

TRANSCRIPT

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Bendigo — 24 October 2017

Members

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Witnesses

Ms Raylene Harradine, chief executive officer, Bendigo and District Aboriginal Co-operative, and chair, Loddon Mallee Aboriginal Reference Group;

Ms Christine Gibbins, health services coordinator, Bendigo and District Aboriginal Co-operative; and

Ms Kate Glenie, Loddon Mallee Aboriginal Reference Group early years project worker, Mallee District Aboriginal Services.

The DEPUTY CHAIR — Welcome to the parliamentary inquiry. I am pleased to welcome Ms Raylene Harradine, chief executive officer, Bendigo and District Aboriginal Co-operative; Ms Christine Gibbins, health services coordinator, Bendigo and District Aboriginal Co-operative; and Ms Kate Glenie, Loddon Mallee Aboriginal Reference Group early years project worker, Mallee District Aboriginal Services. Thank you very much for attending here today.

All evidence taken at this hearing by the committee is protected by parliamentary privilege, as provided by the Constitution Act 1975, and is subject to the provisions of the Parliamentary Committees Act 2003 and other relevant legislation. Any comments you make outside the hearing will not be afforded such privilege. It is a contempt of Parliament to provide false evidence. These proceedings will be recorded and you will be sent a proof copy of the transcript. We will begin by inviting you to make a 15-minute statement and then that will be followed by questions.

Ms HARRADINE — Before I begin I would just like to acknowledge the traditional owners of the land where we gather today and pay my respects to their elders past and present. My name is Raylene Harradine, I am the CEO of the Bendigo and District Aboriginal Co-operative, but I am also sitting here as the chair of Loddon Mallee Aboriginal Reference Group.

The submission you received from the Loddon Mallee Aboriginal Reference Group — I will just say LMARG for short — highlights the important role that Aboriginal community-controlled organisations play as part of the health system. We deliver holistic whole-of-life services which are culturally safe, and we also support our community to access mainstream health services. Although the health system works well for most people, this is not always true for Aboriginal people. Many community members have complex family histories and are dealing with issues of mental health, substance abuse and family violence that are associated with dispossession, racism and intergenerational trauma. To improve perinatal outcomes, earlier or more regular antenatal care is important. Our submission also highlights the importance of timely identification of pregnant Aboriginal women and non-Aboriginal women carrying Aboriginal babies; secondly, culturally safe antenatal and perinatal services, and collaborative multidisciplinary approaches which address the social determinants of health; and lastly, working closely with Aboriginal families during pregnancy when there is a newborn notification, especially in supporting bonding and attachment.

Koori Maternity Services provide an excellent model of care but we do not have KMSs at BDAC. We do have a collaborative agreement with Bendigo Health in relation to women's health in pregnancy, labour and postnatal period, which is due to be reviewed. This is an estimate that around 80 Aboriginal babies are born in Bendigo Health each year. We are also planning to review our MOU with the City of Greater Bendigo around maternal child health services.

I am here today with two ladies who will respond to questions as we go through, but I do understand the inquiry will be talking with our colleagues from Mildura District Aboriginal Services — MDAS — about their early years model at the hearing in Mildura, and that is on 9 November. They will provide details about the model which we are adapting across the LMARG membership — so across our region, the Loddon Mallee. We hope this information will assist the inquiry into perinatal services by highlighting the role that Aboriginal community controlled organisations play in the health system and the importance of supporting self-determining models of care for Aboriginal communities to improve the life trajectories of our children.

The DEPUTY CHAIR — We often hear about the gap in Aboriginal health. Where do you see that main gap opening here and the opportunities to close that?

Ms GLENIE — I guess one of the really important things is identification of Aboriginal women. A lot of services in Bendigo provide antenatal care. Most Aboriginal women go to Bendigo Health for their antenatal care. Some antenatal care is provided at BDAC, but I guess mainstream services need to understand how difficult it is for Aboriginal people to identify and what a monolithic institution health services are in Aboriginal eyes. Often they represent a whole lot of complex things to Aboriginal people that maybe the mainstream services are kind of blind to, even though individuals working in their services might have really good cultural competence. It is so important for people to try and stand in the shoes of people who might be outside the system and see what that monolithic institution represents. I guess that cultural awareness of the hospital is so utterly important in this so that people feel confident to identify and they can get the wrap around services like those provided by Aboriginal community controlled organisations, including BDAC.

The DEPUTY CHAIR — So what steps can be taken to promote that?

Ms GIBBINS — Could I add to that? Do you mean the gap in general?

The DEPUTY CHAIR — I mean the gap that exists in general, but I was looking at the gap in this area.

Ms GIBBINS — Okay. I guess the gap has a lot of gaps within it. I guess in my role as coordinator of health services in our clinic, which is a general practice, there are so many gaps with any one person that comes to the clinic, so a lot of the work that is done on a consult with a doctor or a healthcare worker or a nurse is identifying the priority of what needs to be done with that client at the time. What we might see as gaps in mainstream health may not be a gap to an individual in a consult. By that I mean that there is just a plethora of complex issues in regard to Aboriginal health. When we do get a mum that comes to us it is looking at choice and where we can support that mother to go. So the gaps are large, but within that gap, again, there are a lot of gaps we are trying to close and in some cases it is just getting to the clinic. I do not know if that helps or not, but it is the reality of what we deal with day-to-day.

The DEPUTY CHAIR — One of my questions was going to be about whether they get to the clinics and have that antenatal care early enough.

Ms GIBBINS — In some cases we may not even know we have a client who is pregnant, and this is in terms of the clinic as a general practice. In my short time at the clinic we can be aware of a birth because a doctor from the hospital has rung to talk to a GP about something. One of the things that I am hoping will strengthen that is the reaching out and collaboration between the city council with maternal and child health but also with Bendigo Health themselves and how we can get our Aboriginal mums and Aboriginal dads to come to us as a matter of choice with the services we offer.

The other side of that is within BDAC itself there are other services separate to the clinic where we look after family services. So just a month ago I piggybacked off the fortnightly meetings they have with their stakeholders around some of the issues that are happening in families, because often they are answering questions about what we are looking for in the clinic in regard to finding children or finding mums or finding dads in regard to care. So the reason we run it as a general practice is that there are so many areas that we have to tap into to get people to come to us. The short answer is often we do not know that somebody could be pregnant.

The DEPUTY CHAIR — So are you confident that if they are not coming to you they are not going to somewhere else as well?

Ms GIBBINS — I would hope that they are going to somewhere else, but I do not know if they are. We have about 800 active clients on our books who are predominantly Aboriginal people who come to our clinic. There are also many people who go to other clinics as well, and we do not have access to them. Probably the link is maternal and child health and Bendigo Health, but also right under our nose with family services Aboriginal people that access those services will not necessarily come to our clinic. So that is where I am piggybacking off that to close that gap in regard to pre-pregnancy right through to up to 12 months of age.

Ms HARRADINE — And just in terms of family and community services, we are currently doing the section 18 or guardianship model at the moment. At any time we carry 15 children under the pilot, and we are going to hopefully full authorisation as of June next year. But in saying that, the families that we have worked with, we have discovered that six ladies who were under that program were pregnant and they did not disclose that. It was something we discovered when they were working with us, so then we have tried to link them into our services. However, in trying to link them into the hospital in a timely manner, sometimes that does not really work.

Ms BRITNELL — Thank you very much for your presentation. I am very familiar with the name Harradine. You might know Lionel and the South-West Coast Harradine family. We work very closely with Nonnie.

Ms HARRADINE — Yes, that is my uncle.

Ms BRITNELL — I am not surprised. I worked at Kirrae Health Services for 15 years. It is nice to see you all. I just wanted to understand — you talked about some challenges around engaging and getting the services to

streamline across so you would get the best health care available. Cultural training — is that something you feature within the services so that you can get not only cultural understanding but understanding within the health providers of the challenges?

Ms HARRADINE — We currently do not provide cultural awareness training or cultural competency training ourselves. To undertake the training we need to have someone to be able to do that within the organisation. We are service delivery, so we provide the general services and the reference service, but we do try to work with our traditional owner group — the Dja Dja Wurrung — because they do cultural awareness training, and we do try to refer any of our partners to them as part of that for them to provide the training there. VACCHO is a good model too. We send our own staff who come in, because I think we are at 66 per cent of Aboriginal people employed within BDAC. So even when new staff come on board — it does not matter what background you come from — we always send them off to VACCHO, so they undertake cultural awareness training down there. I do not know if that has responded to your question.

Ms BRITNELL — Yes, it has, very well. Thank you.

Ms GLENIE — I know that BDAC does sit on an internal committee in Bendigo Health and through that committee encourages Bendigo Health to continue to train their staff on an ongoing basis. I know the Department of Health also did a survey of all the mainstream health services in this region to see where they were at with their cultural competency, which might be interesting to this group. It looked at who was flying a flag, did they have an Aboriginal liaison officer, did they have regular cultural training in place. It is a really comprehensive bit of work that compares hospitals across the region.

Ms BRITNELL — Thank you. In your submission you stated there were no KMS services in Bendigo. Why is that?

Ms GIBBINS — At Bendigo, at our clinic; at BDAC itself.

Ms BRITNELL — Not at Bendigo hospital?

Ms GIBBINS — No, at Bendigo district.

Ms GLENIE — I think that maybe it was felt at the time that because BDAC was close to a large regional hospital that that might have been the case. It is one of those blips that are hard to understand in the way that Aboriginal community controlled organisations are funded. They are not seen as part of the health system often or they have just recently been seen as a boutique — you might say it like that — part of the health system, and they often get bits of funding that they put together to try to deliver services, but they are not really seen in that way. I guess the Koolin Balit funding, now that that is all going to be handed to community controlled organisations, should not be seen as funding that should be used to plug gaps; that should actually just come from ongoing regular funding, where you are not looking at a short funding cycle to deliver programs.

Ms GIBBINS — If I could add to that as well — in the past we have had a registered nurse/midwife working at BDAC, so it was filling a lot of roles. We currently do not have that anymore.

Ms BRITNELL — Yes, I understand.

Ms GIBBINS — We have an Aboriginal registered nurse and we have a non-Aboriginal registered nurse, neither of whom have their midwifery. We have an Aboriginal health worker and an Aboriginal health practitioner. I call on both continually around the cultural issues that we are dealing with day-to-day, right down to our paperwork, so that we are still fitting in with guidelines and accreditation standards but also capturing what is appropriate for culture. But in terms of maternity services, we do not have a midwife employed.

Ms EDWARDS — Can I acknowledge that we are meeting on Dja Dja Wurrung country today and pay my respects to their elders past and present.

In relation to some of the issues that you mentioned, Raylene, about family violence for women from an Aboriginal and Torres Strait Islander background, a couple of concerns that I had in relation to that was: what is the impact on them during their pregnancy, and how do they manage post-pregnancy once they have given birth, in particular in relation to coming from a different area to Bendigo, for example, to deliver their babies

and not having a home to go to or even having access to transport to get back to their home? Can you perhaps talk to that?

Ms HARRADINE — That is an issue for us, particularly with Bendigo Health being the major hospital for the region. That does put a strain on our organisation just in terms of us not being funded to go and work at the hospital as such. They do have an AHLO, an Aboriginal hospital liaison officer. However, in an attempt to assist the Aboriginal hospital liaison officer, some of our workers do go up and see some of the ladies when they are pregnant or when they have had their baby. However, we cannot do that all the time. I think that is a resource issue for us in particular. One of the things I would like to see is an Aboriginal person or an Aboriginal hospital liaison officer who works specifically in the maternity ward. That would be wonderful, because at the moment there is a male person employed who works right across the hospital. I should not put recommendations, should I?

The DEPUTY CHAIR — Absolutely. Go for it.

Ms HARRADINE — It is something that would work better for us just in terms of that. We get a lot of phone calls from the community that have come down from Swan Hill, even as far as Robinvale and sometimes Mildura, that have had to be brought down because of an emergency caesarean or something like that. Then they have rung us up to see if we could try and get them back home once they need to go. That is actually a bit of a resource problem for us. You cannot put people in a cab and you cannot put them on public transport as such to be taken back to their homes. I do not know if I have strayed a bit, but we have all of those issues.

One of the things I talk about in general in meetings as well — I have brought up the fact that when we are funded through government, or whoever we are funded by through health dollars, they only take into consideration the population in the ABS for what we have in Bendigo. There is no consideration for the increased population when people come to Bendigo hospitals and Bendigo Health in particular. Our population actually does rise, and that is due to the fact of people coming and using the plethora of services that are in the hospital here. That increases our numbers. I have spoken to Murray PHN about that too, so that when they are looking at funding across the region, that is one of the things that needs to be considered.

Ms GIBBINS — Transport from a clinic perspective — I often get a phone call from a hospital or another ACCO, where we could be on the cusp of a border, which we do not worry about. It is about how we get somebody home to their family, or how we get them say from St Arnaud to the hospital safely. Again we have been asked to put them in a taxi. Well, you cannot put a mum and a newborn in a taxi, even if it is a half hour ride. And we have been asked to put them on buses. You just cannot do that. Even if the mum is pregnant and willing to come, often she will have anxiety around leaving home, let alone putting them on a bus. And they are going into the unknown with no support, which is hard for anybody, let alone our clientele. And often the coordination is not done. We are so insular when we work — the hospital does this, we do this and somebody else does this. We are not coordinating that. At the start of the day we must know somebody is going to be going home. So to get a phone call at 5 to 5 to my office to say, ‘Can you get this girl home tonight to St Arnaud?’, how do you do that?

You do not have the staff. And if you have someone who puts their hand up, they are already fatigued from doing a huge day of their own job, let alone then getting in a car, safely transporting precious cargo and still getting back to our workplace. Then you are looking at time in lieu, which cuts down your resources for the next day. It is really ad hoc, but I think we could do a lot better on the coordination of transport across the region so that it is not just about an infant but it is also about the adult and the family. To me, if I can say this safely in this room, it is almost like, ‘Well, somebody will pick it up’. It just does not work like that.

Ms EDWARDS — You mentioned that you are in the process of putting together a new MOU with the maternal and child health nurses. Do you have a good working relationship with the Bendigo maternal and child health nurses, and more broadly across the region? And perhaps speaking to that, are you aware of how many women from an Aboriginal and Torres Strait Islander background might be falling through the gaps in relation to having access to maternal and child health nurse support?

Ms GIBBINS — On the first part of the question, I started off well in having a good rapport with them but then work took over. We have only just picked it up again in the last few weeks. There were different reasons for that, not just around maternal and child health but also other things that were happening in the clinic. As we got on top of getting the clinic running as a general practice, it is now time to really branch out and link back

into where we need support for our clients, but to do it well. In the past my understanding is that we have had maternal and child health come to the clinic or we can go to the home or the actual maternal and child health clinic. I think even just to me, as the health services coordinator, again it is understanding where that is all coming from. I think certainly — and I am focusing on myself — if I keep focused on driving that, then I believe the team will pick that up with maternal and child health. There is a wealth of support and skill set with maternal and child health. It is just making sure that we utilise it.

Ms HARRADINE — Then if we are looking at it from a local level, we are in the process of hopefully developing a new early learning centre which will be a hub for our young mums and our children. So it is going to be a 3 and 4-year-old kinder, but it will also have playgroups. We are also looking into the possibility of having a maternal and child health nurse there and other relevant services that can go on into that particular building on site at Prouses Road. Doctors can go there. Our doctors from our other building can go in there to do hearing tests and assessments on children. We have a paediatrician as well. That is one of the future developments that we are working on at the moment at a local level. I think Kate wants to talk about the regional level.

Ms GLENIE — I suppose the new Aboriginal maternal health innovative grants have been interesting in this region, having been involved in those. The people in Echuca could not be here today. Kim Warde is an Aboriginal midwife and an Aboriginal maternal and child health nurse. The new model of care they are going to be delivering in Echuca is really fantastic, where the Aboriginal maternal and child health nurse funding is going to allow them to have someone who is going to be based at the Berrimba Child Care Centre and spend one day a week in people's homes, one day a week at the centre and one day a week at the clinic. So it is going to be a really interesting model for the others.

I think when you are in Mildura you will hear some very interesting answers to the question from the Mallee District Aboriginal Services. We see there is a little bit of a gap in the system for the Aboriginal community controlled organisations. I know in Echuca the data is not that great. On the first home visit the council gets notified when the baby is born, not the ACCO. Then the first home visit is done by the maternal and child health nurse employed by the council. I know in Echuca there is a 50 per cent drop-off from that first visit to the next visit. There is a real problem with a non-Aboriginal person going into an Aboriginal person's home without a culturally safe support person. It is much better delivered in concert with Aboriginal workers in some way or another.

Ms EDWARDS — Just at your clinic, do you have access to mental health support for women who are pregnant?

Ms GIBBINS — Yes, we do.

Ms EDWARDS — Perhaps if you could talk to the loss of the commonwealth national perinatal depression funding and if that has had any impact?

Ms GIBBINS — Can I talk about the mental health first and you can do the funding?

Ms HARRADINE — Yes.

Ms GIBBINS — Funding goes over my head, Maree. I guess our latest audit that VACCHO did in June was on what is actually happening in our clinic. The reality is that of our almost 900 active clients over 440 have a mental health issue, and they picked up another 118 — I am not saying they have not been diagnosed — that have been flagged for mental health. If you are looking, for argument's sake, 50 per cent of our clients have mental health issues. We have what is called a social and emotional wellbeing team. There is a female worker and a male worker who work with people that have a mental health diagnosis and/or through our intake process of initial assessment are asking for support with their mental health, so it is both diagnosed and undiagnosed. They are two full-time positions that have case loads that vary. The female worker has the greatest load because she gets the women and the children. Mixed in with that are often alcohol and other drugs. We have a worker for that and they often overlap with the same clientele.

So before we even get to other health issues, including pregnancy or any aspect of maternal health, you are dealing with 50 per cent of mental health clients. It is challenging, it is rewarding, it is frustrating. There is a lot

of joy when you finally get a step forward in a process. That probably takes up a good deal of our day in general practice with those health programs.

We also have a mental health clinician who comes in three days and does that specific one-on-one care. We also have in partnership with the Murray Primary Health Network and Mind another person that comes in twice a day for the high end of mental health issues. They are often out on the road, not in the clinic. Correct me if I am wrong, but we have just employed an addiction specialist.

Ms HARRADINE — Yes.

Ms GIBBINS — That is probably the best way of putting it. A lot of these mental health issues are being clinically diagnosed but there are also mental health issues that are as a result of prescription medications. We also have another program called Bringing them Home, which is around the stolen generation, and without even going into that, it is a huge mental health issue. By the time we get somebody coming in to general practice for an appointment for a sore throat, you have worked through a lot of mental health issues.

Coupled with that then goes the way that we are trying to run the clinic in regard to drugs of addiction and dependence. That is taking a lot of our time and energy, with people that are hurting. We have three doctors that work 3 hours each a week, which is very small. So 9 hours a week go towards predominantly that clientele that are on drugs of dependence and addiction.

Ms EDWARDS — How many of them would be women and particularly women who might be pregnant?

Ms GIBBINS — I do not have the stats of that breakdown, Maree, but I do know that each person is different, and I think 90 per cent of them are Aboriginal, that are coming to us. That is long before we even get to physical health.

Ms EDWARDS — Could you just comment on the commonwealth national perinatal depression funding that was recently lost?

Ms HARRADINE — Yes. That is going to have an impact, particularly on organisations across Loddon Mallee. If we talk from ACCO's point of view, losing that funding is creating an environment where we will not be able to employ enough trained people or specialists in the workforce, so that is going to have an impact on our organisation. We did talk about that, didn't we? It is just a major gap, and also the services. At the moment we are currently picking up a lot of the gaps, using resources within our own organisation and staff being involved in certain things. But this is one of the things that is going to really impact on us. I think one of the major things that we think about is the way that organisations are funded in particular. They are not funded at the front end. They are usually funded either half way through the flow-through effect or —

Ms GLENIE — Crisis management

Ms HARRADINE — Crisis management. That is one of the key things we would particularly like to see being resourced accordingly to be able to work with our community at the front end in the early stages. I think that is where you get more value for dollar. We always talk about it as Aboriginal people. It is the CEOs of ACCOs. It is about if we can invest at the front end and not wait until the last crisis stage. It is better value for money. Investment is going to be so much better for government, if you look at that.

The DEPUTY CHAIR — I have now got some questions with a little bit of a different line. I think you mentioned before, Raylene, that you are guessing about 80 Aboriginal babies were born at the Bendigo Hospital. So looking at the wider region as well, what percentage of those do you think would be young mums or teenage mums?

Ms HARRADINE — The majority of them are young mums. Some of them are young mums who may have three or four other babies as well or three other children.

The DEPUTY CHAIR — What age do you put as a young mum?

Ms GIBBINS — When they have come through intake, where they might need some support with our services, in the last six months I have probably had up to four mums under 28 with six children, some of them starting their families as young as 14 or 15 and in often cases homeless. In some cases, what I mentioned earlier

about social and emotional wellbeing and alcohol and other drugs, sometimes it is those workers that tell me somebody is pregnant. So that is the reality of what you are dealing with and who they are trusting as well.

Ms HARRADINE — A lot of the young mums that come through the doors actually want to be mums too. I do not want to put a negative sort of spin on it. Sometimes there are unplanned pregnancies, but sometimes young people just want to have their babies early and they want someone to love.

The DEPUTY CHAIR — What sorts of support services do you offer for those young mums?

Ms GLENIE — Can I answer that one? I suppose the Aboriginal Cradle to Kinder program, which was recently funded for the Loddon area, went to the Njernda Aboriginal Corporation. But in that funding Njernda is expected to cover the whole of Loddon, and they realised they could not do that without BDAC. I suppose from the LMARG perspective, the ACCOs really do not like competing for funding, especially in a small area like Loddon. In putting BDAC and Njernda up to go for a funding grant, they both had to do the applications. It actually would have been much more sensible if it could have been thought out a little bit more carefully. When those broadbrush programs come out to regional Victoria, down at the worker level it is really difficult. But BDAC and Njernda are actually working together to deliver that. Even though BDAC is not funded through it, Njernda is funding a position which is based at BDAC to actually be able to cover the whole of the region. So they have decided to work cooperatively even though the way it was set up did not work that way. That is for Aboriginal women under the age of 25 who are pregnant.

Probably one of the tricky things about that is that the starting date for the service delivery is really well into the pregnancy. I think the criticism from other Aboriginal colleagues I have spoken to is that you need to start much, much earlier in the pregnancy to be able to get all the services in before the baby is born. If you start over 20 weeks, you have often only got 10 weeks. The babies are often born a little bit premature — some of them. You need to be working from really early in the pregnancy. One of the really tricky things about Aboriginal health in this space is that women get less antenatal care. They often maybe arrive at hospital in labour having had no antenatal care and they are not known to the hospital. So suddenly ACCO gets a telephone call, ‘Look we have got this person here. Do you know her? Do you know anything about her health? Can you help us with this?’. So I guess we are really interested in that really early intervention — preventative work really early. Sometimes the program guidelines start too late for Aboriginal families Is that all right?

Ms HARRADINE — Yes, and we always talk about working with our young people at conception — even prior to conception — and talking about safe sex. There is a kit that we have done that we have provided at a youth camp for our young people around relationships and what that looks like. We are wanting to work really early with our community, especially our young people, prior to them actually even thinking about babies and that sort of thing.

The DEPUTY CHAIR — With regard to early intervention services, do you think that that would make a difference on the documented low infant mortality, low birth rate and perhaps smoking during pregnancy?

Ms HARRADINE — Yes, it would actually.

Ms GLENIE — Yes. I suppose it is interesting what Aboriginal communities see as priorities and what other groups might see as priorities. LMARG recently had a planning session where they invited all the departments to come and let LMARG know what their priority was over the next year. One representative from the Department of Health suggested teenage pregnancy was a priority, but the Aboriginal community controlled organisation did not actually see that as a priority. They see that you will get better outcomes if people are older. For every year you wait you will have better outcomes. They sort of know that. But there are probably so many other things to deal with that that is low down on the agenda. I think even smoking in pregnancy — I went to the First 1000 Days Australia Summit last week where someone said, ‘At least I am not on something harder. I am just smoking’. Putting it into perspective, we have to drop white middle-class values when we think about some of these things and try to see through another lens, I guess.

The DEPUTY CHAIR — So what are the priorities that came out for the Aboriginal community?

Ms GLENIE — I think having culturally safe services where people feel comfortable in accessing the service. That is really critical. People will not come. They will not actually come to the service at all. Although it is often said, ‘Well, not everybody wants to use BDAC’, that is really your starting point because a lot of

people do. So you really need to think about the role that VACCHO plays in the health system in supporting members to deliver that safe service, I think.

Ms HARRADINE — The other thing that came out of the three-day planning was working with our women early. Currently there is a Clontarf program, and it is focused and geared at young males. For us in particular in Loddon Mallee, we are looking at having a Clontarf program but gearing it to young girls.

Ms GLENIE — I guess one of the other issues is that one of the fastest rising rates of imprisonment is young Aboriginal women. That means that women are being taken away from their babies. That is a really troubling statistic in the communities. I think the fastest rising rate of incarceration in Australia is young Aboriginal women. I guess we are really concerned about that — that it separates families really early.

Ms HARRADINE — I think the other one we talked about at that three-day LMARG planning was transitioning Aboriginal children into Aboriginal care. That was the other priority that we will be working on as part of LMARG.

The DEPUTY CHAIR — Thank you very much for coming. It was a really terrific conversation that we have had in the questions that we put to you and your answers. Thank you very much. We greatly appreciate this very important issue.

Witnesses withdrew.