EDUCATION AND HEALTH STANDING COMMITTEE

AN INQUIRY INTO IMPROVING EDUCATIONAL OUTCOMES FOR WESTERN AUSTRALIANS OF ALL AGES

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
WEDNESDAY, 28 MARCH 2012

SESSION ONE

Members

Dr J.M. Woollard (Chairman)
Mr P.B. Watson (Deputy Chairman)
Dr G.G. Jacobs
Ms L.L. Baker
Mr P. Abetz

Hearing commenced at 9.59 am

GATTI, MRS KATE
Clinical Lead, Child and Youth Health Network; Population Health Area Director, WA Country Health Service, examined:

McKERRACHER, MS SARAH
Acting Development Officer supporting Child and Youth Health Network, Department of Health, examined:

The CHAIR: Thank you very much for joining us. On behalf of the Education and Health Standing Committee, I thank you for your interest and your appearance before us today. The purpose of this hearing is to assist the committee in gathering evidence for its inquiry into improving educational outcomes for Western Australians of all ages. At this stage I would like to introduce myself, Janet Woollard, and the other members of the committee; next to me are Peter Abetz, Peter Watson and Lisa Baker. Our research staff are Brian Gordon and Lucy Roberts, and from Hansard we have Kelly Clausen. The Education and Health Standing Committee is a committee of the Assembly of Parliament. This hearing is a formal procedure of Parliament and therefore commands the same respect given to proceedings in the house. This is a public hearing. Hansard is making a transcript of the proceedings for the public record. If you refer to any document or documents during your evidence, it would assist Hansard if you could provide the full title for the record. Before we proceed to the questions we have for you today, I need to ask you: have you completed the "Details of Witness" form?

The Witnesses: Yes.

The CHAIR: Do you understand the notes at the bottom of the form about giving evidence to a parliamentary committee?

The Witnesses: Yes.

The CHAIR: Did you receive and read the information for witnesses briefing sheet provided with the "Details of Witness" form today?

The Witnesses: Yes.

The CHAIR: Do you have any questions in relation to being a witness at today's hearing?

The Witnesses: No.

The CHAIR: Thank you again for coming in. You have had an opportunity to look at our terms of reference. We have invited you in to talk about the FASD model of care. Can you tell us about the WA Child and Youth Health Network and the FASD model of care? Can you set the picture of FASD in WA? We are very lucky to have you for one hour. Please regard us as novices and do not assume that we know anything! Please start and we will come in later with some questions for you.

Mrs Gatti: Thank you for the opportunity to speak before you. I will start with the health networks. The health networks was a concept—I cannot tell you when they were dreamed up with the Department of Health—that links government and non-government people against clinical descriptors, I suppose. It is a way of engaging clinicians in policy development for the Department of Health. Dr Simon Towler was the lead at the time. He has recently resigned. The Child and Youth Health Network is one of those networks of which, over time, I was originally a co-lead; now I am the sole clinical lead of that network. It has an executive advisory group and a significant broader network of clinicians and other interested people. The Office of Aboriginal Health, as it

was titled at the time, approached us back in 2008—it may have been later than that—to consider developing a Foetal Alcohol Spectrum Disorder model of care. At the time TICHR had been doing quite a lot of research and was trying to raise an awareness of alcohol and its effects on an unborn baby. There were suggestions that it was significantly impacting Aboriginal populations, particularly in the north of the state. It is a spectrum of disorders. There is really no agreed diagnostic tool, but a paediatrician in the north of the state at the time had diagnosed some children—I will need to check the title—on the congenital defects register. There was a significant spike in the number that were on this register with FASD. Dr Gervase Chaney, from Princess Margaret Hospital for Children, and, Mr Gary Kirby, from the Drug and Alcohol Office, led a working group to develop a model of care—which I will table; it is also on the website—and arrived at 33 recommendations. In a nutshell, once born with this condition, a person has it for life. However, it is completely preventable. The majority of the recommendations focus on prevention. There is an impact, obviously, on the population now. Work is currently being undertaken on a nationally accepted diagnostic tool, which TICHR has been commissioned to do. I believe it is with commonwealth committees. It has been developed, but it is not out there yet. In the meantime other tools are being used by various groups, including the Lililwan project group—which I think you may have spoken with already—and the child and adolescent statewide child development service also has a modified Washington tool that they are using as well. A little bit of diagnosis is being done.

Developing the model of care is the easy bit; the hard bit is the implementation. The model of care was endorsed by SHEF back in 2010.

Mr P. ABETZ: Sorry; endorsed by who?

Mrs Gatti: SHEF, which is the State Health Executive Forum. The network, of which I am lead, is now moving through a phase to implement the model of care. It requires a multi-agency approach. Health cannot fix this, nor can any one person. Fundamentally, the problem is a cultural issue. We need to change our attitudes to alcohol generally, but in this case particularly around the intake of alcohol during pregnancy. One of the NHMRC guidelines changed and it now recommends that there be no alcohol in pregnancy. There is some pushback in that, because there is not a strong evidence base to support that. Having said that, it is good having the NHMRC guidelines with that recommendation. It underpins the model of care. It is quite timely when you are starting an implementation plan. We have developed a governance structure around who will own this. It is a multi-agency government structure. There are number of interested groups. A lot of work is happening across the country, but particularly in Western Australia, through the treatment diagnosis foster carers down to the McCusker organisation and alcohol in pregnancy child institute et cetera. It is tying that into a coordinated and concerted approach to address this as an issue. Raising it as an issue and having it recognised as an issue has been somewhat of a challenge because of the rather weak evidence base that ties alcohol and pregnancy and the outcome. The Western Australian effort is linked to the national effort. You may be aware that there is a national monograph; it has been picked up there as well. Our effort is linked to that and probably more importantly link to the bottom-up work that is happening, recognising that if we are to change, we need to change cultural attitudes and society needs to recognise this as an issue. No one agency can own this.

The CHAIR: Which agencies are involved?

Mrs Gatti: A number of agencies are involved. We took the model of care to the community services leadership group, which is the director general's group. They are named in my presentation, which I have already provided to Brian. Mr Kim Snowball has agreed to be the lead in this. Effectively, at the interagency group it was agreed that all agencies would contribute to the model of care implementation and contribute resources and endorse the model of care. It is a cross-government agency acceptance.

The CHAIR: There is no reference in this to the Department of Racing, Gaming and Liquor. I ask why it is not involved with this when the Minister for Racing and Gaming is responsible for the Liquor Control Act and any problems that arise with it. The fact that the Liquor Control Act is not being enforced is why some, not all, children will be born with FASD. Are there plans to approach the Department of Racing, Gaming and Liquor to have it involved in this?

Mrs Gatti: That is certainly something that we can and will do. We are at the early stages of implementation. It is not an exclusive group; in fact, what we want is inclusion and an acceptance by each agency for its responsibility in this.

Mr P.B. WATSON: I think it is best to get your program right and then go to racing and gaming, because it will work from your recommendations.

Mrs Gatti: We have an executive advisory group, which is made up of the Drug and Alcohol Office, the Department for Communities, the Department of Education and the Department of Health. It is a project control group for the implementation of this. The Drug and Alcohol Office is closely linked with the Department of Racing, Gaming and Liquor. I would hope that link would be providing, because they strongly align with particularly the regulatory processes. Yes, I take that on board.

The CHAIR: Personally, I think the longer you leave it, the longer you will wait to get any effective change.

Mrs Gatti: We are certainly more than happy for any have advice. This was never going to be easy.

I refer you to the governance paper—it is two or three pages in—which is a FASD governance map. We will look at including the involvement of racing, gaming and liquor. The reason for this effort is, firstly, to link the various efforts as best we can—recognising the discussion we just had—but also to show that there is some governance around this. At the very top is the Australian Health Ministers' Advisory Council, recognising the commonwealth's efforts in this, and the Australian Population Health Development Principal Committee, of which the WA health director general is a member.

The CHAIR: So Kim Snowball is a member of the APHDPC?

[10.15 am]

Mrs Gatti: Yes. I believe he is the current chair of that, but I would need to check that. Then there is the FASD Project Control Group, which is the project control group made up of myself as clinical end of the network, Dr Simon Towler previously—he has just resigned as chief medical officer in the Department of Health—the Department of Communities, the Department of Education and, Mr Gary Kirby, from the Drug and Alcohol Office. That oversees the governance and links the commonwealth and state efforts.

We are just getting to the working groups, the actual implementation groups. You will see five working groups, which we have regrouped into three; namely, the primary, secondary and prevention groups. We have had a number of multi-agency forums, both government and non-government, seeking interest and getting a better understanding of what the activity is out there and the interest, so we can get some really good buy-in into leading the implementation plans within these working groups. Each of the recommendations in the model of care has been grouped under the three working groups. This is, like many documents, a working document in order. Where we are at following a forum, we have pretty much identified agencies, both government and non-government, and key members—up to about 10—within three working groups that will develop the implementation strategies, I suppose, and their measurable objectives for each of the recommendations that have been grouped under those three working groups. Sarah will make reference to the fact that there is a clearer continuum of prevention of FASD and the linking of the recommendations across the working groups. I have not tabled that document, but I will do. Again, I emphasise the focus on prevention; once you have it, you have it. There are various treatment

modalities, but not a lot different to the treatment modalities that these children would receive anyway with or without a diagnosis, because we treat symptoms. The focus, as I will keep emphasising, is on primary and secondary prevention. Primary prevention is our attitude to alcohol, drinking and pregnancy and the like. Secondary prevention is interesting. The whole issue around the diagnosis of a child with FASD is out there for debate. There are two schools and everything in between, really, at either end of the spectrum. There are pluses and minuses depending on where you sit. The benefit, as I see it, of putting effort into diagnosing children, which is a comprehensive, multi-disciplinary, timely and relatively expensive thing, is that we can then work at changing attitudes towards drinking and pregnancy with something more objective; that is, there are X number of children who are directly affected as a result of alcohol in pregnancy. We can put something more concrete and objective to the broader society.

The CHAIR: Brian gave us a document to look at a few weeks ago. It was from Canada, where some work has been done. It gets the message out to the community. It showed the cost per child of FASD. It showed how the cost over a lifetime might be equivalent to 19 coronary angiograms or 34 knee replacements. Which of your committees will be looking at costing? I know in some way it depersonalises the issue. But for us it is one way to encourage Treasury to look at funding prevention measures because it will realise that every child that is born will cost the state X number of dollars in the future. Could you discuss the economic side of it?

Mrs Gatti: I think that is a bit premature in that we do not have an agreed diagnostic tool that we use in Australia. It is a spectrum of disorders. There is a lot of debate between the specialists as to whether X was caused by alcohol and pregnancy or caused by some other given factor. It is a relatively new science, I guess. Before we are able to we need a diagnostic tool that is agreed on to ascertain the prevalence. We do not have an understanding of that in Australia, as I understand it.

The CHAIR: Does the diagnostic tool that is being worked on—we will talk more about diagnostic tools later—have FASD level 1, which includes all the known features of FASD, and then a level 2 and a level 3?

Mrs Gatti: I do not know. I am not a clinician in that respect. I am a nurse, not a paediatrician. I do not know.

Mr P.B. WATSON: Kate, this sounds like a dumb question, but can you get FASD symptoms from anything else?

Mrs Gatti: As I understand it, you have quite specific facial disorders. But that is from alcohol insult to the foetus on day 19 of the pregnancy. There are various effects on a foetus depending on where it is in its stage of development. There is a spectrum of disorders. We, I suspect—as a child development nurse—see these children now and we see them presenting with developmental delays. They might have an autism-type disorder and various sorts of developmental delays, but they have not been given a causative factor diagnosis. They present with developmental delay, which presents with some speech delay and some cognitive delay.

Mr P.B. WATSON: So we are not just dumping everything into FASD that would otherwise be diagnosed as something else?

Mrs Gatti: No, but there may be some things that end up with other diagnoses that will come to FASD with a diagnostic tool. But there will be a whole heap of stuff that is still just developmental delay without a diagnosis or a causative diagnosis. It is not easy diagnosing FASD; it is a multi-disciplinary—you know, speech OT, physio, paediatrician, social work, psychologist assessment over time.

Mr P.B. WATSON: My colleague the member for Bassendean has talked about kids taking Ritalin because they have been diagnosed with ADHD and of everything else being thrown into that. I am a bit concerned that we do not do that here. I know it is a huge problem, but I am worried that everyone will get put into that category.

Mrs Gatti: One of the things in a diagnosis is that you have to have evidence that the mother is drunk relatively significantly during her pregnancy at various points. You have to consider what a child looks like at a certain point, the pregnancy history and a whole heap of things. The diagnosis is quite a complex thing, as I understand it. There are those risks as you mentioned, Mr Watson. The other thing that is probably of benefit from diagnosing is the opportunity for secondary prevention. If you know that a child in a family has been affected by alcohol in pregnancy, there is an opportunity to strongly work with that family to try to prevent further pregnancies being affected in the same way. Often you see similar behaviours in families and you suspect similar behaviours in pregnancies have occurred.

Mr P.B. WATSON: When you look at alcohol consumption, what are you looking for? Are you looking for someone who has a glass of wine, someone who is a regular drinker or someone who is a binge drinker?

Mrs Gatti: This is the issue with alcohol and pregnancy. We know that some mothers drank heavily through their pregnancies, yet their kids ended up being doctors. It is not a pure science—that is the issue with this. There is evidence to suggest that alcohol does affect some pregnancies. We do not know which ones, and we do not know exactly how and to what extent it might affect them. Therefore, the NHMRC guideline recommends that alcohol is not drunk during pregnancy. The previous guideline—this is not word for word—was that it was okay to have a glass or two of whatever occasionally, or whatever it was.

[10.30 am]

Mrs Gatti: But we know that there are some people who have just had a drink at a point in time and their child has been born with a very significant disability.

Mr P.B. WATSON: It is the same as going to a party. Some people, like me, have two wines and fall over, when other people can drink all night and it does not affect them.

The CHAIR: Looking at the "Continuum of Prevention"—Brian is looking through the paperwork to try to find the full list of recommendations. I can see on the second page recommendation 33 down to 39. On the first page it says, "Prevent movement into the 'a risk' group and "Prevent progression to establish disease and hospitalisation" and "Well Population", "At Risk of FASD", Diagnosis...". I notice under "Primary Prevention" you have "Regulation and legislation".

Mrs Gatti: Yes.

The CHAIR: The regulation and legislation is our Liquor Control Act.

Mrs Gatti: And we need to engage them; you are right.

The CHAIR: I was wondering what recommendation that relates to from your committee on the model of care with the recommendations you are now working on with these groups. Which recommendation does that come from, because, to me, it would be number one. Have you found it, Lisa?

Ms L.L. BAKER: No; I am reading 1, 2 and 3.

Mrs Gatti: Recommendation 2 is prevent harmful alcohol consumption; responsible supply and service of alcohol.

Ms L.L. BAKER: They are all relevant.

The CHAIR: I have found it; it is all on the bottom page.

Mrs Gatti: It is very small, sorry.

The CHAIR: It is clearly there as the Liquor Control Act—racing and gaming.

Mrs Gatti: We will engage them.

Ms L.L. BAKER: The one about reducing unplanned pregnancy might be a bit difficult under the Liquor Control Act.

Mr P.B. WATSON: Can you tell me how you are going to do that one?

Ms L.L. BAKER: Make condoms out of it.

The CHAIR: This could be such a huge cost to both the individual, the family and the community. Primary prevention, particularly, is so important. Is the funding coming from different agencies for this work; how are you being funded for this work?

Mrs Gatti: It is within budget of the various agencies. It is within current budgets. New funding is not allocated to it. Having said that, as I indicated earlier, a lot of work is happening anyway. There is the Drug and Alcohol Office; and some COAG funding has gone to the Office of Aboriginal Health to coordinate an Aboriginal foetal alcohol prevention project, so there is some commonwealth funding there. That was closing the gap funding or it might have been ICD 2 or 3. There are little bits of funding. At this stage, it is more around identifying the players and getting a coordinated effort. There is a lot of effort. The more we have played in this, we realise there is a lot of effort going into this area already. It is around tying it in a more socially affecting way to change attitude, which is a big part of what we are trying to do here. It is about being able to have the discussion with mothers who are pregnant that alcohol at any time through pregnancy is risky and saying that they should be giving this child the best chance and the best opportunity. That is the primary aim. It is around linking the efforts and sticking this message to it.

Mr P.B. WATSON: Kate, when we were in Roebourne a lady there spoke to us about the culture and she was living with a 20-year-old guy when she was 14. Obviously, that is the time when they think it is okay to be in a relationship. How early should we be letting people know? Do we go into the schools, into the preprimaries and work everything up so when they do get to that age, they realise. It is no good going out into the community saying, “Oh, you know; it’s no good”, when people are 12, 13 years of age, because they see everyone else doing it.

The CHAIR: They are already sexually active.

Mr P.B. WATSON: Yes. It is just the system. We have to get into even kindergartens and primary schools and do little things.

Mrs Gatti: It is a multi-facetted approach. Schools have a captured audience and we should be educating appropriately the various age levels of kids and empowering them. The reality is that all of us who are parents and have been children realise our primary influences are our family that are closest around us. We need the multiple strategies. We need strategies that are focused at those who are strongly influencing the kids outside school and we need strategies to empower children to make sensible decisions through life.

On Friday just gone I was a participant in the Clinical Senate where we talked about sexual health and youth—exactly the same discussion. A number of recommendations came out of that but it was again this multi-strategy approach. It is very easy for us to sit back and say that we should be educating these kids through school, and there is a lot of evidence to suggest that for younger siblings the older siblings are the primary influence on them and for the older sibling it is the parents or the primary care givers. While that is a strategy, it is one of many and we still have to continue to work very strongly with the parent.

Mr P.B. WATSON: Even if you had Indigenous people coming in and explaining to them, having a Wadjala as we call them—us in Albany—going into a school and saying this is what Aboriginal children should be doing, and everyone else. Why not do it the other way around?

Mrs Gatti: There is a lot of that happening now. I am also on a multi-agency committee looking at STIs in under 14s. We look at each case, each quarter and look at the links and look at the age

disparity and the sexualisation of these children and how we can affect that. It needs to be owned ultimately by that culture and we need to assist in that happening.

The CHAIR: Where is that data reported? That was something that was brought to our attention, again, up north.

Mrs Gatti: Which?

The CHAIR: The increase in the STIs. Who collects population health data for the Kimberley? We know rates have gone up. We know there has been an increase in certain sexually transmitted infections. Does that go into an annual report?

Mrs Gatti: I do not know about that, but there is a database for all notifiable diseases called the WANNID database.

The CHAIR: WANNID?

Mrs Gatti: WANNID, I think. The doctors among you will know.

The CHAIR: I am a nurse too.

Mrs Gatti: It is coordinated by the communicable disease control unit and reports come out of that, and there is a report that I am sure is published every year. On the Kimberley STI rates and being responsible for population health and WACs, chlamydia rates have decreased. I can be cynical about why and how, but STI rates are interesting. If you get more testing, you will often get an increase, so it needs to be linked with the testing rates, obviously. In the Kimberley there has been quite a nice trend over the past three years. I cannot say that for all the other regions. If you were a cynic, you could ask, "Well, how many are you testing?" I would like to think that we are testing more and there has been a decrease.

The CHAIR: From your research, you indicated that around 50 per cent of live births are the result of unplanned pregnancies; therefore, many pregnancies of women and girls are exposed to alcohol before they realise they are pregnant. Was that 50 per cent for both Aboriginal and non-Aboriginal communities and was there an age factor in those unplanned births?

Mrs Gatti: I will refer to Sarah. Can you remember where that evidence was in this report?

[10.40 am]

Ms McKerracher: No, unless it is in the references from the model of care.

Mrs Gatti: I will take that on notice. It will be a population versus an Aboriginal–non-Aboriginal statistic. Another thing I will note and put on the record is that although the public officer of the Department of Health came to us to develop this, this is not just an Aboriginal problem.

The CHAIR: No, it is across the board.

Mrs Gatti: The western suburbs have a problem. I am very keen to try to guard against people thinking that it is somebody else's problem and that we need to affect alcohol licensing and behaviour and not own it as a society ourselves.

The CHAIR: It is the Liquor Control Act and it is across the board. The model of care has a focus on reducing the number of unplanned pregnancies. Do you have any idea how you will target this and how it might be achieved?

Mrs Gatti: Yes. It is a similar strategy to what we have just been discussing. It needs to be a multifaceted approach in raising the awareness of individuals about whether an individual could get pregnant and, if so, whether the individual wants to be pregnant. Also, if the individual wants to drink, how does the individual ensure that she does not get pregnant? It is about trying to think proactively about being pregnant. There are strategies in schools and strategies that strongly influence behaviour. We have to change society's attitude towards discussing this. My youngest child had a twenty-first birthday on Saturday. Talking about alcohol, I was not one of the 10

families in the paper! Using my children and my colleagues as an example, they are better at talking about it than we were. They talk about alcohol and pregnancy and they do not drink and drive like—I will use the royal "we" here—because there has been an attitudinal change. What we need to do is raise awareness through liquor licensing. Legislation has clearly enforced some of that change in behaviour, but it is broader than that. There is more discussion in groups. It is an open discussion I have with my children and their friends. My colleagues and I are very conscious of people who are pregnant. Whether or not that is because we are actively working in the space, I do not know, but I would like to think that it is broader than that. We need to keep enforcing that through social marketing, focus groups, youth groups, schools and the strong influencing factor of parents.

The CHAIR: I think your comments when you first sat down really hit the nail on the head. We still need more evidence to convince a lot of health professionals who see people on a day-to-day basis. There are now a number of health professionals who just accept that without the evidence this is a moral issue and must be addressed. I think it has been good that many of the changes in evidence-based medicine over the past decade have been excellent in challenging the concepts but in this area, unfortunately, the evidence is not clear-cut.

Mrs Gatti: It is not. It will continue to grow as the years go by and further research is done into it, which is the advantage of the Lililwan research project. That will be a significant piece of work that will help inform what it is we are talking about and how we address it. The Lililwan project is looking at an Aboriginal community. I know many of the members of the Fitzroy Crossing community well. The beauty of that project is that it has a very strong bottom-up ownership. The women in that community in particular want to change. From where I sit, this is not an Aboriginal issue; this is far, far broader than that. Personally, the biggest resistance I am getting is from health physicians of various sorts. Generally they are aged 40 years and over, because that is what they did and they believe that they are okay. When we talk about social marketing—this is anecdotal—I am seeing a cultural and attitudinal change in the younger generation. My children and people of Sarah's age group are not the resisters. Those who have the power are the ones who are educated, and they drank and their wives drank when they were pregnant and they see their children as being perfect, just as I see mine. There is a lot of work to be done but it is a broader societal problem. While the Lililwan project is brilliant, we have to be careful to not just say that this is an Aboriginal problem and that we need to address it there.

Ms L.L. BAKER: That is very useful, thank you.

The CHAIR: We have a little bit longer. You have told us about the agencies, and we can see how you have the three different approaches. We know that work is being done here and that a committee in Canberra is looking at this. I am not sure whether it was Queensland or New South Wales—I think one of their committees was going to be looking at —

Mrs Gatti: All the states are doing work on this. I was part of a group that advised on the monograph. I confess that we saw some late drafts.

The CHAIR: Is that the tool?

Mrs Gatti: The monograph is the national —

Ms McKerracher: There are a few notes in the presentation. The monograph is across the country setting out the activity that is going on, from the research to the current projects to the work being done around diagnosis and screening. It is basically pulling together everything that is being done to get a picture of where the country is at in addressing FASD.

Mrs Gatti: Interestingly, it recognises Western Australia as a leader.

The CHAIR: I do not believe we have a copy of that. Can we get a copy of that?

Ms McKerracher: The monograph has not been published yet.

The CHAIR: Who has ownership of it?

Mrs Gatti: The Australian Health Ministers' Advisory Council in Canberra.

Ms McKerracher: The Australian Population Health Development Committee has been providing advice. I will just find the slide on here—I can certainly provide you with a bit more of a background around that out of session if you would like.

The CHAIR: That would be very useful, because we can maybe write to those people and ask for a copy of that monograph.

Mrs Gatti: We can provide you with the feedback that Health Networks has put into it. Western Australia has contributed to it.

The CHAIR: That would be very helpful if we could get a copy of your submission.

Ms McKerracher: It has 10 key recommendations and the 33 recommendations of the model of care align very closely with those 10 recommendations, so we are on the same page. As Kate said, the monograph identifies WA's work on the model of care as a piece of work to look to as a lead for the country.

The CHAIR: In the other states, are committees looking at this or is it just groups like yours?

Mrs Gatti: We have the most coordinated approach to looking at FASD as a state, as I understand. In fact, it is usually people with an interest that have been put up as the state representatives in the few phone conferences that I have participated in. Unlike Western Australia, where we have taken a coordinated multi-agency approach and we can speak more as a collective, they are speaking very much at an agency level, generally. That is how it appears to me.

The CHAIR: With the groups that have been meeting, has someone with a high profile like Noel Pearson been involved in this?

Mrs Gatti: Not that I am aware of, but I would not necessarily know either. Heather D'Antoine is an Aboriginal lady who used to be with the child institute here. She is in the Northern Territory now as a Northern Territory representative and is well versed in this area. Again, she comes from Western Australia and it is her Western Australian knowledge and work with the child institute that is basically her contribution.

[10.50 am]

The CHAIR: The model suggests that there are some populations at high risk of FASD and for which targeted screening should occur. Can you tell us a little bit about who those subgroups consist of?

Mrs Gatti: The Aboriginal population, particularly in many of the communities where there is known to be high alcohol prevalence—some of those. Also, populations where women have chaotic lifestyles; they are at high risk because often substance use is part of their lives. They are the key ones.

The CHAIR: Just last week early childhood centres attached to schools were announced, and they were selected based on the Australian Early Development Index—AEDI—results. Would you use a tool like that to maybe target populations, or how would you target women at risk? When you are saying about women at risk, I would see that as a measure of maybe where women might be at risk; however, how else could you identify the areas where those women are?

Mrs Gatti: Antenatal screening is really important, and so asking women the question about alcohol use pre-pregnancy through doctors when they come through and say, "I'm planning to get pregnant, I need testing for X, Y and Z." The alcohol question needs to be asked there, and depending on what you get there, it would put you into a risk category. That would identify a targeted risk assessment, and those, through antenatal care, who are drinking through pregnancy.

Again, asking the question in the antenatal period would solicit out your targeted response, and given there will always be fixed resources, we should target those most at risk.

The CHAIR: The government is currently meant to offer universal child health visits. We know they are not offering all those visits at the moment, but should there be an additional visit offered to a young mum with a child health nurse when she first discovers that she is pregnant? Who do you see as starting to collect that information? I have worked in GP surgeries; they have to go through a lot of paperwork. Who in that antenatal period should be getting the ball rolling for us in terms of that early intervention? Should it be a child health nurse or the GP —

Mrs Gatti: I think it is multi-strategied. On the birth notification form, at the moment the question around alcohol use is not on that form, and, admittedly, it is too late to ask the question then.

The CHAIR: The birth notification form that goes to the —

Mrs Gatti: The state. Every baby that is born is notified —

The CHAIR: But that goes to the child health nurse; that is when the baby is born. But we are talking about the antenatal period.

Mrs Gatti: Yes, and I am saying that for a targeted assessment and intervention, you could assess from that point. Most midwives have seen that mother antenatally, so if the question is asked about alcohol use on that form—which is one of the recommendations, from memory—you could identify those at risk for intervention at birth. In my opinion, that is too late. It is where these mothers are accessing their antenatal care, and that varies. I do not think it is any one person; I think it needs to be multi-strategied again. I think linking child health nurses back into the antenatal period is a strategy that would be beneficial, in answer specifically to your question. Having said that, I think having that as the only solution would be risky because a number of mothers may choose to link into their obstetrician early, and so the obstetrician or a GP might be the best person. But that question needs to be asked then and that problem identified; it is not routinely asked.

The CHAIR: We have a register for notifiable diseases; should we—this might sound a bit wild—have a register for notification of pregnancies? In the UK each family comes under a health visitor, and the health visitor then covers that family. Should we have a notification of pregnancy register, so that as soon as either the GP, the midwife or whoever is informed, there is a register somewhere where it goes down, and then—like they have in the UK, where their health visitor is the equivalent to our child health nurse—someone is told, "This person in your community is now pregnant"? So that just as we have a zero to 10-day visit scheduled—it may not be in zero to 10 days—at some point some contact can be made by a health professional. I am not saying which health professional it should be—personally I think it should be the child health nurses—but whichever health professional it is should contact that family to maybe let them know about available services, and also then get that message in nice and early and maybe ask those questions about smoking and alcohol.

Mrs Gatti: As a population health person, the earlier that we can affect the outcome of that baby and antenatal care—in fact, the three months leading into that as a healthy mother becomes pregnant—the better. So, fundamentally, yes, there is benefit in every mother engaging as early as possible in her pregnancy—preferably pre-planned with a planned pregnancy—with comprehensive care, or having the opportunity to engage. At the moment, as you know, we have that formal notification engagement at nought to 10 days, and we are not too bad at picking that up in the first three weeks, anyway; if we could do that antenatally, that would be better for many families.

The CHAIR: Maybe I could ask you to take that back to the committees you are on to start the ball rolling in terms of discussion on that type of issue. Even if it is not for a month or two, if you do have discussion, you could maybe get back to us because we will not be tabling our report on this issue until later in the year. It would be interesting to hear if people are receptive and how that

might work, because we realised, after we had tabled our terms of reference, that we had made a mistake by saying from birth to maturity; we should have said from conception.

Mrs Gatti: Or three months before or something.

The CHAIR: Yes.

Mr P. ABETZ: How far advanced is this model of care at this point in time? Is it ready to be rolled out soon?

Mrs Gatti: The implementation is going to be forever and a day. We only recently started the comprehensive implementation. The working groups and their forums identifying the members of the working group are only just being identified and notified now; that is very recent.

Mr P. ABETZ: So what sort of time frame are you looking at to come up with a model?

Mrs Gatti: We have the model; the model has been published for a while.

Mr P. ABETZ: So now it is the implementation phase when you can get that happening?

Mrs Gatti: That is right. The model was endorsed back in 2010. Implementing it and having a measure of success against that implementation is now the challenge, and that is where we are going.

Mr P. ABETZ: So there is quite a bit of pushback, still, about implementing it?

Mrs Gatti: Like all these models of care, it is best practice and they require resources, so it is around where is our prioritisation in the bigger scheme of things, and how do we get the best bang for our buck and which recommendations do we pick off first.

The CHAIR: We have several questions that we have not asked you, and I am sure there are some things that have come along just from our questions and maybe you would like to steer us in certain directions. I wonder whether I could give you a couple of minutes to sum up now, and then I will officially thank you and tell you about being sent the transcript et cetera. But even before your sum up, we accept that you are the expert in these areas and we are the novices, so we would be very happy if things come up that you think would be useful for us as a committee, you could just put them in the mail for us, perhaps once a month, to help us with this inquiry, because it really is such an important issue. We hope we can make some very useful recommendations at the end of the year. Could I ask you to give a quick sum up for a couple of minutes?

[11.00 am]

Mrs Gatti: Thank you, Dr Woollard. Firstly, I would like to say that I am not an expert in this area at all. It is a new science, and it is new to me; I am learning, just like all of us, I think, along the way. Having said that, there is a lot of work, and good work, that is happening out there, and a lot of resource that has been dedicated to trying to address this issue. There is not one person I am sure who wants to see a baby born below potential. So I think where we all stand united is in trying to effect a positive change for these unborn babies. Where we are not all united is on the how. Where we have got to is a model of care that is pretty much accepted. That is the what. The challenge will always be the implementation. As it is an emerging field with emerging evidence behind it, there will be debate, which is healthy in my opinion. I think what we need to do is continue embracing the efforts by many, because there is a lot of interest and passion—a term that I really do not like using—out there, and that has been proven to us in recent weeks and months, with the desire of both government and non-government agencies to engage in trying to effect change in this area. Where it will continue be a challenge I think for some time yet is that the hard, indisputable evidence is not there yet. So it is around building that evidence base, which is why the Lililwan project is so important. As I understand it, that report is due to be passed down in August, or even later. That is good. That is a bit more to add to the story that is emerging. In the interim, we know that alcohol affects some unborn babies. We know that it is a completely preventable condition. So I think we

quite actively need to start a multifaceted approach to have mothers who are planning to become pregnant or are pregnant not drink, because we do not know the effect on the unborn baby.

Mr P.B. Watson: Do not take the risk.

Mrs Gatti: Do not take the risk, yes. I think certainly at this point in time that is where we know we should be putting a lot of effort. When I compare my generation with Sarah's generation, I think there is an attitudinal change. We need to build on that. But we also know that our generation are the influencers. So we need to very actively work on our generation. Just because we got away with drink driving and drinking in pregnancy does not mean that there is not a body of evidence to suggest that some will not.

The CHAIR: Thank you both for your evidence before the committee today. A transcript of this hearing will be forwarded to you for correction of minor errors. Any such corrections must be made and the transcript returned within 10 days from the date of the letter attached to it. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be added via these corrections, and the sense of your evidence cannot be altered. However, should you wish to provide additional information or elaborate on particular points, please include a supplementary submission for the committee's consideration when you return your corrected transcript of evidence. As I said, if there is any further information that you can supply to us—it does not need to be in the form of a submission—even if it is notification of meetings that are to be held discussing this matter that one of us might be able to attend, or papers that you come across that are relevant to the area, we would very much appreciate your keeping us informed. Thank you both very much.

Hearing concluded at 11.04 am