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

Geelong—Wednesday, 30 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

WITNESS

Ms Carol Mioduchowski, North Area Facility Manager, Barwon Health.

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 today, and I pay my respects to their Elders, both past and present, and the Aboriginal Elders of other communities who may be here today.

I also acknowledge my colleagues that are here today. Of course you know Christine Couzens MP, the super Member for Geelong, and Meng Heang Tak MP, the Member for Clarinda. My name is Natalie Suleyman. I am the Member for St Albans.

All evidence taken at this hearing 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, those comments 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 to check when it is available. Transcripts will then be made public and 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 from the members. Carol, can I have you state your full name for the record, thank you.

Ms MIODUCHOWSKI: Yes, Carol Mioduchowski. I am the North Area Health Manager at Barwon Health, so I am based in community services. I have a migrant background—from my name, as you would imagine. I am a first-generation migrant—my parents both came over after the war as well, so I have had personal experience as well as professional experience in that space.

The CHAIR: Fantastic. Thank you.

Ms MIODUCHOWSKI: I hope you do not mind—I have just prepared a short presentation. It was really just to focus, I guess, on representing the organisation in this regard.

Visual presentation.

Ms MIODUCHOWSKI: Christine would know this well, but we are a cradle-to-grave service that provides services down as far as the South Australian border in a range of different areas. We do have community health, aged care, rehabilitation and palliative care services in my directorate as well as our acute hospital and a range of community-based services, and we are a major teaching health service as well.

I guess really in my community health role I have worked with key refugee groups, so I will focus a little bit on the refugee experience and just interlace that a little bit with the migrant experience as well. The particular groups that we have worked with, particularly in the northern suburbs of Geelong, which includes Corio, Lara, Norlane, Bell Post Hill, Bell Park and Hamlyn Heights, are the Karen and Karenni migrant groups and the Afghani, Sudanese and Congolese as people seeking refuge in Australia. We have also worked with a lot of asylum seekers, not as dense in terms of settlement numbers but still people seeking services and not being able to navigate services because of their limited ability to access things as well, such as Medicare et cetera.

As an organisation, and I am happy to say that a lot of it is based in community, we do have some specific refugee health funding in the north. We have worked in collaboration with a number of organisations on specific projects, which I will mention briefly later. We have our infectious diseases area, a public health unit, and I will go through in a bit more detail oral health. We have just established in-house interpreter services with 10 languages, the top two being Croatian and Serbian, so some of those older migrant population groups; and there are maternity services and child and family services.

In our community health program we are currently funded from the Department of Health one EFT for refugee health nursing. That is specifically targeted at people, again from children right through to older adults. The nurse does a comprehensive assessment: developing a needs profile, care planning, service coordination, follow-up and monitoring. Improving health literacy is a really big issue as well for some of the groups. With allied health I have listed all of the allied health services, including diabetes education, so we are being funded 0.9 for that, but we spread that across all of the services. Believe it or not, podiatry, particularly with the older people, is a really big area. In that whole refugee health area we have people that have come over from some

countries where they may have had issues such as Hansen's disease, which is leprosy, so deformity from that particular issue. We do a lot of work in that space: physio, psychology as well, and social work.

From an outpatient's perspective, our infectious diseases clinic kind of caters across the board. That includes doing a lot of work with people that have had TB or may have latent TB. HIV has come up and also sexual health diseases as well. Maternity services and the midwives clinic have really worked hard around cultural safety as well in delivering services. In 2012 we did a consumer engagement with our refugee groups and picked out some issues that were occurring that really required the organisation to have a good look at how we were delivering services around cultural safety, and our newly established child and family services in the north sees a lot of refugee families as well.

Oral health: so again, just broadly, working in specialist school dental oral health with a lot of our north schools who have got a high refugee population. We have also had to look at some cultural impacts on oral health. The Karen/Karenni people chew a lot of betel nut. That has big effects on dental decay and things like that as well, so we have had to navigate those issues. We are also trialling Google Translate as a way to have point-of-care information ready for a range of languages as well, which is tailored for that person. I have not seen an outcome of that. Using Google Translate myself, sometimes there are issues around how it is translated.

Interpreter services: we are transitioning to our in-house interpreters due to the volume of services as well that was required. So of the top 10 languages we have older, more established migrant populations which include, as I said to you, Croatian, Serbian, Italian, Spanish, as well as the more newly arrived languages. I think one of the things that we are looking at is what some of the pathways are of growing access to language service and the capabilities available in our community that kind of, I guess, support that as well.

On community representation, we have done a lot of work with the former Diversitat, which is now Cultura. We worked on a consumer-centred design project around mental health inter organisation and went through a really interesting process where we identified a number of mental health impacts in the community from newly arrived peoples in that particular space. We have worked in that women's health space as well, providing information in language to various groups. We have worked closely with settlement support as well through a number of processes from the federal government, with their HAPlite, their databases, which have got some positives and negatives. But we have worked in that space to try and make sure that we are predetermining as much as we can some of the support that people might need that are settling in Geelong. And of course community kitchens—we are trying to find a way of working with refugee people and some older migrant men as well who might be by themselves around cooking and what is available in the Geelong area in terms of purchasing food and those skills.

What was really interesting in our space was some of the work that we did in 2020 around COVID-19. Being based in the north, we have a significant testing site, and we did a lot of work in April 2020 trying to get correct information out into the refugee community as well, first, all around COVID testing and COVID safe, so we worked with our networks in the schools and Diversitat until that became much more formalised, and then our public health unit worked with Diversitat about immunisation. In regard to vaccination, we did pop-up clinics and translated materials at our hub, and also we did some hesitation sessions as well. I am not sure if you are aware, but a couple of my staff, or one staff member—young people started doing video about getting immunised, which was on our social media, and some of the messages around hesitation were really interesting. Some were things like, 'If you get vaccinated, you'll put on lots of weight' and things like that. That really concerned some of the younger people in particular—I know this is around older.

If we just move through to translated information—you know, making sure that we had interpreter services available for immunisation—Diversitat were fantastic with making sure that that information was getting out to the appropriate leaders in different groups as well, which is fantastic. And we had our Community Heroes program, which was on social media. I guess really whilst we have a broad spectrum of involvement in this space, there is lots of room for improvement, so we continue to push on. I guess there are some things that we identify as gaps. I think there is an issue for staff working in this space continuously about vicarious trauma—and that interestingly translates to the interpreters as well from rehearing the stories—and staff really thinking about ways of getting the information that do not retraumatise people by having them retell their stories or needing them to tell their stories multiple times with different services and trying to find ways to document that so that does not actually keep on becoming an issue.

Interpreting services—so both capacity and capability and making sure that we have got flexible opportunities to work with people who, for example, might be in hospital for two days so we can actually get some kind of communication services to them: we have had terrible issues with people being in hospital for three or four days without having any communication in language to find out how they were going, and it is quite a scary issue, so we are really trying to look at that and build capacity and capability.

Settlement programs and service set-ups: what I am going to may be not organisational but about working in the space, like the chops and changes from the federal government about how they set up settlement programs and how they are basically funded. You know, they pop them out for tender, and you might get a group that runs it, but you do not have the local relationships. That is my opinion, not the organisation's. But from a working perspective, it is really tricky, because it is with the relationships and the networking that you can get things done really quickly.

Mental health service impacts: in this expansion of mental health services that we are undergoing at the moment, we need to make sure that we really consider older migrant people in that space. They too can get retraumatised—like, what is currently going on in the Ukraine is setting people off as well. It is really about thinking about culturally appropriate and accessible services for this group as well as child and adolescent mental health. A lot of our services still are coming from a very middle-class, white approach, so we really need to think about that.

NDIS impacts: being an NDIS pilot site, we got significant amounts of people probably in 2017 and 2018 that came to our door that were highly complex and required significant case management and really quick settlement before they could get onto their NDIS program and get those support services.

And last but not least, employment opportunities in the health sector for people who are culturally and linguistically diverse are really important. You know, we are really lucky at North to have a couple of staff that have an Afghani or Karen background. It is not only those opportunities for speaking in language and getting pieces of information, but it is also the fact that it is actually welcoming for everyone. I think that is 10 minutes for me.

The CHAIR: Thank you, Carol. All right, we will move to questions. We will start with the Member for Geelong.

Ms COUZENS: Thanks, Carol, for that comprehensive contribution. We really appreciate your time today.

Ms MIODUCHOWSKI: You are welcome.

Ms COUZENS: It is really important for us to get that down as part of our deliberations for the final report, so thank you. You were talking about workforce, or employment. What do you see as being some of the key factors that need to change to get multicultural communities or individuals into employment in that multicultural space? For example, Cultura were in this morning and gave evidence about their training program and the difficulties they have had in terms of getting the resources to make that workable—and that is skilling up people from different language groups to work with their communities. Do you think there is a need to have a big push into that area?

Ms MIODUCHOWSKI: Look, I think so. I think thinking that through, because there are two sides to that coin. There is that whole notion about getting people into roles and jobs—well, three things, really—and then pathways into roles that are meaningful as well. It is easy to pop people into the jobs that might not require investment in skill building, language building et cetera, so that is definitely an issue. I think also getting younger people into career pathways in health is really important. Having people of culturally diverse backgrounds is fantastic, because it is a two-way learning process—learning some of those skills and how we operate those Western mores as well as learning about culture. At Corio we have got a Japanese physio. We have got an Indian physio. We have got an Ethiopian podiatrist. It is such a lovely, diverse background that we learn a lot from. We learn about Ramadan and all the different bits and pieces, and that I think gives everyone a really good opportunity to kind of think about how they approach people in different areas. So I think that is sort of one of those pathway things, and I think it is around expectations and really looking at our two staff that we employed. We actually employed our two staff members via the work that we are doing in Norlane. I have forgotten the name of the organisation that does the—

Ms COUZENS: What do they do?

Ms MIODUCHOWSKI: Northern Futures. Sorry. I just had a mental blank then. Northern Futures. We use that pathway as well so that there is some skill building and readiness. I think those kinds of programs are really important, because it is a big leap to come from a background that probably has not been exposed to that environment and then to have some preparation. And then I think the other part of that is the commitment to that as well that sometimes it does take more time and we are just going to have to work through that.

Ms COUZENS: Do you think of ensuring that mainstream services are offering this too? In the north there is a lot happening, for obvious reasons, because there is a high population of particularly newly arrived migrants and refugees and asylum seekers. But across the rest of Geelong do you see incorporation into those mainstream services as being a way of approaching some of the issues that we have?

Ms MIODUCHOWSKI: Yes, definitely. Again, it is that pathway. I guess in the north we have got a bit more of a protective environment, so it really takes some champions in the hospital to actually say, 'This is how we're going to do that', because it is very easy to get lost in amongst that great big group of people and feel isolated. I think it does have to be planned and championed as well, but I think it is the way to go, really.

Ms COUZENS: I mean, they have done a lot in the Aboriginal space obviously, but I think in multicultural areas it is not as good, really.

Ms MIODUCHOWSKI: No. Look, I agree with that. I think it takes commitment, and the model is there already with Aboriginal health. To have multicultural health would be fantastic to work in that space, and multicultural health is not just an interpreter service.

Ms COUZENS: No. Exactly.

Ms MIODUCHOWSKI: It is actually sort of thinking that through and working through that.

Ms COUZENS: And do you see the collaboration across the community as being an important part of all that for those different organisations?

Ms MIODUCHOWSKI: Look, I think so. I think that is another thing that we can do better. I think it is really hard in some ways that Barwon Health is a big entity and it is seen to have lots of resources. In one way it does, and in another way it does not. Small not-for-profits or small organisations will say, 'Well, you're Barwon Health; you can look after that', but it might not fit into our remit. A good example of that is a lot of issues for people are actually not around their health but might be around their residency, getting permanent residency and bringing their families over. That is the stressful part that really—

Ms COUZENS: Which does impact on their health.

Ms MIODUCHOWSKI: Yes, it does impact on their health, but that is not what they are focused on. It is about these kinds of residency issues for people and trying to get their loved ones over, because there might be just one of the family here. That is quite common with Afghan people—that women are over here and their husbands are still there and they dearly want them to come over. Trying to navigate that really caused a lot of stress.

Ms COUZENS: Yes. Thank you.

Ms MIODUCHOWSKI: You're welcome.

The CHAIR: Heang, do you have one question?

Mr TAK: Yes, thank you, Chair. Thank you, Carol. Perhaps if I can come back to the interpreting service. Because of the number of different CALD groups, let us say Karen as opposed to Sri Lankan, would it be correct to say that the level of interpreting service would be different because some communities would be able to converse?

Ms MIODUCHOWSKI: Yes, and we saw that with the Syrian community when there was a group of people who settled in Geelong. They were quite fluent in English, they had very good health literacy and were

able to navigate services pretty easily, so we did not have a lot to do in that. Whereas, for example, with the Karen and Karenni community, first of all finding the right interpreters as well—you know, the issue around people being born in Burma but being culturally Karen or Karenni and a Burmese interpreter being used. They could not understand the language, so some sensitivity to that is really important. Then there is capability and capacity—actually getting enough interpreters in that language. We have seen a lot of interpreters grow from young people that have come here and gone to secondary school. They have done their accreditation so they can be interpreters, but they have also gone off to have careers, so it is just short term. So filling that space is really important.

Mr TAK: Yes. If you could just convert that pathway from interpreter to health worker, that would be fantastic, I would say.

Ms MIODUCHOWSKI: Yes. And I think as well we need to be a little bit more pragmatic. There are people in hospital who need to be checked in on so that they have got everything that they need and are comfortable. That is just a general conversation, so having access to people that can have those conversations so we know that people are okay versus conversations about medical issues and consent, which really need to involve interpreters. So getting our heads around that and building that workforce is really important as well.

Ms COUZENS: So that contact with someone in hospital, for example, is that just informal, or is there a formal structure in place?

Ms MIODUCHOWSKI: That is informal. It is sort of like a quality improvement project, but again you are relying on people understanding who is available to do that as well as having the people to do that. Unless you invest in having a really good program where people feel part of the organisation, it is really hard to lever that—unless you have got some contacts.

Mr TAK: Perhaps one last question: for example, from my own experience sometimes people from Burma, Myanmar, are ethnically Karen but then stay in Thai refugee camps from the time of birth for five years or 10 years, so the language is a bit interesting.

Ms MIODUCHOWSKI: Yes. That is right, and you have got people that have lived in settlement camps in the Thai area for 10 years and have never been into Myanmar. And there are people that have been in quite impoverished conditions that come to Geelong and are put into a house: 'What's all this around us? What's a microwave, what's a heater?'.

Mr TAK: Sorry for my ignorance, but for the interpreting service, who actually pays for that service?

Ms MIODUCHOWSKI: So there are some state grants that pay for that. I guess we have worked with it a bit differently at Corio, where we have a day for a Karen interpreter, who is there for the whole day, and we book everyone into that day, and a day for our Afghani interpreter. That works really well. We do it as a planned approach, so people from the community might have questions and they can follow up with phone calls for us as well. But I guess our grant—I cannot really speak for the organisational grant. All I know is that we far exceed the grant in terms of use for making sure that we use interpreters where needed.

Mr TAK: Thank you, Carol. Thank you, Chair.

The CHAIR: Thank you, Carol. And just one final question: how can the Victorian Government assist with the provision of culturally appropriate aged care?

Ms MIODUCHOWSKI: I think really in Geelong up until this point the multicultural aged care facility, which is part of Cultura, has been the first port of call for migrant people to go to. I have talked a bit about it in McKellar as well. It is limited, and I think thinking through some of those integration pathways about actually having staff from diverse backgrounds working in those settings is the most important thing for me. You know, thinking through the current sort of migrant group, a Croatian person can probably speak or communicate with and do some work with people from a range of different Balkan backgrounds. So just really thinking about the diversity and improving that pathway would be number one, I think, for aged care.

The CHAIR: Excellent. Thank you so much. I think this concludes our questions. On behalf of the Committee, thank you for your valuable evidence today and making the time to be here. We truly appreciate it. Thank you for all the work that you do.

Committee adjourned.