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Support for new parents and babies in New South Wales



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Chair's foreword and summary

Supporting new parents is key to ensuring that every child has a happy, healthy start to life. Pregnancy and birth are times which present unique opportunities to help parents. They offer chances to identify parents who are struggling or vulnerable and help break the cycle of disadvantage. Research shows the potentially life changing impact of early intervention, and the importance of the first thousand days of a child's life to their future wellbeing. It's also clear that early and effective support can reduce long-term disadvantage and is cost-effective in the long-term. Governments have recognised this and are focusing more on supporting parents during their children's early years. Our report looks at ways to better provide this support.

Our recommendations aim to address the needs of all new parents, not just first-time parents.

Better coordination of services for new parents

Universal child and family health services can be hindered by poor coordination and disjointed service delivery. We were told that medical professionals like GPs, midwives, and child and family health nurses don't always collaborate enough and often aren't fully aware of services for new parents. A lack of continuity of care can mean there is a poor transition between pre and postnatal care for mothers. It also limits opportunities for early intervention and support for parenting and mental health issues.

We heard that new parents don't have equal access to services like home visits, as local health districts (LHD) are inconsistent in the way they manage services. Women in some areas find it hard to get access to home visits, attend local clinics and join mothers' groups, because of limited availability. We recommend that NSW Health appoints a coordinator in each LHD to work with other departments and non-government organisations (NGOs) to improve the coordination of services for new parents. Co-locating services can improve coordination and we recommend that opportunities like this be further explored.

We also believe that resourcing for home visits should be reviewed, so parents can get consistent access to visits. We heard how long-term nurse home visiting programs have helped vulnerable parents improve their parenting and bond with their babies. Programs like these with proven outcomes should be made available to more families in NSW.

The way services are funded can affect their quality. We consider that funding arrangements should be reviewed to ensure programs for new parents have clear and measurable outcomes. We heard that current contracts can be too short and don't allow NGOs to tailor their services and properly implement and evaluate their programs.

Fixing gaps in services

We were told the role of fathers isn't adequately recognised and there aren't enough father specific services, such as baby care classes. We heard about a program for new fathers, developed by the Family Action Centre at the University of Newcastle, which has succeeded in engaging dads. We believe that programs like this should be more widely available. We also recommend that NSW Health reviews services for parents, with the aim of involving fathers more and recognising their role in parenting.

Perinatal depression and anxiety affect up to 20 per cent of new mothers and 10 per cent of new fathers. Despite this, community awareness of treatment options is lacking. This means that many new mothers with mental health issues are reluctant to admit they're unwell and ask for help. Their condition can escalate to the point they require hospitalisation. We heard that the lack of mother-baby beds in public hospitals means that women with serious conditions like psychosis are separated from their babies, sometimes for months, while being treated. It's important that mothers with mental health conditions are able to stay with their baby while they are treated, if their condition allows it. We note that the planned creation of new public mother-baby beds has been announced. While we acknowledge this as progress, we recommend that a minimum of 24 beds should be available across NSW.

Research shows that breastfed babies have better outcomes in many areas. In spite of this, the rate of babies fully breastfed on discharge from hospital is dropping. Most women want to breastfeed their babies, and initiate breastfeeding when they are in hospital. We heard that support from well-trained staff can help women to keep breastfeeding. While NSW Health has developed a Breastfeeding in NSW policy, we were told that it hasn't been implemented. We recommend that it be reviewed and fully implemented to improve support for breastfeeding. We also believe that more hospitals and community health facilities should aim to be accredited as breastfeeding-friendly.

Making services more accessible

All new parents should have access to parenting information and resources. However, we heard that services are sometimes provided in a way that isn't accessible to parents, such as those with disability. For instance, parenting courses like Triple P are only available in hard copy, which isn't suitable for parents with vision impairment. Similarly, parents from culturally and linguistically diverse backgrounds can find it hard to use parenting services because of language barriers. While clinicians can book free interpreters for appointments, their availability is an issue. We recommend that NSW Health makes parenting resources more accessible for vulnerable parents.

Some parents, such as foster parents and same sex parents, can feel excluded by current hospital forms and systems, and their ability to give medical consent can be affected. We believe that hospital systems should be respectful to all families and allow accurate recording of a child's family and medical history.

Technology and telehealth can offer new ways to support parents that traditional services struggle to reach, for instance those in remote areas. Today's parents are also more willing to get information online and through their phones. We heard many examples of programs that are bringing services to parents in cost-effective and innovative ways. Text messaging, live chat and telephone helplines are being used to give parents breastfeeding support, parenting advice and mental health counselling. We recommend that NSW Health continues to develop technology-based means of delivering services to new parents, especially in rural and remote areas.

Helping parents who need extra support

Aboriginal children face greater disadvantage because of the impact of intergenerational trauma, violence and abuse. On our visit to Gunawirra House in Rozelle we heard about the challenges many Aboriginal parents also face. Aboriginal community organisations like Gunawirra play a vital role in supporting Indigenous families by providing culturally

appropriate early intervention programs. They also create employment and training opportunities for rural and regional communities. We recommend that the NSW Government gives a higher priority to the protection and support of Aboriginal children, recognising the severity of the challenges many of them face.

We heard that young parents benefit from integrated support with housing, education and parenting. The Young Parents' Hub in Wyong is a model of co-located child care, education and parenting services, which has helped some young parents overcome intergenerational disadvantage. We believe this type of integrated support for young parents should be available in more locations. To meet young parents' housing needs, youth homelessness services should have dedicated positions to support young parents.

We heard that the end of state funded disability services has affected services for families with young children. The transition to the National Disability Insurance Scheme has created gaps and delays in support for babies with disability and developmental delay. There are long waiting lists and children with disability aren't getting the early intervention that is critical to better long-term outcomes. We consider that a whole of government approach is needed to improve the detection of disability and developmental delay in babies and provide them with timely support.

Improving the capacity of health and child protection staff

Adequate staffing and training of child and family health workers is key to meeting the needs of new parents. We heard that services in some parts of NSW struggle to recruit and retain staff, and these shortages result in inconsistent access to services. Understandably, it can be harder to attract staff to rural and regional areas. To address this, we recommend that NSW Health works with LHDs to identify workforce gaps and plan for future staffing needs in each district.

Child and family health is a rapidly changing area of practice for clinicians and regular training is needed to keep them up to date on new research and changing practices. We've highlighted areas where training is needed, including disability awareness, psychosocial screening for perinatal anxiety and depression, and supporting parents and children with disability.

Using data to improve services

Poor information sharing between service providers impacts the quality of services for new parents and babies. We heard some health care staff rely on personal relationships to get information because their systems are disjointed. Giving service providers access to the information they need to support their clients means they can give them better support. Data sharing can also help agencies to plan and evaluate their programs for new parents.

NSW Health and FACS are making changes that will improve integration in health and family services, but we believe these measures should be prioritised.

Acknowledgements

I want to thank the stakeholders who took time to talk to us on our visits to Gunawirra House in Rozelle, the Young Parents' Hub at Wyong, and Child and Family Health at Gosford. We also very much appreciated the submissions we received, and the evidence we heard from witnesses who gave evidence at our Sydney hearings.

I also want to thank the Committee for their non-partisan and constructive work during the inquiry, and Committee staff for supporting us in our work.

Kevin Conolly MP
Chair

Findings and recommendations

Chapter One - Coordination and delivery of services

Finding 1 _____ **1**

Universal child and family health services for new parents and babies can be inconsistent and fragmented.

Recommendation 1 _____ **1**

That NSW Health appoints a coordinator in each local health district to coordinate health related services for new parents and liaise with the Department of Family and Community Services, and non-government organisations.

Finding 2 _____ **5**

Co-located health, housing and community services can reduce fragmentation and improve access to services for new parents and babies.

Recommendation 2 _____ **5**

That NSW Health works with the Department of Family and Community Services to improve service integration, collaboration and continuity of care.

Recommendation 3 _____ **7**

That NSW Health reviews funding for the universal health home visiting program to ensure consistent access to home visits.

Recommendation 4 _____ **10**

That NSW Health and the Department of Family and Community Services expand proven sustained home visiting programs for at risk families more broadly across the state.

Recommendation 5 _____ **13**

That the NSW Government reviews funding arrangements to enable longer contract periods and more flexibility in the design and delivery of child and family health services. Contracts with service providers should specify clear and measurable outcomes.

Chapter Two - Gaps in services

Finding 3 _____ **16**

There are gaps in perinatal mental health services for new and expectant parents.

Recommendation 6 _____ **16**

That NSW Health runs a public awareness campaign about perinatal anxiety and depression to raise awareness about treatment options and reduce stigma.

Recommendation 7 _____ **17**

That NSW Health develops strategies to ensure that women who receive private maternity care are given antenatal psychosocial screening consistent with that provided in the public health system.

Recommendation 8 _____ **18**

That NSW Health funds more public mother-baby mental health units in Sydney and key regional centres, with a minimum of 24 beds across the state.

Finding 4 _____ **22**

Child and family health services and parenting programs can exclude new fathers.

Recommendation 9 _____ **22**

That NSW Health updates parenting information and services to recognise and promote the role of fathers in parenting.

Recommendation 10 _____ **23**

That NSW Health expands programs for new fathers more widely across the state and explores other options for engaging this cohort.

Recommendation 11 _____ **25**

That NSW Health evaluates the Breastfeeding in NSW policy and prioritises its full implementation.

Recommendation 12 _____ **27**

That NSW Health prioritises Baby Friendly Health Initiative accreditation for all public hospitals across the state.

Recommendation 13 _____ **27**

That NSW Health works with local health districts to increase the number of community health facilities that have Baby Friendly Health Initiative accreditation.

Chapter Three - Accessibility of services

Recommendation 14 _____ **29**

That NSW Health develops easy English and Braille versions of parenting information and resources for parents with disability.

Recommendation 15 _____ **29**

That NSW Health provides parenting courses adapted for parents with disability.

Recommendation 16 _____ **30**

That NSW Health develops strategies to improve communication with new parents from culturally and linguistically diverse backgrounds, including a wider availability of interpreters.

Recommendation 17 _____ **32**

That NSW Health reviews hospital forms and systems to ensure they enable accurate recording of a child's family, linking to family medical history, and medical consent to be given by their

family. Hospital systems should be respectful to all members of the community, including those who value their identity as 'mother' or 'father'.

Recommendation 18 _____ **33**

That NSW Health develops telehealth and technology-based ways to deliver services to new parents, particularly those in rural and remote areas.

Chapter Four - Parents and children who need extra support

Finding 5 _____ **38**

Aboriginal children face disproportionately greater challenges arising from intergenerational trauma, violence and abuse.

Recommendation 19 _____ **38**

That the NSW Government gives a higher priority to the protection and support of Aboriginal children, recognising the severity of the challenges many of them face.

Recommendation 20 _____ **40**

That the Department of Family and Community Services increases funding for Aboriginal Child and Family Centres to increase the range of services they can provide.

Recommendation 21 _____ **43**

That NSW Health and the Department of Family and Community Services ensure that early intervention programs for Aboriginal families emphasise nutrition education.

Recommendation 22 _____ **44**

That NSW Health and the Department of Family and Community Services develop specialised, integrated support services to meet the needs of young parents in each district.

Recommendation 23 _____ **46**

That the Department of Family and Community Services allocates dedicated positions for young parents in youth homelessness services.

Finding 6 _____ **47**

The transition to the National Disability Insurance Scheme has created gaps and delays in early intervention services for babies and children with disability.

Recommendation 24 _____ **47**

That the NSW Government reviews services for babies and children with developmental delay and disability, to address gaps and improve referrals for support.

Chapter Five - Workforce gaps and training

Recommendation 25 _____ **50**

That NSW Health surveys each local health district to identify current and future workforce needs for child and family health services and develop strategies to address staff shortages in each district.

Recommendation 26	51
That NSW Health funds additional perinatal psychiatry registrar positions.	
Recommendation 27	52
That NSW Health ensures all staff involved in SAFESTART psychosocial screening receive training to perform the screening effectively.	
Recommendation 28	53
That NSW Health develops and implements training on cultural awareness and engaging with diverse communities for staff who provide child and family health services.	
Recommendation 29	54
That NSW Health includes a consumer voice component in face to face training for child and family health service staff.	
Recommendation 30	55
That NSW Health trains staff who provide child and family health services on appropriate referral pathways for babies with developmental delay and disability.	
Recommendation 31	55
That the Department of Family and Community Services trains child protection workers on support available for parents with disability under the National Disability Insurance Scheme, to enable children to remain with their families where possible.	
Recommendation 32	55
That the Department of Family and Community Services and NSW Health run disability awareness training for child protection workers and staff who provide child and family health services.	
Chapter Six - Collecting and sharing information	
Finding 7	57
Better information sharing between service providers and government agencies could improve the quality of services and programs for new parents and babies.	
Recommendation 33	57
That NSW Health prioritises the implementation of measures to improve information sharing between government and non-government child and family health service providers.	
Recommendation 34	57
That the Department of Family and Community Services and NSW Health implement the use of an information sharing system across the state.	

Chapter One – Coordination and delivery of services

Child and family health services

Universal child and family health services are inconsistent and fragmented

Summary

Child and family health services for new parents need better integration and coordination to ensure parents have access to consistent and appropriate care and support.

Finding 1

Universal child and family health services for new parents and babies can be inconsistent and fragmented.

Recommendation 1

That NSW Health appoints a coordinator in each local health district to coordinate health related services for new parents and liaise with the Department of Family and Community Services, and non-government organisations.

- 1.1 New parents and their children are offered universal primary health care and support during the first five to six years of the child's life and those services are generally provided by child and family health nurses. They include checks of the child's development, and physical and psychosocial screening of the parents, usually the mother, to check their physical and mental wellbeing. There is a focus on early identification and treatment of issues, with referral to specialist services for families who need additional support.¹
- 1.2 The My Personal Health Record (or Blue Book) is given to all new parents when their child is born. It records illnesses, injuries and development as well as immunisation information. It also recommends regular health checks until children are four years old.²
- 1.3 While NSW Health provides a range of health services, it also works with other government and non-government agencies. NSW Health, the Department of Family and Community Services (FACS), and the Department of Education jointly fund and provide numerous support services for families and children with more complex needs. They are jointly responsible for Families NSW, a whole of government strategy to ensure the health and wellbeing of children aged up to eight years, and their families.³

¹ Submission 70, NSW Government, p8

² Submission 70, NSW Government pp4, 16

³ Submission 70, NSW Government, p2

- 1.4 We heard there is little consistency in how local health districts (LHDs) – both metropolitan and regional/rural – provide universal child and family health services. Services aren't coordinated and there is limited, if any, continuity of care. We were told that parents can miss out on support and may not be able to form a trusting relationship with health professionals. Parents can feel uncomfortable talking to a health professional who they feel doesn't care about or understand their needs.⁴
- 1.5 Some new parents receive a home visit from both a midwife and a child and family health nurse. However, evidence indicated that these visits aren't coordinated and can overlap and create confusion.⁵ Delays in transitioning families from midwifery to child and family health services can adversely affect the family. At a time when they may need support the most, mothers can miss out on connecting with local parenting groups or attending breastfeeding clinics.⁶
- 1.6 New parents told us of their experience of the support they received. Ms Kellie Darley was living in the Sutherland Shire when she gave birth to her first child. She was grateful to attend a drop-in breastfeeding clinic and a mothers group. She contrasted that experience to the birth of her second child while living in the City of Parramatta. When she asked for help with breastfeeding she was told this support wasn't available. She was also told that as a mother with two children she couldn't join a local mothers group.⁷
- 1.7 Ms Claire Carpenter, a resident in Epping/Carlingford provided a small qualitative survey of support services available in her area. She received 63 responses to a survey she designed to gauge parents' experience with early childhood centres during their baby's first year. The results reflected other evidence we received: families are often not contacted by health services within two weeks of giving birth; there are delays with home visits; limited access to support groups including breastfeeding services; and difficulty getting appointments to see child health professionals.⁸
- 1.8 Dr Nigel Lyons, Deputy Secretary, Strategy and Resources, Ministry of Health, acknowledged that LHDs have difficulty in providing a universal service: '... the challenge for us in local health districts is that we have a very different range of services in different parts of the State.'⁹

Support services are poorly coordinated and hard to navigate

- 1.9 We heard the system is hard for both parents and health professionals to understand. Ms Julie Hourigan Ruse, Chief Executive Officer, fams, told us there

⁴ Dr Elaine Burns, Executive Committee Member, Australian College of Midwives NSW Branch, Transcript of evidence, 21 May 2018, p2; Ms Lyn Passant, Executive Committee Member, Australian College of Midwives NSW Branch, Transcript of evidence, 21 May 2018, p4; Professor Virginia Schmied, Western Sydney University, Transcript of evidence, 21 May 2018, p33

⁵ Submission 9, Child and Family Health Nurses Association NSW, p3

⁶ Ms Karen Dignam, Membership Secretary, Child and Family Health Nurses Association, Transcript of evidence, 21 May 2018, p5

⁷ Submission 15, Ms Kellie Darley

⁸ Submission 14, Ms Claire Carpenter, p1

⁹ Dr Nigel Lyons, Deputy Secretary, Strategy and Resources, Ministry of Health, Transcript of evidence, 4 June 2018, p17

are many government and non-government services available but parents don't always know about them. She said the system assumes that people know what services are available and how to access them.¹⁰

- 1.10 For new parents coping with the demands of caring for a baby, researching and contacting various organisations for support can be difficult and frustrating. Ms Nhuan Lien Vong told us about her experience of inconsistencies in the care provided by different LHDs. She stated that:
- New mother's shouldn't have to be the ones chasing the service and have to travel to get their children immunised or find someone to talk to if they have concerns. Especially in the early days of bringing home a newborn.¹¹
- 1.11 Health professionals such as general practitioners (GPs), also struggle to understand what services are available. GPs play an important role in supporting new parents and referring them to services. However, we received evidence from several stakeholders that poor communication between GPs, practice nurses, and child and family health nurses limits their ability to collaborate.¹²
- 1.12 Being unfamiliar with local universal services, GPs often refer families that need support directly to secondary services, such as Tresillian and Karitane. These services regularly see families with issues that could be managed by primary care child and family health services. This puts more pressure on their ability to help families that need more intensive support.¹³
- 1.13 Geographical boundaries can also act as a barrier. Parents can only access child and family health centres within their LHD. Parents living on the boundary of a neighbouring health district may not be able to use the closest and most convenient child and family health service if it's in a different district. This can cause frustration and lead to social isolation for new parents.¹⁴
- 1.14 NSW Health and FACS have an important role in promoting child and family health and child protection. We heard that as both agencies focus on an early intervention model of care, there is sometimes confusion about their roles and responsibilities. They need to work together to better integrate their services to support vulnerable families.¹⁵
- 1.15 We heard that the ability of services to coordinate and work together can depend on staff from different services having a trusting relationship and sharing

¹⁰ Ms Julie Hourigan Ruse, Chief Executive Officer, fams, Transcript of evidence, 21 May 2018, p22; Submission 65, Volunteer Family Connect, pp4-5

¹¹ Submission 34, Ms Nhuan Lien Vong

¹² Submission 27, Public Health Association of Australia, p4; Associate Professor John Eastwood, Royal Australasian College of Physicians, Transcript of evidence, 21 May 2018, p6

¹³ Associate Professor Jenny Smit, Director of Clinical Services, Tresillian, Transcript of evidence, 21 May 2018, p14

¹⁴ Submission 14, Ms Claire Carpenter, p18; Submission 42, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, p2

¹⁵ Ms Grainne O'Loughlin, Chief Executive Officer, Karitane, Transcript of evidence, 21 May 2018, p15; Submission 15, Karitane, p8

information. When there are no formal systems in place, these connections are fragile and can end when a member of staff leaves.¹⁶

- 1.16 Data sharing between agencies is a key part of ensuring services are better coordinated and integrated. Historically, NSW Health hasn't had electronic data systems that could share information with other systems or agencies.¹⁷ Measures to improve data sharing are discussed in chapter six.
- 1.17 We heard about a small-scale project involving the Western Sydney LHD and FACS. A vulnerable families coordinator was employed to work with FACS caseworkers. The coordinator collates clients' health records and speaks with health professionals to ensure families receive the support they need.
- 1.18 Ms Lisa Charet, Executive District Director for FACS's Western Sydney and Blue Mountains Districts described the designated coordinator as a 'game changer' and something that should be available in all health districts.¹⁸
- 1.19 Inquiry participants told us that improving universal services doesn't merely depend on allocating more resources. Instead, service delivery and outcomes could be improved by redirecting existing resources to fill gaps and reduce duplication in areas that may be over-served.¹⁹
- 1.20 Many stakeholders told us that there is limited awareness of services, government and non-government, available in each LHD. While there are many providers, there is uncertainty about their competency and the service they provide.²⁰
- 1.21 We heard there is a need for statewide mapping of services to identify the child and family health services available in each health district. This should establish what services are available, who is providing them and help reallocate existing resources to areas of greatest need.²¹
- 1.22 It is for this reason that we've recommended each LHD appoint a coordinator for child and family health services for new parents. The role should ensure a consistent approach is taken to improving services and promoting awareness of them in the local community. Having a specific point of contact within each health district should also improve liaison between agencies, government and non-government.

¹⁶ Ms Dignam, Transcript of evidence, 21 May 2018, p5; Ms Hourigan Ruse, Transcript of evidence, 21 May 2018, p24

¹⁷ Dr Lyons, Transcript of evidence, 4 June 2018, p19

¹⁸ Ms Lisa Charet, Executive District Director, Western Sydney and Blue Mountains Districts, Department of Family and Community Services, Transcript of evidence, 4 June 2018, p19

¹⁹ Submission 20, fams, p7; Dr Burns, Transcript of evidence, 21 May 2018, p8;

²⁰ Submission 65, Volunteer Family Connect, p4

²¹ Ms O'Loughlin, Transcript of evidence, 21 May 2018, pp13, 16; Associate Professor Smit, Transcript of evidence, 21 May 2018, p14; Associate Professor Eastwood, Transcript of evidence, 21 May 2018, p10

Co-located services can improve collaboration

Summary

Co-locating services can help reduce service fragmentation. It helps service providers to collaborate and allows better integration of services. This should improve continuity of care as providers work more closely together to improve outcomes for families.

Finding 2

Co-located health, housing and community services can reduce fragmentation and improve access to services for new parents and babies.

Recommendation 2

That NSW Health works with the Department of Family and Community Services to improve service integration, collaboration and continuity of care.

- 1.23 Co-locating services, such as child and family health, and mental health services, in one location makes it easier for people to know about and access services that can provide ongoing support. This service model also enables service providers to collaborate and integrate their services. The physical location of co-located services is important. They need to be in areas that the people who need the services will visit.²²
- 1.24 We heard that the Redfern RedLink integrated services hub helps local vulnerable families connect with a range of services, including health, housing, education, community services and legal advice. This model also helps local people engage more with their community, reducing social isolation.²³
- 1.25 RedLink is part of the 2015 Healthy Homes and Neighbourhoods initiative, a multi-agency collaboration that includes the Ministry of Health, Sydney LHD and FACS. Families with complex health and social needs can access several services in one location. Many of the local families have intergenerational disadvantage and trauma, with limited previous engagement with services.²⁴
- 1.26 Positive outcomes have been achieved for Aboriginal families by co-locating Aboriginal Maternal and Infant Health Services (AMIHS) with services provided under the Building Strong Foundations program. The services, located at over 40 sites across the state, work closely together and provide a good transition from midwifery to child and family health services.
- 1.27 AMIHS focusses on reducing perinatal morbidity and mortality for Aboriginal children. Services include regular antenatal and postnatal check-ups, and referral

²² Associate Professor Smit, Transcript of evidence, 21 May 2018, p17; Ms Kerry Moore, Executive Manager, Safety and Prevention, Rural/Regional NSW and ACT, Barnardos Australia, Transcript of evidence, 21 May 2018, p27; Submission 27, Public Health Association of Australia, p5

²³ Associate Professor Eastwood, Transcript of evidence, 21 May 2018, p10

²⁴ Sydney Local Health District, [A framework for improving health equity in Sydney Local Health District](#), p18, viewed 8 October 2018

to other support services as needed. Support is also provided on a range of issues including infant feeding and nutrition, health promotion and smoking cessation.²⁵

- 1.28 We also heard about the Barnardos family centre in Warrawong. The centre, located in an area of socio-economic disadvantage, includes services for new parents. It works closely with community midwives, early childhood nurses, housing, and child protection services to support new parents.²⁶
- 1.29 During our visit to the Young Parents' Hub in Wyong we saw the benefit of having multiple services available in one location. Having a range of support available makes it easier for parents to find and engage with providers who regularly visit the hub. Detailed information about the Young Parents' Hub is available in Appendix Two.
- 1.30 We note the 2018 NSW Budget announcement of funding for new Family Care Centre Hubs in Queanbeyan, Coffs Harbour, Dubbo, Taree and Broken Hill. The centres, in partnership with Tresillian, will provide local and intensive parenting support to vulnerable families.²⁷

Continuity of care is important for new parents

- 1.31 Continuity of care is an important part of ensuring new parents and their babies are properly supported. We heard that continuity of care should begin in pregnancy and then seamlessly transition from midwife to child and family health nurse following the birth.
- 1.32 NSW Health's Towards Normal Birth policy identifies the importance of having a continuity model of care for woman centred labour and birth care. However, we heard that not all LHDs have implemented a continuity of care model.²⁸
- 1.33 During their pregnancy many women don't see the same midwife. This limits the opportunity for the midwife to get to know the woman and understand her physical, social and mental health needs. Women may feel uncomfortable and less willing to disclose information if they see a different midwife each time they attend antenatal services. They can be frustrated with having to give their history to a new midwife on each visit.²⁹ It also means women may not be properly screened for psychosocial issues during the antenatal period.³⁰
- 1.34 Inconsistent access to a regular midwife can cause negative outcomes for women as any concerns they have may not be addressed. It can also undermine their confidence to take care of their baby. Different health practitioners can give conflicting advice which adds to the struggle families face when using the system.

²⁵ NSW Health, [Aboriginal mothers and babies](#), viewed 23 October 2018; Ms Julie Collier, Vice-President, Child and Family Health Nurses Association, Transcript of evidence, 21 May 2018, p10

²⁶ Ms Moore, Transcript of evidence, 21 May 2018, p27; Submission 26, Barnardos Australia, p5

²⁷ NSW Health, [NSW Budget: \\$157 million support package for new families](#), viewed 16 October 2018

²⁸ NSW Health, [Towards normal birth](#), viewed 8 October 2018; Dr Burns, Transcript of evidence, 21 May 2018, p8

²⁹ Dr Burns, Transcript of evidence, 21 May 2018, p2

³⁰ Ms Passant, Transcript of evidence, 21 May 2018, p4

- 1.35 Women with more complex needs such as substance misuse, socio-economic disadvantage or poor mental health may fall through the cracks and not get the support they need during pregnancy.³¹
- 1.36 Following the birth, the lack of continuity in care means the transition to child and family health services is unsatisfactory. New parents can miss out on support they may need to breastfeed, settle the baby or take care of their own physical and mental health.³²
- 1.37 It's important that services involved in child and family health care and protection give comprehensive and consistent support to new parents. This is especially important for vulnerable parents with complex issues who need a range of services working together to support them. We heard NSW Health is aware that it needs to better connect with services, such as FACS and Education, that support vulnerable families.³³
- 1.38 The earlier parents get support the more confident they become as parents. Delays in getting help can mean parents struggle to care for and bond with their baby. Responsive and sensitive care in the first months of a child's life provides a strong foundation for their future development. Research suggests that when care is not given in a loving and responsive way, it can have ongoing effects on the child's health and development.³⁴

Universal health home visits

Consistent access to home visits

Summary

Access to the universal health home visiting program needs to be consistent so parents receive timely support as they transition to parenthood. Home visits help with early identification of issues and intervention to manage them. This can prevent problems from escalating and becoming harder to manage.

Recommendation 3

That NSW Health reviews funding for the universal health home visiting program to ensure consistent access to home visits.

- 1.39 NSW Health policy is to offer new parents at least one visit by a child and family health nurse within two weeks of the birth.³⁵ In 2016-17 around 83 per cent of

³¹ Dr Burns, Transcript of evidence, 21 May 2018, pp2, 6, 8; Ms Collier, Transcript of evidence, 21 May 2018, p3; Submission 26, Barnardos Australia, pp2-3

³² Ms Dignam, Transcript of evidence, 21 May 2018, p5; Dr Jacqueline Small, Director, Royal Australasian College of Physicians, Transcript of evidence, 21 May 2018, p6; Professor Schmied, Transcript of evidence, 21 May 2018, p33

³³ Dr Lyons, Transcript of evidence, 4 June 2018, p20

³⁴ Submission 42, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, p2; Submission 70, NSW Government, p6

³⁵ Submission 70, NSW Government, p12

eligible babies received a visit. Families that decline a visit usually prefer to go to a clinic or their own GP.³⁶

- 1.40 However, we heard that the way the service is delivered is inconsistent. We were told that some parents aren't visited or the visit happens too late. Ms Claire Carpenter noted that over half the new mothers who responded to her survey weren't contacted within two weeks after birth. Several mothers received a delayed visit while others were never visited. Ms Carpenter herself was told she couldn't be offered a home visit when her baby was two weeks old. This was then recorded as her declining a visit despite requesting one.³⁷
- 1.41 Home visits allow for early identification of issues with the care and wellbeing of the baby or the parents. Early intervention can prevent issues from escalating. The visits should be performed by a child and family health nurse, as they understand child-parent attachment, the science of brain development and principles of public health. Many are also trained in midwifery and understand the effect that pregnancy and birth has on a woman.
- 1.42 Having child and family health nurses answer their questions and receiving professional advice increases the confidence of parents to care for their baby. The nurses also work with families that may need several home visits to help them through the first weeks of parenthood, or refer them to a secondary service if needed.³⁸
- 1.43 We heard that LHDs don't always have enough resources to recruit suitably qualified nurses. Even when resources are available it can be difficult to attract and retain child and family health nurses.
- 1.44 Recruiting and retaining staff is an issue in metropolitan and regional areas. Lack of staff means that the high demand for services in areas such as south-west Sydney isn't being met. However, retaining staff in rural and remote areas is even more difficult. This is due to issues such as the remoteness of communities and having to travel long distances, and also pay and conditions.³⁹
- 1.45 The work of child and family health nurses isn't equally prioritised across all LHDs. Rather than recruit child and family health nurses, some health districts employ registered nurses who lack the specialised skills to support new parents. This can mean families, especially vulnerable families, are visited by a nurse who lacks the medical and mental health training to properly assess the family's situation. This creates further systemic inequities as families miss out on early intervention or timely referral to secondary support.⁴⁰
- 1.46 Resource constraints mean some LHDs prioritise home visits for families identified as being at risk through SAFE START antenatal assessment and

³⁶ Dr Lyons, Transcript of evidence, 4 June 2018, p13; Submission 70, NSW Government, p12

³⁷ Submission 14, Ms Claire Carpenter, cover letter, pp1, 6, 7

³⁸ Submission 9, Child and Family Health Nurses Association NSW, pp1, 2; Ms Collier, Transcript of evidence, 21 May 2018, p3

³⁹ Ms Collier, Transcript of evidence, 21 May 2018, p3; Ms O'Loughlin, Transcript of evidence, 21 May 2018, p15; Ms Moore, Transcript of evidence, 21 May 2018, pp28-29

⁴⁰ Ms Dignam, Transcript of evidence, 21 May 2018, p7; Submission 27, Public Health Association of Australia, p5

depression screening. Families that aren't identified as being at risk receive a telephone call from their local child health service rather than a home visit. Second-time parents may also miss out on a visit as resources are directed to at risk families.⁴¹

- 1.47 We support universal health home visits being offered to all new parents, whether it is their first or subsequent baby. We welcome the 2018 NSW Budget announcement of \$4.3 million to fund more home visits. Additional nurses will be available to visit new parents, who will have the option of a further home visit from a child and family health nurse in the first months of their child's life. The package includes partnering with Karitane to employ more nurses to provide virtual home visits.⁴²
- 1.48 Home visits help parents transition to parenthood by offering immediate and practical support. The visits also inform parents about the availability of child and family health services. There may be no serious concerns at the time of the initial visit. However, the baby or a parent may develop a behavioural or physical health issue at a later stage. If that happens it's important that the family knows how and where to get help.
- 1.49 The home visits are also an opportunity for nurses to see if parents are experiencing postnatal depression or anxiety. Early detection and referral to treatment can minimise the negative impact of these conditions on the wellbeing of the family. While many families may be happy with one home visit, others may welcome regular visits for a period of time.⁴³
- 1.50 Home visits are also convenient for many new parents who may struggle with the logistics of travelling with a newborn to attend a clinic in the first weeks after birth.⁴⁴
- 1.51 Throughout the inquiry we heard how important a child's first 1,000 days are to their development. The foundations of the child's future physical, mental and emotional wellbeing are laid in those early years. When problems arise it's important to provide support early.⁴⁵
- 1.52 With an emphasis on early intervention, a universal health home visit allows for early treatment options to be put in place. As a result, future health and development outcomes for both child and parent are improved. Successfully dealing with less serious issues early also reduces demand for secondary and tertiary care services.

⁴¹ Associate Professor Eastwood, Transcript of evidence, 21 May 2018, p4

⁴² NSW Health, [NSW Budget: \\$157 million support package for new families](#), media release, 17 June 2018, viewed 16 October 2018

⁴³ Submission 56, Royal Australasian College of Physicians, p3; Submission 70, NSW Government, pp8, 12; Ms Collier, Transcript of evidence, 21 May 2018, p6

⁴⁴ Submission 14, Ms Claire Carpenter, p7

⁴⁵ See Submission 22, Aboriginal Child, Family and Community Care Secretariat, pp8-10; Submission 26, Barnardos Australia, p2; Submission 40, Karitane, p15; Submission 48, Australian Research Alliance for Children and Youth, p7; Submission 51, NSW Council of Social Service, pp6-7

Sustained home visiting

Effective home visiting programs should be expanded

Summary

Sustained home visiting programs help vulnerable families by giving parents the skills to care for and support their child. This helps ensure positive child development and child protection outcomes for families who struggle with the demands of parenthood.

Recommendation 4

That NSW Health and the Department of Family and Community Services expand proven sustained home visiting programs for at risk families more broadly across the state.

- 1.53 Sustained home visits help parents who need additional support to provide a safe and caring home for their child. For families where socio-economic disadvantage or psychosocial risk factors are present there is a risk that poor parenting practices may negatively impact on the child.⁴⁶
- 1.54 Research has shown that home visiting programs help vulnerable parents improve their parenting skills. Early intervention means issues don't escalate and become more complex and harder to address. Parents have a better experience of parenthood as they learn how to care for and interact with their child. This helps them form strong emotional bonds with their child and create a nurturing home environment.
- 1.55 As previously mentioned, positive early childhood care leads to better long-term health and development outcomes. This continues into adulthood as children are more likely to grow in to well-adjusted adults.⁴⁷
- 1.56 We received evidence about a number of home visiting programs that have achieved positive results. These are discussed below.
- 1.57 The Sustaining NSW Families home visiting program supports moderately vulnerable families from pregnancy until their child is two years old. It focuses on giving parents the capacity to form a strong emotional bond with their child to promote the positive social and emotional development of the child.⁴⁸
- 1.58 A 2015 evaluation found the program had positive results and it should be available across the state. Funding was made available in 2017 to expand the program to three additional sites, and an another site in 2017-18. Currently the program has 1,280 funded places in 11 locations.⁴⁹

⁴⁶ Submission 52, Mental Health Commission of NSW, p6; Submission 70, NSW Government, p37; Dr Small, Transcript of evidence, 21 May 2018, pp7-8

⁴⁷ Submission 51, NSW Council of Social Service, pp6-7; Submission 52, Mental Health Commission of NSW, p6; Submission 56, Royal Australasian College of Physicians, p3; Submission 70, NSW Government, p39

⁴⁸ Submission 70, NSW Government, p39

⁴⁹ Submission 70, NSW Government, pp37, 39-40; Dr Lyons, Transcript of evidence, 4 June 2018, p13

Case study 1: Sustaining NSW Families⁵⁰

Sustaining NSW Families is a prevention and early intervention program for vulnerable families with young children.

The program targets families living in areas of low socio-economic status, who are moderately vulnerable and have associated psychosocial distress. It is a nurse-led, evidence based, sustained health home visiting program that begins in pregnancy and continues until the child's second birthday.

It involves a strengths-based approach to work with families. There are regular assessments of the family, and early referral and intervention when adverse parenting issues are identified. Structured, positive parenting support and guidance is provided to prepare parents for the transition to each phase of their child's development. The program's clinicians work in partnership with other service providers, such as GPs.

An evaluation found the program improved outcomes. Around 98 per cent of participants interviewed said the program had improved their parenting capacity and experience. This led to improvements in the relationship between mother and child and in the home environment.

- 1.59 We heard how FACS, through programs such as Making a Safe Home (MASH), provides in-home care to vulnerable families. The program's premise is that money that would be spent on putting a child in care is instead spent on keeping them at home. We heard that sustained in-home care and support gives parents the skills and support to bond with and care for their child.⁵¹
- 1.60 The Intensive Family Preservation service, also provided by FACS, aims to ensure children stay with their parents. The program gives families the problem solving skills to prevent crisis situations developing. A component of the support includes home visits to prevent children being placed in out of home care.⁵²
- 1.61 The Early Childhood Refugee Nurse Program, run by the NSW Refugee Health Service, was established in 2017 to support newly arrived refugee children. The program includes a home visit to assess the child's physical and mental health. Sustained home visiting allows for checks of their developmental and health milestones.⁵³

⁵⁰ Submission 70, NSW Government, pp37, 39; NSW Health, [Sustaining NSW Families program](#), viewed 12 October 2018; [Evaluation of the Sustaining NSW Families Program: Final Report](#), June 2015, p89, viewed 12 October 2018

⁵¹ Ms Charet, Transcript of evidence, 4 June 2018, p15

⁵² Submission 70, NSW Government, p30

⁵³ Submission 70, NSW Government, pp25-26

Case study 2: Early Childhood Refugee Nurse program⁵⁴

Experience of traumatic situations and limited access to health care can mean refugee families, especially children, miss out on health checks and vaccinations.

In February 2017, the NSW Refugee Health Service established the Early Childhood Refugee Nurse program for newly arrived refugee children.

The program offers an initial home visit by a child and family health nurse to refugee families who have a child aged 0-5 years. The assessment of the child consists of a physical examination and a developmental check. There is also a psychosocial assessment for the child and their primary carer.

The nurse works with the family to enhance the child's growth and development. Parents receive support with child-parent attachment, sleep and settling patterns, breastfeeding and nutrition, child growth and development; and addressing any concerns about their child.

They are also linked to local support groups, playgroups and other services in the community, as required.

- 1.62 We also heard about the Victorian based right@home program, which includes sustained nurse home visits. It supports mothers with three or more risk factors. Mothers get advice caring for their baby, including nutrition, sleep and the home environment. The program has a flexible definition of 'home'. A home visit can be done anywhere the mother feels comfortable, such as a park, café or clinic.⁵⁵

Case study 3: right@home⁵⁶

right@home is a relationship-based model of sustained nurse home visits.

The program, available in eight sites in Victoria, focuses on families experiencing risk or adversity. It consists of 25 home visits starting in the antenatal period and continuing until the child turns two. It aims to improve outcomes by building parents' ability to provide safe and responsive care in an environment that supports the child's learning.

Home visits are done by a maternal and child health nurse supported by a social worker. The program is designed to integrate with and support existing universal child and family health services.

While analysis and reporting on the program is yet to be published, there is evidence it improves aspects of parent care, responsivity and the home learning environment above existing universal child and family health services.

⁵⁴ South Western Sydney Local Health District, NSW Refugee Health Service, [Early Childhood Refugee Nurse Program](#), viewed 12 October 2018; Submission 70, NSW Government, pp25-26

⁵⁵ Submission 48, Australian Research Alliance for Children and Youth, pp5-6

⁵⁶ Submission 48, Australian Research Alliance for Children and Youth, p6; Australian Research Alliance for Children and Youth, [right@home](#), viewed 12 October 2018; Sarah Goldfield, Anna Price and Lynn Kemp, [Designing, testing, and implementing a sustainable nurse home visiting program: right@home](#), *Annals of the New York Academy of Sciences*, May 2018, p156, viewed 15 October 2018

The program is a partnership between the Australian Research Alliance for Children and Youth, the Centre for Community Child Health, and the Translational Research and Social Innovation Group at Western Sydney University.

- 1.63 We support programs that provide sustained in-home support to vulnerable families. Current plans to expand Sustaining NSW Families are welcome. We agree that the program has potential for statewide application.
- 1.64 We recommend that proven ongoing programs, like Sustaining NSW Families, be expanded to make them more broadly available across the state. This is particularly important in regional and rural areas where the needs of vulnerable families are currently not adequately addressed.⁵⁷ As noted by the Royal Australasian College of Physicians, programs such as sustained home visits need to be widely available to have a broad population-level impact.⁵⁸

Funding

Changes to funding could improve service delivery

Summary

Changes to funding arrangements could allow service providers to tailor their services to individual families' needs. Contracts should include clearly defined measurable outcomes that allow services to be properly evaluated. Contract periods could be extended to give providers more time to better design and deliver services.

Recommendation 5

That the NSW Government reviews funding arrangements to enable longer contract periods and more flexibility in the design and delivery of child and family health services. Contracts with service providers should specify clear and measurable outcomes.

- 1.65 Child and family health services are funded by state, federal and local governments, and private sources. This model of funding contributes to service fragmentation, service silos, and gaps and duplication. It also creates confusion for service providers about which level of government has overall responsibility for a service.
- 1.66 Funding agencies such as NSW Health, FACS and the Commonwealth Department of Social Services don't coordinate the way they distribute funding. Each agency has different definitions of early intervention and eligibility thresholds can be unclear and subjective.⁵⁹

⁵⁷ Submission 51, NSW Council of Social Service, p5; Submission 62, Winanga-Li Aboriginal Child and Family Centre, p6

⁵⁸ Submission 56, Royal Australasian College of Physicians, p3

⁵⁹ Submission 26, Barnardos Australia, p5; Submission 40, Karitane, pp7, 8; Submission 65, Volunteer Family Connect, p3

- 1.67 Competition for funds and uncertainty about future funding creates instability for service providers. This can lead to insufficient capital investment and a lack of service innovation. Having to compete for funds can also make providers reluctant to collaborate with each other. Providers may fear missing out due to concerns about an inequitable distribution of funds.⁶⁰
- 1.68 Inquiry participants told us that current funding cycles create insecurity for service providers. On our visits to Gunawirra House and the Central Coast, we heard that funding cycles of three years or less are too short, as they don't allow enough time for programs to be designed, implemented and evaluated. It was suggested during our visits that a funding cycle of five years would allow for more strategic long-term service planning.
- 1.69 Short funding cycles also impact on providers' ability to recruit and retain a skilled workforce. Staff are often employed on short-term contracts with no long-term job security as they may not be renewed at the end of the cycle. Stakeholders gave evidence that non-government service providers also lose staff to government services as staff prefer the better pay provided by government agencies.⁶¹
- 1.70 Government contracts should give service providers more flexibility in how they deliver services. We heard that contracts can be too prescriptive in terms of measuring service outputs rather than outcomes for families. Providers shouldn't have a one size fits all approach to their services. They need the ability to take into account the specific needs of each family and offer tailored support.⁶²
- 1.71 Lack of flexibility can prevent people from accessing support. It can also limit the ability to better integrate services. Prescriptive guidelines mean families who clearly need help may not receive it because they don't meet all the eligibility criteria. Contracts should be flexible enough to give service providers discretion in deciding who accesses their services.⁶³
- 1.72 Service providers may need to have a range of strategies and services available to support a family. More support can also be provided on a step-up, step-down model – there may be times when a family needs more intensive support to help them through a particularly difficult situation.⁶⁴
- 1.73 We believe that government contracts should include clear and measureable outcomes to gauge service providers' performance. A focus on measured outcomes – how has a child and family's situation improved – means greater

⁶⁰ Submission 27, Public Health Association of Australia, p4; Submission 40, Karitane, pp7, 8; Submission 65, Volunteer Family Connect, pp3-4

⁶¹ Submission 40, Karitane, p7; Submission 65, Volunteer Family Connect, pp3-4; Ms Moore, Transcript of evidence, 21 May 2018, p28

⁶² Submission 20, fams, pp11, 12; Ms Hourigan Ruse, Transcript of evidence, 21 May 2018, p20

⁶³ Submission 20, fams, p10; Submission 51, NSW Council of Social Service, p4

⁶⁴ Submission 20, fams, p11, 12; Dr Jayne Meyer Tucker, Champion, Volunteer Family Connect, Transcript of evidence, 21 May 2018, p22

consideration is given to how services are designed. This will help ensure services are delivered more effectively.⁶⁵

- 1.74 We welcome the Targeted Earlier Intervention (TEI) reforms by FACS that aim to ensure programs focus on improving outcomes for vulnerable children and families.⁶⁶
- 1.75 Current contract reporting requirements don't always allow for detailed reporting of the work done by a service provider. This limits the ability to accurately identify what is and isn't working. We were told that this is partly because governments aren't clear about what they expect from the services they fund. Often contracts are too focussed on reporting program requirements and responsibilities rather than on how a family's situation has improved.⁶⁷
- 1.76 We also heard that some programs aren't as effective as they could be as staff may not be properly trained to deliver the program. There are also concerns about the way programs are delivered. While funding is targeted at evidence based services, we heard that sometimes the wrong evidence based program is delivered or the evidence to support a program may not be very strong.⁶⁸
- 1.77 Measuring the effectiveness of services need not be overly complex. Longer term quantitative evaluations are valuable but qualitative research can also establish how a program is working. Listening to feedback from parents using a service can help providers identify what is and isn't working, and adjust their service. Ensuring the voice of parents is included as part of a service's evaluation allows for a more informed understanding of its effectiveness.⁶⁹

⁶⁵ Dr Meyer Tucker, Transcript of evidence, 21 May 2018, p20; Ms Hourigan Ruse, Transcript of evidence, 21 May 2018, p21; Submission 20, fams, pp14-15

⁶⁶ Submission 70, NSW Government, p31

⁶⁷ Ms Hourigan Ruse, Transcript of evidence, 21 May 2018, pp20, 21; Dr Meyer Tucker, Transcript of evidence, 21 May 2018, pp21, 22

⁶⁸ Dr Small, Transcript of evidence, 21 May 2018, p2; Ms O'Loughlin, Transcript of evidence, 21 May 2018, pp17, 18

⁶⁹ Associate Professor Eastwood, Transcript of evidence, 21 May 2018, p9; Professor Cathrine Fowler, Tresillian Chair, University of Technology, Transcript of evidence, 21 May 2018, p18

Chapter Two – Gaps in services

Perinatal anxiety and depression

Better awareness of perinatal anxiety and depression

Summary

Stigma around mental illness and fear of being labelled a bad mother can prevent women from seeking treatment for perinatal depression and anxiety. Public awareness needs to be increased to help mothers and fathers feel more comfortable talking about their mental health. A community awareness campaign is needed to reduce stigma and improve recognition and self-reporting of symptoms.

Finding 3

There are gaps in perinatal mental health services for new and expectant parents.

Recommendation 6

That NSW Health runs a public awareness campaign about perinatal anxiety and depression to raise awareness about treatment options and reduce stigma.

- 2.1 Pregnancy and childbirth are a time when women are at a higher risk of developing a mental illness. Around 15 to 20 per cent of women experience postnatal depression, and up to one in 10 become depressed during pregnancy. Severe depression affects five per cent of women, and 0.2 per cent suffer from postnatal psychosis. The rate of anxiety in pregnancy and after birth has doubled in the past decade; around 20 per cent of new mothers experience anxiety. Suicide is a leading cause of maternal deaths in Australia.⁷⁰
- 2.2 Postnatal mental illness can have a negative effect on mother-baby attachment, the child's wellbeing and development, the mother's ability to care for her baby, as well as family relationships.⁷¹
- 2.3 The Royal Australian and New Zealand College of Psychiatrists observed that 'the effects of perinatal mental health problems can be devastating, and without adequate management, symptoms and associated impairment of function can persist for years.'⁷²
- 2.4 Early and effective treatment and intervention can reduce the risk of postnatal depression, improve developmental outcomes for children and reduce child

⁷⁰ Submission 42, Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), p3; Submission 32, Professor Virginia Schmied, pp1-2; Submission 31, Royal Australian and New Zealand College of Psychiatrists, pp2, 3, 4; Submission 50, Perinatal Anxiety and Depression Australia (PANDA), p3

⁷¹ Submission 21, Tresillian, p13; Submission 23, Parent Infant Research Institute, p2;

⁷² Submission 31, Royal Australian and New Zealand College of Psychiatrists, p3

protection risks. It is also important in ensuring that mental health issues don't affect children as they grow and become intergenerational health problems.⁷³

- 2.5 We were concerned to learn that most cases of perinatal anxiety and depression aren't identified or treated. Most women don't seek treatment for perinatal mental health conditions, with 60 per cent of cases going undetected and 90 per cent not receiving adequate treatment. Stigma around mental health conditions contributes to this, making women and men reluctant to disclose mental health concerns.⁷⁴
- 2.6 We agree with Perinatal Anxiety and Depression Australia (PANDA) that there is a need for more discussion of this issue to raise awareness and change perceptions of maternal mental health conditions:
- We need the community to talk about this illness. We can talk about gestational diabetes so why can we not talk about perinatal mental illness? What stops us from doing that? As a community we need to be able to talk about this. Indeed, it should be a conversation that we have whenever someone is pregnant. We should be encouraging mums and dads to be watching out for it. ...⁷⁵
- 2.7 We heard that health professionals asking women about their mental health has been linked to improved help-seeking in the perinatal period. Inquiry participants also told us that better communication and coordination between GPs, child and family health nurses and midwives is needed to ensure that anxiety and depression are identified and treated early.⁷⁶

Screening all women for depression and anxiety

Summary

Women receiving maternity care in public hospitals are screened for anxiety and depression before giving birth, but many women in private hospitals aren't screened until after they deliver. This limits opportunities for early diagnosis and treatment. NSW Health should develop strategies to ensure that antenatal screening is carried out for women who receive private care, in the same way as it is for women in the public system.

Recommendation 7

That NSW Health develops strategies to ensure that women who receive private maternity care are given antenatal psychosocial screening consistent with that provided in the public health system.

- 2.8 The SAFE START program aims to identify and help families with anxiety or depression through ante and postnatal screening. Women are assessed at their

⁷³ Submission 21, Tresillian, p5; Submission 23, Parent Infant Research Institute, pp2, 6; Professor Marie-Paule Austin, Royal Australian and New Zealand College of Psychiatrists, Transcript of evidence, 28 May 2018, p4

⁷⁴ Submission 23, Parent Infant Research Institute, pp3-4; Submission 27, Public Health Association of Australia, p4; Submission 42, RANZCOG, p3; Professor Austin, Transcript of evidence, 28 May 2018, p2

⁷⁵ Ms Terri Smith, CEO, PANDA, Transcript of evidence, 4 June 2018, p2

⁷⁶ Submission 27, Public Health Association of Australia, p5; Submission 41, Australian Association for Infant Mental Health, pp1-2; Submission 56, Royal Australasian College of Physicians, pp3-4

first antenatal care visit, and postnatally at the baby's six to eight week developmental check. The assessment includes screening using the Edinburgh Depression Scale. Women are asked several questions, including about thoughts of self-harm. Responses are used to determine the level of care required by the woman. A care plan is developed for high risk cases by a team which can include maternity, child and family health, mental health/psychiatry, drug and alcohol, social work, psychology and child protection.⁷⁷

- 2.9 While inquiry participants spoke positively of SAFE START, some observed that there are gaps in screening women who receive maternity care in private hospitals. The Royal Australasian College of Physicians said that 'in the larger private metropolitan maternity units, almost a third of all women birthing have not had the required antenatal screening documented in their medical record' leading to reports of 'serious perinatal depression among women receiving care in the private sector'.⁷⁸
- 2.10 Dr Elisabeth Murphy, Senior Clinical Advisor, Child and Family Health at the Ministry of Health told us while that 'it is not routine for an antenatal psychosocial assessment' to be part of maternity care for women in private hospitals, postnatal assessments include a full psychosocial assessment.⁷⁹
- 2.11 We find this concerning given evidence that 40 per cent of women who are diagnosed with depression after birth report having experienced symptoms during pregnancy.⁸⁰
- 2.12 We agree that the 'psychological wellbeing of pregnant women and new mothers should ... be considered as important as their physical health and considered as part of routine antenatal and postnatal care.'⁸¹ This should be the case whether they are giving birth in the public or private health system.

Giving mothers access to public mother-baby beds

Summary

The lack of public mother-baby mental health beds is a significant gap in services. It means that mothers being treated for severe mental health conditions may be separated from their babies for weeks or months, even if they have health insurance. To improve treatment options, mother-baby units should be available in public hospitals around the state.

Recommendation 8

That NSW Health funds more public mother-baby mental health units in Sydney and key regional centres, with a minimum of 24 beds across the state.

⁷⁷ Submission 70, NSW Government, pp10-11

⁷⁸ Submission 56, Royal Australasian College of Physicians, p4

⁷⁹ Dr Elisabeth Murphy, Senior Clinical Advisor, Child and Family Health, Ministry of Health, Transcript of evidence, 4 June 2018, p18

⁸⁰ Submission 50, PANDA, p6

⁸¹ Submission 42, RANZCOG, p3

- 2.13 We heard that mothers and babies have better outcomes if mothers can keep their babies with them during treatment for serious mental health conditions. Bonding between mother and child can be encouraged and the mother's parenting skills and confidence improved. Australian and international clinical practice guidelines for perinatal mental health care recommend that mothers who need psychiatric admission be jointly admitted with their baby.⁸²
- 2.14 Inpatient treatment aims to help women recover from perinatal mental health issues and develop a strong bond with their baby. Programs can include group therapies and support with feeding, sleep or settling issues. Partners can visit and stay overnight and join therapy and skills development. After they are discharged, women can continue to get support as outpatients.⁸³ According to PANDA, inpatient treatment is vital:
- These inpatient services are critical to support mothers with severe perinatal mental illness and are also a crucial early intervention measure to support the future wellbeing of the infant. They play an important role in reducing intergenerational trauma for the infant and family unit resulting from separation during a mother's illness.⁸⁴
- 2.15 Mother-baby beds are available at the St John of God Private Hospital in Burwood for patients with private health insurance. There is also some provision for admission of women with support from FACS. In addition, a small number of beds are available at the Marie Bashir Centre at Royal Prince Alfred Hospital.⁸⁵
- 2.16 According to Professor Marie-Paule Austin from the Royal Australian and New Zealand College of Psychiatrists, NSW has 'really fallen behind the other States in terms of service provision for parents with severe illness', particularly in relation to public sector mother baby beds.⁸⁶
- 2.17 Professor Austin said that the lack of public mother-baby beds means that women are receiving inadequate care in the community: 'What we are doing is leaving the families of these severely unwell mothers to care for, not only the mother but the infant, and increase the risk to both.'⁸⁷
- 2.18 Most states in Australia have a number of public mother-baby beds. There is an eight-bed unit in South Australia; Queensland has a four-bed unit; and Western Australia has two units with 16 beds.⁸⁸
- 2.19 In June 2018 a Victorian Parliamentary Committee released a report which stated that Victoria has 35 beds in six units. Notwithstanding this, the Committee heard

⁸² Submission 21, Tresillian, p13; Submission 31, Royal Australian and New Zealand College of Psychiatrists, p3

⁸³ St John of God, Burwood Hospital, [Mother and baby unit](#), viewed 1 August 2018

⁸⁴ Submission 50, PANDA, p11

⁸⁵ Submission 41, Australian Association for Infant Mental Health, p2; Dr Lyons, Transcript of evidence, 4 June 2018, p18; Ms Charet, Transcript of evidence, 4 June 2018, p19

⁸⁶ Professor Austin, Transcript of evidence, 28 May 2018, p1

⁸⁷ Professor Austin, Transcript of evidence, 28 May 2018, p1

⁸⁸ Professor Austin, Transcript of evidence, 28 May 2018, p2

evidence of waiting lists and recommended that the Victorian Government evaluate demand for mother-baby units with a view to expanding them.⁸⁹

- 2.20 We heard that given the number of births and the occurrence of severe postnatal mental health conditions, NSW needs around 24 metropolitan and regional mother-baby beds:

We get about 100,000 births per annum, one-third of all Australian births in proportion to our population, and that is then associated with a minimum 200 admissions per year for these mothers ... If you do the calculations that means that at a minimum we would need 18 beds and at an optimum we would have 24 beds. That would mean that we would have those units not only in Sydney, which is where the bulk, 70 or 80 per cent of the population live, but also have some in the key regional centres. ...⁹⁰

- 2.21 We note that as part of the 2018-19 Budget, the Government announced perinatal mental health reforms which will provide for additional mother-baby beds. The Mental Health Infrastructure Program contains \$20 million of funding for a number of specialist mental health units, including six to 12 beds for mothers and their babies.⁹¹
- 2.22 However, we consider that there is an urgent need for more public mother-baby beds. While we're pleased to note the announcement of six to 12 beds, we believe that a minimum of 24 public mother-baby beds are needed in Sydney and key regional centres.
- 2.23 We heard evidence of high rates of mental illness among Indigenous mothers, and consider that as part of reforms to improve acute mental health services, culturally appropriate services should be developed for Aboriginal mothers.⁹²
- 2.24 The case study below describes the experience of a mother who suffered from perinatal depression.

Case study 4: Perinatal depression⁹³

The mother was diagnosed with depression at 13 and prescribed medication. She continued to struggle with her mental health and was hospitalised repeatedly.

Her mental health during pregnancy was fairly stable even though she couldn't take her medication. During the birth she suffered complications resulting in a forceps delivery and heavy blood loss.

She felt anxious about caring for her baby, 'I had a lot of anxiety about caring for a newborn and because I couldn't breastfeed and I was getting a lot of

⁸⁹ Parliament of Victoria, Family and Community Development Committee, [Inquiry into perinatal services: Final Report](#), June 2018, pp139-141, viewed 7 November 2018

⁹⁰ Professor Austin, Transcript of evidence, 28 May 2018, pp1-2

⁹¹ NSW Health, [NSW Budget: Record investment in mental health](#), media release, 19 June 2018; NSW Health, [Free counselling for Western Sydney parents](#), media release, 13 August 2018, viewed 15 August 2018

⁹² Associate Professor Kym Rae, Gomerai Gaaynggal Centre, University of Newcastle, Transcript of evidence, 21 May 2018, p32

⁹³ Submission 71, Junee Community Centre

negative reactions from some of the midwives which didn't help my anxiety. My mental health was now starting to deteriorate again...'

During her two home visits the child and family health nurse told her that she 'just had baby blues'.

She started having negative thoughts about her daughter, 'I knew that something wasn't right because my daughter's cries irritated me and I began to feel that I wanted to hurt her to shut her up. I found myself at times having hatred towards my newborn, then feeling guilty about it and doubting whether I was a good mother.'

She knew this wasn't normal but feared judgement and stigma, and thought her baby would be taken from her if she asked for help. Eventually she told her family and saw a GP who recommended she go to hospital to review her medication. She was in a mental health ward for two weeks and was meant to stay in recovery for eight weeks. But as she was missing her baby badly, she discharged herself.

The day after, she experienced psychosis while shopping with her husband and daughter, 'She was screaming again, it got to me, the shopping centre was overly packed and with lack of sleep and treatment, and my husband not knowing how to help me I threatened to harm her.'

After this she was hospitalised again and her relationship broke down. Her husband got custody of their baby. Since then she has struggled to get access to her daughter and continues to struggle with her mental health.

She stressed the need for public mother-baby beds in regional hospitals:

Even if mum and baby units were to be increased in metropolitan areas many people in rural areas cannot afford the cost of travel associated with attending them. It also creates a disconnect from the women's partner and any other children who are left behind at home in rural areas. Additionally, rooming in facilities would assist in supporting the important development of bonding between mother and baby which lasts a life time. Because of my situation and the inability for me to be with my daughter due to my mental illness my daughter didn't recognise me as her mother for a good 12 months. Even though we have now developed a bond she is now nearly four years old and the bond could have been a lot stronger had we had more flexibility with my treatment options when she was first born. ...

Fathers

Parenting services and programs should involve fathers

Summary

There should be greater recognition of fathers' role in parenting and contributing to their child's development. More father specific support is needed, such as baby care classes and playgroups for new fathers. NSW Health should review parenting information and services to ensure they involve fathers.

Finding 4

Child and family health services and parenting programs can exclude new fathers.

Recommendation 9

That NSW Health updates parenting information and services to recognise and promote the role of fathers in parenting.

- 2.25 We heard that programs and services for parents are designed and delivered with mothers in mind, and often aren't accessible for fathers. Child and family health services are provided Monday to Friday, which limits fathers' ability to access them. Inquiry participants called for father-specific parenting classes and support services, as well as parenting health information that recognises the role of fathers.⁹⁴
- 2.26 PANDA told us that fathers are 'not equally valued as key stakeholders in their infant's wellbeing and therefore not prioritised in maternity and child family health systems' and that these systems need to change:
- From a routine care perspective, we have a long way to go in providing integrated equal care and support to men in their parenting journey. The challenge is how do we move from a maternal focused system (maternal health, maternal services, mothers' groups) to one that continues to place appropriate significance on the needs of mothers while also seeing fathers, and same sex partners, as more than the 'primary support person'.⁹⁵
- 2.27 The Royal Australian and New Zealand College of Obstetricians and Gynaecologists observed that studies conducted in Australia and internationally have shown that 'fathers want to be included in perinatal health care and engaged by health professionals about their health and wellbeing'.⁹⁶
- 2.28 Inadequate services and support for fathers reflects a lack of understanding about their role in their child's development. Professor Richard Fletcher from the University of Newcastle's Family Action Centre said that policy makers and clinical

⁹⁴ Submission 9, Child and Family Health Nurses Association NSW, p5; Submission 13, Professor Richard Fletcher, p2; Submission 30, Rainbow Families NSW, pp11-12; Submission 60, Yfoundations, p17

⁹⁵ Submission 50, PANDA, pp7, 10

⁹⁶ Submissions 42, RANZCOG, pp3-4

staff don't know enough about the strong evidence on fathers' input into their children's development:

... fathers influence children in profound ways, including in their social, emotional and cognitive development. Fathers' important role in the raising of children is separate to that of mothers but the two are linked. Fathering involves care and connection with newborns, babies and toddlers in partnership with mothers, and so fathers should not be seen as simply 'a helper' to mothers.⁹⁷

- 2.29 Professor Sharon Goldfeld told us about a study that showed fathers can have an independent impact on their child's language outcomes by reading to them. We also heard about research which suggested that fathers' 'rough and tumble' play with their children affects their neurological development. As Professor Alan Hayes observed, 'the partnership between mother and father is extremely important and it has different effects and benefits.'⁹⁸
- 2.30 We consider that there is a need for services to better reflect changing awareness of the importance of fathers' parenting role.

More programs for fathers are needed

Summary

While it can be hard to engage fathers, we heard about some promising programs such as SMS4dads. Programs targeting fathers need to be more widely rolled out and opportunities to engage dads should be explored.

Recommendation 10

That NSW Health expands programs for new fathers more widely across the state and explores other options for engaging this cohort.

- 2.31 The experience of fathers is also overlooked in terms of the emotional and psychological difficulties that new parents can experience. There is a lack of community awareness that fathers can suffer from postnatal depression. Health professionals may overlook fathers' mental health, focusing instead on mothers. Fathers' lack of contact with child and family health services can also reduce their awareness of depression and treatment options.⁹⁹
- 2.32 Stakeholders described the extent of mental health concerns for fathers. One in 20 fathers experience antenatal depression or anxiety and one in 10 develop these conditions postnatally. However, 60 per cent of Australians don't know that fathers can experience perinatal anxiety and depression. Only 12 per cent of

⁹⁷ Submission 13, Professor Richard Fletcher, p1

⁹⁸ Professor Sharon Goldfeld, Australian Research Alliance on Children and Youth; Professor Alan Hayes, Family Action Centre, Transcript of evidence, 21 May 2018, pp35-36

⁹⁹ Ms Vanessa Gonzalez, Co-Chair, Rainbow Families NSW, Transcript of evidence, 28 May 2018, p20

callers to PANDA's national depression helpline are men, and most of them (65 per cent) are calling about their partner's mental health.¹⁰⁰

- 2.33 We heard that fathers whose partners are depressed are more likely to develop depression themselves. Men can be reluctant to acknowledge their mental health issues, as they feel their partner has had a more difficult time during pregnancy and childbirth. Inquiry participants also told us that there is a need for specialised support for fathers whose partner has postnatal depression.¹⁰¹

... Fathers need to know how they can be there to help their partners and children, and have the practical skills to do this. At the moment many men are in the dark. A review is needed into the specialised support services available to fathers where their partner has post-natal depression or another serious mental health issue. Soft entry service points are needed to actively engage and support fathers for example, support groups for men whose partner has post-natal depression or another mental illness.¹⁰²

- 2.34 A case study of a successful program for fathers is below.

Case study 5: SMS4dads¹⁰³

SMS4dads gives new fathers information and connections to online services through their mobile phones. Dads enter the expected date of their baby's birth so that the texts they receive are linked to the development of the baby (from week 12 of the pregnancy to 24 weeks after birth).

The texts include tips, information and links to services to help fathers understand and connect with their baby and support their partner. Some use the baby's voice to provide information. For instance, 'talk to me about anything dad. Your words will help my brain development', 'Hey dad. I am going to triple my weight in the first year of life. Don't let this happen to you too.'

The texts also prompt fathers to monitor health behaviour (diet, exercise, social connection) and link them to online resources like parenting books, blogs, websites about raising children and video clips about communicating with children.

The messages include a 'Mood Tracker' interactive text which asks dads every three weeks how they are managing. They can reply with 'Awesome, Cool, OK, Shaky or Bad'. 'Bad' responses get a call from a national perinatal mental health helpline.

Fathers commented on the benefits of the program:

The best SMSs were the ones asking how I was going. At one stage I was really struggling and received a call-back from PANDA which basically saved my relationship with my wife and child, as I was getting severely depressed, anxious and stressed. I've since found help and am now back on track. Without getting the

¹⁰⁰ Submission 27, Public Health Association of Australia, p4; Submission 50, PANDA, p7; Ms Smith, Transcript of evidence, 4 June 2018, pp3-4

¹⁰¹ Submissions 42, RANZCOG, pp3-4; Submission 50, PANDA, pp7, 10

¹⁰² Submission 71, Junee Community Centre, pp3-4

¹⁰³ Submission 13, Dr Richard Fletcher, p3

push from SMS4dads to get help I don't like to think of where I could have ended up. Thank you for this fantastic program.

As a busy dad I felt a bit isolated. SMS4Dads helped a lot

I miss the messages. It was a conversation starter with my wife.

Mothers are also supportive of SMS4 Dads.

It helped my partner to feel part of the "baby process", and that his experiences were also important. This made for a more cohesive family unit. The messages gave us both confidence and helped to avoid fights when extreme fatigue set in.

Breastfeeding

Implementing the Breastfeeding in NSW policy

Summary

Greater acceptance and support of measures to increase breastfeeding is needed among health professionals and in the community. A key part of this is implementing measures to increase breastfeeding rates. To help achieve this, the Breastfeeding in NSW policy should be evaluated and fully implemented.

Recommendation 11

That NSW Health evaluates the Breastfeeding in NSW policy and prioritises its full implementation.

- 2.35 Breastfeeding is good for both mother and baby. Breastmilk contains all the nutrients that a baby needs during the first six months of life, and is an important source of nutrition and immunological protection for up to two years and beyond. According to the Australian Breastfeeding Association, research suggests that children who are breastfed for longer have lower rates of infection, higher intelligence and may be less likely to be overweight later in life. Breastfeeding also reduces the risk of sudden infant death syndrome. For mothers, breastfeeding can prevent breast cancer, reduce the risk of diabetes and ovarian cancer, and has mental health benefits.¹⁰⁴
- 2.36 The National Health and Medical Research Council recommends exclusive breastfeeding for around six months and breastfeeding to continue until a baby is 12 months old and beyond, as long as the mother and child desire.¹⁰⁵
- 2.37 In NSW the percentage of babies receiving any breastfeeding rose from 6.8 in 2012 to 13.4 in 2016. During the same period, the percentage of babies that only received infant formula fell from 10.3 to 8.5. However, the percentage of babies fully breastfed on discharge from hospital dropped from 82.1 to 74.9 between 2012 and 2016. Australian Institute of Health and Welfare data for 2014-15

¹⁰⁴ Submission 39, Australian Breastfeeding Association NSW ACT Branch, pp1-2; Australian Institute of Health and Welfare, [Children's Headline Indicators: Breastfeeding](#), viewed 24 October 2018

¹⁰⁵ Submission 39, Australian Breastfeeding Association NSW ACT Branch, p3

showed that the percentage of infants exclusively breastfed at four months of age in NSW was 53 per cent; lower than in all other states.¹⁰⁶

- 2.38 Evidence suggests that some women find it hard to keep breastfeeding. A national infant feeding survey in 2010 found that while 96 per cent of babies were initially breastfed, 61 per cent were exclusively breastfed for less than a month and this dropped to 15 per cent at around six months of age. Reasons mothers gave for breastfeeding were that it was healthier for their baby, convenient, or helped mother-baby bonding. The main reasons for not breastfeeding were wanting to share responsibility for feeding with partners and unsuccessful prior experience with breastfeeding. Many women felt that formula was as good as breastmilk.¹⁰⁷
- 2.39 Support from well-trained health professionals is important to women continuing to breastfeed. The Australian College of Midwives noted that a review of research on breastfeeding support suggested that factors that improve ongoing and exclusive breastfeeding are: face to face support, peer and/or professional support, trained staff, and ongoing contact with a schedule of four to eight contacts.¹⁰⁸
- 2.40 The Australian Breastfeeding Association observed that 'health professional's attitude towards breastfeeding is important because women perceive an ambivalent attitude as not being supportive ... which then results in women breastfeeding at lower rates.'¹⁰⁹
- 2.41 We heard that some health professionals don't have up to date knowledge about breastfeeding and don't know how to provide adequate support to mothers.¹¹⁰ Ms Louise Duursma from the Australian Breastfeeding Association observed that posts on social media breastfeeding groups show the bad advice mothers get from health professionals who aren't educated on breastfeeding.¹¹¹
- 2.42 The 2011 Breastfeeding in NSW policy provides a framework to increase promotion and support of breastfeeding in the health system. It contains mandatory requirements for monitoring and reporting on breastfeeding; continuing education and training for health professionals; and improving continuity of care, referral pathways and support networks. There are also requirements for establishing and promoting breastfeeding friendly

¹⁰⁶ NSW Ministry of Health, Centre for Epidemiology and Evidence, [NSW Mothers and babies 2016](#), February 2018, p20, viewed 24 October 2018; Australian Institute of Health and Welfare, [Children's Headline Indicators: Breastfeeding](#), viewed 24 October 2018

¹⁰⁷ Australian Institute of Health and Welfare, [New report highlights Australian breastfeeding patterns](#), media release, 20 December 2011, viewed 24 October 2018

¹⁰⁸ Submission 63, Australian College of Midwives NSW Branch, pp1, 4

¹⁰⁹ Submission 39, Australian Breastfeeding Association NSW ACT Branch, p11

¹¹⁰ Submission 7, Name suppressed, p1; Submission 24, Beyond Sleep Training, p2; Submission 39, Australian Breastfeeding Association NSW ACT Branch, p11; Submission 63, Australian College of Midwives NSW Branch, pp1, 4

¹¹¹ Ms Louise Duursma, Senior Manager, Consumer Services, Australian Breastfeeding Association, Transcript of evidence, 28 May 2018, p8

environments; supporting breastfeeding in health care settings; and supporting priority groups that have lower breastfeeding rates.¹¹²

- 2.43 We heard that the policy is currently under review. The Australian Breastfeeding Association called for it to be evaluated and implemented:

... we need ... that top down support so the whole of the health service provides the community that is going to support breastfeeding. NSW Health work tirelessly to get the policies done and the policies are very good, it is getting the health services to implement them and make them a priority, which is very difficult.¹¹³

Hospitals and community facilities can better support breastfeeding

Summary

Health professionals must have a better understanding of the benefits of breastfeeding and how to support mothers to initiate and continue breastfeeding. To ensure mothers feel supported, more public hospitals and community facilities should have Baby Friendly Health Initiative accreditation.

Recommendation 12

That NSW Health prioritises Baby Friendly Health Initiative accreditation for all public hospitals across the state.

Recommendation 13

That NSW Health works with local health districts to increase the number of community health facilities that have Baby Friendly Health Initiative accreditation.

- 2.44 Promoting Baby Friendly Health Initiative accreditation for hospitals and community health facilities could help to address some factors that impact on breastfeeding rates. The accreditation could provide more supportive services and environments for mothers to breastfeed.¹¹⁴
- 2.45 We heard that Baby Friendly Health Initiative accreditation has a positive impact on breastfeeding rates, with a trial showing that it 'significantly increased the proportion of mothers breastfeeding throughout the first year and significantly increased exclusive breastfeeding at three and six months.'¹¹⁵
- 2.46 The accreditation provides a framework for hospitals to encourage and promote breastfeeding. It contains 10 steps to successful breastfeeding, including having a written breastfeeding policy and training staff on implementing it, showing

¹¹² NSW Health, *Breastfeeding in NSW: Promotion, Protection and Support*, June 2011, viewed 7 August 2018. The policy also addresses Australia's responsibilities under the World Health Organization's code of marketing of breast-milk substitutes and related resolutions.

¹¹³ Submission 39, Australian Breastfeeding Association NSW ACT Branch, p8; Ms Duursma, Transcript of evidence, 28 May 2018, p13

¹¹⁴ Submission 39, Australian Breastfeeding Association NSW ACT Branch, p10

¹¹⁵ Submission 39, Australian Breastfeeding Association NSW ACT Branch, p9

mothers how to breastfeed and encouraging contact following birth, and giving newborns no food or drink other than breastmilk.¹¹⁶

- 2.47 Only a limited number of hospitals in NSW have the accreditation, even though the NSW Breastfeeding Policy states that NSW Health will focus on furthering implementation in health care facilities. In addition, only one community health facility has obtained the accreditation.¹¹⁷
- 2.48 The case study below gives an example of a successful program to encourage breastfeeding in Aboriginal communities.

Case study 6: Deadly Dads¹¹⁸

Deadly Dads is a joint Ministry of Health and Australian Breastfeeding Association program designed to engage Aboriginal men to support their partners to breastfeed their babies.

Breastfeeding rates for Aboriginal families in regional and rural areas are lower than non-Aboriginal mothers but remain high in remote areas. Research suggests that in addition to peer support from community members, positive support for breastfeeding from fathers and partners is important to improving breastfeeding outcomes.

Deadly Dads is a one day workshop facilitated by an Aboriginal man which enables Aboriginal men to explore their roles as fathers in a culturally safe and supportive environment, and improve their understanding of the importance of breastfeeding and how to support their partner to breastfeed. The workshop also provides everyday parenting items such as baby blankets, towels and nappies.

One participant highlighted their experience of the Deadly Dads workshop:

What I learned from that program is support your wife or your partner and make them feel comfortable and make them realise it's not their fault that things happen for whatever reason and just be the best partner you can to support them.

¹¹⁶ Australian College of Midwives, [BFHI Handbook for Maternity Facilities](#), 2016. Accreditation for community health services contains a seven point plan that focuses on educating staff on the service's breastfeeding policy, providing a supportive environment, and encouraging and supporting women to breastfeed up to and beyond six months: see Australian College of Midwives, *BFHI Booklet 1: Standards for implementation of the 7 Point Plan for the Protection, Promotion and Support of Breastfeeding*, 2013, p2, viewed 7 August 2018

¹¹⁷ Submission 39, Australian Breastfeeding Association NSW ACT Branch, pp9-10; NSW Health, *Breastfeeding in NSW: Promotion, Protection and Support*, June 2011, p10, viewed 7 August 2018

¹¹⁸ Submission 70, NSW Government, p20

Chapter Three – Accessibility of services

Parenting information and programs

Making parenting resources accessible for parents with disability

Summary

Getting access to parenting information and programs can be a challenge for some parents. Parents with disability can find it hard to access and understand parenting information, as parenting courses often don't meet their needs. Easy English and Braille versions of parenting information and parenting courses with adapted content would address this issue.

Recommendation 14

That NSW Health develops easy English and Braille versions of parenting information and resources for parents with disability.

Recommendation 15

That NSW Health provides parenting courses adapted for parents with disability.

- 3.1 Existing parenting supports aren't suitable for many parents with disability. According to People With Disability Australia (PWDA), parents with disability often don't get enough support and receive inappropriate or inaccessible information. A lack of adequate support can be a factor in their over-representation in care and protection proceedings. We heard that parents with intellectual disability are 10 times more likely to have their children removed by child protection services.¹¹⁹
- 3.2 Important resources such as the Blue Book, which records babies' immunisation and health information, aren't accessible for vision impaired parents. Mrs Leonie Hazelton from PWDA explained that the Blue Book's format is a barrier: 'It is big, it is blue and there is a lot of information in very small print. ... in order to facilitate greater interaction it needs to be more accessible.'¹²⁰
- 3.3 Parenting courses can also be unsuitable for parents with disability. Well-known courses like Triple P and Circle of Security aren't accessible as the information is only provided in print, with no other formats. Mrs Hazelton told us that parents with vision impairment or cognitive disability can't access the material or understand the parenting techniques that are covered through the courses:

If you have a parent with a vision impairment, they cannot access it and they cannot participate in that course. A lot of the stuff is easy for most people to read but if you have a cognitive or a psychosocial disability you are not necessarily going to be fully

¹¹⁹ Submission 11, People With Disability Australia, p2; Mrs Leonie Hazelton, Advocate, People With Disability Australia, Transcript of evidence, 28 May 2018, p25

¹²⁰ Mrs Hazelton, Transcript of evidence, 28 May 2018, pp27-28

able to participate or understand the tools and techniques that are being taught to you ...¹²¹

- 3.4 We heard that parenting programs should be available in modified forms so that they are appropriate for parents with disability. For example, programs could be presented in Easy English, Auslan or Braille.¹²²
- 3.5 Creating parenting resources and courses with flexible format and content would help build the skills of all parents, including parents with disability. This would mean that parents with disability 'are able to participate in those programs fully and effectively to ensure that the child remains in the family environment, if it is safe to do so.'¹²³

Communicating better with culturally and linguistically diverse parents

Summary

Due to language barriers parents from culturally and linguistically diverse (CALD) backgrounds can find it hard to access services. This increases their isolation and vulnerability to perinatal anxiety. Interpreters play an important part in improving access to parenting supports, but their availability can be limited.

Recommendation 16

That NSW Health develops strategies to improve communication with new parents from culturally and linguistically diverse backgrounds, including a wider availability of interpreters.

- 3.6 CALD families face extra challenges due to language and cultural barriers and isolation from their families and community. NSW Health noted that we have a diverse population and many factors impact on the health and safety of CALD parents and children. Newly arrived migrant children may have come from countries with limited health screening and immunisation. They can develop behavioural, learning and psychological problems after settling in a new country and living in disadvantage.¹²⁴
- 3.7 Stakeholders told us that CALD parents can also struggle to adjust. They may find it hard to access health and parenting services. Their understanding of the health system and awareness of early childhood services can be limited. Language is also a significant barrier to accessing support services.¹²⁵
- 3.8 Family is central to mothering for many CALD women, and being distant from family can make it hard to meet cultural expectations. We heard that being from

¹²¹ Mrs Hazelton, Transcript of evidence, 28 May 2018, pp27-28

¹²² Submission 11, People With Disability Australia, p3

¹²³ Mrs Hazelton, Transcript of evidence, 28 May 2018, p25

¹²⁴ Submission 70, NSW Government, p25

¹²⁵ Submission 10, 3Bridges Community Ltd, p1; Submission 70, NSW Government, p25

a CALD background increases a mother's risk of developing anxiety during pregnancy or after their baby is born.¹²⁶

- 3.9 Inquiry participants told us that CALD groups are missing out on parenting support. According to Karitane, marginalised CALD groups in south-west Sydney 'are underserved by parenting support services due to multiple levels of disadvantage and language difficulties.'¹²⁷ In addition, there are gaps in universal home visits to refugee mothers who don't speak English.¹²⁸
- 3.10 Public health patients in NSW who don't speak English as a first language can access free professional interpreters. Health providers with a patient who needs an interpreter can use the Health Care Interpreter Service (HCIS). Three metropolitan and two rural HCISs provide 24 hour seven days a week onsite and over the phone interpreting in over 120 languages including Auslan.¹²⁹
- 3.11 We heard that NSW Health plans to expand specialised health services for refugees by improving access to and use of interpreters, and interpreting for all health care appointments. A new statewide phone number for the HCIS is planned. Many LHDs and health services are also aiming to improve interpreter use, especially for emerging language communities.¹³⁰
- 3.12 We also note that translated health information is available. The Multicultural Health Communication Service provides multilingual health resources, social marketing and health communication campaigns. It produces online resources on health topics in 65 languages.¹³¹
- 3.13 We acknowledge that NSW Health is seeking to improve services to CALD communities by providing translated health resources and interpreters. However we were told that lack of access to interpreters and limited bilingual staff are still significant issues.¹³²

Hospital forms and systems

Hospital forms should have accurate family records

Summary

Hospital forms should allow a child's family to be accurately recorded, and enable their parents or guardians to give medical consent. Hospitals play a key role in supporting new parents and it's important that they are accepting of all members of our community.

¹²⁶ Submission 32, Professor Virginia Schmied, p2, 3

¹²⁷ In south western Sydney, 74% of residents speak a language other than English and 78% of recent humanitarian arrivals speak no English: Submission 40, Karitane, pp9-10; Submission 65, Volunteer Family Connect, pp5-6

¹²⁸ Submission 27, Public Health Association of Australia, p4

¹²⁹ NSW Health, [Health care interpreting and translating services](#), viewed 3 October 2018

¹³⁰ Submission 70, NSW Government, p25

¹³¹ Submission 70, NSW Government, pp26-27

¹³² Submission 40, Karitane, pp9-10, 13; Submission 65, Volunteer Family Connect, pp5-6

Recommendation 17

That NSW Health reviews hospital forms and systems to ensure they enable accurate recording of a child's family, linking to family medical history, and medical consent to be given by their family. Hospital systems should be respectful to all members of the community, including those who value their identity as 'mother' or 'father'.

- 3.14 Providing services that are inclusive and culturally sensitive is important for CALD, Indigenous and LGBTIQ families. Practices that are culturally aware and reflect family diversity could improve the accessibility of services for families in our diverse society.¹³³
- 3.15 We heard that NSW Health has reviewed some systems to ensure they meet the needs of all families. A recent review of the Blue Book included an online survey and consultation with parents and carers from diverse backgrounds and a range of geographic locations:
- ... Participants included different groups including: new mothers, Aboriginal mothers, fathers and elders, mothers who had been refugees, parents and carers who identify as Lesbian Gay Bisexual Transgendered Intersex, foster carers, parents of children with a disability and parents and carers from culturally and linguistically diverse backgrounds. There were 272 participants in the consultations and 2,762 in the on-line survey.¹³⁴
- 3.16 The review incorporated recommendations by Rainbow Families to change some of the Book's language. The word 'parent' is now used in relation to the child's development, while content relevant to the mother, such as birth details, uses the word 'mother'.¹³⁵
- 3.17 While the Blue Book review is welcome, terminology used in hospital forms and systems should also be designed to be both inclusive and respectful. We heard that hospitals use different forms meaning that some records of a child's parents are inaccurate. For instance, carers, foster parents and same sex partners may be given forms that only have the option of 'mother' or 'father', rather than 'parent'. This can mean that a child's parents aren't accurately recorded, limiting their ability to consent to medical procedures.¹³⁶
- 3.18 The appropriate recording of information about both biological parents, where available, is of benefit to the individual in terms of longer term medical care.
- 3.19 We also note that people for whom the identity of 'mother' or 'father' is important can feel disrespected when dealing with systems or documentation that do not make those terms available to them. Including these terms among the available options would allow these people to feel included and respected.
- 3.20 We agree that forms should be inclusive and respectful of all families:

¹³³ Submission 40, Karitane, p11; Submission 65, Volunteer Family Connect, p7

¹³⁴ Submission 70, NSW Government, p 42

¹³⁵ Dr Murphy, Transcript of evidence, 4 June 2018, pp26-27

¹³⁶ Ms Gonzalez, Transcript of evidence, 28 May 2018, p23; Submission 30, Rainbow Families NSW, p7

... Today there are single parents, lots of grandparent carers who have full-time care of their grandkids. There are foster parents that want to be called mum but technically cannot be called mum because maybe the children are under the care of the State. There are lots of complexities to family and all we are asking is that the forms allow for children to have their family and those that love and care for them be represented. ... The main thing is that there is choice that can accommodate for the diversity of families and parents that children grow up with.¹³⁷

Technology-based services

Demand for technology-based parenting support is growing

Summary

Parents increasingly use technology to access parenting information. Technology can help reach parents who are harder to engage, including young parents and parents in rural and remote areas. It can also be a cost-effective way to provide sustained support to vulnerable parents.

Recommendation 18

That NSW Health develops telehealth and technology-based ways to deliver services to new parents, particularly those in rural and remote areas.

- 3.21 There is growing demand for technology-based parenting information and support. Developing technology has made this possible, with improved internet capability and access, and widespread use of webcams.¹³⁸
- 3.22 Many parents seek information and support online through websites, parenting blogs, apps and social media. Consultation during NSW Health's Blue Book review found that some parents wanted to access all health information through their mobile phones, apps or online. However others wanted to get paper-based information, as they didn't have access to tablets or computers, couldn't afford mobile charges or lived in areas with poor or no mobile reception. The Government noted that 'information for parents still needs to be available in a range of ways.'¹³⁹
- 3.23 Tresillian echoed this observation, referring to studies of online chat support which showed that parents' preferences can differ significantly. Some wanted face to face contact in a clinic, while others preferred online support.¹⁴⁰
- 3.24 The Parenting Research Centre cited research which found growing evidence that technology can be used to improve parent and child outcomes. The research found that parents accept most delivery methods, and noted that technology-based interventions are in use for hard-to-reach parents, especially low-income families. Web-based, self-directed support/education helps improve parenting skills, behaviour and outcomes, while online therapies and parenting programs

¹³⁷ Ms Gonzalez, Transcript of evidence, 28 May 2018, p23

¹³⁸ Submission 40, Karitane, pp14-15; Submission 70, NSW Government, p43

¹³⁹ Submission 70, NSW Government, p42

¹⁴⁰ Submission 21, Tresillian, p18

can be as effective as face-to-face modes. Online therapies and programs, and web-based learning were more effective when combined with offline support, such as therapy sessions.¹⁴¹

Telehealth can be a low cost way to fill service gaps

- 3.25 We heard that technology-based health care has great potential. It could improve access to hard to reach populations, lower costs and give patients personalised health information. It can also reduce barriers due to physical location, time and travel pressures.¹⁴²
- 3.26 Telehealth¹⁴³ and new technology could fill gaps in rural and regional areas caused by limited availability of local services. Karitane told us that telehealth can help address regional healthcare workforce shortages by giving families access to real-time treatment from experts, regardless of their location. Telehealth is resource-efficient, potentially reducing costs by up to one third.¹⁴⁴
- 3.27 We heard about a number of innovative ways of supporting parents. SMS4dads, discussed in chapter four, is an example of a phone based support, which sends text messages to parents during their baby's first year.¹⁴⁵
- 3.28 Karitane, Tresillian and the Australian Breastfeeding Association have trialled or implemented online live chat support. Tresillian's live chat is a free online service available on weekday evenings. Parents can ask child and family health nurses for advice by logging in to the chat service through Tresillian's website.¹⁴⁶
- 3.29 Inquiry participants also supported wider use of 24 hour telephone helplines and Skype or FaceTime for new parents in rural or remote areas, or those unable to attend clinics.¹⁴⁷ The Australian Breastfeeding Association's 24 hour hotline is staffed by qualified nurses who answer calls at home. We heard that it's a cost-effective way to support mothers outside of office hours, while also allowing nurses to work from home.¹⁴⁸
- 3.30 Telepsychiatry and online cognitive behavioural therapy courses can support parents with mental health issues who find it hard to access services.¹⁴⁹ Western Sydney University's research on perinatal care pathways has shown that personalised apps could support mothers and link them to professionals before their levels of anxiety increase to the point of requiring services ... apps may also

¹⁴¹ Submission 25, Parenting Research Centre, p6

¹⁴² Submission 70, NSW Government, p43

¹⁴³ Telehealth is the use of technology to provide healthcare remotely, for example through videoconferencing.

¹⁴⁴ Submission 40, Karitane, pp14-15

¹⁴⁵ Submission 36, Dr Chris May, p3

¹⁴⁶ Submission 39, Australian Breastfeeding Association NSW ACT Branch, p13; Submission 40, Karitane, p15; Submission 21, Tresillian, pp18-19, see <https://www.tresillian.org.au/>, viewed 5 October 2018

¹⁴⁷ Submission 6, Ms Barbara Lewis, p1; Submission 9, Child and Family Health Nurses Association NSW, p6; Submission 14, Ms Claire Carpenter, p19; Submission 45, Country Women's Association, p2

¹⁴⁸ Submission 5, Mrs Anita Francis, p2

¹⁴⁹ Professor Austin, Transcript of evidence, 28 May 2018, p7

support continuity of care; a key service component that potentially reduces anxiety.¹⁵⁰

- 3.31 The Parent-Infant Research Centre observed that e-health technology could provide a model of care with improved availability, accessibility and coordinated treatment. The Centre has led the development of a website which provides evidence based e-mental health resources and apps, including an online anxiety and depression treatment program and the MindMum app.¹⁵¹
- 3.32 The statewide perinatal and infant mental health outreach service uses telehealth for preconception counselling, mental health assessments and treatments for women, especially in rural and remote areas with limited services. It also supports health professionals in rural and remote areas to manage pregnant women with mental health problems.¹⁵²
- 3.33 While these programs show great promise, we heard that a lack of investment has hindered the development of telehealth.¹⁵³ There has been limited uptake of telehealth for parenting support or early childhood services in Australia. Karitane observed that the implementation of technology-based services has been 'patchy', limited to follow up consultations rather than treatments. Karitane supported further efforts being made to 'take advantage of this technology and realise the potentials of telehealth.'¹⁵⁴
- 3.34 Below are two examples of technology-based parenting support programs.

Case study 7: Karitane's Parent Child Interaction Therapy program¹⁵⁵

Karitane has conducted a pilot program to deliver Parent-Child Interaction Therapy (PCIT) via webcam to families in remote parts of NSW. The program is jointly funded by NSW Health and Karitane.

PCIT is an evidence based parent training program designed to help families of children with behavioural difficulties including aggression, tantrums, defiance, withdrawn behaviour or separation anxiety. It teaches parenting skills, with a therapist coaching and supporting parents as they play with their child. The program is free for families who live in regional or remote areas.

Using a video-based program, the therapist conducts appointments with parents in their own home. The average treatment program lasts six to 12 weeks, with a one hour session each week. Regular appointments and practising skills between sessions are recommended.

Karitane noted the benefits of telehealth: *'preliminary findings suggest that telehealth sessions saved families hundreds to thousands of dollars in travel and associated costs, were convenient, and provided a high quality of care by professionals to which families may not otherwise have had access.'*

¹⁵⁰ Submission 32, Professor Virginia Schmied, p4

¹⁵¹ Submission 23, Parent-Infant Research Institute, pp4-5, see www.mumspace.com.au, viewed 5 October 2018

¹⁵² Submission 70, NSW Government, pp33, 48

¹⁵³ Submission 40, Karitane, pp14-15

¹⁵⁴ Submission 9, Child and Family Health Nurses Association NSW, p6; Submission 40, Karitane, pp14-15

¹⁵⁵ Submission 40, Karitane

The program has also received positive feedback from families who took part:

During the past few months working with the Toddler Clinic, both us and our son's preschool have noticed significant improvements. With the skills we have been taught we feel much more able to manage any challenging moments.

You have given me skills which have made me feel confident in my parenting and most of all, strengthened my bond with my beautiful boys.

Case study 8: PANDA's intensive phone support¹⁵⁶

The intensive program is identifying very high-needs families. There is no limit to what we can do with that service. If a mum needs four calls in a day for us to be sure that she is doing okay, we will make four calls in a day. People are often surprised by what can happen in a phone call but let me tell you, no new mum actually needs someone visiting their home, and having someone walk through the door can be very threatening. What we are not there to do is to check whether the baby is clean. We can use services on the ground to do that.

Through that program there is intensive contact with the family, and it is not just mum, it will be the partner, dad if dad is around, another family member if there are key family members, so we can support them to also support the mum. It is a variable program. It might be five contacts a day for a couple of days and then we might not have contact for a week. It can address counselling as well. It is hard to get out with a new baby. It can be support and counselling. The call might go for an hour or the call could go for five minutes. ...

I will give you a quick example of a family we worked with in New South Wales in the early days when we probably should not have been doing that, in terms of our funding agreement. It was a mum who had not left the home for three months, she was six months pregnant and developed agoraphobia. She had not been to any of her antenatal appointments. Her doctor would not come to her home. We found her a new doctor, we got the doctor to come to her home, and meanwhile our counsellor is on the phone saying, "Let's take the dog and walk out to the front door. I'll stay on the phone with you. We'll get to the front door. Let's walk out to the front gate. We'll talk with your partner about how we can make things work better." It is a long process. We actually worked with that family over six months, sometimes quite intensively, and sometimes we would pull back when things were great. We ended up talking with her obstetrician to organise a planned caesarean section so she had some control over what was going on.

It was a very intensive intervention, but all by phone. It cost in the order of \$2,000, which you understand is nothing in terms of long-term care. ... In the end our final step was we handed over to the [Child and Family Health Service] nurse, a written handover giving the history which meant this mum did not have to explain everything that had happened in her past, because what you do not want is a mum fronting up to a nurse who does not know what had led there—all by telephone. I cannot tell you how much I believe in the telephone. You really can do an enormous amount. If mum is busy when you call, which is quite often with a baby, you can call back in 20 minutes or half an hour, and you have not got a staff member who

¹⁵⁶ Ms Smith, Transcript of evidence, 4 June 2018, p3

has wasted an hour in a return trip to get to an office but a responsive service to a mum.

Chapter Four – Parents and children who need extra support

Aboriginal children and families

Aboriginal children's needs should be a priority

Summary

Aboriginal children face greater challenges than other children in our community. Because of this a higher priority must be given to their protection and support.

Finding 5

Aboriginal children face disproportionately greater challenges arising from intergenerational trauma, violence and abuse.

Recommendation 19

That the NSW Government gives a higher priority to the protection and support of Aboriginal children, recognising the severity of the challenges many of them face.

- 4.1 While there have been improvements in outcomes in recent years, there is still a disparity between Aboriginal and non-Aboriginal children. In the last decade, the gap in the Aboriginal infant mortality rate has almost halved in NSW, dropping from 7.2 per 1,000 live births in 2005-2007 to 4.6 in 2014-2016. However, mortality rates are still significantly higher for Aboriginal infants; the rate in 2014-16 for non-Aboriginal infants was 3.1 compared to 4.6 for Aboriginal infants.¹⁵⁷
- 4.2 Aboriginal children are twice as likely to be developmentally vulnerable in early life, and more likely to be removed from their parent's care. They made up about 28 per cent of children receiving child protection services in 2015-16, and three per cent of children under 12 months (including unborn children). The national early development census measures children's development when they start school, assessing physical health and wellbeing, social competence, emotional maturity, language and cognitive skills, and communication and general knowledge. In 2015, 34 per cent of Aboriginal children were developmentally vulnerable compared with 39 per cent in 2009.¹⁵⁸
- 4.3 The Australian Institute of Family Studies reports that while there are low rates of sexual abuse substantiated by child protection services, evidence suggests that Aboriginal and Torres Strait Islander children are at greater risk of being sexually

¹⁵⁷ HealthStats NSW, Infant Mortality by Aboriginality, NSW 2001 to 2016; Ministry of Health, Centre for Epidemiology and Evidence, [Aboriginal kids - a healthy start to life: Report of the Chief Health Officer 2018](#), June 2018, pp10-11, viewed 13 August 2018; Submission 53, NSW Ombudsman, p4

¹⁵⁸ Submission 26, Barnardos Australia, p4; Submission 67, Advocate for Children and Young People; p2; NSW Health, [Aboriginal kids - a healthy start to life](#), June 2018, p19, viewed 13 August 2018

abused than non-Indigenous children. According to FACS data, Aboriginal children and young people are six times more likely to be involved in risk of serious harm reports and nine times more likely to have a face to face assessment where domestic and family violence is an issue than non-Aboriginal children and young people.¹⁵⁹

- 4.4 We note that FACS has identified Aboriginal children, young people, families and communities as a priority group as part of its TEI Program. Key priorities of the Aboriginal TEI Strategy are:
- targeting resources to Aboriginal people and communities with greatest need
 - Aboriginal Early Intervention service systems based on evidence informed-practice
 - Aboriginal self-determination facilitated through Aboriginal community control of service design and delivery
 - increased flexibility so that Aboriginal clients are the centre of TEI outcomes.¹⁶⁰
- 4.5 The poorer outcomes for Aboriginal children reflect the disadvantage in which many of them are born and raised. For example, in 2016 Indigenous mothers were seven times more likely than non-Indigenous mothers to be teenage mothers; around 14 times more likely to live in remote and very remote areas; and 2.4 times more likely to live in the lowest socioeconomic status areas.¹⁶¹
- 4.6 We heard that services need to recognise the intergenerational trauma and violence that affects many Aboriginal families. Aboriginal children are often born to mothers with a family background of 'generations of poverty, substance abuse, mental illness, domestic violence and family dislocation.'¹⁶²
- 4.7 The Aboriginal Child, Family and Community Care Secretariat (AbSec) said that services must work with families and communities to help them overcome intergenerational trauma and provide safe and nurturing homes for Aboriginal children:
- ... child development occurs within the context of their social and physical environment, with relationships playing a key role in optimal development and adaptive outcomes. ... effective systems approaches to improving outcomes for vulnerable children must include supporting positive change for the child's social network; their parents, extended families and communities. However, rather than simply coordinating separate child- and adult-focused programs, a genuine integration of services that support children both directly and indirectly through strengthening the capabilities, stability (including economic) and resilience of

¹⁵⁹ Australian Institute of Family Studies, [Child protection and Aboriginal and Torres Strait Islander children](#), Resource sheet, August 2017; FACS, [Domestic and Family Violence report – 2016-17](#), viewed 31 October 2018

¹⁶⁰ FACS, [Targeted Early Intervention Program Reform Newsletter](#), edition 33, September 2017, p1, viewed 13 August 2018

¹⁶¹ Australian Institute for Health and Welfare, [Australia's mothers and babies 2016: in brief](#), p42, viewed 13 August 2018

¹⁶² Submission 62, Winanga-Li Aboriginal Child and Family Centre, p7

families and communities is required. In this way, interventions can become genuinely intergenerational, supporting parents, grandparents, aunts and uncles to positively contribute to the development of their children, thereby optimising the developmental context and trajectory of the next and subsequent generations ...¹⁶³

- 4.8 There has been significant investment by federal and state governments to improve outcomes for Aboriginal communities and some progress has been made. We heard that in NSW Aboriginal Maternal and Infant Health Service and Building Strong Foundations program have been effective in supporting Aboriginal mothers, but gaps remain.¹⁶⁴
- 4.9 We were told that Aboriginal mothers are often reluctant to seek help from government and non-government service providers, as they fear the removal of their children. This creates a dilemma for FACS and other agencies as the very parents and families who most need support interventions in order to forestall or avoid child removal are the least likely to seek or accept those supports.

More funding for Aboriginal Child and Family Centres

Summary

Aboriginal Child and Family Centres could provide more services, including to remote Indigenous communities. The Centres should receive more funding to provide a wider range of services to their communities and increase long-term certainty.

Recommendation 20

That the Department of Family and Community Services increases funding for Aboriginal Child and Family Centres to increase the range of services they can provide.

- 4.10 Inquiry participants told us that adequately funded Aboriginal community controlled health organisations (ACCHOs) are best placed to provide services for their communities and improve outcomes through intensive early intervention. The Public Health Association of Australia submitted that 'supporting ACCHOs to work intensively with families within the first 1,000 days of life will help to ensure healthy, happy children and reduce child protection notifications and removal from families.'¹⁶⁵
- 4.11 There are nine Aboriginal Child and Family Centres in NSW. The Centres provide a single point of access to culturally safe services and support for Aboriginal families with children up to eight years old. Services include early childhood education and care, parent and family support and maternal and child health.¹⁶⁶

¹⁶³ Submission 22, Aboriginal Child, Family and Community Care Secretariat, p6

¹⁶⁴ Associate Professor Rae, Transcript of evidence, 21 May 2018, p32; Professor Schmied, Transcript of evidence, 21 May 2018, p40

¹⁶⁵ Submission 27, Public Health Association of Australia, p5

¹⁶⁶ Submission 69, SNAICC - National Voice for our Children, pp3-4; FACS, [Aboriginal Child and Family Centres - About the centres](#), viewed 14 August 2018

- 4.12 The Centres were originally established in partnership with the Commonwealth. When federal funding ended, FACS continued funding the Centres. An evaluation commissioned by FACS found significant progress in achieving outcomes overall and strong evidence for continuing the Centres. It recommended core funding be continued to ensure that outcomes were sustained.¹⁶⁷
- 4.13 We heard that more funding is needed to enable the Centres to meet the needs of their communities and provide a wider range of services. AbSec told us that investment in Aboriginal community controlled supports for new parents and babies is 'inadequate to meet the specific needs of this cohort' and recommended that services be widened through further investment in Child and Family Health Centres.¹⁶⁸
- 4.14 Additional resources would enable the Centres to provide services to remote Indigenous communities through regular visits. Mr Wayne Griffiths, Centre Manager of Winanga-Li Aboriginal Child and Family Centre in Gunnedah, told us that his staff provide services to a number of under-serviced remote towns through monthly visits:
- ... We have staff who provide services to different areas. They are calendared out. Our staff plan their events or they plan in their calendars a monthly rotation around the various places. I can use Wee Waa as an example, where the nurse comes in, out to Pilliga then off to Toomelah and out to Mungindi, and now that we are stretching out to Lightning Ridge we have some of our staff that take patients from Lightning Ridge on a monthly basis into Dubbo. It is a 12-hour trip. They stay overnight and generally pull up at one of the towns on the way back. But it is set in stone. It cannot be changed, because those children need those services and those mums need to get back into where those professional services are available to them that are often not available out in the remote areas. ... That system has worked wonderfully for us.¹⁶⁹
- 4.15 Extra funding would also be an investment in local communities, enabling the training and employment of local Aboriginal staff to provide culturally appropriate services in rural and remote areas.¹⁷⁰ We heard that while it can be difficult to recruit in these locations, if an investment is made, a skilled local workforce can be created:
- ... We did not have the community people trained and skilled enough to run that service alone. ... We did not have the skills and the abilities to do that when we first initiated the childcare centre. We now have 34 people employed; 30 of those are highly skilled and trained — diploma-trained people, people who are heading towards Certificate IIIs in family and child services, people who are doing early childhood teacher accreditation, people who are doing further additional training in

¹⁶⁷ Submission 22, Aboriginal Child, Family and Community Care Secretariat, p9; Cultural and Indigenous Research Centre Australia for FACS, [Evaluation of NSW Aboriginal Child and Family Centres: Final report](#), December 2014, pp83-85, 94, viewed 14 August 2018

¹⁶⁸ Submission 22, Aboriginal Child, Family and Community Care Secretariat, pp4-5, 9

¹⁶⁹ Mr Wayne Griffiths, Centre Manager, Winanga-Li Child and Family Health Centre, Transcript of evidence, 4 June 2018, p8

¹⁷⁰ Submission 67, Advocate for Children and Young People, p3; Submission 69, SNAICC - National Voice for our Children, p3

community management. ... If you create your own work base and establish that in the centres or in those communities, there are people there.¹⁷¹

- 4.16 Culturally appropriate services that employ local staff can also help to overcome a lack of trust towards service providers. As noted earlier, we heard that Aboriginal mothers are often reluctant to seek help from government and non-government service providers, as they fear the removal of their children.¹⁷²

Case study 9: Winanga-li Aboriginal Child and Family Centre, Gunnedah¹⁷³

Winanga-Li Aboriginal Child and Family Centre serves 28 local government areas in the region, running eight programs. Thirty five children attend the long day care service, and the Centre provides services to over 1,000 Aboriginal people every three months.

The Centre has worked with FACS to support local families, as illustrated below:

I will tell you about two parents that we are working with at the moment. Over 12 months ago Family and Community Services came into their lives. Their baby was born prematurely at Maitland Hospital. There was a previous death in this family, which initiated an investigation by FACS immediately. There was another child involved, who they had in their care, and another child had been removed. It was tragic circumstances that they ended up at Maitland and the little bub passed away within a couple of weeks of the birth.

... The partner and the mum were significant drug users—especially the dad. We became involved when they got back to Gunnedah and FACS asked if there was a room available at our centre to discuss some of these issues and the investigation that FACS were going to undertake. ... When they got in there one of the staff members came back over and said, "You need to sit it on this meeting. They're really hammering this poor mum." ...

There has been a long process with this, where mum is now 100 per cent drug free. She has tested negative to amphetamines and marijuana now for over 10 months. Dad's levels of drugs are down to about 10 per cent at the moment. The family are now applying for section 90 to have their other child restored to them, which FACS are now supporting. The whole process from the beginning was a great relationship with FACS. ... Those kinds of relationship are very scarce—pretty much like hens teeth; you just don't get them. I absolutely put my hand up for FACS on how they worked with that situation and worked consistently with the family.

Mum has now bought a car. Their little boy comes to our childcare service on a regular basis—two days a week. We were able to negotiate with FACS. They pay his fees for the next six months whilst mum now has a Centrepay deduction straight from her payments that come into our accounts.

¹⁷¹ Mr Griffiths, Transcript of evidence, 4 June 2018, p8

¹⁷² Submission 62, Winanga-Li Aboriginal Child and Family Centre, p6

¹⁷³ Mr Griffiths, Transcript of evidence, 4 June 2018, pp7-9

Aboriginal families need better nutrition awareness

Summary

Poor nutrition and obesity are a significant problem for Aboriginal mothers and families. Early intervention programs should focus on Aboriginal families' nutrition awareness, to improve babies' health.

Recommendation 21

That NSW Health and the Department of Family and Community Services ensure that early intervention programs for Aboriginal families emphasise nutrition education.

- 4.17 Early intervention programs can help communities by providing life and parenting skills. We heard there is a particular need for antenatal education on nutrition in pregnancy for Aboriginal women.
- 4.18 Barnardos Australia observed that 'a significant ongoing concern ... that is not being well addressed is poor nutrition, obesity and diabetes amongst young Aboriginal mothers in rural and remote communities in Western NSW'.¹⁷⁴ The cost and availability of fresh fruit and vegetables in remote areas can be a factor.
- 4.19 Aboriginal women are 1.7 times as likely as non-Aboriginal women to be obese and 1.3 times and 4.7 times as likely to have gestational diabetes and pre-existing diabetes.¹⁷⁵ Research suggests that up to 22 per cent of Indigenous infants aged two to four are overweight or obese. Indigenous infants taking part in Associate Professor Kym Rae's Gomerai gaaynggal program (outlined below) had a high intake of sweetened drinks, which contribute to early childhood obesity.¹⁷⁶
- 4.20 Associate Professor Rae highlighted the long-term health consequences of poor nutrition for Indigenous families:
- ... about 60 per cent of our cohort are overweight to obese. That has an intra-uterine effect, and that intra-uterine effect is that by the time they are two and three years old, 30 per cent of those infants are then also obese. Those children will have long-term consequences of that, whether it is early onset of diabetes, renal disease—all of those subsequent health problems that will very definitely impact on both their ability to live a long and healthy life but also to engage readily in the classroom. ... the life expectancy of Indigenous Australians is so reduced ... that I think nutrition is the one modifiable thing that we can do.¹⁷⁷
- 4.21 The case study below outlines the work of the Gomerai gaaynggal program:

¹⁷⁴ Submission 26, Barnardos Australia, p2

¹⁷⁵ Australian Institute for Health and Welfare, [Australia's mothers and babies 2016: in brief](#), p44, viewed 14 August 2018

¹⁷⁶ Submission 44, Family Action Centre, University of Newcastle, p7

¹⁷⁷ Associate Professor Rae, Transcript of evidence, 21 May 2018, p39

Case study 10: Gomeroi gaaynggal program – University of Newcastle¹⁷⁸

Gomeroi gaaynggal is a health-related knowledge program for Aboriginal women and their families, in Tamworth and Walgett. It aims to close the gap in Indigenous health through a combination of health research with the community and a community driven ArtsHealth program.

The ArtsHealth program is facilitated by an Elder or Aboriginal artists, who works on artworks with mothers each week. During the art sessions, representatives from various health areas can attend the centre. Midwives, dieticians and representatives from oral health services have all taken part.

The project guides Aboriginal families to improved health behaviours and helps develop culturally appropriate skills in the health workforce.

Knowledge areas covered include dietary information, physiotherapy, mental health, sexual health, population health, obstetrics and gynaecology, women's health and child/family health.

Other services have worked with the program including financial services, TAFE, counselling services, Medicare Local and Regional Arts NSW.

Evaluations have indicated that an informal, long-term approach has the most impact in generating behavioural change.

Young parents

Integrated support services benefit young parents

Summary

Young parents need extra support to overcome the many challenges they face. NSW Health and FACS should develop specialised, integrated support services that meet their needs.

Recommendation 22

That NSW Health and the Department of Family and Community Services develop specialised, integrated support services to meet the needs of young parents in each district.

- 4.22 Inquiry participants told us that while teenage fertility rates have dropped significantly in recent years, rates are higher in the Aboriginal community and in socially disadvantaged areas.¹⁷⁹
- 4.23 Young parents can face extra challenges because of their lack of maturity, life experience and parenting knowledge, less stable financial situation and the social stigma they face. Young parenthood is often associated with complex and connected issues including intergenerational deprivation, low education and

¹⁷⁸ Submission 44, Family Action Centre; University of Newcastle, [Gomeroi Gaaynggal - Gomeroi Babies Program](#), viewed 9 October 2018

¹⁷⁹ Submission 37, Family Planning NSW, pp5-6

learning difficulties, mental health issues, substance use, abuse, and a family history of young pregnancy.¹⁸⁰

4.24 Because of the complexity of these challenges, integrated services are needed to support young parents with parenting, education, health and housing. We heard that support for young parents should be holistic, to give them the skills and autonomy they need to make the best decisions for them and their family.¹⁸¹

4.25 Consultation with young parents undertaken by the Advocate for Children and Young People suggested that they value integrated services that build on their strengths:

Young parents have reported that programs which provide consistent, respectful and positive support have links to health, education and employment pathways and assist with securing and maintaining safe and appropriate housing are helpful. Building on the strengths of young parents and connecting them to the necessary supports at the time in which they need them will increase their capacity for safe and effective parenting, increase the likelihood they will be economically secure and improve their families' health and wellbeing.¹⁸²

4.26 Young parents are one of the priority groups under the FACS TEI Program. Below is a case study of an integrated support service for young parents.

Case study 11: Red Cross Young Parent program¹⁸³

The Red Cross Young Parent program works to improve the capacity of young parents to live and parent independently through its residential, outreach and aftercare programs.

NSW Health provides a grant to the Red Cross to support the residential stage. The residential program provides 24 hour support, accommodation and intensive case management for up to eight young women aged 13 to 19 and their children for up to 12 months. The program aims to develop safe and healthy relationships, self-awareness and independence.

The outreach program helps parents under 25 in semi-supported independent living to manage parenting challenges and access opportunities. The program offers regular support and encourages participants to take responsibility for their family's health and wellbeing.

The aftercare program provides ongoing help for clients aged up to 25 who have transitioned from the residential or outreach programs. The program maintains contact with families, providing referrals and support to mainstream services as required.

¹⁸⁰ Submission 61, yourtown, pp4-5; Submission 67, Advocate for Children and Young People, p3

¹⁸¹ Submission 51, NCOSS, pp9-10; Submission 60, Yfoundations, pp14-15; Submission 61, yourtown, p7

¹⁸² Submission 67, Advocate for Children and Young People, p4

¹⁸³ Australian Red Cross, [Projects we support](#); Talking Realities, [The Australian Red Cross Young Parents Program](#), viewed 15 November 2018; Submission 70, NSW Government, pp15, 28

Young parents need more help with housing

Summary

FACS should have dedicated positions for young parents in youth homelessness services to ensure there are accommodation options for young families.

Recommendation 23

That the Department of Family and Community Services allocates dedicated positions for young parents in youth homelessness services.

- 4.27 Inquiry participants told us that young parents particularly need help with housing. NCOSS stated that over one in six young people aged 15 to 24 presenting alone to specialist homelessness services are single parents, and children under 10 make up one-sixth of clients accessing specialist homelessness services in Australia.¹⁸⁴
- 4.28 The NSW Homelessness Strategy notes that the number of young people (24 years and under) who used specialist homelessness services grew by 37 per cent between 2013-14 and 2016-17. Ninety per cent of young people experiencing homelessness have witnessed violence in their home, 60 per cent have been in out of home care, and 50 per cent have a reported mental health issue.¹⁸⁵
- 4.29 Homelessness has a detrimental effect on young parents and their children, with babies more likely to be born premature and underweight, and being at risk of suffering developmental problems. Children who experience homelessness have a higher risk of long-term poverty, homelessness in adulthood, unemployment, and chronic ill-health. They are also less likely to finish school, more likely to need health support, and to come into contact with the justice system.¹⁸⁶
- 4.30 Being homeless makes it harder for young parents to get support. NCOSS observed that 'a lack of housing and fixed address can pose a major barrier to the effective delivery of other support services to young families.'¹⁸⁷
- 4.31 Youth homelessness service providers can find it hard to engage young parents and provide them with the specialist services they need. Young people can feel that services are too inflexible and reduce their autonomy, or that accommodation is inappropriate for their needs.¹⁸⁸
- 4.32 Ms Zoe Robinson, Chief Executive Officer of Yfoundations, told us of the limited affordable accommodation options that are appropriate for young parents:
- ... there are none or limited single-bed parent units. There are limited spaces that are appropriate for a young family who can co locate with another young family. We

¹⁸⁴ Submission 51, NCOSS, p9

¹⁸⁵ NSW Government, [NSW Homelessness Strategy 2018-2023](#), pp9-10, viewed 15 August 2018

¹⁸⁶ Submission 51, NCOSS, pp9-10; Submission 60, Yfoundations, pp8, 10; NSW Government, [NSW Homelessness Strategy 2018-2023](#), p10

¹⁸⁷ Submission 51, NCOSS, pp9-11; Submission 60, Yfoundations, pp8, 10

¹⁸⁸ Submission 51, NCOSS, pp10-11; Submission 60, Yfoundations, pp6, 11-12

have seen that co-location works really well where there is a service wrapped around it. So there is not enough affordable housing but there are also not enough alternative pathways.¹⁸⁹

- 4.33 We note that the NSW Homelessness Strategy for 2018-2023 focuses on prevention and early intervention, better access to supports that prevent homelessness, and an integrated, person-centred service system. The strategy notes that children and young people can be especially vulnerable to the risk of homelessness and its ongoing impacts. As part of the strategy, the Government is spending over \$200 million on generalised specialist homelessness services in 2018-19.¹⁹⁰

Babies with disability and developmental delay

Reviewing services to fill gaps in diagnosis and referral

Summary

The National Disability Insurance Scheme (NDIS) has caused gaps and delays in early intervention for babies and children with disability. Services for babies with disability need to be reviewed. A whole of government approach is needed to ensure continuity of care.

Finding 6

The transition to the National Disability Insurance Scheme has created gaps and delays in early intervention services for babies and children with disability.

Recommendation 24

That the NSW Government reviews services for babies and children with developmental delay and disability, to address gaps and improve referrals for support.

- 4.34 Rapid assessment and referral of babies and young children with disability is important as early intervention can have a significant impact on their long-term outcomes. It can improve their health overall, and reduce the cost of long-term support:

... The earlier you intervene, the higher likelihood you have of improved physical, mental, emotional health for both the child and family. If we can get the mechanisms right for early intervention it will save huge and enormous costs to community and families as children move through the spectrum of early childhood development and beyond.¹⁹¹

- 4.35 Early intervention services for children were previously provided through the NSW Department of Disability, Ageing and Home Care. Under the NDIS, services for children up to six are provided through the Early Childhood Early Intervention Pathway. Under the Pathway, parents who are concerned about their child's

¹⁸⁹ Ms Zoe Robinson, Chief Executive Officer, Yfoundations, Transcript of evidence, 28 May 2018, p19

¹⁹⁰ NSW Government, [NSW Homelessness Strategy 2018-2023](#), pp7-9

¹⁹¹ Ms Margie O'Tarpey, Chief Executive Officer, Early Childhood Intervention Australia, Transcript of evidence, 28 May 2018, p24

development are connected to an early childhood partner by the National Disability Insurance Agency. The partner supports the parents and gives them information to help them decide what support their child needs. They also help the family to access services in their community, access the NDIS and develop a plan for the child.¹⁹²

- 4.36 Children needing support fall into two groups – those with a disability diagnosed at birth, and those with an emerging disability that becomes apparent after birth through developmental delay. We heard that for the first group, getting support under the NDIS is a priority. Children in the second group need assessment and identification of their developmental delay so they can be referred to an early childhood partner.¹⁹³
- 4.37 Inquiry participants told us that the transition to the NDIS has led to gaps and long waiting times to access services for children with a developmental delay or disability. The NSW Child and Family Health Nurses Association submitted that 'there are children placed on waiting lists that are not actively being seen, assessed or referred on for treatment'.¹⁹⁴
- 4.38 We heard that referrals to the NDIS are vital for children diagnosed at birth. Ms Kerry Dominish, an Early Childhood Intervention Australia (ECIA) board member, told us that referrals have dropped and there are long waiting lists for children to access the NDIS during the transition process. She stressed the need for hospital NDIS liaison staff to promptly refer children through the NDIS pathway:
- In all hospitals, we have NDIS liaison staff and we feel that it should be really important for those staff to immediately look at referring that child into an NDIS pathway and connecting them up with a service that the family chooses. That service is then able to commence and build a relationship for their ongoing requirements over time. ... At the moment we have an absolute decrease in referrals — we do not know where the babies have gone. There are very long waiting lists for the babies to get their NDIS packages, and in the meantime they are actually not getting any services. This gap has turned up because of the roll out of NDIS. They are an identified cohort that we can support to get that early referral going. We know that if we can get that referral happening it will decrease the impact of disability and decrease the likelihood of vulnerable family situations eventuating. ...¹⁹⁵
- 4.39 Identification of children with developmental delay is also being affected. Previously these children were identified through early childhood intervention services provided by the Department of Ageing, Disability and Home Care. We heard that because state services 'are not there anymore, that identification process is falling down'.¹⁹⁶

¹⁹² NDIS, [Early Childhood Early Intervention: how the NDIS can help your child](#), factsheet, pp4-5, viewed 15 August 2018

¹⁹³ Ms Kerry Dominish, Board member, Early Childhood Intervention Australia, Transcript of evidence, 28 May 2018, pp24-25

¹⁹⁴ Submission 9, Child and Family Health Nurses Association NSW, p5

¹⁹⁵ Ms Dominish, Transcript of evidence, 28 May 2018, p25

¹⁹⁶ Ms Dominish, Transcript of evidence, 28 May 2018, p25

- 4.40 To fill these gaps, ECIA suggested more funding to train child and family health nurses, and collaboration between early childhood partners and maternal nurses to ensure rapid assessment and referral of children.¹⁹⁷ Workforce training is discussed in detail in the next chapter.
- 4.41 ECIA also called for an integrated, whole of government approach that would coordinate disability policy and programs, negotiate with the Commonwealth and link agencies such as FACS and NSW Health. A whole of government approach could also address waiting lists and gaps in services, particularly for families that need extra support in Indigenous and CALD communities.¹⁹⁸
- 4.42 We recognise that some of the issues we heard about may improve once the NDIS's early intervention pathway is fully operational. However, we agree that there is a need for a whole of government approach to early childhood intervention for children with disability.

¹⁹⁷ Ms Dominish, Transcript of evidence, 28 May 2018, p25

¹⁹⁸ Ms O'Tarpey, Transcript of evidence, 28 May 2018, pp24, 29-30

Chapter Five – Workforce gaps and training

Workforce needs

Dealing with staff shortages

Summary

Workforce gaps in child and family health services need to be addressed to ensure services are better able to meet demand. This includes securing longer term funding to help increase the number of perinatal psychiatry registrars.

Recommendation 25

That NSW Health surveys each local health district to identify current and future workforce needs for child and family health services and develop strategies to address staff shortages in each district.

- 5.1 We heard the number of qualified child and family health nurses is declining. Factors for this include low pay, excluding child and family health nurses from decision making, the cost of postgraduate study and a lack of workforce support.¹⁹⁹
- 5.2 Other factors include difficulty recruiting and retaining qualified practitioners and poorly defined career pathways. We also heard there is no coordinated workforce plan to deal with the large number of child and family health nurses nearing retirement.²⁰⁰
- 5.3 Child and family health nurses and midwives are very committed to their work, but we were told they are often overstretched in terms of their workload. The workforce hasn't kept pace with general population growth. Workforce gaps are also part of the reason that parents are referred to secondary services for support that could be provided by child and family health nurses.²⁰¹
- 5.4 We were told there is a shortage of midwives in hospitals across the state. This also impacts on the level of care, including continuity of care, that pregnant women receive.²⁰² While there are midwifery vacancies across the public health system, the Ministry of Health informed us that this is due to the way vacancies are managed and '... does not mean that there is necessarily a shortage of [midwives] ...'.²⁰³

¹⁹⁹ Submission 9, Child and Family Health Nurses Association NSW, pp3-4; Submission 65, Volunteer Family Connect, p6

²⁰⁰ Submission 9, Child and Family Health Nurses Association NSW, pp3-4; Submission 65, Volunteer Family Connect, p6

²⁰¹ Ms O'Loughlin, Transcript of evidence, 21 May 2018, p13; Professor Schmied, Transcript of evidence, 21 May 2018, p33; Submission 9, Child and Family Health Nurses Association NSW, pp4-5

²⁰² Submission 68, NSW Nurses and Midwives' Association, pp5-6

²⁰³ Dr Lyons, Transcript of evidence, 4 June 2018, p22

- 5.5 According to the Ministry, from June 2015 to June 2017, the number of midwives across NSW Health increased by 230. Dr Lyons explained that long-term staff vacancies occur because staff take extended leave as well as resigning. These vacancies are often filled with part-time and casual staff. Dr Lyons noted it is a challenge for hospitals to fill ongoing and long-term vacancies.²⁰⁴ We welcome the 2018 NSW Budget announcement of 100 more midwives in 2018-19, bringing the total number of midwives to 3,020.²⁰⁵
- 5.6 As previously discussed, there are difficulties in recruiting staff in both metropolitan and regional areas. This applies to both general medical staff and specialists. We were told that regional health services have difficulty attracting health specialists.²⁰⁶
- 5.7 We heard the size of the child and family health nurse workforce needs to match population growth to ensure universal services meet the needs of families. We were also told that incentive schemes, improved pay and conditions and new graduate programs could attract more staff.²⁰⁷
- 5.8 For people in rural areas it can be difficult to travel a long distance to their nearest specialist. While telehealth technology, such as Skype appointments, helps some people, others need face to face appointments.²⁰⁸ The use of telehealth is discussed in chapter three.
- 5.9 We believe that NSW Health needs to survey each LHD to identify the current and future workforce needs of child and family health services in each district. The results should be used to develop strategies that address workforce gaps and shortages in each district.

Recommendation 26

That NSW Health funds additional perinatal psychiatry registrar positions.

- 5.10 There is a need for more perinatal psychiatry registrars to support parents with severe mental illness. It can be difficult for parents, usually mothers, with severe antenatal or postnatal depression to find a psychiatrist who is properly trained to help them.
- 5.11 We were told that psychiatrists are often afraid to treat expectant or new mothers with a severe mental illness due to lack of confidence and knowledge. They can be uncertain about issues such as prescribing medication during pregnancy or while a mother is breastfeeding. They can be concerned about what to do if a mother threatens to self-harm or harm her baby. Dealing with FACS can also be an issue as some psychiatrists may be unsure about how FACS operates or

²⁰⁴ Dr Lyons, Transcript of evidence, 4 June 2018, p22

²⁰⁵ NSW Health, [NSW Budget: \\$157 million support package for new families](#), media release, 17 June 2018, viewed 16 October 2018

²⁰⁶ Ms Moore, Transcript of evidence, 21 May 2018, p28

²⁰⁷ Submission 9, Child and Family Health Nurses Association NSW, pp4-5; Submission 65, Volunteer Family Connect, p6

²⁰⁸ Ms Moore, Transcript of evidence, 21 May 2018, p28

who to contact there. In these situations, psychiatrists seek advice from their peers who are experts in the area of perinatal mental health care.²⁰⁹

- 5.12 However, we heard there aren't enough experienced perinatal psychiatrists and more needs to be done to encourage junior staff to specialise in this area. There are four perinatal psychiatry registrar positions in the state. The positions are funded by the Commonwealth Department of Health and this is reviewed every three years. The short funding cycle creates uncertainty about the future of the positions, which can make it hard to recruit candidates.²¹⁰
- 5.13 We were told that NSW Health funding for the registrar positions could provide more certainty about the permanency of the positions. In Victoria there are 11 permanent state government funded registrar positions.²¹¹
- 5.14 We heard the NSW public health system seems to focus more on adolescent mental health, and the private system has more opportunities to specialise in babies and children. This can make it hard for perinatal registrars to secure a placement in a public mental health facility. We heard that the Royal Australian and New Zealand College of Psychiatrists, the Health and Education Training Institute, and the NSW Ministry of Health are working to address this issue.²¹²
- 5.15 We agree that secure state funding could help attract more junior psychiatrists to specialise in perinatal mental health. Consideration should also be given to increasing the number of perinatal psychiatry registrar positions. An increase in the number of registrars means more could be placed in regional and rural areas to provide specialist support. With supervision from Sydney-based consultants, the registrars could help fill service gaps in areas where this specialised support is often missing.²¹³

Staff training

Improving psychosocial screening and cultural awareness

Summary

Improving how psychosocial screening is performed could help better identify and support parents at risk of developing mental illness. Additionally, greater disability and cultural awareness will help ensure that parents and children with disability and those from diverse family backgrounds are better supported.

Recommendation 27

That NSW Health ensures all staff involved in SAFESTART psychosocial screening receive training to perform the screening effectively.

²⁰⁹ Professor Austin, Transcript of evidence, 28 May 2018, pp4-5

²¹⁰ Professor Austin, Transcript of evidence, 28 May 2018, pp4-5, 7; Submission 31, Royal Australian and New Zealand College of Psychiatrists, p 6

²¹¹ Professor Austin, Transcript of evidence, 28 May 2018, pp4-5, 7

²¹² Submission 31, Royal Australian and New Zealand College of Psychiatrists, pp5, 6

²¹³ Professor Austin, Transcript of evidence, 28 May 2018, p7

- 5.16 The confidence and ability of health professionals to perform psychosocial screening of pregnant women and new mothers should be improved. We heard that obstetricians, midwives, child and family health nurses, and GPs, often feel uncomfortable talking with parents about their mental wellbeing. They can also struggle to identify signs of depression or anxiety. If they are aware of a mental health issue, they can have difficulty referring that person to a support service. They may not know how to make a referral or what support is available. This means parents aren't always aware of the risk factors for postnatal depression or anxiety. They can fail to recognise symptoms in themselves and seek early treatment.²¹⁴
- 5.17 As previously discussed, not seeing the same midwife throughout pregnancy can have a negative impact on the care women receive. Psychosocial screening will only be successful if the person feels comfortable disclosing their mental health history. Each new midwife may not take enough time to go through the screening questions methodically. Screening can be rushed, with questions asked quickly and in a manner that doesn't allow for detailed answers. Some midwives may decide to wait until the next visit to ask specific questions but because they don't see the woman again, the questions are never asked.²¹⁵
- 5.18 Social stigma about mental illness means parents fear disclosing details of previous or current mental health issues. The fear of being seen as a bad parent and having their baby taken in to care often stops parents from being open about their mental health.²¹⁶
- 5.19 We agree that staff performing psychosocial screening need the confidence and skills to perform it effectively. They need to know how to identify when an issue may be developing and where to refer the parent for treatment. Staff should have a range of skills, including how to have difficult conversations, know about risks in the perinatal period, and obstacles that prevent parents seeking help.
- 5.20 Discussion about mental health as well as physical health should be a routine part of antenatal and postnatal care. Greater awareness by health professionals of available mental health services will also improve cooperation between services and reduce fragmentation.²¹⁷ Professor Austin told us that screening needs to be done more than once, and antenatally and postnatally. This allows enough time to assess if a family is struggling.²¹⁸

Recommendation 28

That NSW Health develops and implements training on cultural awareness and engaging with diverse communities for staff who provide child and family health services.

²¹⁴ Submission 50, PANDA, p5; Ms Smith, Transcript of evidence, 4 June 2018, pp1, 5

²¹⁵ Ms Passant, Transcript of evidence, 21 May 2018, p4; Professor Schmied, Transcript of evidence, 21 May 2018, p33; Ms Smith, Transcript of evidence, 4 June 2018, p2

²¹⁶ Submission 50, PANDA, p8; Ms Smith, Transcript of evidence, 4 June 2018, pp1-2

²¹⁷ Submission 50, PANDA, pp5-6, 13; Ms Smith, Transcript of evidence, 4 June 2018, pp2, 4, 5

²¹⁸ Professor Austin, Transcript of evidence, 28 May 2018, p5

- 5.21 Providing support in a culturally appropriate and sensitive way can lead to better outcomes. Aboriginal and Torres Strait Islander, CALD, young parent, and LGBTIQ families are more likely to engage with services that are respectful.
- 5.22 Aboriginal people are more likely to engage with a service that is sensitive and reflective of their culture. Consideration of cultural sensitivities is particularly important when providing services in remote communities. There is a need to spend time understanding how to provide services in these areas. Whenever possible, services for Aboriginal people should employ Aboriginal support workers who understand Aboriginal culture.²¹⁹
- 5.23 Services working with CALD communities need to recognise and appreciate the cultural preferences of CALD families. These families are often refugees who have experienced hardship and trauma. They can be distrustful of state agencies and uncomfortable accessing mainstream services. Services need to recognise these factors and that language and cultural barriers can take time to overcome.²²⁰
- 5.24 Staff working with young parent families also need to be aware of the impact their attitude and behaviour can have on the parents. Support should be provided in a respectful and non-judgemental way that doesn't stigmatise. Young parents fear being judged negatively by services. This sense of intimidation and alienation makes them less likely to seek help.²²¹
- 5.25 Support for LGBTIQ families also needs to be delivered by staff who understand the increasing diversity of families. While organisations may have policies promoting greater inclusivity, systems and staff may need training on how they can best support LGBTIQ parents. Staff can sometimes ask LGBTIQ parents questions or use language that is unnecessary and offensive. A negative health service experience can make LGBTIQ parents feel discriminated against and reluctant to use the service again.²²²

Hearing consumer voices

Recommendation 29

That NSW Health includes a consumer voice component in face to face training for child and family health service staff.

- 5.26 Including the voice of health consumers in face to face training is an important part of improving the practices of child and family health services. Staff get greater insight and understanding when hearing directly from consumers about their experience of mental illness or about a negative experience with a service. This can be a strong motivator for staff to improve how they support parents and break down barriers.
- 5.27 PANDA told us that its training for child and family health nurses in Victoria always includes hearing from consumers. Feedback from the nurses showed that

²¹⁹ Submission 40, Karitane, p10; Submission 62, Winanga-Li Aboriginal Child and Family Centre, pp1, 5

²²⁰ Submission 40, Karitane, pp11,13

²²¹ Submission 60, Yfoundations, pp6, 11, 13; Submission 61, yourtown, pp5, 6

²²² Submission 30, Rainbow Families NSW, pp4-6; Ms Gonzalez, Transcript of evidence, 28 May 2018, p22

hearing from the consumer was the most influential factor in making them improve their practices to better support parents.²²³

- 5.28 As noted by Winanga-Li Aboriginal Child and Family Centre, hearing from the community helps ensure local services are welcoming, accessible and culturally appropriate.²²⁴

Better awareness of the needs of parents and babies with disability

Recommendation 30

That NSW Health trains staff who provide child and family health services on appropriate referral pathways for babies with developmental delay and disability.

- 5.29 It's important that babies born with disability or who have a developmental delay receive early intervention to limit the need for greater support over their lifetime. Child and family health nurses are well placed to identify babies with disability or developmental delay and refer them to specialist early intervention services.
- 5.30 As previously mentioned, under the NDIS Early Childhood Early Intervention Pathway children are referred to an early childhood partner who helps the family to access services in their community. However, we heard there has been a decrease in the number of referrals as assessments aren't keeping up with demand. This has created long waiting lists for babies to receive their NDIS support package.²²⁵
- 5.31 We heard the decrease in assessments is due to a lack of resources as there aren't enough trained staff to assess babies. It was suggested that child and family health nurses could play an important role in performing assessments. These nurses already have a pivotal role in supporting new parents. Giving them additional training and skills to assess children with disability could help reduce waiting lists for NDIS care.²²⁶

Recommendation 31

That the Department of Family and Community Services trains child protection workers on support available for parents with disability under the National Disability Insurance Scheme, to enable children to remain with their families where possible.

Recommendation 32

That the Department of Family and Community Services and NSW Health run disability awareness training for child protection workers and staff who provide child and family health services.

²²³ Submission 50, PANDA, pp12-13; Ms Smith, Transcript of evidence, 4 June 2018, pp5-6

²²⁴ Submission 62, Winanga-Li Aboriginal Child and Family Centre, p1

²²⁵ Ms Dominish, Transcript of evidence, 28 May 2018, pp25-26

²²⁶ Ms Dominish and Ms O'Tarpey, Transcript of evidence, 28 May 2018, pp25, 26, 30

- 5.32 FACS workers aren't always aware of the support the NDIS can give to parents with disability. Increased awareness of NDIS services could help them provide more holistic support for these parents.
- 5.33 We heard that when both the NDIS and FACS are involved with a family, there can be poor coordination between the services. The NDIS may support the parent with disability and FACS or early intervention services support the child, but the two services don't collaborate. Improved communication between services could allow for more informed decisions to be made about whether a child can remain with its parents.²²⁷
- 5.34 We were told there are also concerns that when parents with disability seek NDIS support, this can trigger child protection concerns. Parents with disability often face stigma and judgement about why they have children.²²⁸ Lack of understanding and poor communication on the part of FACS staff can make it difficult for parents with disability to engage with support services. We heard that the relationship between a family and FACS can deteriorate to the point where an independent advocate is needed to resolve matters.²²⁹
- 5.35 Greater disability awareness and inclusion training could also help improve how child protection, and child and family health services support parents with disability and parents of a child with disability. Parents may need more support in areas such as feeding, nappy changing or how to interact with their child. However, we heard that parents with disability often don't get enough information or get incorrect information.²³⁰
- 5.36 As previously discussed, parents with disability can have difficulty accessing and understanding parenting information. They are often socially isolated which can make it hard to connect with support services, such as playgroups. By understanding the needs of these families, services can help them connect with support services early. This can also address social isolation by connecting families to local community based support groups.
- 5.37 We were told some support services may not be equipped to deal with a child with disability. This can prevent them from providing holistic support for both child and parents. We heard that disability and disadvantage are often linked. Improved awareness of the needs of families with a parent and/or a child with disability can help ensure quick and early referral to the support services they need, leading to better outcomes for families.²³¹

²²⁷ Submission 11, People with Disability Australia, p3; Mrs Hazelton, Transcript of evidence, 28 May 2018, pp26, 29; Ms Dominish, Transcript of evidence, 28 May 2018, p29

²²⁸ Submission 11, People with Disability Australia, p3; Mrs Hazelton, Transcript of evidence, 28 May 2018, p28

²²⁹ Mrs Hazelton, Transcript of evidence, 28 May 2018, p31

²³⁰ Submission 11, People with Disability Australia, p3; Mrs Hazelton, Transcript of evidence, 28 May 2018, p31

²³¹ Mrs Hazelton, Transcript of evidence, 28 May 2018, p28; Ms O'Tarpey, Transcript of evidence, 28 May 2018, p30

Chapter Six – Collecting and sharing information

Information sharing between service providers

Summary

Information sharing is vital to providing coordinated services. There are barriers that limit information sharing and impact on the quality of parenting services. Plans to better integrate health and child protection should be prioritised.

Finding 7

Better information sharing between service providers and government agencies could improve the quality of services and programs for new parents and babies.

Recommendation 33

That NSW Health prioritises the implementation of measures to improve information sharing between government and non-government child and family health service providers.

Recommendation 34

That the Department of Family and Community Services and NSW Health implement the use of an information sharing system across the state.

Better information sharing will improve services

- 6.1 Collaboration and coordination between service providers is key to ensuring that new parents' needs are met. An example of this is seen during the transition from maternity care provided by midwives to care provided by child and family health nurses. We heard that information sharing is an important element of integrated services.²³²
- 6.2 Poor systems for information sharing can reduce quality of care provided to parents. The Royal Australasian College of Physicians reported that changes to the eMaternity medical records system have hindered information exchange between maternity services and child and family services, resulting in 'a significant barrier to the delivery of integrated health and social care systems for parents and infants'.²³³
- 6.3 The sharing and analysis of data can help design and deliver services tailored to the needs of particular groups, such as vulnerable families who need longer term support. The Royal Australasian College of Physicians said that data on primary

²³² Submission 27, Public Health Association of Australia, pp4, 7

²³³ Submission 56, Royal Australasian College of Physicians, p2; Submission 27, Public Health Association of Australia, p4

health care visits can be used to 'inform allocation of resources, community services, education and health, tailored by geographic location where opportunities for prevention are greatest'.²³⁴

- 6.4 A shared data system across departments including NSW Health, Education and FACS could enable data on health and education outcomes to be gathered. This could have benefits including planning for population needs and monitoring effective interventions. Analysis of the data could also highlight what services work best, and accurately assess demand for services.²³⁵
- 6.5 NSW Health agreed that data sharing is a significant issue at both state and national levels. Data linkage between the state and federal systems is important as it can assist with service mapping and minimising service gaps and duplications. Links are also important between state agencies such as NSW Health, FACS and Education, particularly when providing services to vulnerable families.²³⁶

Poor integration limits information sharing

- 6.6 Inquiry participants told us that successful information sharing is often based on individual relationships rather than effective systems. Ms Hourigan Ruse described information sharing as 'patchy', overly reliant on personal goodwill, and vulnerable to breaking down when staff change roles:
- ... We have too many systems that are based on connections that are fragile, at best, rather than on very sound systemic protections for people to be able to share information and understand the barriers. It is definitely patchy but it is mostly based on goodwill, trust and the people in the places where it works well.²³⁷
- 6.7 Staff use personal connections to exchange information because systems within and between agencies aren't compatible. At the moment, LHD systems aren't interconnected and also don't connect with FACS's system. We heard that a universal electronic records system across LHDs is needed to enable better communication between staff employed by NSW Health and other agencies such as FACS.²³⁸
- 6.8 Disjointed agency systems can also act as a barrier for non-government service providers. These service providers want better information sharing to improve their ability to provide localised services, but there are barriers preventing this. Fams explained that FACS districts have different data collection requirements, performance measures and referrals processes.²³⁹
- 6.9 Some service providers have reported poor data collection processes, leading to incorrect data being collected. Providers funded under the Early Intervention and

²³⁴ Submission 56, Royal Australasian College of Physicians, pp2-3

²³⁵ Submission 65, Volunteer Family Connect, p8; Submission 40, Karitane, p12; Submission 56, Royal Australasian College of Physicians, pp7-8

²³⁶ Dr Lyons, Transcript of evidence, 4 June 2018, pp19-20

²³⁷ Ms Hourigan Ruse, Transcript of evidence, 21 May 2018, p24

²³⁸ Submission 9, Child and Family Health Nurses Association NSW, pp4, 6

²³⁹ Submission 20, fams, pp10, 13

Placement Prevention program collect data on program outcomes and send it to FACS. However, the providers and FACS have found the process to be 'cumbersome yet ineffectual and inaccurate'. Providers have interpreted data collection requirements in different ways, meaning the data is invalid.²⁴⁰

- 6.10 Privacy concerns held by clinicians and patients can also inhibit information sharing about patient care. Some patients are reluctant to use electronic medical records. We also heard that contracting services to the private sector has 'led to further fragmentation in sharing of and barriers in accessing digital data.'²⁴¹

Plans to improve information sharing

- 6.11 We note that steps are being taken to improve information sharing through the NSW eHealth strategy. The strategy includes plans to improve coordination and integration of information systems through electronic medical records, HealtheNet and the national My Health Record system.²⁴²
- 6.12 The roll out of statewide electronic medical records will enable sharing of information from all clinicians who care for a patient, to give 'a more integrated picture of patient health across different care settings including hospitals, community and outpatient care, or speciality and diagnostics services.' The system will be implemented across LHDs and will cover clinical documents, test ordering and diagnostic results and electronic medication management.²⁴³
- 6.13 Clinicians will have access to patient information from all LHDs through HealtheNet — a database of clinical history, including patient demographics and identifiers, and hospital discharge summaries. This database will allow information sharing between hospitals, community health, GPs, patients and private clinicians.²⁴⁴
- 6.14 HealtheNet will also be integrated with the national My Health Record system. My Health Record is an online health summary drawn from patients' medical records. It includes information on allergies, medical conditions and treatments, medicine details and scan reports. Patients control the information that goes on the record and who can access it. They can also opt out of having a record.²⁴⁵
- 6.15 Health data analytics is a key part of the eHealth strategy. The NSW Health Analytics²⁴⁶ Framework sets out a plan to integrate healthcare through data and insights that support evidence based decision making, planning and performance.

²⁴⁰ Submission 20, fams, Appendix 2, p18

²⁴¹ Submission 56, Royal Australasian College of Physicians, pp6, 8

²⁴² NSW Health, [eHealth strategy for NSW Health 2016-2026](#), pp2-3, viewed 25 September 2018

²⁴³ NSW Health, [eHealth strategy for NSW Health 2016-2026](#), p16, viewed 25 September 2018

²⁴⁴ NSW Health, [eHealth strategy for NSW Health 2016-2026](#), p17 and NSW Government, eHealth, [My Health Record](#) and [HealtheNet: Better healthcare](#), viewed 25 September 2018

²⁴⁵ NSW Health, [eHealth strategy for NSW Health 2016-2026](#), p17 and NSW Government, eHealth, [My Health Record](#) and [HealtheNet: Better healthcare](#), viewed 25 September 2018, and NSW Government, [eHealth NSW news](#), May/June 2018, p8, viewed 23 October 2018

²⁴⁶ Health analytics is using data, technology and quantitative and qualitative methods to inform decisions to improve health outcomes and health system performance: NSW Health, [NSW Health Analytics Framework](#), January 2016, pv, viewed 27 September 2018

Implementation of the eHealth strategy will underpin the Analytics Framework.²⁴⁷

- 6.16 We heard that the NSW Data Analytics Centre is working to improve the way in which agencies share information. While legal requirements around privacy need to be considered it is hoped that the Centre's work will lead to data being shared between government agencies and the community sector.²⁴⁸
- 6.17 Ms Simone Czech, Executive Director at FACS, gave an example of how FACS has used data analytics to develop services for vulnerable young mothers:
- ... They are looking at a number of cohorts of vulnerable families. One of those cohorts is young mothers and their children. What they do is look at all the data that is available from respective agencies. We are using the Data Analytics Centre ... to pull data together and link it. What they are doing is understanding the data but then designing solutions to particular cohorts. That is quite exciting because that gives you the innovation but it is embedded with the data and the evidence as to what works.²⁴⁹
- 6.18 FACS is also aiming to improve information sharing through ChildStory — an IT system that helps collaboration between family, carers, child protection caseworkers and service providers. Everyone involved in a child's life can add to their online record, and they can access their record (depending on their age). FACS, NSW Police, Education, non-government service providers and mandatory reporters will have access to the system. It's currently being rolled out to non-government providers. Once it's implemented, NGOs or NSW Health will be able to use it to see a child's child protection history.²⁵⁰
- 6.19 Legislative change in 2012 paved the way for better information sharing. The law established a scheme for information exchange between organisations and required them to make an effort to coordinate services.²⁵¹ Ms Czech said that the changes led to more requests for information and enabled agencies 'to actually pick up the phone and seek that information from each other.'²⁵²
- 6.20 FACS and the Department of Education have both used a web-based app called Patchwork. FACS trialled the app to coordinate services for families, and Education used it for its distance education program. It allowed users to see the other services that were working with families to get an idea of their role in

²⁴⁷ NSW Health, [NSW Health Analytics Framework](#), January 2016, p2, viewed 27 September 2018

²⁴⁸ Ms Hourigan Ruse, Transcript of evidence, 21 May 2018, p24; Professor Hayes, Transcript of evidence, 21 May 2018, p40

²⁴⁹ Ms Simone Czech, Executive Director, Department of Family and Community Services, Transcript of evidence, 4 June 2018, p20

²⁵⁰ Ms Czech, Transcript of evidence, 4 June 2018, p20, and ChildStory, <https://childstory.net.au/>, and the ChildStory program, <https://childstory.net.au/about/>, viewed 24 September 2018

²⁵¹ Organisations include the NSW Police Force, state government departments and public authorities, government and non-government schools and TAFEs, public health organisations and private health facilities, and adoption service providers: see *Children and Young Persons (Care and Protection) Act 1998*, Chapter 16A, and FACS, [Exchanging information related to child protection and wellbeing](#), viewed 26 September 2018

²⁵² Ms Czech, Transcript of evidence, 4 June 2018, p20

supporting the client. However FACS told us that it wasn't rolled out more widely because of funding limits.²⁵³

- 6.21 Below is an example of a system that is used to link data and inform health and medical research in Western Australia.

Case study 12: Data Linkage System – Western Australia²⁵⁴

Western Australia's Data Linkage Branch sits within the Department of Health. The branch oversees the WA Data Linkage System (WADLS), which was established in 1995.

Having operated for more than 20 years, WALDS has been a national and international leader in population-level data linkage. WALDS aggregates and links data from numerous government and non-government agencies for health and medical research. Core datasets cover health and social issues including hospital admissions, emergency services, and public health; mental health and community services; and other data such as births, deaths, marriages, and electoral information.

Linked data is used to support approved research, develop policies, and plan and evaluate services. Research using linked data is very valuable and efficient because it includes all people in WA, not small parts of the population. This gives a more complete picture of the health of people in WA.

While WALDS isn't parenting-specific, it has contributed to several research projects related to parenting. These have covered topics including parents' mental health; parenting in the Indigenous population; parenting with intellectual disability; the efficacy and economic benefits of parenting programs; and the effectiveness of child health services for parents.

²⁵³ Ms Czech, Transcript of evidence, 4 June 2018, p20; Mr Mike Tom, Leader, Rural and Distance Education, Department of Education, Transcript of evidence, 4 June 2018, p24

²⁵⁴ Answer to supplementary question, Professor Alan Hayes, Family Action Centre, 21 May 2018, see also Data Linkage Western Australia, [About the Data Linkage Branch](#), and [What is Data Linkage](#), viewed 11 October 2018

Appendix One – Conduct of inquiry

Terms of reference

On 13 September 2017 the Committee resolved to inquire into and report on support for new parents and babies in New South Wales, including:

1. The adequacy of current services and structures for new parents, especially those who need extra support, to provide a safe and nurturing environment for their babies.
2. Changes to current services and structures that could improve physical health, mental health and child protection outcomes.
3. Specific areas of disadvantage or challenge in relation to health outcomes for babies.
4. Models of support provided in other jurisdictions to support new parents and promote the health of babies.
5. Opportunities for new and emerging technology to enhance support for new parents and babies.
6. Any other related matters.

Call for submissions

The Committee called for submissions through a media release and wrote to key stakeholders inviting them to make a submission. Information about the inquiry was posted on the Legislative Assembly's Facebook page and Twitter feed.

Submissions closed on 18 December 2017. Seventy one submissions were received from the community, colleges and professional associations representing health and medical clinicians, NGOs, research bodies, advocacy groups and government departments.

A list of submissions is at Appendix Three. [Submissions](#) are available on the Committee website.

Site visits

In March 2018 the Committee attended two site visits – one at Gunawirra House in Rozelle, and the second to the Young Parents' Hub in Wyong and Child and Family Health at Gosford. The site visit reports at Appendix Two outline the issues that were covered during the meetings.

Hearings

The Committee held three hearings at Parliament House in May and June 2018 with witnesses representing medical professionals, research centres, advocacy and support groups, NGOs and agencies that provide services to new parents and their babies.

Appendix Five is a list of witnesses who appeared at the hearings. [Transcripts of evidence](#) taken at the hearings are on the Committee webpage.

Appendix Two – Site visits

Monday 5 March 2018

Meeting with Norma Tracey, Acting CEO, Graham Toomey, Aboriginal cultural advisor and artist, Cate Osborn, social worker and psychoanalytic therapist, and Sharini Samarakoon, art therapist, Gunawirra House, 19a Quirk St, Rozelle

Gunawirra is a not-for-profit organisation of Aboriginal and non-Aboriginal professionals that works with Aboriginal young women, men, and their children from zero to five years. Gunawirra works with Aboriginal community member preschools across NSW. Key programs are Five Big Ideas and Young Aboriginal Mothers Groups.

The following issues were discussed:

Impact of trauma on Aboriginal communities

Government policy to enrol Aboriginal children in preschool has been successful, but children need better support at preschool. Aboriginal children often experience trauma such as family violence, sexual assault or drug and/or alcohol abuse at home. Many of the children seen by Gunawirra staff are exposed to family violence and sexual abuse.

Children who experience trauma can have learning difficulties. Trauma is often intergenerational. It is also caused by loss of country, culture and spirituality.

The Five Big Ideas program is run in 25 preschools in NSW. Staff visit the schools regularly to provide individual and group therapy to children, and train teachers to support children dealing with trauma. Art therapy, educational toys and books are used to teach children about their culture, identity and understanding their emotions. Aboriginal learning kits containing items like message sticks are used.

Gunawirra recognises the need to support teachers and allow them to process their experiences of working with traumatised children. Teachers in regional and rural areas are paid less than those in metropolitan areas, making it harder to recruit and retain them.

Gunawirra proposes a community hub model to support children and teachers. The model includes a specialist centre for workers to debrief, technology for video conferencing, and an emphasis on cultural awareness. It would improve referrals between preschools and community health centres, which are often under resourced.

Funding

Gunawirra is not funded by the NSW Government. Funding comes from the Department of Prime Minister and Cabinet, and corporate and private donations. Gunawirra is reluctant to seek FACS funding as it could deter vulnerable mothers from using its services, as they fear their child being taken into care. It works indirectly with other agencies such as NSW Health.

Funding cycles for NGOs are too short, with some lasting only 12 months. This limits NGOs ability to design and implement quality long-term programs. Funding cycles of at least five

years would allow organisations to implement more comprehensive programs. Reporting requirements should focus on measuring program outcomes and achievements.

NGOs have to compete with each other for funding. A better way would be to have a central agency that funds NGOs as needed. Concern about duplication of services is unwarranted as current services aren't meeting clients' needs.

Engaging with mothers

Pregnancy is the best time to support mothers and help them connect with their child. Many mothers have poor family connections – no mother or grandmother to call on for support.

Gunawirra works with Royal Prince Alfred Hospital midwives to connect with pregnant Aboriginal women and encourage them to use its services. However, many won't attend prenatal classes for fear of having their baby taken away from them. Many only attend when they are about to give birth. Gunawirra has recently started working with GPs as another way to engage with pregnant Aboriginal women.

Regional and rural areas

In addition to the difficulties of recruiting and retaining preschool teachers in regional and rural areas, there is a lack of clinical psychologists in these areas. Support is lacking for people who need mental health services. Many vulnerable mothers wouldn't have their children removed if they had access to better mental health services.

Aboriginal fathers

Many Aboriginal fathers are not a regular or positive part of their child's life. Many fathers are violent and/or in gaol and others are dead, often as a result of suicide.

Friday 23 March 2018

Meeting with Simon Harrison, Business Manager and Jaime Boys, Head of Communication and Development, Young Parents' Hub, 2a Amy Close, Wyong

The Young Parents' Hub (the Hub) is a place-based model of integrated service delivery. It supports young parents and jobless families to break down barriers to education and employment.

The following issues were discussed:

Model of service delivery

Service providers and support agencies come to the Hub to see clients, as it's a convenient and relaxed place to engage with parents. This model is seen as best practice in connecting young parents with the support they need. It provides a soft entry point for young parents, as they attend voluntarily rather than being referred by other services.

The Hub's Young Parents Governance Committee helps guide how it operates and supports young parents.

Services provided

Early Learning Centre

The Hub has on-site child care where parents can leave their child while they attend the educational and other services available at the Hub.

The Early Learning Centre (ELC) isn't government licensed as it doesn't have the required indoor/outdoor assimilated space. The local council has refused planning approval for the indoor/outdoor space but the Hub is pursuing the matter. The Hub's future would be more secure if the ELC was an approved venue as it would qualify for the Child Care Benefit.

Education and learning

Most mothers attending the Hub have only completed up to year 8 or 9 of high school. Many reach their early 20s and realise they need to study further to improve their own and their child's prospects.

With St Philip's Christian College, the Hub offers young parents an alternative three year HSC course. The on-site child care allows them to attend classes knowing their child is cared for while they study. Most parents attending the program are mothers; only a few fathers graduate. The program connects with agencies that help parents to get support while they study.

Pre-vocational and vocational courses are also offered. After finishing educational and vocational training, parents are supported as they pursue educational or employment opportunities. Support includes pathways to TAFE and community colleges; parenting and life skills such as cooking and a healthy diet; support for those who have experienced domestic violence; and help to stay in the private rental market rather than entering social housing.

Support services

The Hub partners with government and non-government organisations that focus on long-term support including: The Benevolent Society, Uniting, Kanga Training, Central Coast Family Support Services, Central Coast Health, Playgroup NSW, Department of Human Services, and FACS.

The Hub also partners with parents who have graduated from its educational programs to support and encourage those coming after them.

A food bank service is available for families that are struggling financially. There is also an on-site café (The Pantry) where parents receive food services training such as barista training.

For every \$1 spent on prevention and early intervention \$6 is saved on longer term support.

Profile of parents attending the Hub

The Wyong local government area is in the top 10 nationally for rates of teenage pregnancy. The Central Coast has the highest rate of domestic violence in NSW. Around 67 per cent of the Hub's clients identify as Indigenous reflecting the recent growth in the Aboriginal and Torres Strait Islander population on the Central Coast.

Most of those using the Hub have a background of welfare dependency, often inter-generational. Many have experienced trauma such as domestic violence. The programs and services try to break the cycle of welfare dependency. Many parents completing their HSC are the first in their family to do so.

There's a need to better educate children in primary and secondary school about teenage pregnancy. Better education could reduce teenage pregnancy and break the cycle of welfare dependency.

It can be difficult for parents, especially those relying on public transport, to travel with a baby or very young child. A minibus service is provided to help parents travel to the Hub.

The Hub's engagement with young parents has seen an 85 per cent drop in the number of reports to FACS about parents and children at risk of significant harm.

Funding cycles

Current funding cycles are too short and don't allow for better long-term planning. Extending funding to a five year cycle would give services more security and allow more strategic and long-term service planning.

Future plans for the Hub

The Hub will shortly be able to produce social measurement data and analysis about its programs. This data will show how successful its programs are. It's also looking to expand to other locations including Cessnock, Kurri Kurri, Newcastle and the Lake Macquarie area.

Meeting with Dr Philip Watt, Service Director Child & Family Health, AHOD Paediatrics, Clinical Director Central Coast Kids & Families, Sue Knibb, Nurse Unit Manager Child & Family Health, Fiona Dunmore, Nurse Manager Child & Family Health, and Julie Draper, Acting Nurse Unit Manager, Sustaining NSW Families, at the Gateway Centre, Gosford

Central Coast LHD's Child and Family Health Service provides a range of services to families with young children in their early years. Many services are provided in community health centres on the Central Coast, including at the Gateway Centre, Gosford.

The following issues were discussed:

Home visit program

Child and family health nurses offer a home visit to all new parents. The visit includes a child assessment and referral to services as needed. Nurses focus on health promotion and early intervention. Not all parents accept the visit even though many who refuse need support. Others prefer to go to their GP rather than get a home visit. Aboriginal families may prefer to use their local Aboriginal medical service.

There isn't enough public awareness of services provided by child and family health nurses. Nurses and GPs need to work more closely together. GPs are a key point of contact for families and well placed to refer parents who need support to child and family health nurses.

The LHD offers a home visit to 98 per cent of new parents. Parents are called three times, followed by a letter if phone contact is unsuccessful. When calling parents, the LHD's number

comes up as silent. Many people don't answer calls from silent numbers. A text message could instead be sent with details of the home visit service, or the visit could be arranged before the mother and baby leave hospital.

Home visits take about 90 minutes. The nurse asks questions about the family's home life to work out how parents are coping and if there are any issues with the baby. Blue Book health checks are also done. If the mother's partner is there the nurse won't ask if she is experiencing domestic violence. A follow-up visit may be needed if a baby is losing weight, there are breastfeeding issues or the mother was upset during the initial visit.

The home visit is insufficient particularly for first time mothers. It could be useful to train nurses as midwives to give them a better understanding of antenatal and postnatal issues that women experience.

Information sharing between services

Antenatal and maternity services don't readily communicate and share information – there is often a delay in notes being entered in the system, so information isn't always current. A midwife visits a new mother once within five days of her baby's birth but there is no regular communication between the midwife and child and family health nurse. There is also limited data sharing with FACS although FACS often asks the LHD for information about clients.

Better use of technology could improve communication between services and the timeliness of services. However, sufficient funding would need to be made available.

Vulnerable families

Some vulnerabilities faced by new parents, especially mothers, are domestic violence, mental health problems and drug and alcohol misuse. First time mothers usually go to antenatal classes but are less likely to do so during later pregnancies. However, they often attend other groups such as new parent support groups. Many vulnerable mothers don't like having home visits and prefer to go to a clinic for services. Nurses can try to connect with mothers by going to drug and alcohol clinics to meet parents.

There may not be any appropriate services for mothers experiencing domestic violence or mental health issues, or services may be unable to take them on as a client. There's no waiting list to see child and family health nurses, but there are waiting periods to see social workers for more intensive support. Around 10 per cent of new mothers may need extra support.

Infant hearing screening (SWISH)

The Statewide Infant Screening - Hearing (SWISH) program identifies all babies born with significant permanent bilateral hearing loss by three months of age. Children with hearing loss are referred to the appropriate intervention by six months of age.

The program can enable child and family health nurses to connect with parents who haven't seen a nurse. This can happen if the mother had a home birth or lived outside the LHD when she gave birth.

Breastfeeding support

Most new mothers are discharged from hospital very soon after giving birth. This limits the ability of nurses and lactation consultants to teach them how to breastfeed. Many give up trying to breastfeed when they have problems. Classes on how to feed and settle baby aren't available to new mothers in hospital. Instead, limited information is provided via an information video.

Towards Normal Birth policy

The Towards Normal Birth policy seeks to promote a woman friendly low risk birth that protects, promotes and supports a normal birth. To support the policy, more funding is needed to employ more midwives. However, for some mothers and babies the best birth is an interventionist one. The increase in obesity means women are more likely to have an interventionist birth. Poor nutrition can also affect a mother's mental health.

Sustaining NSW Families

Sustaining NSW Families is a nurse-led home visiting program for vulnerable families with young children. The Central Coast LHD is one of 11 locations providing the program. A child and family health nurse helps families establish positive, healthy relationships with their child and promote positive social and emotional development. This has long-term benefits for the child and the family.

175 families in the LHD are part of the program. Families are identified through a universal health assessment given to all pregnant women booking in to a public hospital. The program consists of 24 home visits beginning in pregnancy and continuing until the child turns two.

Children with disability

The Central Coast LHD can connect families that have a child with disability to support services, including NGOs and disability support services provided by the LHD. There are different levels of support for children with disability depending on the LHD.

The transition to the NDIS isn't going smoothly. LHDs need to tailor their services to the needs of their population rather than having a one size fits all service across all LHDs.

Meeting with Maria Parlow, Acting Senior Social Worker, FACETS and Family Care Cottage, and Jayne Klijn, Clinical Nurse Specialist, Family Care Cottage, at the Gateway Centre, Gosford

The following issues were discussed:

Supporting new mothers

It's important to normalise baby behaviour problems and not medicalise issues. Parents need to understand that it's normal to have a period of adjustment after a baby is born and establishing new routines takes time.

A major focus for social workers is reducing the impact of postnatal depression. Many Central Coast new mothers are isolated, which is a risk factor for postnatal depression. Many have partners who work in Sydney, and get no support for much of the week. They often don't have

a local support network. Couples who move to the area due to housing affordability in Sydney are away from their immediate and extended family.

Social workers take a holistic approach with vulnerable families. A safety plan details support services and how the family can connect with them. Services get positive results but need more resources.

Family Care Cottage

Family care cottages support families with children aged up to five who need extra support with sleep and settling, breastfeeding/feeding and weaning, child behaviour problems, parenting, stress and anxiety, and postnatal distress/depression. The cottage sees more younger mothers, perhaps because young parents are now more willing to seek help.

SWISH

Around 99 per cent of NSW babies are assessed for permanent hearing loss. SWISH is available in every LHD, but each district runs its program differently. There is no coordination or link between LHD SWISH programs, which makes it hard to ensure all children are screened.

There are three referral centres for babies that need intensive assessment and treatment: John Hunter Hospital, Westmead Children's Hospital, and Sydney Children's Hospital, Randwick. The Central Coast LHD has an audiologist qualified to do these assessments but lacks the equipment to act as a referral centre.

Appendix Three – Submissions

No	Author
1	Name suppressed
2	Dr Melanie Strang
3	Name suppressed
4	Ms Jacqueline Barker
5	Mrs Anita Francis
6	Ms Barbara Lewis
7	Name suppressed
8	Mrs Jessie Albert
9	Child and Family Health Nurses Association NSW
10	3Bridges Community Limited
11	People with Disability Australia (PWDA)
12	Maternity Consumer Network
13	Dr Richard Fletcher
14	Ms Claire Carpenter
15	Ms Kellie Darley
16	Name suppressed
17	Mrs Jessica Giles
18	Name suppressed
19	Name suppressed
20	fams
21	Tresillian
22	Aboriginal Child, Family and Community Care State Secretariat (AbSec)
23	Parent-Infant Research Institute
24	The Beyond Sleep Training Project
25	Parenting Research Centre
26	Barnardos Australia
27	Public Health Association of Australia (PHAA)
28	Playgroup NSW
28a	Playgroup NSW
29	Pregnancy Birth and Beyond Media
30	Rainbow Families NSW
31	Royal Australian and New Zealand College of Psychiatrists

No	Author
32	Professor Virginia Schmied
33	Early Childhood Intervention Australia NSW/ACT
34	Ms Nhuan Lien Vong
35	Confidential
36	Dr Chris May
37	Family Planning NSW
38	Helping Children and Families Association Inc
39	Australian Breastfeeding Association
40	Karitane
41	Australian Association for Infant Mental Health Inc
42	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
43	Contact Inc
44	Family Action Centre, University of Newcastle
45	Country Women's Association of NSW
46	Australian Multiple Birth Association
47	Royal Australian College of General Practitioners
48	Australian Research Alliance for Children and Youth (ARACY)
49	Women's Legal Service NSW
50	Perinatal Anxiety & Depression Australia (PANDA)
51	NSW Council of Social Service (NCOSS)
52	Mental Health Commission of NSW
53	NSW Ombudsman
54	Ms Leanne McDonald
55	Ms Linda Deys
56	Royal Australasian College of Physicians
57	Centre of Perinatal Excellence (COPE)
58	Dr Elizabeth Reimer
59	Red Nose
60	Yfoundations
61	yourtown
62	Winanga-Li Aboriginal Child and Family Centre
63	Australian College of Midwives
64	Montessori Australia Foundation
65	Volunteer Family Connect
66	WarraWarra Legal Service

No	Author
67	Office of the Advocate for Children and Young People (ACYP)
68	NSW Nurses and Midwives' Association
69	SNAICC – National Voice for our Children
70	NSW Government
71	Junee Community Centre

Appendix Four – Witnesses

21 May 2018

Parliament House, Jubilee Room, Sydney, NSW

Witness	Position and Organisation
Associate Professor John Eastwood	Royal Australasian College of Physicians
Dr Jacqueline Small	Director, Royal Australasian College of Physicians
Dr Elaine Burns	Executive Committee Member, Australian College of Midwives NSW Branch
Ms Lyn Passant	Executive Committee Member, Australian College of Midwives NSW Branch
Ms Julie Collier	Vice President, Child and Family Health Nurses Association NSW
Ms Karen Dignam	Membership Secretary, Child and Family Health Nurses Association NSW
Associate Professor Jenny Smit	Director of Clinical Services, Tresillian
Professor Cathrine Fowler	Tresillian Chair, University of Technology
Ms Grainne O’Loughlin	Chief Executive Officer, Karitane
Ms Sharlene Vlahos	Director, Education and Business Development, Karitane
Ms Julie Hourigan Ruse	Chief Executive Officer, fams
Ms Kim Stace	Capacity Building Consultant, fams
Dr Jayne Meyer Tucker	Champion, Volunteer Family Connect
Dr Rebekah Grace	Researcher, Volunteer Family Connect
Ms Kerry Moore	Executive Manager, Safety and Prevention Regional/Rural NSW & ACT, Barnardos
Professor Alan Hayes	Director, Family Action Centre, University of Newcastle
Associate Professor Kym Rae	Gomeroi gaaynggal Centre, University of Newcastle
Ms Zoya Gill	Project Manager, Australian Research Alliance for Children and Youth
Professor Sharon Goldfeld	Department of Paediatrics, Faculty of Medicine Dentistry and Health Sciences, University of Melbourne
Professor Virginia Schmied	School of Nursing and Midwifery, Western Sydney University

28 May 2018**Parliament House, Macquarie Room, Sydney, NSW**

Witness	Position and Organisation
Professor Marie-Paule Austin	NSW Branch, Royal Australian and New Zealand College of Psychiatrists
Ms Nicole Bridges	NSW Branch President, Australian Breastfeeding Association
Ms Louise Duursma	Senior Manager Consumer Services, Australian Breastfeeding Association
Ms Zoe Robinson	Chief Executive Officer, Yfoundations
Mr Andrew Johnson	Advocate for Children and Young People
Ms Vanessa Gonzalez	Co-Chair, Rainbow Families NSW
Ms Margie O'Tarpey	Chief Executive Officer, Early Childhood Intervention Australia NSW/ACT
Ms Kerry Dominish	Board Member, Early Childhood Intervention Australia NSW/ACT
Mrs Leonie Hazelton	Advocate, People with Disability Australia
Ms Sue Kingwill	Chief Executive Officer, Contact Inc
Ms Ashlee Tenberge	Chairperson, Board of Directors, Australian Multiple Birth Association
Ms Joanne O'Keeffe	NSW State President, Australian Multiple Birth Association
Ms Karen van Woudenberg	Manager, Programs and Quality, Playgroup NSW

04 June 2018**Parliament House, Macquarie Room, Sydney, NSW**

Witness	Position and Organisation
Ms Terri Smith	Chief Executive Officer, Perinatal Anxiety & Depression Australia (PANDA)
Mr Wayne Griffiths	Centre Manager, Winanga-Li Aboriginal Child and Family Centre
Dr Elisabeth Murphy	Senior Clinical Advisor, Child and Family Health, Ministry of Health
Dr Nigel Lyons	Deputy Secretary, Strategy and Resources, Ministry of Health
Mr Mark Piddington	Principal, Sydney Distance Education High School, Department of Education
Mr Mike Tom	Leader, Rural and Distance Education, Department of Education

Ms Simone Czech	Executive Director, Department of Family and Community Services
Ms Lisa Charet	Executive District Director, Western Sydney and Blue Mountains District, Department of Family and Community Services

Appendix Five – Extracts from minutes

Meeting no 11

1.37pm, Wednesday 13 September 2017

Room 1254

Members present

Mr Conolly (Chair), Mr Notley-Smith, Mr Harris, Ms Doyle, Ms Wilson

Apologies

Mr Greenwich

Officers in attendance

Simon Johnston, Dora Oravec, Kieran Lewis, Mohini Mehta, Ze Nan Ma

1. ***

2. Confirmation of minutes

Resolved on the motion of Mr Notley-Smith, seconded by Ms Doyle, that the minutes of the meeting of 24 May 2017 be confirmed.

3. ***

4. Proposed inquiry – support for new parents and babies in New South Wales

The Committee considered draft terms of reference for an inquiry into support for new parents and babies.

Resolved on the motion of Mr Notley-Smith, seconded Ms Doyle, that the Committee conduct an inquiry into support for new parents and babies in New South Wales, in accordance with the draft terms of reference.

The Committee discussed the inquiry timeline and stakeholder list.

Resolved on the motion of Ms Doyle, seconded Ms Wilson, that the Committee call for submissions to be received by the end of the second week in November and write to stakeholders on the targeted list requesting submissions.

The Chair advised that he would issue a media release announcing the inquiry, and that links to the media release would be posted on the Parliament's social media accounts. Discussion ensued.

Resolved on the motion of Mr Harris, that the Chair issue a media release announcing the inquiry.

5. Next meeting

The Committee agreed to meet in the last sitting week in November.

The meeting adjourned at 1.53pm until a time and place to be determined.

Meeting no 12

12.32pm, Tuesday 21 November 2017

Room 1254

Members present

Mr Conolly (Chair), Mr Harris, Ms Doyle, Ms Wilson, Mr Notley-Smith

Apologies

Mr Greenwich

Officers in attendance

Simon Johnston, Dora Oravec, Kieran Lewis, Mohini Mehta, Ze Nan Ma

1. Confirmation of minutes

Resolved on the motion of Ms Doyle, seconded by Ms Wilson, that the minutes of the meeting of 13 September 2017 be confirmed.

2. Inquiry into support for new parents and babies in New South Wales

2.1 Correspondence

Resolved on the motion of Mr Harris, seconded by Ms Doyle, that the Committee note the correspondence from ***

2.2 Consideration of submissions

Resolved on the motion of Mr Harris, seconded by Mr Notley-Smith, that the Committee publish submissions numbered 2, 4 to 6, 8 to 15, 17, 20 to 32, 34, 36 to 37 and 39 to 43 in full.

Resolved on the motion of Ms Doyle, seconded by Ms Wilson, that the Committee publish submissions numbered 1, 3, 7, 16, 18 and 19 with the authors' names suppressed.

Resolved on the motion of Ms Doyle, seconded by Ms Wilson, that the Committee publish submission number 33 following confirmation from the stakeholder.

Resolved on the motion of Ms Wilson, seconded by Mr Harris, that the Committee publish submission number 38 with the names of individuals in the references to personal communication redacted.

Resolved on the motion of Mr Notley-Smith, seconded by Ms Doyle, that submission number 35 remain confidential to the Committee and not be published.

2.3 Closing date for submissions

The Committee noted a number of requests from stakeholders for an extension of time to make a submission.

The Committee agreed that a follow-up email be sent to the stakeholders who did not respond to the Committee's initial invitation to make a submission. Members were also invited to forward details of other additional stakeholders to the Committee secretariat.

Resolved on the motion of Mr Notley-Smith, seconded by Ms Wilson, that the Committee extend the closing date for submissions to 18 December 2017.

2.4 Site visit and public hearing arrangements

The Committee discussed options for potential site visits and public hearings.

3. Next meeting

The meeting adjourned at 12.55pm until a time and place to be determined.

Meeting no 13

1.40pm, Thursday 15 February 2018

Room 1254

Members present

Mr Conolly (Chair), Mr Harris, Ms Doyle, Mr Greenwich, Mr Notley-Smith, Ms Wilson

Apologies

Ms Cooke

Officers in attendance

Jonathan Elliott, Dora Oravec, Kieran Lewis, Mohini Mehta

1. ***

2. Confirmation of minutes

Resolved on the motion of Mr Harris, seconded by Ms Wilson, that the minutes of the meeting of 21 November 2017 be confirmed.

3. Inquiry into support for new parents and babies in New South Wales

3.1 Consideration of submissions

Resolved on the motion of Ms Doyle, seconded by Ms Wilson, that the Committee publish the amended version of submission 13 in place of the original version.

Resolved on the motion of Ms Wilson, seconded by Mr Greenwich, that the Committee publish submission 38 in full following confirmation from the stakeholder.

Resolved on the motion of Mr Notley-Smith, seconded by Ms Wilson, that the Committee publish submissions 44 to 70 in full.

3.2 Site visit and public hearing arrangements

The Chair noted the draft witness list and invited Committee members to comment. Discussion ensued.

Resolved on the motion of Mr Greenwich, seconded by Ms Wilson, that the Committee invite the following stakeholders to give evidence at public hearings to be held on dates to be confirmed with members: Royal Australian College of Physicians; Australian College of Midwives; Child and Family Health Nurses Association; Tresillian; Karitane; fams; Volunteer Family Connect; Australian Breastfeeding Association; Playgroup NSW; Absec; Winanga-Li Aboriginal Child and Family Centre; People With Disability Australia; Early Childhood

Intervention Australia; YFoundations; Advocate for Children and Young People; Barnardos; Contact Inc; Australian Multiple Birth Association; Rainbow Families; PANDA; Royal Australian and New Zealand College of Psychiatrists; Australian Association for Infant Mental Health; Family Action Centre; Australian Research Alliance for Children and Youth (Right@home Partnership); Professor Virginia Schmied; NSW Ombudsman; NSW Health; Department of Family and Community Services; and Department of Education.

The Committee discussed options and arrangements for possible site visits.

Resolved on the motion of Ms Doyle, seconded by Ms Wilson, that Committee staff make arrangements for a site visit in the Sydney metropolitan and Central Coast areas.

4. Next meeting

The meeting adjourned at 2.04pm until a time and place to be determined.

Meeting no 14

9.49am, Monday 21 May 2018

Jubilee Room

Members present

Mr Conolly (Chair), Mr Harris, Mr Greenwich, Mr Notley-Smith, Ms Wilson

Apologies

Ms Doyle, Ms Cooke

Officers in attendance

Jonathan Elliott, Dora Oravec, Kieran Lewis, Mohini Mehta, Ze Nan Ma

1. Deliberative meeting

1.1 Confirmation of minutes

Resolved on the motion of Ms Wilson, seconded by Mr Greenwich, that the minutes of the meeting of 15 February 2018 be confirmed.

1.2 Consideration of submissions

Resolved on the motion of Ms Wilson, seconded by Mr Notley-Smith, that the Committee publish submission 71 in full.

1.3 Media orders

Resolved on the motion of Ms Wilson, seconded by Mr Notley-Smith, that the Committee authorises the audio-visual recording, photography and broadcasting of the public hearing on 21 May 2018, in accordance with the Legislative Assembly's guidelines for the coverage of proceedings for parliamentary committees administered by the Legislative Assembly.

1.4 Answers to questions taken on notice

Resolved on the motion of Mr Notley-Smith, seconded by Ms Wilson, that witnesses be requested to return answers to questions taken on notice and supplementary questions within one week of the date on which the questions are forwarded to the witnesses.

The meeting concluded at 9.51am.

2. Public hearing: Inquiry into support for new parents and babies in New South Wales

Witnesses and the public were admitted. The Chair opened the public hearing at 10.03am and after welcoming the witnesses made a short opening statement.

Dr Jacqueline Small, Director, Royal Australasian College of Physicians; Dr Elaine Burns, Executive Committee Member, Australian College of Midwives NSW Branch; Ms Julie Collier, Vice President, Child and Family Health Nurses Association; Ms Karen Dignam, Membership Secretary, Child and Family Health Nurses Association, were affirmed.

Associate Professor John Eastwood, Royal Australasian College of Physicians, and Ms Lyn Passant, Executive Committee Member, Australian College of Midwives NSW Branch, were sworn.

Professor Eastwood, Dr Small, Dr Burns and Ms Collier made opening statements.

The Committee commenced questioning the witnesses. Evidence concluded, the witnesses withdrew.

The hearing adjourned at 11.10am and resumed at 11.20am.

Mr Harris joined the hearing at 11.20am.

Associate Professor Jenny Smit, Director of Clinical Services, Tresillian, and Professor Cathrine Fowler, Tresillian Chair, University of Technology, were affirmed.

Ms Grainne O'Loughlin, Chief Executive Officer, Karitane, and Ms Sharlene Vlahos, Director, Education and Business Development, Karitane, were sworn.

Ms O'Loughlin and Ms Smit made opening statements.

The Committee commenced questioning the witnesses. Evidence concluded, the witnesses withdrew.

Ms Julie Hourigan Ruse, Chief Executive Officer, fams; Ms Kim Stace, Capacity Building Consultant, fams; Dr Jayne Meyer Tucker, Champion, Volunteer Family Connect; Dr Rebekah Grace, Researcher, Volunteer Family Connect, were sworn.

Dr Grace, Dr Meyer Tucker, Ms Hourigan Ruse and Ms Stace made opening statements.

Dr Grace tendered a document for the Committee's consideration.

The Committee commenced questioning the witnesses. Evidence concluded, the witnesses withdrew.

The hearing adjourned at 12.46pm and resumed at 2.04pm.

Mr Notley-Smith withdrew at 12.46pm.

Ms Kerry Moore, Executive Manager, Safety and Prevention Regional/Rural NSW & ACT, Barnardos, was affirmed.

Ms Moore made an opening statement.

The Committee commenced questioning the witnesses. Evidence concluded, the witnesses withdrew.

The hearing adjourned at 2.31pm.

3. Deliberative meeting

The Committee commenced a deliberative meeting at 2.32pm.

The Committee considered the schedules for the 28 May and 4 June public hearings and discussed options for rescheduling witnesses appearing on behalf of the Winanga-Li Aboriginal Child and Family Centre.

The Committee agreed to hear from the Winanga-Li Aboriginal Child and Family Centre representatives at 11am on Monday 4 June.

The meeting concluded at 2.37pm.

4. Public hearing: Inquiry into support for new parents and babies in New South Wales

The hearing resumed at 2.58pm.

Professor Alan Hayes, Director, Family Action Centre, and Associate Professor Kim Rae were sworn.

Ms Zoya Gill, Project Manager, Australian Research Alliance for Children and Youth; Professor Sharon Goldfeld; Professor Virginia Schmied were affirmed.

Professor Hayes, Associate Professor Rae, Ms Gill, Professor Goldfeld and Professor Schmied made opening statements.

The Australian Research Alliance for Children and Youth tendered a document for the Committee's consideration.

The Committee commenced questioning the witnesses. Evidence concluded, the witnesses withdrew.

The public hearing concluded at 4.03pm. The public withdrew.

5. Post-hearing deliberative meeting

The Committee commenced a deliberative meeting at 4.05pm.

5.1 Publication orders

Resolved on the motion of Ms Wilson, seconded by Mr Greenwich, that the corrected transcript of public evidence given today be authorised for publication and uploaded on the Committee's website.

5.2 Acceptance and publication of tendered documents

Resolved on the motion of Mr Harris, seconded by Mr Greenwich, that the Committee accept and publish the following documents:

- Document tendered by Dr Grace, Volunteer Family Connect
- Document tendered by Australian Research Alliance for Children and Youth.

5.3 Rescheduling witnesses

Resolved on the motion of Mr Greenwich, seconded by Ms Wilson, that the Committee invite representatives of the Winanga-Li Aboriginal Child and Family Centre to appear at 11am at the public hearing to be held on Monday 4 June.

5.4 Additional questions

The Committee discussed additional questions for witnesses. The Committee agreed to consider any additional questions submitted by members on Monday 28 May.

Discussion ensued.

6. Next meeting

The meeting adjourned at 4.20pm until 9.45am on Monday 28 May in the Macquarie Room.

Meeting no 15

9.53am, Monday 28 May 2018

Macquarie Room

Members present

Mr Conolly (Chair), Mr Harris, Mr Greenwich, Ms Wilson, Ms Doyle

Apologies

Ms Cooke, Mr Notley-Smith

Officers in attendance

Jonathan Elliott, Dora Oravec, Kieran Lewis, Mohini Mehta, Ze Nan Ma

1. Deliberative meeting

1.1 Confirmation of minutes

Resolved on the motion of Ms Wilson, seconded by Mr Harris, that the minutes of the meeting of 21 May 2018 be confirmed.

1.2 Media orders

Resolved on the motion of Ms Doyle, seconded by Mr Harris, that the Committee authorises the audio-visual recording, photography and broadcasting of the public hearing on 28 May 2018, in accordance with the Legislative Assembly's guidelines for the coverage of proceedings for parliamentary committees administered by the Legislative Assembly.

1.3 Answers to questions taken on notice and additional questions

Resolved on the motion of Mr Harris, seconded by Ms Wilson, that witnesses be requested to return answers to questions taken on notice and additional questions within one week of the date on which the questions are forwarded to the witnesses.

1.4 Additional questions for witnesses – 21 May public hearing

The Committee agreed to forward an additional question to Professor Alan Hayes. Discussion ensued.

The meeting concluded at 9.56am.

2. Public hearing: Inquiry into support for new parents and babies in New South Wales

Witnesses and the public were admitted. The Chair opened the public hearing at 10.00am and after welcoming the witnesses made a short opening statement.

Professor Marie-Paule Austin, NSW branch, Royal Australian and New Zealand College of Psychiatrists, was affirmed.

Professor Austin made an opening statement.

The Committee commenced questioning the witness. Evidence concluded, the witness withdrew.

Ms Nicole Bridges, NSW branch President, Australian Breastfeeding Association, was affirmed.

Ms Louise Duursma, Senior Manager, Consumer Services, Australian Breastfeeding Association, was sworn.

Ms Duursma made an opening statement.

The Committee commenced questioning the witnesses. Evidence concluded, the witnesses withdrew.

The hearing adjourned at 11.17am and resumed at 11.30am.

Ms Wilson withdrew at 11.17am.

Mr Andrew Johnson, Advocate for Children and Young People, and Ms Zoe Robinson, Chief Executive Officer, Yfoundations, were affirmed.

Mr Johnson and Ms Robinson made opening statements.

The Committee commenced questioning the witnesses. Evidence concluded, the witnesses withdrew.

Ms Vanessa Gonzalez, Co-Chair, Rainbow Families, was affirmed.

Ms Gonzalez made an opening statement.

The Committee commenced questioning the witness. Evidence concluded, the witness withdrew.

The hearing adjourned at 12.37pm and resumed at 1.48pm.

Ms Margie O'Tarpey, Chief Executive Officer, Early Childhood Intervention Australia, Ms Kerry Dominish, Board member, Early Childhood Intervention Australia, and Mrs Leonie Hazelton, Advocate, People With Disability Australia, were sworn.

Ms O'Tarpey, Ms Dominish and Mrs Hazelton made opening statements.

The Committee commenced questioning the witnesses. Evidence concluded, the witnesses withdrew.

Ms Sue Kingwill, Chief Executive Officer, Contact Inc, was sworn.

Ms Kingwill made an opening statement.

The Committee commenced questioning the witness. Evidence concluded, the witness withdrew.

The hearing adjourned at 3.02pm and resumed at 3.15pm.

Ms Wilson joined the hearing at 3.15pm.

Ms Ashlee Tenberge, Chairperson, Australian Multiple Birth Association and Ms Joanne O'Keeffe, NSW State President, Australian Multiple Birth Association, were sworn.

Ms Tenberge made an opening statement.

The Committee commenced questioning the witnesses. Evidence concluded, the witnesses withdrew.

Ms Karen van Woudenberg, Manager, Programs and Quality, Playgroup NSW, was sworn.

Ms van Woudenberg made an opening statement.

The Committee commenced questioning the witness. Evidence concluded, the witness withdrew.

The public hearing concluded at 4.05pm. The public withdrew.

3. Post-hearing deliberative meeting

The Committee commenced a deliberative meeting at 4.07pm.

3.1 Publication orders

Resolved on the motion of Ms Doyle, seconded by Ms Wilson, that the corrected transcript of public evidence given today be authorised for publication and uploaded on the Committee's website.

3.2 Next meeting

The meeting adjourned at 4.08pm until 9.45am on Monday 4 June in the Macquarie Room.

Meeting no 16

9.52am, Monday 4 June 2018

Macquarie Room

Members present

Mr Conolly (Chair), Mr Harris, Mr Greenwich, Ms Wilson, Ms Doyle

Apologies

Ms Cooke, Mr Notley-Smith

Officers in attendance

Elaine Schofield, Dora Oravec, Kieran Lewis, Mohini Mehta, Ze Nan Ma

1. Deliberative meeting

1.1 Confirmation of minutes

Resolved on the motion of Mr Harris, seconded by Ms Wilson, that the minutes of the meeting of 28 May 2018 be confirmed.

1.2 Media orders

Resolved on the motion of Mr Harris, seconded by Ms Wilson, that the Committee authorises the audio-visual recording, photography and broadcasting of the public hearing on 4 June 2018, in accordance with the Legislative Assembly's guidelines for the coverage of proceedings for parliamentary committees administered by the Legislative Assembly.

1.3 Answers to questions taken on notice and additional questions

Resolved on the motion of Ms Doyle, seconded by Ms Wilson, that witnesses be requested to return answers to questions taken on notice and additional questions within one week of the date on which the questions are forwarded to the witnesses.

1.4 ***

The meeting concluded at 9.57am.

2. Public hearing: Inquiry into support for new parents and babies in New South Wales

Witnesses and the public were admitted. The Chair opened the public hearing at 10.00am and after welcoming the witnesses made a short opening statement.

Ms Terri Smith, Chief Executive Officer, Perinatal Anxiety & Depression Australia, was affirmed.

Ms Smith made an opening statement.

The Committee commenced questioning the witness. Evidence concluded, the witness withdrew.

Mr Wayne Griffiths, Centre Manager, Winanga-Li Aboriginal Child and Family Centre, was sworn.

The Committee commenced questioning the witness. Evidence concluded, the witness withdrew.

The hearing adjourned at 11.13am and resumed at 11.23am.

Ms Lisa Charet, Executive District Director, Western Sydney and Nepean Blue Mountains District, Department of Family and Community Services; Dr Elisabeth Murphy, Senior Clinical Advisor, Child and Family Health, Ministry of Health; Dr Nigel Lyons, Deputy Secretary, Strategy and Resources, Ministry of Health, were affirmed.

Mr Mark Piddington, Principal, Sydney Distance Education High School, Department of Education; Mr Mike Tom, Leader, Rural and Distance Education, Department of Education; Ms Simone Czech, Executive Director, Department of Family and Community Services, were sworn.

Dr Lyons and Mr Piddington made opening statements.

Mr Piddington tendered a document for the Committee's consideration.

The Committee commenced questioning the witnesses. Evidence concluded, the witnesses withdrew.

The public hearing concluded at 12.58pm. The public withdrew.

3. Post-hearing deliberative meeting

The Committee commenced a deliberative meeting at 1.05pm.

3.1 Publication orders

Resolved on the motion of Ms Doyle, seconded by Mr Greenwich, that the corrected transcript of public evidence given today be authorised for publication and uploaded on the Committee's website.

3.2 Tendered documents

Resolved on the motion of Ms Wilson, seconded Mr Harris, that the Committee accept the document tendered by Mr Piddington.

Resolved on the motion of Mr Harris, seconded Ms Wilson, that the Committee publish the document tendered by Mr Piddington.

Discussion ensued.

3.3 Next meeting

The meeting adjourned at 1.08pm until a date to be determined.

Meeting no 17

9.07am, Thursday 15 November 2018

Room 1136 and via telephone

Members present

Mr Conolly (Chair), Mr Notley-Smith, Mr Harris, Ms Wilson, Ms Cooke

Members via telephone

Mr Greenwich

Apologies

Ms Doyle

Officers in attendance

Elaine Schofield, Dora Oravec, Kieran Lewis, Ze Nan Ma, Mohini Mehta

1. Confirmation of minutes

Resolved on the motion of Mr Harris, seconded by Ms Cooke, that the minutes of the meeting of 4 June 2018 be adopted.

2. ***

3. ***

4. Inquiry into support for new parents and babies in New South Wales

4.1 Correspondence

Resolved on the motion of Ms Wilson, seconded by Ms Cooke, that the Committee publish correspondence from Ms Simone Czech, dated 26 June, and Ms Sue Kingwill, dated 27 June, clarifying evidence they gave at public hearings on 28 May and 4 June.

4.2 Consideration of submissions

Resolved on the motion of Mr Harris, seconded by Mr Notley-Smith, that the Committee publish submission 28a with the name of an individual redacted.

4.3 Answers to questions taken on notice

Resolved on the motion of Mr Notley-Smith, seconded by Ms Wilson, that the Committee authorise the publication of answers to questions taken on notice by Professor Alan Hayes, Contact Inc, NSW Health and Yfoundations.

4.4 Consideration of Chair's draft report

The Chair spoke to the draft report, previously circulated. Discussion ensued.

The Committee agreed to consider the report chapter by chapter.

The Committee discussed Chapter One of the report.

The Committee agreed to amend the first sentence of paragraph 1.45 by omitting 'equally valued' and inserting instead 'equally prioritised'.

The Committee agreed to amend the last sentence of the Summary paragraph on page 13 by omitting 'should' and inserting instead 'could'.

The Committee discussed Chapter Two of the report.

The Committee agreed to amend the second sentence of the Summary paragraph on page 18 by omitting 'unless they have' and inserting instead 'even if they have'.

Chapter Three, read and agreed to.

The Committee discussed Chapter Four of the report.

The Committee agreed to amend recommendation 19 by omitting 'high priority' and inserting instead 'higher priority'.

The Committee discussed Chapter Five of the report.

Chapter Six, read and agreed to.

Resolved on the motion of Ms Wilson, seconded by Mr Notley-Smith, that:

- The draft report, as amended, be the report of the Committee and that it be signed by the Chair and presented to the House.
- The Chair and Committee staff be permitted to correct stylistic, typographical and grammatical errors.
- Once tabled, the report be posted on the Committee's website.

The Committee discussed tabling arrangements.

Members thanked Committee staff for their work.

The meeting adjourned at 9.35am until a time and place to be determined.