

# TRANSCRIPT

## FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

### Inquiry into perinatal services

Mildura — 9 November 2017

#### Members

Mr Paul Edbrooke — Chair

Ms Cindy McLeish — Deputy Chair

Ms Roma Britnell

Dr Rachel Carling-Jenkins

Ms Chris Couzens

Ms Maree Edwards

Mr Bernie Finn

#### Witnesses

Ms Jacinta Molloy, manager, Early Years Service, and

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

**The CHAIR** — I welcome to these public hearings Ms Jacinta Molloy, the manager of the early years service, and Ms Kate Glenie, the early years project manager of the Loddon Mallee Aboriginal Reference Group, and thank you for attending here today. All evidence at this hearing taken 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 this 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 of the transcript. I now invite you to make a 15-minute statement and we can follow that up with some questions, if that is fine by you.

**Ms MOLLOY** — Sounds great.

**Ms GLENIE** — It sounds intimidating, but it is not.

**The CHAIR** — We are all friendly people.

**Ms MOLLOY** — I am Jacinta. Thank you for the opportunity to speak today. I would like to start by acknowledging the traditional owners of the land that we meet on today, the Latji Latji people, and their closest neighbours, the Barkindji people, and as the first people of this nation I would like to pay my respects to their elders past, present and future and honour their culture.

### **Visual presentation.**

**Ms MOLLOY** — I wonder if we could show a short video about why we do what we do at Mallee District Aboriginal Services.

Why we had to change what we were doing. Back in 2012 an 18-year-old Aboriginal girl committed suicide at 37 weeks gestation. It became obvious that there were lots of people working with this young woman outside and within MDAS but not necessarily talking to each other, so not being collaborative and perhaps working in silos. MDAS's response to this was to really focus on the early years.

What is the model? The model is a key worker, family-centred, strength-based wraparound model of engagement from conception to school. We took workers from across health and early years and put them in a team — early intervention for families and young children — and provided intensive support from conception to school. It is culturally rich and all staff are trained in trauma-informed care, attachment theory and safe base theory.

How do we do it? I guess the struggle is to get funding. We had to pull funding from different areas, so we took funding basically from DHS, Education and Training, and also from Prime Minister and Cabinet and put these services together — Koori Maternity Services; maternal and child health; intensive case management, which includes Cradle to Kinder; playgroups; Koori preschool assistance program; HIPPY; and capacity-building groups Sacred Sistas, Collaborative Therapy and Circle of Security.

At the centre of the model is the family, and the key worker supports the family by wrapping around and basically walking them through what can be a complex service system, both internal and external services provided by MDAS and also outside. The vital elements of the model you can see there. Basically it is not just the family that gets wrapped around, the worker gets wrapped around as well. We are lucky enough to have a wonderful lead practitioner in our organisation and all of what we do is informed by theories. This approach to infant and family wellbeing is embedded at all levels of the organisation.

Education and training is paramount to what we do, and we are really lucky to have access in-house with our lead practitioner, and supervision and reflective practice is also very important. Obviously with the work that we are involved in we have a lot of families with many vulnerabilities, suffering traumas and intergenerational trauma. This can cause vicarious trauma for the staff, so having reflective practice enables staff members to also debrief and to heal. It can also trigger events from their own lives.

The model is based on a replication of the Safe Base. Many of you are probably aware of the Circle of Security model. Basically MDAS becomes the safe base for the parents so the parent can be the safe base for the child. As the child goes out to explore the world and then experiences distress, they can come back to the parent, who is helped by the organisation and the key worker.

DHHS commissioned an evaluation of the early years model. This was done over the financial years of 2014 and 2016. The evaluation itself was commissioned and completed by Effective Change so an outside service. This is just a snapshot in time. This is not the whole time over those two years, but at the time this snapshot was taken we did not have any children permanently removed that were currently in case management and we had good results in terms of breastfeeding, maternal and child health, and antenatal care appointments as well.

Also the results of the external evaluation found that there were many outstanding features, including a high standard of training, intensive use of theory, solid community connections and an emphasis on culture. It made a great impact. It gave a visible point of entry for Aboriginal families into the service system and a place where they felt safe to come to, and it has effectively supported families with young children. For some of those families it has been life changing.

We have not always been successful, integrated and collaborative, but we are working hard to grow and to change. Some of that evolution is through a new program that is called Wondering from the Womb. Wondering from the Womb — and I brought it if anyone wants to have a look at it — is an antenatal yarning tool that was developed at MDAS. It is designed to facilitate bonding and attachment, and to do this by honouring the voice and wisdom of the unborn child, so the least threatening person to ask questions and so it allows parents to raise questions, anxieties and fears and have them discussed. They run from conception to birth and then after the baby is born we also involve them in NBOs (New Born Observation) with the Royal Women's Hospital, so it is also an attachment tool. It is used up to three months of age of the baby. It is also a way for the baby to show the parents what they can do and what they know and it facilitates bonding and attachment as well. The research is being done with Susan Nicolson at the Women's hospital.

Koori Maternity Services: we are pretty lucky to have Koori Maternity Services in Mildura at MDAS. There are 14 KMS in the state. We are here speaking on behalf of LMARG as well. Unfortunately MVAC in Robinvale and BDAC in Bendigo do not have access to Koori Maternity Services. We would obviously like that to change. I think that it ensures women and families receive holistic care delivered and strengthened by Aboriginal culture and practice. In each Koori Maternity Service an Aboriginal person who is also a health professional is employed for not only their health knowledge but also their cultural knowledge locally and their knowledge of local families. So they live and work in their own community. Basically that is what it is.

We have KPIs we have to meet set by the Department of Health and Human Services, but I think sometimes it goes unrecognised the work that a KMS midwife does. There are a lot of social determinants of health and work that are done behind the scenes. It is like a drop-in centre with flexible appointment times and home visits — wherever they want them we will do them. It is kind of just always being there. It is prescribed to have 10 antenatal visits, but we will give 25 if that is what they want. Sometimes it is pretty challenging. Obviously these women often have very chaotic lives and are experiencing lots of challenges in their lives. For us those 10 antenatal appointments are the most important thing, but for them there are many important things going on in their lives; for example, if you have not got a house or you cannot feed your children, your antenatal appointment is not at the top of your list.

These are just a whole lot of basically what I talked about: things that the KMS has to refer out and be involved in and be knowledgeable on. The KMS workforce generally involves midwives who do not necessarily come with a big background in many of these areas, so it is a big learning curve as well.

On transiency, I did not speak about transiency, but the Aboriginal community is reasonably transient often along the river to Swan Hill — we do have a KMS in Swan Hill as well — but also to Broken Hill and Adelaide, and all around the place really, so that can create lots of challenges in antenatal care.

In terms of some challenges across the Mallee, I guess our challenges are impacted by challenges that the local birthing hospital has, so attracting and retaining qualified midwives and medical staff is a challenge for them and also for us, because there are three of us from KMS who work in MDAS but we are pulling from the same pool. That provides a challenge in terms of — I know that Sandra is going to talk later about this — the staffing and the workload of the hospital. This means for us sometimes we feel like there is an early discharge and there are difficulties with communication. I know they are really under the pump and our need for information is not necessarily the top of the list when you have got an emergency in the birth suite.

Some challenges in this area are access for our women with transport and appointments. Sometimes there are expectations from outside providers. I think it needs to be recognised that most Aboriginal women in this town

do not drive; they do not have licences. The public transport system is poor. If they are discharged at the weekend, they cannot get home. That is a challenge for us. The KMS midwives are not paid or supported by guidelines from the Department of Health to work on weekends but we do have to enable our clients to get home, or we provide taxi vouchers, but sometimes obviously we do not know they are going to be at the hospital. So that is challenging.

Transfers to tertiary centres are often really difficult. Lots of our women have never been on a plane. They have never been to the city. They have no family in the city and no means of supporting their partner or other family members to go to that tertiary centre. So it is better for us if they go to a tertiary centre that has a KMS because we can liaise. Obviously they all have AHLOs, but they are pretty under the pump as well so often they come back obviously prior to when we would like them to come back for the best care they could have gotten in a tertiary centre. They come back for reasons that are really good for them that we have to support.

In terms of cultural competence of mainstream staff, I think we had the MANE workshop at MBH recently. That is an emergency workshop with a cultural lens, which is great. I think for the Aboriginal community hospitals are not necessarily seen as safe places, not places they really feel — I do not think welcome is the right word but historically there have been issues around birthing and the removal of children from birth suites and hospitals. These are the grandmothers and the great-grandmothers of the babies birthing now. So that continues to be challenging for those women and families. There is an ongoing fear of DHHS and also of DOCS from across the river. So often they want to leave early even when there is no need for them to leave early, because they are fearful of what may come if they stay or what may be heard or found out about them.

I think some of the women — I am not saying that this is necessarily true — but they feel sometimes that there are stereotypes around their smoking and around their desire or choice to breastfeed or bottle-feed, which for some can make them feel victimised. I think in this town you can only get your ultrasound by bulk-billing at SMI. You cannot always get an appointment there so that is a \$130 charge for your ultrasound. It is \$114, I think, to have your 12-week, first semester pathology done. This is really restrictive for people on low budgets so we at MDAS have to cover the costs, which obviously creates its own challenge. It is not really what we are funded for, I would not think, but they are entitled to receive ultrasound and pathology care the same as everyone else.

Jason spoke about Cradle to Kinder. I would just like to mention that I think that you cannot be accepted into the Cradle to Kinder program until you are 26 weeks pregnant. That is way too late for these women at 26 weeks. We are having Aboriginal women who are birthing in greater rates than non-Aboriginal women in premature birth at less than 37 weeks yet we cannot get Cradle to Kinder in until after 26 weeks. I would just like to put it out there that I think 12 weeks is when these women should be able to join Cradle to Kinder for that intensive case management.

Currently legislation in Victoria states birth notifications must go to the local municipal council. We think for women who are choosing to have their antenatal care or who are Aboriginal and who come to an ACCO that has its own Maternal and Child Health there that notification should be coming to the ACCO. Currently here in Mildura we have to get the women to sign a consent that goes to the maternal and child health service (LGA) who then can release the information from the birth notification to us. We do have an MOU with the local council, but there are many challenges in regards to funding and funding around seeing Aboriginal women and Aboriginal families. Regardless of consent and their choice, these women are still being asked to go to the local council.

Also I would like to say that our Maternal and Child Health service is funded federally because we cannot get state funding even though in the mainstream all maternal and child health nurses are funded by the state government. In Swan Hill our maternal and child health nurse is totally self-funded by the MDAS service because we recognise the importance of that maternal and child health nurse within an ACCO, but there is no funding for her.

In terms of our model in general, obviously we are pulling funding from all over the place and what we would really like, in that it has been evaluated and proven to be successful, is that we have access to block funding so we can continue to provide for the families in Mildura and Swan Hill and Kerang.

**The CHAIR** — Thank you, Jacinta. Do you mind if we ask you some questions now?

**Ms MOLLOY** — Yes, that is okay.

**The CHAIR** — Fantastic. Just one thing that stood out immediately to me and probably two of the committee members as well is the success rate of your breastfeeding at 100 per cent.

**Ms MOLLOY** — That was 100 per cent of women who said they were going to breastfeed did breastfeed. That was a snapshot in time; I am not saying that is something that continues.

**The CHAIR** — No, I am not going to hold you to it. It is still quite impressive.

**Ms MOLLOY** — At that time we had a maternal and child health nurse who was also a lactation consultant.

**The CHAIR** — That was my next question. How did you get there?

**Ms MOLLOY** — I guess we do have lower than average breastfeeding rates in Sunraysia, and within the Aboriginal community they are even lower. With the Koori Maternity Service they obviously do breastfeeding education. We also do breastfeeding education with maternal and child health nurses antenatally so that there is already a relationship with that maternal and child health nurse and the Koori Maternity Service midwife visiting the hospital when the woman is in hospital, and obviously we can provide daily visits to the home post birth.

**The CHAIR** — And just one more question from me before I hand over to the other committee members. Has the model that you use received funding to be rolled out in any other areas or is it operating in any other areas in Victoria?

**Ms MOLLOY** — Do you want to speak to that, Kate?

**Ms GLENIE** — Yes, that is actually why I am here. I did appear before the committee when your hearing was in Bendigo as part of the Loddon Mallee Aboriginal Reference Group. I am employed by MDAS, but I actually work across the Loddon Mallee region on the rollout of this model into Bendigo and District Aboriginal Cooperative and Njernda Aboriginal corporation. LMARG is a group that is about advocacy, cooperation and communication of the Aboriginal organisations in this Loddon Mallee region. They recognise the success of this model, and over the last three or four years they have been working towards rolling it into the other services, which is my role. It was funded through the Koolin Balit regional plan. That funding ended in the middle of this year, but the work continues at the moment with LMARG. They have just done the next iteration of their plan, so they are working on that at the moment.

**Dr CARLING-JENKINS** — Thank you very much for your time and for coming in today. It is a fascinating service. I just want to note your point around 26 weeks down to 12 weeks gestation. That is a really important thing for us to take back.

**Ms MOLLOY** — It was a real struggle prior to having our own Cradle to Kinder because we had to refer to Child FIRST. So we are really happy that we do not have to do that anymore because sometimes that would be stalled there and it would be over 30 weeks before we saw someone, even though they were already in our service. It created lots of problems for us, so we are really happy to have Aboriginal Cradle to Kinder run by us.

**Dr CARLING-JENKINS** — Yes, I can imagine. I want to commend you for that booklet as well.

**Ms MOLLOY** — Thank you.

**Dr CARLING-JENKINS** — *Wondering from the Womb* — it is awesome.

**Ms MOLLOY** — I have to take it back. It is just to look at, because I do not think that is the published version with the correct references.

**Dr CARLING-JENKINS** — That is okay. Do you distribute that to all of your women?

**Ms MOLLOY** — No, we do not.

**Dr CARLING-JENKINS** — Because it looks like a bit like a workbook. There are lines that they can write on.

**Ms MOLLOY** — So it has two functions in that currently it is still in the testing phase. It was spoken about at the world congress for infant mental health in Prague last year, and that was the initial talk about what it was, and next year in Rome we are hoping to get up to speak about the research. Currently it is done one-on-one with an antenatal. A woman could be with her partner — it is up to them what they want to do — the midwife and Lead Practitioner. There are nine sessions, because they are each a yarn. It is just an invitation from the child to talk about things that are sometimes difficult to be brought up by a professional. Then it is also used, in that workbook form, as a way of reflective practice for staff, so for staff training to use it to question what you are doing as a worker and thinking always from the child's point of view.

**Dr CARLING-JENKINS** — That is fascinating. Is it an initiative that you are looking at rolling out more broadly? Obviously you are taking it internationally. I think it would be great to have that rolled out across Victorian services, for example.

**Ms MOLLOY** — Yes. Recently we spoke at the First 1000 Days conference in Brisbane. That book was spoken about by the lead practitioner, Kathy Crouch, who is a psychologist. Because we are in the early stage of the research, that is why it is still one-on-one. For some families it brings up some really challenging stuff. What has been found is it has actually changed the language of the midwives, so in the way that she talks and does her antenatal education and her antenatal checks, in that she is talking about the protection of the unborn child rather than, for example, 'Oh, your blood pressure is high. If your blood pressure is high, you know how that is affecting your baby and the placenta'. So sort of changing the way that we are doing antenatal care is something that was not necessarily thought would happen.

**Dr CARLING-JENKINS** — You are becoming more child-centred.

**Ms MOLLOY** — Yes, it is more child-centred, for that unborn child. I know Jason was talking about it before. You cannot always see the damage that is done.

**Dr CARLING-JENKINS** — Sure. I can see that would be a great advantage for mothers.

**Ms GLENIE** — The lead practitioner who is employed by MDAS, through the rollout of the model, does provide training to the staff in Bendigo and at Njernda. Her work hopefully will eventually roll out to those other services. I think the other thing about those reflections is that so much work can come out of just one session with one family. There is so much other referral work and ongoing work with that family that there are not the resources probably to be able to do it on a really large scale at the moment. It is small and it is in MDAS.

**Ms MOLLOY** — I think also we should acknowledge that the community were consulted and the stories in the book were derived from local community members and elders.

**Dr CARLING-JENKINS** — Fantastic; thank you very much for that. Just one more quick question. You mentioned the cultural competence of mainstream staff, and I can imagine that is quite a challenge. You mentioned one workshop that you had run. Is that something that you do regularly?

**Ms MOLLOY** — We did not run it. It is through the Department of Health and Human Services —

**Ms GLENIE** — It is run by the Royal Women's Hospital.

**Ms MOLLOY** — and the Royal Women's. I think they are free workshops that they have run all over the state, and it is for that cultural competence.

**Dr CARLING-JENKINS** — So do you play a role in upskilling particularly practitioners in your area around cultural competence?

**Ms MOLLOY** — I guess that is one of the challenges for an ACCO because everybody wants a piece of you and everybody wants their cultural competence taught by their ACCO, and the ACCO is not funded to educate every other service sector in the region on how to be culturally competent.

**Dr CARLING-JENKINS** — Even though you would love to be able to do it.

**Ms MOLLOY** — Well, it would be a great thing to be able to do, but it is not viable at this point in time. We do have a cultural liaison officer at MDAS, but we have a workforce of 250 staff and 53 per cent are

Indigenous, so we have a lot of our own staff that require cultural competence training. So it is a big ask to try and roll it out for everyone. We were involved in that, but we were not the lead. We were there as a presence, as KMS. We worked alongside the hospital but the Royal Women's put it on.

**Dr CARLING-JENKINS** — So would you say there is still quite a gap in the rural areas around that kind of training being accessible?

**Ms MOLLOY** — Yes, I think so.

**Ms GLENIE** — I suppose if you think about maternal child health nurse services, they are set up for everybody, aren't they? They are set up for middle-class, white people who live in Melbourne to go and get their 10 ages and stages, and often the workforce is really expecting to see those women. Most of their clients are those women: middle-class women coming with their babies to have the 10 ages and stages. So it is almost like there needs to be a specialised workforce that actually works with families with more complex stories really; that are not there just to get their 10 checks, but maybe need a whole lot of different services in a different way.

**Dr CARLING-JENKINS** — Sure. Thanks very much; I appreciate that.

**The DEPUTY CHAIR** — I want to pursue a little bit too on *Wondering from the Womb*, because I thought it was really quite interesting. You mentioned that there are nine sessions and each are a yarn. I have had a look and I can see quite clearly how each session is a yarn. At what point do they have those nine sessions?

**Ms MOLLOY** — I guess when they want them. So we hope to get all antenates in prior to 13 weeks — that is one of our KPIs — and we generally have been more successful at that because they come to our GP. So the timing is kind of driven by the women themselves really. They are offered it early, and it depends on when they want it. Sometimes they do not do all of the yarns. Sometimes they do three or four and are happy with that or achieve whatever it is that they want to achieve. But it is not a time frame; it is a flexible program.

**The DEPUTY CHAIR** — What is the take-up?

**Ms MOLLOY** — The take-up? It is new. So on the take-up, we probably had about eight through this year. We have about 40 Aboriginal births a year at KMS and probably see about 60 antenatal families. We are hoping to increase that obviously. Obviously it is slow at the moment because the midwife and the lead practitioner are doing it one-on-one. So we are hoping to get to a point where we have tested it enough to know that it can be done in a group because at the moment it is difficult obviously to get throughput.

**The DEPUTY CHAIR** — You mentioned before about the KPIs, and you said that there is a lot of other stuff that is unrecognised. What else would you put in the KPIs?

**Ms MOLLOY** — I would put in things like we do a lot of work supporting women with domestic violence issues, supporting them to Mallee DV, to Meminar, which is our local Aboriginal refuge.

**The DEPUTY CHAIR** — What is your KPI around it?

**Ms MOLLOY** — There is no KPI around that.

**The DEPUTY CHAIR** — No, but what would you put it in?

**Ms MOLLOY** — What would I put it in? I guess that is the challenge. I guess it would be around social supports or even just — I do not really know what it would be. Our other one is we do lots of transporting. We have had women in Ouyen that we drive up and down to the hospital; it is 100 kilometres away. It is more around those social supports or what traditionally would have been seen as like a social worker-type role. I do not know what the KPI would be.

**The DEPUTY CHAIR** — I would just like you to now just elaborate a little bit on the transfer or the referrals to tertiary centres. You said that ideally they have got a KMS service. Are there many of those hospitals around?

**Ms MOLLOY** — There are 14 KMS services in the state, but only three are in hospitals — Northern, Sunshine and there is one more, maybe at Peninsula Health, but it does not run quite like ours. It just means that because we are part of a statewide network who meet four times a year we know each other, we talk often and you can ring that midwife up and say, ‘I have got such and such on ward 4E at the Royal Women’s’, or whatever, and they can help with the liaising.

**The DEPUTY CHAIR** — How does that work in terms of on the ground? So somebody needs to be transferred to a tertiary hospital in the city. How do you say, ‘Hey, listen, don’t go to that one. Go to this one because they’ve got this service’.

**Ms MOLLOY** — No. I have no ability to do that.

**The DEPUTY CHAIR** — Who does have that ability?

**Ms MOLLOY** — The hospital that has got the bed, basically.

**The DEPUTY CHAIR** — And is that something they are cognisant of?

**Ms MOLLOY** — Around whether there is a KMS there? I would think not.

**The DEPUTY CHAIR** — Would that be a consideration?

**Ms MOLLOY** — I would not think so, no.

**The DEPUTY CHAIR** — Has that been a discussion that has ever been had with the hospital?

**Ms MOLLOY** — I would not think so. They all have AHLOs. I imagine the pressure on beds — probably Nikhil and Sandra can talk more to this — would not make that possible at all.

**Ms EDWARDS** — Thanks for coming in; lovely to see you again. Following up on some conversations we had in Bendigo with BDAC —

**Ms MOLLOY** — Do you want me to give this back to Kate?

**Ms EDWARDS** — You could probably both answer. It is in relation to the transport issues that we discussed in Bendigo, and I imagine it is a much more difficult proposition up here given the longer distances. Does the hospital have a patient transport service that actually assists mothers who have just given birth to get home? I know that the Red Cross run patient transport vehicles. Is that accessible for Aboriginal women?

**Ms MOLLOY** — You mean from Mildura Base to home?

**Ms EDWARDS** — Yes.

**Ms MOLLOY** — No. I imagine Sunassist could be involved, but we do not usually use them; is that right? Generally when we know and if we are around we can do it, but if we do not know or we think it might happen overnight or at weekends, we leave taxi vouchers at the hospital.

**Ms EDWARDS** — What is the answer to this? It is a very significant problem, so what do you see as the solution?

**Ms MOLLOY** — A hospital could have a transport driver available to the maternity ward 24/7. That would be fantastic; that would be great.

**Ms EDWARDS** — So they do not currently have that?

**Ms MOLLOY** — No. Does any hospital have that?

**Ms EDWARDS** — Patient transport support, yes, they do.

**Ms MOLLOY** — No, there is no patient transport.



**Ms EDWARDS** — The committee is very familiar with the *Closing the Gap* report obviously and the disparities between Aboriginal and Torres Strait Islander women and non-Aboriginal women in terms of outcomes, particularly in relation to birth weights, infant mortality, smoking rates et cetera. I know that you are doing fantastic work in this space as are the other Aboriginal support services, but I want to know perhaps how well we are closing the gap, and if we are not, what needs to be done better. I am specifically talking about women in the perinatal period.

**Ms MOLLOY** — I guess, not being an Aboriginal person, the self-determination, having Aboriginal people involved in Aboriginal decision-making, is what they want. We do have an Aboriginal health worker who has to work within the KMS, so having that person involved, I think —

**Ms EDWARDS** — Do you only have one?

**Ms MOLLOY** — You can have more obviously, but there is one identified position, which is the Aboriginal health worker. You must be an Aboriginal person. The midwife could be an Aboriginal person, but currently I think there is one, or maybe two, around the state in the KMS service. That is certainly open. I think having that cultural liaison person within the service is helpful.

**Ms EDWARDS** — I probably should ask the hospital when they present, but in terms of midwives and maternal and child health nurses in this area, do they have cultural training?

**Ms MOLLOY** — The hospital have the training that we spoke about earlier. I know our KMS midwife, Hannah, has been up there recently and run an information session on what the KMS is and what it does. I think maybe in general perhaps in Mildura it is hard to know what MDAS does. It is a big organisation with lots of programs and lots of acronyms. A lot of us tend to focus on our own area of expertise, and when it crosses over we do not necessarily know. I think it is hard really to know what everyone is doing. The maternal and child health nurses — I do not know if they do cultural training, but I think their person is speaking after lunch; is that right?

**Ms EDWARDS** — Yes.

**Ms MOLLOY** — I am sure they have asked. The Best Start program have asked to come to MDAS and have a tour and an explanation of what services are available. That is happening in the next few weeks, and certainly we will be sending one of our maternal and child health nurses to their monthly meeting to speak to them about what we do, what we do differently and why it is important that our service is actually offered to clients in maternal and child health in Mildura.

**Ms GLENIE** — It would have been really good to see the video. I actually do not think it is embedded in that slide, but we could send that to you because we really do believe in that strength-based approach, and we think this model is that. It is saying, 'This is an innovative way of working, it is having some good results, it is based on self-determination, and have a look at these families who are doing well now because they have got the right supports around them from a service that they can trust'.

**The CHAIR** — We would love a copy of the video. If you could organise it with Greg and Helen at the end, that would be fantastic.

**Ms GLENIE** — Yes.

**Ms MOLLOY** — One of the strongest points I would like to make is the lack of respect or acknowledgement for maternal and child health services within ACCOs. I think there are only three in the state, and we have got two of them — one here and one in Swan Hill. It is a real challenge for us. Those women and families are entitled to continuity of care, and we know that service has worked within ACCOs and Aboriginal people access their health service within their ACCO, yet it seems to be the last bastion. Maternal and child health for some reason is not thought to be necessary inside an ACCO. We know that these families are experiencing some of the most vulnerabilities, yet for some reason we are not funding what they need.

**Ms EDWARDS** — That is good to know. Thank you.

**Ms COUZENS** — I suppose that comment draws to my question around closing the gap and the significant deficiencies within our services, not just in Victoria but across the country, but in terms of Victoria we are still

nowhere near closing the gap. How do we do that? What do we need to put in place to ensure that we are meeting those targets?

**Ms MOLLOY** — No-one has really come up with an answer yet, have they? But I think —

**Ms COUZENS** — I think they have. I think we know.

**Ms MOLLOY** — self-determination is really, really important to the Aboriginal people. I do not want to be too political, but they want that treaty. It is important to them.

**Ms COUZENS** — They are getting the treaty, so how do you then tie in the closing the gap —

**Ms MOLLOY** — It is that acknowledgement, I guess, and then to grow from that.

**Ms GLENIE** — I will have a little go at that too. I suppose it is that thing of actually recognising what Aboriginal community controlled organisations do. You can have the treaty, but actually the best thing we have got in Victoria is these organisations that do provide holistic services. They need to be funded in a better way so that they are not scrabbling for bits of money and then having to integrate that internally themselves to actually create services that work for their people. They need to be funded in a much more holistic way. The Department of Health and Human Services have now said that the Koolin Balit money must be applied to Aboriginal organisations, and I think that is food for thought for other government departments — that maybe Aboriginal funding should be spent in Aboriginal organisations and Aboriginal funding should not go to mainstream organisations. They should do that work because they provide universal services, and that means services for all. They are already funded to do that. So Aboriginal funding should not go to the mainstream; it should come to the organisations. I think the treaty will really help that happen. I do not think we have structures like they have in Canada and New Zealand and the States, and a treaty in Victoria is a really great starting place — and then recognition of the ACCOs as the strongest vehicle for that self-determination that we actually have here.

**Ms COUZENS** — In terms of the professional staff within your organisation, how many are actually Aboriginal people?

**Ms MOLLOY** — The organisation has around 53 per cent Aboriginal employment.

**Ms COUZENS** — Is there a willingness to ensure that young Aboriginal people, for example, are being skilled up and given those opportunities?

**Ms MOLLOY** — I guess each of us within the organisation recognises that our role with the Aboriginal staff is to mentor and train, and then ultimately our job is theirs. I think all traineeships within MDAS have to be for Aboriginal people. We have identified positions within the organisation as well, and certainly we try really hard to help bring those staff along. We work in the schools as well. We run the Sacred Sistas program at Koorie Girls' Academy at Chaffey Secondary College here in Mildura. That is being run every term of this year. We have had about 40 girls through. It is about empowering them and educating them and giving them strength in themselves to feel confident that they can do something and that they can achieve things.

**Ms COUZENS** — Do you think one of the issues for Aboriginal people in the profession is that they are not paid at the same rate as everybody else, that there is an Aboriginal award that actually pays them less and that is becoming more and more of an issue in the sector? Are you aware? Sorry, I do not know if you are aware of it.

**Ms MOLLOY** — Well, I am aware they have an award. I am not sure about being paid less for the same —

**Ms COUZENS** — Yes, they are paid less.

**Ms MOLLOY** — It would not be for the same role. I cannot speak to that. You would have to ask — I do not know who.

**Ms COUZENS** — I just wondered whether you are aware of it, because I know in a lot of the health services — the VACCHOs — it is becoming a big issue that Aboriginal professionals are leaving and going into mainstream services because they are getting paid more for the same job.

**Ms GLENIE** — I guess as LMARG, the Loddon Mallee Aboriginal Reference Group, our role in advocacy — at the moment we are also involved in the review of the midwifery workforce that is being undertaken by the Department of Health and Human Services. We would really like to know what has happened with the midwifery traineeships which were dedicated to Aboriginal people. Who took up those traineeships? Did they finish them? Are they working out in the sector? How many people are there? We would really like to know that information so that we can actually maybe support a group of people in this region to come here and work here. We have in Echuca the Aboriginal midwife and the maternal and child health nurse, which is a fantastic thing to have in Echuca, but it would be great to have more professional staff working out in the regions and to attract people to the jobs, properly paid jobs.

**Ms COUZENS** — Yes, exactly.

**The ACTING CHAIR** — Are there any more questions? I think I had one actually, just before we finish. How many people do you have employed?

**Ms MOLLOY** — In MDAS or in the early years service?

**The ACTING CHAIR** — MDAS.

**Ms MOLLOY** — I think MDAS is around 230. Do not quote me.

**The ACTING CHAIR** — So the 53 per cent that you gave Chris before refers to 53 per cent of the 230?

**Ms MOLLOY** — Yes. I can give you the exact figure if you like, because 230 — it is around there.

**The ACTING CHAIR** — No, no. More than 200 — that is fairly substantial.

**Ms MOLLOY** — I started in July 2013 and I think there were about 120 staff then, so it is really growing.

**The ACTING CHAIR** — Where do you recruit your workers from?

**Ms MOLLOY** — I guess locally mostly.

**The ACTING CHAIR** — And is that a problem? For every job you advertise are you getting plenty of people applying, or is it difficult?

**Ms MOLLOY** — No, there are some challenges. Because we obviously have the Swan Hill office as well, it is more challenging in Swan Hill. It is a small pool of people that you are trying to employ from, with competition from Mallee Family Care and co. We found our most difficult recruitment is in Swan Hill. I am not sure of the actual reasons behind that. I think it is just a small area. MDAS does not necessarily have the same presence or acknowledged presence in Swan Hill. In Mildura we certainly get a lot of applicants. We do not necessarily have trained staff, and we do recognise that with our Aboriginal staff it is really important to train on the job.

**The ACTING CHAIR** — Are there particular types of roles that you are struggling with? Are some easier than others to fill?

**Ms MOLLOY** — The maternal and child health role in Swan Hill took 12 months to fill, so that was a challenge. I think maternal and child health in Swan Hill in general have quite a few vacancies that they cannot fill. Then that staff member came from Robinvale, which then opened up another problem in the area in that that maternal and child health nurse is now at MDAS, so now there is not one in Swan Hill. I mean, I do not know if they have filled it; they may have. So that is a challenge. I guess for some people there is the idea that the funding is not ongoing yet. If you are a maternal and child health nurse in the mainstream, not knowing if your job is going to roll on could be challenging. We have to put in our contracts that these are subject to funding, so not everybody wants to take that risk.

**Ms EDWARDS** — I just had a question in relation to the model that you rolled out and if over time, since it commenced, you have seen the number of child protection orders reduce amongst the Aboriginal and Torres Strait Islander women and families.

**Ms MOLLOY** — I do not have actual figures at the moment. We think definitely we have had a reduction in, certainly, removals. The notifications I would have to check, but I imagine they are still reasonably high. I think part of the problem is unborn notifications. It would be really nice if families knew about the unborn notification prior to hitting — and I am sure Sandra would agree — the maternity ward. That would be great. Sometimes there is work that could have been done to prevent that becoming an active case but that sometimes does not happen when people are unaware.

**Ms EDWARDS** — Do you have any idea of the number of unreported —

**Ms MOLLOY** — Of unborn reports?

**Ms EDWARDS** — Yes, that attend the hospital.

**Ms MOLLOY** — No.

**The ACTING CHAIR** — Sandra, any idea? There would be lots.

**Ms DOYLE** — I would have to find out.

**Ms MOLLOY** — Sometimes they are a challenge. We know there is an unborn report but it is not in the history, which is not the fault of the hospital. That is coming from the department. We know, but it is not in there. You cannot hold people without an order. Sometimes that is challenging. I think also — just from my experience; I have obviously worked at Mildura Base and other hospitals — when you are working in a workforce that is often —

I think between the thoughts of what is notifiable within a hospital and those working in community there is a huge gap, and certainly I was a part of that in my previous role at the hospital. What we see as normal in community is seen as abnormal by staff in the hospital, which is no fault of their own. That is their world, I guess, so that is a challenge in that sometimes notifications are not done and it is thought that they should be done, but when you work in community you realise that there is a normality to some of that stuff, and I think that can sometimes bring a bit of a challenge. Does that make sense?

**Ms EDWARDS** — Yes, absolutely. So we would not have any idea really of the number of women from Aboriginal and Torres Strait Islander communities who might not be engaged with any kind of service and perhaps giving birth at home unassisted without any supports?

**Ms MOLLOY** — No, and I guess that is the struggle, isn't it? The most vulnerable — we do not know who they are or where they are. They are not coming to any service, and they are the ones that need us the most. I guess sometimes they go to the hospital — BVAs — and have had no antenatal care. I do not know if we have any figures.

**Ms DOYLE** — It is a fairly small number, a very small number because we usually get notified —

**The ACTING CHAIR** — What you are saying is not being recorded for Hansard.

**Ms MOLLOY** — I can speak to that. Obviously it is a small number, but if they never come in —

I would doubt there are many born unassisted at home that never present to a service. I would think that that would be extremely low — I cannot say none. But certainly there are some Aboriginal women picked up in the hospital who have not received antenatal care, and certainly sometimes this can happen due to a fear of DHHS.

**Ms EDWARDS** — Thank you.

**The ACTING CHAIR** — Thank you very much, Jacinta and Kate, for your presentation from MDAS.

**Witnesses withdrew.**