to achieve.

So just a very brief word about demographics. There are about 885 000 women who live in Victoria who were born overseas in a non-English speaking country and about 248 000 have dependent children aged zero to nine, so it is quite a sizeable figure of women who we are talking about. About 10 per cent of this group have low English proficiency, so they have marked on the census that they speak English not very well. There are 25 600 women with dependent children who have low English proficiency, which I would suggest make up a particularly marginalised group. So where I would say women need to be at the centre, I think there is that particularly marginalised group that on which perhaps there should be particular focus. Within this group, 10 000 women have partners who also have low proficiency in English, so I think they would be families that have particular challenges—where both parents are challenged in that way.

I would like to suggest that there are particular barriers for women when they seek to use early childhood services for their children, or early primary, and that women need to actually be quite empowered to navigate those services and to overcome the barriers. At the same time, it needs to be a two-pronged approach. We were also looking at the services and how they can be more responsive to women, which I am sure you are doing anyway.

Some of the barriers that have come to our attention are certainly language for those women with low English proficiency and the navigation of new systems in the settlement period. At the service that I work in we do specifically target women with low English proficiency, and the way we do it is through in-language engagement and through outreach methodology. So for us that is a pretty winning combination of strategies that will reach women who are actually quite isolated and may not access services immediately.

One of the other things that we find is the impact of temporary visas in particular. Women who are on temporary visas are particularly vulnerable for a whole range of reasons, but I guess in terms of this area cost is a real barrier. For families where they are on a temporary visa, they do have to pay out-of-pocket for child care and for primary school. If it is an optional service, many parents will opt out of course or choose not to take it up—child care for example.

We know the solution that you were talking about before, with the grandparents, is a huge solution. In some cases it is the preferred option for some families, but other families actually do not have a lot of other options and so they have to rely on family members and grandparents. And the grandparents are not always really the optimal people to be looking after the children. I think it is a situation that works out really well. My own

parents looked after my child when I could not get any child care; it just was not available. So that was actually a really positive experience, but I actually know that some grandparents work themselves; they are not actually the best people to be looking after the children. The best option would be some kind of a service, but they are not available because of cost or other reasons.

With the issue of visas, there has also been quite a bit of—am I running out of time?

The CHAIR: No, not yet. Go ahead, conclude.

Dr MURDOLO: All right, that is good. Okay. There is lots of research to show that women who are on temporary visas are also much more vulnerable to family violence—you probably have already heard about that—but they are often forced, really, to stay in a situation where the person who is responsible for their visa, or their sponsor, is the same person who is perpetrating the violence. So they often stay in a situation that is dangerous for themselves or for the children. And the other issue that sometimes keeps women in that situation is if they have a temporary visa but their children are Australian citizens and they fear losing their children—so there are a lot of really good reasons why.

But I guess when we are thinking about the sector I am not sure the degree to which considerations of family violence are taken into the early childhood and early primary sector, but I think if there is more we could do then that would be a good thing to think about. In many family violence situations the children will experience it in some way, whether it is witnessing, being victims themselves or just living with the consequences of that violence. So it really would be something to consider whether people—workers who are in that sector—are adequately trained to deal with those situations, and the specific circumstances for migrant communities as well, where we know that perhaps there has not been the capacity for those women to take action on that violence for a whole range of reasons.

The final thing that I wanted to talk about was mental health. We have done a little bit of research in relation to mental health considerations for migrant refugee women. Perinatal mental health is a big one. Migrant women are at higher risk of perinatal mental illness and we do not really have the services that can address those issues. For example, in the northern division, which is where we did a little bit of research about perinatal mental health, we found that there are only two services that can cater for migrant women that are specifically for migrant women, so they can take into account cultural language issues, and that also have expertise in perinatal mental health. One of them was in Mildura, which is great for Mildura people; the other one was metropolitan-based. But there were no other services anywhere else. So I guess in this sector it would be important to take into account that there would be a sizeable number of women who are experiencing perinatal mental health challenges and they do not get any treatment or support for it. And there have been some quite tragic cases of migrant women in the media in Victoria where there have been some tragic outcomes from that. So definitely support for mental health challenges is important.

I guess just in terms of recommendations I would make—I can talk about that later or just briefly some them up now. What is your preference?

The CHAIR: We might just go to the questions and then come back.

Dr MURDOLO: Sure.

Ms COUZENS: Thanks, Adele, for coming along today. We really appreciate you sharing your information with us. We really appreciate it, so thank you.

Dr MURDOLO: A pleasure, thank you.

Ms COUZENS: It was really good to hear you mention gender equity. That is obviously an issue that this Government has high on its agenda, and we will be passing a gender equity bill in the chamber hopefully by the end of this year, which is really exciting. Hopefully that will make a significant difference for a lot of the women around the state—and also of course family violence. We have heard from others about family violence and the impact of that. Do you see local government having more of a consistent role in children's services for CALD communities? I am not sure what your experience is around that, but whether there is a better, consistent provision of those services rather than a bit of ad hoc depending on the council and how it is delivered, which

appears to be the case now. Do you think local government has a role to play in that, and if so, how would that benefit?

Dr MURDOLO: Yes. I think they would definitely have a role there. They do run those services and they definitely need to be part of the strategies to address the issue. I think it would be great to also have specific expertise guiding the way that local councils do that work, because, as you said, at the moment we do hear some great stories but you also hear some not-so-great stories. So if there was a way of making their approaches much more consistent, and with the expertise coming from—well, depending on what the program is, I guess. With gender equity, for example, coming from a place where there is expertise on gender equity but not only more generally for migrant refugee communities, because it is different. One thing I did not mention is that we run programs with migrant communities on gender equity and prevention of violence against women and they are very different approaches that we take. So I think you need that combined expertise, so I would really like to see local councils playing a role but certainly with a mechanism that can make sure that there is a consistent approach that is informed by evidence-based expertise.

Ms COUZENS: Yes. Local government will be impacted by that bill, so it is going to be very interesting as to how it plays out.

Dr MURDOLO: Yes. Barriers that you see for the women that you are working with—are there some key areas that you think the Committee should know about for this Inquiry?

Dr MURDOLO: In terms of barriers or services, or either?

Ms COUZENS: Either.

Dr MURDOLO: Yes. I think definitely women knowing about services makes a big difference, which is why I guess I feel like the solution to that has to lie outside of the services themselves, because unless the women know about the services, then—

Ms COUZENS: Yes.

Dr MURDOLO: So there need to be education campaigns outside of them—some of that discussion that you were having before with the other two people who were here about making sure that women see themselves as playing a role in their children's education at a really early point. There could be some great education programs in migrant refugee communities about that, which again would build their capacity to navigate the system. They can find out about it, what their role could be in it. A good start would be obviously doing lots of things even outside of that system that could support kids. So that is important.

At the same time some of the barriers do not rest with the women or the families but they rest with the systems. I guess that is where there definitely is a need to make those systems more appropriate for migrant refugee communities, because there is dropout. Just as I mentioned earlier on maternal and child health, I think there are lots of complex reasons why women drop out of the system. One of them is certainly about feeling judged, and I guess that comes back to a context of racism, which is not necessarily the Victorian Government's own problem only but is much more pervasive, I guess. But that is something that we could build into those services to reduce that perception that women have, to build the capacity of maternal and child health nurses and that whole program to respond more appropriately to communities. I think the workforce is an issue.

Ms COUZENS: Yes. I reckon that was Natalie's next question.

Dr MURDOLO: Absolutely, because maternal and child health nurses are wonderful, but it would be great to see some diversity within the workforce. I know one of the reasons is that it is such a long course and you need quite advanced qualifications to be able to do that job. You have also talked about bilingual workers earlier. They could actually be a supplementary workforce to maternal and child health which does not need to have the qualifications of maternal and child health nurses but which could do that engagement work, which can, I guess, avoid some of those barriers where women feel that these services are not for them or coming in and feeling like their cultures are being judged or that they are going to be seen as bad mothers and potentially lose their kids. So I guess that could be a really great strategy to have a supplementary workforce that can provide something like a mediator between the hard-core maternal and child health and the communities.

The CHAIR: You did talk about some recommendations that the Multicultural Centre for Women's Health had. Did you want to just touch on those important recommendations?

Dr MURDOLO: Yes. They are very broad, but I guess the first one, as I mentioned at the opening, is to place women at the centre of the Inquiry's concerns and do it consciously, so to do that with a bit more conscious recognition; recognise the role of gender and race inequality as barriers to engagement; and consider the ways that gender and race equality can contribute to improvement of women's engagement with the system; take a two-pronged approach to both change the systems and to empower the women; and build their capacity to use it. With respect to building capacity amongst women, we would really recommend an in-language outreach methodology such as the one that we use in our centre, which is an evidence-based methodology that has been found to be very effective at engaging women and building their knowledge about services. Then take a holistic and gendered approach to looking at those gendered barriers like language, social isolation, knowledge barriers, family violence and mental health that can prevent women from actively engaging with the system and that can also at the same time prevent the system from adequately meeting the needs of the women in the community.

The CHAIR: Just on a final question, what is one thing that stands out? I mean, this is broad, but one thing for your organisation that you can provide advice to State Government on?

Dr MURDOLO: Our systems are already there, I guess. If you were to stand back and think about how you might design a system that is for a multicultural community, and we have so much diversity in our multicultural community, then you might—I guess it is about standing back and saying, 'We don't need to just be happy with the system. We've got to make a few little changes around the edges'.

I think to completely rethink what systems are available to communities and what needs to be done to really address the needs of the community. I guess to consider things like cost. We know we have got temporary migrants in our community. If the systems are completely inaccessible to them because of cost, can we subsidise their use of the services? If we know that mental health is going to be a barrier to using those services, how do we make sure that we are providing the mental health services that parents need to be able to facilitate access to the services that we have got, in culturally appropriate and linguistically appropriate ways? I guess they are pretty broad, aren't they? I am not talking very specifically.

The CHAIR: That is fine. I suppose you have mentioned the role of grandparents, and that is increasingly growing. It is no longer the traditional sense of the unit of being a mother or father, it could be single parents. There is such diversity now. The role of grandparents is becoming increasingly much more than what it was. I suppose young parents are making use of grandparents. How do we include that in our deliberations? It is no longer the role of parents but the role of broadening out—

Dr MURDOLO: The whole family, yes, absolutely. That is a really important consideration. I think another thing that has come to our attention is the cost of visas that young families will pay to bring their families out. That can sometimes put a lot of pressure on the family and it can put a lot of pressure on the grandparents to feel like they owe a debt to the family.

The other thing is that those grandparents are then quite unconnected. If they are just at home looking after the kids during the day, they do not really have connections to, maybe, pensioners clubs or the clubs that maybe other migrants who have been here a longer period and are in their older age are connected to. So they can be quite socially isolated. There is a lot of stress around finances.

I think that strategies could alleviate some of those situations where we are reaching out to older parents—sorry, grandparents—who have come on those visas to try and link them into the services or social networks that they might need to more actively participate in the community. We have heard some quite serious stories of isolation of parents. Sometimes it is both parents and sometimes it is just one, like a mum coming over to help, but yes, really it is very, very difficult for them to link into their local communities. Language is also an issue. Some language support for them, language classes even—we often do not think about people who have come later in life as needing language classes but certainly there is a lot of support they could be given at that point.

The CHAIR: Excellent. On that note, there being no further questions, can I thank you very much for taking the time to present to us today. On behalf of the Committee, I also thank the Multicultural Centre for Women's Health for all the work that you do, and I have seen firsthand all the work that you do particularly in Brimbank, in my electorate. The next step will be that your submission will play a part in our deliberation. Next year we will table a report to Parliament with some strong recommendations. Your submission will be a valuable part of that process, so thanks again and see you soon.

Dr MURDOLO: Thank you very much for the opportunity.

Committee adjourned.