T R A N S C R I P T

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Geelong — 11 December 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

Mr Rodney Jackson, CEO, and
Ms Mandy Miller, Midwife, Koori Maternity Service, Wathaurong Aboriginal Cooperative.

The CHAIR — Welcome to this public hearing, Ms Mandy Miller, Midwife of the Koori Maternity Service, and Mr Rodney Jackson, CEO from the Wathaurong Aboriginal Cooperative. 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 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.

I invite you to make a 10 to 15 minute contribution to the Committee but, firstly, I would just like to introduce myself. My name is Paul Edbrooke, I'm the member for Frankston and the Chair of the Committee.

Ms McLEISH — Cindy McLeish, Deputy Chair and member for Eildon.

Ms COUZENS — Chris Couzens, member for Geelong.

Ms EDWARDS — Maree Edwards, member for Bendigo West.

Ms BRITNELL — Roma Britnell, member for South-West Coast.

The CHAIR — We're in your hands.

Mr JACKSON — Thanks very much. Thanks for inviting us to the hearing. Mandy is probably well tuned with her work over many years in our service, particularly in the maternal and child health and midwife area and obviously we're involved in the birthing centre at Barwon Health. Our area runs from the Werribee River through to Colac to Apollo Bay, so we've got quite a large catchment, and also right up to as far as Ballarat so we've got a fairly large catchment.

Our population is about 3,500 Aboriginal people and we're currently at about 100 births a year, Mandy? Not quite. We have also given a written response to Maree over there as well to some of the questions that you have asked and certainly Mandy has prepared some of this in my absence so I might hand over to Mandy for those questions. Obviously, I've been involved in Aboriginal health for about 15 years at three or four services as well as the Victorian Aboriginal Health Service and here at Wathaurong so I'm familiar with the health and wellbeing of these programs but certainly the hands on and day to day activities are under the leadership of Mandy.

The CHAIR — Thank you, Rodney.

Ms MILLER — I would just like to start by acknowledging the Wathaurong Country that we meet on today and pay my respects to the Elders past and present and the Aboriginal people in the room today. I'm a bit nervous so I'm just going to read — —

The CHAIR — Please don't be nervous. I'm more nervous than you are sitting between all these ladies; there's a lot of pressure here.

Ms MILLER — Continuity of care is well documented as best practice for perinatal care for both low and high risk models. The KMS program at Wathaurong Aboriginal Co Operative provides a continuity of care model that is culturally responsive, evidence-based, focuses on decreasing health inequity and includes the full continuum of maternity care. In order to close the health gap for Aboriginal people, we need to ensure our children have the best possible start to life. In order to achieve this, we need healthy Aboriginal mothers receiving best practice antenatal care, birthing healthy babies within a healthy weight range who develop into healthy children who are school ready. This takes a multidisciplinary team based approach across the early years, starting with Koori Maternity Service, following onto maternal and child health and supported by programs like Cradle to Kinder, Aboriginal Stronger Families, Child First Innovations, in home support and Kinship Care, all working together to provide care, support and capacity building for our families.

The first question, the availability, quality and safety of health services delivering services to women and their babies during the perinatal period:

As Rod said, the traditional boundaries of the Wathaurong People span the coastline from the Werribee River to Lorne peninsula and traverse inland in a north westerly direction towards Ballarat, some 18,000 square

kilometres. University Geelong Hospital provides excellent care for our regions to women and children during the perinatal period. However, Aboriginal women face barriers in accessing a service which will meet their needs. This highlights the important role Aboriginal community controlled health organisations play, particularly the Koori Maternity Service in relation to perinatal care. Wathaurong Aboriginal Co Operative takes great pride in the strong working relationship it has developed with University Geelong Hospital to provide best practice perinatal care that is strong in cultural responsiveness. The KMS program is available to all Aboriginal women, and non-Aboriginal women having Aboriginal babies. A registered midwife and an Aboriginal health worker work closely together to provide holistic care and support in a community setting to Aboriginal families during the perinatal period.

In collaboration with University Geelong Hospital, an Obstetric Clinic is held once a month at Wathaurong Health Service which provides excellent care for both low and high risk women in the community setting where our families feel most comfortable and supported and this is evidenced by an ongoing 92% attendance rate. Importantly, this clinical approach also enables vital continuity of care which has been demonstrated to improve outcomes for women and their babies. While KMS provide most of the perinatal care for their clients, they also play a very important role in the co-ordination of care, including assistance to access other service providers, inclusive of ultrasound, housing, attending appointments, transport, advocacy and support with child protection matters, Centrelink obligations and making appropriate referrals to other services such as domestic violence and drug and alcohol services.

Traditionally, birthing is women's business but fathers are becoming more involved and as such the KMS team also provides support and education for fathers as well as linking them in to services that they may require. For the most part, the support role that KMS undertakes is unfunded but is extremely important in achieving the best possible outcomes for mother baby and family.

The impact the loss of Commonwealth funding; in particular, the National Perinatal Depression Initiative, will have on Victorian hospitals and medical facilities and on the health and wellbeing of Victorian families:

It is well documented that the perinatal period can be a time for increased social and emotional difficulties, increased anxiety, mood disorders and mental health issues for Aboriginal women. Our clients have complex family issues, with domestic violence and drug and alcohol, child protection involvement, housing uncertainty, and involvement in the justice system, all of which have an adverse impact on the social and emotional wellbeing of our families.

Pregnancy, however, is a great opportunity for families to receive assistance when they access the health service. Unfortunately, accessing such supports is not an easy task, especially since the loss of funding for the PHEP program. Many mainstream services lack cultural responsiveness, female counsellors are not always available, waiting lists are long and it can take some time to get an appointment. Often this means that emotional and social support falls to the Midwife and Aboriginal health worker further increasing workloads.

The adequacy of the number, location, distribution, quality and safety of health services capable of dealing with high risk and premature births in Victoria:

The KMS program has been operating at Wathaurong since Feb 2008 and employs one EFT Midwife and one EFT Aboriginal Health Worker who provide care for women across an 18,000 square kilometre area. On average each year we work with 40-45 clients of whom 80-90% are classed as high risk and have 25-30 births. Providing perinatal care alone for this caseload stretches capacity to breaking point. University Geelong Hospital data shows an average Aboriginal birth rate of 50-55 a year, which suggests that KMS numbers will continue to increase and potentially may double in the next few years.

The majority of our clients are now presenting as early as 5-9 weeks, having 10-12 antenatal appointments, averaging five postnatal appointments and an average birth weight of 3.3kg. We have developed an excellent collaborative partnership with University Geelong Hospital, enabling clients at all levels of risk to continue care with KMS. It is well documented that the need for early and regular antenatal care can improve the outcomes for Aboriginal and Torres Strait Islander women and their babies. In particular continuity models of care with midwives have demonstrated a reduction in premature labour and birth and the quality management of high risk pregnancies and birth, in the document McLachlan et al, 2012.

The quality, safety and effectiveness of current methods to reduce the incidence of maternal and infant mortality and premature births:

For many of our clients, the fact that they are Aboriginal automatically classes their pregnancy as high risk. Historically late presentation and poor attendance for perinatal care has increased this risk. We need our families to feel comfortable and safe to seek care early in pregnancy and to maintain regular visits throughout the perinatal period.

With the early presentation, we are finding that medical and obstetric issues in the perinatal period are being picked up early and monitored by KMS with the support of the University Geelong Hospital Obstetric Team. We have identified that the community-based approach is working with increased perinatal visits, increased birth weight and increased breastfeeding rates as a result.

Ideally, we would like to be able to educate our women, and in particular young women, pre-conception so that they are in the best possible health when they become pregnant and thereby reduce perinatal risk. Currently we have no capacity to run sexual health and women's business education sessions, which would be particularly valuable to our teenage girls. It would also be of great benefit to be able to engage male workers to conduct similar men's business sessions.

Access to and provision of an appropriately qualified workforce, including midwives, paediatricians, obstetricians, general practitioners, anaesthetists, maternal and child health nurses, mental health practitioners and lactation consultants across Victoria:

The Wathaurong KMS program provides a gold standard model of care for our community, but it is extremely difficult to provide the same level of care to areas outside of Geelong, and in particular to Colac and surrounding areas, with the current work-force. We are very fortunate to have an exemplary commitment from University Geelong Hospital to assist us in closing the health gap. University Geelong Hospital provides a Paediatrician, Obstetrician, Psychiatric Registrar and Endocrinologist, all whom conduct clinics at Wathaurong and as such are providing a bulk-billed service which is accessible for our community.

Wathaurong has also been fortunate to receive recent funding from DET for an Aboriginal Maternal and Child Health Initiative 12-month pilot. This funding is providing a MCH service at Wathaurong and employs a MCH Nurse and MCH Aboriginal Support Worker. We are very excited to have recently commenced this program as it has been well identified as a gap in services for our families. While KMS supports families until six weeks post birth, many of our vulnerable families have been falling through the gaps as they feel unsafe for many reasons to access mainstream services.

In the recent Korin Korin Balit-Djak Aboriginal Health, Wellbeing and Safety Strategic Plan 2017-2027, there is a commitment to increase access to culturally responsive early years services, that is the strategic direction 4.2.1. Recent data indicates that approximately 75% of Aboriginal women who gave birth in Public Hospitals have accessed Antenatal care through a KMS program. The development of the KMS guidelines cater for the provision of culturally safe and high-quality maternity care.

Disparity in outcomes between rural and regional and metropolitan locations: The majority of our clients' medical/obstetric needs can be met by University Geelong Hospital, however, on occasion there is a need to attend a tertiary hospital in Melbourne. This often causes a number of issues for our families. Namely because we are under 100kms from Melbourne, accommodation for partner and family support is unfunded, transport is difficult, parking is expensive as is buying food. This makes the prospect of accessing care in Melbourne very difficult for our families.

Also, due to our Regional classification, Wathaurong KMS is not eligible to claim Medicare benefit 16400 for a midwife to conduct an antenatal check on behalf of a medical practitioner. For regions R3-7, this claim can be made up to 10 times in a pregnancy and helps raise Medicare funds that can be redirected into KMS to help provide the extensive and fully integrated service that we provide.

Identification of best practice:

The Wathaurong KMS program is an example of best practice providing culturally responsive perinatal care. With the inclusion of AMCHI we are now developing a strong early years' service. For the health gap to close

significantly for Aboriginal People we need our Mothers to have the best perinatal care and for our babies to be born in the best health to give them the best start. With an early years' approach, we can ensure the growth and development of our children is optimised, parenting capacity is strengthened and that our families are nurtured with the ultimate goal of our children being happy, healthy and ready for school.

In conclusion the KMS program is making a significant difference during the perinatal period but we have a long way to go as we continue to close the health gap for Aboriginal People. Ideally, we need an increase in KMS funding so that the program can grow to meet the future needs as the birth rate increases. Further funding will also aid in an increase presence, particularly in Colac and surrounding areas, to provide a much needed cultural responsive perinatal program. Increased funding would also enable us to commence preconception education running women's business groups particularly for our young women. Importantly, we also need to secure ongoing funding for Maternal and Child Health at Wathaurong following the AMCHI pilot. MCH is the key to the development of a strong early years' approach that can build on the results currently being achieved by the KMS program.

The CHAIR — Thank you for that. I would just like to pass on my appreciation of the passion and commitment you display, and I know that it's not an easy road and you would have seen that over three decades, Rodney, and we might get to that in a minute but I would to invite Chris to kick off with some questions.

Ms COUZENS — Thank you so much for coming along today. The collaboration with University Hospital Geelong, as we know, is quite extraordinary. We heard from them earlier and that collaboration is clearly working and I know very well there's a long way to go yet but compared to what else is happening around the state it's exceptional so thank you for putting that on record today.

I would like to get your view on how you think the new birthing unit will operate at Geelong Hospital, the Aboriginal Birthing Unit.

Ms MILLER — We're very excited to be a part of that and we've had community consultation and women have put forward some ideas of what they would like in the room. We have a local artist who is doing the artwork. Traditionally we had a birthing cave here at Geelong, down at Portarlington, so the artist is going to be doing a mural that is the view from the birth cave which will be of the bay and the You Yangs. The women are very, very excited about that. The wall then goes onto a wall where the window is and what we're planning is to have a birth tree that goes around the window. The women don't want their babies to come until that room is done now; they're a bit worried they're going to miss out, but I'm sure they will get there with number two, three and four.

The women are aware that they may not be able to use the room when they come in — it's not just for Aboriginal people — so they are aware that it may not be available and when they do come into labour. But the fact that they know it is there actually makes a huge difference.

Ms COUZENS — What was the rationale for making it a shared facility?

Ms MILLER — Because Geelong Hospital has such a large birth rate, and we have at most 50, 55 births a year, you can't hold a room aside for that amount of people. I think it's also an opportunity for education of the wider community and for all the midwives, they will have to know the story of why we have this room, and to be able to give some education to women around Aboriginal health and why the things are important I think is a great opportunity as well. Last year Northern Hospital did a birth room and they are finding that non-Indigenous women are actually asking for it because it's so beautiful and it makes them feel relaxed, which is fantastic, so that education I think is really, really valuable as well.

Ms COUZENS — Workforce is obviously an issue, getting enough Aboriginal people into the health sector, particularly midwives and maternal and health nurses, and obviously Wathaurong has 64 percent Aboriginal employees, which is quite high compared to a lot of the other communities. Have you got an answer to encouraging young Aboriginal and Torres Strait Islanders to get into the health sector? What do you see as being some of the solutions to that?

Ms MILLER — We've had some of the schools actually bringing their students in Year 10 out for a bit of a health taster, so just get some thinking in those years where they're starting to decide what sort of subjects they want to do and what their future careers might be. I think that's been really very positively welcomed. Also, we

encourage a lot of our young women to apply for the health worker positions, support them to do the education, both by paying for it, the KMS program pays for the education of the health worker, and we also pay them for the time when they're up at VACCHO one week a month, so I think that's really important being able to give them that support.

I think as we're building an Indigenous workforce that role of the Aboriginal health worker and the Aboriginal support worker is so valuable and fundamental. As a non-Indigenous person myself, having an Aboriginal health worker work with me — and when I first started it was Renee Owen, her community knowledge and everything — —

Ms COUZENS — Poached by Geelong Hospital.

Ms MILLER — Yes, I know. Don't make me cry. That's how I got into the homes, how I met people, how I got to be known. If Renee trusted me, we will give her a go. Now I'm able to go into the homes unescorted and people are coming to me, which is fantastic, and I think that's really important. I really hate it when people say they're just a health worker. Their role is more important than my role. Anyone can be the midwife, but no one can be the Aboriginal health worker, so just letting them know their value in mainstream services, in our own community, is really, really important because they're the ones who are going to mentor and role model for the kids that are coming up.

Mr JACKSON — Just on that, Chris, through Deakin IKE, of course, we also encourage — I'm on their advisory committee, so we are trying to advise and to assist some of the people that are attending there to do nurse training and also to do Aboriginal health worker training. The current worker that we've got for the Aboriginal health worker is doing it at VACCHO Training, because she had a Cert III in another qualification we are up for a $16,000 fee plus her non-attendance at work and other expenses, so that needs to be taken on board when you're talking about the cost of the service, every month she is away for a week or something, so it's just another add on that even though you've got them trained you've still got the cost to doing that and a lack of someone in attendance.

Also, the work that Mandy does is around the clock in a way because she is there to assist seven days a week on call, I think that should be taken into consideration in our discussions as well, just adding to some of the complexity and flexibility of the work that we do.

Ms COUZENS — So there's an issue around the funding?

Mr JACKSON — The funding model, yes. That's a discussion we have regularly about how we fund some of our services and particularly when we can't claim on some of those Medicare funding issues that are add ons to the provision of service that we need to do.

Ms COUZENS — Do you have any other ideas around how we encourage Aboriginal and Torres Strait Islanders to take up that training?

Ms MILLER — I think exposing them at a younger age. Even like the women's business camps and things that we would like to do, while it gives them the sex education and all of that sort of stuff, it also exposes them to what a health worker does and what a midwife does and I think that's valuable in itself and if we can get some of the male workers involved and doing the men's business as well, I think similarly that would be a fantastic opportunity to highlight the health side of the workforce.

Ms COUZENS — The maternal and child health nurses, can you just dig down a little bit about how that connects with Wathaurong?

Ms MILLER — A lot of our vulnerable families haven't been accessing the universal services through City of Greater Geelong and it's for a number of reasons. Sometimes it's cultural safety, they don't feel culturally safe; they see maternal and child health as an arm of child protection so they're very frightened — transgenerational trauma is very high around that — and because the City of Greater Geelong is so busy, there's no flexibility in their appointment book. If a mum has had a bad night with one of her children and can't get up and get to the appointment, then they miss that appointment, there's no way of them being able to come later or going home to do a home visit or any of those sort of things, so that all impacts. Also, it's very prescriptive on

what they teach the women and sometimes the language that they use can be very disheartening for the mum with: no, you can't do that. Well, it's my baby. It's not culturally safe.

We know the recommendation is not to co-sleep with your baby, we know that there is increased risks of SIDS and sleep accidents, but the reality is our women culturally will sleep with their baby so they will just say: oh, no, I don't sleep with my baby. So, you've lost an opportunity to discuss that and to discuss what is the harm minimisation approach we can use here, how can we do it safely? Okay, we don't have our baby in our bed if we've been drinking alcohol or taking any other drugs, or if you're really, really tired. You can get little inserts that can go in your bed so baby has their own space. All of those sorts of things. What we've found in the research is that mums, all mums, are so scared about sleeping with their baby that they fall asleep on the couch with their baby and babies are falling off the couch and becoming injured or slipping between the cushions and smothering. We're scaring mothers out of doing one thing but they're actually replacing it with something that's unsafe because we don't have that conversation. Some of our mums have been in trouble because they've got a mattress on the floor in the lounge room and everyone is sleeping in there. But that is culturally very, very appropriate for our families so there's lots of those sorts of things.

We have had a pilot program at Wathaurong for the last 12 months prior to the AMCHI pilot and just one day a week where one of the maternal and child health nurses from City of Greater Geelong have come and sat at Wathaurong and we have had 14 families access that service who had never accessed the mainstream service at all, which is fantastic, and I think it was another 12 that had re-engaged through that program. The community is really speaking up loud that this is their preferred model of care, that they get to know the KMS midwife and health worker very well in the pregnancy and it's our office that is used by the maternal and child health nurse so they feel very comfortable. It becomes a one stop shop, they can have their immunisations done on the same day that they have their key age and stage check. If the maternal and child health nurse is concerned about something we've got a GP that can come and participate in the consultation. We have a direct referral process with the paediatrician who comes out to visit and it all happens at home, it all happens at Wathaurong, so it makes a really big difference.

Ms COUZENS — Is that going to continue?

Ms MILLER — If I have my way, Christine, yes.

Mr JACKSON — That's part of our funding model we've got through this early education, Department of Education and Training, just a 12-month funding. That's only until up June.

Ms MILLER — September.

Mr JACKSON — That time frame is also vital to us, of course. As Mandy has said, trying to expand into Colac where we've got our service open there, the new hub opened only last month, so that is an important stepping stone for us too because there is a lot of disadvantaged Aboriginal mums down there so we're trying to work on that. The concept of a one stop shop for Aboriginal services is really vital. It works, and that's what they want otherwise, as we know, they just don't engage so that's really important for us.

Ms MILLER — The other wonderful thing too is that a mum might turn up with their baby for the Key Age and Stage visit but might have her niece or nephew and her sister with her, so the maternal and child health will do a Key Age and Stage on all of them and check out whether anyone is behind in their immunisations and get that done as well so that opportunistic care is so vital as well. We're already seeing the difference that it's making. Linking in with the children that are in the family services programs, they're all bringing their clients now, which is fantastic, and even if they're in outer home care encouraging the carers to bring them to Wathaurong for that one stop shop as well is great so that the kids, even if they're in and out of home care, can still have that cultural connection to Wathaurong.

Ms McLEISH — Can you just confirm the breast feeding rate after six months?

Ms MILLER — The last 12 months to two years we've had probably 80 per cent of our women breast feeding at six weeks and probably 50 per cent are still breast feeding at six and 12 months. It's been really good. We've had a lot of older mums having their second and third babies who are breast feeding and modelling that for some of our younger mums. A lot our younger mums are taking it up and we talk a lot about breast feeding during pregnancy so a lot of them are at least giving it a go, which is fantastic. KMS have purchased five

electric breast pumps, which we lend out to the mums so that their life can be normal. If they want to go out shopping or go out and celebrate their 21st birthday, we can do it and still breast feed with expressing and storing breast milk. Dads can be involved because we have got breast milk in freezers all over the city now. Really, really proud of our increase in breast feeding.

Ms McLEISH — What about immunisation rates?

Ms MILLER — Immunisation rates are over 92 per cent in all age groups. The thing is that it's a one stop shop, the opportunistic, all of that, so our immunisation rates are excellent.

Ms McLEISH — The question I was quite keen on, you mentioned that there is probably 50 to 55 Aboriginal births at Barwon and that you see maybe 25 to 30. What do you need to do to pick up the other 45-50 per cent?

Ms MILLER — Some families won't want to come to Wathaurong for political reasons, family reasons, all of that sort of stuff, and that's always going to be the case. I think that the most important thing for Aboriginal families is the choice, having the choice to go where their needs are going to be met best. Also in some of that, women who have moved into the region who don't know about KMS. We've been working with Barwon Health and they are now on first visits, if the women identify as Aboriginal, or having an Aboriginal baby, then they tell them about Wathaurong and the KMS program so we're now getting referrals from Geelong Hospital and that's why I think those numbers will increase.

Also, Auntie Athalie Madden, who is an Aboriginal midwife, worked at Geelong Hospital for about 40 years so a lot of woman saw her there, particularly at pre KMS, and Athalie retired from Geelong Hospital a couple of years ago and we quickly knocked on her door and she works one day a week out at Wathaurong with us, which is fantastic. Talking about continuity of care, she is now delivering babies of babies that she delivered, which is fantastic. And she is just a beautiful soul.

Ms EDWARDS — Thank you for coming in. Congratulations on all that you are doing, it really is a model that needs to be replicated. A couple of the issues that we have heard as we have travelled across the region is access to transport for women who are leaving hospital once they've had their babies, in particular Aboriginal and Torres Strait Islander women. Is there some program that you have or support that you have in place?

Ms MILLER — At Wathaurong we're very lucky. As part of our funding for KMS, our state funding was for a vehicle and we are very lucky that the senior managers and the CEO allow that car to actually just be for the KMS rather than in the pool. A lot of other KMS programs across the state have access to a pool vehicle. I'm on call, as Rod said, 24/7. I've actually been on call eight years out of the 10 years I've worked there so I take the car home of a night so that if I'm called out I can go. We have a capsule in the car all the time so any of our women that need to be picked up to take in for a birth, or picked up to take home, then we do that. It's fantastic, especially for some of our young mums, who don't have access to a car and whose family don't have access to a car seat, it's really, really important and it works very well for our families.

Ms EDWARDS — You probably do a few kilometres then.

Ms MILLER — Yes, we do a couple.

Ms EDWARDS — Just in relation to the Family and Children Service programs and the holistic programs that you run there. Is there a family violence section in that? I'm curious about the rates of family violence in your community, in the Aboriginal and Torres Strait Islander community in comparison to others and how you're addressing those issues?

Ms MILLER — I don't know the stats because it's not one that is in the top of my head but we do have a relationship with Minerva and — —

Ms EDWARDS — Sorry, I don't know — —

Ms MILLER — Minerva is the family violence — —

Ms EDWARDS — CASA.

The CHAIR — Minerva CASA.

Ms MILLER — We have an Aboriginal worker who works at Wathaurong two days a week from Minerva and we also have a housing officer that is for family violence as well. CASA come out and visit at Wathaurong once a week for adults and once a week for children specifically, which also helps in that area.

Ms EDWARDS — But not for pregnant mums?

Ms MILLER — Yes, our pregnant mums can access.

Ms EDWARDS — Do you think the programs that you're running — we've got a list here — the Aboriginal Stronger Families Program, the Aboriginal Family-Led Decision Making Program and the Best Start Program, are they working in terms of support?

Ms MILLER — Yes. The Aboriginal Stronger Families is a fantastic program, the workers I couldn't speak highly enough of them. We've just got Cradle to Kinder so that's also linking into that higher needs end, which is going to be fantastic because they can actually work during the pregnancy as well, which would be great because that will take the load off myself and Tamara.

Mr JACKSON — Just on that Aboriginal Stronger Families, that was run by another organisation and I fought hard to get that. We took that on and it's been one of our real success programs in terms of teaching mums to be better mums. We've opened up our Forster Street hub only in May last year, where they can go there and they can do cooking classes and mothering classes and all that sort of thing. The Aboriginal Stronger Families has just been one of our highlights this year of getting a program from another agency back to where it belongs so that's really a high success with us, that particular program.

The Aboriginal Family-Led Decision Making Program is really good too and that is part of the child protection issues. Some of our areas that we've been concerned about is the unborn registrations around how we deal with some of that and that's been an issue which might come more to our force under Section 18, which is fast approaching through Minister Mikakos, so we are looking forward to actually doing some of that. We are also embarked in a Resi care program now with McKillop which will come to fruition when they finish building, which will give some Aboriginal content, so we can take over some of those facilities which will lead to better outcomes, as we said, through the education process as well with expecting mums and those sorts of things.

Ms EDWARDS — Are you seeing a reduction in the number of mums having to really push their children through these programs?

Mr JACKSON — That's the real aim and some of those areas are really complex but we are working more closely with child protection as well and now that's just come under the regional director as well for her responsibility just recently, so that will give us better dialogue under the Taskforce 1000, which is the children and families program, which will be enforced through the Commissioner with Andrew Jackomos' dialogue. It has been really forceful in making sure that we engage better with the program so out of that Taskforce 1000 we saw numbers increase but we've also got large families here too that we have got to concentrate on how we get really good outcomes. What Mandy said too, we try and make our transport network more vigorous, and I've invested in that to make sure that we've got better access to vehicles for mums and our region has grown quite considerably.

Ms MILLER — Two people that have sprung to mind while Rod was talking. A young mum whose first child was removed when he was about six months old and she worked with Stronger Families and worked really hard and regained custody of her son and she's just had her second baby and child protection aren't involved. And another one, a young mum and dad whose first baby was also removed and had been placed in permanent kinship placement and they've had their second baby, who is about 18 months old now, and they've maintained her care the whole time and they're now having overnight visits with their elder daughter. So, these are really, really positive outcomes. The thing that we need to realise is that, particularly for our young mums, who often have grown up in the child protection system themselves and in residential care, they haven't been nurtured and haven't been role modelled of parenting or anything and then we expect them to be able to push out a baby and know exactly what to do and how to do it so there is a real focus on capacity building for our parents. I think that is the thing that is going to make a difference in the long run, is building that capacity.

Ms BRITNELL — I want to ask, first of all, about the birth weights and congratulations on having an average of 3.3, that's very good. The issue of the ones that are under 2.1 or 2.2 — —

Ms MILLER — 2.5.

Ms BRITNELL — 2.5. What's the process there, do you actually assist with the care between getting to 2.5 or are you the primary care person at that point?

Ms MILLER — For all our women, after they're discharged from hospital, we do the dom care on behalf of the hospital, and we've actually got a process now that we charge Geelong Hospital, and they pay us to do that, which is fantastic. Because my background is also in paediatrics, I was a paediatric nurse for 20 something years as well as a midwife, I also do all the home visits once the baby has been discharged from special care nursery, so I do all that surveillance of their weight and helping with breast feeding and maintaining observation and surveillance until the baby is over 2.5.

Luckily for us, the only babies that have been under 2.5 have been premature so their birth weight at birth, even though they've been born early, has been where it should be for that gestation, which is fantastic. Our premature births, we've had a couple that have been related to drug use but our other has been from a medical complication where the placenta was low and mum bled and baby had to be born by emergency caesarian so most of our premature births, that number is decreasing, which is fantastic as well. We're never going to be able to do things about where a placenta attaches in the uterus but the other ones are decreasing, which his fantastic.

Ms BRITNELL — We heard in the last presentation from the local maternal and child health clinic here and they don't actually pick up babies until they are 2.5, their policy won't allow that. Is it because of your paediatric background and they don't have paediatrics?

Ms MILLER — Quite possibly. I've worked at Geelong Hospital for 13 years and I worked in the special care nursery and I suppose because I'm known to them, and my practice was known to them, that we have been able to develop that. Whether that can continue when I leave, then I'm not sure but it's working very well at the moment.

Ms BRITNELL — At one of the other hearings we heard a lot about the change in the way societies work with people, extended families that don't exist like they did once and working with people in a medical model of checking prenatal checks and postnatal checks but what was absent was the social and emotional health, preparing for bringing babies home and family dynamics and changes that will occur. Is that what you involve in your prenatal checks? Does your program allow for that real holistic approach to change?

Ms MILLER — Definitely. And it's not all about this baby growing in this tummy, it's everything and everything that can impact on the pregnancy. Did not attend is like a swear word to us, we do not like did not attend because it's why have they not come? What is going on in their life that they haven't been able to come? So we will go out and find the mums and see what's going on, see what other assistance we need to put in place, what other things we need to do. I've done antenatal checks at Corio village, I've done them out on nature strips as I've been driving past and I've found a mum. It's not so much where these visits are happening but that they're happening. We do a lot of education around births and the first few weeks at home and normalising that a baby can cry for 14 hours out of 24 hours and that's normal, so that their expectations aren't that this baby will just feed and sleep. So, we do a lot of education around that.

Ms BRITNELL — You mentioned also about your desire to work in the sexual health area as a prerequisite, I imagine, get the Folic Acid in and stuff like that prior to a pregnancy. Does VAAHS play any part in that, the old Trish Wakefield person that used to be in sexual health and still is there?

Mr JACKSON — We still do all that. Because we take a holistic approach, as Mandy said, we encourage all those activities. Because we've got an early childhood centre as well, we can meet with the mums there. Also, we've just embarked with funding for more mental health too so some of our cross pollination of the information is really, really vital and that's a great program. We've got people like Dr Russell Gulliver there, who I met today, he is working with a whole range of people, as is Paul Thornton, he's been a psychologist with us for some time so they also know the families and some of the history. Even Kylie in the early childhood program identifies some of the mums, or knows some of the families that are in need of different activities or

need some help in different areas so that's really vital to us. The long standing information is sometimes more vital than the missing information.

Ms BRITNELL — So can you tell me a bit about the Aboriginal health worker training.

Mr JACKSON — VACCHO is heavily involved in that, of course. We've even got a male health worker there who was a former motor mechanic and came to us to do domestic type work and he's doing the training alongside Tamara who is doing the Aboriginal health worker training at the minute so we've got a couple of people there. That's vital to us as well.

Ms BRITNELL — And that training has an element of sexual health in the curriculum?

Mr JACKSON — Yes, right through. All the work that we do through VACCHO is really important to the sector and the RTO has stepped up a lot to what it was for a while so there's been a lot of discussion around making sure that we get good outcomes from there. The change of legislation with some of that training is tricky with us because sometimes if people have done courses we've got to fit the bill so that's a factor for us. Obviously too, we've only got one off people in programs, it's quite a distraction for us to make sure you've got continuity of programs.

Just adding to that, some of the things too that we've done around that is around the Deadly Dads programs, it's really teaching the dads to be really good. Sometimes when I sit on Koori court I meet the young guys who have got young children and I say to them: you should be in this as the deadly dad, not on your way into prison. We're actually doing a lot of work around connecting with families as well. I think the approach that we've taken is really strong.

Ms BRITNELL — I wanted to highlight that because it is a very holistic approach to talking about this and I think the Aboriginal community have got a very good history.

Mr JACKSON — I think we've got a good model and it's a shame that we're so poorly looked upon sometimes to get the outcomes that we get, because we are dealing with a lot of disadvantaged in housing.

Ms BRITNELL — Mandy, are you saying there's an issue in new pregnancies that you weren't seeing five years ago with increasing obesity rates and BMIs that are a risk in the community?

Ms MILLER — We do have a lot of women that have an elevated BMI so automatically classes their pregnancy as high risk. One of my women, before we'd started the obstetric clinic and we had to come into pregnancy care clinic at Geelong Hospital, and the doctor had said to her: you've got a high risk pregnancy so you can't go to Wathaurong, you have to come here. She said: I'm not a box to be ticked and I'm not high risk until I'm high risk. So, yes, I might be at high risk of developing diabetes or blood pressure but I haven't at the moment. I've really taken that on board over the last few years because when I think about it, for a lot of our ladies who have got an elevated BMI they actually lose weight during their pregnancy and they haven't developed complications and it has been some of our women with normal BMIs who have actually developed diabetes. I think the fact that we can't label people and give them a model of care that they don't want because they won't attend. If we know, yes, you're at an increased risk and we can talk to the women about an increased risk, so we may want to see you more often, and that they come more often to see us at Wathaurong is better than them being called high risk and not going at all to the hospital.

Ms BRITNELL — Rod, just a quick question. The new hub at Colac, how many Aboriginal families are now in the area for you to set up there?

Mr JACKSON — A population of about 200, so 40 odd families, 40 to 50 families. One of the highlights of that at the opening that we did last month, we were expecting about 100 people there and we had 360 people arrive to the opening of that centre. The Minister Natalie Hutchins was there, of course, and it was just fantastic. We were catering for about 100 odd people and all of a sudden 400 turned up so I think that shows that we've been long overdue with doing something like that. Mandy has been there quite often on the Mondays as well as part of the program where we've got a GP.

Ms BRITNELL — You've got a GP in Colac?

Mr JACKSON — Yes, in Colac on a Monday. So, I think that is showing a reason why we should be doing something vigorous down there. When I first came here a few years ago and looked at all the statistics and where there was population and all that sort of thing, I said: why aren't we concentrating more on that? The work that we are doing in conjunction with Barwon Health and CASA and those sort of organisations and Koori Youth, some of the youth and justice programs. In fact, John Boy Clark has decided he'd like an office in that facility too. So it's probably rent free, but they are the sort of things that we do. And that's been in conjunction with Colac Area Health because I've had a long association with Geoff Iles, the CEO down there, so we worked hand in hand.

Ms MILLER — I just wanted to say one thing about the Aboriginal health worker course. It's a Cert IV in Aboriginal Health and it's recognised Australia wide. After completion they can actually elect to register with AHPRA as a health practitioner. In Victoria we only have about six practitioners across the state and we've got two of them here at Geelong and hopefully at the end of next year we will have two years more, which will be fantastic.

Because it's a national accredited training, health workers are taught about giving immunisations and injections but because of the Drug & Poisons Act here in Victoria they're not actually allowed to do it because in the Act it says that it has to be done by a nurse. Having that legislation changed will go a long way in helping immunisation rates and things because having the health practitioners being able to do what they're trained to do will make a big difference.

The CHAIR — Thank you for your time, Rod and Mandy. It's been a wealth of knowledge for us and it's obviously a worthy model and it's getting results. Congratulations and thank you so much.

Mr JACKSON — Thanks very much.

Ms MILLER — Thank you.

Witness withdrew.