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—Friday, 18 February 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

WITNESS *(via videoconference)*

Professor Irene Blackberry, Chair and Director, John Richards Centre for Rural Ageing Research, La Trobe University.

The CHAIR: Good afternoon. 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 welcome here today Professor Irene Blackberry, the Chair and Director of John Richards Centre For Rural Ageing Research, La Trobe University. I also acknowledge my colleagues participating here today: Neil Angus, Member for Forest Hill, and Meng Heang Tak, the Member for Clarinda.

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I now invite you to proceed with a brief opening statement to the committee, which will be followed by questions from the members.

Prof. BLACKBERRY: Thank you, Chair and committee members, for the opportunity to appear before you today. I would also like to acknowledge the traditional custodians of the lands on which we meet today and to pay my respects to elders past, present and emerging.

I am from La Trobe University and based at the Albury-Wodonga campus. As you may be aware, Albury-Wodonga is one of the regional footprints of La Trobe University. We also have footprints in Bendigo, Shepparton and Mildura. For the past 15 years we have undertaken programs of research that make a difference to the wellbeing of a diverse range of older people living in rural communities, and I would like to acknowledge my colleague Dr Rebecca McKechnie for her contribution in our submission.

Our submission has highlighted many issues affecting the health and wellbeing of culturally and linguistically diverse older persons more broadly and those living in regional and rural areas more specifically. About one in three older adults live outside metropolitan areas, and while the actual number is small, the proportion of older adults living in rural and regional areas compared to the urban areas is definitely higher. One-third of older adults in Melbourne and approximately about 10% in regional and rural areas of Victoria have culturally diverse backgrounds. Overall there is a lack of research focusing on rural older migrants and refugees, hence this inquiry is very critical in terms of the timing. So in my brief opening statement I would like to provide some key perspectives from the rural and regional areas.

Firstly, older adults are heterogeneous. There are also variations within and between culturally diverse populations. Culture obviously is critical to older adults' understanding and beliefs about health and wellbeing, and we highlight the importance of cultural safety framework and person-centred care. For example, for the Karen community in Bendigo, health is perceived as holistic and includes physical, mental, social and emotional health. Beliefs about health are also multifaceted and encompass concepts such as the absence of pain, feeling happy, feeling like one is able to participate in activities of daily living and feeling strong and energetic. So due to different perspectives on what health is, many older people from CALD backgrounds believe that symptoms that are social and emotional are also important, but often this is not addressed on many occasions.

Our work in the area of volunteerism also highlights the importance of maintaining cultural identity and social connectedness. The loss of social roles that is common in ageing can have significant consequences for the mental health of older CALD people. Cultural identity and a sense of belonging are important to older people

from CALD backgrounds; in some cultures it can be a particularly important component of their health and wellbeing. Older adults from CALD backgrounds may be particularly prone to loneliness and social isolation due to resettlement issues that are life-stage specific, so the provision of culturally specific services and programs may serve to reduce this. However, aged-care and support services that are specifically targeted for ethnic or CALD communities rarely exist in the rural context.

Secondly, older CALD people face multiple barriers to accessing care and support services, and that includes not only the sense of not belonging, language barriers and difficulties with communication. In our experience these barriers give rise to difficulties understanding referral letters, navigating the system—not only the healthcare system but the aged-care system—and locating services in unfamiliar locations or within large buildings.

The lack of care providers or transport options, coupled with isolated geographical locations, is a huge barrier to accessing services in rural areas. The stigma that receiving support is associated with the loss of independence exists and results in a reluctance to access services until crisis points. In our research we found that aged care in rural areas is a thin market. People do not have any choice or option. Digital resources have the ability to bring care to people in regional and rural areas that would otherwise be unavailable, and this is evident in our research in partnership with the Royal Flying Doctor Service and the telehealth specialist service. However, the lack of digital literacy exhibited by older adults more broadly and the lower levels of education, low incomes and limited English skills found in CALD people can intersect to further increase the digital divide created by low levels of digital literacy.

Appropriate staffing within organisations is crucial for service delivery and sustainability. However, the disconnect between federal and state government funding and responsibilities can create confusion for the consumer. Further, at the local government level changes to health promotion models, high-level restructuring and the withdrawal from the home and community care services also create some confusion and affect the sustainability of the program targeting older CALD people in rural and regional Victoria.

Thirdly, the skilled workforce shortage in healthcare and social support services in regional areas is another big-ticket item. The Aged Care Workforce Strategy Taskforce obviously have identified a severe aged-care workforce crisis in rural and regional areas, and this is characterised by an unskilled, low-renumerated workforce and the lack of career pathways. Despite the growing number of migrants working in the aged-care sector, we identified a number of concerns relating to their employment status and barriers to career development for CALD people employed in the aged-care sector, which contributes to high staff turnover and skill shortages. This includes a lack of support for further training and opportunity for the caretakers to gain qualifications as enrolled or registered nurses. Geographical barriers to networking in regional and rural locations, as well as language barriers, were also highlighted. Recent ABS data highlighted major depths in healthcare and social systems job vacancies in Australia. We really need to transform our thinking of aged care from a welfare and consumption issue to a carer economy, which is the largest growth industry in Australia.

Finally, each rural community is unique. Older CALD people draw on a complex network of resources, including health and social support professionals, families, friends and local community as their key resource for advice, assistance and support. Trust is very important, and we have found that strong interorganisational networks and engagement within the whole of the rural community is very critical to the success of any initiatives or programs that are being implemented.

In our submission to the inquiry we have provided a number of recommendations as to how these challenges may be addressed, from the introduction of measures such as embedding cultural safety within healthcare and social organisations to greater connectivity between community networks. We would like to acknowledge the contribution made by older migrants and refugees from diverse backgrounds from rural and regional Victoria, and we really appreciate the opportunity to share our research in this important inquiry.

And if I may, I do have a brief video about the migrant aged-care workforce that I would like to share with the committee. Committee secretariat, if you could please begin the video. Thank you.

Video shown.

Prof. BLACKBERRY: Thank you, Chair.

The CHAIR: Thank you for that presentation. I will move on to questions, and I have got a question before we begin. My question is around dementia. Do you see dementia as a unique challenge for culturally diverse older people in rural and regional areas, and what more can be done in this area?

Prof. BLACKBERRY: Recently we completed a project about dementia-friendly rural communities. So specifically what we have done is actually build not only a physical or local support structure but also a virtual structure. And part of what we developed was the local network, if you like, but we also developed how each of these local networks can be connected with other local communities and other local carers. The first part of that was about providing some information to the local communities about how to engage, how to connect and how to use the technology, because these days all of the information is available online—for example, from Dementia Australia—so it is rather difficult to actually have much more, I guess, in the library or the model of a physical print version.

So we have volunteers helping the consumers, the older people and the carers, with how to connect online, and we have also developed some bite-size information about how to identify signs and symptoms of dementia. And obviously we also created some pathways for people to be able to access support services, not only what is available locally but also for them to be connected with other carers and other older people who experience dementia, because there is a lot of knowledge that can be shared. And through experience sometimes what we found was that in the small rural communities there may only be a small number of people with dementia and a lot of the community people do not actually understand what dementia is. There is still a lot of stigma obviously associated with that. So this is the importance of, I guess, bringing everyone together from other communities to actually help each other and share the learning.

The CHAIR: Thank you, Irene. I will move on to Neil.

Mr ANGUS: Thank you very much, Chair, and thank you, Professor, for your presentation today and also for your written submission. I just want to follow up on your key finding 7, which said a strong digital divide exists for older people with CALD backgrounds and this is exacerbated for those living in rural and regional areas. I suppose I am just interested for you to flesh that out a bit more, please. And also, in the midst of that, I know you have made some recommendations there, but if you could just sort of articulate a little bit more some of the solutions that you see to that problem which, as you have identified, is more exacerbated in the rural area. That would be great. Thanks, Professor.

Prof. BLACKBERRY: Thank you. Thank you for the questions. I guess what we have learnt so far with the COVID pandemic is it has really forced people to use the technology. There was a strong push. We did a project recently, funded by the Commonwealth, about increasing physical activity, and we implemented that across the Loddon Mallee in partnership with 10 local government agencies. Initially when I proposed to the committee the conception of using technology and delivering that online, people were saying to me, 'Oh, no, no. We don't do online. We don't do online programs'. So initially the study or the programs were face-to-face in the local gyms or in the local support centres, and because of COVID we did have to change. This is, I guess, the value of bringing people together in the partnerships—that we actually bring different key stakeholders together to come up with a solution. In that project in particular what we managed to do is that we engaged with the local councils, the rural health services and the community health centre and also the community more broadly, and I did speak directly about volunteerism. A lot of people in the rural communities do get back into the community through volunteering, and this is where you can achieve outcomes when you bring people together. So it is good that we have the NBN, if it is working, but as you may be aware we do have black spots. We do not have access to everything. But within what we can do together, bringing people together to come up with solutions, this is where we can achieve outcomes to bridge that digital divide. I hope I gave an answer to your questions.

Mr ANGUS: Sure. That is very helpful. I guess that is just the tyranny of distance in rural and regional Victoria. That is one of the ongoing and immovable challenges that are faced.

Prof. BLACKBERRY: I think there is a lot of reluctance for people to change, particularly older people. I think a lot of people feel embarrassed if they try the technology and they do not know how to navigate the technology, but we find that particularly with these group exercise programs, when you are actually doing it together, then people can actually learn together and that actually helps solve some of the issues when some people are more proficient than other people. This is where you can help each other to achieve similar goals—

Mr ANGUS: Yes. Absolutely. That is very good. Thank you. I noticed, too, that you said that a lot of your work and your submission was based on research that you have undertaken with older people and key stakeholders. How long ago was that? I might have missed that somewhere in the document, but when was that research undertaken?

Prof. BLACKBERRY: The centre itself has been here for the last 15 years. We have undertaken a lot of research in health services and aged care and in technology for older people and in the workforce in the past 15 years. We have done a range of projects, and some of the projects that I have alluded to in our submission relate to and are more relevant to older migrants and people with refugee backgrounds.

Mr ANGUS: Right. Okay. Thank you. Thank you, Chair.

The CHAIR: Thank you. Heang, do you have a question?

Mr TAK: Thank you. My question relates to interpreting services in rural and regional areas. Professor, can you expand a bit more on interpreting services in rural and regional areas?

Prof. BLACKBERRY: Yes. I guess for us it is about accessibility and funding. A lot of the work that I have done to overcome some of the issues would be in work with rural health services. There are not many bilingual workers there. I am not just talking about in the health sector but also in the community programs. It is very difficult. I remember, a few years ago we had one specialised language and we could not even get anyone on the phone from Melbourne or Canberra. So it is an ongoing issue, and I think some of the solutions that we need to probably foster are really about developing or building capacity within the rural communities. Say, for example, we have a Sudanese or a Somalian community come to a regional area. I think it is particularly important not only to think about what services those people need but also to think about what type of employment people in that community can actually undertake that will benefit not only the local community but also Australia more broadly.

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

The CHAIR: Thank you, Heang. On a final question, if I may: how can the Victorian government help service providers to build strong relationships with culturally diverse older people in regional Victoria?

Prof. BLACKBERRY: I know that there are a number of support services. For example, here in Wodonga we have Albury-Wodonga Ethnic Communities Council, and they have been extremely active in supporting the local communities, but I do know that they do not have, I guess, enough funding and support, so it has always been a limitation as to how they can do more in the local community. So reaching out for them is an issue, and it can be costly, because in the rural communities even travelling to access the hard-to-reach population everything is just multiplied quite easily not only by travel plans but also staffing parameters for people to come and visit the hard-to-reach population. So I believe that the government can play a critical role in providing support, funding and services, and technical support even, to not only these community organisations, the ethnic community organisations, but also the rural health services.

People often think about the regional health services, but I think what my research found in the last 8 to 10 years with the local communities and with the rural health services is that they are there to support the community, so a lot of the work that they do is around health promotion. It is particularly relevant to what we are trying to achieve here in maintaining and preserving the health and wellbeing of older migrants and refugees. A good example of that is the great work that is being undertaken at the moment by the West Wimmera Health Service around public health. There is just opening up of an opportunity for people from the community to come and meet together in an open space—have a chat and have a talk about 'What's happening with you? What's important in life? Is there anything we can do together?'. So it is about community participation; it is about social connectedness and being part of the community. I think there is a lot that can be done, and I think that the funding is not only for the local government but also I think more broadly for how we can support a lot of these other parts of the community that can also together bring some support to people to contribute back to the community.

The CHAIR: Excellent. Thank you so much, Professor. I think that concludes the questions. Again, on behalf of the committee I thank you very much for your valuable contribution and taking the time to be here

today to present to us and of course all the effort that you have taken to provide an in-depth submission as part of your evidence. Thank you again, and we wish you all the very best in your endeavours.

Prof. BLACKBERRY: Thank you very much, Chair.

Witness withdrew.