TRANSCRIPT

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

7 December 2017 — Bairnsdale

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Witness

Ms Brianna Ellis, general manager, Gippsland and East Gippsland Aboriginal Co-operative.
The CHAIR — I welcome to these public hearings Ms Brianna Ellis, general manager from Gippsland and East Gippsland Aboriginal Co-operative, which we know as GEGAC. Thanks 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.

Now that is out of the way, I would just like to say that we do not bite. We are here today to find out as much information as possible about what is going on in this area with perinatal services so we can pass the information on through a report to the government to improve our performance. So anything you can contribute will be fantastic. If you would like to begin with a 10-minute contribution about where you fit in the scheme of things, then we might ask you some questions and have a discussion, if that is all right.

Ms ELLIS — Yes, sure. Before I start I would just like to acknowledge the traditional owners of the land that we meet on today, the Gunaikurnai people, and pay my respect to elders past and present.

Thank you for giving GEGAC the opportunity to speak. I would also like to make an apology for our CEO. He did want to come, but unfortunately he had a prior booking. GEGAC is a community-controlled health service. We have an Aboriginal board. We are a cooperative, and we have a whole range of services. We have got a medical centre, a dental centre and a lot of peripheral services that we offer here in Gippsland. Our Koori maternity service provides comprehensive and holistic pregnancy care for Koori women in Bairnsdale and the surrounding area. We have approximately 50 births per year and operate out of the Brabuwoolong Medical Centre. The official opening was yesterday. It is a new building that was constructed in 2016 with some Closing the Gap funding. We offer free antenatal care and postnatal care, including outreach to Lakes Entrance and the Lake Tyers trust.

At present we have two people employed in our Koori maternity service. We have a full-time midwife, Narelle, who is here. She has many, many years of experience in the sector. We are also very fortunate to have an Aboriginal trainee nurse at the moment, who is in the second year of her nursing degree, who is shadowing and working alongside Narelle. I also recognise some other familiar faces here. The purpose of the program is to encourage women to engage in the KMS early. Referrals tend to come from our internal GP clinic, but we do have a whole range of services that refer in. Appointment times are very flexible and are designed to suit the women’s needs. On average women are seen by the GP or obstetrician at least eight times during their pregnancy and then the midwife at least six times to try to provide comprehensive pregnancy care.

We do transport to appointments, to childbirth, breastfeeding education, support through labour and birth as well as postnatal services once discharged from the hospital. We also have, because we have got these other health services that we tie in together, dental checks, which are provided free of charge to pregnant women, transport to ultrasounds and pathology appointments, linking in with the hospital and booking-in paperwork. It is quite comprehensive.

We are very fortunate. We have got one of the biggest allied health services in East Gippsland for Aboriginal people operating out of a medical service. That includes dietitians, diabetes education and mental health support, and we also link in with maternal and child health services locally. Women who require specialist care due to high-risk pregnancies are supported through their pregnancy with transport to appointments and specialist treatment. Once the baby is born we help and support women postnatally by providing home visits for up to six weeks, six-week postnatal checks with our gynaecologist and with our GPs, postnatal Pap smears and a contraception service. We also provide and encourage full immunisation for all our babies and mothers. We can also help and support with Centrelink and registration issues.

Our funding is provided through what was the department of human services — the state-level funding for the Koori maternity service. I know that a portion of it is ongoing, and we are eligible through another program. We have had a top-up for the last couple of years which has allowed us to have the second employee. It is always a very tightly funded program, and we are quite fortunate that the medical service is able to provide some of those peripheral supports to our local families.

I am talking really fast. I am sorry; I do talk very fast. The ladies have listed here for me a couple of challenges. I think I heard the lady who spoke before us talk around the fact that we do not get any brokerage to support
women with pregnancy. When we have preterm or high-risk births there is often no accommodation available for families to support the mums if they have to go down to Melbourne at short notice, or even to Sale. So we are often relying on other programs or even our community support to try to support families. We do have quite a high rate of preterm births in our community and some high-risk pregnancies as well.

Ms McLEISH — Could you give us a bit of a case study along those lines where somebody —

Ms ELLIS — I am aware of one recently, and correct me if I get off track here, because I know that I got a request for emergency relief — we do not get funded for emergency relief either — but we did certainly provide relief in this circumstance. It was a young mum. She went in through emergency up to Melbourne, and then she ended up coming back down to Sale. She was quite a high-risk mum. She is engaged with a few of our services, so she is well known to us. I think we are very lucky. I describe GEGAC as somewhere where we will do anything sometimes to get through the doors of these families. We have quite a comprehensive early years service. It would not be unusual that if the kinder spotted one of the mums who was looking pregnant or talking about a pregnancy they would be encouraging her, ‘Have you been to the KMS? Have you been to the medical centre?’, and all of those sorts of things.

This mum was engaged and ended up going down to Melbourne. She had other very small children in her care. They went to a sibling to be looked after. Mum was in Melbourne in quite a bad way for a little while, and then we had to try to get the family down because she needed the family support, including seeing the little ones because the baby was in hospital for quite a while.

Ms McLEISH — So that is where the cost is incurred.

Ms ELLIS — Yes. Medical transport for us is not funded either, but it is one of the activities that we do out of our medical centre. It comes up all the time at our community meetings. We do our absolute best to provide transport, but we are not often able to in all circumstances. In this situation it took quite a while for mum to get back to Bairnsdale. So as the health of the little one improved and mum’s health improved they came back to Sale hospital, which is still a 45-minute drive away. In the meantime the three — I think she has got three — other little ones were in the care of her sister in town who was struggling enormously with the additional financial costs and those sorts of things.

I can think of quite a few scenarios. There was another young mum very recently who lost her baby at nearly full term. It was quite traumatic. The same sort of thing: she was rushed down to Sale. We had quite a few family members who were trying to get down to provide support to this young mum. We ended up supporting with funeral expenses for the baby as well because it was stillborn.

From what I have seen coming through, and I am normally in the administration area, we do have engagement with some very high risk families, families where there is drug and alcohol abuse or a high risk of preterm birth. Smoking is not uncommon in the community, and I think the KMS team do an amazing job trying to improve the knowledge and the awareness of some of those issues for families.

I will keep going through the issues really quickly. We work independently as a Koori maternity service, and Bairnsdale Regional Health Service is not necessarily really involved in pregnancy care unless it is required. So that means that the pregnant women come into the clinic as opposed to having their prenatal care at another clinic. But most mums do birth at the Bairnsdale regional hospital. We have found that Koori women tend not to want to engage so much with the mainstream services for their pregnancy care. The challenge we see is that when they go into birthing at Bairnsdale Regional Health Service they are not necessarily familiar with the medical professionals that might be working there, and for good continuity of care we would like to be able to provide more support through the labour and immediate after-birth care.

We do work quite closely with the mainstream services, including maternal and child health. The challenge with this is engagement. We tend to follow quite closely with the mums and then sometimes over and beyond. We have also got some other programs that we work to link in with the families. Our early years services are primarily funded by the Department of the Prime Minister and Cabinet and the Department of Education and Training, and we try as much as possible to provide a comprehensive pathway for families through our early years services to get them engaged in education.
So the KMS service available for birthing women is currently only Monday to Thursday, 9.00 a.m. to 5.00 p.m. I think the ladies have mentioned that the birthing, of course, is very unpredictable, so it sometimes means that we are not able to be there to provide advocacy and support during the labour or after the birth, and these relationships that have been developed during the prenatal care cannot be carried through to that actual point of the birth.

But there are a huge number of positives around our program at GEGAC. We are very proud of it. We have high engagement rates for women attending KMS, antenatal clinics and appointments with other services. Our vaginal birth rate is high compared to other services. The KMS Aboriginal health worker is in her second year of her bachelor of nursing, and since we have had the new appointment of the midwife in May this year — we had another midwife previously; she had retired after a long time with us — we have seen an increase in the engagement and stronger relationships with the Bairnsdale Regional Health Service’s maternity services due to the fact that our KMS is able to provide extra supports and care for Koori women.

We now have a specialist obstetrician-gynaecologist visiting women monthly at our medical clinic, which has helped increase Pap smear rates. Women are engaging well and taking out offers of a free belly cast program. They are made by our team, and then they get to take them home and decorate them. Our breastfeeding rate post discharge is higher than last year, and we are continuing to work on that. We have been able to obtain donations from other companies, such as Huggies, Johnson & Johnson and Kleenex, because we provide a baby-mummy pack for when they get home.

In summary, it is operating quite well at GEGAC. We are engaging. We do sometimes have a challenging cohort in terms of that engagement, but because we provide the comprehensive service and it is a place where families feel safe to come to, I believe that we are making inroads. We are very grateful to have the Koori maternity service at our clinic.

The CHAIR — Thanks, Brianna. I am going to throw to Chris to begin, and I would love to ask you some questions a bit later.

Ms COUZENS — Thank you for coming in today. We appreciate it. How many of the staff are Aboriginal and Torres Strait Islanders?

Ms ELLIS — At GEGAC or in the medical service?

Ms COUZENS — Yes, at —

Ms ELLIS — At GEGAC — and this is something that we are working on at the moment — it is about 35 per cent of our total cohort. I think we have 170 staff in total throughout GEGAC. We are quite fortunate in the medical service, and we have, I think, two or three Aboriginal health workers and Jess, who is training as a nurse. We have another nurse who has just finished and moved over to AOD. So part of GEGAC’s responsibility to community — because we are a community-controlled organisation — is to provide those training and capacity-building development opportunities to the Aboriginal community here in East Gippsland.

Ms COUZENS — Is the midwife Aboriginal?

Ms ELLIS — No, but the trainee — she is a trainee nurse — at the moment is.

The CHAIR — Where does she do her training?

Ms ELLIS — Good question. I think it is with Charles Darwin University, and that is supported by our program. She is employed full-time. She was also fortunate to get a Koolin Balit scholarship, which helps — we are only allowed to apply for two per year, and we try to share them around the services; she did get one two years ago — with some of her accommodation during placement and those sorts of things.

Ms COUZENS — Are there other scholarships for Aboriginal young people to enter the health profession?

Ms ELLIS — Not that I am aware of, or not that we use. We do support trainees. We run traineeships internally, so they are paid to train. It does come at an expense because that is time that we would have otherwise, but we have a responsibility to capacity build. We have actually got this really exciting program at the moment that is self-funded by GEGAC — we are calling it the GEGAC academy — where we have got a
group of five trainees who are going to be intensively ready to work with training and placement throughout all of GEGAC, because we find a lot of our programs quite difficult to recruit to. The funding we get has a requirement for a minimum level of experience or education for us to deliver the service, but we are not able to recruit suitably qualified people. It is a bit of a battle to recruit; we all poach off each other at various points in time. But it is good. We are happy to see our Aboriginal staff get those opportunities in other agencies too. We do not resent it, but it is a battle to try to keep getting Aboriginal people into the positions.

Ms COUZENS — That sounds great. Are there other things that you are doing within the service to try and recruit Aboriginal people to the service?

Ms ELLIS — Yes, we do. The academy have been going through a whole-of-organisation change at the moment, really getting back to our core values as an Aboriginal cooperative under Aboriginal community control. The GEGAC academy was probably one of the main initiatives, because we are finding that the fear of what the role might look like is a barrier to people even applying. So the idea of the academy is to get on-the-ground shadowing of people in roles and also development with a little bit of pre-employment training, hoping to find there is a good fit, and then, rather than advertising, we will use it as a method of succession planning and training into roles. It is only brand new. We are advertising at the moment to take the first five trainees. They could end up anywhere within the organisation, and medical will be one of the places that they do spend a bit of their work placement time.

Ms COUZENS — Obviously, I am assuming, you have cultural training?

Ms ELLIS — Yes, of course.

Ms COUZENS — In terms of training, is there a focus on family violence and mental health in particular?

Ms ELLIS — Most definitely, yes. We are finding that that is an area that is quite hard to recruit people into, particularly the Aboriginal community. Because we live in Bairnsdale, everyone knows everyone else’s business. It can be quite a hard area to get into, some of those more confrontational — not confrontational but more challenging — sorts of roles where you are dealing with difficult circumstances with families. GEGAC is very fortunate in terms of the breadth of services that we offer. We have a women’s shelter, we have specific family violence services, we have the medical service and we have an AOD — alcohol and other drugs — service that is quite successful and quite large. So it is not unusual that you will find clients are participants in a number of programs throughout GEGAC, and we work really cooperatively to try and provide that comprehensive care.

The training that we have been rolling down recently has more of a focus around gaps that we are seeing within our work group. We have just done a big push on lateral violence training and the effect of that within communities and how to support each other in the role and how to build the capacity of community. We do a lot of trauma training, and with family violence we are actually throwing around some ideas with the Department of Health and Human services at the moment around some therapy — play therapy sort of ideas — for that zero to five range. We were successful with some funding through the Aboriginal children and family centre, and we have been trying to figure out where that actually fits. We are thinking at the moment it is most likely going to be in medical, because they have got a waiting list of families that have been exposed to some sort of trauma or family violence where there are little people. Our biggest issue is trying to get qualified people to deliver the services. There is such high demand. We are all fighting for them.

So GEGAC’s commitment is then — and we have pushed this back with the department — that if we do get a clinician or someone who is qualified, we want them to train or to mentor while we do some capacity building within GEGAC so that we have the ability to continue to offer the service.

Ms COUZENS — You may not want to answer this directly, but how is your relationship with the mainstream services in the community?

Ms ELLIS — Look, I would say generally it is really positive. We try as much as possible to be cooperative. There are no — I am not aware of any — issues per se. I know our community feels at home, they own the service, so you will find that a lot of Aboriginal clients do come towards GEGAC. Even when we have people that leave to go to mainstream services, at some point they end up coming back. We have quite a lot of relationships with Bairnsdale Regional Health, which is over the road, and it is not just in the medical service;
we share a detox bed with Gippsland Lakes Community Health at Bairnsdale Regional Health. We have quite a lot of partnership sort of arrangements.

**Ms COUZENS** — So those partnerships work well within the community?

**Ms ELLIS** — Yes, I would say that they do. We are not in competition for the clients. I think it is sort of recognised that we have a niche to provide.

**Ms COUZENS** — What about the funding though? Are you in competition for the funding?

**Ms ELLIS** — That is starting to change. Previously I would have said Aboriginal funding would tend to come more towards GEGAC. We have noticed in the last probably two or three years with the more competitive tendering, particularly around commonwealth funding, that we are exposed, and I do think it has fractured the relationships a little bit. There have certainly been circumstances — and this happens to GEGAC quite a lot, and I will be really frank in this space — that we have become a tick a box. They will apply for funding. It will be Aboriginal-specific funding or targeted at the Aboriginal community. They are not able to deliver the funding, and often they will come to us halfway through a project and go, ‘Oh, here are these dollars; can you please do this?’ In the past GEGAC have just said, ‘Well, we’ll do it’.

Under our new sort of approach to what is best for community and making sure we align ourselves with our values, we are challenging that quite a bit. I know that there was a recent one, and it was around maternal and child health with another agency, that we have not been able to progress because they have applied for the funding without the consultation that possibly should have happened with GEGAC, and we feel that it would actually undermine the service that we are offering.

With the change in our commonwealth funding around health, the KMS is a critical part of what we do in the Aboriginal health service, but the primary funding that we get for the medical service actually comes from the commonwealth under the Department of Health and the whole model around the commonwealth funding is changing as well. We are being pushed to become much more businesslike in how we approach it, but what it also means is that if the community does not support our services, we are not going to continue to get the funding to be able to offer the services.

We are really rethinking our model and our engagement with the community, and they are the conversations that we are having at community meetings to say, ‘Look, we want this to be your place of choice. We want to offer the best possible option to you, but you have to support our service in return’. There are quite a lot of services that we do that would not be available at a mainstream clinic, like transport, some of the medications that come out of it. We get block funding but we also have some Medicare income and we do get to negotiate about where the priorities in our community are. Transport is absolutely one of them and so is emergency accommodation and those sorts of things. I do think we have a niche, and we are trying to appeal to the community to say we need to work together to make sure that this service is viable going forward.

**Ms COUZENS** — My experience with other Aboriginal communities is exactly what you said. The mainstream services that are getting the funding are either not being able to provide the service or do so in a half-hearted sort of way and then go to the Aboriginal service saying, ‘Well, deliver this’. I think a lot of them are now reviewing what happens when that happens. A number of the elders in the community would argue that is why *Closing the Gap* is an issue.

**Ms ELLIS** — Yes. We are being much more clinical about how we approach them. I can think of at least two in the last probably two years where we have had to pull out of an agreement like that, because we were actually out-of-pocket. We are collecting the stats, we are doing all of the work, but when we look at it we are not able to meet —

We have three tests that we use: does it employ Aboriginal people; is it of benefit to the community and is it something that the community needs, wants or has identified as being a need; and is it sustainable? I have looked at a couple of these programs. When you take all the emotion out of it, we are not able to achieve those objectives, so we either cannot employ an Aboriginal person to do it or because of the level of the qualification that we need it is unlikely that we are going to be able to employ someone. It is short-term funding, so you are not able to train someone into the role, and then we are actually losing money on it to boot. We have had to be
quite clinical and have quite frank conversations with some of our partner organisations but also with our community as to why we have withdrawn from that service. Sorry, I talk a lot.

The CHAIR — No, it is great, Brianna. We are all taking notes. Just one question from me, and I suspect the answer is not going to be basic anyway. We know that the Aboriginal and Torres Strait Islander population statewide is over-represented in a lot of areas — infant mortality, smoking, drinking, AOD while pregnant. I think we have been at a bit of a loss to put the brakes on those statistics while our perinatal statistics for the white population, I guess you would say, are fairly stable. Are there any initiatives that you have in your community to address that?

Ms ELLIS — I suppose where we are having a lot of success starts with the KMS actually, because it is the first keystone in what we have been able to develop in early years. We were funded for an Aboriginal children and family centre. We are only one of two in Victoria that were funded from a commonwealth education program. The reason Bairnsdale was selected is that we only had seven Aboriginal children in our region enrolled in kindergarten, and we know that we have got a lot more children than that. This is going back seven or eight years, when we first applied for the funding. We now run a kinder. We have 44 Aboriginal children enrolled and we have a waiting list to get into the service. We are still battling for funding to make that work.

I will give you an example. In our four-year-old room at the moment we have 22 children enrolled, and 15 of those children have diagnosed language difficulties at varying levels, so it is not your standard kindergarten. But having those diagnoses and having the conversations with families happening at that level pre-school starts with the KMS service. We try to have this warm process that is non-threatening. It is an engagement process where the families start with the KMS and they are introduced to the playgroup service. In playgroup we start to build the capacity of families and even around those early learning or early development milestones. Then they move on to three-year-old kinder and then four-year-old kinder. The schools are actually starting to give us feedback that they know which kids have come through our kindergarten program and which kids are presenting at the primary schools without having come through. We are still trying to figure out how we collect that data, but the feedback from the primary schools and the case workers has been enormously positive.

My answer to that is it is self-determination for Aboriginal communities. If you give the power back to Aboriginal communities to take responsibility, take ownership, that is where the solutions are going to come from, because where we have been able to provide at each step it is where we have been able to make a real difference. There was one family with two little boys — a very high-risk family. The parents were very nocturnal, so they were awake all night. The house was dark all day. There were two little boys living in the household that were non-verbal and had their own little language together. We did a transport for the kinder program. It started with playgroup, where we know these little people are in the house. We go out and knock on the door and say, ‘Are you interested in coming to playgroup?’ and that is something that our community can do. If you have Aboriginal workers, they can get into the houses to engage the families in a non-threatening way.

The two little boys ended up coming through the whole program — three-year-old kinder, four-year-old kinder. They were extraordinarily difficult to separate because they had spent so much time together, with mum and dad sleeping during the day and the babies awake by themselves. Kinder really became their safe place. There would be times when they would come into kinder and the kids would go into one of the play corners, grab a blanket and have a sleep, but they were getting out of the house. There have been days where we have had the kids waiting at the front door in their PJs with their lunchboxes ready to get on the kinder bus, even if mum and dad are not quite there yet. But it is non-threatening. There is no judgement. We are just there to provide the service.

I think having the programs like the GEGAC Academy, which is so new, but also having trainees like Jess. We have got another Aboriginal health worker. They are smashing it. I think it is giving the opportunities and providing the support through an agency where they feel safe and comfortable. But we have got another one of our nurses who came the whole way through the medical centre. She decided that she wanted to have a go at AOD so she has moved over to a nursing role in AOD, but she has actually just accepted a graduate position at Bairnsdale regional health. We do partner and share, and I think breaking down those barriers has to come from the community. The Aboriginal community controlled model can be really challenging, but when it works, it really works.

The CHAIR — Fantastic. You should be really proud.
Ms McLEISH — You have given us some really great examples as you have talked today, which is really enlightening and valuable evidence for us to hear. Can you tell me, because I was just a little bit confused, the whereabouts of Charles Darwin University?

Ms ELLIS — I think they are actually in Brisbane maybe or Darwin.

Ms McLEISH — Darwin. So it is all done online?

Ms ELLIS — Yes. GEGAC, where we can. VACCHO, which is our peak body in Victoria, do quite a lot of training. I heard the lady mention before — and it absolutely applies to us as well — that the cost of getting our staff to Melbourne to do professional development and also to do things like the training and the courses is really prohibitive. We get funded for a position, but they do not necessarily take into account the cost of getting someone ready to be in the position.

Ms McLEISH — Skilled up.

Ms ELLIS — VACCHO have been fantastic, where they can, by bringing the training down here. So if they can get enough people, they will actually bring the trainers to us rather than asking us to take our staff to Melbourne, which is fantastic when it can happen. As a model, our experience has been that distance education is challenging. VACCHO offer a face-to-face Aboriginal health worker course and we do send staff down. It is like a week at a time where we support them. They are running one out of Nowa Nowa at the moment, which is one of the more remote areas, but it has captured Orbost, Lake Tyers, Lakes Entrance and Bairnsdale, and I think there are other people travelling.

Ms McLEISH — Are these people you have employed that are doing the training?

Ms ELLIS — Yes.

Ms McLEISH — What about the pool of people out there who could work there — do they get access to suitable training? Because, as we have heard many times, if people get trained and skilled locally, then they will stay and work locally, which is what we want. So I am thinking of the pre-employment pool that is out there.

Ms ELLIS — The rate of Aboriginal employment in the medical centre is fairly high because we have been able to access these training services, but what you generally find is they are not in senior positions. So that is a challenge for GEGAC, where we are trying to build the capacity, because we want to have representation from the community all the way through. Our CEO is Aboriginal, but we want to have it all the way through our management levels.

I think there is a bit of a gap, and this is what we are trying to address with the academy. Post that school-leaving age we lose a lot of the kids locally. There has been a lot of work to get them through year 12, but they are not necessarily employment ready. We are seeing in applications that you have got someone who is interested and keen but is not necessarily ready to get into a role, and some of the roles are really challenging, like AOD, nursing, some of the family services roles, family violence. You cannot put an 18-year-old into a role like that, and they are not ready also to leave families and go away and do study.

So recruitment is hard, and we are willing to try anything. DHHS have actually been very kind. We had some unspent funds out of our youth homelessness refuge — so we have got two residential services as well. One of them is a women’s shelter and one is a youth homeless refuge. We had some unspent funds and they let us negotiate the academy concept, so it is a trial being rolled out by the Department of Health and Human Services, and GEGAC is committed that, if it works and we can get it up and running, it is something that we will try to continue. We have had expressions from a lot of other stakeholders — the department, the shire, East Gippsland Water, who we have had a partnership with, and a couple of other agencies — where they want to take our trainees for real work experience as well.

Ms COUZENS — That is fantastic. What you are talking about is very true that when the kids are coming out of year 11 and year 12 we are losing them. There has been a suggestion about putting in a much longer process to get to some of those key training areas by working with those young people on a pathway, I suppose you would call it, which is a lot easier, but it builds up to that —

Ms ELLIS — Work readiness?
Ms COUZENS — Yes.

Ms ELLIS — You have families where there are no role models, so you might have a mum and dad who have never had a job or have only ever had casual employment. We have done an analysis of our workforce and certainly the Aboriginal staff within GEGAC tend to be more in part-time or casual roles or in the lower 20 per cent of the level of pay within the organisation. So one of our challenges and where we are trying to focus is to move people into full-time employment, but in a way that is safe and is not setting people up to fail, because there have been plenty of times when we have got someone with lots of potential but they have still got lots of challenges. So it might be a young family or it might be they have got extended family members or there is family violence and those sorts of things happening in the background that inhibit whether or not they are able to really take up the opportunities, because we have got plenty of opportunities.

We have been trying to work really closely with providing those supports and career pathways. So they are stepped out, and it gives people the option to sort of go, ‘I’m not quite there yet, but I’m going to sit here and I know that once I’ve got myself together we’re going to move forward’.

The CHAIR — We are running a little bit over time.

Ms ELLIS — I’m sorry.

The CHAIR — No, don’t apologise for telling us stuff because you are filling in a lot of gaps for me and I am sure for other people on the committee too.

Ms BRITNELL — I just wanted to explore the transport. Can you just tell us a little bit about what it looks like, and I am not sure everyone would understand the service that you provide, so I would like that down on the record.

Ms ELLIS — Okay, GEGAC is not specifically funded for transport but we do transport. So we hire medical drivers. Some of them do local visits only. Even in Bairnsdale and surrounds we find that families often — you know, it is quite a trek to get from East Bairnsdale over to the medical clinic.

The other thing about when you pay for a service basically is that when people do not show for appointments, then we are not able to bill them. So we committed to going out and getting the families or the appointees when they need to come to appointments. That is not actually the problem for us; the big issue is the Melbourne trips. It is quite often that we are not able to get access to specialist services or specialist services that bulk bill in our region, or there are long wait lists, or they are in Sale, Traralgon or Melbourne.

A Melbourne trip for us we have worked out costs about $900, because you have got the car, the travel allowance, staff wages — all of the other overheads that come with getting a person to Melbourne and back. We have also got safety risks. We try really hard to book appointments around midday so that they can do an up and back in one day, because we are 4 hours from Melbourne. If for any reason they get waylaid or the appointment is running late, we have got staff that are sometimes out for 12, 14 or 16 hours, who have left early in the morning and then come back. We have tried bundling people together in terms of taking three or four people on a trip, and that is quite challenging too because some people are waiting around all day.

Ms BRITNELL — And health services do not cooperate.

Ms ELLIS — No, and then you have got a 10 o’clock appointment, and it might be that the person gets asked, while they are in Melbourne, ‘Can we drop you in for this other appointment?’ We have found that that can be really disruptive. We have also found that for people that have chronic illness or that are experiencing quite a lot of family stress and those sorts of things, the idea of getting on the train and then having to navigate Melbourne when they get there is prohibitive. So we do a lot of Melbourne transport at some expense, and other programs dip in where they can and we try as much as possible to spread the load, but it is the access to specialist services, and obviously we have a lot of community members that have chronic health needs. We have tried as much as possible to get people to come to us, and we are very fortunate in having a gynaecologist and obstetrician; we have a visiting psychologist; and we have got a visiting paediatrician. Wherever possible we try to get them to come to GEGAC, but that is not always doable.

Ms BRITNELL — Why do your clients need transport though?
Ms ELLIS — Often it is financial.

Ms BRITNELL — So they do not have a car?

Ms ELLIS — They do not have a car on the road. Quite frequently it is vehicles that are not fit to travel those sorts of distances. Some of it is confidence, where you have got people that have never been familiar with driving in the city, and the idea of going in there is just a complete freak out. They would prefer not to go to the appointments. And I think it is the cost of the petrol definitely and the reliability of vehicles.

Ms McLEISH — Could you link in with another service, say down the line? I do not know exactly where the train goes, but you know, someone else could hop on at Warragul or Dandenong or even meet them in the city. So you have got another service that can pick it up at that end so you are not having to have your staff do the 7 hours but you have got somebody else doing it.

Ms ELLIS — We have tried that with VAHS, because they are quite a big service in Melbourne, but they do not get funded for it either. So if it is our client, they get halfway there and then they are not funded for it either. We have tried taxi cards, we have tried Met tickets — we have tried everything. The best solution for us is where possible we get services to come to us. That is not always possible though. I think we have got a cardiologist that is visiting at the moment. In terms of our range of services it is quite comprehensive, but it is still not exhaustive, so there are quite frequently Melbourne trips.

The CHAIR — Thank you so much, Brianna. It is actually quite inspiring to hear you speak and to hear some of the initiatives. The biggest surprise of the day is that you got some money off the department for an initiative. I need you on my side. Thank you so much for your time today.

Ms ELLIS — I am known for stalking them, do not worry! I think they have got my number blocked.

The CHAIR — So I should say, ‘Brianna told me to Facebook stalk you’?

Ms ELLIS — Yes!

The CHAIR — Thank you so much for your time today.

Witness withdrew.