SELECT COMMITTEE INTO ELDER ABUSE

INQUIRY INTO ELDER ABUSE

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
MONDAY, 14 MAY 2018

SESSION TWO

Members

Hon Nick Goiran, MLC (Chair)
Hon Alison Xamon, MLC (Deputy Chair)
Hon Matthew Swinbourn, MLC
Hon Tjorn Sibma, MLC

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Hearing commenced at 11.00 am

Ms HELEN MADDOCKS
Manager, Strategy and Planning, Office of Multicultural Interests, sworn and examined:

Dr RITA AFSAR
Senior Strategy, Planning and Research Officer, Office of Multicultural Interests, sworn and examined:

Mrs KIM ELLWOOD
Executive Director, Office of Multicultural Interests, sworn and examined:

The CHAIRMAN: On behalf of the Select Committee into Elder Abuse, I would like to welcome you to this morning's hearing. Before we begin, I need to ask each of you to take the oath or affirmation.

[Witnesses took the oath.]

The CHAIRMAN: Thank you. Each of you will have signed a document entitled "Information for Witnesses." Have you read and understood that document?

The WITNESSES: Yes.

The CHAIRMAN: These proceedings are being recorded by Hansard and broadcast on the internet. Please note that this broadcast will also be available for viewing online after this hearing. Please advise the committee if you object to the broadcast being made available in this way. A transcript of your evidence will be provided to you. To assist the committee and Hansard, please quote the full title of any document you refer to during the course of this hearing for the record. Please be aware of the microphones in front of you and try to talk into them. Ensure that you do not cover them with papers or make noise near them. I remind you that your transcript will become a matter for the public record. If for some reason you wish to make a confidential statement during today's proceedings, you should request that the evidence be taken in closed session. If the committee grants your request, any public and media in attendance will be excluded from the hearing. Please note that until such time as the transcript of your public evidence is finalised, it should not be made public. I advise you that publication or disclosure of the uncorrected transcript of evidence may constitute a contempt of Parliament and may mean that the material published or disclosed is not subject to parliamentary privilege.

We do have a number of questions for you this morning; however, at the outset, would any of you wish to make an opening statement to the committee?

Mrs ELLWOOD: I might start with an opening statement on behalf of the Office of Multicultural Interests. I might just read the statement, if I could.

The CHAIRMAN: Yes, of course.

Mrs ELLWOOD: Older people from culturally and linguistically diverse—which we will call CALD for this purpose—backgrounds, particularly women, are potentially at a greater risk of elder abuse due to their comparative low levels of English language proficiency, levels of education and lower socioeconomic status. For those reasons, they can be at a greater risk of social isolation and have limited access to social supports and preventive programs. Given the high proportion of seniors from both CALD groups and the wider population, the Office of Multicultural Interests would

welcome a high-priority focus on this cohort that would actively support efforts that would lead to safer and more secure futures for this group.

The CHAIRMAN: Thank you. We will start with the definition of elder abuse, which is the first term of reference for the committee. The Office of Multicultural Interests, I note, is a member of APEA—the Western Australian Alliance for the Prevention of Elder Abuse. They have recently produced the "Elder Abuse Protocol". The definition of elder abuse has been upgraded there to match that of the World Health Organization. However, in your submission, you refer to the age of 55 years as being when the Office of Multicultural Interests classifies a person as "older". It would assist the committee if you could just explain to us why you focus on that age rather than, for example, 60 or 65.

Dr AFSAR: There is no universal definition of seniors. Different agencies use different definitions. Following some of the existing practices, such as banking services or pensioner services, we thought that 55 is the onset of the ageing process. We considered 55-plus as the onset of ageing but that does not exclude us from examining people 60-plus or 65-plus because whenever we compare people 55-plus, we usually also give the conditions and situations of people aged 65-plus or 85-plus because the whole process of ageing has different implications for different age groups. That is why we thought that 55-plus, as the starting point, would be better to capture the onset and how it affects different age groups, and men and women.

Hon ALISON XAMON: One of the reasons we are trying to ask about this issue of age is because it certainly has come up in the context of Aboriginal Australians. That is specifically because we are looking at significantly reduced life expectancy. One of the reasons the committee is interested in particularly talking to OMI about why you are also looking at lowering that age is whether there is any sort of comparable concern around population groups; and, if so, I was hoping you could elaborate a little bit further on that.

Ms MADDOCKS: I can comment on that, although I could unnecessarily elaborate too much. That is definitely a consideration, particularly if we are looking at some of the more recently arrived groups from some of the African countries where life expectancy is significantly lower than those in western countries. In that context, somebody who is 50 can sometimes be considered an elder and, in that context, it is very much relevant to some of the communities that we work with.

Hon ALISON XAMON: Is it particularly new arrivals coming from Africa? I am trying to get an idea of how widespread within the Western Australian community the concerns may be.

Ms MADDOCKS: We would need to do a little bit more research into those particular countries but, yes, anecdotally, the feedback we have had is that it is a significant issue in relation to some of the African countries.

Dr AFSAR: This whole issue of longevity applies in some of the Asian countries as well where women have a much lower life expectancy than men. So we have considered the whole range of age groups and their implications. Accordingly, the issue of Aboriginal people having a lower life expectancy was definitely there.

The CHAIRMAN: I do not want to spend too much time on this because we have a lot of questions to get through and really, at the end of the day, the choice of the age is a pretty arbitrary thing. But I am interested to know whether there is consistency across government. Is the choice by the office to choose 55 shared by your colleagues in the Department of Communities; Department of Health; and Department of Planning, Lands and Heritage, who are also part of APEA?

Mrs ELLWOOD: I would say there is a combination across government, looking at different ages, depending on their programs and the services they provide. So even within our own department,

we may look at different ages depending on the programs. Some of our department will look at lower age groups because of the Aboriginal nature and others would look at people 60-plus depending on their aged-care card or Seniors Card. That has also made an impact on services that are available and to how to choose eligibility for seniors.

Ms MADDOCKS: If I can add, when we do provide statistics in relation to seniors, we generally provide them on the basis of people aged 55-plus, 60-plus and 65-plus because of the different ways in which they are defined.

The CHAIRMAN: We will move to the prevalence of elder abuse. In your submission, page 2 refers to the collectivist orientation, intergenerational expectations, financial dependence, fear of shaming the family or community, or even deportation as factors which may lead CALD seniors to not report elder abuse. You touched on that in your initial remarks, but is there anything further that you wish to bring to our attention with respect to the prevalence for that community?

[11.10 am]

Dr AFSAR: I think these are quite broad and very relevant. In addition, we have also mentioned that there are the problems of language proficiency. For example, when CALD seniors reach 65 years or 55 years and above, their proficiency level is lower than the CALD population as a whole. For people aged 65-plus, for example, it comes down to 21 per cent. Similarly, we have examined their level of education. It is kind of a very paradoxical situation, whereas for the CALD community as a whole, we have very comparative levels of graduates with a tertiary-level education or technical education, but when it comes to also having a low level of education—that is, year 8 or below—or having no schooling at all, it is also very high for seniors aged 65-plus or 85-plus. About a quarter of them do not have that level of literacy. They have low literacy levels and low language proficiency and low income, because we also found about three-quarters of seniors in that age group have a level of income that is zero or less than $500 a week. That means this all acts as a vicious cycle. They also have a very high and persistently high levels of disability. At 85-plus years, women have 61 per cent disability—who need assistance in their daily core activities. With all this combined together, their dependence on others is very high. Obviously, their risk increases because of all these factors and social isolation.

The CHAIRMAN: The federal government has funded a prevalence study. Has there been any opportunity for the office to contribute to that?

Mrs ELLWOOD: No.

Ms MADDOCKS: No, not as yet. In fact, I was not aware of the study until the federal budget was released. So having found out that piece of information, we will certainly be contacting the relevant departments to have some input into it.

The CHAIRMAN: The office was not aware until last week about the prevalence study?

Ms MADDOCKS: Correct.

Hon ALISON XAMON: It was announced at the beginning of the year.

The CHAIRMAN: Yes. Whenever we went to the National Elder Abuse Conference—February, I think.

Hon ALISON XAMON: At the beginning of the year—had there been no contact since then?

Ms MADDOCKS: No.

The CHAIRMAN: I will move to forms of elder abuse. In your submission, again at page 2, you make mention of this. It would be helpful for the committee to know: how older people from CALD backgrounds experience elder abuse and how does this differ across cultural groups?

Hon ALISON XAMON: Can I please add that perhaps it is useful then to talk about the specific elements that you had identified in your own report that were unique to the CALD community as risk factors.

Dr AFSAR: Yes. In that report we detail these risks of implications for CALD seniors, particularly women. For example, financially, you might migrate at a later age and you are a dependent migrant under a parent visa and you have low levels of literacy and a language problem, yet you had property in your home country, which you might have transferred to the name of your children.

These children who are already in the Australian culture and facing financial difficulty—they might extract your property and abuse you. And you have no power—nothing, because you are dependent and you do not know even the rules of this country. You are not even a permanent resident. You may be a resident but you still do not know. You are in social isolation. The risk becomes much, much higher for CALD seniors.

I do remember a very typical SBS presentation where a family from the south of India migrated because their daughter and son-in-law had some very great difficulty in health. Their health situation was deteriorating—having cancer or something so they were under treatment. It has a huge cost, for which they had to sell their property and come here to look after so that the daughter could work and the son-in-law was in hospital. Once this daughter and son-in-law got better, they said that the house was too small for the parents to share with them so they just threw them out and these people became homeless. They were very respected people in their home country in the south of India, from which they came. Here they were completely vulnerable. They were homeless. They cannot speak English very well. That was a critical case of vulnerability. As I said, with cognitive impairment, disability and dementia, for these people making decisions. To talk about this is often problematic because you always think about your community or family and their prestige is more important. You fear that if you talk about this, it might become public. That fear is also very high. Social isolation, educational endowment and the current situation of visa status—all this has different levels of impact for CALD seniors of different age—women in particular.

Ms MADDOCKS: The other comment that I would make is in relation to proficiency in English—particularly looking at older women from CALD backgrounds who often will not have had the opportunity to participate in English language programs that have been available, have not necessarily been working in the workplace and have not been able to gain a proficiency in English. Information is power—access to networks and so on. For that reason, there is a much greater reliance on the people who are closer to them—the family members—and they are much less able to access the information and supports that are available to them.

Hon ALISON XAMON: Do you find there is a lack of programs to assist people, particularly with poor English, around how to access advice around power of attorney, power of guardianship, and the best ways to manage your affairs? Did you want to make some comment on that?

Mrs ELLWOOD: Also, the use of bilingual workers and the knowledge of agencies to know that they should be and need to be providing bilingual workers for these people in particular when they have no language. They need to be trained bilingual workers as well and understand the context. Otherwise it is quite often family members who are translating, which in this case is where part of the problem is. A lot of CALD seniors would not know that they can have access to bilingual workers.

The CHAIRMAN: These are good points with regard to the risk factors on elder abuse. I am keen to know on the forms of elder abuse, APEA has identified six different forms of elder abuse: financial, psychological, social, physical, neglect and sexual abuse. Of those six, is one a more prevalent form of elder abuse for the CALD community or is the prevalence across the CALD community in terms of those forms of abuse reflective of how it is for the whole community?

[11.20 am]

Ms MADDOCKS: I would be hesitant to comment on that, simply because of the lack of research. Certainly, we have had feedback around issues, particularly around financial abuse, as Rita has outlined, but definitely, also, psychological and emotional. But that is purely from anecdotal feedback that we have had from community members.

Dr AFSAR: While these are very much prevalent, in addition the political, meaning visa status, is also very important. The fear of deportation for those who are associated with the primary applicant or a very temporary kind of visa—for them I think it matters very much how you have migrated to Australia and under which visa category. For CALD seniors and women it matters.

The CHAIRMAN: Is there anything further on forms of elder abuse? If not, we will go to risk factors, which we have, obviously, started touching on already. Your submission refers to the additional risk faced by older people with cognitive impairment and how this risk may be increased if the older person comes from a CALD background. Can you discuss the risk factors that CALD older people may face? I think you have certainly done that with respect to the whole issue of visa applications, which is something that I do not know the committee has had drawn to its attention until this morning. Are there any other risk factors that you think we need to factor in, particularly with respect to the CALD community?

Dr AFSAR: I think I have already spoken about it, but still I would emphasise social isolation, because, as I said, all the different conditions that we have spoken on so far—English proficiency, low level of education, low level of income and high level of disability. Altogether, in social isolation, it really has a very high propensity for these people to be vulnerable to abuse. In addition to English proficiency et cetera, I think there should be something similar to adult literacy programs. We have adult English proficiency but we do not have as much adult literacy, which is very important because we have to take into consideration that levels of low literacy are higher among older-aged CALD seniors. For them, if we want to take a preventive program without adult literacy as a bridge between that, it is very difficult to break that social isolation and that vicious cycle.

The CHAIRMAN: If a person was in that situation with poor English literacy, with some question marks on the prospects of permanent residency, feeling under pressure, would it be common for a person in that situation to contact their consulate from where they originally came?

Dr AFSAR: Not likely—no.

The CHAIRMAN: Is it not likely because it would not be thought of or is there some other barrier?

Dr AFSAR: Fear of deportation, public transport—their knowledge of transportation and how the society works and all these matters.

Ms MADDOCKS: And it is a power thing with status—a fear to approach an authority figure.

The CHAIRMAN: From the original country? Okay. So it would probably be the last place they would go for assistance or information.

Ms MADDOCKS: Quite possibly. Again, it would be dependent upon the individual case and the person.

The CHAIRMAN: The reason that I was keen to explore that is because it seemed to me that if I put aside for one moment those barriers, it would be a place where a good level of information could be provided about resources available in the community with people who would not have the language barrier. But if you are not prepared to talk to those people, it is not going to be helpful.

Ms MADDOCKS: My comment would be that it would need to be an independent organisation or avenue to go through and not necessarily associated with —

Dr AFSAR: Or religious institutions or doctors—because most people go to religious institutions and also doctors—GPs—where if you have the information, some people may definitely come. These are much better places where they can access the information.

Ms MADDOCKS: One comment I wanted to make in relation to this—I was looking at it in terms of social isolation. They were looking at situations of elder abuse within the community setting as well as within the institutional setting. I think, in terms of the approaches that are required, we need to consider both of those different environments because within the community there is clearly a need for community resources and outreach. In terms of what is available within the aged-care system institutionally, it is about what kind of supports are available within that environment as well. That will differ.

Hon ALISON XAMON: I want to come back to some of the key risk factors that you were talking about that were unique to people from CALD backgrounds. Could you please explain to me a little bit more about collectivist orientation?

Dr AFSAR: Collectivist orientation is opposed to individualistic orientation. In the West, for example, it starts with individual autonomy and choice, whereas in collectivist orientation, it is more like a family, like a group as a whole deciding about the welfare of a person. It is very much instead of you deciding about yourself, you are asking your parents, your siblings, your close relatives or cousins, "Okay, what is best for me?" That concept of "I" and "me" is often used more as "we" and "our". In that collectivist orientation, the whole family bears the accountability and responsibility. That is why this whole thing of shame and fear of shame comes in. In Oriental culture, the responsibility of looking after the parent goes to the children. If the children are not looking after the parents and the parents sometimes are abused by them, they feel shy of reporting because it goes against their cultural norms. It is so natural to think that their children will look after them. Then they do not look because they have some other problems when they are settling in in other countries, so they have their own problem.

[11.30 am]

Hon ALISON XAMON: I am curious to know whether this is an issue that is getting particularly aggravated where you are talking about generations that have been raised within a western context, an individualistic context, then effectively clashing with a traditionally recognised approach within the family structures. Is that part of what is aggravating the situation here within Australia?

Dr AFSAR: Whether it is aggravating or exacerbating that, I do not know, but definitely intergenerational conflict has been very, very prominent in many of these cultures, particularly in the initial years of settlement when the younger generation have a completely different view because they are getting more quickly adopted and adjusted to the culture and they are also learning some of the evils of western society much quicker, whereas the older generations are learning less English, are less exposed to it and they are trying to protect. That becomes kind of a very frequent source of tension.

Ms MADDOCKS: We have heard examples, with the federal government's introduction of the new aged-care packages and the focus on the customer having control over the allocation that is made

to them, of children and family members still taking responsibility for determining how that money is being spent and the older person definitely deferring to their children because that is the way that things are done because they are culturally accustomed to being looked after by their children. Then the decision about what the parent gets and how much and for what rests with the children, so it does undermine the parents' control over their own destiny.

The CHAIRMAN: We know that the office is a member of APEA. We also know that the office has not had an opportunity to respond to the federal government's prevalence study, but outside of those two avenues, are there any other avenues in which the office has an opportunity to respond to elder abuse or develop policies around elder abuse?

Ms MADDOCKS: The office is a part of Partners in Culturally Appropriate Care, which is a federal program that supports aged-care providers in the delivery of culturally appropriate care. That is one mechanism that we can use to some extent to influence what occurs at both a policy level and a program level.

Dr AFSAR: We do organise every year multicultural cafes since 2015. We have some partners from the aged-care sector—so we collaboratively organise—in which obviously elder abuse issues came up very frequently. This we have been doing since 2015. Even this year, we will have one on 21 June. We bring together all the aged-care service providers, even CALD seniors. We organise it at different local government areas, so the local governments also become very active in this process. We try to sort of answer and address some of the issues being experienced by CALD seniors. For example, every year we have different presentations on aged care, like aged-care reforms and how it has implications for CALD seniors. This year we are planning to have a presentation from an ACAT team, like how they do the assessment, particularly in which CALD seniors are involved, how long it takes and how it impacts the seniors. We also have some presentations on dementia. We started first with the symptoms—just basic symptoms—in 10 minutes and how people can identify that. Now we are planning to go for, if you identify some symptoms, where to go or who provides different kinds of services for dementia. We provide statistical proof of CALD seniors in those areas and also over time. We also are collaborating with FECCA. Since 2012, when we did the first publication based on the 2006 census, we analysed the situations and issues of CALD seniors. That we updated with the 2011 census, and now we are updating it with the 2016 census. FECCA, for its diversity framework, is very much interested to have that fact sheet and the findings of the fact sheet as their case studies for the action plan. We are actively collaborating with FECCA.

The CHAIRMAN: Just for my benefit, remind me who is FECCA?

Ms MADDOCKS: The Federation of Ethnic Communities' Councils of Australia, which is a strong advocacy body. They have been a very good ally and support for OMI, particularly in terms of its aged-care work. I think the partnerships that we develop are really critical and, as Rita has mentioned, the multicultural cafes in partnership with the federal government as well that come along to present. It is developing those kinds of relationships that are often as effective as any. We really work a lot in terms of developing those kinds of partnerships and identifying the networks that are going to be useful to us.

The CHAIRMAN: I am going to move now to initiatives to empower older persons to better protect themselves. Page 6 of your submission refers to advocacy as a key primary intervention method to empower older people. What specific advocacy strategies do you support or promote that target CALD older people?

Dr AFSAR: I think here the most prominent role was played by Aged Rights Advocacy Services Inc—ARAS—in South Australia. I was looking into some of the good practices and strategies through research. First of all, we have so much of a dearth of data in terms of prevalence. It is much less in

terms of better practices. So in finding these examples, it really was quite a tough time I had. But I was so happy to see that South Australia was a good leader in this respect, particularly when it comes to that advocacy service. They are doing very good work in terms of the number of both institutional and community-oriented work. I would say that their work is something that merits some replication if possible.

Hon ALISON XAMON: If I can make an observation, this lack of best practice globally is something that has already been well and truly brought to our attention. Would you be able to elaborate a little bit more on the elements of that service that you think make it particularly useful for CALD older people?

Dr AFSAR: I think their role in reaching the seniors and different groups of seniors at the community level is something which we would like to highlight and underscore, because that is the element which is often missing in other efforts.

Hon ALISON XAMON: So just getting in contact with the relevant person in the first place you find is the principal challenge?

Dr AFSAR: Yes, of course that is.

Ms MADDOCKS: When you are talking about social isolation and the reliance on the family and the lack of access to networks' information, it is actually locating the people and getting in touch with them that is the challenge. That is the outreach that is so important. That is why agencies like Umbrella have things like a community van to go and collect people to reach into their homes to go out to them.

Hon ALISON XAMON: You mentioned before, though, particularly the role of churches or faith groups or GPs as being a useful first port of call. Umbrella obviously deals with a different model yet again. I am curious to know what you think is the most effective approach.

[11.40 am]

Dr AFSAR: A very concrete example is Umbrella's transport service. We organised a multicultural cafe in Belmont. We had a very large attendance by CALD seniors because of two things. One was this Ishar Multicultural Women's Health Centre. They contacted their clients to be there and also Umbrella sent their transport to its client groups to be there. We had an audience of about 60 people, many of them from CALD communities, so we had to use the interpreter services. It was so good. We were quite surprised that many of them did not even know that we have an interpreter card which they can use to talk to the service providers. We had to latterly send this interpreter card. We took the addresses of these people who needed it and then we sent the interpreter card to them and then they started communicating. The other thing with this communication channel is that another program OMI supported is the community Dementia Champions program, which was very successful in a sense where the community organisations or community groups, if they have one staff member to be trained, then Alzheimer's Western Australia trained these persons in how to deal with the initial symptoms of dementia et cetera. They trained them, they gave them resources and then the staff members came back to the community and they were working for the community. This way, the objective of linking this program with the community through Dementia Champions is a very helpful bridge between these two. We found that it has been very, very effective.

Ms MADDOCKS: In terms of the best model, my comment would be that a range of different strategies are required, particularly for different groups. Just like any program, it is not a one size fits all—if you do this, then this will solve the problem. I would say that it is very important to resource ethno-specific services, because they know their group, they know the culture and they

know the language, in the same way that not every information-sharing approach is going to be effective via purely bilingual workers or via translated information. Multilingual strategies are required because we have many different cultures and languages within Australia and no one approach is going to meet the needs of all those communities. To pick up on a very popular phrase at the moment in terms of co-design of services, at least involve communities in the development of the programs and services and policies that are going to impact them. Just on that, there is the importance of cultural and linguistic data collection, because until you know what the prevalence is and what the issues are for particular groups, it is very difficult to design a program that is going to meet their needs.

The CHAIRMAN: Who can access the interpreter's card?

Ms MADDOCKS: Anybody can access the card via OMI. We produce the card and we generally disseminate it via non-government organisations that service CALD communities.

The CHAIRMAN: What benefits come from having the card?

Ms MADDOCKS: OMI is responsible for the Western Australian language services policy; the current iteration is 2014. It requires all state government agencies to engage an interpreter or use translated information if required, so if a person takes an interpreter card to a government agency, all the card really does is identify that person's language so it makes it easier for the government agencies to contact an interpreter for that person in that language.

The CHAIRMAN: If I contact OMI and ask for an interpreter's card for French, they will give it to me?

Ms MADDOCKS: You would write out that French is your language.

The CHAIRMAN: But it only requires me to ask?

Ms MADDOCKS: Yes, and ideally you would not need to ask OMI. Ideally, one of the services that you were currently accessing would have interpreter cards and be able to provide them to you.

The CHAIRMAN: How many of these cards do we have?

Mrs ELLWOOD: It is not a discount card. It is for information and identification.

The CHAIRMAN: It is an identification card, so do we have a record of how many are in existence WA?

Ms MADDOCKS: There are thousands. I can get you a specific number.

The CHAIRMAN: Is it something you would have records of back at the office?

Ms MADDOCKS: Of how many?

The CHAIRMAN: Yes.

Ms MADDOCKS: Yes.

The CHAIRMAN: You could take that on notice?

Ms MADDOCKS: Yes.

The CHAIRMAN: Let us make that question on notice 1.

Hon TJORN SIBMA: In relation to all the terms of reference all tied up together, but particularly term of reference (h), which is sort of initiatives to assist people to empower themselves and proposals OMI might have, I am curious to know about OMI's relationship with the Department of Communities, particularly because the Department of Communities is designated as the lead state government agency dealing with elder abuse. Could you reflect on how you might consult with them in the development of some of your plans and processes?

Ms MADDOCKS: We have a close relationship with the Department of Communities. We were part of the Department of Local Government and Communities prior to the recent machinery-of-government changes, so we have been part of the age-friendly communities interagency group the Department of Communities convened. It has not met in some time. We have liaised with them, particularly in relation to questions like the level of engagement with CALD seniors around the Seniors Card. So, we do have a strong relationship with the Department of Communities and maintain that.

The CHAIRMAN: I would like to ask you about the CALD champions project. How much funding does OMI provide and what kind of activities do community champions undertake with older people?

Dr AFSAR: The exact figure is not here.

The CHAIRMAN: Could you take it on notice?

Dr AFSAR: Yes, we can provide that.

The CHAIRMAN: Let us make that question on notice 2, before I forget!

Dr AFSAR: We provided at different stages of its development, like initially that program when they were developing, I think, OMI then funded them so that —

Ms MADDOCKS: They funded Alzheimer's Australia WA.

[11.50 am]

Dr AFSAR: Yes, Alzheimer's WA. They can implement it with different community groups, particularly for CALD seniors—the appointed staff member to liaise with the community. It was one of the major reasons in our multicultural cafe to focus on dementia, because we could see at the community level, particularly in the CALD communities, that information on dementia is often lacking—so how to bridge that and send information on dementia to the community. We used this multicultural cafe as a forum for that; that is one of the purposes also. We found that during the multicultural cafe session, a number of organisations showed their interest to send their staff members as community champions to get that training. The number of CALD champions has increased through this process as well, and also through their promotion and work to have more champions on board. OMI funded that through a number of phases and weeks.

Ms MADDOCKS: A model that has been used successfully for conveying information to culturally and linguistically diverse communities is to train up people within the community—not necessarily staff members of service providers, but community members—and give them the information that they can then share amongst their community. That tends to be a very effective model, because we find that when it comes to information provision, that face to face is the most effective for most communities, and, definitely, translated information is not always the way to go. It is the informal networks that really make the difference.

Dr AFSAR: It also helps to have these dementia-friendly local government frameworks to include CALD issues, because some of the local governments have dementia-friendly communities. But often age-friendly communities or dementia-friendly communities do not include CALD issues specifically, because, say, in the WHO domains of age-friendly communities, with gender and culture being the two cross-cultural components, people assume that it will automatically be addressed. But when you look into the framework, each component, say, transportation, housing or aged care, all these are done, but if we ask them whether they have addressed the CALD communities or involved the CALD communities, they say no—meaning what? "What are their needs then? How are you going to—?" "Well, it is age friendly; it is all inclusive." Yes, that is true, but just because it is crosscutting, does not mean that crosscutting will come automatically; you have to take some

initiative in order to do that. With the help of these champions talking about the CALD issues, the local government areas where we work now have age-friendly plans in which CALD issues are included, so they have a multicultural action plan. On the other hand, some of them that embark on dementia-friendly communities have also considered CALD issues. Some of these things happen, but obviously it will take time to generalise that, yes, it is a direct impact of our champions. A champion may be one of the components; there may be some other things, because in social science you know that the causal implications are not so straightforward; they vary.

The CHAIRMAN: How many of these champions do we have in WA?

Dr AFSAR: We do not have the numbers. We would have to take it on notice.

Ms MADDOCKS: I think we can find that.

The CHAIRMAN: Would it be a significant number or a small number?

Ms MADDOCKS: A small number.

The CHAIRMAN: Let us take that on notice anyway. That will be question on notice 3.

I have one final question and I will open up to members before we conclude. On page 7 of the submission you indicate that the office supports an active service model, or wellness approach, when dealing with older people, but that such services are underutilised by CALD seniors and that more culturally appropriate strategies for education and to inform these communities are required. Can you suggest what strategies may better suit CALD seniors and what action the office is taking to encourage the take-up of these services by CALD older people?

Dr AFSAR: On this underutilisation it is very clear, because if you look into AIHW reports, you can see that the number of seniors from mainly English-speaking countries or who are Australian born, their use is much higher. One obvious reason is lack of culturally appropriate services. When we discuss that, it is both ways. CALD seniors have expectations of their cultural practices in the place they live. On the other hand, the support services, although sometimes they may not be fully aware, they also do not have enough funding. Because of the funding crunches coming almost every year, they cannot keep the same staff. Staff members are very familiar to or liked by some of the seniors and they cannot keep the same staff over time, so that creates a huge gulf in the expectation and the demand and supply situation, I would say, in economic terms. Obviously, this whole issue of seniors being a joint territory of the commonwealth and the state government is something to be decided very clearly; for example, how they are going to fund these services?

Definitely, these culturally appropriate services are important, because more and more services and funding on this aspect are declining, and we have to be cautious, but the number of CALD is increasing, and some of the communities are really rapidly more ageing. The older European communities who migrated in the post–Second World War period, their proportion of CALD seniors is more than 50 per cent to 90 per cent, so the whole population in that community is about 70 per cent to 80 per cent of CALD seniors. Obviously, they are ageing more rapidly and their need for aged-care services would be much greater. Definitely, that need for culturally appropriate aged-care services is very, very important. We are trying to do a number of advocacy activities, through multicultural cafes, through our research and writings, and also whenever there are different committees, we are very well represented. In our capacity for funding, we look at whether they have some component of empowerment or we look into the services of the CALD seniors and we try to find that, but obviously we have to go through a panel that looks into it. We can recommend that something should be funded, but the funding decision comes from the panel and the minister.

[12 noon]

The CHAIRMAN: Do the cafes attract a certain, specific discrete amount of funding?

Ms MADDOCKS: The cafes themselves are low cost, and it is very much a partnership to which we all contribute, and it varies depending on the venue. The cafes themselves are low cost, but in terms of programs, OMI has funded some specific CALD seniors programs to do the kinds of things that we have been talking about and OMI does promote the CALD aged-care services and their relevant programs. We have recently included information about CALD-specific aged-care services on our website, so that people know that they exist. One of the key issues for these providers, because they tend to be smaller providers, is to compete with the generic universal services, so we do our best to support those and to make communities aware that they exist.

Hon TJORN SIBMA: Throughout the hearing, you have repeated the focus on culturally appropriate services and advocacy. My problem with that is that it is a very broad conceptualisation, and I think it would be helpful, for me at least, if you could explain in finer detail what you mean when you say that, bearing in mind as well that we speak of CALD communities as a homogenous group, but that is anything but the case. Would you be able to elaborate what a culturally appropriate practice might be for an older member of the sub-Saharan refugee cohort, as compared to someone whose ethnicity is Italian or Greek? I think it would be probably a little more useful for me if we could be concrete.

Dr AFSAR: It starts from the language, and again in language you have to consider a number of things. When I was calculating low English proficiency language groups, an interesting finding was that there are two configurations. One configuration is by a number, so if I determine low English proficiency language groups by number, the top 10 or top 20 languages that appear through that process are different from when I do that by the percentage of speakers of each of these languages. For example, when I do it by number, Mandarin, Vietnamese and Arabic are among the top 10, but when I do it by percentages, it is Hazaraghi, Khmer, and those kinds of languages that have a very small number of speakers, but the percentage of low English proficiency is very high for these language groups. They have about 78 per cent or 90 per cent of the speakers who have low English proficiency. Obviously, these language groups need to be considered if you are doing an aged-care site. If you are thinking what are the top 10 languages spoken, or the top 20 languages spoken, you have to go beyond that model and look at the level of proficiency also. Which language groups have a low English proficiency, both by numbers and percentages? That is one aspect.

The second thing is a food. As you grow older, obviously, you become more attached to your traditional types of food. The menu should contain, depending on the boarders, at least one day to serve one community's food, so that every community is catered for.

The third thing is your place for prayers. It may be church; it may be a mosque-type praying situation; it may be a temple; and it may be Buddhist. It can be a range of religious arrangements, but there should be something further.

Suppose you have very conservative seniors in your aged-care centre. One of our partners said that they had one dating night, and the seniors were shocked, because they never had this type of experience before. One has to really consider: who are their boarders and what are some of the cultural issues? SBS has a very good interactive cultural atlas. You can just touch any country and you will get all the dos and don'ts and cultural norms—everything will come—plus their statistics in Australia, like who are this community and what are the numbers.

I would consider that at least these four or five themes in terms of cultural appropriateness need to be considered.

The CHAIRMAN: That resource that you mentioned there, who provides that?

Dr AFSAR: SBS.

The CHAIRMAN: Are there any final comments from the witnesses?

Ms MADDOCKS: Only that we really appreciate the opportunity to speak on behalf of this group and just to emphasise that we really feel it is important that attention is given to their particular needs.

Dr AFSAR: Just one additional piece of information. OMI also does cultural competency training. We have Diverse WA online cultural competency training, and so far we have more than 15 000 users.

The CHAIRMAN: On behalf of my colleagues on the committee, I want to thank you all for attending today. A transcript of this hearing will be forwarded to you for corrections. If you believe any corrections should be made because of typographical or transcription errors, please indicate these corrections on the transcript. A few questions were taken on notice today, and we will write to you about those. We simply request that you provide the answers to those questions when you return your corrected transcript of evidence. If you want to provide additional information or elaborate on particular points, you may provide supplementary evidence for the committee's consideration when you return your corrected transcript of evidence. Once again, thank you very much.

Hearing concluded at 12.07 pm

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