REPORT ON PROCEEDINGS BEFORE

COMMITTEE ON COMMUNITY SERVICES

SUPPORT FOR NEW PARENTS AND BABIES IN NEW SOUTH WALES

At Macquarie Room, Parliament House, Sydney, on Monday 4 June 2018

The Committee met at 10.00 a.m.

PRESENT

Mr Kevin Conolly (Chair)

Mr Trish Doyle
Mr Alex Greenwich
Mr David Harris
Ms Felicity Wilson

TERRI SMITH, Chief Executive Officer, Perinatal Anxiety and Depression Australia, affirmed and examined

The CHAIR: This is the third and final hearing of the inquiry of the Legislative Assembly Committee on Community Services into support for new parents and babies in New South Wales. Today the Committee will hear about the adequacy of mental health services for new parents and babies and support for Indigenous parents. We will also hear from witnesses representing the government agencies that provide services to new parents and babies. The first witness this morning is Ms Terri Smith from Perinatal Anxiety and Depression Australia [PANDA]. Ms Smith, before we commence do you have any questions about the process?

Ms SMITH: No.

The CHAIR: The Committee has read your submission so it is not necessary to go over that again. Do you wish to say something by way of a short introductory statement before the Committee proceeds to ask questions?

Ms SMITH: I would like to make a couple of points. Clearly PANDA's interest in this inquiry is around perinatal mental illness. This is a very common and serious mental illness that a lot of mums still do not know about, they do not acknowledge it when it happens to them and they do not seek help for it. We still have a long way to go to ensure that mums feel confident to reach out and to get help. Fundamentally, through our maternal health system we deal on a daily basis with physical health in a really positive and proactive way. But what we know through PANDA's experience, running a national helpline, is that there is a huge reluctance to address mental health issues in the same way as physical health issues are addressed. I guess from where we sit, because we are buried each and every day in the national helpline work, it is still a constant surprise to us that there are excellent health professionals out there who are very comfortable talking about gestational diabetes—for example, no mum will get through a pregnancy without being assessed, tested and having knowledge about gestational diabetes, which is actually less common than perinatal mental illness—but a lot of the terrific health staff out there are still struggling to feel confident to recognise perinatal mental health issues and to help new mums watch out for this issue so they can keep an eye out and get help early. We know that getting help early is the most important thing that can happen. There is no point in suffering longer than someone needs to.

I would like to say one last thing before we jump into questions. Again, from our position as a national service provider in this space, there is one glaring omission in the New South Wales service delivery sector—that is, the absence of any public mother-baby units. I know the Committee has heard about mother-baby units before but I could not sit at this table and not mention the importance of a service that cares for a mum's health alongside her baby's health. Removing a child from a mum at that stage in a baby's development is not only an unfair impost on a mum but also it is really bad practice—it is bad for the baby and it is bad for that connection between the mother and baby. Addressing a mum's serious perinatal mental health concerns at that stage with an inpatient admission is crucial but coinciding that with the baby is so important. I understand that it is not a cheap intervention but in the long term it is a cost-effective and humane intervention. It is going to pay off to allow the mum and baby to be together. It supports the whole family unit and accommodates dad as well—if dads want to stay over—because no-one wants to bring home a baby and be separated.

I do not know if any of the Committee members had the opportunity to see this. Serendipitously on the weekend there was a beautiful four-page story in the *Sydney Morning Herald* Good Weekend Magazine—when I say "beautiful" I say that with some reserve. Two of our community champions shared very explicitly their personal stories of postpartum psychosis. That is a horrifying illness and mums need to be aware that it can happen. The importance of a mother-baby unit for postnatal psychosis and also for severe depression should be noted—for example, in Victoria, where 25 per cent of the nation's babies are born, there are six public mother-baby units; in Western Australia, where 11 per cent of the nation's babies are born, there are two public mother-baby units; and in New South Wales there are still no public mother-baby units. I am very happy to take questions from the Committee.

The CHAIR: I am not going to ask about public mother-baby units because I will be asking the Government representatives about that later today. The Committee read in your submission that there is a high level of non-disclosure and a real challenge around women feeling free to confide in the practitioner or the person who is supporting them. To a large measure the whole process depends on self-disclosure to be able to help someone, but how do we overcome that challenge?

Ms SMITH: It is a cultural change that we are after. There are two key areas to consider. The first is as a broad community there is still a lot of stigma around mental illness. Now beyondblue has made enormous inroads into that but we still have some way to go. We have to acknowledge—this is what we hear every day on the phone—a mum who to be prepared to declare that she has a mental illness feels that she cannot be a good mum. She feels a real stigma about the potential for her child to be taken away. We have just been having a great conversation outside in the waiting room. I do not think there would be anyone sitting in this room who would not understand that if you were a young Aboriginal mum experiencing those feelings they could very reasonably think that someone might take their baby away because there have been generations of babies taken.

The Committee will probably be more surprised to know that we talk to women every day who look like the women in this room—they could be medical professionals or corporate lawyers; it does not matter because this illness does not discriminate. We are still surprised sometimes how very capable and competent women—women who have had very powerful work lives in some cases—will share the feeling: How could I possibly be trusted with a baby? It is very common to have feelings that you are never going to act on but feelings that you could hurt yourself or your baby and that your baby will be much better off without them. They are not rational feelings but they are feelings that can be associated with this illness.

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. That is a harder job but the job I think we can do is to address in-service training and pre-service training for the range of medical practitioners who mums come into contact with. Unlike lots of other illnesses or depression or anxiety at other points in life, this is a point in life where we know the mum is there and we know she is at risk—one in five of all pregnant women will be at risk. It is a big job to reconsider the way that we train health professionals.

Just as a by the by, we are based in Victoria and we do have support through the State Government to do active training with the maternal child nurses. Sadly, the Government came to us after some maternal deaths—mums can die from this experience; they can take their lives. The came to us and asked us to do some training and we do see a higher acknowledgement through our helpline of women whose maternal child health nurses have had the conversations.

Maternal child health nurses—Child and Family Health Service [CaFHS] nurses here in New South Wales; there are different names throughout the country to make life confusing—those staff have a great opportunity, as do midwives. We need to look at the antenatal period right from the start. No new mum should be introduced to the world of pregnancy without being aware of all the possibilities, including the possibility one to two mums in a thousand births will experience postpartum psychosis. Sometimes what we hear from those health professionals is the mums do not want to hear it. I get a bit frustrated, to be honest, about that response, because there are lots of things in life we do not want to hear about and there are lots of things that are good for us. Education is still key so that those health professionals can feel more confident about raising those issues. That, in turn, will help the mums take a step in to meet them.

The CHAIR: To follow up on that, apart from better training for practitioners is there a problem in terms of the process or structure that means not everybody is being asked or screened in a systemic way for this issue and is that related to the continuity of care that mums receive through the whole natal process?

Ms SMITH: There is no doubt where continuity of care is provided, and we know that is a patchy experience and certainly not only in New South Wales but across the country, there is more likely to be trust in that relationship. We do know that the Edinburgh score, the depression score, should be asked of all new mums during pregnancy and in the period after the birth. It is not universally applied and sometimes when it is applied what we hear from mums is that the nurses ask the first questions. The scale works through a range of questions and the pointy questions are at the end of the scale. Quite commonly, if you ask a question that says something like, "Well, you haven't thought about hurting yourself or your baby?" and you move on, that is not going to elicit an answer.

Continuity of care is really important. And there are opportunities to be recording in a consistent way. New South Wales has done some great work in perinatal mental health. I should have acknowledged that earlier. From our view the specialist perinatal mental health services are doing a great job, I think it is more in the generalist services. Once people get to the services, apart from the lack of mother baby units, there is some good work. The generalist services need to include GP care where general practitioners are providing care through the pregnancy.

The CHAIR: On a different tangent, I want to talk about the intensive services coordination and support program, which I understand is fundamentally delivered by phone. It is a remote service.

Ms SMITH: Solely by phone.

The CHAIR: How does that differ from other helpline structures, and how does it reach a bigger audience or have a greater effect than just having helplines available at various agencies?

Ms SMITH: I guess the essence of the helpline is that a mum reaches out to a helpline when she needs a helpline. In truth PANDA's general helpline has a follow-up service from that and some of the more local services in New South Wales also do some follow-up. 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. As importantly there is another part of the program which is around active service advocacy.

If you say to a vulnerable new mum, "There is a service over there that can help you," that is not going to work. If we say, "We've been on the phone to them, we've got you in, we've got this appointment arranged. How can we help get you there? We can call you the day of the appointment. We can call you and help sort through what is happening so you might make that appointment," being able to actively advocate to a whole range of services.

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 councillor 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. We could pull back. In the end our final step was we handed over to the CaFHS 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 CaFHS 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 has wasted an hour in a return trip to get to an office but a responsive service to a mum.

Mr DAVID HARRIS: I really like the How Is Dad Going? site at *www.howisdadgoing.org.au*. Through the inquiry we have heard about a lot of services that focus on mums and babies. On your site you have a heap of resources and links to other things. It is really good. How as a government do we do better at getting information out for fathers to understand that there is information out there that they can use?

Ms SMITH: That is a tough question. You will have noticed that we address the need to engage dads in future care. We are a little idealistic at PANDA, we keep dreaming big. We know every child is going to benefit from another parent or adult in their family, whether same-sex or extended family, it does not have to be a parent. Realistically there is dads in the vast majority of families in the country, most of whom want to be engaged. A lot of services just by naming cultural and system change—I will come back to where we started the conversation today. There is so much about the system of healthcare, and dads tell us consistently, that pushes them out of the services from the start. It was never about them.

I want to say up-front that women do have a crucial role to play—they carry a baby, they go through the hard yards there—but we as a community are going to benefit if dads are involved. We know from the data that around one in 20 dads antenatally will experience depression or anxiety and one in 10 after the birth of the baby. They will often exhibit quite different behaviours in response to that. We hear stories of inappropriate drug and alcohol use, gambling—I am reluctant to say violence. There is no evidence to suggest that violence increases with depression through this time. That said, we do know that the period when a woman is pregnant is when she is most at risk of family violence in her life. We need to bring dads in.

There is a terrific model running out of the University of Newcastle. Richard Fletcher and his team have introduced SMS4dads. I would absolutely encourage you to look to that model. It is a beautiful model. PANDA provides an escalated service. For full disclosure, we have a tiny role. Dads can enrol in that program at any time during the pregnancy and they start receiving messages from the baby, simple text messages on the phone that say, "Hi, Dad, I am this big." After the birth of the baby there will be texts about the things you would expect. There are texts about "the colour of my poo" and texts about "I am starting to think" this, and there are questions that say, "How are you doing?" It is those "How are you doing?" questions that give an opportunity for dad to speak. It is not only how they are doing it. Lots of dads really struggle, but it is okay to feel things and there is help around. It is a terrific model. It has just been rolled out in South Australia with the Government's support. It has been trialled and they are just putting the dots on the key first phase at this stage.

Otherwise it is about persistence. But it is also about starting to change systems. We talked about health professionals earlier. They have a great role to play in engaging fathers in projects. It is not easy. I have worked in public health for a very long time. Women get together and talk. I am making gross generalisations, but on the whole men do not step into those activities. We must engage them systematically. SMS4dads is the only effective system I have seen used so far. There is a couple of interesting groups around the country that are working on getting dads together. They are taking very small steps, and we need to encourage it.

PANDA's work with How Is Dad Going? started a few years ago because we were hearing from dads. The helpline definitely talks to dads. About 11 per cent of our calls come from men, and about half are about themselves and half are about their partners. We have been pleased to have a service that is open to dads, but we still find it much harder to find men to engage with. We need men to help us to do that work and we have about 250 community champions across the country. I will say generously that women and men share their stories, but in truth three are men the rest are women. If you know any men who would be willing to share, send them my way.

Mr DAVID HARRIS: Are you aware of any programs that specifically help dads to recognise depression in their partners?

Ms SMITH: Beyondblue did some new work last year on a healthy dads project with funding from the Movember Foundation. Again, we were an advisory party in that project. They produced some terrific online resources. That information is still beyondblue's presence in the family space. There is a lot of learning through that process, including that dads want very quick messages. That would be the obvious universal program. We work across the country and it is very big. Beyond that, I do not have knowledge of significant local projects. However, we do have a database and from time to time we hear bits and pieces about effective dads groups, but they are very localised and have not been extrapolated to a universal model.

Mr DAVID HARRIS: Would I be right in assuming that if male partners do not understand or cannot recognise depression that might lead to some issues and deepen the depression?

Ms SMITH: Absolutely. It is crucial. Depression will resolve for a small group of people who experience it. However, that is not true for the majority of people; it will continue to compound. Fathers whose partners are experiencing depression or anxiety are also at higher risk of experiencing depression or anxiety. Clearly, if a mum is experiencing it, the next question is how is their partner going. Knowledge is a really important thing. I started today talking about stigma. One of the ways we can break it down is by normalising these experiences. It is really common and it does not make you a bad parent; it makes you like one in five other parents.

Ms FELICITY WILSON: You said that with your intensive work you might work across different services such as government agencies, general practitioners et cetera. The Committee has heard from different organisations about fragmentation of the system. Do you have any observations or suggestions about how the primary universal health care system could be improved at the secondary and tertiary levels?

Ms SMITH: As an observation, when we first introduced a coordination program some years ago we expected we would support families, and we have done that. That is probably the program I am most proud of in our work. However, what we had not expected was the power of education in the work we do. We did not understand that we would have a great role to play in educating health professionals. We see an enormous amount of fragmentation.

A simple example is that if we call a woman's general practitioner to tell them what we were doing and how we are working with her and then talk about medication, we find that the general practitioner is paralysed and does not know what to do. They do not know that there are safe medications for the mum to use. We would say, "Well, there is this drug helpline at the local health service. You can talk to them." We are not going to give a general practitioner advice about medication; that is outside our scope. However, we will provide advice about the range of medications available and who they can call about them.

They would say that they had no idea and that it was fantastic. Of course, they will ring them and take the help when it is offered. We have been able to change practices. A really satisfying part of this for us is that sometimes we have the general practitioner on the phone telling us or writing, "You know that thing you did for so and so, can you do that for this patient?" We know that they are learning from us and sharing that information with others, but the fragmentation is very real.

We do have health professionals who are under a lot of time pressure. We all experience time pressure; we all have other things we could fit into every day. Each day we all make decisions about what we will address. We know that many of those health professionals will choose to address physical health rather than mental health. They often tell us that the fragmentation is exacerbated because they do not have knowledge. Again, we are a bit frustrated about that. For example, what does an obstetrician do if they think someone has a diabetes issue? They know how to refer; they know the system. The same systems apply.

Confidence is one of the things that gets in the way of a system working together well. We have health professionals doing a great job, but they do not like to confess that there is something they are not good at. That is how the world is; it is very complicated and there are lots of things for people to know about. We have been talking about this for 20 years in the health system. I am still surprised that we have the level of fragmentation we have. Sometimes that it is about federal, state or district funding systems where data is not working together. I think we still have great opportunities to have integrated health systems.

Ms FELICITY WILSON: One witness made the observation that some of the knowledge, training and confidence challenges can be generational. Do you have a view? Is the training of obstetricians and general practitioners improving, and do you think we will see that wash through the system? Or is there something else we need to do now for the training of new general practitioners and obstetricians versus those already in the system?

Ms SMITH: There have been significant improvements and there are some fantastic older practitioners who have been doing ground breaking work for years. In fairness, the newer groups coming through are getting very different training and therefore have greater confidence. As a consumer organisation, I must say that there is still plenty more scope in that training to engage a consumer voice. There is nothing more powerful.

If the Committee is interested, we have champions who would be happy to share their personal experience. There is nothing more powerful than telling that real story, particularly in terms of breaking down barriers. As I said, this is a very interesting illness because it does not discriminate. I cannot tell you how many of our community champions are health professionals, including CaFHS nurses and midwives. Some of them spend the entire pregnancy with their patients telling them they are going to be the best mum in the world.

Ms TRISH DOYLE: That segues nicely into my question, which is about recommendation No. 2. Thank you for coming along today. It is great to capture your wealth of knowledge and years of experience from everyone at PANDA within a short space. Thanks for your comprehensive submission as well. I want to ask a question relating to recommendation No. 2 about the importance of the consumer voice being heard, which is what you have seen over time. I am seeing a lot of women who are having less than satisfactory experiences in the public health system when having their babies. Whether it is that they have checked in with someone who is not quite sure where to refer them because there was some mention perhaps of screening for or diagnosis of mental health issues emerging or whether it is the many women—and this is the subject of some media attention at the moment—who feel they are being pushed out of hospital quite quickly after having their babies. The question is: Are they?

Obviously there is a clear need we have to address. I wonder whether those women do check in with their GP, a community service, their neighbour or someone on the phone at PANDA, or are they coming to me? I have seen an increase in the past couple of years of women who want to share their experiences of the health system. They are telling me that they would like, at each stage, to be able to feel and know that there is someone who understands, who they can check in with. I think that recommendation No. 2 goes directly to the need for training of health professionals and that training must include the consumer advocate.

The CHAIR: Can we get to your question, please?

Ms TRISH DOYLE: I also learnt recently that a small group has set up in my area called YAWN, You Ask, We Nurture. They made recommendations to a woman who was struggling with what they felt were mental health issues and referred her to PANDA. Through these phone calls, what number of women are you hearing from and touching base with about pre-existing mental health conditions and what are their stories telling you about the need for that consumer advocate?

Ms SMITH: It is probably important to understand that consumer advocacy is across a spectrum. We know in a health context that any patient—it does not need to be a mum and new baby—who can actively engage in the consultation, it will be a better outcome. Specialists, regardless of what their training is, cannot provide all the answers if they do not have the right answers to the questions, but they have to be able to ask the right questions. We know at that level that we need health professionals to be able to engage effectively with consumers. We know also that globally we need health systems to be effectively and routinely scrutinised in data to understand the outcomes. Outcomes are really important and outcomes need to take account of quality of life measures, not just cost factor measures.

There are some really interesting questions about women going home so soon after having babies. We do not have answers for those. We talk on a day-to-day basis with women who have had trouble sharing their experience with their health professionals. We were shocked when we had a look at our figures, which was 87 per cent of our callers. These are callers to PANDA. This is not 87 per cent of the community who had not shared their experience of depression or anxiety with their health professional, either midwives or CaFHS. More of them had shared their story with their GP, which was interesting to us.

Then there is the system as a whole. When new programs are being developed, it is really important that a consumer voice is engaged in that notion of what the service is going to look like. That it is not just health professionals saying, "This is what we should have." Most accreditation processes require some level of a feedback loop, some checking in. They can be more effective in some circumstances than others. This particular area we are looking at, because mums recover really well—we should take a second to say, "This is a serious illness." One of the best things about it is that women do recover and they will generally recover really well. They are there to share their stories and PANDA is able to facilitate that. There are local groups in New South Wales that can also do that.

Mr ALEX GREENWICH: On the importance of the consumer voice, and feel free to take this question on notice if you prefer, have there been successful models across Australia or good cases within New South Wales in which the consumer voice of someone with a lived experience of perinatal anxiety has worked really well and what support would you like to see from government to encourage a focus on the consumer voice?

Ms SMITH: I will give an example. In Victoria, we have been funded and are working with the Department of Education and Training, which is where our CaFHS nurses sit in Victoria. In any of the training we run—we run pre-service and post-service training—we engage consumers. We would never run training without a physically present person. We have some great video resources too, but I can tell you that each one of those sessions, the participants will argue that the best part of the training or the part of the training that was most likely to impact on their practice—because that is what we want to know, we want impact on practice. We do not want someone to have a good experience or be moved, we want to change what they do. I think it is 96 per cent of our respondents tell us that was the thing that was going to change their practice. We almost always use our health professional consumer advocates to do that because it is pretty powerful having a midwife say it to a bunch of midwives.

We ran some training in Sydney last week, by chance, which we do not normally do. It is a long story about why. It was with three hospitals in Western Sydney and in fact in one of those cases the mum had birthed in one of those hospitals. Several of the nurses took an opportunity to say, "I am really sorry that was your experience." That is a powerful motivator to change things.

The CHAIR: Thank you for appearing before the Committee today. We might send you some additional questions in writing if Committee members come up with some later. Your replies will form part of your evidence and be made public. Would you be happy to provide a written reply in those circumstances?

Ms SMITH: Yes, of course.

The CHAIR: Thank you very much. We appreciate your contribution to this inquiry.

Ms SMITH: Thank you for the opportunity. Good luck with the rest of your work.

(The witness withdrew)

WAYNE GRIFFITHS, Centre Manager, Winanga-Li Aboriginal Child and Family Centre, sworn and examined

The CHAIR: Welcome, Mr Griffiths. Before we start do have you any questions about the Committee process?

Mr GRIFFITHS: No. Before I do the oath, I would like to acknowledge the traditional owners, the Gadigal people, the traditional owners of this land.

[Speaks in Gamilaroi language]

I thank my grandfather for allowing me the opportunity to come here to speak the Gamilaroi language on their country, and I acknowledge their elders past and present and all the emerging elders that are in this wonderful town of Sydney and the Gadigal country.

The CHAIR: We have read your submission. We do not need you to go over it, but we would like to ask a number of questions. If you would like, you can make a short opening statement about something you would like us to know, and then we will dive in and ask questions.

Mr GRIFFITHS: I think we might dive straight in, if you do not mind. I might wind up quickly at the end, if that is okay with you. It may be different.

The CHAIR: Okay, we will do it that way.

Mr GRIFFITHS: It is a bit like an abattoir, we try to get through things quickly; kill the beast while he is still sitting at the table.

The CHAIR: In that case, I will ask you a question. We are all interested in how services can possibly be delivered to all the remote locations there are in New South Wales, given that some of them have substantial populations and some of them are very small, and there are significant distances between them. What model of service delivery do you think offers us the best chance of reaching mums and babies in all of those contexts?

Mr GRIFFITHS: Wow. It is a reasonably difficult question but I would probably sum it up in a few ways. For me personally, as the centre manager for Winanga-Li, one is that the whole focus we have is on infrastructure, because money is just not going to solve some of those problems—it will not work. But if the community—and I will use a couple of communities for example—our organisation is very fortunate to have won a tender to deliver services out of Lightning Ridge and Brewarrina over the next three years through Family and Community Services. Those two Aboriginal child and family centres have been shut for a couple of years now.

We are just about to reignite those two organisations and make them wholly and solely community focused so the delivery of the services is by people from the community and people who have resided there for many years—using the current infrastructure that is in their community, the services that are being delivered through other services or other organisations in the community, and bringing those into these Aboriginal child and family centres to ensure there is some quality output for a lot of those Aboriginal mums and the surrounding families in that whole area. If we are going to work with just one individual in the community or in a family it is not going to work. Our organisation takes a whole-of-family approach, which makes it so much easier.

Infrastructure within those communities such as Brewarrina and Lightning Ridge is absolutely crucial: somewhere to go to, somewhere to chat with someone, somewhere that when you walk through the door there is a friendly face and an introduction to whatever services may be available. If I look at Brewarrina, something like 1,500 people live in their community. The services out there are very limited. It is well known that it is one of the most disadvantaged communities across New South Wales for the lack of services there. Recently we have paid some visits to the community. Even with their childcare centre that should have been opened three years ago, they are undergoing some significant renovations because of the lack of due diligence from the company that constructed the centre. The repairs that are being undertaken now delay that process for another six months, so our organisation will be delivering some interim services pretty much on the ground, through a park or through another organisation that we may get invited to attend.

For me alone it is the human resource for people at the coalface to be there and have some really well-constructed, culturally appropriate infrastructure for people to work out of. And also not forgetting that in within those communities there are also a lot of non-Aboriginal people that are suffering. If I look at the Wee Waa community alone, we partner with the local church out there. Over a period of a fortnight the church is delivering Foodbank services to some of the farmers to the value of around $1,000 per fortnight. Some of those farmers are really crippled. So for the Aboriginal community itself, the services that we deliver out of there, especially some of the antenatal and parenting programs, are non-existent.

The CHAIR: To pursue that line of reasoning, it would be wonderful if we had unlimited buckets of money, but no government ever does, so we could not put a child and family nurse in every single little village or hamlet on a full-time basis. But if we did have that bucket of money, would there be the people to hire? Is the workforce available amongst people who are culturally aware and able to provide that? If we were looking for Aboriginal-trained child and family nurses, would they be out there to recruit?

Mr GRIFFITHS: You will never know until you commit to giving the bucket of money out there. If you look at Family and Community Services themselves, in our district alone over $116 million goes into out-of-home care and permanency care. Our organisation gets $500,000 of that. We deliver services to 28 local government areas across our region and we provide eight different programs on that slim amount of money that we receive. It is about having a review of that whole process. If I can sum it up this way, we run an Aboriginal child and family centre. We have 35 children that attend our centre every day in a long day care service. We did not have the community people trained and skilled enough to run that service alone. We deliver services to over 1,000 Aboriginal people every three months. 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 community management. To answer your question, you will not know until we go out there, but as far as I am concerned there are people—

The CHAIR: It sounds like you trained them yourselves or brought them through yourselves.

Mr GRIFFITHS: If you create your own work base and establish that in the centres or in those communities, there are people there. You just have to provide the facility and provide the infrastructure for that to happen. If you look at the outback division of Health, the Royal Flying Doctor Service flies in to Lightning Ridge on a monthly basis. They deliver certain services. By the time they come back, those people are still ill. There are additional people who do not get served. If you look at a town like Gunnedah, where I come from, you cannot get to a general practitioner for over three weeks. We live in a community of 10,000. But with Brewarrina or Lightning Ridge, no-one knows how many people live at Lightning Ridge. There are people living out in camps all over the place.

I was talking to a community member out there last week who had to ring an ambulance and he is out on a mine site. There are no streets on the mine site so he has to advise the back to base ambulance: "I'm at red car door, tourism plot No. 5." So they have to go out and find this red car, drive up through the camps, and this guy is trying to explain to them where he is at. They were lucky there were a couple of guys who said, "Don't worry about it. We'll just drive him in to the hospital."

To answer your question—I know I have danced around a little bit like John Travolta—in the whole system to that there is no-one prepared to back the communities themselves. We are going to be fortunate enough to have that infrastructure in those two centres out there, so we will be asking community services and the other services that deliver to come along and deliver their service out there. We will create a position or positions in those services for community people to attract those professionals into the community, which is difficult to do. Royal Flying Doctor Service has to come in there. But where there is a way there is always the will of the people to do that.

The CHAIR: I will float one model quickly. If you had staff who could go out into different towns and they would have a roster of one day a week in five different locations, so their week was spent going to that, would that work for some of these smaller remote communities to have face-to-face access to somebody on a one day a week basis rather than come in to the bigger town?

Mr GRIFFITHS: Yes. We already do that. 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. Sometimes they are there at certain times. That system has worked wonderfully for us.

Mr ALEX GREENWICH: Thank you very much for coming in today and for the awesome work that you do. Could you take us through any success stories of supporting mums with mental health or substance issues and where the funding and support gaps are which, if filled, would help you to continue those success stories?

Mr GRIFFITHS: I probably cannot tell you about the support gaps because I would be here for a couple of days, and I am sure we do not want to be hanging around here for a few days.

Mr ALEX GREENWICH: Sure.

Mr GRIFFITHS: 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 Family and Community Services 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.

Absolutely, positively no-one was talking to this mum. The partner and the mum were significant drug users—especially the dad. We became involved when they got back to Gunnedah and Family and Community Services 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. Obviously we did have a room. 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." So we went back over.

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 Family and Community Services are now supporting. The whole process from the beginning was a great relationship with FACS. That is one of very few. 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. By the time the six months is up, she will have a significant amount of credit. Now that the new childcare system has changed she will be eligible for a little bit more childcare benefit and childcare rebate under those conditions. On the other hand, it is driving some of our other parents away from child care.

That is a fantastic story it is a credit to the staff members that have worked heavily with that family. It is a real credit to FACS. Those stories are few and far between. If I can use an example, we have progressed about five situations like that. I can tell you of a few others where there were tragic circumstances but there have been some really good outcomes. The kind of money that is poured into the removal and placement of children with other NGOs it is very significant. We are not funded to do that service. It is not in our program level agreements, but we do it because we are the only Aboriginal organisation that, as an NGO, can make decisions and we are in within our right to do that.

The partnership was great, and there have been some other instances in relation to that. There was a tragic situation just recently, where a mum had not had access to any pre-natal or antenatal services. She had not been to a general practitioner. She lost the baby. They had to send her immediately to John Hunter Hospital. The baby only survived for a couple of hours. She should have had access earlier. The baby was born with significant disabilities. She could not pay for a funeral. We had to pay for a funeral. There is just none of that service out there in our communities. It is a terrible situation. It also highlighted to us that there is more work that we have to do in that whole space. It was horrible for mum but now our staff members out at Narrabri—we have small house that we rent out there—are getting that mum off to some mental health counselling. They are getting the dad, through our Aboriginal fathers project, off to some other mentoring and counselling, too. The services that we wrap around those families are really crucial. It is not much good staying in their lives for six weeks. It will not work.

Ms TRISH DOYLE: Thank you so much for your honesty, Uncle Wayne—I presume that is what your name is out in the western parts that you travel around—and for the work.

Mr GRIFFITHS: Some say that.

Ms TRISH DOYLE: Thank you for your honesty and for being here today to talk to us. There is so much to cover in a short period of time so I appreciate you being here and the work that you do. I imagine that there is some really tough stuff that you and your team see. I am looking at some of the examples you have given in your submission of the programs that are doing good stuff for communities that are in isolation or have suffered the impact of intergenerational trauma. So there is a whole lot of added needs for parents with newborns.

From your submission it seems that earlier intervention would help. I just thought you might like to comment a little bit on the programs that you say need extra time and extra resources, including human resources. They might go for a year or six weeks. For example, Gunawirra and the Young Aboriginal Mothers Program and the Tree of Life program look fantastic, but they only go for really short periods of time. What in your view, and from what you are hearing from families, would be a more appropriate length of time to make that generational change in supporting that next lot of Aboriginal youngsters to play a role in their communities? Is it three years or five years? What is your view?

Mr GRIFFITHS: Lifelong support, from the beginning. Early intervention is 100 per cent the answer to a lot of the issues. It is quite often not delivered in our area. There is a lack of it. I am not being critical of Family and Community Services but a lot of other services wait until there is a crisis within a family and then they will ring or say, "Can you guys come and help with this whole process." It is incredibly difficult to achieve an outcome when a family is at significant risk of losing children. There had to be some identifiers in the beginning. Seriously? We pay professionals in various fields to do that—to identify these issues. They are paid a significant amount of money. Some of them just do not do their jobs. To be blunt, they need to get up off their arses, get a shovel and start digging—start helping out.

When you look at that whole process you see that the whole intergenerational issue starts way back. We cannot change the past but, by Jesus, we can learn from it. Each week as we go on—even from 2015 through to 2018—there have been significant inquiries into closing the gap and, in New South Wales the overrepresentation of Aboriginal children in the child protection system. Have a look at that. Have a look at the children that have been removed. We are currently working with a family where the kids are nine months old to nine years old. We are working heavily with the mum and dad. We cannot work with the kids because they are currently with another NGO, Challenge. So the services that we can offer to that in terms of facilitating even some supervision back to the parents depend on whether or not those guys want to be nice to you. Quite often they are not, but that is just the way it is structured out in those regional areas and it does not work for a lot of families.

The way to change intergenerational change, the way to change the whole system, is to have some human resource and some people who have an ability to say, "Well, hang on, we are not going to do it this way." If you look at the legislation—and Family and Community Services changed the legislation— and their report into 1,000 children that were removed a couple of years ago, how many children do you reckon have been restored? Not many. I can guarantee you that, because we were involved in part of that process. I know of one family in Gunnedah where the children have been restored. You know what? It has now gone up another 6 per cent that Aboriginal children have been removed in New South Wales faster than the other States in this country. In the north-west district, in the New England district I should say, we are at the highest level.

Some of those problems are contained within the system itself. If they can change the way that system works and allow an ability for people to communicate at another level, it would be so much easier, certainly for us and for other people. There is a certain due diligence that a lot of organisations must follow. Let us have a look at that. Has it really worked? I think not. I will be really blunt and honest, convincing politicians of that is sometimes a bit hard. It is very difficult to do. If this Committee has some influence to that, I would absolutely and strongly urge you to take that message through, if you would please. Look at our submission but do not just believe me. Come out and have a look—we will take you around and show you.

Ms FELICITY WILSON: I will start with one of the stories that you told us. There are two things that I hope you can present an opinion on. One was a mother not accessing any universal health services early on or at all during her pregnancy. There was obviously a story there—both good and bad—about Family and Community Services and how there was a bit of change in how that worked. We have heard other times that there is often a reluctance to access different government services, even health services, and that there might be some fear, trauma or stigma. Is that your view as well, or do you think there are other reasons why? When we have a universal health service or if we have some options for early intervention and support services, why are people not accessing it?

Mr GRIFFITHS: You will never ever be short of an opinion from me, to be quite honest. To look at that whole process, a lot of services are just too clinical. The absolute classic example was last week when we visited Lightning Ridge with a senior person within community services, because there is currently some services that are being delivered out of there by the outback division of Health—and I am not criticising them one bit whatsoever. When we walked through the door, there was not an Aboriginal face. It was an Aboriginal child and family centre and there was not an Aboriginal face within the reception at all. There was a lady there—a really nice and lovely lady. But she had a thousand keys on her. So everybody had to ask her. We had to ask, "Can you open this door so we can go through this one?" or, "Can you use your card to swipe this one?" In the finish, we ended up calling her the key-meister. Unfortunately for me, to take our services out there, we are only going to be caretakers of our community for three years. So we have got three years to set up an infrastructure that is going to be really soft entry points for not only Aboriginal families or vulnerable Aboriginal families but vulnerable non-Aboriginal families too that need that assistance and a leg-up.

I know I have dodged your question a little bit, but to be really blunt, Aboriginal people will not go into those services for the fear of reports. If you look at the coffee shop across the road, the lady over there is probably a mandated reporter. That is the way Aboriginal people look at it. Whenever you go to any professional service, everyone is a mandated reporter. If they go in and say, "Look, since this has happened, this has happened, this has happened", they will make a report. Whether it be to the cops, whether it be to Community Services, to a caseworker or to the hotline. Once that mandatory report is done, it is hard to come out of it. Once you are in the system, it is extremely difficult. Once you are entrenched in the child protection system, it is not one that you want to be in. It is very difficult for a lot of families to convince any caseworker who may say, "Well, you need an open plan."

To give you an absolute classic example, two caseworkers will rock up to your house, they will have an open case plan, and they will say ,"If you don't sign this today, this could happen. You are at risk of losing your children. If you don't sign this, this will happen." We challenge those caseworkers, "Why did you say that? This child is not at risk at home." They say, "Well, hang on, we got a report saying this." Some of those reports sometimes over the hotline are fabricated. Where is the true evidence in that report? It is only when whoever it may be attends that office. It drives people away from that whole system. That has been happening for a heck of a long time. Also it is the lack of ability for people. Some people just have not got a motor car. They cannot get there to travel a long distance.

I know great old chaps out at Mungindi called Ronald Prince and Jeffo Prince. We ran some services and a program out there a few years ago. We still deliver services to that community now. There is an organisation in Moree that is supposed to visit that community on a regular basis. It was Jeffo who said to me, "We haven't seen them for a couple of years. This is the first time we have seen them." It is because we had a whole-of-organisation approach. There were four or five organisations that went out that day and provided some services to the community. We do that on a regular basis. The remoteness is so difficult. To go from Gunnedah, generally you will not get an appointment with the paediatrician, so we have got to go to Narrabri. The paediatrician has got to fly in from Armidale to Narrabri or he flies in to Moree.

The alternative for us is to drive to Armidale. It is only 2½ hours up the road but in winter the roads are not the best in terms of ice on the roads. It is a full day to do that. Generally we would do two or three parents to get access to that paediatrician. What I am talking about there is specifically children who possibly would have an undiagnosed disability. We have 12 of those in our service at the moment where we cannot get to a paediatrician or we have had numerous paediatricians. You would have noticed in our submission that the Ability Links program that we run, it is difficult to get access to that. When you do get an open plan through the National Disability Insurance Scheme—one absolute classic example is one of our children with a cochlear implant who pre-NDIS plan had 26 hours access to health professionals within Hunter New England Health. That is on a quarterly basis. He now has 12 hours a year access. So it was pointless him getting on the NDIS, absolutely pointless in getting a plan. My point is that some Aboriginal people can get along to those health professional services and by the time they go back the cycle has started again.

Mr DAVID HARRIS: Thank you for the acknowledgement of country at the start of your evidence. I have travelled out that way a fair bit. I will drop in and say hello next time I am out that way.

Mr GRIFFITHS: You are welcome. We will certainly make a cup of tea for you.

Mr DAVID HARRIS: I have been to Moree so I understand what you are saying about the distances. Where are mums going to have their babies?

Mr GRIFFITHS: We are fortunate enough to have Kevin Anderson as the politician out that way. He does a fair bit of work in the community. Gunnedah hospital has just got a significant grant to have the whole birthing area at the hospital revamped and what not. That has been hanging around for a fair while but there is no money to get those mums to it. What is the good of having a maternity ward if none of them are going up that way?

Ms TRISH DOYLE: Is there any staff at the hospital?

Mr GRIFFITHS: Yeah, there is staff out there—when they are not rude they can be out there. Why do they not just put some of the resources where we can actually say to the mums, "This is how important it is for you to get there, otherwise we will have to go to Tamworth." It is really crucial that this happens on the ground. Putting $750,000 into that is fantastic, wonderful, great for the community but if none of the mums are using it then what a waste.

Mr DAVID HARRIS: Are there any Aboriginal midwives in your area?

Mr GRIFFITHS: The only midwives I see are the ones on television in *Call the Midwife*. That is the only midwife I see. No, we do not get a lot of them. There are some Aboriginal health professionals out there—Gena and June. Those two ladies do a great bit of work at the hospital but they are interacting through the general practitioner, which is really good. I know that Gena does some work with them—North West Medical—and June has been at the hospital for awhile. They do some lovely work with some of the Aboriginal mums who do go up to the hospital. There is our local Family Support Program—Gunnedah Family Support—that do get some of the ladies go in but they are only allocated X amount of hours. I think it is something like six weeks that they are allowed to work with those mums and basically they say to the mums at the end of it, "Sorry, you cannot come back any more."

Mr DAVID HARRIS: I have a lot more questions but I might come out and have a visit.

Mr GRIFFITHS: That would be good. Just rock up.

The CHAIR: Mr Griffiths, you wanted to make a few comments as a finishing statement.

Mr GRIFFITHS: I tell you what, I have talked too much I think. Just reiterating, a lot of people come to our community. We have had Nigel Scullion and Barnaby Joyce—we all know that he is not the flavour of the month with everybody at the moment, especially the ladies—but it is not much good of people coming and promising anything. That is just not going to work. My appearance here today is really a plea to you guys. I really did have a think about if I should come. We have to drive 5½ hours to get down here and I hate the city. Then we have to go home. But I thought the only way to make a difference is to put our case forward. I really do hope what I have said here today that you guys do take to heart. I can only see by your faces that you are interested and willing to make a change. It only requires one person. Obviously one person can sing a song and two people are a duet but if you have got a choir you cannot go wrong. A choir makes enough noise for people to listen so please do that. Thank you.

The CHAIR: Your contribution today will certainly help our inquiry.

Mr GRIFFITHS: It was a pleasure.

(The witness withdrew)

(Short adjournment)

ELISABETH MURPHY, Senior Clinical Adviser, Child and Family Health, Ministry of Health, sworn and examined

NIGEL LYONS, Deputy Secretary, Strategy and Resources, Ministry of Health, sworn and examined

MARK PIDDINGTON, Principal, Sydney Distance Education High School, Department of Education, affirmed and examined

MIKE TOM, Leader, Rural and Distance Education, Department of Education, affirmed and examined

SIMONE CZECH, Executive Director, Department of Family and Community Services, affirmed and examined

LISA CHARET, Executive District Director, Western Sydney and Blue Mountains District, Department of Family and Community Services, sworn and examined

The CHAIR: I welcome each of you here today to help us with our inquiry into support for new parents and their babies in New South Wales. Does anybody have any questions about the process? The Committee thanks you for your submissions. I understand each department would like to make a short separate introductory statement and following that members of the Committee will grill you with questions.

Ms CZECH: On behalf of Family and Community Services I can indicate that we are not intending on making an opening statement.

Dr LYONS: Health does have an opening statement. I will start by acknowledging the traditional custodians of the land on which we meet today, the Gadigal people of the Eora nation, and pay my respect to the elders past, present and emerging. The New South Wales public health system is world class. It is the biggest public health system in Australia and the country's largest healthcare employer, with more than 114,000 full-time staff. This system works towards supporting the almost 100,000 babies that are born each year in New South Wales. We have 75 birthing units and 410 child and family health services delivering high-quality care to mothers, babies, children and families across the State.

We have targeted services for Aboriginal communities, including our flagship Aboriginal Maternal and Infant Health Service that provides culturally safe maternity services at over 45 sites across New South Wales. In 15 locations we have Building Strong Foundations programs, which are culturally appropriate child and family health services. Most are collocated with the Aboriginal Maternal and Infant Health Services providing continuous care for Aboriginal families in pregnancy up to when a child is five years old.

New South Wales prides itself as being a national leader of maternity and child and family health services in Australia. New South Wales was the first State to introduce Statewide Infant Screening - Hearing [SWISH], which is a universal hearing screen for new babies. Last year we screened approximately 99 per cent of all babies born in New South Wales. The latest data for the free Statewide Eyesight Preschooler Screening [StEPS] program shows 80 per cent of all four-year-old children were provided a test. In addition, New South Wales has introduced universal health home visiting where all new parents are offered a home visit by a child and family health nurse in the first few weeks of the baby's birth. Out of all of the eligible babies for the home visiting program in 2016-17 approximately 83 per cent received a universal health home visit.

Currently, we are leading a National Collaborative Network for Child Health Informatics. This work is across jurisdictions as part of the Australian Digital Health Agency. An example of this is the digitalisation of the Blue Book, which we have had for many years in the paper form, or the child personal health record. As a result of this work the service providers, regardless of jurisdiction, will have real-time information about each child's health status, their immunisation status and their interaction across the entire health system.

New South Wales takes a rigorous approach to the development and implementation of policy and programs that are informed by the best available evidence. For vulnerable families, New South Wales has implemented nurse-led home visiting programs for families from pregnancy until the child is two years old. An example of this is the Sustaining NSW Families program, which provides 1,280 funded places across eight sites. With our partners, the Department of Family and Community Services [FACS], we have expanded this service to a new site in Wollongong and the three existing program sites to target families receiving social housing assistance.

The Ministry of Health is in the final stages of drafting a new strategic policy document for the early years of life. This new framework will draw on a strong and growing body of evidence about the vital importance of the first 2,000 days of life for health and wellbeing across the lifespan. This framework will support the system we have in place of proportionate universalism, where every family in New South Wales has access to primary universal health services, with some families needing more resources and support proportionate to the level of risk and need. We know that when new parents and babies are able to access the services they need when they need them they will thrive.

In conclusion, we have enviable universal health infrastructure to support all families, and with targeted services to support those families with greater need. We are working at a national, state and local level to ensure that all families are provided with care that is connected, world-class and responsive to the health needs of parents and babies. While we can be proud of our extensive network of healthcare services, we acknowledge that there is much more that can be done to meet the current and emerging needs of our communities. We welcome the opportunity this inquiry provides to highlight where our future efforts may be redirected or enhanced to access care and support.

Mr PIDDINGTON: Thank you for the opportunity to speak about what I think is a fabulous success story for public education. As principal of the Sydney Distance Education High School, which is a few minutes walk across the park in Woolloomooloo, I have prepared a document containing information about how we support pregnant girls and young parents, and in particular the 240 we have supported over the past 13 years.

The most exciting thing I would like to leave with the Committee is our film, which can be seen on our website. It is called *Learning for Two*, and it is a wonderful reflection of our how our students are supported. I will leave that with the Committee and also the document, which summarises what we do. This is a small but very important part of our enrolment. It is 1.5 per cent to 3 per cent or 4 per cent of our enrolment, but normally about 2 per cent. However, it is extremely important to every student, their baby, their family and their extended families and to our school community.

The CHAIR: I had a lot of questions primarily targeting health. However, having heard the previous witness, I will ask FACS a pointy question. One of the real difficulties the Committee has heard about in submissions and in testimony is the fear of having children removed preventing people coming forward and identifying issues they may have and seeking support. We can all acknowledge that that is a conundrum. Children absolutely need protection, and if they are in situations where FACS must intervene no-one would argue that that must not happen. How do we grapple with the fact that that also drives people away from accessing the help that might prevent the child removal being necessary in the first place? The previous witness said that sometimes phone reports are not genuine—they are vexatious or invented—and that the first response to a report is that FACS staff come to the parents with a plan and they are told that if they do not sign they will be at risk of losing their children. I hope there is an intermediate step before that happens. Can you talk about that?

Ms CZECH: When someone rings our child protection hotline, which is the central point that someone can ring with concerns about a child or a young person, we use structured decision-making tools to determine the level of risk. We want children to remain living safely at home where that is possible. For the first time last financial year we had 900 fewer children enter care. Normally about 2,900 children[1] come into out-of-home care each year, and it was 900 fewer last year, and we are on a similar downward trend line this year. That tells me we are getting much better with our diversionary programs, including child protection, in providing services to families. It is not only about child protection caseworkers within FACS but also the services that we fund, within the non-government sector in particular.

We have a range of programs and $131 million has been invested in what we call Targeted Earlier Intervention. It is currently undergoing a reform process that is looking at how we meet unmet need at that earlier stage of prevention rather than when a child is reported as being at risk of significant harm through the helpline. That will do two things. First, it will meet the greatest need in the community. I saw reference in some of the Committee's submissions to providing much greater flexibility in contracts for non-government organisations to deliver services in an innovative way that meets outcomes for families.

We also have a range of evidence-based services we are trialling under the Their Future Matters reform, which is a whole-of-government to response to the "Independent Review of Out of Home Care in NSW" done by David Tune a couple of years ago. Those two programs in particular involve multi-systemic therapy, which has an international evidence base in helping families to resolve risk where it is presenting itself. Secondly, we have Functional Family Therapy. They are two slightly different models, but they are embedded in significant evidence and program history that can help parents to make the required change.

The Government has provided $64 million for the Brighter Futures program, which is aimed at children who have been reported as being at risk of significant harm but at a much lower level. Again, we are trialling

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[1] See Ms Czech's letter clarifying her evidence, published on the Committee’s website (Inquiry: Support for new parents and babies in New South Wales, Other Documents)

evidence-based programs focusing on building capacity or parenting skills using the SafeCare Model. It is an 18 week to 20 week program that helps parents to build their general parenting skills so that they can keep their children safe.

Ms CHARET: I will provide some local examples. I am fortunate to look after Western Sydney and the Nepean-Blue Mountains. I have incredibly strong relationships with my colleagues in the various services and agencies, particularly with Danny O'Connor, who is the head of Western Sydney Health. This is something we have talked about. I absolutely agree, particularly with regard to Aboriginal families. We are still "the welfare". My dream is that we pull up and people say, "Thank God, I'm going to get help." However, that is not the reality.

We have put in place a couple of things that I believe are effective, and we now have an evaluation from Western Sydney University confirming that. One is called Pregnancy Family Conferencing. As soon as we know a mum is pregnant, we go to talk to her or to her family and tell them our worries. We ask how they feel and what we can do to help. In that way, when babies are born we have been working with them all the way through the pregnancy to resolve our worries and to prepare them. As of now, 75 per cent of those babies who would have been removed are going home and are still at home a year later with no risk-of-harm reports. We have also started Making a Safe Home [MASH]. The premise for that is how much we spend putting a kid in care. Why not spend that keeping a kid at home? That is mainstream.

We did not set out to target Aboriginal families, but more than half of the families in the MASH program are Aboriginal. I will provide a couple of examples. One was a young woman who had three children removed. She grew up in care and had one of the most horrendous histories I have ever seen. As a result of an assault, she became a paraplegic. We met her when she was pregnant with her fourth baby. She spent the first three months using very colourful language to tell the caseworkers to go away because she was scared. People might appear hostile, but they are scared, as I would be. She finally gained a level of trust. That baby it is now two years old and is happily and safely at home, and there have been no risk-of-harm reports.

Another Aboriginal family had eight children removed, and we met them when they were having their ninth. Again, they had never been parents; they had never parented a child. They had no idea how to be a parent. We moved a mother craft nurse into the home full-time, 24/7, and tried to work with them. They were very willing to work. The motivation was the hope. They took their bub home from hospital and they worked with a nurse until they could work out how to attach, how to bond, how to feed, and all of that. We stepped it down and stepped it down. They have gone on to have another child. I think that was three years ago. They are the families who came into the program first. That is still happening and often a pathway from the pregnancy family meetings is in-home care to divert them from out-of-home care and provide support.

The CHAIR: Can I read into that that the drop from 2,900, on average, probably to around 2,000 is primarily due to greater support given to families who are now more successfully parenting rather than any other screening change or anything like that?

Ms CZECH: It is fair to say we pulled it apart as much as we could and completed some analysis of the why. If something is working, of course you want to replicate that. We have found that it is multiple factors that are leading to that decrease in children entering the system. Ms Charet has spoken to some of their initiatives. There are a couple of other things in particular that I think are important to mention. One is that we recently—about 12 months ago—for the first time ever introduced a practice framework for our staff, which is about dignity-driven case work. When a caseworker interacts with a family, they do that in a way that is respectful, it is considerate, it is aligned to our legislation policy and procedures and strives to one of our core objectives, which is helping children and their families reach their potential. That framework, in essence, has been helpful for our caseworkers to set a context.

The other key driver decreasing the number of children entering care has been the use of family group conferencing. We introduced that in 2014 for the first time. Family group conferencing is a model that we picked up from New Zealand. There are various models around the world. They have proven to reduce the number of children entering care, but, more importantly, they have helped mitigate risk factors in families and also keep children safe. That involves an independent facilitator bringing all members of the family together. It could be extended family, members of the community—particularly for Aboriginal families that we work with—and developing a family action plan. That involves speaking openly and transparently about the presenting issues. The family and the child protection workers come up with a plan for that family. That is strengths-based and is focused on keeping the kids home, where we can possibly can.

The CHAIR: I will go back to the health representatives and to the universal level of service that the inquiry started out with. I heard you say 83 per cent of families receive a universal visit. Why is it not closer to 100 per cent and are we missing the 17 per cent that we might want to be most reaching? Secondly, is one visit enough in any case or is this part of the fragmented approach when it would be better to have a continuity of care that went beyond that?

Dr LYONS: It is important to acknowledge first and foremost that we are part of an overall health system. When I talked about the services that NSW Health offer, we need to put in context that the New South Wales public health system is not the whole system of healthcare delivery. We have a range of general practitioners. We have people working in private practice. We have a range of non-government organisations that are also involved in providing health service delivery. We see this as being a continuum. This is part of the challenge. The complexity of the number of people involved in providing health care and continuity of care are things that often come up, but we do not see it revolving around just one home visit. This is a continuum from the time that people find they are going to have a baby all the way through the care and support that is provided. This will include general practitioners who might be involved in that initial period when somebody finds out that they are going to have a baby and then connecting to the services that provide the appropriate support. Along the way there are also clinical assessments around the level of need, assessments of risk, and tying services that are available locally into the support for the family as well as the mother are very important.

The challenge for us in a universal health system and with the geographic coverage that New South Wales has is that the range of services that are available vary in different communities. The context in which we are offering services is really important as well. There are large distances often when we go to rural and regional environments and the specialist services may not always be available in that local community. It is about providing the best support we can for the local practitioners through supports and connections with the services, but also using telehealth and other mediums and technologies to support those practitioners in those local environments, and, wherever we can, connecting people with those supports so that they can access the services they need. The assessments that are made allow the appropriate referral on.

This is a challenging area. We have highlighted in NSW Health the need to do a lot more in this space. We recognise that the connections, particularly with the primary care sector, are critical. At the moment we are working with the primary health networks at the local health districts who are our service providers working with the primary health networks, which are the Commonwealth equivalent, with GPs and other primary care providers and starting to look at how we deliver services across the continuum with a focus on prevention, early intervention, providing care and support so that people do not progress into needing those more specialised services.

Creating opportunities to look at what services are available in the local area and making those connections is really critical. Things like the health pathways program has been actively implemented across many of our services in New South Wales. This is where the local providers come together, look at what services they have around a particular cohort of people who might need care and then look at who does what and they organise themselves so that they can most appropriately provide effective care. This is particularly challenging when you start to think about the range of services that people might need to get access to, so it is not just around generalist services but specialist services in things like mental health or in disability services, or in drug and alcohol.

The CHAIR: We will get to those. My question is around the universal primary level, and the timeliness and efficiency of that process. For instance, we have had people tell us that they wanted advice about breastfeeding at a particular time, and if it does not coincide with when their one universal health visitor is coming, then it is difficult for them to access that particular question and need for advice at the time that they need it. We know that in some settings they will get a visit from the midwife and in others they do not. Some health districts will have a visitation system, others will have a phone call or drop-in system. It seems uneven and inconsistent. Therefore, it is hard to tailor, "How do I access this service when I need it?"

Dr LYONS: That is one of the challenges that I outlined. In certain places around the State, depending on the way the services are configured and the staff that are available, it may be that the service is organised around a personal visit to a home or otherwise it may be through a telephone contact. Either way, if there is anything that comes out of those interactions such as there is concern that there is further need that is required by the parents or family, then other services can be organised for that family. If there is a concern then there will be follow-up.

Mr DAVID HARRIS: A couple of questions to Health first of all. What strategies are in place to enhance recruitment of Aboriginal health workers and, in particular, midwives?

Dr LYONS: I think this is a really challenging area for us. We are very committed to increasing the Aboriginal workforce and, in particular, looking at how we can increase the number of Aboriginal people who are employed in health professional roles. We have had significant increases in the number of people who are employed in those roles, but it is an ongoing challenge. I was going to indicate the sorts of numbers of increases. I have some figures here, which I am looking to access so I can give you some specific numbers. At June 2017, NSW Health employed 3,100 Aboriginal staff, which included 93 doctors and 793 nurses. I do not have the number of midwives broken down but there are 69 currently enrolled in programs to support developing skills in those areas. So it is, I think, an area of focus for us. There is no doubt we can do very much more in that regard and we are committed to increasing Aboriginal employment across the State.

Mr DAVID HARRIS: Would you be able to supply the Committee with the figures on midwives at some point down the track?

Dr LYONS: Certainly.

Mr DAVID HARRIS: Thanks. We have heard from a number of witnesses in the not-for-profit sector they are supplying different services. As a whole-of-government approach, how do we stop duplication in those services—that is, funding being spread where people are doing the same things in the same space? One of the areas is, for example, the support hotlines. I would have thought having one support hotline with one number that could be promoted may be preferable to having five or six different hotlines. You may have a different view on that.

Dr LYONS: Is there a specific hotline you are speaking about where it is duplicated?

Mr DAVID HARRIS: No, but we have heard from different organisations that they have hotlines that people can access. There does not seem to be one central one. There are all different ones that people go to.

Dr LYONS: There are a range of different access points. I think what you are alluding to is that many services that have a specific focus will establish an access point that might include telephone access as a point of enabling people to access the service. That does create a proliferation—absolutely an issue for all of us—in that there are many specialist services that see the need to have the ability to access that service through telephone points. The services might be delivered differently in different geographies and the people involved in providing access to those may have specific needs or knowledge that they feel should be available when someone lacks access through that point. This is an issue for all of us.

In health we have Healthdirect which is a national contact point for health services, but then there are other telephone access points for other different types of services as well. How you ensure that people get to the right point when they need it is an ongoing challenge for us. That is where all these promotional activities occur in local communities where, as I said, people come together and look at what services are available and how they ensure people have the relevant knowledge they need. It is an issue about how we promote those effectively in the community, how we give people the knowledge and health literacy to know what they might access when they do need it but also, very importantly, that we have the ability to assess, triage and refer if the person makes access to a point which is not relevant to their needs—they can be referred to the more appropriate service. But that is a big challenge for us.

Mr DAVID HARRIS: Finally from me, why does there seem to be a lack of consistency of services across the local health districts? For example, the Committee visited the Central Coast, which is my area. It has a great child and family health section but they made the comment, "We are lucky that our health service sees this as a priority," which seemed to indicate that other local health districts may have different priorities and may not be providing the same level of service.

Dr LYONS: I have worked in the NSW Health system for over 30 years now and I have worked in all parts of the system including out in the rural and regional parts. There is no doubt the challenge for us in local health districts is that we have a very different range of services in different parts of the State. The challenge for us is about recruitment and retention of people with specialist skills to work in those environments. The other challenge for us is that as we have increased the level of knowledge and deepened knowledge and understanding of what evidence there is around how we improve care, what services are required, the skills and knowledge are deeper, which means specialisation has increased and the ability to recruit people with that specialist knowledge everywhere is a challenge, so it varies enormously what is available in different places.

There is no doubt that in a metropolitan setting it is usually easier to recruit people with those specialist skills and knowledge. But having said that, even as you move to the western parts of Sydney it becomes more challenging. But if you go out into the regional and rural areas it is enormously challenging. There are a range of strategies the districts put in place and the New South Wales ministry supports to ensure that we have the right people in the right places with those skills and, if they are not there, to ensure that if a person seeks care they can be linked in to make sure they do get access to that care, but it is a big challenge for us.

Ms FELICITY WILSON: I would like to start on mental health, if I may. We have received evidence that the general perinatal depression and anxiety screening can be very patchy. We have heard views that it could be due to lack of training or lack of willingness to disclose and that there is a difference between the private and public systems and the practitioners a person uses for the main management of their child's birth. I am quite fortunate that my electorate is the home of the Gidget Foundation. They have a pilot program with my local private hospitals where they undertake screening, but I know that is not universal in the private system. More than half of the births in my area take place in the private system. Do you have a view or have you done work on how to improve this screening or how to work with primary health networks, general practitioners, obstetricians and educators of our next generation of medical professionals to improve the screening process? Because I think we all acknowledge that that early intervention is what will get the best outcome for mums and dads.

Dr LYONS: I can speak about what we do in the public system. It is much as you said in the private sector—there are a range of different things in place and it varies enormously. As our primary responsibility is the public health system I will keep most of my response to the sorts of things that we are doing. It is an important area and it is increasingly gaining focus from our services. For women who may have issues with mental health during a pregnancy and the birth of their child we are looking at how we can increase the assessment and screening to assess if people are at risk and what services we can put in place early to support them.

In the New South Wales public service there is a SAFE START initiative where in the antenatal care period people are being offered psychosocial support and assessment but are also being screened for the potential for domestic violence and also for mental health issues. In that screening process, where there is a need, referral and support are considered in the antenatal period, recognising that in the stressful postnatal period, the more you can do to support people during the early stages and link them into a service, the better outcome they will have. That is an example.

We are also investing significantly into perinatal mental health services. We recognise this as an area of need. Historically it has not been an area that has had as much resource invested in it, so in the Living Well reform which is the current mental health reform in New South Wales there has been a decision to invest an additional $9.3 million from 2016-17 into a Mums and Kids Matter program, which is around perinatal mental health services. That means that more health professionals are being employed to provide services.

There have been 19 new perinatal and infant mental health service positions funded since 2016-17, and that has increased access significantly for people who have that need and particularly those with severe mental health issues that need support. There has been around a 28 per cent increase in activity in that service across the State which has enabled more women to get access to the care they need. But we recognise that is an area that needs further investment. In particular we are looking at what additional things we can do. We will be planning for further investments in that space over future years.

Ms FELICITY WILSON: The Committee has consistently heard the same view on postpartum psychosis and severe depression and the need for mother-baby units. Any witnesses who have mentioned it in their evidence and any local practitioners or consumers have said this too. There have been a lot of rumours in the past about mother-baby beds or units being introduced at, perhaps, Marie Bashir. Is there a reason why we have not introduced this? Are there any plans to introduce these units in New South Wales? Because it is consistently seen as a need.

Dr LYONS: We recognise that this is an area that will need further investment over time. As I said, we have that investment that was made under the Living Well reform which has had a focus primarily on care in the community setting rather than inpatient care. Although women who have severe psychoses postpartum are able to access inpatient care, it is not in a designated mother and baby unit.

We have access to facilities at the Professor Marie Bashir Centre, as you have heard, where there are a couple of beds available for women to have their babies with them. But in terms of need, that is not going to be enough in the longer term. Under the Mums and Kids Matter program—where, as I mentioned, there has been investment—we are able, through a contract with St John of God, to access the beds that they offer, but that is not available for everybody. So we will be looking at a planning process for mental health services. This is a specialised statewide service. It would not be able to be offered everywhere. It would probably be a unit that was providing a statewide service. We are going to be going through a planning process for mental health in the next 12 months, looking at what additional statewide services we need to be investing for the future. That will certainly be one of the major areas that will be looked at for future investment.

Ms FELICITY WILSON: I get a bit of feedback about second-time parents—that sometimes there is not enough focus on second, third, or fourth children or however many children families like to have. There is a real focus on becoming a first-time mum or dad. For instance things like mothers' groups are less accessible for second-time parents. In many areas, including in my electorate, there are not always support networks. We can have quite a transient population and people do not live near their families. Is there a view that you can share on whether or not we are doing enough to provide those kinds of services beyond the first-time parents?

Dr MURPHY: In reference to your previous query about going through the private maternity service, in New South Wales approximately one third of families go through the private service. As you mentioned, it is not routine for an antenatal psychosocial assessment to be part of that, whereas it is in our public sector. However, once a baby is born that postnatal assessment includes a full psychosocial assessment for all families, regardless of whether it is a first, second or third baby—so it is for every one of the 100,000.

That may not be, as we heard at the beginning, 100 per cent of families who have a universal health home visit, but that does not mean that every family is not approached by the public Child and Family Health services to see about their baby and for us to go through what we recommend as the schedule of visits for the best outcome for that child and family. Families can always refuse the universal health home visit but there is a service offered at one of our 410 child and family health services. We give every family a personal health record known as the Blue Book so that they are aware of the kinds of things that we think are important to be assessed for their child up to the age of five, and the timing of when we think that that is important for their health and development. That is regardless of whether this is a first, second or third baby.

In reference to groups, there is a large focus—that is correct—on first parents' groups. However, with respect to supports that have been put in place, that is just one of the kinds of things that could be offered to support a family. There are also play groups and lots of other resources that are available in every one of our Local Health Districts. The Child and Family Health services would be aware of the kind of resources that would be available through the government, non-government or private sectors to support families who may be in need.

Ms FELICITY WILSON: I have one final question about data and data sharing. We hear quite a bit about fragmentation and lack of coordination. Most of the feedback is that it is very challenging for all of the agencies to work together. There can often be things like privacy restrictions as far as data-sharing goes. Early on in one of our site visits we heard that there is not always automatic information-sharing between, say, the hospital and the Child and Family Health services or between FACS and Child and Family Health services. There might be different IT systems. We heard it relies a lot on relationships, including pre-existing relationships between individuals, who are able to pick up the phone and have a conversation.

We talked a bit about whether there has to be some kind of central agency that can take up the cudgels to try and link all the agencies together or whether there should be some kind of tsar that does that. What is the whole-of-government view or approach about the issues of people falling through the cracks or information not being shared or asking the same questions of people over and again, and impacting that rapport that can be developed and access to services? How do we improve the system and utilise data technology better? Who should be responsible for that?

Ms CHARET: I can give one local example. It is only in Western Sydney, and I am bringing it up because I am sure my colleagues right across the State are really jealous. We were given a bucket of Keep Them Safe money that was given to NSW Health in Western Sydney. They employed a vulnerable families coordinator, whose whole job is to speak to FACS caseworkers to help pool the health records—the history—and to speak to any number of practitioners who might be involved or need to be involved and to prioritise them for services in the public system and/or source and pay privately. We have commonly used that to pay for St John of God admissions for mums and bubs—because that is a critical area—or to pay for specials for a mother and baby in a psych unit. I just think it has been incredibly helpful. Every caseworker in my district knows Kylie Hughes, who is the vulnerable families coordinator. It has been a game changer. If my colleagues had access to the position, and if Health had access to the funding, it could be statewide.

Dr LYONS: Data-sharing is a massive issue, as you quite rightly heard. It is not just within the State and across the State; it is also between State and national levels. In health we have major challenges. How we can ensure that information is available where it is needed is a primary focus of ours. Within eHealth, responsible for the computer systems and the electronic support of digital information—which is where we are all headed—has a primary role in how we get the appropriate integration of those different systems to enable information to be shared.

That is a different challenge because of the different systems that have grown over time. Some of them are a lot older than others, and the level of integration that was available when they were first put into place varied enormously. Increasingly, we are requiring systems to be able to link with each other. We are creating single records for the whole State, so that for people, no matter where they are cared for, the information will be available, ultimately, to support the clinicians who are providing care.

We are linking in, through HealtheNet with My Health Record, which is the Commonwealth's new personally controlled electronic health record, which will be implemented in the next 12 months. So New South Wales is at the forefront of preparations for My Health Record. In the next couple of months there will be some publication to the community generally about the need to signal if people do not want a My Health Record, because we have gone for an opt-out model based on a successful trial in Penrith over the last 18 months. That opt-out model nationally means that most people will have a My Health Record unless they specifically choose not to have one.

It will have information that goes back two years about what has been on the Medicare Benefits Schedule and the Pharmaceutical Benefits Schedule. Things like the drugs that they are on and what tests they have had, what doctors they have seen will be available on that record. On the State side we are looking to do that same thing. We would like to have up to two years worth of information available from our system. So if someone has been in a hospital there will be discharge summaries and what investigations have been ordered while they have been in that care. If they have been to an emergency department there will be a summary of what happened to them while they were there. Ultimately, even what has been going on in community health will be available in the My Health Record. We see that it will be a significant step forward in having information that travels with people to the clinicians that they are receiving care from. That will be a major advance on what we have at the moment.

We are also signalling to the Commonwealth that data linkage is critical. Data linkage, in an ongoing way for people who have information that is in the Commonwealth and State systems, is critical to looking at what care we provide, how we map service delivery more effectively and ensure that there are no gaps and that we reduce duplications where they occur. That is an ongoing discussion at the Australian Health Ministers Advisory Council and at COAG Health Council. That is on the health side. Then there are links with what goes on in education and what happens in relation to Family and Community Services. Those are other important connections that we are keen to make for those vulnerable families where a number of agencies need to be involved in providing care. That is another level of complexity. It is an important focus area. There is much more that needs to be done but it is a very strong focus of all our agencies about what we need to do to improve that information that is there to support people when they receive care.

Ms CZECH: From Family and Community Services' perspective, I think it is fair to say that there is work to be done, as you have heard, no doubt. It sounds as though that has been the case. Back in 2012 we changed the legislation to introduce what we called 16A, which is a provision to share and exchange information. For the first time ever, that provided an enabler, if you like, for prescribed bodies to actually pick up the phone and seek that information from each other. We saw a significant increase in the number of information-sharing requests that were coming through the system.

There are a couple of other things that are on foot at the moment. FACS is in the process of implementing our new IT system called ChildStory. We have completed release one which was for FACS caseworkers. But we are about to embark on release two in July. What is, in part, important about release two is that for any of our funded services we have got a referral portal but the referrer, for example a non-government organisation or Health, will be able to see relevant child protection history or information about a particular child or family. That is the first time that Family and Community Services at least have had that in a system where we can actually exchange it at that level. Obviously, we have got to take privacy law into consideration but I think that is going to be an important way forward.

The other thing over the last 12 months that has been in train has been the work that has been carried out by Their Futures Matter. 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 in particular 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.

Finally, there is a range of arrangements in each of our 15 districts across the State where we work with both Health and Education around some early planning either prenatally or when children are born where there might be a risk of significant harm report. That collaboration at that level was critical. It probably goes back to the very first question about how do we position families or help families to keep their children safely at home. So it is that early collaboration that is working. Finally, we have previously trialled an application called Patchwork. That was an app that allowed agencies to see who was involved with a particular family. The issue with Patchwork has been that we have not been able to roll it out statewide because of some funding constraints. There are examples out there that the Committee would like to consider. I am happy to provide some more information on Patchwork if that is what you would like. I do not think it is a case of reinventing the wheel. There are so many different components that it is actually quite complex. The system is one, the people are another thing.

Ms TRISH DOYLE: Thank you all for coming along and being here to answer questions and elaborate on a comprehensive submission. I want to start by commenting on page 5 of your submission about consumer feedback. These days more and more with very targeted funding streams, communities and community services are finding that they are struggling a lot to provide support, whether it is Health, FACS, Disability—primarily across those sectors. I find a lot of people at the pointy end but also with soft entry problems are coming through to my office. I am trying to channel them through to the relevant departments, especially at local level. I want to begin with saying that it is good to see that there and I will continue utilising the system where I can. What I am hearing of late is that communication is key. Sometimes there is a complete lack of coordination when there should be between FACS and particularly Health, especially with the rollout of NDIS. I will come to that later. I wanted to make a couple of comments and then ask some questions.

My colleague the member for North Sydney has commented upon the mum and bub units, especially around mental health issues that need to be addressed. If there are beds available, then no-one we have heard of in this process knows about them. We have had the Royal Australian and New Zealand College of Psychiatrists saying, "There is not one bed in the public system." We have had the Multiple Birth Association and Perinatal Anxiety and Depression Australia, you name it—whoever has come to sit here and raise the issue of mums with young bubs and mental health and talked about these beds being available, no-one knows of them. There is some good feedback to you about getting the word out. I presume that will be part of our recommendations that come out of the Committee because everyone mentioned it. It is a complete lack of equity that in the public system there is not that sort of resource. We heard from everyone about that.

Linked in with that is the lack of bed space and midwives in our hospitals. That has received some media attention today. I get a lot of mums telling me that they have been moved out of hospital way too quickly. Therefore, FACS has got a more difficult job of tapping in and having to address the needs because the hospital system or the health system has not been able to offer them the time that they need. I wanted to make that comment. In relation to FACS, the Targeted Earlier Intervention [TEI] reforms is causing considerable angst and concern in my community. Services are feeling as though the stripping of money from small, unique services that work in a collaborative manner to target the most vulnerable families is actually leaving a whole heap of other families that eventually become vulnerable themselves. It is a little ironic as it comes the full circle around to only targeting vulnerability when what you end up capturing some point down the track is increased vulnerability. That is some feedback.

The CHAIR: Ms Doyle, you might let people comment on that. You will have more time but there is a bit of feedback there, I guess.

Ms TRISH DOYLE: It would be good to hear about the TEI reforms from FACS in terms of how services seek some clarification about what the terms of those reforms mean. Then I have a question for our education sector.

Ms CZECH: I am happy to start on targeted earlier intervention. The first thing to say is that there is $131 million invested. That does not change through the reform but I take the point about the less pointy end, if you like, potentially not having those services available into the future. It is right to say that the TEI reform is about aligning the available funding and services to best meet the needs of vulnerable children and families. The second focus of the reform is focusing much more on outcomes, which is not peculiar to targeted earlier intervention—all of government services are having a much greater focus on outcomes. The third plank of the TEI reform is increased flexibility for services. Services have told us consistently that they are sometimes constrained by the particular contract that they might be on or the program level of agreement. The reform aims to increase flexibility and allow agencies to be innovative in the way they deliver the services. Each of our 15 districts—my colleague Ms Charet might like to speak to this—is undertaking a co-design process to develop a plan for the reform. That is in train as we speak. Ms Charet, you might like to talk on that point from your district.

Ms CHARET: We are trialling it in part in your area. Do you know about the Linker Network?

Ms TRISH DOYLE: Yes.

Ms CHARET: That was developed in partnership with the NGOs. Somebody from Mountains Youth Service, Damien, came offline to develop that. Basically, we are trying to create a franchise model. If you go anywhere in the world and you want a clean toilet, you would head to McDonald's. You know what you would get if you go to JB Hi-Fi. You know what you would get if you go to Apple. What we want to create—and that is a big want—we have a logo called the Linker Network so it does not matter what service you go to you will know it is no wrong door. For example, if you are sitting in Mount Druitt and you need help do you go to Family by Family or do you go to the WASH House? They are services that are great but they do not mean anything to me as a young mum, say. So the idea of it will be we do some common inductions, some common training and we have collaborative practice groups that meet.

We are writing that into our early intervention contracts because what we want is if I go into a youth service I do not get sent away—we know that people will often only give it one shot and if they do not get help then we do not see them again stop—so it will be, "Come in, Lisa. I can help you. I can get you to where you need to be. I can hold you until I know you are there, you are hooked in and you are getting the service that you want." The Blue Mountains was one of our first trial areas so from a local point of view that is what we are doing.

Ms TRISH DOYLE: The services are going to struggle without additional resources to roll out such a fantastic concept. There is a lot of angst at the moment. You said that this is in train so where should those services be going for clarification as this is all unfolding? I am hearing they are not getting any clarification.

Ms CZECH: There are a couple of points they can access. There is a considerable amount of information on the FACS website about the targeted early intervention reform, including where the aims of that reform are up to, and there is a monthly newsletter that also goes out. I would say that is a point of contact for agencies. The other point of contact would be their local district contacts—in each district there will be a person who is responsible for the reform—and if that fails I would suggest the executive district director in each of the districts and for those conversations to be had at that level. Also in head office, where I work, there is a TEI reform team and again there are contact details on the website. There are points of contact.

Ms TRISH DOYLE: I have tried each of those on behalf of my community whom I am told have tried several times so I have written directly to the Minister. We should not need to do that. Local people should be able to contact other local people.

Ms CHARET: Hopefully we will get some answers there.

The CHAIR: Dr Lyons, would you like to comment on the workforce issues that have been raised around midwives?

Dr LYONS: I think there has been a fair bit of media today as well about shortages of midwives at certain hospitals. We have heard about the fact that there are not enough midwives across the State. There has actually been an increase in the number of midwives across New South Wales. I am just going to give the Committee some figures about that—from June 2015 to June 2017, there was an increase of 230 midwives across NSW Health. There are other issues around: Is this a turnover in workforce? The turnover rates in midwifery are actually lower than the turnover rates in the general workforce in NSW Health—7.7 per cent is the turnover rate in 2016-17, which is lower than the NSW Health turnover rate for the total workforce of 8.9 per cent.

We do have some vacancies in a number of hospitals in midwifery—and you would expect that with a workforce as large as ours across the State—but it does not mean that there is necessarily a shortage of those people who are available to provide care. So if there is a vacancy due to people resigning, being on long service leave or being on maternity leave, the hospital management will look at their workforce and look at the increasing the use of casuals and a part- time workforce to ensure appropriate coverage of people with the skills to provide appropriate care for the people in those services. That is a challenge if there are ongoing and long-term vacancies but I am sure those hospitals will be actively recruiting. In relation to decisions about leaving hospital, those decisions are always around what is safe and clinically appropriate. People would not be allowed to go home from hospital unless the decision of the clinical team was that it was safe for them to do so.

Ms TRISH DOYLE: I can give you three examples right now of women who have recently been to my office who were told within a matter of hours that they needed to get out because they had booked the bed in for someone else.

Dr LYONS: I stand-by my point that no-one would be allowed to go home unless it was clinically appropriate and safe for them to go home.

The CHAIR: Is there pressure because of the patient intake that people are being asked to leave sooner than otherwise might have been the case?

Dr LYONS: I cannot comment on what people are being asked; all I can say is that staff would not allow anyone to go home unless it was safe for them to do so. I know, for example, in many of our midwife-led models that the expectation is that a woman will come in and have her baby and may well go home within hours of delivery.

The CHAIR: Is there a standard or normal time that a woman would expect to stay in hospital?

Dr LYONS: It is very much around the model of care that is being delivered and the choice of the women often. Women often chose not to stay in hospital for a long period of time afterwards and it should be their right to choose that.

The CHAIR: I know that some women want to go home to their own beds.

Dr LYONS: Equally we have got increasing numbers of women who are having caesarean sections as the mode of delivery. If that is the case then it is not appropriate for them to go home within hours of delivery. So these changes are impacting on what is happening in the units but they are driven around models of care and what is appropriate and safe. Many of our services across the State have seen increases in activity over the past few years as the birth rate has increased, and in certain parts of the State it has increased proportionally to others. I think it is always something that is looked at. While our services are busy and there are lots of demands placed on them by nature of the fact that birthing is not predictable necessarily on an hour-by-hour basis—it is in the longer term but not in the short term—there can be periods of time where there is pressure on a service as a result of women coming through. There is no doubt about that.

Ms TRISH DOYLE: The Committee has heard from a number of people about education of young people, especially when we see what appears to be children having children in some communities. Participants to this inquiry have told us that there is a desperate need in the education sector for life skills education for young people and young parents. Can you provide more information about whether in distance education young parents are being provided with life skills? If so, is there scope to grow this need?

Mr TOM: My role is looking after the provision of policy and support for distance education. Mr Piddington is the principal of the school that looks after Sydney basin. Mr Piddington, would you like to make a comment about that?

Mr PIDDINGTON: In terms of formal curriculum there are a range of places where students can engage in life skills—it might be in the PD Health area.

Ms TRISH DOYLE: I am a teacher so I know the curriculum inside out and back to front. There are gaps.

Mr PIDDINGTON: There will be a range of formal syllabus areas where we teach the New South Wales syllabuses in a distance mode. In terms of the young women who come to us because they are pregnant, and who are then young mums with us, we have a program of support for those young women that is very much totally individualised. We have an individual plan for each person. We have somebody who is a supervisor specifically as part of the student well-being team. Her role is to look after pregnant girls and young parents, male and female, to work with them and do a lot of whatever is appropriate or needed in terms of life skills. That person will go to TAFE appointments or go to medical appointments and they will provide information about what is available in different communities.

Since 2014 we have a supervisor of girls, a supervisor of boys, three head teachers, welfare, we have a range of year advisers, all those things that you would expect in a face-to-face school and because of the nature of our enrolments—where the vast majority of students have significant support needs—we have a very extensive student well-being team. This particular position we thought was important because probably at about the time that we created that—I think it was about 2014—we seemed to have more girls coming to the school pregnant. There is the formal side, in terms of curriculum provision and, of course, I could talk more about the general capabilities that are across the various syllabuses and all syllabuses are meant to have an aspect of learning about life. In terms of this particular group of people we have a student well-being team who work closely together. There might be a particular family with a young kid who stays with us for a year or a year and a half and there will be the head teacher welfare involved with that, there will be the supervisor of pregnant girls and young parents, and there will be the careers adviser who will start to provide advice around what might be the most appropriate pathway.

The data is in one of the tables in the back of the document I have given you. Around about a third of our students have left Sydney Distance Education High School to go back to a face-to-face school or go to TAFE. In a sense we have been the link. And there are another two-thirds where that has not been the case. It is very much individualised. Our school motto is "Quality individualised education", and as much as possible we have individual plans, personalised learning pathways for Aboriginal students and we have learning support plans for a whole range of other students, including pregnant girls.

Ms TRISH DOYLE: That is reaching out into remote areas as well?

Mr PIDDINGTON: No, Sydney Distance Education High School deals with the Sydney Basin. We have a geographic area that goes up to Newcastle out to the Blue Mountains and down to the northern area of Wollongong.

Ms TRISH DOYLE: What sort of scope is there to reach that program into more remote areas?

Mr TOM: Secondary distance education is serviced by five schools across New South Wales: Mr Piddington's school in Sydney; one in Queanbeyan; one in Dubbo; one in Ballina and; one at Port Macquarie.

Each of them cover zones or areas of New South Wales. In most cases for rural situations we run an outreach process where we are looking at providing usually a safe location for children to come in and interact with teachers on a reasonably regular basis. Some of them are once or twice a week. Others we might go out and open up an area where the children can come in and be part of a group. We link with as many services as we possibly can. Health is certainly one that we try and link with our outreach services, the Royal Flying Doctors Service is another one and I also back up the comments that FACS made about Patchwork. That piece of software is also being used by our distance education coordinators to coordinate services as well.

Ms CHARET: For me it feels like I am obviously working at the pointy end. It goes well beyond education. The critical gap for me is supported living arrangements for young mums and bubs and it is critical for us. It is very difficult. There is a place at North Richmond called yourtown where the mums live with their babies and they do a lot of life skills learning and if we had more of them we would have more babies safe with mum.

Ms TRISH DOYLE: Housing is the missing factor.

Ms CHARET: Yes, supported living.

Mr PIDDINGTON: I think there is scope for—I do not have any information about how many young girls become pregnant. We have girls from year eight. The break down of the last 13 years is in the back of this document for years eight, nine, 10, 11, and 12. I do not know how many young girls fall pregnant when they are at school. We obviously only know about the ones that come to us. I imagine that there are significant numbers that are supported quite comfortably in their own school communities. I have enjoyed a couple of Ms Charet's stories. I was the principal of Sir Joseph Banks High School from 2000 to the end of 2007 and one of my joyful memories there was a young year 12 student who fell pregnant towards the end of term one.

I still remember her towards the end of that year dancing wildly pregnant after her Higher School Certificate at the year 12 formal. From memory it was a mere few days after that she gave birth. She was in this school in Revesby on the edge of Bankstown, well supported by a very strong family network in a context you may not necessarily have expected that. Well supported by the family, well supported by the extended family and the school and by her school friends and by us as a school. It was just what happened. There was no great, "look what is happening here." I would love to think that there were lots of those stories. I do not have the information about whether there are.

Obviously there are, for all sorts of cultural and religious and other reasons, situations where young girls and their families do not feel comfortable or do not feel it is appropriate that they are supported to stay in their face-to-face school where they are probably more likely to get the life skills support and connection in the local community you were talking about. In terms of slipping through the cracks, our job is to make sure that kids, whether young mums or kids with high anxiety, or whatever, do not slip through the cracks. For the number of students we have supported over the years that is what we do. I do not have much information about what is actually happening in a range of other schools.

I do know in 2015 we sent a team of three people to CCCares @ Canberra College. I was reminded by a Deputy Principal last Friday and I printed it off from their website and I will leave it with you. CCCares is Canberra College Cares and in about 2015, which was the year that our team went down there to look at what happened, they opened a $14 million facility on the school grounds. They bus kids in from the Australian Capital Territory and reaching into New South Wales as well. They have this extraordinary comprehensive program which is part of the bigger school that links into VET courses, life skills courses, transition programs and standard education—there is a beauty salon there. It sounded totally and utterly amazing. They came back in 2015 and we thought we have to do what we can in our little school to enrich what we can for the students. But, would it not be wonderful as a model?

I know geographically the ACT is slightly smaller than New South Wales, but would it not be great if geographically for those students who did not feel comfortable staying on in their particular school if there were places that could be part of face-to-face schools? I am aware of a program at Plumpton High School back in the nineties where this was the case. I do not know any more about it other than it was a high profile situation back then. I do not know what happened to the program. To build it in, not as there happens to be a principal or a school community that will do it for a bit, but as a systemic thing, that would be an amazing way to supplement what we do and would absolutely reinforce students with their life skills far more effectively than we can. In the end we are at a distance. Kids come in, students come in to the school and we go out to them and we make the connections, but it is not like going somewhere six hours a day.

Mr ALEX GREENWICH: I have two general questions for anyone and then one specific question. We have heard from various non-government organisations in various submissions the issues of vulnerable or at risk parents and their trust in working with government agencies. That can often be the responsibility of this side of the table rather than your side, but we also see some amazing front-line staff in each of your departments supporting those vulnerable people, breaking through those barriers. That must come at quite a personal or emotional cost at times. My question concerns the employee assistance programs and supervisor counselling support that is given to your front-line staff and what that is like? I imagine, Mr Piddington, at distance ed the educators must share a rewarding journey but a challenging journey as well at times with some of the students they teach. I would love to hear from everyone about that.

Mr PIDDINGTON: We are very fortunate that we look after each other. Everyone is aware of the formal employee assistance program, which is totally confidential. No-one in the school or the Department of Education knows who accesses it, how often or when. You are absolutely right, the nature of some of the advice we need to get from the school child wellbeing unit and the reports we all make to FACS is highly distressing. One fairly graphic example involved the head teacher, welfare. A family had been out of contact and we could not find them. We have a field service visit program and the teacher went out to the home again, only to find that it was no longer there; it had been bulldozed. Where are these people?

We have had some very distressing situations where we have made reports about a homeless family with a young baby or child. We have made contact with the police about that and we are connecting with FACS. Yes, there are some situations that are very distressing. The year advisers, who often do a lot of the frontline work, can access head teachers' welfare to whom they are responsible. They each have a deputy. We talk and we look after each other. More broadly, as I said earlier, pregnant girls represent on average 2 per cent of our enrolments and more than 400 students are on the Nationally Consistent Collection of Data on School Students with Disability; and most schools have five, 10, 15 or 20. The vast majority of our students have significant support needs and high anxiety. We have more than 60 on the autism spectrum. It is tough, challenging and very fulfilling work. In the end, like teachers everywhere, we do the best we can to look after ourselves.

Ms CZECH: From a FACS perspective and from personal experience having been a caseworker, it is one of the most rewarding jobs you can do. That said, it is incredibly challenging, as all of our jobs are from time to time. It is important that the department has very good support systems in place for frontline staff. Some of them include what we call "professional supervision". That is usually a monthly one-on-one meeting between a caseworker and their manager.

We have supervision spans, usually of one to six between a manager and caseworkers. Therefore, the team is small enough to be able to provide support. Another key day-to-day feature for a caseworker is the briefing and debriefing aspect of the work. For example, if a caseworker is responding to a child reported as being at significant risk of harm, they will have a pre-briefing that could take up to an hour. When they return there is a debrief and a discussion about the way forward. They are critical elements in keeping staff doing a good job, making it rewarding, and also not taking home the turmoil. As has been mentioned, some of the cases are horrific.

We also have supports around caseworkers. We have about 80 casework specialists. As the name implies, they are specialists in the field of casework who can provide clinical support to casework staff. We also try to focus on the good work that happens in the department. Each year we publish "Shining a Light on Good Practice in NSW". I encourage members to get a copy because it is great reading. It contains stories of families or service providers and their experience with FACS or a non-government organisation that we fund. That is a really important publication because a lot of good work happens. Yes, things do go bad from time to time, but enormous good happens.

Ms CHARET: Our Office of the Senior Practitioner has tried to create a very deliberate culture with our workers, which is good. I remember that when I first started in the district a single manager would make a report about which cases to close or to allocate. That would not happen today. In terms of sleep lost, that is a good thing. We have group supervision so that people get a chance to talk to their colleagues. I was talking to staff a couple of weeks ago after a staff member was assaulted. We are open about the fact that you can go home at night and someone will ask how your day went, but they really do not want to know because it was not great. I think the culture among the caseworkers is very much one of comrades in arms. Our Senior Practitioner has cultivated the language with regard to how we speak to one another and about our clients.

It is extremely hard. Whenever there is anything big and hard, we have the employee assistance program and we get them out to do some talking. It is about the managing group closing around the caseworkers, talking, being honest about our feelings, and encouraging people to say they are doing it tough, that they do not feel safe and that sort of thing. At a local level, it is hard and we need to get better at stopping people burning out and stopping the high turnover.

Dr MURPHY: Thank you for the question. The way we care for the people providing the service is absolutely key to the service that can be provided. In particular, those of us who work in child and family health do not have expensive machines or technology. It is so much about the individual, their background and what they bring to their daily work that is very important. How do we do that in Health? It begins with recruitment. When we start the recruitment process, we look at the background and specialist skills the person will have.

I know that the Committee has received a submission from the Child and Family Health Nurses Association (NSW) Inc. that discusses the requirements for child and family health nurses, who are our universal frontline service. To that end, there is in the background their professional development and training. However, at a systems level, NSW Health provides further professional development. For example, when we began universal health home visits as opposed to a clinic-based service, we funded a statewide program called Family Partnership Training for everyone who would be involved in this new approach. It is an intensive program over 10 half days that looks at how participants would reorientate a respectful working in partnership with families model as opposed to the previous model, which was that they were at the clinic and they were the expert. We wanted to enable and to work together much more with families. As members can imagine, that was a radical change for the system and for the individuals working there.

Every one of the psychosocial questions we have been talking about has an individual training program that is delivered online and in person so there is proper support for the clinicians who are going to be involved in that. There is ongoing professional development not only at the clinical interface but also at the new frontiers. It is so exciting to be involved in the mothers' and babies' world because each time you go to a conference or open a new journal there is new and very important literature to look at to see how we may implement.

We work in teams. There are clinical nurse consultants, clinical nurse educators and clinical nurse specialists who will be working in different areas. Not everyone is working at the frontline; there are tiers as well as, of course, the important management component, where there is a responsibility for individuals. At the systems level, there is clinical supervision. Of course, at the individual level, New South Wales also has EAPS, and people are expected to take it up.

Mr ALEX GREENWICH: My next question relates to the growing diversity of families in New South Wales. The Committee received a good submission from Rainbow Families and we know that the last census indicated that there has been a 20 per cent increase in same-sex parented families with children. What work is being done to ensure that language in publications, guidelines and so on is inclusive of this growing diversity in families in New South Wales?

Dr MURPHY: This Blue Book is our personal health record. We do a major review of it every five years and that review was undertaken last year. To that end, we did extensive consultation with the Rainbow Families playgroup. We had a focus group of parents there. We had representatives from Rainbow Families meet with members of the Maternity, Child, Youth and Paediatric Unit at the Ministry, and the recommendations that they made have been incorporated into this, so it is "parents/parents" in its ongoing nomenclature. That is the book given to every baby born in New South Wales so that, I suppose, is one important component. In the broader NSW Health system, we have clear policies on "Your Health Rights and Responsibilities Policy" to try to address that concern as well.

Ms CZECH: It is similar from a Family and Community Services point of view. We are updating policies and procedures as we can. The focus of our efforts in relation to Rainbow Families has predominantly been in fostering and adoption. We have targeted recruitment with Rainbow Families being absolutely brilliant foster parents and we have many, many parents in the system. The same goes for adoption, so there are a number of children in out-of-home care for whom adoption is their case plan goal and we changed the legislation a few years ago now to allow Rainbow Families to adopt children. That has been fantastic. Again, we are on track this year to record a record number of adoptions from OOHC [Out Of Home Care] and many of those are adopted parents, so that is fantastic.

Mr ALEX GREENWICH: My final question is to Health. The member for Blue Mountains highlighted Professor Austin's submission and a document around the model of care for mother/baby units in New South Wales. She had said that work had been done in 2014 and that they sought comment for that, but nothing had come from that. In terms of that model of care for mother/baby units, where is that up to? Is that going to be part of this new strategy that you spoke about being released?

Dr LYONS: What I indicated before is that this is identified as an area of need. We have not got solutions that are comprehensive at this point. We do have a focus on ensuring that people have access to care, but it is primarily in an out-of-hospital space at the moment. There is an opportunity that if people need to be admitted for inpatient treatment, they do so, but it is not with their baby, and that is the missing piece at the moment. Apart from those places that I talked about before where there is access to some beds, it is not as much as we would like, so that will become part of the planning process that we will be undertaking in the next 12 months for the statewide services and then further investment and we will probably need to look for a capital solution in relation to a service for the bed numbers that have been flagged in those submissions.

Mr ALEX GREENWICH: In respect of that model of care document that Professor Austin spoke about, where is that in its life span? Is it completed? Is it going to be incorporated in future policies?

Dr LYONS: I am not sure of the detail of that specific piece of work that was done a couple of years back. If we are a looking at a planning process, we look at the current evidence, what is considered to be contemporary practice, what is in the literature worldwide, what is appropriate to provide. There are usually some planning parameters that are looked at in terms of what is the requirement for inpatient care versus community care, where is that highly specialised model required, what sort population do you need to warrant how many beds are provided, and a safe way to provide the staff with the level of work, experience and knowledge to maintain skills appropriately. All of those things are thought through. For a service like this, we would look at it being highly specialised and probably a statewide service; it would not be available everywhere, and the configuration of the number of beds and what was built to support that would be looked at as part of the process.

The CHAIR: I have a couple of follow-up questions before we finish. The first follows Mr Greenwich's question about language. You referred to the nomenclature in the blue book. Do I understand that would mean removing the words "mother" and "father" from that book?

Dr MURPHY: Where it is relevant to the mother as in birth details, obviously the name mother is there. Where it is looking at issues with the child's development, it is parent, because that is the important part from a development perspective.

The CHAIR: As I asked the representative of Rainbow Families when she was here, in an attempt to give respect to one group, we do not want to take respect away from other people to whom the identity of mother and father is incredibly important and fundamental as to how they see themselves. It is a juggling act, but the end goal is respect for the individual. Is that something we can accommodate in that process?

Dr MURPHY: For example, the questions are for parents/carers, and that is what is important because we are assessing the child. Each of this has been looked at very seriously. Where you would be looking at birth history, obviously that is relevant. We would be looking to the mother and it would say that, but where we are looking at, "Is my baby exposed to smoking in the home or care", that is a parent.

The CHAIR: It is either way.

Dr MURPHY: That is the differentiation.

The CHAIR: That is the only point I wanted to make: ensuring that we extend respect generally and that we appreciate people's sensitivities. I have a question about the coverage of secondary and tertiary supports for parents and babies geographically across New South Wales. It seems to me that some of the services, particularly non-government ones, are historically based and have not necessarily strategically planned where they are and what they cover. Is there a strategic vision of a spread of secondary and tertiary services for babies and parents and how we allocate the supports that are available across New South Wales?

Dr LYONS: From a health perspective—

The CHAIR: It is primarily a health question. It is about how we map what is where and how we find that support.

Dr LYONS: The issue from our perspective is how we ensure we plan appropriately for those secondary and tertiary services across the local health districts. The primary planning vehicle will be the local health districts at the local level to ensure that they have the services in place that they need for their communities. Where they do not have those tertiary services—most of them will have secondary services—and how they distribute them across their geography will be worked out based on their population, the services they have and how they link them together. Then it is about how we link the secondary with the tertiary services and ultimately sometimes there are quaternary services in some highly specialised areas. Those are looked at on a statewide basis. The ministry has responsibility for planning those more statewide functions.

Where there is a need for highly specialised services that we just talked about, for instance, relating to perinatal maternal health, the ministry would look at that on a statewide basis and make decisions about what was required and where it should be delivered from. That does not always happen in the non-government organisations effectively. One of the things that we are keen to do, as we contract with non- government providers, we are conscious of the linkage with other services and how we create the right connections so that no matter where a person accesses a service or care, that they can link in with what is required in other places and that the practitioners and providers are aware of how those linkages can be made in the referrals.

The CHAIR: I am conscious that Karitane and Tresillian exist in some places and not others. It is generally a matter of history where they came from and how they got to be there. Is there a plan to partner with them and help them roll out in other places or is the Government going to provide services where they are not?

Dr LYONS: We certainly value the connection with both Tresillian and Karitane and I suspect that over time there will be further investment in those services that support families and parents to do the best they can for their children. We will see, over time, more of those services across the State.

The CHAIR: We have come to the end of our allotted time, plus some. Thank you very much for all of your input. It has been highly valuable. It is possible that members of the Committee may have subsequent questions that come to mind. If we put those to you are you happy to put those in writing and they will become part of the evidence?

Dr LYONS: Yes.

Dr MURPHY: Yes.

Ms CZECH: Yes.

The CHAIR: Thank you.

(The witnesses withdrew)

(The Committee adjourned at 12.59 p.m.)