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TRANSCRIPT OF PROCEEDINGS

O/N H-1063570

MS L.J. BRIGGS AO, Commissioner

IN THE MATTER OF THE ROYAL COMMISSION INTO AGED CARE QUALITY AND SAFETY

MELBOURNE

9.20 AM, MONDAY, 7 OCTOBER 2019

Continued from 13.9.19

DAY 51

MR P.R.D. GRAY QC, counsel assisting, appears with MS B. HUTCHINS and MS E. BERGIN
MR G. KENNETT SC appears with MR B. DIGHTON for the Commonwealth
MS C. HARRIS QC appears for the State of Victoria
MR A. YOUNG QC appears for Home Care Provider

COMMISSIONER BRIGGS: Good morning. I'd like to start by acknowledging the Boon Wurrung and the Wurundjeri people, who are the traditional custodians of the land that we're meeting on today. I would like to pay my respects to their Elders past and present and extend that respect to other Aboriginal and Torres Strait Islander people present today. Mr Gray, before I call on you, I should note that by letters patent dated 13 September 2009, the Royal Commission was granted an extension of time within which to complete its inquiry. Our final report is now due on 12 November 2020. By those same letters patent, Mr Tony Pagone QC was appointed a commissioner. He will join me tomorrow. Commissioner Tracey is unable to be with us at this hearing today. However, you might be assured that he will read the transcript. Mr Gray.

MR P.R.D. GRAY QC: Thank you, Commissioner. I appear with MS BROOKE HUTCHINS and MS ELIZA BERGIN. We also acknowledge the traditional owners of this land and pay our respects to other Aboriginal and Torres Strait Islander people who may be present here today. We pay our respects to their Elders, past, present and emerging. Diversity is a hallmark of humanity, yet aged care providers and the aged care system as a whole have not always responded to needs that are out of the so-called ordinary. Some needs remain invisible.

Barriers of a cultural, linguistic and experiential nature can always too easily intrude between those providing and those receiving care. Unless careful attention is given to these aspects of care, there is a real risk that the system will leave older people isolated and neglected. This hearing will focus on the diverse experiences and needs of people from culturally and linguistically diverse backgrounds, of lesbian, gay, bisexual, transgender and intersex people, people who are separated from their parents, country and culture, including Forgotten Australians, former child migrants and the Stolen Generations, Aboriginal and Torres Strait Islander people, people who are homeless or at risk of becoming homeless, and our Defence Force veterans.

It's too simplistic to think about individuals as members of these groups. Collective descriptions of peoples' backgrounds and experiences are simply inadequate to convey the rich diversity of individual identity and need. That said, for some people, belonging to these groups and thereby acknowledging their fellowship with others of shared background and experience is a very important element of their own identities. And, of course, an individual may belong to more than one of these so-called groups. And the groups themselves are far from exhaustive.

There are many, many other circumstances that can give rise to needs that require special attention in aged care. To name a few, disability, mental illness, cognitive impairment, including dementia, and a history of trauma from mistreatment of various kinds, including family violence, or severe hardship from social and financial disadvantage, HIV positive status, a history of incarceration, and the list goes on. Later today, we will lead evidence from members of the committee, called the Sub-Group, who produced the Aged Care Diversity Framework.

The framework was developed to guide the aged care sector in relation to diversity. It has been adopted by the Australian Department of Health. Our society has changed over time and will continue to change. In designing the future aged care system, we should not only consider diversity within Australian society today but look ahead to the future and the changing make-up of the community. The demand for culturally-appropriate services is likely to increase considerably in the future, and this demand will change over time, as the different culturally and linguistically diverse populations continue to age at different rates.

Some of the witness statements in this hearing suggest that there will be people for whom admission into any kind of institutional environment would be retraumatising, such as many of the Forgotten Australians. This point has profound implications for designing care which will meet their needs. And this is a cohort of Australians who are now reaching the age of need for aged care in increasing numbers. Designing the system for diversity cannot be regarded as merely an incidental matter. It must be a deliberate design feature. The new quality standards, which all aged care providers must comply with since 1 July 2019, supports this principle. The consumer outcome in standard 1 provides:

> *I am treated with dignity and respect and can maintain my identity.*

And the organisation must demonstrate under standard 1, subparagraph (3)(a):

> *Each consumer is treated with dignity and respect, with their identity culture and diversity valued.*

And, (b):

> *Care and services are culturally safe.*

We will be hearing much more about cultural safety as the hearing progresses. In standard 7, the human resources requirements include, sub-standard paragraph (3)(b):

> *Workforce interactions with consumers are kind, caring and respectful of each consumer's identity, culture and diversity.*

And these matters are reflected in the Charter of Rights for aged care recipients. Incorporation of these principles in the written framework for the system is one thing, but what happens in practice? I'll speak briefly about what the Royal Commission's heard already. The Commission's already received a range of evidence in hearings from and about people from diverse backgrounds and with diverse experiences. It has held roundtables with providers, academics and experts in relation to challenges and issues in aged care for people from culturally and linguistically diverse backgrounds, LGBTI Elders. And when I use the expression LGBTI, I'm not meaning to intend that there's a homogenous group. The characteristics of each person must be considered separately.

And the roundtables have also considered challenges and issues in aged care for Aboriginal and Torres Strait Islander peoples. The Royal Commission has also heard 10 community forums so far. The way the aged care system is structured and subsidised by the Commonwealth includes various responses to so-called special needs, which is a term defined in section 11-3 of the Aged Care Act. That provision is now displayed. There are financial supports intended to ensure people with so-called special needs can get into aged care. These include supplements paid to providers, which are designed to incentivise them to provide care to diverse groups. The supplements operate in different ways.

The viability supplement recognises cost pressures faced by particular types of facilities. For example, facilities in rural or remote areas and those who support residents who are homeless or Aboriginal and Torres Strait Islander. The supplement applies to all residents in the facility. The accommodation supplement pays part or all of a resident's accommodation costs when the resident doesn't have the means to meet the cost. Combined with the operation of the supported-resident ratio, this ensures access for people with low means. Or, at least, that is the policy intention.

The veterans supplement and the homeless supplement are paid to a provider in relation to a particular resident or particular residents in recognition of the additional costs associated with supporting those residents. These categories of supplement are akin to another dimension of the aged care funding instrument in measuring care needs and funding. Or, at least, that is the policy intention. In addition, there are aspects of the statutory framework which are intended to provide an incentive to providers to give priority to people with these so-called special needs, including provisions relevant to the allocation of residential aged care places and the ratio I mentioned a short time ago, the supported-residents ratio, which is intended to ensure that people of low means have access.

We will explore measures that are said to be available to ensure that diverse groups have access to home care packages assigned through the national prioritisation queue directly to care recipients. The framework of statutory provisions in relation to that matter is, as we will see, silent as to ensuring equitable provision of those packages to people with diverse needs. The Commonwealth Home Support Program supported over 780,000 people in 2017/18, which is the financial year for which a report is most recently available. This number is well in excess of the numbers of people accessing residential care and home care packages combined.

We will examine how well the Commonwealth Home Support Program responds to diversity and supports people with diverse needs and experiences. During the hearing, Commissioner, you will receive statements from government witnesses, outlining a number of funding programs and diversity-related initiatives. In addition to the relevant work done by government, there are many providers who are showing leadership in terms of responding to diversity in aged care. You will hear from some of them this week.

Commissioner, I will just mention what is not in scope for this hearing. While this hearing will cover many of the groups who are described as people with special needs in the terms I've described, the hearing will not cover all of those groups. This hearing will not focus on the needs of those who are financially or socially disadvantaged, except to the extent that they also have other diverse needs. These issues will be considered in other hearings to come. In addition, this hearing will not focus on the needs of people living in regional or remote parts of Australia. There has already been some focus on those issues in hearings to date and we'll hear more about those issues at a forthcoming hearing in Mudgee in early November.

It will not be possible in the five days of this hearing to cover off on all the issues relating to diversity and diverse groups, or to hear all perspectives. However, we have received many submissions that are relevant to this hearing and which are a valuable resource for the Royal Commission. We encourage individuals, groups and organisations to continue to make submissions to the Royal Commission. In light of the extension of time for this Royal Commission to undertake its work, the due date for receiving submissions has been extended until the end of April 2020. Submissions may be made via the Royal Commission website, by post or by calling 1800 960 711.

Commissioner, I'll mention the key themes for inquiry in this hearing. We will explore themes that have emerged from evidence to date, including the relationship between person-centred care and care that is designed for diversity, the importance of cultural safety in aged care, the importance of trust in order to facilitate communication, the importance of communication to relationship-based care and social connection, the importance of culture and other forms of connection with people of shared experience and background in reducing social isolation, the need for trauma-informed care, the need to address and respond to discrimination and the need for reliable data collection and analysis.

We also anticipate receiving evidence about the importance of co-production and co-design. That is, involving the people receiving care in the way the care is delivered to them. This concept was the subject of evidence at the Perth hearing and we anticipate hearing more about it this week. Commissioner, I'll turn to an overview of the evidence. This morning, you will hear evidence from a panel the representatives of the Aged Care Sector Committee Diversity Sub-Group: Ms Samantha Edmonds, Ms Noeleen Tunny and Ms Mary Patetsos. They will discuss the work of the Diversity Sub-Group which led the development of the Aged Care Diversity Framework, which was published in December 2017.

We will explore with them some of the challenges and also the opportunities in relation to aged care for diverse groups and how the aged care system might better respond to people with diverse needs, histories, experiences and characteristics. Later today, we will hear from the first of the providers, a witness, Ms Samantha Jewell, from Lifeview, which is a provider that has a Rainbow Tick accreditation. We will hear from Ms Fiona York, the CEO of Housing for the Aged Action Group, an advocacy group. Housing for the Aged Action Group, HAAG, is a Victorian-

based organisation that provides housing and homelessness advocacy, information and referral services.

On Tuesday we will hear further evidence from aged care providers with a focus on providing aged care to diverse groups: Mr Nathan Klinge of RSL Care SA and Ms Helen Radoslovich of Helping Hand. On Tuesday afternoon we will hear from Dr Duncan McKellar, senior consultant psychogeriatrician and head of unit at the Older Persons' Mental Health Service of the North Adelaide Local Health Network. Dr McKellar will give evidence about trauma-informed care and the important role that it can and should play in aged care, particularly for people from diverse groups.

On Thursday and Friday, we will hear from providers whose focus is on servicing care recipients, diverse needs, both through home care and residential care. Throughout the hearing there will be evidence on the design of an aged care system that will respond to diverse needs. With this in mind, you'll hear evidence, Commissioner, from Dr Philip O'Meara, director, Diversity and Community Participation of the Victorian Department of Health and Human Services. Dr O'Meara will provide evidence about the development of the Designing for Diversity program within the Victorian State Government.

You'll also hear evidence from David Panter, CEO of the ECH Group. Mr Panter has a background in the Housing and Human Services sector in the United Kingdom, the hospital system in South Australia and has led ECH Group through a period of change, which has included an increased focus on diversity. You'll hear from a number of Commonwealth witnesses in this hearing, as I mentioned a short time ago. On Tuesday, you will hear evidence from Elizabeth Cosson AM, Secretary of the Department of Veterans' Affairs.

On Wednesday, you will hear from Mr Jaye Smith, First Assistant Secretary, Residential & Flexible Aged Care Division, Australian Department of Health. You'll hear from Mr Smith about the approach that has been taken by the Department of Health to responding to diverse needs, particularly in the context of residential aged care but not limited to that topic. Later on, Wednesday, you will hear from Dr Nicholas Hartland PSM, First Assistant Secretary, In Home Aged Care Division, Australian Department of Health. Dr Hartland will be giving evidence in relation to the approach to responding for diversity in the context of the Home Care Package Program and the Commonwealth Home Support Program.

On Thursday, you will hear from Ms Ann Wunsch, executive director, Quality Assessment and Monitoring Operations, Aged Care Quality and Safety Commission. Ms Wunsch has given evidence to the Commission before. On this occasion, she will be giving evidence about how the Quality Commission responds to diversity and how it assesses providers against relevant standards. Importantly, Commissioner, you'll be hearing from many direct evidence witnesses this week. You'll hear firsthand about some of the challenges that people from diverse backgrounds and who have diverse experiences face in aged care. You'll also hear about opportunities, including opportunities for systemic improvement.

Angelos Angeli and his parents moved to Melbourne in 1975 as Cypriot refugees. Mr Angeli lives with and cares for his 82-year-old mother. He will tell you about issues he has encountered accessing Greek-speaking workers to provide home care services to his mother, the impact this has had on her mental health and the consequent social isolation he has observed in his mother. Malloy, a lesbian woman in her 80s, will tell you about discrimination she experienced at the hands of an aged care provider when volunteering her time visiting residents at an aged care facility. This experience has significantly impacted her. Malloy will say that she:

> *Experienced a lot of discrimination when I was younger, and these events brought back all those negative feelings.*

Heather Brown, a Forgotten Australian, will tell you that she lived in a number of state ward homes from the age of two and, and I quote:

> *Would be terrified if someone told me I had to move into a residential aged care facility.*

Ms Brown will tell you she sees aged care facilities as institutions, and, I quote:

> *Just like the ones I grew up in.*

Elizabeth Karn, a profoundly deaf 68-year-old woman, will give evidence through an Auslan interpreter about her experiences of aged care and the impact of the lack of funding for deaf people over 65 to have access to interpreters. Ms Karn will say that she is, and I quote:

> *Exhausted –*

and feels broken –

> *along with my friends who are in the same situation as me. We feel excluded, neglected and now isolated because of our disability and age. Where do we belong? When are we going to be included and accepted, as valued as Australian citizens?*

Janette McGuire, another Forgotten Australian, will tell you that when she was 14 her mother went missing and never returned. Ms McGuire moved into a state-controlled child welfare institution. She will tell you about her experience staying in an aged care facility after an operation and the ways in which it triggered memories and flashbacks of her time as a state ward. Brian Lynch, who served in the Australian Army for 14 years, will give evidence about his particular needs in aged care as a veteran of the Vietnam War. Mr Lynch has post-traumatic stress disorder. He tells you that since transferring to a residential aged care facility for veterans his specific care needs has been attended to and his health has improved. Another witness will recount how her partner was diagnosed with younger-onset dementia

and recently moved into residential aged care. The witness will speak of her experiences in dealing with aged care providers as a lesbian couple.

Catharina Gesina Nieuwenhoven is 78 years old. She grew up in Amsterdam, before moving to Australia with her family when she was 16. Ms Nieuwenhoven's mother experience in hospice care motivated her to establish a Dutch residential aged care facility in Adelaide. Ms Nieuwenhoven how receives home care services from the same provider that she established. Uncle Brian Campbell and Uncle Brian Burch are Aboriginal Elders and residents of the Aboriginal Community Elders Service. They will tell the Commission about their difficult life experiences and their needs from the aged care system. Commissioner, I will now ask the operator to display the index of documents constituting the tender bundle for this hearing. Commissioner, this constitutes 127 tabbed documents. I tender the general tender bundle for this hearing.

COMMISSIONER BRIGGS: The general tender bundle will be exhibit 10-1.

EXHIBIT #10-1 GENERAL TENDER BUNDLE

MR GRAY: Thank you, Commissioner. Before we call our first witness, I want to make a few comments about language in this hearing. Language is important. The way we describe people and issues matters. In describing people with diverse backgrounds and experiences and characteristics, reference is often made to diverse groups. We recognise and acknowledge that each person will have their own experience and cannot be defined solely by reference to a group. Individuals may choose not to be identified as part of a group and some may identify across more than one group. Conversely, identification with a particular diverse group may be an important part of a person's identity, as I mentioned at the outset.

In the course of this hearing, we propose to try to minimise our use of the language of groups to the extent possible. However, it's difficult to avoid it entirely and, indeed, in this opening I've at times made reference to particular diverse groups. I wish to emphasise that where we do refer to diverse groups, we acknowledge that those groups are made up of individuals with individual needs and experiences. We also note that diversity has different meanings for different people. For some people and in some contexts, diversity is something to be celebrated. For others, their diverse experiences are related to hardship and trauma.

Finally, there's a range of different terminologies used to describe people with different backgrounds and characteristics. Different people use different language to describe similar things. Many people choose that language carefully and for very good reason. For the most part, we propose to follow the lead of our witnesses and to use the language that they're using at the time. In the language we adopt, our intention is to respect all the people whose needs we will be discussing, and we hope that none of our choices of terminology will cause any affront to anyone. I'll now

invite any party which has been given leave to appear during this hearing to announce their appearance, if they wish to do so at this point.

MR G. KENNETT SC: Yes. If the commission pleases, I appear with MR DIGHTON, for the Commonwealth in this week's hearings.

COMMISSIONER BRIGGS: Thank you and good morning.

MS C.M. HARRIS QC: If the Commission pleases, I appear for the State of Victoria.

COMMISSIONER BRIGGS: Good morning.

MR A.P. YOUNG QC: May it please the commission, my name's Young. I appear for the home care provider referred to in the statement of Mr Angeli, to which reference has been made, pursuant to leave granted on Saturday afternoon, as I understand it. The statement to which I've referred contains a number of adverse allegations concerning the, the home care provider, all of which are disputed. However, as a result of discussions between my instructor and those assisting the Commission and, indeed, with counsel assisting the Commission, I understand that those assisting the Commission do not intend that the home care provider be identified publicly and do not intend to urge the Commission to make any adverse finding concerning the home care provider and the particular allegations. That being so, I don't expect there to be a need for me to say any more.

COMMISSIONER BRIGGS: Thank you.

MR GRAY: Commissioner, I'll now ask Ms Hutchins to call our first witness, Mr Angeli.

COMMISSIONER BRIGGS: Good morning, Ms Hutchins.

MS B.L. HUTCHINS: Good morning, Commissioner. I call the first witness, Mr Angelos Angeli.

<ANGELOS ANGELI, AFFIRMED [9.49 am]

<EXAMINATION BY MS HUTCHINS

MS HUTCHINS: Mr Angeli, your full name is Angelos Angeli?

MR A. ANGELI: That is correct.

MS HUTCHINS: And you have prepared a statement for the Royal Commission?

MR ANGELI: Yes. Yes. I have.

MS HUTCHINS: Operator, please document up document WIT.0511.0001.0001. Do you have a copy of the statement in front of you?

MR ANGELI: Yes. I do.

MS HUTCHINS: And do you have any amendments that you'd like to make to the statement?

MR ANGELI: No. Not at all.

MS HUTCHINS: Are the contents of the statement true and correct, to the best of your knowledge and belief?

MR ANGELI: Yes. That is correct.

MS HUTCHINS: Commissioner, I tender the statement of Mr Angelos Angeli, dated 2 October 2019.

COMMISSIONER BRIGGS: The witness statement of Mr Angelos Angeli, dated 2 October 2019, will be exhibit 10-2.

EXHIBIT #10-2 WITNESS STATEMENT OF ANGELOS ANGELI DATED 02/10/2019 (WIT.0511.0001.0001)

MS HUTCHINS: Now, Mr Angeli, you're a carer for your mother who's currently aged 82 years old?

MR ANGELI: That is correct.

MS HUTCHINS: Yes. And you are an only child?

MR ANGELI: That is correct.

MS HUTCHINS: And you currently live with your mother in your family home, in the northern suburbs of Melbourne?

MR ANGELI: North-west.

MS HUTCHINS: North-west?

MR ANGELI: Yes.

MS HUTCHINS: And what's your family's cultural background?

MR ANGELI: We are – we're of Greek Cyprian decent.

MS HUTCHINS: Yes.

MR ANGELI: My parents and myself were born overseas. We came to Australia shortly after the – I guess the war ended in Cyprus, I believe. And, basically, we came to Australia as refugees.

MS HUTCHINS: Yes. And how old were you when you moved?

MR ANGELI: I was a toddler. I don't remember. So, I was told I was two and a half.

MS HUTCHINS: Sure. And when your parents moved to Australia, were they able to speak English?

MR ANGELI: My father could, because of his line of work. He was – actually worked – he was a boat mechanic in the tourist industry, so he engaged with tourists. So, part of his job, he had to speak English. My mother cannot speak English. She has some knowledge, but - - -

MS HUTCHINS: Yes.

MR ANGELI: - - - it's very poor.

MS HUTCHINS: And so, is that still the position with your mother today? That she's - - -

MR ANGELI: Yes. That is correct.

MS HUTCHINS: - - - got very limited English? So how much can your mother understand of English?

MR ANGELI: Simple words, simple numbers. Interestingly though, when – if it's – something is repeated, as in the – when the nurses attend, to support my mother, they follow a plan and she can understand it because of the plan. She knows what the questions are and how to answer.

MS HUTCHINS: Yes. And so, when your parents moved to Australia, did they involve themselves much in the local community?

MR ANGELI: Yes. When they – well, the reason my parents came here, apart from being refugees, is my dad's brother was here, as well as my mother's two sisters. So, they instantly were engaged in the community, the Cyprian community as well as the Greek community.

MS HUTCHINS: And what's your mother's health like today?

MR ANGELI: Quite poor. She has had diabetes for 40 years, poor eyesight. Her memory is starting to go. It's getting to the point where she will constantly ask me the same question within five minutes. Easily confused. Yes. So physically and mentally, she's, unfortunately, deteriorating.

MS HUTCHINS: And in your statement, you note that your father died in 2013 of a brain tumour. During the time that your father was alive, did he look after your mother?

MR ANGELI: Yes. He – basically, my father supported, I guess, myself and my mother. I didn't realise how supportive he was of her until he passed, and I took over the role. But, basically, he would take her to appointments, translate for her. Yes.

MS HUTCHINS: And how was your father's health in the lead-up to his death?

MR ANGELI: It was a bit of a surprise, because dad was always quite strong, quite capable. And we just started noticing him becoming a little bit more confused. And he had a seizure. We couldn't figure out what was wrong. The doctor couldn't figure out what was wrong. And then eventually they found the brain tumour and he passed very quickly after that.

MS HUTCHINS: And did you act as a carer for your father - - -

MR ANGELI: Yes. Once his - - -

MS HUTCHINS: - - - in the lead-up to his death?

MR ANGELI: - - - memory started to deteriorate, I took over the role of driving the family and supporting them that way. Yes.

MS HUTCHINS: And did you have any aged care assistance?

MR ANGELI: No. Not at all. It was pretty sudden with dad.

MS HUTCHINS: Yes. And you mentioned that your father used to help your mother with translating.

MR ANGELI: Yes.

MS HUTCHINS: Would that involve attending general practitioner appointments with her?

MR ANGELI: Yes. Any engagement with, I guess, the outside community, he would work – he would support her in a translating role.

MS HUTCHINS: And so, after his death, who was assisting your mother with translating at general practitioner appointments?

MR ANGELI: Predominantly myself. Yes.

MS HUTCHINS: And - - -

MR ANGELI: Unless I – sorry. Unless I could get a professional translator in.

MS HUTCHINS: Yes. And so presumably this was an English-speaking GP.

MR ANGELI: Yes. Within the Cypriot clinic near us, that was – it was basically – my mum would either go herself and the doctor knew what was to – well, what – that she wanted scripts. But something more complicated, I would need to go and help translate.

MS HUTCHINS: Yes. And did you say on occasions you had a translator attend?

MR ANGELI: When she had appointments at the hospital or some type of outreach clinic linked to the public health sector, they usually supplied translators.

MS HUTCHINS: Yes. And so, your mother's been receiving aged care services for about three years?

MR ANGELI: Mmm.

MS HUTCHINS: Yes. And what were the circumstances leading up to engaging home care for your mother?

MR ANGELI: Okay. From – best of my memory, it was – because she had a fall and she actually cracked some ribs, I believe – and she was in quite a bit of pain, so I ended up having to call the ambulance. And the ambulance took her in. And because of the fall – no one knew why she fell. So, the – so the – I think it was – no, it wasn't Werribee. It was Williamstown Hospital – there's a fall clinic, I believe. So, they supported her. And part of the recommendation – well, it was part of the discharge plan, I should say, was to link her in with the ACAT team, or the aged care team, who then made the recommendation to – for the funding.

MS HUTCHINS: Sure. And how did you find the process of applying, you know, for the home support? As in with your interactions with the aged care assessment service?

MR ANGELI: Really good, because they supplied the translator. Mum was engaged. She was actually happy to have a service such as that.

MS HUTCHINS: Yes. And - - -

MR ANGELI: They also, I believe, got the council involved.

MS HUTCHINS: Okay. And what was it that you were looking for in a home care provider when the support was approved?

MR ANGELI: Just predominantly to support my mother, but also someone who – be it – a service that could allow my mother to engage and have a discussion. I understand that because the field that I work in, I – it's important that our clients have a say in their treatment. So that's something that I wanted from the service provider, which, effectively, meant translators, interpreters or Greek speakers involved.

MS HUTCHINS: Yes. And for the Commission, you mentioned the field that you work in.

MR ANGELI: Yes.

MS HUTCHINS: You're a social worker. Is that correct?

MR ANGELI: Yes. I'm a social worker.

MS HUTCHINS: Yes.

MR ANGELI: I work in the mental health field. So yes. So, a part of our goal – our role is to engage the client and make sure they have a say in their treatment.

MS HUTCHINS: Yes. And so, your mother was originally approved for a level 2 package?

MR ANGELI: No. She got approved for a level 4 package. But, unfortunately, there's limited packages. So, what tends to happen is they get the level 2 first, then move up to a level 3 and then eventually a level 4.

MS HUTCHINS: Yes. And so originally, she was receiving the level - - -

MR ANGELI: Yes. She was - - -

MS HUTCHINS: - - - 2 package?

MR ANGELI: - - - receiving a level 2 package. She got it about – I don't remember the duration. It took about a year, roughly.

MS HUTCHINS: Sure. And what type of support did that provide for you?

MR ANGELI: It supported – in that it linked in the service provider as well – to come in and offer respite, support for my mother, as well as helping out around the house.

MS HUTCHINS: Yes.

MR ANGELI: Whatever her needs were. But it also allowed the local – well, RDNS – or Bolton Clarke to come in and support her with her medication and that.

MS HUTCHINS: Okay. And so, what is it that the Bolton Clarke support involved?---Bolton Clarke basically managed her medication, because one of the beliefs of why she fell is that she couldn't manage her medication correctly. So, she was either undertaking it or overtaking it. And that was what they believe caused the fall. So, they've been marvellous, in that they have been engaging, supporting and managing – and engaging with the GP to modify the medication, to keep her diabetes and other illnesses under control.

MS HUTCHINS: Yes. And in terms of the respite services that you are being provided, what were the types of services that they involved?

MR ANGELI: Some cleaning around the house, maintenance of the property, as well as allowing my mother to go out. So, she would like to go – she wants – she liked to go visit my father's grave. As well as support to attend the GP. So, if she needed some help at the GP they will attend. And at that time, they had a Greek-speaking worker. So that really supported mum, as well as allowed mum to buy stuff that, I guess, I couldn't support her with because of limited time. They allowed her to go to a – some place – a specific shop and buy whatever she needed.

MS HUTCHINS: Sure. And in terms of the Greek-speaking worker who first attended, how did it come about that you were provided with that? Did you need to put in a special request or - - -

MR ANGELI: No. What happened was that – she was, I believe, originally a council worker. And she was also part of a service provider. And mum really, really liked her. So, we – I said, "Okay. Yes. If you like her, we'll get the service provider in to take over", and, yes, so that's how we got her.

MS HUTCHINS: Yes. And so, in your statement you identify that after a period of time, the Greek-speaking worker was no longer available.

MR ANGELI: That is correct. Yes.

MS HUTCHINS: What kind of impact did that have on your mother when it was non-Greek speaking people coming?

MR ANGELI: Well, it initially made her socially isolated effectively, unfortunately. Basically, the worker would attend. They wouldn't – they couldn't communicate, or the communication was at the – very limited. It probably made her just socially isolated would be the best way and lonely.

MS HUTCHINS: Yes. And did you make any inquiries about whether there could be Greek workers to come and - - -

MR ANGELI: Yes. I - - -

MS HUTCHINS: - - - attend or other types of services that might be available to help your mother with communicating?

MR ANGELI: Yes. I did request – we did request Greek speakers ..... because it was really difficult for mum to communicate and get her needs met, or her wants and her needs met, I should say, especially around attending GP clinics or attending – going to see my dad's grave stone or buying anything from the local shop because she couldn't communicate what she wanted.

MS HUTCHINS: So, your mother would still attend those outings but not be able to communicate with the person that was taking her.

MR ANGELI: No, no. She wouldn't – she didn't get any more outings. It was pretty much they would attend the house and basically sit there or do some task around the house for her. So, there were – I think from the best of my knowledge, there was some attempt at communication, but nothing effective.

MS HUTCHINS: Yes, and so when there was that change, did that mean that you then took on that role of taking her out - - -

MR ANGELI: Yes. I – basically meant that I had to take time – her visits to the GP greatly – the times – the amount of times she went to the GP reduced because I work, and the time I could take off is limited, unfortunately. So effectively meant she attended the GP less and when she did, she either had to go by herself, or I had to take time off work, basically.

MS HUTCHINS: And in terms of your mother otherwise engaging with the community, does that only occur when you are able to take her out, or are there, I guess, other people or other activities or anything that she is engaged in?

MR ANGELI: Okay. It has gotten worse because unfortunately a lot of her friends have become unwell, and so they've been put in homes or they've passed. So, she has become socially isolated more and more. I had to step up. Of course, I stepped up, but the council has also implemented a Greek – elderly Greek community, and they bring a bus, and they take her every Monday. So, Mondays, she actually engages really well with the – she gets out and meets people, but the rest of the time up until the weekends, she is, effectively, home alone, or the nurses attend, but they only attend for a short amount of time.

MS HUTCHINS: Sure. And would you be able to provide a bit more explanation of what this service is that's provided by the council in terms of the bus with the activities. Is there certain eligibility requirements around being involved or - - -

MR ANGELI: I don't know actually. I don't know how my mum found that or who found it for her. I know she loves it. It took a while to get her motivated because of you are anxiety, but every Monday, she attends, and she's happy.

MS HUTCHINS: Excellent. And so, in your statement, you identify that in the beginning of 2019, the home care packages that your mother has provided has moved to a level 3. What is the impact that that has had on the level of service that you receive?

MR ANGELI: Well, it – effectively, that meant Bolton Clark has had to way the way they fund – they accept payment or their fees. So effectively what that means is we don't longer use any respite service, and that money had to be pulled up and is being used by Bolton Clark. I don't know how much of the money is left or what is being done with it. I'm basically – yes. It caused me a lot of stress because I didn't know how I was going to support my mother and how to best manage her medication.

MS HUTCHINS: And so, do you think you were in a better position when you were receiving the level 2 services?

MR ANGELI: Level 2 package, yes. That is correct.

MS HUTCHINS: And so today how often is it that you have staff from Bolton Clark coming to see your mother?

MR ANGELI: Bolton Clark attend seven time – sorry, seven days a week. Every day apart from Sunday, they come twice. So, they come in the morning and at night. They set up the – they give her the insulin and the orals, and on a Saturday night, they will set up the orals and the insulin for the Sunday morning because mum wants to go to church. I take her to church. When she gets back from church, she will take her insulin and her oral medication at that time.

MS HUTCHINS: And you still are not receiving any respite type services.

MR ANGELI: No, no. Mum's basically, yes – no.

MS HUTCHINS: And so, you mentioned earlier that the Bolton Clark workers also aren't Greek speakers. Is that correct, and – but they – you seem to manage?

MR ANGELI: Yes. There is one Greek that I know of. There is one nurse who is actually Cyprian as well, and she is a Greek speaker. So, mum engages her, but she may come once a week or once, maybe twice a week. The rest of them are multicultural. So yes. But mum engages with them because there's pretty much a plan, and that – it's happened repeatedly for so long that she knows what they're going to ask, and she can respond.

MS HUTCHINS: And has your mother considered moving into a residential aged care facility?

MR ANGELI: No, I've spoken to her, and she is adamantly against it, and I know – I'm having words with my cousins, they have really tried, and she's really against it. She wants to pass away in the house type of thing. It's her home. She wants to live there for the rest of her life.

MS HUTCHINS: Do you think that's feasible the way things are going?

MR ANGELI: No. Certainly not. She is already socially isolated, and I'm only working four days a week. The club is on, which allows her to get out. But as – unfortunately, at her age, her friends have started to pass. It means she will become more socially isolated, and there's structural designs in the house that aren't appropriate for people who are ageing like the steps.

MS HUTCHINS: So, if your mother does need to move to a residential aged care facility, what are the types of things you would be looking for, for her?

MR ANGELI: Cultural and language are the – as well as support. So, there is one that we have been looking at, that we've looked at, which is basically in Sunshine. It will be great because they're of Greek Cyprian. I think they're run by – the – I believe – or at the very least, they're Greek. So, there's people who speak the language and understand the culture and the religion which will allow her to engage in church because church is a very big part of my mother's life.

MS HUTCHINS: And in terms of her cultural needs by virtue of her Greek Cypriot background, what are the types of things that she would – you would be looking for, for her to make her more comfortable in an aged care facility?

MR ANGELI: Well, I think predominantly is being able to communicate with people, that friendship. The – and understanding where we come from, I guess. And the religion is the other thing.

MS HUTCHINS: And so, we touched on this briefly earlier in terms of your mother's isolation. How else would you describe the quality of your mother's life today?

MR ANGELI: Can you – I don't understand the question. Sorry.

MS HUTCHINS: So, in terms of, I guess your mother's experience by virtue of having care workers, say, or nurses that are aren't able to communicate with her well and that she is socially isolated, how else do you think that is affecting her health?

MR ANGELI: Well, it certainly – loneliness is predominantly – which would be impacting on her, making her depressed. It impacts me as well, in that mum gets highly anxious when I'm not home which means when I try to go out, she will

question, "When are you getting back", and when she – and she will try to stay up waiting for me to get home. So, in other words, she is not comfortable sleeping or relaxing when – if she is alone. So, she needs, I think, to be engaged to talk to people and to make sure she feels safe at home with me around.

MR ANGELI: And should it be available to you to receive the supports that would make your life easier and give your mother the kind of care that she needs in the home, what are the types of things that you would like to have access to?---Respite, ability for her to attend GP appointments when it's not an emergency. The translators or interpreters, I should say, that are available, I guess, to some more society services such as the GP clinic, etcetera. Greek speakers would be awesome. All Greek speaking workers would be great, just so she can engage and have a conversation with people and understand when I guess things aren't the norm that what's going on, so she can have a say in her own treatment, in her own, I guess, her own life.

MS HUTCHINS: Unless there's anything further that you would like to bring to the attention of the Commission, Mr Angeli, I don't have any further questions.

MR ANGELI: Okay. I'm just going to say Bolton Clark have been remarkable for my mother. I believe without them. My mother would be in further worse condition. I just want to say thank you to them. Thanks.

COMMISSIONER BRIGGS: Just a minute, Mr Angeli.

MR ANGELI: Sorry.

COMMISSIONER BRIGGS: I wanted to say I thought you enunciated very well the situation of the isolation your mother and those like her can feel when they can't communicate in their native language nor be with people who understand their circumstances or have the supports to get her out and do the things she wants to do. So, thank you very much for your evidence today.

MR ANGELI: Thank you.

COMMISSIONER BRIGGS: We really appreciate it as the first speaker in this access and equity hearing, and you will be pleased to see that you are free not to provide any more evidence before this Royal Commission. Okay. So, thank you very much.

MR ANGELI: Thank you.

<THE WITNESS WITHDREW [10.10 am]

COMMISSIONER BRIGGS: We are a little ahead of schedule. Do you want to break and return at 10.30, or what will be the plan?

MR GRAY: Yes, please, Commissioner, and we will make arrangements for the next panel of witnesses to be accommodated on this side of the courtroom.

COMMISSIONER BRIGGS: Okay. So, we will adjourn to 10.30, I think.

ADJOURNED **[10.11 am]**

RESUMED **[10.32 am]**

COMMISSIONER BRIGGS: Mr Gray.

MR GRAY: Thank you, Commissioner. Next I will call three witnesses to give concurrent evidence in a panel. I call Samantha Edmonds, Noeleen Tunny and Mary Patetsos.

<SAMANTHA EDMONDS, AFFIRMED **[10.33 am]**

<MARY PATETSOS, SWORN **[10.33 am]**

<NOELEEN TUNNY, SWORN **[10.33 am]**

<EXAMINATION BY MR GRAY

MR GRAY: Ms Edmonds, I will ask that the operator display your witness statement, so you can see and verify it. WIT.0396.0001.0001. Do you recognise that to be the front page of the statement you've made for the Royal Commission?

MS EDMONDS: I do.

MR GRAY: And that statement is dated 27 September 2019.

MS EDMONDS: Correct.

MR GRAY: To the best of your knowledge and belief, are its content true and correct and the opinions stated in it the opinions that you do hold?

MS EDMONDS: Yes.

MR GRAY: I tender the statement.

COMMISSIONER BRIGGS: The witness statement of Samantha Edmonds 2019 will be exhibit 10-3.

EXHIBIT #10-3 WITNESS STATEMENT OF SAMANTHA EDMONDS DATED 27/09/2019

MR GRAY: Ms Patetsos, I will ask that the operator display your witness statement. WIT.0437.0001.0001. Ms Patetsos, you previously made a statement dated 12 March 2019 which is existing exhibit 2-37 in the Royal Commission, and this is your second statement before you now on the screen, isn't it?

MS PATETSOS: Correct.

MR GRAY: This statement is dated 23 September 2019. Do you recognise this as the front page of that statement?

MS PATETSOS: Correct.

MR GRAY: Thank you. To the best of your knowledge and belief, are its correct true and correct and the opinions stated in it opinions that you do hold?

MS PATETSOS: Yes.

MR GRAY: I tender the statement.

COMMISSIONER BRIGGS: The second witness statement of Mary Patetsos dated 23 September 2019 will be exhibit 10-4.

EXHIBIT #10-4 WITNESS STATEMENT OF MARY PATETSOS DATED 23/09/2019

MR GRAY: Ms Tunny, I will ask the operator to display your witness statement, WIT.0422.0001.0001. This is a statement dated 24 September 2019. Ms Tunny, do you recognise this as the front page of your witness statement you prepared for the Royal Commission dated 24 September 2019?

MS TUNNY: Yes.

MR GRAY: Are the contents of the witness statement to the best of your knowledge true and correct, and are the opinions in the witness statement opinions which you do hold?

MS TUNNY: Yes.

MR GRAY: I tender the statement.

COMMISSIONER BRIGGS: The witness statement of Noeleen Tunny dated 24 September 2019 will be exhibit 10-5.

EXHIBIT #10-5 WITNESS STATEMENT OF NOELEEN TUNNY DATED 27/09/2019

MR GRAY: Thank you, Commissioner. Operator, please display the Diversity Framework exhibit 2-38. Thank you. We go to page 0003. Members of the panel, you're each members of the subgroup who are responsible for preparing the Aged Care Diversity Framework referred to in this document. That's correct, isn't it?

MS TUNNY: Correct.

MR GRAY: And your names appear on this page. I will briefly make some introductory remarks about each of you in turn. Ms Edmonds, you are the Policy and Research Manager at the national LGBTI Health Alliance, and you've been in that position since August 2019. Is that correct?

MS EDMONDS: Correct.

MR GRAY: Prior to this, you were the Silver Rainbow national project manager from July 2014 to July 2019 at the same health alliance.

MS EDMONDS: Correct.

MR GRAY: And what is Silver Rainbow?

MS EDMONDS: Silver Rainbow is the National LGBTI Health Alliance's aging and aged care project.

MR GRAY: In terms of qualifications you have a master's degree in social administration. That's correct.

MS EDMONDS: Correct.

MR GRAY: And in politics and public policy and international relations.

MS EDMONDS: Correct.

MR GRAY: And you're the chair of the Aged Care Sector Committee Diversity Sub-Group.

MS EDMONDS: Yes, I am.

MR GRAY: Thank you. Ms Patetsos, you have previously given evidence to the Royal Commission, but just for those viewers who may not have viewed that footage, I will briefly make some introductory remarks about some of your positions and achievements. You are the chairperson of the Federation of Ethnic Communities' Councils of Australia, or FECCA. That's correct, isn't it?

MS PATETSOS: Yes.

MR GRAY: And you've held that position for two years now.

MS PATETSOS: Correct.

MR GRAY: Prior to appointment as chairperson, you were appointed as the CALD, culturally and linguistically diverse – that's the acronym we're using – CALD aged care specialist on the ..... correct?

MS PATETSOS: Yes.

MR GRAY: You're a qualified social worker with a postgraduate degree in sociology, you've worked in the health care sector, and you were the immediate past chairperson of the South Australian Housing Trust. You are the chairperson of the aged care and housing group as well as deputy chairperson of the Health Performance Council. In addition, to those and various other non-executive positions as I mentioned at the outset, you are a member of the Aged Care Sector Committee Diversity Sub-Group, and you are also a member of the National Aged Care Alliance. Thank you. Ms Tunny, your position is Acting Director, Policy and Advocacy Unit at the Victorian Aboriginal Community Controlled Health Organisation, VACCHO.

MS TUNNY: Yes.

MR GRAY: You've had that role since February this year.

MS TUNNY: Yes.

MR GRAY: You've been an employee within VACCHO's Policy and Advocacy Unit since 2011. Correct.

MS TUNNY: Correct.

MR GRAY: And you were occupying your substantive role as manager of policy and advocacy since 2016.

MS TUNNY: Correct.

MR GRAY: In terms of formal qualifications, you have a master's degree in public health, a postgraduate diploma in nutrition and dietetics and a Bachelor of Science degree and a management diploma.

MS TUNNY: Yes.

MR GRAY: You established the ageing and aged care portfolio at VACCHO in response to findings of a report commissioned by VACCHO which suggested overrepresentation of Victorian older Aboriginal people in lower levels of care.

MS TUNNY: Yes.

MR GRAY: Prior to working at VACCHO, you worked for the then Victorian Health Department as a regional health promotion adviser for the north-west region in Melbourne for two years, 2009 to 2011, and for nearly 12 years prior to that, you held a variety of managerial roles in the Victorian division of the National Heart Foundation. The most recent of those roles was as manager of Aboriginal and Torres Strait Islander cardiovascular health.

MS TUNNY: Correct.

MR GRAY: Thank you. I want to ask some introductory questions of each of you in turn, if I may, starting with you Ms Edmonds. Operator, please display Ms Edmonds' statement at pages 00030 to 31 showing paragraphs 130 to 131. Thank you. If you are able, Operator, to please zoom in to 130 and 131. That will be much appreciated. Thank you. Ms Edmonds, in this passage of your statement, you illustrate the effect of accumulated stigmatisation and decriminalisation and potential violence on older LGBTI people by giving an example of somebody who was born in Australia in 1939. Ms Edmonds, in summary, what are the particular kinds of needs which are of chief concern and relevance to the National LGBTI Health Alliance which it comes to aged care, and what are the key goals and activities of the alliance?

MS EDMONDS: So, our particular needs are looking at an aged care system that is inclusive of older LGBTI people, and when we're talking LGBTI, we are also acknowledging people of other diverse sexualities, genders, bodies and relationship that aren't captured under that acronym. Our key work is around making aged care inclusive. So, we do that through providing training to aged care providers to on how to be inclusive of LGBTI elder people. We have an online module, which is like an introductory module, and we also have a – or in the process of developing some more intensive modules for work for people working in aged care who work with particular groups in the community. So, if someone who identifies as lesbian

comes into your service, you can do a module on working with lesbian elders and have a deeper understanding of what that means. Our work predominantly in my role was working with government around policies and legislation, obviously the Diversity Framework and action plans about making the whole system inclusive of LGBTI elders and older people, and that's what – you know, obviously what we would like to see happen. So that's making sure whenever there was policy discussions that we ensured that the issues that LGBTI elders faced were addressed in those policy discussions. Whether there was unintentional exclusion, like maybe a recommendation was made, and that recommendation would actually exclude LGBTQI people. So, we were there to be the voice and to make sure those voices were heard and considered in those processes. We know – I mean, obviously this shows it, that LGBTI older people have lived through a time of intense discrimination and stigmatisation. We know it still continues today, and every time there's a public debate about the rights of LGBTQI people, you know, it then builds in and reinforces that trauma that our elders and people have faced. So, we need to ensure when they are accessing aged care, whether it's residential care or home care, that it, in fact, is safe for them to be there, it is safe for them to be out, and they don't have to feel they have to hide when they access those services.

MR GRAY: Thank you. Operator, if you could please display from the general tender bundle, tab 72. Ms Edmonds, this is a consultation report. Could you explain to the Commissioner the background under – in which this document was prepared?

MS EDMONDS: So, when we were developing the LGBTQI action plan or action plan for LGBTQI elders, we consulted nationally across Australia. We held 23 consultations. Those consultations were in every state and territory of Australia, and we also did some very targeted specific consultations as well. So, we met with – sorry – transgender and diverse groups, we met with older lesbians, we spoke directly to intersex elders and those representing intersex people, and we did some direct as a consultation around bisexual people as well. So, this report is actually the – I guess, the final result of all those consultations, and we also did an online survey as well. So, we asked people to complete an online survey and have that as part of our submission process. So, this report is pulling together all that information that we gathered during those consultations and from that online survey, and that's what then fed into and developed the action plan for LGBTI elders. And a lot of the recommendations and a lot of the information that's in this consultation report is, in fact, reflected then in the action plan.

MR GRAY: Thank you. If we go to page 0047, there's some information on that page concerning differential mental health and wellbeing outcomes for older LGBTI people. Is there evidence and science behind the notion that there are differential and poorer outcomes for LGBTI elders when compared to the general population?

MS EDMONDS: Yes. There is. So, there are research and academic papers that demonstrate that LGBTI elders experience mental health concerns or mental health issues at a significantly higher rate than the general population, and that, overall,

LGBTI people have higher rates of suicide and suicidal ideation – sorry, suicidal thoughts and self-harm than the general population.

MR GRAY: If we look at the bottom of the left-hand column, we see there's an intersectionality issue raised. What is this notion of intersectionality?

MS EDMONDS: That's acknowledging that people aren't in a box. So, while you may be LGBTI – and I guess I should, sort of, clarify. You use the acronym LGBTI – recognising that we are talking about five different population groups and that some of the issues faced by some groups aren't faced by other groups, even though there's common issues to all of them. So, when we're talking intersectionality, we're saying that someone who is a lesbian may also be from an Aboriginal community, may also be homeless, may also have, obviously, mental health concerns and may have experienced other forms of trauma in their life. So, it's recognising that people don't exist in a bubble or within one particular identity or expression, that there's lots of different aspects to a person that we need to consider, and that those aspects can result in multiple stigmatisation, discrimination experienced by that person.

MR GRAY: Thank you. Ms Tunny, I'll turn to you, if I may. I'm going to ask you about the particular needs of Aboriginal people and, in particular, Aboriginal people who live in an urban setting. If we have regard to your statement at pages 3 and 4, we see you've made a number of points at paragraph 9 concerning the particular needs that you identify for the group – the group of Aboriginal and Torres Strait Islander people living in urban settings in particular. You refer to socio-economic disadvantage, meaning that those people, generally speaking, are likely to lose out in a marketised system. You refer, at (b), to complex chronic disease, which has a higher cost. At (c), you refer to client vulnerability. Ms Tunny, what are the particular kinds of needs which are of chief concern and relevance to VACCHO, and what are VACCHOs key objectives and activities in advancing the interests of Aboriginal people in urban settings in relation to aged care?

MS TUNNY: Before I commence my testimony, I would like to acknowledge that we are meeting today on lands of the Kulin nations, who are the traditional custodians of this area. I pay my respects to Elders' past, present and emerging, and to any Aboriginal people who may be in the room today. I think that when you're looking at the needs of Aboriginal people, particularly from VACCHOs perspective here in Victoria, that shows the peak body for health and wellbeing for Aboriginal people in Victoria and the peak body for 30 Aboriginal community-controlled organisations.

Our goals for urban Aboriginal people are the same as our goals for Aboriginal people in remote areas, which is that they can access high quality, culturally-appropriate care that actually meets their needs. But in terms of our objectives and in terms of our objectives for people in metropolitan areas, we're looking for the provision of navigation and outreach services by trusted entities. We're looking to increase representation of Aboriginal people in all aspects of the aged care and aged care provision, building the sustainability in reach of those services, which have

specialised skills in the provision of care to Aboriginal people, and to build the capacity of Aboriginal people and their representative organisations to provide nuanced policy advice in relation to aged care.

And I think there are particular areas in relation to the last of those two objectives, around building evidence base and building capacity, that are particularly relevant to urban people – urban Aboriginal people. And they relate to trying to embed the knowledge, awareness and understanding that Aboriginal people who live in metropolitan and regional areas are – also experience thin markets and, you know, lack of culturally-appropriate services. Although there may be many services on offer, the acceptability and appropriateness of those services may differ, depending on their cultural safety.

And also, by virtue of the fact that if you're looking at Aboriginal people in metropolitan areas, they are predominantly small, dispersed groups of Aboriginal people. So, if you take, for example, metropolitan Melbourne, there are more than 28,000 Aboriginal people living around the north and west boundaries of Melbourne in the metropolitan area. But when you consider that in Melbourne, as a whole, there's more than 4 million people, those groups are diluted. And groups in regional areas tend to live in clusters of populations of 300 or populations of 3000, but not necessarily in a group that's large enough to actually drive the market and drive market preferences.

I think there's also a need for urban Aboriginal people to embed the knowledge and understanding that urban Aboriginal people who do not necessarily live traditional life styles are still culturally distinct from mainstream populations. So, I think there tends to be a feeling that Aboriginal people who live in a remote area, who speak English as a fifth language, are culturally distinct from the Australian mainstream population. Whereas Aboriginal people who live in metropolitan areas, who may speak English at home, albeit Aboriginal English, but still speak and can be understood without a translator, are less culturally-distinct.

There isn't – there's a bit of a conflation between, you know, similarity of language and similarity of culture. And it doesn't recognise that Aboriginal people in metropolitan areas still have cultural obligations to family, community and to country. There is also a need to embed the realisation that Aboriginal people in metropolitan areas, as well as those who are living in remote areas, experience similar rates of chronic disease, almost identical rates of dementia and complex social needs. They are equally deserving of having aged care support services that enable them to receive culturally-appropriate support in their community and on culture and on country, which may, in fact, be in a metropolitan area.

MR GRAY: And have you been involved in the preparation of the submission to the Royal Commission, which you quote from in paragraph 9(c), now displayed on the screen? That's the NAGATSIAC - - -

MS TUNNY: The NAGATSIAC. Yes.

MR GRAY: - - - submission.

MS TUNNY: Yes. Indeed.

MR GRAY: I'll ask the operator to display that. RCD.9999.0222.0001. And at page 16, 0016. Thank you. You and the other authors of the submission give sources and identify some of the foundational material on the disparity in health and wellbeing outcomes - - -

MS TUNNY: Yes.

MR GRAY: - - - for Aboriginal people, including in urban settings; is that right?

MS TUNNY: Yes.

MR GRAY: Thank you.

MS TUNNY: Absolutely.

MR GRAY: Ms Patetsos, I'll ask you similar questions about what you perceive to be the particular needs of culturally and linguistically diverse people who need aged care services and what the role of FECCA is and what its objective are in the aged care context. Could I, first, ask the operator to display your statement. That is, your second statement, at page 2, paragraphs 10 to 11, where you return to a point you identified in your first statement earlier in the year concerning the importance of language and interpretation. Its foundation or – according to your evidence earlier in the year, if communication fails, then care needs can never be understood, for one thing. Social isolation will, obviously, result as well. Would you care to elaborate on that point?

MS PATETSOS: Yes. Certainly. I certainly made the point in the earlier – in my earlier evidence that language and communication is critical and remains critical. The reasons for that is that a lack of communication, a lack of capacity to communicate undermines people's wellbeing, it undermines people's right to be understood and to understand. And it also undermines their capacity to control their care plans and their experience in care, regardless of whether that care is happening at home, but particularly so if it's happening in a residential facility, where they get less access to family members who can assist.

The issue of communication remains real for CALD communities. And given their sheer numbers, given that – depending on the way in which you describe – the way in which you compile statistics, their sheer numbers are between 29 and 36 per cent of the population. And what we do know is that increasing numbers of those older people are suffering from dementia-related disease, which impacts on their capacity to retain the language they learnt later in life. Communication is critical. So, without resolving that issue, anything else we do falls short. So, we continue to say

the obvious, that people's communications needs need to be met in full where that communication requires formal communication.

So, if it's a communication that's a personal care matter – that is, a daily routine, that perhaps you can use unqualified staff to manage. But where it is about explaining clinical conditions, medical conditions, the right that we have to understand a doctor or a nurse or a physiotherapist, to know what it is that we are managing for ourselves, our right to have that information direct from a professional requires the use of professional interpreters. So, it's not just a matter of basic communication being achieved but the correct level of interpretation. So, if a physiotherapist is explaining to someone their condition, it ought to be explained at the same level. And that can only be achieved through professional interpreting.

MR GRAY: Are there gaps in the system for funding the provision of these interpreting services or is there a shallow market for those interpreters? What's the issue?

MS PATETSOS: The issue is partly resourcing. It's FECCAs position that communication is a basic right and that an older person should not have to use service or care money to meet their communication needs. So, it should be a cost that's borne by the government, to ensure that communication occurs. And/or the provider, depending how the funding is packaged together. So, it shouldn't be a choice for an older person to eat up their package to use interpreters in order to be understood. It should be something that is provided to them and not compromise their other care. So, we're fairly clear about that. And anything less than that falls short.

MR GRAY: On the same page of your statement, at paragraphs 13 and 16 respectively, you identify cultural and religious needs and also social isolation as other key needs issues. Would you care to elaborate on those briefly?

MS PATETSOS: That's correct. So, basically, we always go to language as a core. But we acknowledge that all of us have culture and religious, spiritual needs that need to be met. And the point is that if we fail to meet those, then our individual needs as a person are not met. So, it goes to all of us – that we are complex beings, and meeting our needs requires an attendance to all those that make us unique. And our uniqueness comes from our lived experience, which is a combination of culture, language and spirituality. To the degree that that is relevant for each individual, it depends on each individual. So, for some, spirituality may be less important than, in fact, their culture may be. So, it is, ultimately, individual.

The critical nature of language is there because without language not only are you left with less information, but you're also in a position where you're socially isolated. If you cannot communicate with the people around you, you have no one to talk to for most of the day, because your family is only there for a limited amount of time, if at all. So, the level of socialisation for individuals who do not share a common language in a facility is extreme. So – and we later point to the – to those

smaller communities where their isolation is almost – I believe that the research shows quite strongly that their socialisation leads to compounded complexity in their care and to mental health issues within residential facilities.

MR GRAY: I will ask you about clustering a little later during the panel discussion.

MS PATETSOS: I look forward to it.

MR GRAY: Ms Edmonds, I will direct some questions to you and then give the other panel members a chance to comment, but I will principally direct these questions to you because you are the chair of the subgroup, and these are questions about the generation of the Diversity Framework in 2017 and the action plans published under the Diversity Framework so far in respect of CALD LGBTQI and Aboriginal and Torres Strait Islander people with a draft homelessness action plan in the process of production, as I understand. And I will be asking about the process which led to the generation of publication of those documents. Could we, operator, please again display the Diversity Framework, exhibit 2-38. Firstly, Ms Edmonds, can I just ask you about, on page 5, there's an outline of the approach taken to human rights-based approach and the objective of the framework. Were these matters of the subgroup had in mind all through the process of generating this document?

MS EDMONDS: Yes.

MR GRAY: And would you just explain to the public and to the Commission what's meant by the human rights approach and, in particular, how it ties in with the objectives you have in mind – you had in mind for the framework.

MS EDMONDS: A human rights-based approach looks at, I guess, the rights that are embedded within people, their rights to safety, their rights to wellbeing, their rights to health, their rights to non-discrimination and their rights to access services that meet their needs where they're at. And what really drove us around having a human rights-based approach was that it's actually about recognising the person and the people. It's about having the person – as we talk about person centred care, but it's about having the person as the focus of the Diversity Framework. So, what we wanted was that people, regardless of their diverse life experiences or characteristics, were at the centre of the delivery of care and that those characteristics were met and addressed and responded to by aged care providers whether they were home care or residential care. But also, that they're addressed across the whole of government, that it's not just about those that are delivering the services; it's actually about having a whole aged care system that is actually inclusive of people regardless of their diversity needs and that recognises those diversity needs and puts them at the centre rather than add ones and additions all the time.

MR GRAY: Thank you. The subgroup is a subgroup of the Aged Care Sector Committee. Would you just explain how the subgroup was convened and what circumstances led to its being convened?

MS EDMONDS: Yes, so what initially happened was in 2016, representatives from the Federation of Ethnic Communities' Councils, the national Aboriginal Community Controlled Health Organisation and the Australian Association of Gerontology and ourselves met together recognising that the then existing CALD aging and aged care strategy and LGBTQI ageing and aged care strategy were about to end in 2017, and as far as we could see, no work had been done to replace those strategies because while there had been some change, there was still a lot of change that needed to happen, and we also recognised that there had never been – or there was no plan for Aboriginal and Torres Strait Islander Elders either. So, we got together. We wrote to the then Minister for Aging, Minister Wyatt. We put together a briefing document explaining why we felt there was a need to continue the work in the diversity area, and then we sort of did, I guess, a walk to the halls of Parliament.

So we met with Minister Wyatt and put our proposal to him that what we saw would be beneficial is the creation of a Diversity Framework to catch all diversity groups, and that would have the high level principles and actions that could be taken, but then there needed to be some real specific focus and, obviously, for us, the initial focus was LGBTI CALD and Aboriginal and Torres Strait Islander, and that recognised that while there's needs and issues that cut across all diversity groups, there are some very specific needs to each of those groups that need to be addressed and met, if aged care is to be inclusive. So, we had that discussion with the Minister. He was very supportive and agreed that that's the way it should happen, and then we also met with the Shadow Minister and with the cross-benchers as well, and they were all very supportive of it. In that meeting with the Minister, he announced that he was going to create the diversity subgroup and that the representatives that were there meeting with him would be on that subgroup and would drive that change, and it would become a Sub-Group of the Aged Care Sector Committee.

MR GRAY: The Aged Care Sector Committee is a consultative body to inform itself of issues in aged care when it is considering reforms; is that right?

MS EDMONDS: That's correct, yes.

MR GRAY: So, in terms of the final adoption of the framework after a consultative process, which I will ask you about in a minute, is it a document that is regarded as a government document?

MS EDMONDS: Yes.

MR GRAY: Yes, and it – the formal process for its adoption involves adoption by the Aged Care Sector Committee itself as a precursor to it being adopted by government; is that right?

MS EDMONDS: Correct.

MR GRAY: Now, could you just tell the Commissioner something of the process of consultation in 2017 leading to the publication of the overarching document which is

now on the screen, the Diversity Framework itself and then separately I will ask you about the documents that sit beneath it.

MS EDMONDS: So, the Diversity Framework had two major consultation phases. So, the first phase was in March/April 2017, and that was also part of an evaluation of the existing LGBTQI and CALD strategies, and what we felt was that we needed to evaluate those strategies to see what might need to carry forward into the Diversity Framework and the ongoing action plans. So that was for a couple of months.

There was also an ability to put submissions online as well, and that – some of that work then informed the initial drafting of the Diversity Framework. We then had a further consultation process in May/June. Again, there was a – this time, though, sorry, there was a – the draft action plan was – the draft Diversity Framework was available, and, again, it went public. It was online. It was promoted through, you know, through the Department of Health, through the peaks that were represented on the diversity subgroup through as many networks as we possibly could. So, all that information then came back into the subgroup to work on the framework and to determine the priorities and the principles and the work that we were going to do. In that, as well, we also had direct involvement with the peak aged care providers. So, we had a phone call conversation with them, I think it was, in June or July. And then we had a face-to-face meeting with their representatives in November as well.

MR GRAY: Operator, please display Ms Edmonds statement page 0005 at paragraph 15. Please go on Ms Edmonds. You were coming to the consultation with the peaks, and they are the Aged and Community Services Australia, the Aged Care Guild and Leading Aged Services Australia; is that correct?

MS EDMONDS: That's correct. Yes. So, we had a – we organised a face-to-face meeting with the peak providers. They were represented by their policy staff, and we had a discussion with them around the Diversity Framework. Our idea in developing the Diversity Framework had always been for it to be a mandatory document that needed to be addressed and completed across the aged care sector. The – while the peaks stated that they were supportive of diversity, they didn't want to see any document become mandatory because it was considered to create additional red tape on top of existing reporting requirements that their members had to face.

So, it did make discussions challenging in some ways and – look, and it was certainly useful because it also allowed us to reflect on some of the stuff – some of the actions that we were doing within the Diversity Framework. We then put the Diversity Framework forward to the Aged Care Sector Committee out of session for consideration. We, again, had pushed back from the aged care provider peaks about some of the information, and they felt that they hadn't been properly consulted and engaged throughout the process. We then demonstrated all the different ways that providers had been consulted across the process, and the Aged Care Sector Committee then approved the Diversity Framework.

MR GRAY: Thank you. I ask the operator to display paragraph 15 of – I ask the operator instead to display paragraph 39 on page 0009. That's the – where you document the account you have just given to the Commission.

MS EDMONDS: Yes.

MR GRAY: Sitting beneath the framework itself, is a set of action plans; is that right? I will ask the operator now to go back to page 0005 and to call out paragraphs 14 and 15. What was the process which led to the generation of the three existing action plans?

MS EDMONDS: So, each of the action plans were – was actually developed in a different way, depending on the peak body that was driving the development of those action plans. So NACCHO represented through Noeleen, and Matt drove the Aboriginal one through the NAGATSIAC. Mary and Christina at that time from the Federation of Ethnic Community Councils had a particular process with how they engaged with CALD Elders and older people, and for the Alliance, we did that national consultation where we went out to every community we could to get as much feedback as we could around what people felt were the priorities and what they would like to see providers do to make aged care inclusive for LGBTQI elders and older people. So, each plan, I guess, was developed in a very consultative manner with the very communities that those plans were for in a way that actually met the needs of that community and represented the way that community engaged with their peak organisations and with the aged care system. So that's what sort of led to the development. We then, as a subgroup, worked together to review each other's plans.

So, we actually would have quite a few meetings where we would work through each of the plans. We would look at where the consistent recommendations and actions were. So those that cut across every group. And that led to then the creation of, I guess we call it, a general action plan which has those actions that are consistent across every group in terms of what people want to see happen. And that also led to deciding what kind of layout would work for different groups and then a consistent layout and then developing not just the plan for providers but a plan for consumers because when we went through a lot of the consultations documents that we had and the information we had gathered, it could be actually divided into what consumers wanted to see providers do and also what they wanted to be able to ask providers to do.

So we created the two supporting documents, if you like, together so there's a provider action plan, a consumer action plan, and the consumer plan is very much about what they can expect providers to do, and the provider plan is very much of this is what you can do and should be doing, and that also, after lots of discussion, led to a recognition that there are some providers who are doing diversity really, really well and really get it and really understand it, and there are those that probably still haven't even thought about what it might mean to work with people who have diverse needs, and that sort of helped establish the layout of those action plans from those who are just starting out to those that are, you know, somewhat along the way

and to those that are leading the way. So that then formed the framework for how we wrote those plans based on all the information we had gathered.

MR GRAY: I want to go back to this point about whether the principles in the Diversity Framework or indeed the action proposed in the action plans should be made mandatory or not. Was there a position on contents of the action plans being made mandatory adopted by yourselves within the subgroup on the one hand, and the three peak bodies representing the sector on the other?

MS EDMONDS: Yes, we would like to see them mandatory. How that happens I think there's some discussion around, whether it's actually seeing them as mandatory as part of the Aged Care Quality Standards, whether it's seeing them as mandatory through the creation of diversity action plans or whether it's seeing them mandatory in their own right. And I think that's probably a discussion that we're still sort of thinking through. At this point in time, though, the Aged Care Quality Standards are obviously the requirement and the expectation, so we would certainly like to see the framework and action plans mandatory through that process. We do have diversity recognised in the Aged Care Quality Standards so there's certainly a linchpin, if you like, to hang those documents off as being a mandatory requirement. And as stated previously, while the provider peak supported diversity, they were not keen to see the documents made mandatory because there was that consideration of seeing them as additional work or additional red tape on top of the work they're already doing in terms of accreditation processes.

COMMISSIONER BRIGGS: Could I ask, Ms Edmonds, how did they approach the fact that each of you had developed your action plans with the people using your services or likely to do so. So very much a person-centred approach. So, you were presenting three kinds of person-centred approaches to a series of providers who, for the most part, say they provide person-centred care. How did they relate to what you were saying?

MS EDMONDS: It was – I guess a difficulty we faced was that in terms of all our consultations we consulted with providers themselves were engaged in those consultation processes and certainly in those consultations we spoke about the plans possibly being mandatory and our expectations around those plans. And the providers in those consultations certainly never raised issue with that and actually, you know, saw that as a useful thing, as a good thing to happen. The disconnect seemed to happen between what we were hearing from providers on the ground and then what we were then being told by the peak providers after they had consulted with their members. We couldn't get further information about who they had spoken to and though we saw some of the issues, at the end of the day we had to balance out that we were here for consumers. It was about person-centred care and, therefore, what consumers were asking had to take precedence in some way over what the providers were asking.

COMMISSIONER BRIGGS: Thank you.

MR GRAY: I will just take that topic a little further by asking the operator to display general tender bundle tab 70. This is NLH.0001.0001.0001. This is a document referred to in your statement in the course of the discussions about consultations on the action plans.

MS EDMONDS: Yes.

MR GRAY: And about two-thirds of the way down that first page, the peaks say:

> *We provide the following high-level comments based on feedback from members and staff where available to meet to discuss our concerns. (2) The documents use descriptive language in places instead of guiding language.*

Was this the tenor of the discussion that followed the presentation of this document and how did the action plan or each of the action plans end up on this topic? Did they end up adopting guiding language rather than prescriptive language?

MS EDMONDS: No, they didn't. So, we certainly stuck to the language that our consumers used. We didn't think that using guiding language around – so, for example, an aged care provider should consider how they will do X, Y, Z because you can consider but they never taken an action from that consideration. So, we very much kept the language as active language as, you know, provide should do X, Y, Z because that was what consumers were asking of us and that's what they wanted to see happen and we were reflecting what consumers wanted when they accessed aged care services. So, in the end we did maintain that more directive, if that's what you want to call it, language in all action plans.

MR GRAY: One of the other points raised over the page on page 0002 at paragraph (c) is a suggestion:

> *Instead of suggesting consumers ask, "does your organisation have a diversity action plan", which is not a requirement, we think a better question would be something like "does your organisation have information that describes how you provide person-centred care".*

Was that a key theme, that person-centred care and adherence to the principles of person-centred care would be sufficient and that the peaks were resistant to additional requirements?

MS EDMONDS: I think what we see happens quite a lot is people see person-centred care and as that as the only thing that needs to be done. So, we have – we develop a care plan. It's person-centred. We meet the needs of that individual and therefore we will then meet their diversity needs. What that fails to recognise is that you can have the best care plan in the world but if your organisation isn't culturally safe then that care plan isn't going to be sufficient to meet that person's needs. So what we were trying to drive with these action plans was that person-centred care isn't central; it is really important, but unless you actually look at the broader

organisation from the governance level right the way down and actually have policies, processes, systems in place and that you are engaged with the communities of the people that these action plans are about, then in fact you actually aren't going to have person-centred care.

So, talking around LGBTI people, if your service isn't culturally safe then someone is not going to identify as LGBTI. So, you can have a fantastic plan but actually you will be missing out on a whole portion of that person's life experiences and meeting those needs and experiences because they actually haven't come out and told you that they might be LGBTI and there's some really particular needs around that that need to be met. So, you know, you might think you are meeting and been delivering person-centred care, but you are not. And I think that's what we were really trying to drive through with the action plans was that, yes, it is about the person being at the centre but there's this whole other thing around that person that needs to be safe as well.

COMMISSIONER BRIGGS: These are the sorts of arguments that used to be used toward women. It's all right for the blokes, therefore, it's all right for you. And I'm hearing that now in relation to these groups.

MS EDMONDS: Very much so.

COMMISSIONER BRIGGS: Dear me.

MR GRAY: I just had a final question about the consultative process. It also involved the then Quality Agency, now the Australian – I beg your pardon, the Aged Care Quality and Safety Commission previously the Australian Aged Care Quality Agency. Now, what was the nature of the consultation with the agency? You refer in your statement at page 0012, paragraph 61 to attempts to have the Quality Agency have a role in monitoring the implementation of the framework and for review to occur as part of the accreditation process and elsewhere in your statement, at paragraph 76, you refer to a recommendation that the Commission of Quality and Safety – the Aged Care Quality and Safety Commission should have a role in reviewing the implementation of the Diversity Framework as part of accreditation. What was the nature of the consultation?

MS EDMONDS: So, we had, I think it was, two meetings with the then Aged Care Quality Agency. Speaking at that stage when we were hoping that the framework and action plans would be mandatory, talking about how they could have at that monitoring role, because they were going in to do accreditation anyway, so they would be reviewing the systems and processes of that provider; they would be talking to consumers, so they were in the best position to see if the providers were being actually inclusive of people with diverse needs and characteristics and what that might look like, and then use a Diversity Framework and the action plans as, I guess, a way of seeing where providers were along that journey, because, as I was saying, those action plans were in three stages, so how inclusive are they being; is it

being effective; is it working? And we certainly thought that that was a really good role for them as part of their processes.

I can't remember all the discussions but obviously it never sort of moved beyond those initial discussions. They certainly were very supportive of diversity and inclusion, but it never actually then eventuated into a role because the plans were never made mandatory and they instead became part of the guidance materials.

MR GRAY: Does the subgroup currently have a position on whether that should remain the case or whether implementation of the Diversity Framework should become part of accreditation?

MS EDMONDS: I would say I think we do believe the Diversity Framework should become part of accreditation, yes.

MR GRAY: Ms Tunny, can I, in more briefer compass, ask you some questions about your perspectives on the development of the Diversity Framework and the action plans. Firstly, just on that human rights approach that's mentioned in the Diversity Framework itself, you touched upon this in your statement at paragraph 6. What's the importance of having a human rights approach?

MS TUNNY: I think from a – from an historical perspective the human rights of Aboriginal people have been largely ignored, certainly before 1967 when they were part of the Flora and Fauna Act rather than citizens of this country. Subsequently, we see widespread intergenerational trauma across communities that has emerged from the colonisation process. It's absolutely essential that the human rights of Aboriginal people are aligned with the services that they receive; that those human rights are fully acknowledged and embedded in the services, embedded in the, I guess, recognition that services which are enjoyed by the rest of the general population should actually meet the needs of Aboriginal people as well, despite the fact that they are a smaller – they are a relative small population group within the Australian general population.

MR GRAY: Was there anything you wished to add to what Ms Edmonds had said about the nature of the consultative process, the position of the peaks, the position of the Quality Agency?

MS TUNNY: Well, in relation to the nature of the consultation process, as with the development of the LGBTI plan and the CALD plan and the subsequent homelessness plan, and the Diversity Framework itself, extensive consultation was undertaken with Aboriginal people and also with Aboriginal people involved in the provision of care to Aboriginal people as well as to mainstream peak bodies and mainstream providers. There was an acknowledgement across the board in that consultation process which was also documented in a consultation plan similar to that which was displayed with Samantha's testimony this morning and which I believe has been provided to the Royal Commission earlier in the process; that actually, you know, calls for those services to display – you know, to actually be

inextricably linked to the human rights of Aboriginal people and to take into account the broader experience of socioeconomic disadvantage, the broader experience of trauma, the more complex social and care needs of Aboriginal people, and also the right of Aboriginal people to self-determination.

MR GRAY: Ms Patetsos, what's your view on the importance of the Diversity Framework being made mandatory and do you wish to comment on any other aspects of the evidence the Commission has heard on the development of the framework and the action plans?

MS PATETSOS: Thank you. I support and would like to add a couple of my observations. It became very clear to me in the direct conversation we had with the peaks that I had misunderstood something. I assumed that the peak representative of the bodies' main purpose was to make sure that the industry did its job and did it as well as it could to support the community that it served. That was my interpretation. You didn't think that they were a watchdog for impost. I didn't think that their role was to protect the industry from possible burden of care. So, on reflecting on the Diversity Framework and the action plans from their perspective I would have thought that they would see the documents as useful as providing useful insight into what their members could do to ensure that the people they looked after were looked after really well.

And so, there was an assumption on my part that the documents would, in fact, be embraced as documents that their members, constituent members could use to facilitate the best care possible. So when there was push back and a description of them as red tape I reflected again on whether they had anything in them that would be particularly offensive to a provider and, on reflection, if you look at the framework and what it states, which is on the overhead there, equity of access, empowerment, inclusion, equality, capacity and responsiveness, that in order to meet the standards, I would have thought that they are, in fact, mandatory obligations that are there anyway regardless of whether they're stated in a framework or whether they're stated in a policy document somewhere. So, I guess my – I guess it's arguable that the principles should be mandatory because they actually are, because to meet, in my mind, the quality standards, you must meet the principles that are outlined in this framework.

So, I think that it's critical to understand that caring for people in the way that meets their absolute needs honestly is not an impost. It's not red tape. It is not an additional thing they need to do. We are not trying to burden them. We are trying to ensure that they do what they promise that they will do, when people are in their care.

MR GRAY: Thank you. I just, finally, ask about the homelessness action plan and the progress on that document, and also any other consideration that the subgroup is giving to emerging groups. Ms Edmonds, I'll direct those questions to you.

MS EDMONDS: So, we discussed the draft Homelessness Action Plan at our last Diversity Sub-Group meeting about two weeks ago. So, it's in its final draft phase. We're just going – the Department's just going through it at the moment, just doing some layout around that. We then will take it to – I'm trying to – sorry, I'm looking at Mary because I think we're taking it to further consultation or – yes. Further consultation, and then taking it to the Aged Care Sector Committee for final signoff.

MR GRAY: Thank you.

MS EDMONDS: In terms of emerging groups, I think our hope is that the next action plans would be on rural, regional and remote people and people with a disability accessing aged care, but we're very much waiting to see if the subgroup continues its existence after 2020 – next year.

MR GRAY: Thank you. In the Diversity Framework itself – Operator, if you could please put it back up – the infographic on page 5 includes people with poor mental health, people with cognitive impairment, people with disability. On page 12, there's also reference to people with HIV-positive status. Is the subgroup in a position yet where it has identified these groups as emerging groups for whom it's possible that action plans could be formulated in the future?

MS EDMONDS: I think we're aware that there are – in addition to those groups, there's many other existing groups that could possibly or would need action plans into the future. We haven't had specific discussions around that at this stage in time. Certainly, in terms of the actions for LGBTI elders, we included a number of actions around people living with HIV. We included them within our action plan. And in our action plan for consumers as well, we highlighted a number of actions for people living with HIV. But in terms of the subgroup as a whole, we haven't had those discussions as to what other emerging groups we would address.

MR GRAY: Thank you. I want to turn now to a different topic. But it's, of course, related and it, in fact, got a mention in the course of your evidence, Ms Edmonds. It's whether person-centred care is enough. The question could be put this way. If person-centred care were to be planned and implemented by service providers properly, would there be any need for additional organisational change and practice to meet care needs of people with diverse backgrounds, experiences and characteristics? That's a difficult question. If you're able to answer that by reference to experiences that you know about – I'll direct that question first to you, Ms Tunny.

MS TUNNY: Look, I think part of the difficulty that we face when we talk about person-centred care is defining what you actually mean by person-centred care. It appears to me that aged care providers, when they're talking about person-centred care, are specifically talking about a personal care plan that includes medical needs defined in the context of a western medical model, plus or minus, perhaps, some personal-care, attendant-type needs. And addressing person-centred care in this way can't hope to meet the needs of Aboriginal people. And it's, you know, of course,

Aboriginal people whose needs I will be using as examples in my answer to this question.

MR GRAY: Operator, please display page 0007. Thank you.

MS TUNNY: It's actually impossible to provide person-centred care to Aboriginal people without embedding a focus on cultural safety for Aboriginal people. And that, actually, then automatically extends the remit of care from the individual to the individual in the context of their family, the family in the context of the community and the community in the context of their relationship to country, and the reciprocal obligations that exist between the person who is receiving care and all of those interlinking rings of responsibility.

You know – I guess, you know, the obvious examples around that inclusion of, you know, culturally-safe care are the ones that most people are familiar with. So, things like return to country isn't a holiday, Sorry Business is not optional. But when you're talking about something like Sorry Business and the ways that – or the expectations of elders in the context of a funeral, particularly a family funeral, that immediately takes their care needs beyond just the individual to the obligations that that Elder might have to host family or, certainly, to be present at an event that might be hundreds of kilometres away.

I'd like to use – as an example of an organisation that has extended person-centred care beyond the individual human and into their surroundings and family, I would like to use the example of Jimbelunga Nursing Home, or nursing facility, which is just outside Brisbane. It is an Aboriginal community controlled facilitate. Their interpretation of how they meet the needs of the individual and draw in the community are – you can – are evident in the planning of their grounds, which include a playground and a barbecue, so that the families can actually come in.

So, we're not taking the Elder out to visit their family or attend a family event; we're actually having the four-year old's birthday party or their 21st birthday party actually in the grounds. They invite the local football team in, because you can't extricate the individual from their community. And, in fact, you know, the elders want to observe and provide instruction on how the football training happens as well. So, it's bringing that community in. And then, again, if you actually look at the actual design of the facility itself, the Commission for Quality – in Aged Care Quality and Safety mentioned to the facility that they felt the wider corridors gave the building a hospital feel. But what they didn't see, when they looked at those wider corridors and looked up, was the high ceilings and the clerestory windows that mean that you can see sky wherever you go throughout that facility.

Given the proportion of Stolen Generation survivors who are in that facility and their fear of being caged in, the actual design of the facility takes into account their experiences and their conditions. You know, from that perspective. We also have to look at, I guess, the holistic quality of care and taking care outside an individualised western medical model. And there are a number of organisations that have gone out

of their way to connect with broader remits of service so that they can provide that holistic care. So, Institute for Urban Indigenous Health in Brisbane provides some aged care. It also provides primary health but has been collaborating with the primary health network in Brisbane.

We're also talking about, for example, Aboriginal Community Care Services in South Australia, which is an Aboriginal aged care provider exclusively providing aged care, that has then gone out of its way to make partnerships with primary care facilities. You know, particularly Aboriginal community controlled primary health care facilities, but, certainly, primary health care wherever and however it needs to be accessed, to be able to provide a broader service.

MR GRAY: Operator, please go to the next page. And I just, Ms Tunny, ask you about paragraph 25. You refer there to the concept of co-design.

MS TUNNY: Yes.

MR GRAY: And you say there's been a minimal opportunity for Aboriginal people to be involved in co-design so far. Could you just briefly outline what you mean by co-design?

MS TUNNY: So, I'd like to – that particular paragraph refers to co-design in the systematic – in the aged care system sense. I would also like to throw in an example around co-design from a service perspective sense. You know, when you are actually looking at co-design, we're talking about the opportunity, in the Aboriginal context, to involve both community members and/or representative organisations to actually be involved in the process of the design, to actually influence the way that design occurs, to influence the way that system's delivery models are developed, and also to implement the way, potentially down the track, that those services and/or policies are implemented.

Throughout – there has been emphasis throughout the last few years around co-design bringing service providers and peak bodies into the process with government, to actually work on design of policies. But when you're talking about involving Aboriginal people and their organisations in that process, social disadvantage is widespread in Aboriginal communities. And community-controlled organisations, with few exceptions, are small specialist providers of health care and/or aged care. When you give them very short notice and when you, you know, don't have the capacity to provide them with accommodation or travel costs, it's very difficult to pull somebody off the front line at short notice and scrape together the money to actually have them participate in a design forum of any kind.

That's the systemic level, and that was certainly what we were observing. And I think Sam and Mary can provide similar examples for their organisations and the difficulties of being fully involved in that design process and for those reasons. In terms of at lower service level, we've seen some really good examples of co-design, both with community members and with – by cultural workers and, you know,

representative organisations. And I'd give, for example, the Lungurra Ngoora model of aged care and disability service provision that operates out of the Looma community in the Kimberleys as one really good example.

And I'd also throw in at least one mainstream example. There's an organisation called Care Connect; that's a mainstream aged care provider operating here in Victoria. Their initial foray into providing care for Aboriginal people involved them convening an Elders Council. And I can tell you that we've had numerous positive comments about the quality and cultural safety of services provided by Care Connect in a variety of regional areas, you know, downstream from the convening of that Elders Council.

MR GRAY: Thank you very much. Ms Edmonds, in your statement, page 0025, paragraph 115, you remark that it's often heard from providers:

We treat everyone the same.

At paragraph 126, on page 29, you say:

More than person-centred care is needed, though this –

person-centred care –

is important, of course.

Could you elaborate, please, on those related points?

MS EDMONDS: Certainly. So, what we're saying – when we hear providers saying, "We treat everyone the same", we see that as not recognising the diversity of the people that were in that service. So, if you treat everybody exactly the same, then you're not delivering person-centred care and you're not meeting the diverse needs of those people. So, when we're looking at person-centred care, it is absolutely important, but it has to be more and above and beyond treating everybody the same. And it's about recognising that diversity. When we think about that example you showed at the beginning for my submission, the person born in 1939 and their lifetime experiences of abuse and often institutionalisation, we are now saying to that very person, "Hey, come and trust these services that actually discriminated against you for your whole lifetime. You know, you can trust them now. They're going to do person-centred care, you will be fine, and you will get good services." And that fails to recognise that the environment in which that person-centred care can be delivered can actually be seen to be quite frightening.

Whether that service will or not be discriminatory is kind of moot in a way because people expect to be discriminated against because their whole life they've been discriminated against, so they're just expecting that's going to happen when they access aged care services. If they do access services and there is discrimination, then of course that person -and you probably would have heard about people talking about

going back into the closet. So, hide themselves again. So, as I said earlier, we really believe that in terms of person-centred care, it is about the whole organisation. It is about cultural safety that Noeleen spoke about. It's about the whole system of aged care from government systems right down to provider systems and service delivery, being culturally safe for LGBTI people. Understanding that for many LGBTI people they're very isolated. They no longer have family connections. They've been rejected by their family. So, community is really important.

So again, while you might be focusing on doing person-centred care, it's about recognising that there's that need to connect to community as well, and that there might be what we call families of choice that people have created around them that need to be part of that person-centred care. But if your service isn't culturally safe, well, you are not going to talk about your family of choice. You're not going to talk about your historical experiences, you are not going to talk about your needs and any issues that you might be facing. So, the person-centred care will meet maybe 50 per cent of what you need but it won't meet 100 per cent of what you need because you are not going to expose yourself to the risk of facing further abuse and discrimination. And then that can also be, you know, exacerbated, if you like, or built upon because LGBTI people are part of other community so they are part of the Aboriginal community, they are part of the CALD community. So, then you have lots of other actions happening around person-centred care, including cultural care as well.

We have – I guess the prime example of really great person-centred care and culturally safe environment is a provider in Western Australia who had transgender Elder access their service who decided to transition in that service, and they provided full support. They helped the person with their family, and then they went on and got Rainbow Tick as well. So not only did they do person-centred care, they recognised that they needed to make their whole service culturally safe for that person, so they felt included across the whole organisation and safe within that particular provision. You can balance that against a recent consultation that was held where we had feedback from someone – again, a transgender woman – who is receiving aged care services but is not out and says that "no one in this service knows that I am a trans and gender diverse and I would not come out because this environment isn't safe." So, I would believe the provider thinks they're delivering fantastic person-centred care to this person but they're actually not because that person is not feeling safe, is not feeling included, is listening to transphobic slurs that are happening across the organisation and, you know, so they're just sort of hiding themselves and just going along and pulling the line and pretending that everything is fine. So, while person-centred care is important, it's only a part of the whole picture. And unless we actually have fully culturally safe services, person-centred care will never be as actually effective as it could be.

MR GRAY: Thank you. It sounds like the discussion has now really become one about cultural safety just as much as it is about person-centred care and the need to go the extra steps required to provide a safe space in which person-centred care can actually occur. Is that a fair description of your evidence?

MS EDMONDS: Yes. Yes.

MR GRAY: Ms Patetsos, in that context, I might ask you to comment as you choose on the initial question I propose for discussion, which is person-centred care enough or is more required and, if you choose, a discussion about cultural safety and the creation of that space in which person-centred care can occur. Could I just ask the operator to display a part of your statement, at pages 002 to 3, paragraphs 17 to 19 on the concept of clustering that you explain in your evidence. I would be grateful if you could refer to that concept in your answers.

MS PATETSOS: I will just pick up on what's already been said and not repeat. Only to add that we shouldn't take away from the importance of the individual. So personal care plans, which is what personal care is all about, are critical elements of the way in which care is provided. And they provide evidence that, if done properly, that individual characteristics are picked up by the provider and with the hope that they will be delivered on, met. The issue is not only the matter of disclosure by the consumer. So, picking up everything about an individual, how much they're willing to talk about and how much you are able to discover about them, those two things require cultural safety because people feel they have permission to tell you about themselves, everything about themselves that you need to know as being, as an entity responsible for their care. So that requires a cultural safety.

In addition to that, what's required is a capability in the organisation to then meet the requirements of the personal care plan. So there needs to be a measurement that once you've actually, once the consumer has disclosed and you've got a care plan that is personal, that you then have the capability to deliver on the care plan. And all three are required. So safe disclosure, the documentation, and then the evidence that you're meeting the needs. So that's the only bit I want to add to that. In regards to – I turn my mind to perhaps not always picking up on negatives or issues or concerns that we've heard but start to point to possible ways forward and we've called something that is a possible way forward as some providers, some consumers clustering. It's really a very simple idea.

The idea is that in an environment where you have, in terms of the CALD community, numbers of people living in geographic locations and knowing that family is really important and knowing that people generally go to services within a reasonable 10 kilometre radius of where family live and knowing that you can't build ethno-specific facilities in every district or every region or every suburb, the concept of having rational decision-making in terms of creating groupings seems to be reasonable. So, to give you an example: a provider or a number of providers that could be operating out of, you know, south-eastern suburbs of Sydney, they have high numbers of Vietnamese people in their community, and it would make, be a rational choice for a provider to become very good at catering to the community needs and to form groupings. In short, we think it's a very sensible market response to a challenge which is diversity in terms of culture and language.
So, I think it's a rational business decision because you can market yourself as a very good provider, an expert on doing that community.

It also addresses some of the very fundamental needs that individuals have, which is the joy that we all have to be around people we share many things with. So, it's not a very complex idea to describe and it actually makes sense, but it has been almost impossible to execute. And my understanding is that we've attached some work that has been done in this space since the middle 80s where there has been some thinking that if you place people together in an environment and you are able to become then very good at meeting their needs that everybody is in a better place at the end of that. And there has been sufficient work about grouping, grouping people together. Let's call it clustering to say that as a way forward it's a model that I think the provider peaks should turn their mind to as something that their members could consider in terms of the way they deliver services.

It's certainly a model where research has been found to be very positive in respect to people with dementia because, again, you can become very good at doing that and you can market to the community that that's what you're good at. You can invest in it as a provider. You can train your staff. You can get staff, in the case of dementia, are experts in that or in the case of catering for the Vietnamese community, perhaps speak Vietnamese, understand the culture. And you can do it in a way that has a positive business outcome for you. You can be meeting your standards, you know, with flying colours and you can meeting your community need and people will be happy. So that's the concept, in a nutshell.

MR GRAY: Thank you. You made a connection a minute ago to it being less practicable or perhaps less practicable than in the past to have ethno-specific services and in your statement you make a connection to Australia's migration program in that regard.

MS PATETSOS: Yes.

MR GRAY: What's that point?

MS PATETSOS: So, what we do know is that larger communities, the Greeks, the Italians, the Chinese have historically been able to gain capabilities sufficient to become providers themselves. So, the communities themselves own and run residential care facilities and they also provide home care. What we do know is that as Australia's migration is changing and you're getting less, fewer numbers and less concentration. The capacity of today's communities to do what the Greeks and the Italians and Chinese have done, which is to build their own ethno- specific facilities, will diminish. There simply won't be the numbers or capability and perhaps not even the resourcing to establish that.

So, my concern from a FECCA perspective is if we put all our eggs and the community hope in building ethno-specific facilities, that hope will be dashed because it's not possible to do so for a variety of reasons. So, we must come up with ways of dealing with the challenges of a diverse population that doesn't rely simply on ethno-specific funding for models of care. That's not to take away their value, so I'm not devaluing them at all. What I'm suggesting is that we can't – it would not be

doing consumers a favour if we invested only in thinking about ethno specific care, but we must come up with alternative models. In addition to that, it really is every provider in the country has a responsibility to meet the needs of all Australians. So, it's not the responsibility of ethno-specific providers or communities to look after that community.

Every provider that gets Commonwealth funding that exists with a licence to operate has a responsibility to meet the needs of any individual that may knock on their door. And to focus on an ethno-specific model as if that is not the case is not doing a service to anyone. So, the point being that ethno-specific works for some communities. It's wonderful when it does work. It can't meet the needs of the majority of people. If 36 per cent of the population are CALD they will not all be in ethno-specific facilities. So, our responsibility is to make sure that the whole system is totally responsive and in the models of care with follow and ethno-specific is one of those.

MR GRAY: Thank you. Ms Tunny, what's your response to this idea of (a) all approved providers having to have the competence to deliver culturally safe for Aboriginal people, just as Ms Patetsos was outlining on why it was incumbent on all aged care providers to provide care that's safe and appropriate for CALD people, and (b) whether grouping or clustering is an answer.

MS TUNNY: So, I guess I would start my statement by saying that there are sometimes a few sensitivities about the tendency to – the way that our constituents would put it is lumping us in with, you know, CALD people. However, there are a range of areas where we face similar difficulties. And I think that the concept of, you know – it's quite possible that the needs of Aboriginal older people will not always be met by Aboriginal providers simply because, as I previously mentioned, many of the Aboriginal organisations are relatively small, and as much as we would like to see community-controlled organisations, you know, evenly dispersed across the country, that may not ultimately happen.

So, point number 1, every provider should actually have the capacity to provide non-discriminatory care, and we would certainly like to see each aged care provider undertake cultural safety training from a reputable organisation, reputable community-controlled organisations that is relevant to their local area. I notice that there was a map in the foyer of Aboriginal nations across Australia. There's about 500 of them. So, having an online generic training is inappropriate, but having local training is both appropriate and necessary. In terms of the idea of clustering, we have seen, I guess, some service provision models that actually do try and actually provide that culturally safe care in the context of a mainstream organisation that didn't feel it had the capacity to do so. I'm particularly thinking of Dhuawurd-Wurrung Elders & Community Health Service based in Portland that for a while was providing – it had a memorandum of understanding with the local provider so that they were able to provide the staff and the care to the Aboriginal person based in that service.

And I would say that certainly, you know, partnerships are the cornerstone of culturally appropriate care. And development of service models that actually incorporate, facilitate that partnership between those services that have an in-depth specific and nuanced understanding of what cultural safety means for the people of that locality and a mainstream provider that is willing to pick up those learnings and apply them both with the involvement of those staff from the Aboriginal community-controlled organisation or because they've been trained by them, is appropriate. So, I would say that, you know, I guess concepts that are similar to the clustering idea could potentially be feasible.

MR GRAY: Ms Edmonds, if you wish, is there any contribution you wish to make on these topics that have emerged at the end of the discussions, grouping and co-design clustering?

MS EDMONDS: Certainly. And I certainly agree with both Mary and Noeleen have raised. One of the issues with LGBTI people is that we are across every different cultural group. So, if you cluster, does that mean I go to my LGBTI cluster, or do I go to my Greek cluster? Will I be accepted in my Greek cluster, but that's really important to me? So, it's – you know, there are certain tensions for LGBTI people in that model. When we have consulted with our elders and older people, some would really love to have a wing of an aged care facilitate that's an LGBTI wing where everyone can get together and have their community. Some would like to see lots of different wings, so there's the lesbian wing, the gay wing, the trans wing, and others would like to be part of the general community.

So, I've been part of this community my whole life. I just want to be part of the community. I don't want to be identified and put into a special wing or section of the service. There are Rainbow Tick or LGBTI accredited providers, and that's often seen as the best standard, but we recognise that not every single aged care provider will be able to do that and particularly some of the smaller providers in rural and remote areas. So, in that way, we would see that it's really important that every aged care provider is inclusive and has that cultural competency to work with LGBTI elders and older people and, you know, similar to Noeleen. Engagement with community. Engagement in partnership with LGBTI organisations that have that specialist knowledge that can help your service provide really good care, who can connect that LGBTI elder to their community and ensure that there isn't that social isolation. So, while, you know, we look, there's certainly some benefits around that type of model, I think there's a lot more complexities when you are talking about people who are LGBTI.

MR GRAY: Thank you. I want to now go to another topic. Again, it could well be related to what has gone before. It's the topic of trauma and trauma-informed care. Ms Tunny, I want to start by asking you this question. It's well known that intergenerational trauma has affected the Aboriginal community to a very significant degree. How is the care provider and its staff to understand what needs to be done and to do it, and is it core business or a specialisation which should be identified by the provider? And if you are able to also comment on how is the quality

Commission to address this issue of trauma-informed care? Is it to be regarded as a mandatory element of what's required under the quality framework?

MS TUNNY: Well, I think asking whether, you know, trauma-informed care should be considered as a speciality or as a feature or a theme running through each care provider's service delivery is a little bit like asking whether dementia is a specialist area or should be a thread through everyone's delivery. I think it's sufficiently common that it should actually be a feature of all care delivery whether we're talking about delivery specifically to Aboriginal people or whether we're talking to delivery throughout the community. I think we mentioned the concept of intersectionality a little bit earlier in our discussions, and if the trauma isn't related to your Aboriginality, it may actually be related to another aspect of your lived experience. In terms of what should be done, there are – there has been, I guess, an increasing body of evidence and knowledge around what trauma-informed care looks like.

There has been, you know, research and work done by the Blue Knot Foundation, and in relation to what trauma-informed care and healing looks like for Aboriginal people, I particularly, you know, refer the Commission to the work of the Healing Foundation that deals with that group of Aboriginal people who have experienced very explicit and very overt trauma, and that's the people who have survived the Stolen Generation and assimilationist policies of their youth as well as their immediate relatives who may have had to force – relinquish a child under forced circumstances. They, in particular, have provided work with a group called Social Compass that looks at a theory of change that is specific to looking at trauma, and there is also a particularly good framework that they have developed in relation to actually violence prevention in the domestic circumstances that they – when they were evaluating some violence prevention programs in Aboriginal communities they developed a model that provides four pillars of, you know, healing for trauma, safety and creating safe spaces, identity, reconnection and trauma awareness.

You know, this research is certainly out there. A good start would actually be to ensure that all staff are provided with training in how to provide trauma-informed care. But as with many other features that we are looking at in the aged care system, you know, one session of training isn't really going to cut it in terms of providing, I guess, ongoing knowledge and safe care for people. It needs to be embedded through the organisation's policies. It needs to be, you know – boards need to be made aware of it and how it can be addressed in their – in the communities that they serve. And the Quality and Safety Commission can, for starters, look at the policies of organisations, look at the training for staff to see what has been provided for them.

MR GRAY: Thank you. Ms Edmonds, trauma-informed care, how is the provider and its staff to understand what needs to be done? Is it core business or a specialisation, and how is the Quality Commission to address it?

MS EDMONDS: Look, I agree with Noeleen. I think trauma-informed care is, and should be, a core part of all aged care service delivery because there are so many groups that have experienced trauma in one form or another over their lifetimes, and

we can't sort of isolate one group out over another. It might be different forms of trauma, but it's still certainly trauma-informed care that is needed. Within LGBTI communities, trans and intersex elders are often the ones that talk about the need for trauma-informed care because of their life time experiences, and they sort of highlight that as a really particular need in terms of their care delivery when they're receiving aged care services.

I can't really add more to what Noeline has said. I think there needs to be education, but I think it needs to be ongoing. I agree you can't have a one-off session and god, yes, we have done trauma-informed care. We are done. We need organisations to have policies and practices in place that the accreditation – sorry, the Safety and Quality Commission can actually look at, and then they need to talk to people in the service and find out, you know, and are you receiving, in fact, care that is addressing the trauma that you have experienced, and do you feel this service is doing that? I also think again there's that need for that partnership with LGBTI organisations, particularly the more specialist. So, if you're working with someone who is intersex within the organisation, then connecting with the intersex peaks and talking with them about what are the particular needs and issues this person might be facing and the supports they might need and the same for every other part of the LGBTI community.

MR GRAY: Thank you. Ms Patetsos, from the CALD perspective, are you able to comment on the topic trauma-informed care, what needs to be done? Is it core business or a specialisation? What should the Quality Commission do on this topic?

MS PATETSOS: I think trauma is a very complex issue for providers because most people in fact in their care, most individuals, most people in this room have experienced some form of trauma, some more obvious than others. Certainly, in the case of CALD people, their migration experience and those especially who have arrived in Australia as refugees have specific survivor issues in regards to their migration and refugee experience that surfaces very strongly as they age and recall their past life experiences are central to who they are, what defines them. So, I think it's core business. And it's sometimes incidental to the knowledge that we have of individuals.

So, there's an example which I will give, and it will summarise what I'm trying to say. There was a group of women who migrated here. Many of them were Jewish background women, post-World War II. Some were, in fact, German women. They found themselves in a residential facility. Many of them had qualifications that were not recognised on arrival. Many of them ended up working very long hours in factory settings in Australia in the fifties and sixties and ended up in care. The interesting example here – the interesting fact here is that in the residential facility, none of their previous experiences were picked up on. So, their experience of the war, their experience of having family members who died during the war and their experience and arrival in Australia where they worked as vulnerable – in a workforce that made them very vulnerable in factory settings that – environments that were very punishing – none of that was picked up. So, the facility decided that the best way to

keep them entertained was to give them craft work, and that that craft work would be something that they did for a great proportion of the day.

What wasn't understood was that those women actually interpreted the gifting of craft work not as an entertainment or past time, but as a requirement for them to pay board or to deliver a product as if that was a production line. So, they literally knitted and crocheted for hours on end feeling it was their obligation as women who had no rights to ask for anything else, but to continue to produce as they did in the factory, to produce goods, to have the right for the meal at the end of the day. So, the example that I give is one where there was a complete lack of understanding across culture, a complete lack of understanding of the vulnerability of these women that they never felt they had an entitlement to something unless they worked for it, and so the facility in the end would gift these crocheted goods across to the Red Cross. So, there was quite an industry going on as a result of all of this, none of which would – I think – actually meeting the needs of these women who felt they had been put to work. So, I give it as an example of somewhere someone's lived experience as a young person going through a period of trauma in a war environment in their 80s and 90s continues to traumatise them because no one has understood what that actually means to them. So, the little group over here of people who had not that experience understood knitting and crocheting to be a recreation, for this group it was something quite different.

MR GRAY: Thank you. It's a good entry point into the next topic which is trying to find out what the true needs of the individual are and the difficult issues that surround self-identification of needs for some people, disclosure of the personal details that would allow care staff and nursing staff to understand needs and matters of that kind. What are the myths and the reality about seeking disclosure of special needs and how should the provider and its staff and, indeed, regulators and complaints officers support the person receiving care? Ms Edmonds, I will ask you that rather long question first and feel free to comment on any aspect of it as you see fit.

MS EDMONDS: Okay. It was interesting because, as I said, we have done more consultations and one of the bits of feedback we got was, "Stop pussyfooting around. Ask us and give us the opportunity to come out." So, there's very much that feeling that people need to ask the question instead of – ask the question, "are you LGBTI", rather than hiding from asking that question. And what we feel or what we think is that the question is not asked because they don't want to upset the non-LGBTI people. They don't want to ask someone who is not LGBTI "do you have a diverse sexuality or gender or an intersex status" and upset that person rather than giving the opportunity for LGBTI people to actually be able to identify themselves and say, "Well, actually yes, I am, and these are my particular needs."

We also say that you can't just ask the question once. So, when someone comes into your service, they don't know you. They don't know how safe you are; they don't know what the service is like. They don't know if you are inclusive at all of people who are LGBTI. So, you may ask that initial question and they might say no, but

then you need to provide lots of opportunities for that person to identify over time. So, every time you might relook at the care plan or do a review, you ask the question again and you give the person that opportunity again to identify if they're from the LGBTI communities. Because over time they will build that relationship and they will build that trust and it might be that the first time they might only come out to one person and say, "Don't tell anyone else but I'm happy for you to know." And then as time progresses and that person can work with the LGBTI elder or they can work across the organisation to make the organisation more inclusive, then that person might say, "Okay. Now I'm happy for other people to know, I'm happy for other residents to know."

So, it's about multiple opportunity throughout and it's also about asking the right questions in the right way. So, you wouldn't just necessarily use some of the language that's in data collection at the moment, which is currently being used because the questions completely inappropriate and, in fact, doesn't provide you any useful information. So, you need to go and talk with LGBTI communities and go how do we ask these questions, when do we ask these questions, what are the questions we need to ask that will be inclusive and safe and people will feel comfortable answering.

MR GRAY: I will get you to explain a concept you refer to in your statement as the cycle of invisibility by reference to a document you attach to your statement. Operator, please bring up tab 74. And on page 0082 there are two case studies and then there's a further case study on the next page. By reference to these case studies, if you wish, could you just explain in practical terms what can happen if nobody confronts the issue?

MS EDMONDS: Well, I mean, as shown, if nobody confronts the issue then the person's needs don't get met and they get treated in a way that actually isolates and hides that issue once again. The cycle of invisibility is very much about providers saying, "Well, we don't have anyone here. There's no one in my service that's LGBTI." They have never asked the question but as far as they're concerned there's no one in that service that's LGBTI. And, you know, we have to look at how recent some of these changes are. Prior to 2012 LGBTI elders weren't considered within the aged care system. Apparently we ceased to exist. So, it was really not until 2012 and the strategy came out and we started talking about LGBTI elders and older people. But that doesn't mean that services have moved on in that sense. So, what we are saying is in a cycle of invisibility - - -

MR GRAY: We'll go to page 81, please, operator.

MS EDMONDS: - - - you don't believe that there's anyone in your service that's LGBTI, so you don't ask the questions. You don't ask the question, so the person starts to have fear and distrust of that service, "Why should I let you know because I'm not feeling safe here. You're not asking me. You are not doing anything within your service to be inclusive." As I said, people go back into the closet, hide themselves, hide who they are, don't explain who they are. They become even more

invisible in the service. Service believes there's no one in the service, and round and round we go. And that's then highlighted by there's no data collected. So, if you're not asking questions, you are not collecting data; you don't know who is in your service. So, they continue to remain invisible in the services. So, the more invisible people become, the less services they receive, the less appropriate services they receive and the less likely they are to disclose.

So again, we circle to that whole idea about cultural safety and about the environment and recognising that while no one might be out in your service, there are LGBTI people within your services. We are looking at somewhere between 9 to 11 per cent of the population. So, there are LGBTI people in your service. You need to ask yourself is why aren't they disclosing? Why aren't people identifying in my service and saying that they're LGBTI. What is it that's holding that person back? And I refer to one provider who has a Rainbow Tick who says it's about the aged care provider coming out not the person. So, it's about the provider saying "Yes, we are inclusive. We are here for LGBTI people." And then the person themselves don't have to identify because ever system within that service recognises that person and is supportive of that person.

MR GRAY: Ms Tunny, does that resonate in any way with your perspectives on the experiences.

MS TUNNY: Lots, lots and lots of parallels there. Lots and lots of parallels. I guess when an Aboriginal person goes to – if we're talking about a residential care service in particular, but, you know, all aged care services that are not provided by community-controlled organisations, they kind of triangulate the data that they see and experience. So, on your way into a service, do you see acknowledgement of traditional owners. Are there pamphlets in the waiting room that actually display Aboriginal colours. Is there artwork on the wall that is local artwork, not, you know, hey we are in Victoria but here is a picture of some artwork that was produced somewhere west of Alice Springs. But they will also then triangulate what they have heard from the communities, so a lot of people will bypass services that they have heard from community members or from Aboriginal service providers that they have heard are unsafe. They will use all of those different data sources to determine whether it is safe to disclose even if they are asked the question.

So, yes, I think, you know, many, many parallels and there has to be, I think, the very overt messaging from the service that we are respectful and we are culturally safe, multiple questions to multiple opportunities to, you know, to use Sam's phrase, come out even to one staff member and let one staff member know that they are Aboriginal because particularly in metropolitan areas up and down the coast, some Aboriginal people aren't particularly dark complexioned and will pass themselves off as being of another nationality or ethnicity if they feel a service is unsafe. And I've got a particular example of a 90-year-old lady from a very prominent Aboriginal family here in Victoria who is, you know, in her grand old age has decided it's time to go in a residential facility and she is telling her family members, "Don't let them know I'm Aboriginal, will you."

MR GRAY: Ms Patetsos, could I ask for your perspectives on this issue with regard to the interests of CALD people but also perhaps if you could lead into a discussion about data. Ms Edmonds mentioned that one of the vices of the issue not being confronted is that data doesn't get collected and you've got some very clear views in your evidence about the inadequacies of data collection including in relation to CALD people. Would you care to elaborate on those points?

MS PATETSOS: Yes. I think I agree with all that has been said about cultural safety and I reiterate again that if you cannot communicate, if you do not have a shared language with those around you, and if the mechanisms of complaint – if you are exposed or vulnerable or in fact if there is any level of abuse, if the mechanisms of complaint do not allow you to communicate or you do not have the means of communicating, then the risks for you are extraordinary. So, the safety is critical, that communication without, it doesn't really matter. I mean, if there are people – and there are people in residential facilities in particular who have no means of communicating, if something is happening to them that is unsatisfactory or in fact puts them at risk. So, we must break down that communication challenge for them and for the provider and, in fact, for the accreditation agency – Commission.

So that goes to my earlier point and I will keep on saying it until we solve that problem. I will probably – I don't know when it will stop but anyway I will keep on saying it. But in regards to data, the critical nature of data is that without it we don't know what's going on. So, it is absolutely critical that we collect data at critical points on entry, on every point that is possible. And that that data then be used. So, in the case of CALD there is some data being collected. The access to that data and use of that data becomes something that is challenging for us, but I know for the other two communities that we're talking about here, access to data is – even collecting the data is substandard. So, the critical nature of data is that if you collect it, you know what you've got. You know what you're dealing with and you know what actions you need to take. Government can be informed, as can be communities. The reason you don't collect data potentially is because you consider it to be red tape, additional red tape or an impost on you that you do not wish to bear. So – or in fact that you just don't know how to do it, which I think is the issue with the LGBTI community. There's a fear of collecting data so you just don't do it. I think that government has a responsibility to ensure that the entities that it accredits and licences to operate meet their responsibility in terms of data collection.

MR GRAY: In your first statement, perhaps if the operator just puts that up, that's exhibit 2-37, WIT.0084.0001.0001 at pages 3 and 4 there's a section identifying data gaps in particular for CALD people. You've got an issue you raise there about uncertainty in the definition, or the breadth of the definition of CALD and you speak of work that's done with the AIHW which is identifying inconsistencies and gaps in data. Has there been any remediation of those issues in the months since?

MS PATETSOS: Not to my knowledge.

MR GRAY: Ms Tunny, in your statement at page 10, paragraph 30 (b) you refer to a data issue relating to the inability to track a person through My Aged Care and you say this has implications for trying to work out how to model the responsiveness of the subsidy programs provided through My Aged Care in addressing the rates that one would expect by reference to regional characteristics and profiles of populations who need aged care. Could you elaborate on that?

MS TUNNY: Look, there's a number of issues around data collection and the one that I didn't mention there is also the lack of contextualisation of the data that is collected. So, in terms of, okay, how many Aboriginal people would you expect to access the system to start with given higher rates of dementia, given higher rates of complex care needs and health issues? So, some data is being collected. You know, we can say that numbers – even if you take out of the consideration the possibility that identifying data has not been uniformly and accurately applied and that the question hasn't been uniformly asked, there isn't, to the best of my knowledge, the capacity yet to be able to track somebody all the way through the My Aged Care system from initial registration process through their varying, you know, assessments, eligibility – you know, "Yes. You're eligible for a package", "Yes. You have a page now. You're ensconced in an actual system", in an actual, you know, service.

You know, we do know from the data that is available that Aboriginal people, when they are in receipt of a package, are overrepresented around level 2 – level 1 and level 2 of the system. And, certainly, under-represented in residential care, but there's no contextualisation as to why that might be. And, you know, I think the issues that we haven't spoken about, and maybe we'll have a chance to sum up later, around cultural safety of the actual assessment process is also difficult here.

MR GRAY: Well, you refer – on page 19 - - -

MS TUNNY: Yes.

MR GRAY: - - - paragraph 47, you, in effect, hypothesis that there are some real access issues and that Aboriginal people are, in effect, being either deterred or in some other way prohibited - - -

MS TUNNY: Yes.

MR GRAY: - - - from getting the access that equity dictates, according to their needs.

MS TUNNY: That's one thing - - -

MR GRAY: You make some suggestions there about services that should be implemented to address that point.

MS TUNNY: Yes.

MR GRAY: Would you elaborate on those, please?

MS TUNNY: Yes. Certainly. So, one of the pieces of very hard data that we do have is successive iterations of the report on government services provided by the Australian Productivity Commission. And that report, year on year, has indicated that Aboriginal people are less likely to receive an aged care assessment per eligible thousands of population by comparison to both CALD communities and comparison to the mainstream general population, and that this under-representation of recipients of assessments holds for every Australian jurisdiction and at a national level also. So, you know, that's the starting point. But even in – I expect that, you know – or I hope that we will talk about navigation services at some stage of the proceeding.

MR GRAY: Please do now.

MS TUNNY: Okay. Beaut. So, the government currently is trialling some navigation services. They are, I guess, doing a bit of a comparison in the Aboriginal context between how effective is a mainstream service trying to provide a navigation to Aboriginal people, as opposed to an Aboriginal service or trusted entity, as we call them, trying to provide that service. You know, I guess we'll have to wait for the outcomes of that evaluation process, but early indications seem to suggest that mainstream providers are having difficulty – or mainstream providers of that navigation service are having difficulty connecting with Aboriginal people. We can also say that in recent meetings of the My Aged Care advisory – gateway advisory committee, four points of disconnection were identified across My Aged Care as, I guess, cracks in the system, where people – vulnerable people might slip through.

By comparison, Aboriginal Community Services South Australia, who has received dementia and aged care grant money to, you know, pilot a system for tracking people through My Aged Care, have identified 10 points of disconnection where people might potentially fall through that system. You know, in terms of actually connecting with those people and Shepherding them through the system, you know, we have in our aged care action plan, you know, indicated that you really do need to connect with trusted entities. The more vulnerable the client, the greater the need for the trust connection to actually assist people through that system.

In addition to that, when you actually take a look at the data that is currently available, about who's sitting in what services – and I've already alluded to overrepresentation in level 2 – there are approximately 3.1 per cent of level – of home care pages are being provided to Aboriginal people. There is the tendency to way, "Well, you know, Aboriginal people, three per cent of the population, three per cent of the packages", but, once again, that overarching lack of analysis that would actually say, "Well, how many Aboriginal people should be in the system? What level of package should they be occupying?" That type of overarching analysis hasn't, you know, been implemented anywhere.

MR GRAY: Thank you. Well, just before leaving you, Ms Tunny, can I just ask about the access and support program you mention as one of the possible - - -

MS TUNNY: Okay.

MR GRAY: - - - paradigm or exemplar services in this regard. It's - - -

MS TUNNY: Certainly.

MR GRAY: - - - I understand, a program that's only available in Victoria.

MS TUNNY: Yes. The access and support program is a Victoria-specific program that used to be part of, I guess, Home and Community Care; that used to be known as HACC. Currently, it's being funded through the sector support and development funding stream provided through the Commonwealth Home Support Program by the Commonwealth. It provides 13 weeks of hands-on, face-to-face assistance for vulnerable clients. There are Aboriginal access and support workers. There are access and support workers who work in CALD community, and there are access and support workers who just work with general mainstream population experiencing difficulties.

They are not evenly distributed across the state, but they do give an example of, I guess, an in-depth linking service, which is, I guess, very similar in nature to the services that are often provided, unfunded, by Aboriginal community controlled organisations, in actually making connection with the client and brokering across a range of systems, as well as assisting the person through the aged care registration process, through the assessment process and onward into receipt of services.

MR GRAY: Thank you. A minute ago, you made a point about there not being any analysis as to whether need's being met in respect of – I think you said home care packages. Or maybe - - -

MS TUNNY: Well, the whole - - -

MR GRAY: - - - you just meant services generally.

MS TUNNY: The whole system generally, but, in particular, I guess, home care packages and at higher levels of complexity. Or complexity that meets the need.

MR GRAY: I'll ask the other panellists. Ms Edmonds, with respect to the Consumer Directed Care initiative that's been fully implemented in respect of home care packages since 2017, do you have any views on whether, and to what extent, that measure is meeting the needs of LGBTI people for home care, whether more attention needs to be given, whether there's any analysis missing? Do you have views on those topics?

MS EDMONDS: Sure. So, I guess, picking up a little bit from the previous question around data, there is no data collected on LGBTI people. We don't know how many LGBTI people there are in the country, let alone accessing aged care services. So, in terms of is CDC meeting the needs, well, we don't know, because

we don't know how many LGBTI people are receiving home care packages and what they're doing with those packages and if those packages are meeting their needs. Our discussions with elders and older people, some are finding the CDC model very effective. They're finding it very inclusive and it's certainly working for them.

But there's also others that are very much faced with – you know, we have this Consumer Directed Care model, but we can't actually, really, implement it because we're living within communities where the people around us are actually quite homophobic, biphobic or transphobic, but we have to invite them into our home to provide services, so we just – you know, we hide who we are. As I said, that, sort of, happens all the time, and we just accept what's been given to us. So, it's really – it is really hard to comment without the data collection. Without anyone asking any questions, we really don't know. And, at best, we can only guess.

MR GRAY: Ms Patetsos, with particular regard to CDC and home care packages, any comments from the perspective of the interests of the CALD community?

MS PATETSOS: Yes. I think there – I think generally there is a concern of the amount of unspent funds in CDC pointing to something that is not quite right. So, the continued accumulation of unspent funds by providers, the under-utilisation of options by consumers points to the lack of connect between what consumers' needs are assessed as and what consumers are, in fact, consuming. That, I think, will place enormous pressure on providers, the consumer, but also on government, to work out what's going on. For CALD consumers, it's particularly complex, because there could be a very serious element of them not understanding CDC and how to use it to benefit them and what it is that they can do and can't do, and what it means for them when they engage with CDC.

So, there's a very big risk that we have established a mechanism which is not working for the benefit of anyone. And if you parallel that with the under-expenditure of funds in NDIS, there's a pattern that we're seeing. And I'm not sure – I mean, it would need a very serious look at why. But I don't think we've got it right from a CALD perspective. But, more importantly, I think that – as a member of the Australian general population, I don't think we've got it right for anyone, which is a problem.

MR GRAY: Commissioner, those are the questions I have for the panel.

COMMISSIONER BRIGGS: Thank you. I am very interested in your views about whether or not the Home Support Program works more effectively for the groups you represent than home care packages or residential care. And it flows a bit, Mary, from your last comment. There's much more flexibility around how those funds are used and allocated and so on.

MS PATETSOS: I think home care – the investment in home care makes absolute sense, because people want to live in their home for as long as they can. The trick, I think, is to understand what it is to be an informed, rational consumer. To make

decisions about the way in which you expend resources, you need to have information about what it is that you need, and then make wise, rational decisions about how to spend. I think there's a disconnect between the informed rational consumer and the reality that we're facing. So, home support, home care, as an option, as a way in which we can look after ourselves as we age, relies on some really good fundamentals in terms of the consumer making wise decisions.

It also relies on the system having enough capability to respond appropriately and to provide the consumer with what they need. And for the consumer to be able to navigate the options and to understand what it is, it's very traumatic for older people to receive complex billing and it's very confronting to them to be spending money because they come from cultures where spending money is something that they should not do because at some point in the future they may need it more than they do right now. So, they're very difficult things. And I don't think it's culturally specific. I think it's a common problem that we're facing.

I think the other issue about home care – and it's one that goes beyond my particular remit at the moment, but I need to mention it, because it some way links quite clearly to CALD communities, is that there's a presumption of a carer at home. And in CALD communities, there is an issue about that, that there's an expectation or a stereotype that, you know, Greeks and Italians and Chinese all look after their family members better than Anglos and they should be able to stay at home forever because there's these mythical carers at home looking after them. The truth of it is that in our society, in the 21st century, there is no mythical woman at home looking after people constantly.

That woman has disappeared. And it's mostly women; there are some men. But the idea that there is a carer at home that can plug every hole in a care environment at home that isn't formal care is not real. And, certainly, it's not real for the general community. And it is very dangerous to think that CALD communities, because they are perceived to be family friendly, have any more numbers of women hanging around at home with nothing to do than anywhere else. So, I think home care reaches a natural end in terms of its usefulness when you consider the lack of available full-time carers who aren't in paid full-time employment.

MS TUNNY: Home care is culturally – is a culturally resonant form of care for Aboriginal people. We've done a little bit of background research that suggests that Aboriginal people are more willing to go into residential care facility if it's – if that residential care is provided by other Aboriginal people, but people want to be at home on country and in their community. And talking about the Commonwealth Home Support program particularly, yes, that flexible funding is invaluable. We have, I guess, a long tradition of Aboriginal service providers who when they finish meeting their Commonwealth Home Support designated targets spend the rest of the time that the worker has in their day making connections for referral pathways, making connections with assessors, actually identifying the most culturally safe assessor, skilling them up, introducing them to the community so that it's not an unknown face that the people are connecting with and actually getting people – and

actually those sorts of referral connections are vital work-arounds for them in dealing with My Aged Care which has, I guess, proved disastrous for Aboriginal people for a range of reasons that have been outlined to you, I'm sure, Commissioner through a range of submissions thus far.

The other thing about, you know, Commonwealth Home Support program at this point in time for, you know, Aboriginal providers that are mostly small, it actually enables them to compensate for their lack of economies of scale by providing that block of funding. But if you're also looking at the consumer, what isn't often emphasised about Aboriginal recipients of Commonwealth Home Support where there isn't always a mandatory fee or a high fee in relation to those services, it enables them to actually meet their cultural obligations to their family.

When we actually interviewed all of our Aboriginal community home providers, home support providers across Victoria and we asked them, you know, what's your views on fees, do you, you know, charge them? At the moment, most of them don't, and most of them find themselves grappling with this question because if provided with its option to pay for a service for them self or to buy footy boots for the grandkids or breakfast for the grandkids or support the adult child with a mental health or substance abuse or whatever, the older person will, you know, automatically divert their funding to those groups. And whilst that is frequently acknowledged in, I guess, very traditional and tribal areas, it's not acknowledged for metropolitan and regional dwelling Aboriginal people.

So, you know, having that flexibility where, you know, the community-controlled provider bears the brunt of the cost, they are flexible in how they can use the funding and the older people can keep most of their own home resource for the complex care relationships that they support, that works very well. In terms of – I'm sorry. Can I elaborate a little bit on the home care packages? I endorse everything that Mary said about the need for, you know, informed consumers. There is a major information deficit for Aboriginal people and even Aboriginal workers about how the system works. And in terms of social – socioeconomic capacity and in terms of numbers, Aboriginal people are never going to drive a market. They are too small a group and too, by and large, impoverished a group to actually have consumers running to them to provide for their more complex needs. So that is the conundrum we face in relation to home care packages and the delivery of those.

MS EDMONDS: And certainly, look, picking back up on what Mary said about the expectation there is a carer at home, we certainly know with our current older generation of LGBTQI people they are quite isolated. They don't have family. They've been rejected by their family. So, they can feel – even though their home is seen to be a place of safety where they can be safe, there's that fear of inviting other people into that home and what happens if that person doesn't treat them safely and then their home environment loses its sense of safety for that person. We do hear in terms of consumer directed care – you know, we have got a home care package, and here is your options you can choose from, and many people are like, "Well, why can't we choose what we need rather than this menu that might not actually suit us,

but we have to choose something from that menu, but actually we want something from this menu over here?"

And some of the things we have heard is – particularly in regional areas is, "Why can't we get home care funding and use that to skill up LGBTQI youth to come into our homes and provide us support. So that intergenerational connection and that sense of people coming into my home are people from my community and who understand my experiences and understand what I go through and what I have done, and I actually don't have to explain anything because they get it because they're from my community. And it's kind of looking at, you know, can we make home care more flexible to meet these needs and look at different ways of delivering those services that will actually be respectful of and inclusive of all people and LGBTI people.

COMMISSIONER BRIGGS: Thank you. One of the things that I've consistently found throughout this Royal Commission is the people who are within the system are trying to make it better for everyone else. It's a wonderfully generous reflection on the Australian people. I found this morning's almost two and a half hours discussion incredibly interesting, and I also found your witness statements quite helpful in terms of understanding these issues between person-centred care and care that is genuinely inclusive and respects diversity.

You've given, I think, us a lot of food for thought, and I really appreciate your appearance this morning. And it's – I must say it's good to see you again, following your help with us at the round table earlier in the year. So, Ms Edmonds, Ms Patetsos and Ms Tunny, you are excused from giving any further evidence, but I really do want to thank you for coming in today.

MS TUNNY: Thank you.

MS PATETSOS: Thank you.

<THE WITNESSES WITHDREW [12.52 pm]

COMMISSIONER BRIGGS: I think we are going to adjourn, and we will resume right on 2 o'clock, if that's okay.

ADJOURNED [12.52 pm]

RESUMED [2.01 pm]

COMMISSIONER BRIGGS: Ms Hutchins.

MS HUTCHINS: I call the next witness, Ms Samantha Sarah Jewell.

<SAMANTHA SARAH JEWELL, SWORN [2.01 pm]

<EXAMINATION-IN-CHIEF BY MS HUTCHINS

MS HUTCHINS: Your name is Samantha Sarah Jewell.

MS JEWELL: Yes.

MS HUTCHINS: And you have prepared a statement for the prehistoric.

MS JEWELL: Yes, I have.

MS HUTCHINS: Operator, please bring up WIT.0397.0001.0001. Is this a copy of your statement in front of you?

MS JEWELL: Yes, it is.

MS HUTCHINS: And do you have any amendments you wish to make to the statement?

MS JEWELL: No.

MS HUTCHINS: Are its contents true and correct to the best of your knowledge and belief?

MS JEWELL: Yes.

MS HUTCHINS: I tender the statement of Ms Samantha Sarah Jewell, dated 19 September 2019.

COMMISSIONER BRIGGS: The witness statement of Samantha Sarah Jewell dated 19 September 2019 will be exhibit 10-6.

EXHIBIT #10-6 WITNESS STATEMENT OF SAMANTHA SARAH JEWELL DATED 19/09/2019

MS HUTCHINS: Ms Jewell, you are currently employed as an Executive Manager, Sales and Marketing at Lifeview Residential Care. Is that correct?

MS JEWELL: Yes.

MS HUTCHINS: And what does that role involve?

MS JEWELL: So that role oversees all sales and admissions as well as all the marketing, but it also encompasses our Pride Portfolio. So – and guiding a team of Pride Champions within the business and just ensuring that we are across our community connections, our education and our training.

MS HUTCHINS: Excellent. And so Lifeview has four residential aged care facilities across Melbourne south-east suburbs. Is that right?

MS JEWELL: Yes.

MS HUTCHINS: And what's the model of care that's implemented in your facilities?

MS JEWELL: So, we have a modified small house model of care. It's based on relationship model non-institutionalised, and we call it home to home.

MS HUTCHINS: And what are the key features of that home to moment model of care?

MS JEWELL: Well, basically, that model of care is set up by residents for what the residents want to do. So, we run neighbourhood. So, we turned smaller homes, our homes, into smaller neighbourhoods within them. So, we took the traditional nursing home model and turned it into the smaller home model. So, we have built them into neighbourhood. So, residents live and eat within a neighbourhood, but they come together in the larger areas for functions and things like that. So, they have dedicated carers in those neighbourhoods as well. So, we only deal with two or three carers maybe on a shift as opposed to up to 20. We don't use agency staff. So, they're always there, and they can build special relationships between them. The residents know who they can trust, and staff get to know the residents a lot better on a different level. So yes, that's the basis of it. There's lots of elements to it, such as the residents design the menu with the chefs, and then when they eat in their smaller dining areas, staff join them for that meal, just like you would at home.

MS HUTCHINS: And what do you see to be the benefits of this model compared to the more traditional model that we see in the home pride 2016?

MS JEWELL: Okay. So, to start with, it's not as big and scary as a normal nursing home, but you're also based in your neighbourhood with people you know and trust. We see the residents helping other residents where they want to where they can. So, at breakfast, it's a system of people rise when they want. They're not all woken up at 6am to be given meds and be showered and, you know, into the dining room. So, if I traditionally sleep in, then I will continue to sleep in, and when I'm ready I get up, and I put on my pyjamas, and I will go to the kitchen to get my breakfast. If I'm not

capable of doing that, of course, there is assistance because that's what we are there for. But then there are other residents that also step up because they like to assist and help. So, we have one resident who always makes the ladies at his table their cups of tea in the morning, and that to him, also is important because he is continuing to give back. We have other residents who deliver the mail, some who fold the sheets. So, it's a home environment, and it's a more normalised environment.

MS HUTCHINS: And in your statement, you make reference to an initiative known as Nothing About Me Without Me. What is that initiative?

MS JEWELL: So basically, that's based around the new standards, but the resident tells us what they want. So, we have a shared decision-making. So, we will sit with that resident and see what it is that they're trying to achieve. And it's about also what the resident wants. It's not about what the staff might want for that resident. It's not about what the family might want for that resident. It is actually about what that resident would like to do. As an example, we have a resident who is living with dementia. He likes to walk around the home and also the home's gardens which are secure. But the family had real concerns. They didn't want him to go outside and continue to walk around in that garden. But to take that away from him would cause him distress because that's what he likes to do. He's not very verbal in communicating, but that gave him pleasure and made him happy during the day. So, we had to sit with the family and discuss those options with the family, that this is what's right for this resident, this is what this resident wants, and that's what it's based about.

MS HUTCHINS: And Lifeview currently holds a Rainbow Tick accreditation. I would like to ask you a series of questions about that accreditation. Firstly, starting for those that don't know, would you be able to provide a bit of an explanation about what the Rainbow Tick accreditation is.

MS JEWELL: Yes, Rainbow Tick accreditation is a series of – what am I going to call them – it's a set of standards that have to be met. It's run by QIP, Quality Improvement Performance. So, it sits outside of aged care, and any business or company can go for Rainbow Tick to prove that they are inclusive, and they are safe and that they have met all of these standards.

MS HUTCHINS: And why was this accreditation sought by Lifeview?

MS JEWELL: Look, we did know that we had some residents who identified as being from the LGBTQI community, but we also have personal experience of our CEO. She lost a very close friend who was from that community, but also during that troublesome time in her life, there was – she saw that there was gaps. And we are actually in a position to change something. So, she discussed that with our director and with the rest of the executive team, and everybody was on board to go for this accreditation and to make change within the industry.

MS HUTCHINS: What do you understand to be the particular needs of LGBTI people in their interactions with the aged care service environment?

MS JEWELL: So basically, what they're looking for is they're looking for somewhere where they are accepted for who they are, that they're respected, that their family and their chosen family are also accepted and respected, but then they're giving their support, just as we give all our residents, but the support they need but it might be tailored to them. So, it's really about yes, acceptance, respect and the dignity.

MS HUTCHINS: Yes. And as a consequence of going through the process of becoming accredited, did that require any changes to the service delivery that was in existence prior to the Rainbow Tick accreditation process?

MS JEWELL: Yes. We made quite a few changes. So, through the accreditation process, you know, we learnt a lot about ourselves, but we also learnt a lot about the community and what they were looking for and how to meet their needs. So, it was a lot of staff training. So, everybody in the organisation from director down underwent specialist training. That's ongoing. Every year, we retake some of our training. We looked at all our literature. We looked at all our systems and processes just to ensure that we had language right. We ensure that everybody is covered. And the biggest thing is that we ensure that people's privacy and dignity is respected.

MS HUTCHINS: And you mentioned earlier that you have a pride committee.

MS JEWELL: Yes.

MS HUTCHINS: What does that committee do?

MS HUTCHINS: So, we have a committee of Pride Champions. So, they're out there in our homes. They're on the floor every day. They wear a badge. So, people know that that – if they have something that they want to say or to speak up, that's somebody they can go to who is trusted and trained. They also look out for everybody's rights and ensure that they're being treated with the utmost respect and dignity. But they also work on other fun things. So, it might be getting guest speakers in from that community to ensure residents are connected to their community. Or participating in the pride march to show that as a business, we fully support the LGBTQI community.

MS HUTCHINS: And in your statement, you note that changes to staff recruitment and education as part of this accreditation process has seen better outcomes. What are the types of changes that were made to recruitment and education?

MS JEWELL: Well, the first thing we have is all of our materials including our job ads and website, etcetera. They all have a statement on that shows very clearly that we are inclusive, and we welcome from people from all backgrounds including those from the LGBTQI community. So, people are aware that is our standard straight up.

We then, at interview, run through a series of questions based around acceptance and inclusivity and respect, and we just see how they are answered, and then we go on to training.

MS HUTCHINS: And what's the type of training that you offer in this area?

MS JEWELL: So, we have face-to-face training. So, we use local resources Transgender Victoria, Val's Café and others, the LGBTI Health Alliance to come in and train our staff face-to-face, and that can be some quite confronting training, especially when we hear some of the lived experience, and it makes people really, you know, open their eyes and note what has gone on in the past. Then there's online training, and then there's – each day, we have staff on the floor who are continually mentoring and assisting staff should they run into any troubles, and then there are toolbox sessions if there's needed for a clinical issue.

MS HUTCHINS: Yes. And what are some of the other measures that you've put into place at your facilities to try to create an inclusive or open environment for LGBTQI community members?

MS JEWELL: Okay. So, we do have a lot of elements from – we run pride circles. So that's twice a month activity where residents who are interested can get together in a safe space and discuss issues pertinent to LGBTQI community, being that for themselves or their children or their grandchildren or something of a topic. When the marriage debate was going on, that was, you know, highly talked about and different things like that. So that's a safe space. And they might also have a guest speaker come in from the out and about service which is run here in Victoria which is a volunteer service. We have a pride notice board. So, there's always articles and information up there that residents, family, staff, can access. We have our Pride Press, which is a bimonthly newsletter which goes out with relevant articles in and new movies that are coming out and book reviews all from the LGBTQI community.

We participate in the Pride march, as I've mentioned before. We also head out to the Midsumma Festival, which is held here in Victoria, and we have a stand, and we work with the local community, if they want to come and ask us any questions about aged care, about accessing aged care, you know, just help them navigate the system. We've also recently just signed on as a foundation partner of the Victorian Pride Centre which will be the first in Australia of that type of building and community will be able to come together there for their information, etcetera. And we, through that, hope to assist more LGBTQI elders to access aged care, appropriate aged care and just help them through the system. That doesn't mean that they will come to us, but it is to help them through the system and to, you know – because people from the LGBTQI community don't access aged care because of that fear and past prejudice, it's about breaking down those barriers.

MS HUTCHINS: Yes, and as part of that work, have you heard any feedback from LGBTI community members about difficulties they might have in using the My

Aged Care platform and whether they would like to see any particular improvements in that regard?

MS JEWELL: Look, the My Aged Care platform is quite difficult for most people, not just people from that community. My issue with the platform is that any provider can tick the box in the back end that states they are LGBTQI inclusive. There is no checks and balances on that. So, when they're searching, and they think they've found somewhere that is inclusive, that may not be the case.

MS HUTCHINS: So, what do you think would be an appropriate check or balance to put in place in that regard?

MS JEWELL: Well, there needs to be some auditing of what companies put on the My Aged Care website to start with, and I think the box should possibly read, "We have Rainbow Tick accreditation".

MS HUTCHINS: So, in terms of understanding your residents, what type of measures does Lifeview take to endeavour to understand whether someone entering your facility comes from a diverse background or has life experience that may impact upon the care that they need?

MS JEWELL: Okay. Well, when a new resident comes to us, there's a lot, as you walk in you will see the big Rainbow Tick and a lot of literature about the home is on display and it is prior to them coming to us, whether they tour or their family tours prior, it is made quite clear to them that we are Rainbow Tick accredited and we are accepting of all people and that if that's not right for somebody, then normally they won't come to us anyway. There's a lot of choice out there and that's one of the choices that they can make. But then due to privacy and dignity and because a lot of discrimination people have faced in the past, we don't ask "are you from the LGBTI community" but it is something that we are looking at as to whether we should ask that and how do we ask that. Because we believe people, once they're can see they are safe with us and they can trust us, then if they would like to disclose they can. Then they have a choice as to who they disclose to, whether they disclose to the clinical team or whether they disclose to the whole home.

MS HUTCHINS: In instances where you do have a new resident come and disclose that they may identify as a member of the LGBTI community, what are the types of practical measures that you might put in place to assist that person? If it's helpful please feel free to use an example of a resident that you may have.

MS JEWELL: Yes, so we would work with that resident as to, you know, like I said, who do they want to disclose to. And if they are open about it and happy with that, we will work on a number of measures. We cared for a transgender lady who had previously had home care and she was quite discriminated to through that home care. A lot of the staff that would come and care for her would say, "But you're a male, you're not a female" and that was quite disturbing to her. A lot of her paperwork used to come in her former male name even though she had changed her

name quite a few years ago; there was no recognition of that. So, once she came to us, when she walked through that door with us, she was female, and she was treated like a woman, like a lady for the whole time she lived with us because that was who she was.

One other reason she came to us is because we are also pet friendly, so she could bring her cat which was very important to her. So, we look at what's important to residents, but unfortunately the paperwork that came with that was written in her former name and it made her feel ashamed. So, while she lived with us it was very important for her for her hair and make-up and presentation. So, it did take a lot longer to assist her to get ready most days than others who don't need as much assistance, but we were prepared to put that time in. It could take up to an hour to get her ready every morning. And also, one other thing that was really important to her was that she was shaved perfectly, because that was part of who she was as being a female. It wasn't having facial hair. We also reconnected her with her community. So, we used the visitors scheme, the out and about visitors scheme, and she had a volunteer who would come and visit her, take her on outings, be her buddy and confidante for whatever she needed. So, we made sure she facilitated those things, and she also attended the coming back out ball with some of our other residents and staff.

MS HUTCHINS: What has been your experience more broadly with the visitors scheme?

MS JEWELL: The visitors scheme here in Victoria, that's the only one I can comment on, but it's a really fabulous scheme. They've got some lovely people who they partner each of our residents who would like a visitor up with. They look at their interests and, you know, just get them a general partnership. But it is a fabulous scheme. It is voluntary. And I know that it relies on funding. So, we use them wherever we can.

MS HUTCHINS: Do you find that there's enough volunteers to meet the demand for visitors to visit your residents?

MS JEWELL: Yes, we haven't run into any trouble with it.

MS HUTCHINS: Yes. Now, Lifeview has plans to build a residential aged care in Prahran which is described in your statement as intended to be LGBTI elders and friends aged care community, and the Commission understand that Lifeview has been successful in obtaining 120 special needs places for LGBTI persons at this facility; is that correct?

MS JEWELL: Yes. Yes.

MS HUTCHINS: And we when like to understand what the vision is for this facility; would you describe it as being a specialist facility for the LGBTI community?

MS JEWELL: The vision is that we're building a home in the community in which the LGBTI people live. So, it's specialist in the fact that it is in their community, but it's – that community also, it's not everybody that lives in Pahran or the surrounding suburbs is from the LGBTI community but that's where they currently live. So, you shouldn't have to move to the country to go to a facility that recognises you. But it will also have specialist services because there are a lot in that area already. There are a lot of medical practitioners, etcetera, who work within that community. So, they're not being ripped out of their community. It's ageing in place where they currently live. So, it's just a need for a service there.

MS HUTCHINS: Yes. So, did you specifically look to see where there was a need for an LGBTI say focused facility when deciding to build a facility there or - - -

MS JEWELL: Yes, so we need to build a facility where that community lives and that's very important to them, and to us. Because with all of our homes we know people don't really travel very far to go into a care. It's usually within the 10-kilometre radius.

MS HUTCHINS: Do you think specialist facilities are more desirable for people from various diverse groups?

MS JEWELL: I don't know about the other diverse groups because that's not something we really focus on. But this one is "and friends", so we are not saying just because you live there, your friends or your chosen family can't also live there. It's about remaining in that community in which you live in.

MS HUTCHINS: Yes. And do you think that that would provide more desirable outcomes for residents and their friends than, say, a more main stream provider that may be might not have as greater emphasis as you do?

MS JEWELL: Yes, I am sure it will because, you know, if I was going into care and I knew my family and friends were close by and that I was also respected, trusted and my dignity was remain, then yes. And that's what we aim to - - -

MS HUTCHINS: And are you familiar with the LGBTI action plan that has been made under the Aged Care Diversity Framework?

MS JEWELL: Yes.

MS HUTCHINS: What do you understand to be the purpose of the action plan?

MS JEWELL: From my perspective, it's more sort of a guidance, a nice to have document for providers to look at if they're looking to become inclusive and to improve on their inclusivity.

MS HUTCHINS: Yes, and do you think that it's an effective tool to encourage providers to take steps in relation to LGBTI initiatives?

MS JEWELL: Not really. It's – there's nothing to it that says it needs to be implemented. So, until it comes with some kind of accreditation or some kind of checks and balances, it really just is another document.

MS HUTCHINS: And in your witness statement, you say that by undertaking and maintaining the rainbow tick accreditation you feel that Lifeview has surpassed the LGBTI action plan. Would you be able to explain a bit further why it is that you hold that view?

MS JEWELL: Okay. So, the action plan has three levels of outcomes. I think the top one is exceeding. So, it has three levels, and if we go through those levels and look at what they're asking you to do and achieve and then comparing them with everything we did to get and maintain our Rainbow Tick, we quite clearly can demonstrate that we have, you know, achieved more than what is being asked there.

MS HUTCHINS: And in relation to the new quality standards, standard 1 sub(3)(b) requires providers to provide culturally sensitive care. What do you understand that term to mean?

MS JEWELL: So that's understanding each resident, what their needs are, showing them respect, protecting their dignity and delivering care services that meet their individual needs.

MS HUTCHINS: And I understand that Lifeview has been the subject of an assessment by the Aged Care Quality and Safety Commission since the introduction of this new standard. What observations can you make about the assessment process on that occasion and, in particular, how compliance with this standard was measured?

MS JEWELL: Okay. So, the new – yes, we were assessed very early on in July and it's great that the assessors now want to speak more to residents to see that outcomes are being achieved. But on this occasion, under that standard that you highlight, we had provided all the written literature and the self-assessment, but we felt that it wasn't checked upon. So, they took what we had written as being enough. Whereas, it would have been great from our perspective and to confirm what we were doing if they had spoken to a couple of residents who may attend the marigold circles or who may have openly identified as LGBTI, just to check what we were saying. So rather than just taking what is in writing and saying yes, and you've got Rainbow tick so yes, you've ticked that point, we would like to see a few more checks and balances.

MS HUTCHINS: What do you think would have been – sorry, no, I withdraw that question. At paragraph 43 of your statement, you suggest a number of potential systemic reforms that you say may go towards improving the quality of safety of aged care services provided to people with diverse characteristics and life experiences. I would like to take the opportunity now to work through a number of these with you. Before we start going to a number of them in turn, are there any in

particular that you would like to highlight as being of particular importance to the Commission?

MS JEWELL: Well, I think the most important is the improved training of carers, personal care workers. From our perspective and my perspective, the certificate is not in depth enough. There needs to be more training in dementia care and care for LGBTI elders and the on-the-job training is only 120 hours. It doesn't seem to be enough.

MS HUTCHINS: Yes.

MS JEWELL: People are very green when they come out.

MS HUTCHINS: And what's the type of further training that you think is necessary in relation to LGBTI?

MS JEWELL: There's a lot of training that can be done around intimacy and sexuality. There's a lot of training even just around privacy and dignity and caring for people with special needs such as the transgender community.

MS HUTCHINS: And the next suggestion that you make is that carers should be required to be registered and have a requirement for continuous professional development. What are the shortcomings that you see with the current lack of registration?

MS JEWELL: So, if a carer has worked for a previous employer and they've been let go for something, we have no way of checking that. And there are a lot of carers who work two or three jobs, and we don't know that they're actually up to standard. We get a lot of carers come to work for us and we, for better term we put them through un-training. So, what they've learnt more institutionalised training, we put them through un-training so they get to know the resident, get to know what the resident would like. It's not all about these are my tasks for the day and I have to do it. So, it's not task-oriented. We try to un-train them from that training as soon as possible.

MS HUTCHINS: Yes. And in terms of requirements for continuous professional development, what would you think is appropriate for some, I guess, minimum standards in that regard?

MS JEWELL: I don't really work in the HR space. So, but I would like to see more hours on the floor prior to coming to us, more specific dementia training. That's really relevant. We put our staff through a lot of dementia training, but a lot of them haven't had any training by the time they finish their short degree.

MS HUTCHINS: Yes. And in terms of the current funding system, do you think it incentivises good outcomes for residents?

MS JEWELL: No. I don't. I think the current funding system is looking at unwellness. So, the sicker a resident is, of course, the more funding that is tied to that resident. There's not a lot of funding tied to social activities and social wellness, mindfulness – you know, just resident wellbeing. We'd like to see, you know, more funding towards that. We offer a very extensive social program for our residents. But – and we can do it because our staff are creative and they know the residents and know what the residents would like to do. But there is no funding tied to it and, you know, one day we won't be able to do that until they look at the resident wellness.

MS HUTCHINS: Operator, if you'd please pull out subparagraph (e), which is, "Change to a merit system". Could you please explain what's the issue with the current system which this suggested change is going towards?

MS JEWELL: So, following accreditation, if you pass, the current system just says, "Met". Everybody gets "Met". But we would like to see something like, "Exceeded standards", or, you know, "Exceptional in this area", something that sets the people apart – who are going that extra mile, doing everything they can to improve the lives of those entrusted into their care, rather just be all lumped in the one lump sum of "Met".

MS HUTCHINS: Thank you. And in terms of the next two suggestions which relate to the quality of assessors in terms of the training of the assessors themselves and the assessment process, what are some observations you've made about the quality of, I guess, the skill base of the assessors themselves that you think requires some attention?

MS JEWELL: From the assessors who have been to our homes, we don't see many from multicultural backgrounds. So, we'd like to see a bit more of a mix of assessors coming from those backgrounds. We'd also like to see assessors coming from other industries, where they've got different learnings and different approaches to what we do, because at the moment aged care is, sort of, stuck and the same people are being recycled through the assessors. And they don't come with a lot of innovation thoughts or look at different ways that things can be done. It's – unfortunately, it's the same people doing the same job, year on year, and it would just be nice to inject some newness into there, some new thinking, some new talents.

MS HUTCHINS: Yes. And what is, I guess, the main direction that you would like to see the new thinking heading towards, as opposed to the current state of affairs?

MS JEWELL: We'd like to see innovation rewarded and not so tied to having to do things a certain way. So, we like to do things that are right for the resident, and that's not always achievable when you've got so many rules and regulations. So, yes, for that. And it's about, also, some more diversity training for the whole industry, and especially the assessors and the agency.

MS HUTCHINS: Yes. And your suggestion at subparagraph (h) refers to navigating the system. What observations could you make in relation to the current state of affairs, in this regard?

MS JEWELL: Well, for the LGBTI community, navigating the system is really hard. People – if they don't have documents in their current name, it makes it hard. Chosen family aren't always accepted, but they are their family and we have to accept them. And that's their choice, because quite often their previous family don't want anything to do with them. And then they've also got a history of discrimination, that they're afraid to come into care. They're afraid to even pick up the phone because what it means – that they have to reveal to get to that point. So, there are some assistance out there and there are supports, such as Val's Café, etcetera, that – they continually need to be funded to be able to assist this community, to access what they deserve.

MS HUTCHINS: Yes. And at subparagraph (i), you point to a need for widespread, national, proactive community education and promotion from the government. What are the types of things that you outline here that you think are important for the community more generally to be aware of?

MS JEWELL: That aged care is accessible for everybody. But I think the other thing that is part of education is that aged cares are not hospitals. So, we can only provide up to a certain level of care. We are not a hospital. We don't have the hospital funding. We don't operate under a hospital environment. So that's part of that education as well. But there's also education around services available to specific community needs. So, if it is LGBTI-specific or – and friends, then that needs to be pointed out. There are, you know, your ethno-specific homes and those types of things. So, there is a place for everybody, but it really needs to be communicated better.

MS HUTCHINS: Certainly. Thank you. And are you able to, please, explain for the Commission what Lifeview's experience has been in applying for residential aged care for people with special needs, particularly LGBTI, older Australians through the Aged Care Approvals Round?

MS JEWELL: Okay. So, as you mentioned, we were successful in applying for our licences for our Prahran home. We have also previously applied for some additional licences in a suburb, Emerald, which is up in the hills, here in Victoria. We believe that we demonstrate that we do care for LGBTI people and we can care for them, as well as peoples from financially-disadvantaged backgrounds and those living with dementia. We have been unsuccessful in obtaining any of those licences.

MS HUTCHINS: And do you understand why that is?

MS JEWELL: Not specifically to our case. We understand that there's only so many licences that are given out each year and that we weren't within the area that the government was looking at the time.

MS HUTCHINS: And - - -

COMMISSIONER BRIGGS: Might I ask, when the licences were given out, did they go to other providers with a Rainbow Tick?

MS JEWELL: There were licences in that round who went to providers without the Rainbow Tick. Yes.

MS HUTCHINS: Thank you, Commissioner. We have no further questions.

COMMISSIONER BRIGGS: Okay. Well, I might ask you a couple more things. This morning, we heard evidence around this area as well, so you might have heard some of that. I'm interested in the extent of LGBTI-appropriate home care services and whether you're familiar with a range of those services?

MS JEWELL: We don't operate in the home care - - -

COMMISSIONER BRIGGS: No.

MS JEWELL: - - - space. So, I'm not really across that. Sorry.

COMMISSIONER BRIGGS: So, there does seem to be a bit of a gap in those services, although at the round table we were aware of a number existing. I want to ask you another question, and it flows from both your witness statement and your evidence. It appears that you did quite a lot to give joy for people, and we haven't heard enough about that. And something I've been pondering over is do you get joy in going out from residential care or do you get joy with others coming in and visiting you, which is kind of a bit like the institutional model we're familiar with, or can you do better at both? And your evidence is you can do better at both, but can you talk to me at that, kind of, philosophical level?

MS JEWELL: So, our activities and bringing joy to residents is based on what that resident would like to do, whether that's go across the road for coffee or whether it's go to the movies. So, we have a program called Magic Moments. And each resident, each year, gets a magic moment. It's like a bucket list, but it's not all jumping out of planes and things like that. They can be quite simple things, such as bringing in a Chinese takeaway for that resident, or it can be – we had a gentleman who loved Batman, so we hired the Batmobile. And Batman came and drove him around the suburb for half an hour, and you couldn't wipe the smile off his face.

So, it'll depend on those things. And we do have – a lot of entertainment comes into the home, because there are people who can no longer, really, access the community easily, and then there are others who still love to go to their bingo or their bowls every week, and we make sure that that can happen for them. So, I think it is really driven by that is that resident's wish and what has been their life experience and where do they want to remain connected.

COMMISSIONER BRIGGS: And the other residents in your, at least, existing homes that predated you getting the Rainbow Tick, how do they feel about the combination of the different groups?

MS JEWELL: Before we went on the Rainbow Tick journey, we spoke to all of our residents and said, "Look, this is something we're looking to do. Are you on board?" And we did not have one resident say no. They were over joyed to do it. They – the main thing that we got back was, "We like living here, so why shouldn't everybody get the chance to live here and safely?" And since that journey, we've had residents who do identify actually feeling comfortable enough to come out; not just to staff, but to other residents, and they're celebrated for who they are. So, we haven't had anybody, you know, really, say this is not the right thing to do. And we thought that may have been the case, given, you know, the age and those – of our residents, but we've never had one complain about it.

COMMISSIONER BRIGGS: Okay. But your evidence does suggest that staff need particular training - - -

MS JEWELL: Yes.

COMMISSIONER BRIGGS: - - - to deal with this. So, there's a cultural issue here or some kind of social issue. Why is that?

MS JEWELL: Staff need some training in things, some things that they've never been exposed to. So, you know, you don't want staff pulling back the sheets, going to give somebody a bath and finding out they're not who they thought they were. So, it's about, you know, training them and having that mindset of how to deal with those situations and knowing those residents. But we also – in society, there are a lot of people who just aren't exposed or aren't accepting of everybody. So, we also work with our staff and – "Look, unfortunately, if that's not your mindset and you can't check that at the door and when you come through this door you are open to everything and accepting of everybody, then maybe we're not the employer for you."

And that's just, really, much – we have to put a line in the sand and say to people, "This is it." We provide the ongoing training. We provide counselling, should they need it. But we haven't really had too much of an issue. We've even had staff who now have come out themselves or have children from the LGBTI community who they're just so proud to be able to talk about now. And the same with the residents; they're very proud if they have an LGBTI-identifying grandson or daughter – you know, that they previous – didn't feel that in their social circles they could talk about them that much because of a social stigma. But they don't feel that any more. Now they're proud of who their family are.

COMMISSIONER BRIGGS: And is there any sign of any desire from either the lesbian or the male homosexual community to live separately from one or the other?

MS JEWELL: Yes, we did undertake some research with the community prior to announcing our build plans for Prahran. And some of that came back – yes, some lesbians would like their own wing, some others would like their own wing, but others want to just live as part of a wider community. So, it is a juggle about everybody's wants and needs, but I think at the – when it happens, it's at the time of who comes in and what they want. At this point in time, our residents can select if they want a male or a female carer attending to them as well. So, there is that within the home. But we don't have specific communities of only lesbians here at this point in time.

COMMISSIONER BRIGGS: Do you have any further questions?

MS HUTCHINS: Nothing arising, Commissioner.

COMMISSIONER BRIGGS: Okay. Ms Jewell, thank you. It has been very interesting hearing from you today about hearing what is possible. If – you're convicted to delivering a service suited to the group you want to serve. So that's very good and we appreciate very much your evidence here today and you are excused from giving further evidence.

MS JEWELL: Thank you very much.

<THE WITNESS WITHDREW [2.45 pm]

MS HUTCHINS: Ms Bergin will call the next witness.

MS BERGIN: I call Fiona York.

<FIONA June YORK, AFFIRMED [2.46 pm]

<EXAMINATION BY MS BERGIN

COMMISSIONER BRIGGS: Ms Bergin.

MS BERGIN: Your full name is Fiona June York.

MS YORK: Yes.

MS BERGIN: Have you prepared a statement for the Royal Commission, Ms York?

MS YORK: Yes.

MS BERGIN: Operator, could you please bring up document WIT.0398.0001.0001. Is there a copy of your statement in front of you, Ms York?

MS YORK: Yes.

MS BERGIN: Could you please turn the pages and identify that it's a true copy.

MS YORK: Yes.

MS BERGIN: Do you have any amendments to your statement?

MS YORK: No.

MS BERGIN: And is it true and correct to the best of your information and belief?

MS YORK: Yes.

MS BERGIN: I tender the statement of Fiona June York dated 23 September 2019.

COMMISSIONER BRIGGS: The witness statement of Fiona June York of 20 September 2019 will be exhibit 10-7.

EXHIBIT #10-7 WITNESS STATEMENT OF FIONA JUNE YORK DATED 20/09/2019

MS BERGIN: Ms York, could you please tell the Commission what Housing for the Aged Action Group does generally?

MS YORK: Okay. Housing for the Aged Action Group is a community group that started about 35 years ago by a group of older women, tenants who wanted to advocate for housing justice. Since that time, we've grown quite considerably and are now delivering services. Our main service is the Home at Last Program which is funded partly through the Commonwealth Homes assistance with housing and that program is providing housing information to people aged 50 plus who are experiencing homelessness or at risk of homelessness. Since around 2013 we've housed 900-odd people in long-term secure housing and we also provide supports for those people once they've moved. So, we're not actually housing providers ourselves but we do try and link people in with appropriate housing.

The other part of that service is the retirement housing service which is funded through Consumer Affairs Victoria and that provides information and advocacy for people who are living in retirement housing or considering moving into it and we also support around 300 people a year through that as well. We have an early intervention approach and so that involves trying to reach older people through community education and through professional education of different providers to

recognise when people are at risk of homelessness and intervene before they end up at that crisis point. So, we specifically targets culturally diverse communities and we are now moving into the LGBTI space as well. And as a result of our culturally diverse project we now have around 60 per cent of our clients are from a CALD background. Three-quarters of our home support staff are bilingual and we use interpreters every day, so we are very cognisant of what you need to be able to do to access those communities.

The other big part of your work is a partnership with Adelaide University and it's looking at the data around housing and homelessness and people at risk of homelessness, particularly aged 50 plus and that's moving around State to State at the moment, producing reports on what the ABS statistics and what the Centrelink data is saying about the housing situation for older people.

MS BERGIN: Ms York, what's your position at HA?

MS YORK: I'm the executive officer.

MS BERGIN: And has HAAG been involved with the diversity subgroup of the Aged Care Sector Committee in preparing the draft homelessness action plan?

MS YORK: Yes, we were commissioned in around December last year to develop the homelessness action plan and we now sit on that diversity subgroup.

MS BERGIN: And in the market or in the NGO world, is it fair to say that HAAG is in a unique position in that you straddle the aged care sector as well as the homelessness sector?

MS YORK: Yes, there's not many specialist older people's housing services and we are the only one of this type. There's other services like Wintringham that provide housing but for us we are a housing information service, and so what we found is that we sit in a position where we have one foot in the aged care space and one foot in the housing and homelessness space. And housing and homelessness as a sector is generally focused on family violence and younger people and doesn't necessarily have a big focus on older people. And also, the aged care sector isn't necessarily across housing and homelessness and understands that it's not the first thing they think of when they're interacting with older people. So, yes, we do sit in both spheres.

MS BERGIN: You personally sit on the diversity subcommittee of the Aged Care Sector Committee; is that right?

MS YORK: Yes.

MS BERGIN: Now, I want to turn to the topic firstly of what homelessness and at risk of homelessness means. What would be HAAG definition of at risk of homelessness?

MS YORK: So, for us, when we were developing the homelessness action plan we were using Bureau of Statistics definition which is slightly broader and - - -

MS BERGIN: I'll just bring that up for you, Ms York.

MS YORK: Sure. Yes.

MS BERGIN: Operator, if you please bring up RCD.9999.0212.0001 and turn to page 7.

MS YORK: Yes. So - - -

MS BERGIN: If you could zoom in please operator under the line in brief the ABS statistical definition is. So, at about point 25 if you could zoom into those first two paragraphs and bring them up. Please continue, Ms York.

MS YORK: So, I guess what springs to mind when people think of homelessness is what is called rough sleepers, which are people living in parks and in their cars and things like that, and that is certainly a definition; any homelessness definition should clue that, but it also includes people that don't necessarily have adequate or safe or secure housing. So, for us that includes people that may be not only living in their cars but living in temporary housing like hotels or boarding rooms, living in inadequate housing like caravans but also couch surfing, staying with friends and family longer than they need to or want to because they don't have a choice and also living in poor quality or unaffordable private rental. So for an older person that is perhaps living in a house where they have no control over that environment because they need to ask the landlord permission in order to install ramps and rails or get a stepless bath or the doors are too narrow for them to be able to access if they are using a wheelie-walker, etcetera, these are all issues that are in private rental and if they're paying 85, 90 per cent income on their rent it's unaffordable. So, our definition of homelessness and at risk of homelessness encompasses that group of people as well.

MS BERGIN: So, in your explanation, that second dot point when a person has no tenure or if this initial tenure is short and not extendable - - -

MS YORK: Yes.

MS BERGIN: Where does that concept sit in the rental market in say Victoria?

MS YORK: Every State has different legislation that governs residential tenancies. In Victoria there has been some recent reforms to that which – some of which are already in place and some are due to be implemented next year but, really, if someone can be evicted from their home with, you know, six weeks, eight weeks, even, you know, three months' notice, or they're on – there needs to be a good reason to evict those people, so no-reason notices to vacate, that's not secure tenure and unfortunately that's the case across many jurisdictions in the country. And

we've advocated along with a lot of other tenant advocate groups that we get to get rid of no-reason notices to vacate and we need to offer longer term leases and also allow – you know, allow modifications to the home to allow people to age in place.

MS BERGIN: Thank you. I should have mentioned at the start that there's no definition of homelessness or at risk of homelessness in the Aged Care Act.

MS YORK: Yes.

MS BERGIN: It's a term that's used in section 11-3 of the definition of special needs. There is legislative definition both at a Commonwealth level and a State level and I will just bring that up. Operator, if you could please bring up RCD.9999.0216.0002. This is the definition taken from the Supported Accommodation Assistance Act. What comment would you make about this definition, Ms York? Is it consistent with the HAAG definition?

MS YORK: Yes, it's broadly consistent. I guess, for us it is safe, secure and affordable. If you have safe, secure and affordable housing, then you're not homeless and not at risk of homelessness. And that definition does mention safe and secure and affordable, so yes, it does encompass. It's around security of tenure. So, when we say security we are not necessarily talking about dead locks on the door or that type of security; we are talking about security of tenure and that's a really fundamental thing to acknowledge when we're talking about older people ageing in place.

MS BERGIN: So, in paragraph (d), for example:

> *A person is taken to have inadequate access to safe and secure housing and therefore meet the definition cross-referenced from paragraph 1 if the only housing to which the person has access places the person in circumstances which threaten or adversely affect the adequacy, safety, security and affordability of that housing.*

So, in the Commonwealth definition, security of tenure is only one element of four, if you like.

MS YORK: Yes.

MS BERGIN: All of which must be met for a person to be classed as homeless.

MS YORK: Yes.

MS BERGIN: Is it your position that that is too broad or not sufficiently broad?

MS YORK: I think it needs to be all of those things. It needs to be affordable, safe and secure. So, if any of those elements don't exist, then the person is potentially at risk of homelessness, if not homeless.

MS BERGIN: I see. So, you would say if the person is in circumstances where the adequacy or safety or security or affordability of their housing is threatened, then they're at risk of homelessness; is that right?

MS YORK: Correct.

MS BERGIN: So, you would advocate for a broader definition.

MS YORK: Yes.

MS BERGIN: Thank you, Ms York. Now, why is the definition of homelessness and risk of homelessness important?

MS YORK: I think it's around perception of what is homeless and it's partly driven through, I guess, popular media depictions of what homelessness is. And I think that if you're – a lot of our clientele are older women, in particular, who have worked their whole lives in low paid jobs and are finding themselves struggling to pay the rent when they're in their late 50s, early 60s and even 70s and those women would probably not see themselves as at risk of homelessness and the service providers wouldn't either. And so that means if you're providing a service – if you're trying to get help for their person and they're not a self-identifying and you're identifying as a worker, then that's an issue in terms of their health and wellbeing in the long-term.

MS BERGIN: What risk to ageing in place does homelessness present?

MS YORK: So, over the last, I don't know however many years, there has been a focus on being able to provide as much support in the home to allow people to stay in the home as long as they can to prevent premature entry into residential care and these days the percentage of people in residential care is quite small compared to the overall older population. That's all predicated on an assumption that somebody owns their own home and has safe housing. It's very difficult to be able to provide home care in the home, whether it's Commonwealth Home Support or a home care package, if that housing is inappropriate, insecure, unaffordable. So, it really is an underpinning assumption.

It also assumes that older person owns their own home and will be able to sell that home in order to move into residential care. So that's not necessarily the case either. Over the last 10 years we have seen a real change in the demographics of older people and their housing circumstances. We are seeing people who are retiring without having paid off their mortgages. We are seeing more and more people in private rental and more and more people in private rental paying unaffordable amounts of rent. This is just clearly seen in the statistics that the ABS produces. So, if you have a look at those statistics you can see that things have changed. People are either not achieving home ownership all or falling out of home ownership and this has really big implications for the delivery of home care.

MS BERGIN: Ms York, are you suggesting that provision of home care or Commonwealth Home Support really relies on having a stable home?

MS YORK: Absolutely, and if – it's not just around service delivery either. It's about social connection and it's about health and wellbeing and most of – there has been a recent study through the Benevolent Society that said that the number one factor for an older person's health and wellbeing is affordable housing. So, if you – in our experience, what we find – and we see it time and time again through all of our clients that come through is that once they've got their stable housing and their secure housing, they can afford it, lots of their other health issues drop away. So, they suddenly become socially connected and they suddenly, you know, are able to manage other chronic health conditions. So, we know from our work that secure housing – homelessness isn't necessarily a life time of complexity. You can fall into homelessness through an event that's beyond your control and all of a sudden find yourself in this situation, and if you have safe, secure and affordable housing, a lot of the other issues fall away. So, people can age in place with a lower level of services if they have that housing.

MS BERGIN: Ms York, one of the elements of your definition is affordability of housing.

MS YORK: Yes.

MS BERGIN: So, what is unaffordable housing?

MS YORK: So, the definition of affordable housing, or a person being in housing stress is if they're paying more than 30 per cent of their disposable income on their housing – on rent, and unfortunately with rising rents we're seeing that there's not much of that any more, yes.

MS BERGIN: You've mentioned that the statistics are alarming, and I want to come to those in a moment, but, firstly, could you describe in broad terms what systemic factors lead to homelessness.

MS YORK: Yes. So, I guess the number one factor that causes homelessness is unaffordable housing. So, it's not necessarily personal issues. It can be personal issues, of course, it can be family violence, it can be divorce or, you know, losing your job or having to care for your ageing parents or your, you know, sick kids. All of these things can lead to a crisis point that tips people over into homelessness, but the number one factor is affordable housing and the lack of affordable housing.

MS BERGIN: And is that connected with, in paragraph 23 – you mention that one of the factors causing these increases includes an ageing population, decreasing rates of home ownership.

MS YORK: Yes.

MS BERGIN: Is there a connection here?

MS YORK: Yes. I think - - -

MS BERGIN: Affordable housing?

MS YORK: Yes. I think the statistics show that people are not so much getting into home ownership any more. There has been a decrease over time, and as the population ages that's what the data is showing.

MS BERGIN: More people retiring with mortgages.

MS YORK: Yes.

MS BERGIN: Is that also a factor with homelessness.

MS YORK: Yes. That's definitely a factor. Yes.

MS BERGIN: And then you point to the significant reductions in public housing supply. Is that a recent factor?

MS YORK: There hasn't been any real investment in public and social housing for a long time and what investment there has been hasn't kept up with demand. And so, as the population needs increase and as rents go up, there's less and less options. Public and social housing used to be able to provide for more people than it does now just because of our – you know, because of the lack of investment and the increasing population.

MS BERGIN: And is your comment about the reduction in public housing supply – is that primarily focused on Victoria?

MS YORK: No. That's across the whole country. Yes.

MS BERGIN: Now, turning to the statistics, you mention at – in your statement that the number of women aged 65 to 74 using homelessness services over the last five years has increased, and there has been a 75 per cent increase in older women sleeping in their cars.

MS YORK: Yes.

MS BERGIN: Could you explain that statistic.

MS YORK: In terms of explaining where it came from or explaining the reasons behind it?

MS BERGIN: Could you explain the reasons behind it. I think you've helpfully given us the source at paragraph – at footnote 3 to paragraph 22. Operator, if you could bring up paragraph 22, please.

MS YORK: Yes. So, in terms of – what we have been seeing through our client work, and I think the data is demonstrating this as well, is that older women use all of their resources before going to help. They may not identify as being at risk, and then once they've run out of other options – so they can't afford the rent any more – they've stayed with friends and family as long as they can. We also have people that have been house sitting for a long time or, you know, moving from place to place, then the only option left to them is, you know, rough sleeping, sleeping in their cars. So yes, we are definitely seeing those people as well come through, and that's why it's so important to have early intervention.

MS BERGIN: Why is this specifically an issue for women?

MS YORK: I guess it's around safety, isn't it? But I also think – I think in terms of why are more women accessing services and why are there increases in the number of women who are experiencing homelessness or at risk of it, it is around a life time of systemic issues and disadvantage. So lower wages, women couldn't get their own home loans until the late 80s without getting it counter-signed by a man. There wasn't any superannuation. A lot of people have been in and out of the workforce caring for people. There's all of this unpaid labour around volunteering. None of it gives you any money in the bank, and you get to an age where, you know, you're in your late 50s and early 60s and lose your job, and there's age discrimination in the workforce, and you are paying 80/90 per cent of your income on rent, and then you're on Newstart, what are you going to do?

MS BERGIN: And then in terms of that second component two-thirds of single older women on the age pension have less than 50,000 in savings and 35 per cent of women aged 60 to 64 have no super.

MS YORK: Yes.

MS BERGIN: Is the – are you referring to single older women – is that women over the age of 60.

MS YORK: Yes.

MS BERGIN: And on the age pension, would you be able to afford market rent, or is rent - - -

MS YORK: No. So – no. That's the factor that's really terrifying is that Anglicare did a rental snapshot, and they found if you are a single person on Newstart, there are zero properties in the entire country that are affordable. So less than 30 per cent of your income on rent. And on the aged pension, I think it's 0.6, around 0.6. So, if you are a single older woman and you are on a fixed income like Newstart or the

pension, and you are living in private rental, the reality is that you are at risk of homelessness, and that's a very confronting thing for the whole of our society to think about, but that's the reality.

MS BERGIN: Ms York, that study that you mentioned by Anglicare, that was a national survey that was published earlier this year.

MS YORK: Yes, I think in May. Yes.

MS BERGIN: And did you say that the finding was that no rental properties were affordable for the cohort on the aged pension or any pension.

MS YORK: On the Newstart, there's zero. On the aged pension, there's about 0.6.

MS BERGIN: 0.6 on the aged pension. Thank you.

MS YORK: And that's not making any comment about the appropriateness of the housing. So, as you would know, the lower end of the rental sector isn't necessarily appropriate for the older people or anyone really, but to aging place – if there's mould, if there's narrowed doorways, if there's steps over baths – all of these things in a rundown private rental is no place for an older person to age.

MS BERGIN: Turning to paragraph 20 please, Operator. You mention the census in 2011 and 2016.

MS YORK: Yes.

MS BERGIN: And say there has been a 42 per cent increase in people aged 65 and over paying unaffordable rents in Australia.

MS YORK: Yes.

MS BERGIN: Numbering more than 132,000, and that's unpublished ABS census information, published by the University of Adelaide.

MS YORK: Yes.

MS BERGIN: Could you comment on what that means?

MS YORK: So, it's even worse if you look over the 10 years but – so this is the data that's come through our Ageing on the Edge National Project. So, we are looking at census data and we're – the benchmark that we're using is 30 per cent of your income. If you're paying more than 30 per cent of your income on rent. So what that means in reality is that there's a lot of people who are hidden, who are going about their daily business who aren't going to be captured in rough sleeping counts, but are at risk of homelessness because of these really, really high rents and – yes, their managing people are amazingly resourceful, and they are pulling on the

community resources, but some people don't have those community resources, and so we need to be able to provide stable and secure housing for people in order for them to survive, and so that's the data. It's a lot of people.

MS BERGIN: Operator, could you please turn to paragraph 21. Homelessness has increased by 48 per cent for people aged 55 and over between the 2006 and 2016. Is that the census?

MS YORK: Yes. That is the 10 years.

MS BERGIN: And that's the 10-year bracket that you're talking about. And 53 per cent for people aged 65 to 74, the greatest increase for all age cohorts.

MS YORK: Yes.

MS BERGIN: Why is it the greatest increase for all age cohorts?

MS YORK: I think it's partly around the ageing population. So as people get older, they fall into that age bracket, but I think it's also about a lifetime of systemic barriers, and although a lot of the focus for housing and homelessness is on youth, the biggest growth area is unfortunately older people.

MS BERGIN: And, Ms York, I want to ask you to explain how this large increase in homelessness is also a health issue and an issue related to aged care.

MS YORK: Yes. Well, like I was saying earlier, housing is the number one factor for people's health and wellbeing. In terms of aged care provision, it's very difficult to be able to provide aged care in the home if someone doesn't have stable housing. So, although there may be a sense that it's – housing is too hard and too complicated, and we don't want to deal with it, the reality is we need to deal with it in order to be able to provide aged care. And it also causes – the amount of stress that people are under when they're at risk of homelessness – it means that they are prematurely ageing as well. So that's another factor that we need to take into consideration.

MS BERGIN: So, when you say we need to take these factors into consideration in providing aged care, that's both in the home - - -

MS YORK: Yes.

MS BERGIN: - - - and is it to manage the risk of entry to residential care as well because of the health risk.

MS YORK: Yes, definitely. Yes.

MS BERGIN: Now, you mentioned that there is a significant lack of public and community housing or other affordable housing options to address the short fall.

MS YORK: Yes.

MS BERGIN: What does that mean for aged care services?

MS YORK: Because there's not as many options as there needs to be for older people. So, in an ideal world an older person doesn't need to be a home owner to be able to access quality care. Like, you should be able to be a renter in the public and social housing system. You should be able to live in independent living units or different forms of retirement housing and still have safety and security and affordability. That shouldn't be – it shouldn't be up for grabs, really. So, I think it is important for the aged care system to recognise that housing and homelessness is a big issue for their clients, and also they need options, and that's partly why we advocate not only for service navigation for the aged care system, but service navigation for the housing and homelessness system because it is big and complex. People don't know what options there are, and you do need someone, a specialist service like what we have at Home At Last and what we'd like to see all over the country is a place where people can go, they can find out their housing options tailored to their circumstances and then be assisted to obtain that housing and then hopefully be linked in with aged care services as a result of having stable housing.

MS BERGIN: Ms York, I want to ask you about access and barriers to access in a moment, but, firstly, before we turn away from this topic of the cohort that we're talking about - - -

MS YORK: Yes.

MS BERGIN: - - - people who are homeless or at risk of homelessness and require aged care services – you mentioned independent living units. Are they an example of community housing that's affordable?

MS YORK: So independent living units – they are called different things this different places, but they are usually in small clusters dotted around the suburbs often owned by small not for profit and sometimes also owned by residential care providers as well. So, it's not residential care, and there's a common misconception that retirement housing and residential care are the same thing, and they're not. So, retirement housing is independent living. So, it's just like being able to live in – as a home owner. Often times, it's – you pay a small in going, and then the rent is fixed – your income as is with community and social – public housing. So those are all set at 25 per cent to 30 per cent of your income regardless of what that income is. So, you are always going to be having affordable housing.

And so, what's – what we're seeing is that the independent living unit sector is a thing that people want, a place where they want to live in the community. It's usually connected in with different services. However, that sector hasn't really been supported by government for a long time, and it seems that it's changing, and it's very opaque and hard to get into, which is what our retirement housing service does. We try to get people into independent living units, and this is usually people that are

over the asset limit for public and social housing. So, In Victoria, public and social housing asset limit – it does recognise that there's a cohort for 55 plus which is great, and there's also specific 55 plus housing which doesn't exist in other states that is owned by the government or owned by community housing providers, but that's different to independent living units.

We need more of everything, basically. We need all options available for older people to make choices about where they want to live, and, unfortunately, those options are narrowing because lack of funding and lack of long-term investment. So, we always advocate for more public housing to be able to provide for the very low income no asset cohort. Then there's quite a big gap, and that's for usually women who have a small amount of savings, meaning they're ineligible for public and social housing, but they can't afford to buy anywhere else, and there's really very limited options for those people.

MS BERGIN: So, when your officers at HAAG are looking to assist a client find housing, and that person is, say, over the age of 65, is one of the features you are looking for that their cost of the rent is set at 25 to 30 per cent of their income, whatever that might be?

MS YORK: Yes.

MS BERGIN: And how often do you find that in the current market?

MS YORK: We, if they don't have any assets, our first point of call is public and community housing. So – and we house about 12 people a month in public and community housing. The biggest issue that we find are the ones that have more than $30,000 in savings and so if you have 50 or 60 thousand dollars you aren't eligible for public and social housing and you don't really have many other options, and we find that much more difficult. Unfortunately, the way it is, you deplete your savings until you don't have anything else and then you're eligible, and that's not what superannuation was supposed to be. That's not what savings are supposed to be. So ideally we would like to see more investment in different types of housing for those people that fall through the gaps but also much more investment in public housing.

MS BERGIN: And do you see that as the responsibility of State Governments or Federal Governments?

MS YORK: Both.

MS BERGIN: Why is that?

MS YORK: Because I think it's the responsibility of our society to provide safe and affordable housing and that's what our taxpayer dollars are for. So, it's about prioritisation as well as investment in housing which everybody thinks is very difficult. It really is about prioritisation and there are some innovative models as

well as public housing, but we do need to be able to provide that base level of housing for people and, yes, and services to help them connect with that.

MS BERGIN: Thank you, Ms York. Now turning to the topic of barriers. Why do homeless people have particular and additional barriers to access aged care and home care as compared to people who aren't homeless or at risk of homelessness?

MS YORK: Well, what we found, so we have – we're one of the information hubs for the service navigator pilot project and we are targeting homelessness. What we've found is, first of all, under the Commonwealth Home Support guidelines, the eligibility for accessing services so accessing an assessment and then potentially getting services is 50, whereas aged care is 65 and so that is probably one of the biggest barriers that we come across. A person is under a lot of stress so they prematurely age and they need services but they get knocked back at the first door and that is trying to get them registered on My Aged Care. So, our – since we've started this - - -

MS BERGIN: Can I just pause you there, Ms York.

MS YORK: Yes.

MS BERGIN: When you say there's a cut-off of 65 and over, what do you mean by that?

MS YORK: So the eligibility for – even though there's no age in the Aged Care Act, it's commonly thought of through the CHSP as well that 65 is the cut-off age for Commonwealth Home Support, and that means that when you try to access an assessment through a regional assessment service or through ACAS, the first thing you need to do when you get on the phone to My Aged Care is to say what your age is and if you are under 65 you just get bumped off. And that's not the case. So even with strong advocacy, even with our workers sitting on the phone and calling back and calling back and trying to get people registered, we've had no success in getting anyone registered who is under 65 even though they are eligible under the guidelines. And there has been communiques go out from government. We've been told there's going to be training but first cab off the rank you can't get through that door.

Then if by some miracle you do get through the door, then you need to go through assessment and often the assessors aren't aware of the eligibility. They have really inconsistent information around what they tell each other, what they tell their clients and, yes, and so that's another barrier. And then if they do actually get assessed then there's, what happens if you move, where do the letters go to? Do you have 100 points of ID? All of those things are quite difficult for people who are transient, who are couch surfing, who are moving from place to place relying on friends and family. The letter with the number goes missing, or they're confused about what the letter means. So, there are so many barriers before you get even the most basic of support, so, yes.

MS BERGIN: You make the point in your statement that I think at paragraph 30, as you've just said then, that ACAS and RAS assessors are often unaware of the age eligibility for people at risk of homelessness - - -

MS YORK: Yes.

MS BERGIN: - - - for home care packages and there you are talking about I think the approval of care recipient principles.

MS YORK: Yes, but also the Commonwealth Home Support Guidelines, yes.

MS BERGIN: And the guidelines refer to age 65 but there's no such reference in the guidance for officers assessing eligibility for home care packages; is that your understanding?

MS YORK: No, but – yes. There's – under the CHSP, particularly the assistance with care and housing program, which is funded through Commonwealth Home Support, and that is the linkages program that's across the whole country. Unfortunately, it's not expansive enough; it doesn't cover all geographies and it certainly is underfunded. But the eligibility for that is 50 plus and that is under the Commonwealth Home Support program. So, it does refer in those guidelines to people who are prematurely aged due to being at risk of homelessness can be 50 plus. And that's the real lack of – people are aware of Aboriginal and Torres Strait Islanders' age eligibility to some extent but they're not for people at risk of homelessness.

MS BERGIN: And that test is a test not only for residential care but also for home care. In clause 7, 1, 2,3 and 4, it includes as part of the eligibility assessment, a person who is not an aged person - - -

MS YORK: Yes.

MS BERGIN: - - - undefined, there are no other care facilities or care services more appropriate to meet the person's needs. So that gives officers flexibility in assessing eligibility for home care.

MS YORK: Yes.

MS BERGIN: Now, you mentioned the phrase "premature ageing."

MS YORK: Yes.

MS BERGIN: Is there a definition of that phrase?

MS YORK: No, as far as I'm aware there's no definition of the phrase. Anecdotally through our day-to-day work we can see the effects of not having safe housing compared to having it because we follow up with our clients after they've

been housed and all of a sudden they're able to contribute, you know, to society again. They're able to get their chronic illnesses under control, etcetera. So, we can see it but I don't think it has been defined anywhere. But that's not to say that it's not a factor. It's definitely a factor.

MS BERGIN: Okay. Thank you, Ms York. So, you're saying, then, that in terms of people who may be at risk of homelessness, so, for example, falling into that category of having insecure tenure.

MS YORK: Yes. Yes.

MS BERGIN: They are missing out, if they're under the age of 65 and you say there are no other facilities or care services more appropriate than, for example, home care.

MS YORK: Home care package, yes.

MS BERGIN: They're missing out.

MS YORK: Yes. Yes. They're definitely missing out and we would like to see a lot more kind of consistency around the training and the guidelines for both the people at the My Aged Care portal end on the phones but also the assessors.

MS BERGIN: And when you talk about the people at the end of the phones and the assessors, do they, in your experience or in what you've been told by your clients at HAAG – is there any flexibility applied during assessments?

MS YORK: It really depends. It really depends and it's very inconsistent. So, we're doing a project at the moment with the Deakin University and National Ageing Research Institute where we are trying to roll out training around for ACAS and RAS assessors around what to look out for in their clients when they go into the home. So, if a person is on the pension and in private rental and is single and likely to be at risk of homelessness, so make an early referral in and they're telling us that they find it – they weren't aware of the age eligibility being 50 and also they find it difficult to even find the assistance with care and housing program in the MAC portal.

So, within the referral pathway it's quite hard to find and that's a problem because that's a well-known, well respected service but it's very small. And we would be advocating for a significant expansion of that program because we know it works, but the geography of the country means that some people are missing out. There's around 60 services across the whole country but there's four in Queensland, There's only two in Tasmania and it just doesn't have the reach. And from when we were doing the homelessness action plan, going around from place to place, we were finding workers that were going above and beyond and doing a great job of linking people in with housing but they don't have any brokerage funding to help with hoarding. They don't have assistance to help people move and they're sometimes

having to use their own cars, you know. It's just a very under-funded program but it's a very effective one.

MS BERGIN: At paragraph 31 you offer some reasons why My Aged Care might – I withdraw that. You offer the explanation that it's often difficult for people to have 100 ID points of ID for example if they're at risk of homelessness.

MS YORK: Yes.

MS BERGIN: Can that affect the outcome of an assessment by My Aged Care?

MS YORK: Yes. Well, all they need to start with is a Medicare card. So that's the first step. But, yes, what we were hearing when we were doing our consultations was that, for example, if somebody – so people will go to services that they trust, whether it's an aged care service or homelessness or a GP or community health. People will go to the places that they know, and sometimes because of the delay in registering somebody on My Aged Care and then the assessment might be quite a long time after that, there's no flexibility around being able to do that assessment right there and then when you have that person. So even that process could be streamlined if we could actually empower people at that front-line level to get people registered and assessed as soon as possible while you have them, then they wouldn't be having to chase those 100 points of ID and they wouldn't have to be chasing letters as they move around. You know, someone that is house sitting, for example, where do the letters go? So, this is a barrier and, yes, we would like to see more flexibility around that very initial assessment.

MS BERGIN: Ms York, you say at paragraph 39 that Commonwealth Home Support and home care package services may be denied or withdrawn where the service provider determines the environment to be inadequate or unsafe as a workplace for their staff.

MS YORK: Yes.

MS BERGIN: Is that, for example. with reference to what you said earlier in your evidence about inappropriate rental accommodation where there might be mould.

MS YORK: Yes. So, we've had – I mean, we've heard about and had clients who have had home care packages in place or Commonwealth Home Support in place and workers have had to be withdrawn because of OH and S issues because the house is too run down, it's too overcrowded. If somebody is living in a shed or a laundry or whatever at the family's home, it's very difficult to be able to provide a safe working environment for the personal care workers or the home care workers to go into the home and that's obviously illustrative of the broader issue around how difficult it is to provide home care supports if the housing is inadequate.

MS BERGIN: Should home care packages be available to assist tenants to restore the status of a house which meets which meets OH and S as an interim measure or as an emergency measure?

MS YORK: My first thoughts on that is that it's a landlord's responsibility to provide a house that has minimum standards and it should be the landlord's responsibility. I guess in an emergency they could use their package but that seems to me to be a bit of a Band-Aid solution. I think the packages could go to fixing up needs rather than fixing up somebody else's house where they still have no security of tenure and it still might not be affordable.

MS BERGIN: Sure. And what most commonly would those needs look like?

MS YORK: In terms of?

MS BERGIN: Needs to would be appropriate to be served through a home care package or a Commonwealth Home Support?

MS YORK: Around housing?

MS BERGIN: Yes.

MS YORK: Look, I think it's the same supports as everybody needs. They need – you know, if they have, need shopping assistance or home care or personal care or whatever, it shouldn't matter where you're living. You should be able to get that. But unfortunately, because of the state of the lower end of the private rental market, the cheaper end, it's difficult for that to actually happen, yes.

MS BERGIN: Now, you note in your statement, I think at paragraph 34, that for those who are homeless and prematurely aged, noting that that is a term that is used a bit loosely at the moment and perhaps might be defined in the future, appropriate residential aged care are often the most suitable form of accommodation.

MS YORK: Yes.

MS BERGIN: What do you mean by that?

MS YORK: I guess this is not – we are not as connected with the residential aged care sector as, say, some of the other providers who get the homelessness supplement. So Wintringham obviously in Victoria but there's others in New South Wales and South Australia and other places that provide less of an institution and more of a home for people that have experienced chronic homelessness. It tends to be men, I have to say, not so much women. But yes, that allows, you know, if they – a lot of them are very careful about how they select their staff. They allow dignity of risk and they do provide a home environment for people that haven't had stable housing for a long time and in those cases, then yes, they are most appropriate. For our cohort though we tend to get the more hidden homeless, the people who are

struggling in private rental or couch surfing or living with friends and family and our – their care needs are lower. All they really need is stable housing and potentially some home care and they will be fine.

MS BERGIN: I see. So, there are some limits.

COMMISSIONER BRIGGS: Can I ask - - -

MS BERGIN: Sorry.

COMMISSIONER BRIGGS: What's the relationship between your organisation and the state housing providers? So, the public housing providers?

MS YORK: We're partially funded through Housing and Homelessness. Yes.

COMMISSIONER BRIGGS: And the people you're talking about should largely be considered to be in an emergency situation, shouldn't they?

MS YORK: Yes.

COMMISSIONER BRIGGS: And get some priority on the public housing list?

MS YORK: And they do.

COMMISSIONER BRIGGS: And they do? Okay.

MS YORK: They do get priority, which is why we can house people relatively quickly. So, between three months and 12 months on average, if they only want one bedroom. If they want two bedrooms, then they're going to wait for a lot longer. But it's really about supply.

COMMISSIONER BRIGGS: Okay. Thank you.

MS YORK: Yes.

MS BERGIN: And when you say it's about supply, it's supply of affordable housing?

MS YORK: Yes. And lack of that.

MS BERGIN: Yes. Now, HAAG has a special role in identifying and advocating for the needs of homeless and risk of homelessness cohort, of course. Is trauma-informed care relevant to people who are part of that cohort?

MS YORK: Yes.

MS BERGIN: And what does that look like?

MS YORK: I think trauma-informed care is probably better established in the housing and homelessness sector. It's much more, kind of, embedded than in the aged care sectors, from my experience. And I guess what it means is understanding people's reactions may be different because of the trauma that they've experienced. And rather than, kind of, lumping them in with – as a difficult client or whatever, recognising that this is often a lifetime of systemic barriers that have led a person to this point. So, I do think it's really important. And our – we have all social workers on staff pretty much, and we are encouraging as much as possible for people to take that approach. Yes.

MS BERGIN: Is a client likely – first, presenting at HAAG for assistance, is a client likely to disclose their status as homeless or at risk of homelessness?

MS YORK: By the time they get to us, yes, because we've reached out to them. So, what we tend to find when we're doing that early intervention, community education, particularly in culturally-diverse communities, we're talking about stories that illustrate when someone's at risk of homelessness. So, we're talking about couch surfing, we're talking about house-sitting, we're talking about all of those – overcrowding. All of those sorts of pressures on an older person. And then we would say, "This places you at risk. If you need assistance, come to us." And we really want to get people before they're sleeping in their cars, so we can have that lag time between, you know – as I was saying, it's about 12 months to get someone housed. So, we want to get them early, before that happens. And to encourage people as much as possible to put a plan in place about what happens for their housing – consider housing as they get older. Yes.

MS BERGIN: And is that a message you give to younger - - -

MS YORK: Yes.

MS BERGIN: Younger people seeking assistance. Now, do you need a break, Ms York?

MS YORK: I'm fine.

MS BERGIN: Okay.

MS YORK: Yes.

MS BERGIN: And I just want to turn, finally, to the topic of the draft Homelessness Action Plan - - -

MS YORK: Yes.

MS BERGIN: - - - proposed under the diversity framework. How was it developed?

MS YORK: We were commissioned in around December last year to develop the Homelessness Action Plan. So, it was the fourth action plan after the LGBTI, the culturally-diverse and the ATSI ones that came out. And we engaged Dr Sandra South, who – we seconded her from the Australian Association of Gerontology. And herself and our national project development worker conducted the consultations. We had a survey that went out for older people who are at risk of homelessness or had experienced homelessness, and then a survey for service providers. We had around 480-odd service providers complete the first survey and around 120 older people. So, we got a really good spread. Then we did around 45 site visits across every state and territory. And we were specifically targeting people who receive Commonwealth funding for homelessness support.

So, the three funding streams that we were looking at was residential care facilities that are getting the homelessness supplement – that means they need to have 50 per cent of their residents having experienced homelessness, and the Assistance with Care and Housing program, which is that one I mentioned earlier. There's 60 providers of that across the country. And that's a linking service that helps people, kind of, get from – you know, provide a support to get housing and then also link them in with aged care supports. And then the third one was Access and Support, which is only a Victorian program, but that has homelessness-specific workers as well. So, they were the funding streams that we looked at. And then, after we'd done those site visits, we did the draft plans and we put them out to a Delphi survey. So that just said, "These are the recommendations that we're proposing. You can vote them up or vote them down. And put - - -"

MS BERGIN: Can I pause you there? When you say that you put them out to survey - - -

MS YORK: Yes.

MS BERGIN: - - - are you talking here about the draft - - -

MS YORK: Yes. The recommendations.

MS BERGIN: So, there are three components - - -

MS YORK: Yes.

MS BERGIN: - - - as I understand it, to the Homelessness Action Plan.

MS YORK: Yes.

MS BERGIN: There's the actions to support older and prematurely-aged people who've experienced or been at risk of homelessness, a guide for aged care providers.

MS YORK: Yes.

MS BERGIN: The, secondly, there's a guide for consumers.

MS YORK: Yes.

MS BERGIN: And, finally, there's the plan. So - - -

MS YORK: That's for the government. Yes.

MS BERGIN: That's the government's draft plan?

MS YORK: Yes.

MS BERGIN: Were you involved or was HAAG involved in drafting the draft plan - - -

MS YORK: Yes.

MS BERGIN: - - - for the government? So that's the – those three - - -

MS YORK: Those three - - -

MS BERGIN: - - - components is what you were commissioned for.

MS YORK: That's right.

MS BERGIN: And were all of them put out to consultation?

MS YORK: Yes. And - - -

MS BERGIN: And how did the consultation go?

MS YORK: We got a good response. And all of the – none of the recommendations were voted out. So, all of the recommendations were endorsed. And that was across – we had a good range of providers from every state and territory vote those in. And because of that level of consultation and because of the layers of, kind of, expectations around what people can do – so it's not just the responsibility of people who are specialists in this area, it's also the responsibility of any aged care provider to at least attempt the foundational recommendations – the foundational actions in those recommendations. Yes. So, in terms of what we would like government to do, it's around, really, having a look at the Assistance with Care and Housing program and elevating that, expanding that and recognising that as a really important component for people who are at risk of homelessness as an early intervention strategy.

MS BERGIN: I asked you a moment ago – I should mention, Commissioner, that all three of those documents have been included in the general tender bundle. And at appendix 3 of CTH.0001.1001.2031, Operator, if you could please turn to native

page 20, which is at .2050. I asked you before about whether a client's likely to present and let you know that they're at risk of homelessness or homeless.

MS YORK: Yes.

MS BERGIN: And I should have asked, how does HAAG initiate a conversation about a person's homeless status?

MS YORK: Yes. I think the three factors that we look at is whether someone is on a fixed income, how much rent they're paying, if they're paying rent, and their age. So, when those three factors intersect, particularly for single people, then we can safely assume, because of the rental market and because of the low rates of Newstart and the Age Pension, that they're at risk of homelessness. But they're unlikely to identify themselves as being at risk of homelessness. It's very – you don't think – you don't go around saying, "Hey, I'm homeless." So, I think it's up to the people who are working with older people, who are interacting with older people, to have that gentle conversation around housing and housing futures and make a plan.

But also, I guess, yes, recognise that people aren't going to self-identify. And they also might not know what there is. And that's why it's really important to have these sorts of, you know – as we have a housing information service or a service navigator where people can actually go through options – and you might just want to have a very gentle conversation around housing, what happens – even with couples. So, you know, we have a couple at the moment and they're both on the aged care pension. If one of them dies, they won't be able to afford the rent. And they've talked about it; they know about it. This is, sort of, you know, how to have a conversation about what's going to happen. Yes.

MS BERGIN: Thank you, Operator. It's native page 20, point zero – thank you. If you could – yes. Appendix 3. So are these – appendix 3 is the – thank you very much.

MS YORK: Yes.

MS BERGIN: We were talking before about possible training of My Aged Care operators.

MS YORK: Yes.

MS BERGIN: Is this a topic that, in your view, should be able to be tackled in appropriate circumstances - - -

MS YORK: Yes.

MS BERGIN: - - - by telephone operators? Or is it too sensitive?

MS YORK: I think – I think relying on a telephone or internet interface for people, older people, particularly people at risk of homelessness, is not an adequate way to – for people to navigate the system. That shouldn't be the gateway for people. What we found is that face-to-face supports work best and that people come to services that they trust and that they know. And if you're in a trusted position, you're much more likely to be able to have that conversation. And I think that will be reflected through all of the diversity discussions that you have this week. It's all around trust and building up that rapport. And that's certainly what we found with our Homelessness Action Plan and why we continue to advocate for the need for face-to-face support for people who are vulnerable. And if you're in housing stress, you are vulnerable.

MS BERGIN: Thank you, Ms York. Now, arising out of the work that was done on these draft action plans, one of the recommendations you mention in your statement is to provide block funding for intensive case management to support people who are at risk of homelessness to access aged care and to make informed choices. How can block funding assist?

MS YORK: We think that block funding assists because it allows – it should exist because it allows a flexibility in the approach, and it's not reliant upon individual kind of packages or – a service can plan if they have block funding, and then they can provide that flexibility that a person may need to be able to, first of all, access it and then make a choice. So, it's – we can't rely on, I guess, the market to help everybody, and there's going to be people that fall through the gaps, and without that kind of ability to be able to do that short-term case management role where your linking a person into the system, that's very difficult without block funding.

MS BERGIN: And is the reason block funding assists in this space because one person's query may be answered quite quickly, but it might take extra time to answer a more complex query.

MS YORK: Yes.

MS BERGIN: And with block funding, you've got more flexibility in the case management services.

MS YORK: Yes, and also, you can allow people to come back over time as well. Which is what we often find. Sometimes, we will provide the information, and someone might not act on it for 12 months, and that's okay. At least they're acting on it. So that's one of the things that allows you to have that flexibility as well.

MS BERGIN: I think you mention in your statement that the Home At Last program is partly funded by the Commonwealth home support. So that's an example of block funding.

MS YORK: Yes. So, all of the Assistance with Care and Housing is that. You still have deliverables that you have to meet, number of hours of service provision.

Unfortunately, it's just not enough to be able to provide a really long-term kind of case management, and I guess it doesn't include things like brokerage, which we found in our service to be really important. For example, with hoarding, we often hear, we run a network of assistance with care and housing providers in Victoria and we often hear particularly in rural areas that hoarding is a major issue. There's no funding to deal with it. So, to get somebody into a safe housing when their house is full of stuff, it is really difficult without specialist support. Also, people who need to move, we provide assistance with removalist costs and packing and things like that to help older people because it's very difficult for them at that age as well. So yes, all of these flexible approaches require support funders. Yes.

MS BERGIN: How could assistance with care and housing ACH be expanded with additional block funding?

MS YORK: So, our recommendation in the homelessness action plan is that it needs to be expanded ten-fold and that's based on geography as well as the amount of kind of cross-subsidisation that's happening. Because it hasn't actually expanded in real terms for a long time, what it means is that the amount of money is so small it gets absorbed into other services often. So even if they do have ACH funding, it will be subsumed under all of the other funding, and it's difficult to make referrals. So, what we would like to see is that the program is much better recognised, much better funded and is able to provide that linking between someone that's about to fall into homelessness and the aged care sector.

MS BERGIN: Now, what's the current status of the draft Homelessness Action Plan?

MS YORK: It has gone through the diversity subgroup, and it has been presented to government. We did that in – I think it was around end of May, I believe. So, yes.

MS BERGIN: Have you had any formal feedback?

MS YORK: No.

MS BERGIN: HAAG consider that there are a number of changes required to the government's assistance with Care and Housing subprogram to make it more effective, and you mentioned linkage services, and you've mentioned a few times that service navigation and navigating the aged care system is important. What does HAAG consider would make – I withdraw that. What is your view of the current navigator trial?

MS YORK: It's early days. We're finding that it has been really difficult for our clients, our cohort to be registered on My Aged Care, and it has been really difficult to – even if they have been registered, it's not – the idea of the service navigator was to get people who are pre-any aged care at all. So, they have not received an assessment. So, what we're finding is even if we do get them registered, that's not the last time we see them.

They will be coming back to us with questions about what's happening next? What's happening with the assessment? What does the letter mean? When is the service provision going to happen? And I think that's just testament to what is actually needed which is a trusted person that can walk you through the process. It's not just up to that first point of call. We have had, most of our clients are over 80 years old. Lots of them are from refugee backgrounds. They may be experiencing elder abuse; they are in overcrowded unsuitable housing.

They don't want to sit on the phon. It's too much for them, and 40 minutes minimum with an interpreter to go through some basic questions before you can even get registered is too much. And obviously we don't leave them then; if they come back, we're going to help them. And I think that's the reality of any service that is working with vulnerable people will find people keep coming back, coming back, and why we always advocate for face-to-face ongoing support for people. And, yes, that's why we want to have the idea of having these housing information services across the country where people can actually not just navigate aged care but navigate housing.

MS BERGIN: Finally, Ms York, is person-centred care an appropriate part of the solution for this cohort?

MS YORK: Yes, I mean it definitely is but what does that actually mean in reality? And I think that's the question. So, you can be person-centred in the way you speak to people and talk about their goals and make a care plan. But if there's no services available, if they can't even access the service, it's not really a meaningful concept. Ideally, yes, person-centred care, of course, but what does that mean when you can't even access anything? So, it's less about choice and more about access.

MS BERGIN: Thank you very much, Ms York. Commissioner, that concludes my examination.

COMMISSIONER BRIGGS: Thanks, Ms Bergin. I'm wondering, is there any scope to deliver Commonwealth Home Support programs in day centres or community centres to support these people?

MS YORK: Yes, probably, yes.

COMMISSIONER BRIGGS: Okay. And are you aware of it happening or not?

MS YORK: No, I'm not. I think maybe residential care providers or the providers of actual housing would have more to say about that, yes.

COMMISSIONER BRIGGS: And are the groups of women, largely women, that you're talking about, is this primarily a city phenomenon or are you seeing this right across the country?

MS YORK: Right across the country, and the thing that we have also seen is people moving to the rural areas think that they're going to have cheaper rent, finding themselves very car-dependent, very socially isolated and the rents aren't that much cheaper. And then really finding themselves in a lot of trouble.

COMMISSIONER BRIGGS: All right. This issue in the last two to three years has had a lot of public attention. Have the states and territory housing departments begun to get on top of it or what's happening?

MS YORK: I think people recognise that it's a problem, and there has been a lot of publicity for older women, and there has been some innovation around different models, which is good to see. But there's also a lot of, to be frank, buck passing, who's responsible for it. And I think, as I was saying, it's everybody's responsibility from all levels of government to be able to provide housing for its citizens. So, at the moment, there has been a little bit done in various state jurisdictions, and there has been some new models come out, but there hasn't really been the level of investment that's needed, and it has not been prioritized.

COMMISSIONER BRIGGS: Right. And the structure of the income or assets testing for public housing, you mentioned $30,000.

MS YORK: Yes.

COMMISSIONER BRIGGS: So presumably, there is some tapering away of access or entitlement after that amount.

MS YORK: Yes, or there's zero access.

COMMISSIONER BRIGGS: And to what extent are those authorities now understanding that these people are dealing, perhaps, with the savings of a life time and a bit of superannuation? Any recognition of that, or is it just the queues are so long more generally?

MS YORK: Yes. I – in Victoria, and I can probably only speak about Victoria, there has been recognition of the asset limit for older people, and there has been prioritization for people aged 55 plus. In New South Wales, I believe it's 85 plus, and I don't think there's any other age prioritization in any other state, and part of our work in the national project is to engage with government to, first of all, let them know about the demographics and what's coming and what's existing now, but also come up with solutions, and one is investment in housing and the other is investment in services for access what housing does exist because a lot of it is very spread across a lot of different jurisdictions, and there's no real central place where you can go and find out what your housing options are.

COMMISSIONER BRIGGS: Why does that not surprise me. Okay. Certainly, you wouldn't be looking at My Aged Care for that. Ms York, thank you very much. I found this very, very interesting and, in many ways, quite disturbing.

MS YORK: Yes.

COMMISSIONER BRIGGS: I will think some more about this, or we will think some more about this and what might be done to at least elevate the issue.

MS YORK: That would be great.

COMMISSIONER BRIGGS: And get some attention to it. So, thank you very much and you are excused from giving further evidence.

MS YORK: Thank you very much.

<THE WITNESS WITHDREW [3.50 pm]

MS BERGIN: May it please the Commission. If the Commission could be adjourned for the day.

COMMISSIONER BRIGGS: I think, Ms Bergin, we may well be able to adjourn the Commission for the day, and I think we're going to resume at 9.15 tomorrow morning. So, thank you all very much.

MATTER ADJOURNED at 3.50 pm UNTIL TUESDAY, 8 OCTOBER 2019

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