REPORT ON PROCEEDINGS BEFORE

COMMITTEE ON COMMUNITY SERVICES

SUPPORT FOR NEW PARENTS AND BABIES IN NEW SOUTH WALES

At Jubilee Room, Parliament House, Sydney on Monday, 21 May 2018

The Committee met at 10:00 am

PRESENT

Mr Kevin Conolly (Chair)

Mr Alex Greenwich
Mr David Harris
Mr Bruce Notley-Smith
Ms Felicity Wilson

JOHN EASTWOOD, Associate Professor, Royal Australasian College of Physicians, sworn and examined

JACQUELINE SMALL, Developmental Paediatrician, Director Royal Australasian College of Physicians, affirmed and examined

ELAINE BURNS, Executive Committee Member, Australian College of Midwives NSW Branch, affirmed and examined

LYN PASSANT, Executive Committee Member, Australian College of Midwives NSW Branch, sworn and examined

JULIE COLLIER, Vice-President, Child and Family Health Nurses Association, affirmed and examined

KAREN DIGNAM, Membership Secretary, Child and Family Health Nurses Association, affirmed and examined

The CHAIR: I declare the hearing of the Legislative Assembly Committee on Community Services open. I thank everyone for your attendance. It is valuable for the Committee to hear from people from various parts of the community about the inquiries we undertake, and we look forward to what we will learn today from each of you. We are hearing evidence today on the Committee's inquiry into support for new parents and babies in New South Wales. We will be examining a number of issues today, including the adequacy of services and structures for new parents and babies and whether those structures could be changed to improve physical health, mental health and child protection outcomes.

The Committee is looking at support for new parents in other jurisdictions and how technology could enhance support services for parents. Does anybody have any questions about the process today? I will briefly introduce the Committee members: I am Kevin Conolly, member for Riverstone in the Legislative Assembly and the Chair of the Committee on Community Services. On my left is Bruce Notley-Smith, the member for Coogee; Alex Greenwich the member for Sydney; and on my right Felicity Wilson the member for North Shore. David Harris, the member from Wyong, will join us later. I thank you all for making submissions on this subject, which is important and will contribute to the welfare of people in New South Wales.

We understand the time and effort that went into those submissions and the valuable content. Each of the Committee members has spent considerable time on poring over those and on considering the direction we would like to take. I will invite each of your organisations, and you can decide between yourselves who will do it, to make a brief opening statement about who you are and what you do. The Committee members have read your submissions and do not need you to go through those again. We will explore additional information through questions from the Committee members. I will start with the Royal Australasian College of Physicians.

Dr SMALL: We have prepared for each of us to give a short opening presentation. Is that acceptable?

The CHAIR: How short?

Dr SMALL: Very short.

The CHAIR: It is, but clearly the focus of the time is for Committee members to ask questions. If we can keep that tight, it will be all right.

Associate Professor EASTWOOD: I am John Eastwood and, on behalf of the Royal Australasian College of Physicians, we appreciate the opportunity to appear and give evidence today. The college represents 17,000 physicians and 7,500 trainees across Australia and New Zealand, including 5,000 paediatricians across 30 subspecialties. Our members work routinely with newborns, infants, young children and their families. The Paediatric Child Health Division is currently undertaking policy work relevant to the inquiry in a number of areas including early childhood, Indigenous child health and inequities in child health.

Just briefly about myself: I am a paediatrician and public health physician, formerly a policy and program director for the New Zealand Public Health Commission where I assisted the Department of Prime Minister and Cabinet on an inquiry and intervention for at-risk families, which is relevant today. I have been in Australia since 2003 and focused on the area you are focusing on today, which is: policies and programs for new parents and their families for up to the first 2,000 days; designing and implementing proportionate services within this metropolitan basin; integrated perinatal pregnancy child birth services within the basin since 2003, which led to SAFE START policies; sustained nurse home visiting, which you will hear about this morning; and child protection services. This has all led to an integrated approach in central Sydney of healthy homes and neighbourhoods for vulnerable families.

To summarise our submission very briefly: whilst advances have been made in implementing integrated perinatal care and perinatal coordination services in New South Wales with the SAFE START policy, the Royal Australasian College of Physicians [RACP] fellows have observed that these reforms have only partially been implemented, with significant system barriers to integration between non-government and government and private providers. To that end we believe it is necessary for an integrated whole-of-system approach with the new structures and systems. Our particular concern is the failure to implement any evidence-based programs at scale or in sufficient dose to effect change and for any of those programs to be evaluated.

Dr SMALL: Thank you for inviting us to appear this morning. I am a developmental paediatrician and I have been chair of the Paediatric Policy Committee in the RACP for six years, and I am now a board director of the college. As well as the submission, we are working on a range of other policies that are directly relevant to this particular area and I would like to quote from one recently released about inequities in young children.

> All children, no matter where they live or who they are, should have the same opportunity to fulfil their potential. Child health inequities are differential outcomes in children's health, development and wellbeing that are unjust, unnecessary, systematic and preventable, and many start early in childhood and increase along a clear social gradient.

We recommend increased accountability for improving child health by ensuring that directors general and chief executives are accountable for achieving equity-based key performance indicators. I believe this is directly relevant to the implementation of the sorts of programs my colleague has just recommended for the earliest years of a child's life and their most important carers.

We also recognise that a breadth of interventions is required that address a range of needs, such as the mental health of the mother, the nutrition of the child, physical activity and education. Clearly, integration across a range of sectors outside Health and within Health is vitally important for the effective delivery. There is a range of evidence-based programs, some of which we mentioned in our submission, such as the Common Approach, which the Australian Research Alliance for Children and Youth [ARACY] developed, and other approaches from overseas, such as the Abecedarian Approach. Some of the common elements of those approaches include tools for clinicians and tools for parents to support the development of the child, particularly around the vital aspects of enhanced development and interaction, language and communication.

What is clear is that when tools and programs such as these are taken and not effectively implemented using people who are not effectively trained, the outcomes are not as good as when they are tested during their development. We believe very strongly that not only should these programs be developed to scale with proportionate universalism but there should be clear evaluation and measures of inequity for younger babies and their mothers.

Dr BURNS: Ms Passant and I are executive members of the Australian College of Midwives NSW Branch. We both work in midwifery. Ms Passant is a consultant and I work in education. The focus and strategic directions of our association are around enabling women to become strong and confident mothers, and ensuring maternal and infant health and wellbeing. Midwives provide care across pregnancy, birth and the postnatal period. Most of our submission focuses around what we, through our own research, have found is a common issue in maternal and infant health, which is the fact that midwifery care is fragmented. There is not a continuity-of-care approach and within that fragmented system, midwives do not know the women very well because they don’t meet them on a day-to-day basis. Also, women do not know the midwife, and in this context the focus of care is on providing care that is safe and meets the immediate physical needs of the woman and her baby after birth. But, because there is no caring relationship between the midwife and the woman, there is not attention paid to the psychological and social needs, or in understanding the longer-term health factors.

In that context, midwives working in that fragmented system feel that they struggle with day-to-day issues within the system. Women are dissatisfied with that system and that model of care because they have to tell their story over and over to different people. Also, they get conflicting advice from health practitioners. They often experience physical problems following the birth of their baby, and they are unable then to gain confidence in caring for themselves and their baby. It seems that currently no attention is paid to significant transition that women are making when they become new mothers in the first few weeks after birth. In our submission we present some of the findings from our research, which I will not go into now. We know that continuity of models of care provide the right help at the right time in the postnatal period, in particular. We know that if midwives are connected to women antenatally, and if they get to know the woman and have a vested interest in what happens in the postnatal period, there is less opportunity for women to fall through the cracks. A change in the way the services are provided is required in order to improve women's experience of that transition to motherhood and breastfeeding.

We have also made reference to some of the randomised controlled trials [RCTs] that have been held around caseload midwifery care in New South Wales and the maternity outcomes from those in the postnatal period, mostly around breastfeeding support. We suggest a shift away from the fragmented model of maternity care provision to one that supports continuity of midwifery care and woman-centred care to lead to improvements in women's experience in the early transition to mothering. That will increase women's confidence with their new baby, potentially increase breastfeeding rates and improve the detection of postnatal depression and other psychosocial determinants of health.

Ms COLLIER: Ms Dignam and I are from the Child and Family Health Nurses Association in New South Wales, and we both work in child and family health within NSW Health. Children are our most precious commodity, and it is our duty from a national perspective as well as a health professional focus to ensure that we value this. The antenatal and postnatal phase is the most critical time frame within a family's life and when the experience is supported by quality clinical expertise by health professionals, we may change the lifelong trajectory for individual development and family relationships. Midwives and child and family health nurses play an integral part in these families' lives by providing realistic family-centred care to facilitate optimal physical, social and emotional wellbeing. Nationally our health outcomes are measured by quantitative data, but it is the qualitative data that is the most relevant to a mother or carer and their family for children from birth to school age. Mothers and carers report that it is the support, child assessment and psychosocial understanding from the attending child and family health nurse that is the most critical to enhance their confidence and ability to process their new role as parents.

The continuity of care from the birthing unit to the community setting inclusive of all health professionals is essential for the optimal health outcomes for mothers, carers and babies and to support ongoing breastfeeding rates. The Child and Family Health Nurses Association is concerned with current limitations and inconsistency of access to child and family health nurse services across New South Wales in relationship to the delivery of quality universal child and family health care for all mothers and carers. The issues are multilayered within the local health districts, but are underpinned by NSW Health directives and budgetary constraints. Child and family health nurses identify the importance of establishing vital links with midwifery and allied health services to ensure a seamless transition of care for all women across maternity, child health and community, including those women presenting with complex needs. The universal health home visiting program is a vital family partnership model to assess and support families in the initial transition to parenthood requiring consistency for ongoing family partnerships developed with expert child and family health nurses. The relationship between parents and carers with child and family health nurses is built on trust and supporting families to navigate parenting. Child and family health nurses are an integral link to ongoing community support, including general practitioners as well as secondary and allied health services to sustain safe and nurturing environments for infants and children across New South Wales.

The CHAIR: I thank all of you for your opening statements. Each Committee member will now ask questions to explore themes of interest to us. When we set up these terms of reference we were focusing on how to support babies in New South Wales to have a good start. It seems relatively straightforward and clear, but it unpacked an array of issues as well as a number of dimensions and layers that perhaps did not immediately strike the eye. I will start by honing in on that initial focus and we will proceed from there. My first couple of questions are around the universal service that is provided to parents in New South Wales. The first questions are: How adequate is the goal of that universal service to reach every parent once? How well is that goal implemented and delivered? It seems quite limited in its scope because there is only one home visit after a birth. Is that an adequate goal? Is that adequate goal even being achieved consistently across parts of New South Wales in all contexts? That is open for each of you to answer, but I might start with the child and family health nurses whose role is directly involved in that.

Ms DIGNAM: Currently across New South Wales, the implementation of NSW Health Keep Them Safe policy's universal health home visit is a key performance indicator [KPI] for child and family health nursing, which is home visiting 75 per cent of all newborns and their families within 14 days of birth. Across New South Wales, that varies greatly depending on the local health district. There are a couple of influences on that: one is whether the local health district employs qualified child and family health nurses into their child and family health registered nursing positions; and two are the available resources, which entail child and family health nurses and cars and distance travelled. There are a lot of exceptions to that in remote and rural areas.

The benefits of undertaking universal health home visits is that it promotes the relationship between the child and its family, and the family health nurse. One of the aims of the universal health home visit was for a health professional with expert qualifications in child and family health to assess the living environment of that child and to give us a broad spectrum of the living environment of that baby and their family to promote child safety, alert us to risk factors and then prioritise follow-up if we identified any risk factors for the woman or her infant.

The biggest issue across New South Wales is our resources. Some local health districts meet that KPI very well—up to 85 per cent in the area I work in, including nearly 6,000 private births, which is quite a feat when you consider that it is a manual task to register those babies in our electronic medical record. Other areas have had to prioritise so that a universal health home visit is offered only to vulnerable families. As child and family health nurses, we know that the importance of maintaining a universal health service is that we protect families from developing complex needs, if we offer universal service.

The CHAIR: Can you tell me an area where it has been prioritised to only at-risk families? Is there a particular place where that is happening?

Ms DIGNAM: There are a couple of local health districts that are prioritising because of the lack of resources.

The CHAIR: So, in effect, it is not a universal service there. It is an at-risk service.

Ms DIGNAM: Yes.

The CHAIR: I now hand it over to other panellists.

Associate Professor EASTWOOD: I would like to comment. My role in 2003 was at a district level where our district had 1.7 million of the population. My role was to report on universal health home visiting as a public health paediatrician. I would like to comment that child care is a name used for universal child health services nought to five, and some jurisdictions have quite a comprehensive program, which is not what you are asking us today, which is a series of universal contact all the way through to school entry. You can look at the blue book as an example but the blue book visits are not resourced, so they cannot actually be delivered. The evidence for that comes from a study that we did with the child and family health nurses in 2008 in which we asked all the child and family health nurses in the State to report on their visits during that month. We were able to show a very steep decline in coverage to about 50 per cent of six months down to as low as 20 per cent in the second year. That is supported by the New South Wales child health survey data.

Subsequently, we got a National Health and Medical Research Council [NHMRC] grant to do a cohort study in south-west Sydney, which again confirmed this huge drop-off in contact. There are just not the resources available in the sector to provide not only the first two-to-four week home visit but anything of any substance subsequently. Of course, well-motivated and assertive parents will avail themselves of the services. Parents who have experienced trauma or psychological abuse in their childhood are afraid and distrusting of services. This can, in part, explain why the most vulnerable are not always accessing, or being accessed, for the services where the more educated and articulate are. That is what we saw in the cohort study. I was not in Australia when that was set up but my understanding is that it was part of the original design of Families NSW Families First. It was to provide a universal platform upon which the State would build. The subsequent building of that was to have been sustained nurse home visiting programs because the first home visit gives an opportunity to assess the needs of all families in the State. I do not think that, as a State, we ever achieved more than about 65 to 70 per cent coverage, at best.

There are some districts—and I work in one of them—that are elected to use a different type of universal delivery, which means that every new mother will get a phone call from our child health information centre. Rather than a home visit, we have reverted to second-time mothers getting contacted in that way, thus freeing up resources to provide more support for those who need it. Underlying all of this is to provide the best for all families in our district within the resources available to us. The other thing that has happened since we started universal home visiting was that SAFE START was implemented. It started as an integrated perinatal care way back in 2000. As it rolled out across the State it has given the sector an opportunity to assess all women and their partners during the antenatal period. Therefore, by the time we get to the postnatal period, we, as a service system, have already worked out who is going to need the extra support and who is not. That is partly why some of these districts changed their policy. It was because that restratification approach was not really needed in that home visit anymore. I have said enough and will leave it to my colleagues.

The CHAIR: Would you like to make a comment?

Ms PASSANT: This fragmented approach in hospital is challenging. We do conduct SAFE START risk assessments on women but if midwives get to know the women, they actually disclose more and we can set up their antenatal journeys through collaboration and working out what they need antenatally. There are a lot of women who may fly under the radar because, in the rush of the antenatal visit, they might not be screened appropriately or, I guess, it is just the gesture sometimes. They also have home visiting after the birth by midwives from the hospital. They could have up to two weeks, depending on their needs. On average they probably have three to four visits but that is apart from the universal visits. I guess we are talking about different things here.

The CHAIR: I am interested to hear this. Some people are getting midwife visits after the birth as well as the universal child and family nurse visit.

Ms PASSANT: We think the more, the better.

The CHAIR: Is that structured or is it ad hoc?

Ms PASSANT: It is a home visiting program that is built in from the hospital. They have a Midwifery Support Program, and hopefully they will dovetail that visit to the universal visit with the child and family health nurses. We would set that up with the women and explain that that is the next phase of their postnatal care—going to the child and family health nurses in the community. There are clinics, and they will have the home visit as well.

Ms DIGNAM: Can I comment on that? Supporting Families Early, the NSW Health policy we work to, clearly states that midwives and child and family health nurses can work in collaboration and be home visiting families at the same time.

Ms PASSANT: Yes.

Ms DIGNAM: We do experience issues with that, at times. It comes down to relationships. If child and family health nurses have fantastic relationships and knowledge of the midwifery services we are working with, the referral processes are smooth and it is a smooth transition for families. Unfortunately, that does not happen in all local health districts. Our experience with some midwifery programs is that, if they do hold their women for an extended period of time which sometimes can be a six-week to eight-week period, we find that mothers and babies miss that vital time to join our new mothers group and they do not attend our breastfeeding drop-in support clinic. If it goes well, the transition from midwifery and child and family health nursing—we can work together. The majority of New South Wales child and family health nurses are midwives. You do not need to be, but historically most of us are. It goes brilliantly for the family. If there is any division between services, the family is affected.

The CHAIR: I will ask a couple of follow-ups, which you might like to comment on. I heard it said, and it was one of my questions, that there is a differentiation being made between first-time parents and parents of subsequent children who are perhaps to be judged as more experienced. Should we build that into the universal service? Should we have home visits or a base level for every parent and some extra for first-time parents?

Dr SMALL: There does need to be a tiering of services, but the higher risk group must include additional parents such as those with an intellectual disability, those who are vulnerable for a range of other reasons.

The CHAIR: I fully understand that and we are going there. I started by looking at the universal service. My initial comment was that I know it opened lots of other doors for specialists—secondary, tertiary, referrals and so on. I am trying to explore the universal first.

Associate Professor EASTWOOD: I could comment on that. My background is that I have worked in this field since I was a medical student and was with the Royal New Zealand Plunket Society, which is New Zealand's equivalent of our child and family workforce. I can see that what you are saying would be possible if you had a resource-constrained situation. However, I do not think it is as simple as to say that a second-time mum should not get some extra visits. That has to be based on an assessment of need by our midwifery colleagues, our obstetric colleagues and our child and family nursing colleagues. I fully support what my midwifery colleagues are saying about a midwifery-led practice, which is something we are trying to move towards as best we can to get the continuity of care.

I have also observed, having worked in the sector for a while, that there are all sorts of things that fragment the sector. One is the way funding is delivered. Every time there is a new appropriation of funds it creates a new fragmentation if it is labelled with a word other than an existing word. Our craft groups have a tendency to want to do our own thing. Part of the challenge of the New South Wales integrated care approach, which is going on at the moment, is to try to solve some of those problems, such as how to get our professions working together just because we label a bunch of money something else. You may well come to that later. It is more complex than just to say, "We have not got enough money, therefore, first-time mums just get one visit."

The CHAIR: I was hinting the other way. Do we need a bit more for first-time parents on top of what is our base at the moment?

Associate Professor EASTWOOD: I think you are absolutely right. In the districts, my child and family health nursing colleagues were trying in every way they possibly could to get at least six visits in for first-time mums. That might have meant cutting back in some other areas.

Mr BRUCE NOTLEY-SMITH: In your experience, are there any first-time mums that you visit and conclude that there is no need to go back, that they are perhaps surrounded by sisters, mums, aunts and uncles who, between them, have had 30 kids or something? Has that ever occurred?

Ms COLLIER: There is an assumption that there are women who have had a baby and they are nurtured within their environment and within their family. But the issue that often happens is that, as the parenting time frame unravels, so do the issues. The worried well, if you wish to call them that because sometimes they are labelled that—when we would highlight a parent with fewer complexities—may actually escalate some time in that first year of their baby's life. It is really important that they build up those strong connections with someone, particularly child and family health nurses, after they have left the midwifery services and of course their community services as in general practitioners [GPs]. But often women will return to a child and family health nurse even if they have had a considerable time away and they have thought, "I am okay. Everything is fine", and everything falls apart along the way. It is vital to the parents to have a connection to someone. That is not a telephone connection. Face to face is really important and usually in a clinical setting by that stage.

Dr BURNS: I would have to agree with that. We feel the same way in terms of midwifery care. It is about that face-to-face visit and, in terms of continuity of even a service provision, that women have that opportunity to engage with the service. They may not need the service at that point in time. They may feel well supported, but just identifying that there is a service there and introducing a person belonging to that service opens the door for that woman to then be able to access the service when she needs it. I have to agree with my child and family health colleagues that that transition, in terms of midwifery care being provided through the antenatal period, helps to build a strong and confident mother. Then following that person up in the postnatal period with the same provider has an impact, but also transitioning that person to the child and family health service and having an opportunity to do that home visit collectively with both services is only going to benefit the woman and her family. Whether that happens or not is sporadic at the moment. I have to agree that the transitioning of service to child and family health is really important.

Ms DIGNAM: One of the major factors for our new parents within New South Wales is in fact isolation. They do have family, but the majority of the parents we see have moved to affordable housing. They work until they are 37 weeks or 38 weeks pregnant so they can afford to continue to live and they have not met their neighbours. That is statewide. Even if they are in Sydney and are a migrant, they are working and living in apartments and do not know the people around them. That is quite isolating. Very few have the luxury of having that 12 months off after work. The benefit of having parental leave and having the father at home for that two weeks is insurmountable. That is such a benefit to new parents. Even if they have sisters, mothers and aunties, usually they still are quite isolated within their own living environment.

Dr SMALL: This is about the mother and the baby. The diet is not static as well. We have recognised that there is a range of family and community-based factors that are really important to understand, but the actual diet and the baby change dramatically through the first few weeks, few months and even the first year of life. Advice that may be relevant at one point in time, such as the first few days of life, may not be addressing the needs that arise a few weeks later, which can be very substantial. Sleep and feeding issues may emerge only then. Children develop very rapidly in the first few weeks and months of life. Those issues are not going to be revealed at the very earliest stage if we restrict our service to one visit. Clearly, the only way one visit can suffice is if there are other services that replace what that visit would otherwise do. I would be very concerned if there was going to be a restriction to one visit and that was to become standard practice—though I know that is what we are discussing—because the issues continue to evolve and they are really critical issues.

Associate Professor EASTWOOD: I would like to follow on from that from a public health perspective and a prevention perspective. There is a national framework for child and family health supported by the Australian Health Ministers' Advisory Council, of which we are a signatory, and which provides the overarching framework for these services in Australia. We currently are relying on untrained general practitioners—and I say that with some knowledge—to deliver that because we are not investing the resources. The sorts of things that we might be thinking about are that the heart changes at six weeks, and that could be missed. There are developmental changes that might be missed, and the opportunity to ensure that the home is safe from scalding, from running over in the driveway and that the infant is properly belted in. I have an injury prevention background. We could talk about parenting practices. Relationships between mum and dad might break down at some point in that first year of life. I fully support my colleagues that isolation, loneliness and support systems are all important.

As I said, we have a national framework. We as a country are not resourcing that framework. As a State, as a jurisdiction, we could at least start to resource some of that framework even if we were to say as a State as stage one that we would like to support that framework for the first 12 months. What I am working on currently is a training program for general practitioners, which is not part of your focus today, around trying to upskill GPs and practice nurses to support us. That is because we have to do something because our child and family nursing colleagues are just not resourced financially to the level needed to deliver that framework. That is why we have reluctantly turned to training practice nurses to try to fill what is a huge gap.

Mr BRUCE NOTLEY-SMITH: You touched on a couple of local health districts that were under-resourcing this area. I want to find out a little more about the cause of that under-resourcing. For example, in mental health in the regions it is difficult to get qualified mental health nurses. It is not for want of money that they are not able to fill those positions. I am not saying that is the case, but could you elaborate on the resource demands that are not being met?

Associate Professor EASTWOOD: I do not think I am qualified to comment and we should take that on notice, but I would like to direct the Committee to work that was done from the University of Wollongong looking at the funding of community health over a period. It would be to look at how much of health was going to child and family health over the past 10 years. I think that will be illuminating. We do not have those facts but there were substantial reports done and one done again recently I think. That is part of the answer. In midwifery and obstetrics it must be a different story but something similar I guess.

The CHAIR: Are there sufficient child and family nurses to be employed if there were more money to employ them?

Ms COLLIER: Yes. In my case where I am working at the moment there are a lot of child and family health nurses. We had recruitment last week and we had eight applicants for 1.6 positions. If we could employ them all we would but we cannot. We do not have the resources to do that. There is definite interest and there are definite resources but I am not in the same area as Ms Dignam.

Associate Professor EASTWOOD: I would like to speak on behalf of the inner west districts in plural because those districts have been advertising and have not been able to fill those positions. We can only surmise that we think it is related to the property market but we do not know. We do not have the research. But we have been advertising and we have not been able to fill the positions. We are aware that our colleagues in other districts have been able to fill the positions.

Ms COLLIER: I have worked in a position that was virtual across New South Wales in rural and remote areas and metropolitan. The situation exists that there are a lot of areas that they cannot recruit to for many professions, including duty medical officers, midwives, child and family health nurses, et cetera. It is then also the retaining of those staff as well. You need to get the interest and then retain them. Of course, all those services deplete the further rural and remote you go.

Ms DIGNAM: In metropolitan areas it is very dependent on our director of nursing and then the CE as to whether or not having a child and family nursing degree is required to undertake our position. The Child and Family Health Nurses Association [CAFHNA] feels extremely strongly that it is; it is a speciality field that we have. We work in partnerships with family. We all undertake family partnership training and we are expert in child development and psychosocial screening and the recognising of complex family needs. It is a speciality area that is not as well received as midwifery. That is one of the issues we are trying to address on the CAFHNA level at a national level.

Certainly midwives are revered and child and family health nurses often do not have a really clear identity. Sometimes we are early childhood nurses, sometimes we are baby clinic nurses, sometimes we just weigh babies. It is quite a unique speciality field that I feel is undervalued across a health profession status. If the CE has a belief that we have a vital role in early intervention and prevention that qualification is added to our position description and we can recruit to that. If they do not hold that belief and feel like a registered nurse can undertake our role that becomes part of the recruitment process. It is very difficult because we have a fairly strong position statement. Our CAFHNA position statement is quite strong that we are a unique and valuable service for families across Australia and New Zealand.

Dr SMALL: One of the challenges is when health services or health professionals try to support vulnerable families. It inherently takes a lot more time. Additional staff such as social workers and other staff are needed to help engage the families and then help to implement recommendations and follow up. Most of our current methods of funding health services work well for those who are more able and better resourced but do not work particularly well once their needs become more complex. It is time consuming, labour-intensive work—much of which is away from face-to-face contact. Our health system still has to grapple with what that really means in order to reduce inequities.

Mr ALEX GREENWICH: It has been extremely valuable to hear where the gaps are, from affordable key worker housing through to the fragmented system that we are dealing with. Referring to the gaps, where do you think should be the starting point for government? What areas should government be prioritising, beyond the answer, "We need more money for the sector", because it is how that money is spent that makes the difference. If I could ask you all that question. I am particularly interested to hear about the data gaps referred to in the submission of the Royal College of Physicians and the need for better data sharing amongst government agencies.

What are the long-term negative impacts on the mother and the child from not making the urgent improvements to the system that are needed?

Dr BURNS: From a midwifery perspective our focus is on what we know are positive outcomes from a model of care where there is continuity, where a midwife meets and follows a woman throughout her pregnancy, birth and postnatal care. There is so much research that we have now that shows positive outcomes for mothers and babies. Obviously if you have a confident mother that has an impact on the baby. We can redirect resources to enable more continuity models to be available for everyone. At the moment we have that happening across local health districts [LHDs] but some will have more availability of continuity than others. Some LHDs have no continuity models at all. Very strongly from our research that is an area that we think will make a huge difference.

Mr ALEX GREENWICH: There is a policy gap in respecting the importance of that continuity of care and also a resourcing gap to make sure that there are midwives to be able to provide that care?

Dr BURNS: And that there is a commitment to that model. We have the Towards Normal Birth Policy, which advocates for an increased number of continuity of care models. There were even benchmarking years when that should have happened and some LHDs have not started any. It is not necessarily about piling in lots more resources; it is just about redirecting the resources. The other area is definitely the gap in the transition—once we know a woman and the areas that are of most concern and the vulnerabilities, to be able to pass that on to child and family health services is an area that is not working very well. In some jurisdictions it will but in others it is not. That is something that really needs to be streamlined so that people are not falling through the gaps, so that those babies that we do need to be monitoring a bit more closely are being monitored. I guess from my perspective those would be the two areas that really need attention.

Ms PASSANT: There are pockets of examples that work really well and we should model it on those examples. It is just that the leadership on the ground cannot see beyond the hustle and bustle of the busy ward. They are just trying to keep it safe basically; thinking outside of that is too much of a challenge. We need people to come in and help them implement different ways of working that surrounds the care around the woman and working with our colleagues outside of the hospital environment to make a better journey transitioning back into home and community.

Dr SMALL: Thank you for highlighting the various aspects that do need attention. As far as evidence- based interventions, sustained home visiting is one that really has very strong evidence for it because it does address a range of factors that are important for the wellbeing of the child and the mother. I think there are new resources that are required and there are substantial costs, some of which have been clearly demonstrated—lifelong costs in physical and mental health and wellbeing, lifelong financial cost to the community. There are sensitive developmental periods that can be missed and the vital early months are foundations for building communication and relationship skills that are important for the long-term mental health and wellbeing of the child. Even the amount of weight gain. So advice around good eating, good dietary habits, breastfeeding, et cetera, can have lifelong impacts because the rapidity of weight gain in the first 12 months is a factor that is related to lifelong obesity, which is becoming a major problem for our community. Inequities are established in the earliest days and there are some programs that have been demonstrated to help address some of those inequities through parent support and parent training. There are lifelong impacts if they are not addressed.

Associate Professor EASTWOOD: That was clearly the focus of my opening statement and the focus of the work that I have done throughout my career. The whiteboard in my office has a diagram that would answer your question. There was something I picked up years ago called "High-risk Pregnancy Tracking" from California. The title itself says what we need to do. We are failing to share information across the government sectors. Our systems are not yet working together, despite the fact that we have been talking about it for a long time. There are significant attempts at the moment with the ChildStory and Family and Community Services [FACS] and I hope we will be able to access that in the future. To rephrase, we can achieve a lot by fixing the fragmentation of what we have got but that may require some changes in structures and processes. You asked us a question and I think we have all been not wanting to give you the answer that you are looking for. But I would like to endorse your question—structures and processes do need to be changed. For example, there have been some initiatives from our FACS colleagues over the years that probably would have been really good if they were more connected with the other education and health sectors.

The Federal funding of early childhood education in itself is a bit of a problem. The Abecedarian project was around quality, early childhood education. The Brighter Futures program that we currently have is for that but the Committee may or may not know that it has been cut back—90 per cent of the intake is from FACS, which means that the rest of the sector cannot refer to Brighter Futures. That was not the original design. Brighter Futures, which came out of the early EIP project, was a fantastic initiative. When it was first started it front-ended with Health in Bankstown, for example, which is where our SAFE START project really started from. So joining those systems up across welfare, health and education is what we have got to do. I am not able to give you the answers; that is really a piece of serious policy work. You asked about data. Some of our data systems hark back to an earlier period before we did psychosocial screening. So we do not have in the midwives dataset at the moment psychosocial questions from SAFE START—it would really help if they were in that dataset. We do not have an outcome measure other than that plan or the Australian Early Development Census. Would it not be great if when every child started school there was an outcome measure that related to what we were trying to do in the early years? And as a State we should be able to do that. There have been attempts in the past to have a wellness sort of check at school entry so we would know whether our sustained nurse home visiting program for group A had worked better than for group B, which might be sustained home visiting plus wraparound models of care. We would be able to know that.

Again, as I said in my earlier opening statement around evaluation, we have rolled these things out in an ad hoc way. There are methods now available to us in the scientific community to evaluate complex intervention. Often all it really requires is for the Government to organise who gets what and when and to have some measures in place to measure them. It does not have to be an expensive randomised controlled trial. These things are called stepped wedge designs—where you do it in local government area A and local government B and then next year you do it in a different area and measure the outcomes to know whether they are actually working. My last comment would be around qualitative research. Qualitative research is really important for us to understand what is working on the ground. How it is working or why it is not working comes from the stories of our mothers and fathers, it comes from the stories of our practitioners. They can tell us and so often what they tell us is the truth. It does not take quantitative, randomised controlled trials, which do not ever tell us that answer. They say, "It is not working because of X." We should be listening to the mums themselves.

Ms DIGNAM: From the moment mothers and mothers, and mothers and fathers, and fathers and fathers know they are expecting a baby they are parents. We have clear evidence that anxiety and depression in pregnancy has a significant risk to develop into postnatal depression, which affects the lifelong trajectory of a child—their brain synapses are developed in those first three years. It is crucial that we get resources to support that pregnancy and then the referral processes to child and family nursing. The research that is coming out of Perth, Melbourne and South Australia is that we can clearly indicate that a child is experiencing developmental delay by nine months. We know early intervention and prevention is the key to developing these children to their best potential. Often, most little ones will wait on a speech or an allied health waitlist. Their benchmark is 13 weeks but it often is longer than that as well.

It is just looking at the big picture. It does take a tribe to raise a baby, and we are working in silos and our families are living in isolation without that clear ability to navigate quite a difficult system. When you have a well and healthy baby and mother and father, or mother and mother, or father and father it is a difficult system to navigate and if you put any form of complex vulnerability in there it becomes extremely difficult to navigate.

Ms FELICITY WILSON: The main theme for me that has come out of our site visits and the submissions and you appearing today is around integration. As to continuity of care and fragmentation, I think some of that came in your answers to Mr Greenwich's questions. But I still feel, as somebody who has not gone through this system—and a number of us have not; I think the Chair is the only one here who has a family at this stage—it is very hard for us, not being engaged in the system, to really understand what is missing and what needs to change. We have had some feedback and some tangible, concrete suggestions around things like IT—sharing data between hospitals and child and family nurse systems—I know you are saying it is a very large policy piece, but for us to try and look at addressing that fragmentation, integration, deliver some kind of continuity of care, in some ways we need some quite concrete, tangible suggestions about how to go about doing that, because we are not the experts in the field, you are; and you are living with those systems and processes every single day. Maybe if you have a couple more suggestions you can add now?

Associate Professor EASTWOOD: I am going to take a punt—it may not be taken. We as a society and a culture have an aversion to tall poppy syndrome and yet I think what has been missing is leadership. Where there has been leadership in the State we have had success. We had Kaleidoscope in the Hunter, the work in south-west, the work in central, the work in south-east, the work currently in Murrumbidgee and the work in Mount Druitt in Western Sydney. So where there is strong leadership these things start to work. In the space that we are talking about today, when we had a contract from FACS we employed two perinatal coordinators: One was a clinical nurse consultant from a child and family nursing background and the other one was a social worker. I still believe to this day that that has been very successful, and it is still working down in Campbelltown if you want to look at the model, and central Sydney recently went down there to look at the model to see whether we would do the same.

Where you have large birthing units you have got midwifery, obstetrics, drug health, mental health, child and family, general practice, numerous non-government organisations [NGOs] like the Family Referral Service, et cetera, and it is just a recipe for fragmentation. Putting some form of leadership in place, whatever you want to call it, seems to help. I am sorry if that is not the answer you are looking for.

Ms FELICITY WILSON: At a local health district level?

Associate Professor EASTWOOD: I think at a local health district level and a facility level. As a college we train our community child health specialists in three main disciplines: child protection, child development and child public health. Where we have had successes in the past there have been a few people in child public health because they are trained to look at it from a systems point of view. So they are looking at maternal, child and family health from a systems point of view. That is the leadership I think we need in all of our districts—I am not saying they have to be physicians; in a lot of cases they have been allied health and nursing leadership, but we need that. If they are busy seeing patients all day long they have not got time to think about how the system is functioning. We need a bit of 0.5 or something—some sort of non-clinical time and an accountability and responsibility for system change, system leadership.

Our colleagues in New Zealand in the Paediatric Society for a while there were trying to do exactly the same; they were advocating that each district health board [DHB] in New Zealand would have a 0.5 person responsible for what we call in our discipline "population child health"—essentially the same idea though, which is to provide that systemwide leadership. It does not have to be a doctor; it could be nursing or allied health or even non-clinical, but it is that responsibility to provide local leadership.

Ms COLLIER: There are two things I would like to bring up. One is about IT. I do agree with that. Across New South Wales there are lots of community-based and acute care IT services that do not—

Ms FELICITY WILSON: Talk to each other.

Ms COLLIER: —talk to each other; you cannot talk between LHDs, and that is really klutzy and really fragmented. So that is an area that I have always been concerned about. The other area I would like you to look at is—this is outside of my representation from CAFHNA but, having worked in the Aboriginal Maternal Infant Health Service and Building Strong Foundations, those two services work with Aboriginal and Torres Strait Islander families and they work very closely; they are usually collocated and they work intricately together. They consult, they have a very good transition of services from midwifery across to child and family, and it works well.

Ms FELICITY WILSON: So use that as an example?

Ms COLLIER: Use that as an example.

Associate Professor EASTWOOD: I am sorry, I got so much on the leadership one I forgot that one. Tasmania has implemented their child and family centres. So the hub-based approach is a way of bringing people together. What we have found in the Redfern RedLink model, where we have got FACS, housing, drug health, everybody all collocated, including consumers, is that they form a relationship with each other and learn to work together, including our civil lawyers, our tenancy lawyers—they are all part of that. It is really a whole-of-system approach. Then that has a ripple effect that appears to be meaning that that join up, working together, is spreading out beyond that particular place. So these child and family place-based initiatives are a way of bringing groups together.

Ms DIGNAM: I was the clinical lead, with Associate Professor Eastwood, for the introduction of an electronic medical record to all community health, as per the Community Health and Outpatient Care [CHOC] electronic medical record [EMR]. All New South Wales, except Hunter New England, is now on the same system, and yet still there is no information exchange; we have access to one discharge summary letter. The information with data is extremely problematic, which, for our service in child and family health nursing, a perfect example is the domestic violence [DV] screening that is statewide now, the report. I am quite au fait with running our reports in the CHOC electronic medical record and there is no sequence of where that data is being pooled from from the medical records. So for midwifery, that domestic violence screening report is very favourable, but for child and family health it does not illustrate how much screening we do because there are errors in where the data is being pooled from within the medical record.

So one system that could really help New South Wales families is if our electronic systems could talk to each other. We have to do a separate referral system to our tertiary Karitane and Tresillian, we do a separate referral system to Family and Community Services, we do a separate referral system to the Child Wellbeing Unit, and our most vulnerable clients know that our systems do not talk to each other and therefore will then birth within different local health districts. So the local health district they reside in has no knowledge that they have had—

Associate Professor EASTWOOD: There is a lot of detail we can go into.

The CHAIR: I will give the last comment to the midwives before we wrap the session up.

Dr BURNS: I advocate for that community hub idea. I think co-locating services is the way forward. I would advocate for mothers, for women, to go there in pregnancy as well. We have them as a captive audience when women are coming to our services for that whole pregnancy. They are engaging with health services. Let us get them in a centre where they can see all the things available after they have the baby.

Associate Professor EASTWOOD: We want to do that at Forest Lodge.

The CHAIR: We may need to send you additional questions. If we do, your replies will form part of the evidence and be made public. Will you be happy to provide a written reply?

Associate Professor EASTWOOD: Certainly.

(The witnesses withdrew)

(Short adjournment)

CATHRINE FOWLER, Tresillian Chair, University of Technology, affirmed and examined

JENNY SMIT, Director of Clinical Services, Tresillian, affirmed and examined

GRAINNE O'LOUGHLIN, Chief Executive Officer, Karitane, sworn and examined

SHARLENE VLAHOS, Director, Education and Business Development, Karitane, sworn and examined

The CHAIR: Welcome to the hearing today and thank you for making yourselves available for this session. Thank you for your submissions, which we have read with interest. Committee members will have their own questions to pursue as a result. I do invite you to make a brief opening statement so we can go to questions rather than go over something we have already read. Does anyone have any questions about the process today?

Ms O'LOUGHLIN: No.

The CHAIR: I will invite both groups to make a short opening statement and we will launch into questions from Committee members exploring the themes we have taken from the submissions.

Ms O'LOUGHLIN: Karitane is a parenting support service established since 1923. It has a long history providing statewide services across New South Wales. We have a broad range of funders and collaborators. We are funded by NSW Health, by Family and Community Services and by the Department of Social Services for various programs. We provide inpatient residential care beds at our Carramar and Camden facilities. We have four parenting centres at Liverpool, Fairfield, Camden and Randwick. We provide a range of perinatal infant mental health services, toddler behaviour services and parent education support services across New South Wales. We have a very strong and robust education and training program for parents, health professionals and in partnership with Western Sydney University for training new graduates. We have a robust perinatal and infant mental health research program in partnership with the University of New South Wales.

Associate Professor SMIT: I would break with a bit of tradition and, given that we have a good introduction of our services in our submission, I will lead with the voice of one of our consumers who was present at the launch of a regional centre of ours and spontaneously provided this address, and who is happy for us to use it at this time. This is Elise's story:

> We first attended the Tresillian family care centre when Nash was five weeks old and like many of the babies who have been carried through those doors he was refusing to sleep. The first few weeks after Nash was born we had both my husband's and my family visit us from Port Macquarie and from Sydney and then everyone went home. My husband went back to work and I began my journey as a stay at home mum. I think this time was possibly the hardest. I was tired, hormonal, irritable, judgemental and certain that everyone was a better mother than me. As someone who had suffered from depression and anxiety pre-pregnancy, I was very aware of the need to monitor my mental health both throughout and after my pregnancy. I was terrified I would suffer from perinatal depression but every time I walked through this door and I was feeling down one of the nurses would look at me and say, "You're not okay today, are you?" And that was like a weight lifted from my shoulders.
>
> Navigating the uncertainty that is parenthood can be mind boggling. Having a place like the family care centre to go gave me a routine and support that I felt I was not receiving anywhere else. If my mother could be here today she would be giving each and every one of the staff a big kiss. As a first-time mum it is not easy for me not having my mother close by but I also know it is not easy for her to be so far away from me on this journey, but knowing I had this place to go to was a big relief to her.
>
> I also wanted to acknowledge the amazing support the centre gives with breast feeding. Almost every single mother I met through the mothers' group is still breast feeding at 12 months—which is well above the national average of 28 per cent. Nowhere else in my community was I given the support and encouragement to continue through the difficulties I encountered breastfeeding.
>
> The family care centre is the most amazing service. The staff are fabulous, the skills they teach are absolutely invaluable and the friendships I have developed through the centre's mothers' group have all made me a confident parent and given me the support I lacked having both mine and my husband's families living so far away.
>
> The people of the region are so very lucky to have this service available. It means hundreds of families each year can get the support and advice they need without needing to travel to Sydney or Brisbane or pay thousands of dollars to private consultants. I am so very happy to know that this service will be here for the parents that come after me and for me when I convince my husband to have another child.

Which she has successfully done.

The CHAIR: I will introduce the members of the Committee. My name is Kevin Conolly, I am the member for Riverstone and Chair of the Committee. Felicity Wilson is the member for North Shore, David Harris is the member for Wyong and Alex Greenwich is the member for Sydney. We have read the submissions and have some areas to follow up. If I can go back a step. When we set up the terms of reference of the Committee we were looking at the big picture and as we unpack it we have discovered many more facets to this issue than we realised were going to be there. The brief outline we understood is that in the field of looking after babies and parents in New South Wales there is a level of universal service provision provided through the health districts and then there are secondary and tertiary services for referral for people with particular needs. I would like a general comment from you about the strengths and weaknesses of this current system in New South Wales as it serves babies and their parents.

Ms O'LOUGHLIN: That is correct. Certainly from the health system perspective we have a strand of funding from health. We have universal, secondary and tertiary and Karitane fits into the secondary and tertiary referrals for our parenting centres being secondary and our tertiary beds for admission. I guess where we find some challenges are some of the gaps in the universal programs and when there are gaps in either service provision or nursing workforce on models of care and we find that there are people and families referred into secondary services who may not meet the threshold for a secondary service, but have no other avenue to pursue.

I would also say that for admissions into our tertiary referral beds, when you look at triaging the family's needs, particularly the rural and regional families, we have a third of our admissions from south-western Sydney, another third of our admissions from south-eastern Sydney local health district and another third widespread across New South Wales. Some families in rural and regional New South Wales may not reach a threshold for admission, but because they have no local services their only option is to travel to Karitane in Camden. There is also confusion because we have a plethora of non-government agencies providing services across local health districts, and there is no clear mapping as to who is providing services at the universal and secondary level.

As the child protection system and the risk of significant harm and families looked after in the FACS system moves towards an early intervention model of care, where Health has predominantly sat, there seems to be confusion as to the roles and responsibilities and who is delivering that level of care, particularly in the secondary space. We need to look at the skills and qualifications of the workforce delivering in the secondary space, whether they be health professionals or caseworkers with FACS. We can give examples of some of the work that Ms Vlahos runs with circle security programs and parenting programs.

Ms VLAHOS: That is done in partnership with some of the non-government agencies. A strength of that is that there is some collaboration between a service like Karitane with some non-government agencies, but the funding is quite inconsistent and the skill mix can be inconsistent. A lot of families that come to seek our service are mandated by court in restoration or preservation of custody of their children; they are mandated to attend a parenting course. We know from experience that attending an eight-week parenting course is not going to give you all the skills and support you need to meet the needs of your children, because of their history and their experiences of their own parents. That tends to be a real weakness. The collaboration is a strength, but having a really robust model of care to support those families has been highlighted.

Ms O'LOUGHLIN: If I could make one more point: It is the mapping of those services across New South Wales that is a significant gap. It is the distribution of those services: Are they meeting the needs where the more vulnerable families and communities are, geographically speaking? Whilst there may be evidence of strategic discussions between FACS, Department of Social Services [DSS] and Health, at the practical, operational, clinical interface that is very fragmented. As a service provider, that interface is very difficult to navigate.

Professor FOWLER: We need to look at new, innovative models of care, ones that are integrated—as everyone this morning has been talking about. We do not always need bricks and mortar; it is often looking at other ways to deliver the service. For example, Tresillian is about to open on the North Coast a mobile service to the Aboriginal community, where a child and family health nurse plus an Aboriginal health worker will go into the community to deliver the service, rather than expecting these families to come to us. Another example is that we work very closely with a non-profit organisation called Kathleen York House, which is in Glebe. It is an abstinence-based program for drugs and alcohol. It was recognised that for these mothers parenting is a major stressor. They can be rehabilitated, but if they leave the centre after six months they will go back onto the drugs, because they do not have support in the community.

We have a nurse as part of our extended home visiting program using evidence-based tools. She does an assessment using a program from the University of Washington, Seattle, the parent-child assistance assessment tool. She develops with the drug and alcohol worker an intervention, and they intervene. The beauty of the tool that she uses is that they can redo it and then they have an outcome measure. That is the sort of innovation that we need to look at. Tresillian has been doing lots of that work in regional areas and integrating very closely with the district health services.

Associate Professor SMIT: You asked about the universal—

The CHAIR: The strengths and weaknesses of the model in New South Wales and how the universal service works in collaboration, referring to secondary and tertiary.

Associate Professor SMIT: —and changes in the universal services have a downstreaming effect on secondary and tertiary services insofar as services that did not before offer secondary and tertiary child and family health services are now funded to do so. The Sustaining NSW Families program has in eight pockets across the State identified extended home visiting programs. We provide the training for that and we provide the training to nurses across New South Wales to provide these services. That has had a flow-on effect. Previously, we were the only secondary and tertiary child and family health services in one of our districts, and we were impacted by it. We found that monitoring and being very flexible in growing new services or identifying new areas that are not being well served is the way that we have survived for 100 years.

The CHAIR: That is strategic coordination, which picks up the point about mapping made by Ms O'Loughlin.

Associate Professor SMIT: That is exactly right. It would be good if that mapping was a bit more explicit on the various services in the area, so it is up to each service provider to be astute, vigilant and redirect their resources so that we do not duplicate services. We are not interested in duplicating the universal services, but we are certainly impacted by the decisions that are made at a local health district level about where the services are provided. Associate Professor John Eastwood this morning identified training GPs, because now our referrals from GPs have more than doubled. With that comes a slightly less prepared family; if they had come from child and family, they would have had first-level strategies already tried and tested and then been resistive to those first-line strategies, which makes our second-line strategies more impactful. For those who are referred by GPs, we need to provide more first-line services, because they certainly are not resourced.

The CHAIR: That sounds like the universal service not really living up to its design and not being implemented in a way that the policy says it should be.

Ms O'LOUGHLIN: That is correct.

Associate Professor SMIT: Professor Fowler mentioned new ways of working. We have designed a day services model of care around packages. The model is very flexible around the needs of families. If they have come from a GP, it might be more appropriate that they attend a quick clinic, because their issues are likely to be less complex. They have a quick clinic, and from there we make an assessment to see if they need a secondary level intervention program. That applies for our regional services as well.

The CHAIR: I have a related question. Given the intent that people with high needs are referred to secondary and tertiary services as appropriate, when people are referred to you, is that happening in a timely way? Are they referred when they should be referred as a norm, or is there often delay in people reaching the help that they need?

Ms O'LOUGHLIN: I will speak for Karitane. Yes, It is absolutely patchy, and it depends on the local support systems. With the plethora of parenting support services that exist across New South Wales, sometimes families find it quite challenging to navigate where to go for help. If that is to their GP, we have our significant online referrals to make that process of referral quite quick and slick. It depends when the parent seeks the report. If there is no universal or home visiting program, or they are not tapped into that, it is picking up these families at that very vulnerable phase. Intake and triaging of families is a significant problem across the State because we have families sitting on various people's waiting lists. They may be on Karitane's waiting list at the same time that they are on Tresillian's waiting list. Getting to the point of care is one issue that is patchy, but once you get to the point of care, then there is the access and waiting time to get to the service. But you might come to that in a later question.

Ms FELICITY WILSON: Thank you for being here; it is lovely to see you all again. I have a few questions that you have already touched on and maybe you will be happy or unhappy to expand on those. One question is about the geographical regions and the different needs. Are there areas where you think we are not addressing those needs because we do not have services that are provided in those areas or do you think there is—I do not know if you could ever do it—an over-service in certain areas? I thought maybe you could observe if you think there are different types of risk in those areas. When I meet with people, families and parents in my local area, there is a large number of children in private hospitals. We also have a much later average age of first-time mums and dads. Are there different factors, different types of needs in different regions, and do we have the adequate services to address those?

Associate Professor SMIT: It is really important that you get a feel for the community. You can go to the Socio-Economic Indexes for Areas [SEIFA], or you can go on a much more responsive relative index for need. In the north shore you will not pick up people that run a little below the threshold where they are easily identified, so with regards to postnatal depression, perinatal depression and anxiety, we have thresholds where all sorts of resources kick in if they score on an average scale, but it is the people who are running below that that require an intervention. The sooner we get to them the better for the most impact we will have on the long-term sequelae that we know occurs for them as adults. It is really important that under a span of collaboration and consultation that we engage with the community. At Wagga, we have engaged with the Indigenous community who are identifying to us the way in which the services should be delivered. They have branded the centre. In fact, the centre is in the Indigenous language and it is translated into English, which sends a loud message to that area. It is not Indigenous that is the need, but it is linked to poverty and neglect and abuse, and that says these are vulnerabilities that we must address early. We are doing a PhD study.

Ms FOWLER: Yes. One of our staff members who works in the rural area is doing her PhD with me and she is looking at how we can translate existing Tresillian models into the community in rural and isolated communities. We know that we cannot just pick it up and replicate it in all areas. She is doing an action research project and using Wagga Wagga and Lismore as her case studies. She is involving both the original community as well as the stakeholders and consumers in her research to see what is needed to adapt the current model into a rural and isolated area. The other thing I think I need to say—the joy of working in a clinical chair with Tresillian—is that I have another student at the University of Technology Sydney who has been looking at the mental health of two women post-delivery in private hospitals on the north shore. She has found that there is a real deficit of asking psychosocial questions that are asked in the public hospital. There are more women, and I cannot off the top of my head remember the number, from a private hospital who end up with a mental health disorder than from the public system.

Ms O'LOUGHLIN: If I could add a few points, please. Coming back to your point about the geographical areas and the different regions, we can work on the SEIFA, and there are families who do not meet a particular threshold, I guess, of vulnerability on these measures, but they may have social isolation. I think you are going to hear from the Volunteer Family Connect program about how those families may be better supported in the community. When we look at the children who are in out-of-home care and at risk of significant harm and we look at those particular communities, we can see there is a significant overrepresentation of Aboriginal children in care. We know that our early intervention prevention methods are not as effective as they could be, even when we are well resourced. We are in south-west Sydney, which is a huge geographical area, but we have trauma, refugees, domestic violence, a huge culturally and linguistically diverse population, so even when you have what are considered to be a considerable amount of resources compared to rural and regional, we are still not meeting the needs of our local communities.

We are looking, as are Tresillian, at telehealth models for the rural and regional communities, but there is a scepticism among rural and regional communities for fly-in and fly-out models—people coming out from the city and "fixing" our problem. So it is that immersion and how you build the trust of communities to have a presence in the community, whether it be Aboriginal or other communities that are rural or regional. We are looking at a program called internet-delivered parent child interaction therapy [PCIT], and we are delivering our program to young behaviourally challenged toddlers through the internet, which is supported by the New South Wales mental health innovations tender. Also, how do we do virtual consults with these families and how do we build an infrastructure for information technology [IT] support so that families can access all services through the web or through virtual consultations? I am sure we will explore that a little bit later when we come to technology. I do think it is very patchy and it is not necessarily that the more resourced districts are getting to see all the families either.

Ms VLAHOS : It cannot be cookie cutter either. There are only 12 secondary parenting services funded by Health across the whole of the State, so when we look at it—there are 96,000 births in New South Wales each year—we are looking at those disparities. Even for the perinatal infant mental health services, Karitane has Jade House, which is specific for parent and infant mental health. When we look at the statistics from last year on that service, we saw just over 600. When you have one in 10 who are at risk of developing a perinatal mood disorder, that is 10,000 women; but only 600 were seen. A good point was raised about screening in private hospitals versus what happens in the psychosocial screening process in the public system, which is probably well cemented. But there is that disparity. Where are they accessing those types of services? They can be geographically bound. We have local health districts versus FACS boundaries, which are different; they are not the same. Where do they all fit and who goes to who? It is difficult for parents, but it is also difficult for the health professional or other professionals who are trying to navigate the system and find the best service for those families.

Ms FELICITY WILSON: From your experience do you have any views on the adequacy of antenatal screening for mental health risk factors and whether or not we are doing a good enough job of that so that they are identified early enough and managed and do not have to go towards a secondary service postpartum? What are your views on the tertiary support services available, particularly for mums? I get a lot of feedback about not having enough mums and bubs beds for people with acute psychiatric needs. Do you have views on those two aspects?

Associate Professor SMIT: I absolutely agree about the lack of beds. We have been working with the ministry. Even three years ago there was a focus group headed up by Beth Kotze about mother-baby beds during the acute psychotic phase postnatally or even antenatally. There is an absolute dearth of them in New South Wales. Most of the States in Australia have them but not the Australian Capital Territory, not the Northern Territory and not Tasmania—and, really, apart from two, not New South Wales either. But I do know that there are big moves afoot as we speak on eight mother-baby beds in our district. I do see a definite role for the likes of us for our residential beds, of which there are very few, to provide a step-down service straight from the secure unit once the mother is a little more stable and more receptive to then be supported by our services around attachment and parenting. But that is very much at the one end.

In the middle is a lot of psychopathy that is not well enough addressed in a holistic, integrated way. I do not think there are enough services out there. I think that is the one area where there is unmet need, firstly, due to identification and, secondly, due to access. There are the parenting programs for postnatal depression and Circle of Security. We run a sequential postnatal depression program followed directly with Circle of Security where we are getting good feedback—it is actually unpublished research at this stage—on how efficacious that is. Once mothers have had 16 hours worth of postnatal depression programming support they get a lot of value out of the attachment-based therapy in the Circle of Security program.

Professor FOWLER: The good thing about that is we invite the fathers to the Circle of Security component of it and they also have some sessions within the postnatal therapy group.

Associate Professor SMIT: Their feedback is they love having it with this spouse who is much more present in their relationship and in the interactions.

Ms O'LOUGHLIN: You talked about the screening in private hospitals. There is some work being done. I do not know if you will be interviewing Dr Vijay Roach. He is part of the Gidget Foundation but also about to be the president of the Royal College of Obstetricians. Karitane has a researcher who does some screening work antenatally in the private hospitals on the North Shore. That is certainly a model that Vijay and we would be keen to roll out to other private hospital models so that there is that earlier risk factor identification. Dr Jane Kohlhoff is our researcher in that field. I would absolutely concur and agree with Associate Professor Smit and Tresillian's comments around the lack of mother-baby beds. We see our secondary or tertiary residential units as a step down or even a step up into those units. I would also go one step further that those mother-baby beds need not just health professionals but also child and family health nursing services where the baby is admitted alongside the mother so that there is a real wraparound support service for those babies.

In psychology and psychiatric intervention there is a gap across New South Wales. It is very patchy. I think I have seen a submission from the Statewide Outreach Perinatal Service for Mental Health around telehealth outreach services. I know the Gidget Foundation has just recently launched its Start Talking Medicare-funded type intervention. Again, I think we are getting a number of services popping up but there is no real gap analysis of who is accessing them, is it the right people at the right time, is it coordinated, who are the service providers, and are we in danger of duplication with all these pop-up telehealth models and outreach services? There is no real and cohesive strategy that brings all of us as service providers together to ask what is Tresillian doing, what is Karitane doing and what is Gidget doing? You can get a real helicopter view, even though I would say every one of us is doing fantastic initiatives.

Ms VLAHOS: You asked if there is enough antenatal screening being done. There is some stuff around governance around sharing of information that families do not fall through the cracks and so some of them are screened antenatally, but where does that go? There are what we call SAFE START meetings but it is very strict about who can attend even though there could be other great service providers that could provide the best service. We should be really looking at those governance strategies to ensure that those families do not fall through the cracks.

The CHAIR: It is not just an IT thing. It is the protocol about information sharing and access.

Ms VLAHOS: Absolutely, with the child at the centre of the care. I think we have to keep the child in mind. That is really important.

Mr DAVID HARRIS: Is there enough being done with prenatal care, and how does the amount of prenatal care impact on what you do after birth?

Ms VLAHOS: We are trying to engage and work closely with maternity units and antenatal classes that are available. There is some work around whether parents are receptive to that type of information, because in the early stages we get a lot of people saying, "Why didn't anybody tell me it would be like this?" That is one of those things that we have to break down. I do not know the right answer to that or what the solution is, but parents are very focused, naturally, on just delivering the baby safely and having the baby. How early do we start some of this education around parent-child interaction and the infant attachment and responsive parenting and all of that stuff that we know around brain development and early attachment? That is one of the things. It is about getting in very early and linking those services antenatally.

When they are going to those birthing classes we can say, "Here is a really important thing that we know now about your baby", and try to build that relationship and connection because we know now from the research that a high stress pregnancy has those effects on children's brain development and their attachment in the early stages. I think there has to be a shift with that and a focus. They are not going to hear it all at that particular time but certainly let us plant the seed so when there are things that we are introducing and starting to talk about they can go, "I remember that. I remember someone mentioning that before."

Ms O'LOUGHLIN: I also understand that there is a new Medicare schedule item that was introduced last year for private obstetricians particularly that between the delivery and the six-week check there are some child and family interventions that are funded to be provided for some of that earlier screening, certainly for mental health, domestic violence and other issues that are cropping up. It is a question of timing. We are going to have to work with the obstetricians and the midwives at that very early postnatal phase because by the time people get back to their obstetricians or go to their GP with a presenting problem you have already lost some valuable time. Then they are sitting on a waiting list. On our waiting list it can be 10 to 12 weeks for a single family to come in and up to 21 weeks at the moment for a family that has another toddler that needs to be co-admitted, because we have no bed space. That is nowhere close to timely intervention. You can imagine how you would hold and support those families that are in desperate need during that time.

Associate Professor SMIT: Definitely further to that, it is important to reassign resources to where they are needed. If the universal, the secondary and the tertiary service can be sitting around the table prenatally so that that family understands that, at various transitions of their family life, the midwives and obstetricians will have a primary role and thereafter it is child and family. It is clear that these risk factors are identifiable based on a trusting relationship, a therapeutic alliance with the health provider and the family. It takes a while to build up that trust because, for those who have had experience, some of it is not that positive. But if we could all be sitting around that table prenatally case reviewing with the family then none of this will be a surprise to them in terms of relationships. If these resources can be focused on families that really do need it to start but we have still got to provide services to everyone else because of Elise's story—clearly she had risk factors but there was resilience there. It is identifying where the resilience is and dropping off to focus on others where there is deep ongoing need that is going to require a wraparound. A co-location of service providers is very important—psychology services, child and family health services—long term. I do not think we should cease services prematurely.

Professor FOWLER: Just to add to that, NSW Health is already doing some excellent work with the Sustaining NSW Families Program [SNF]. The nurses go in during the antenatal period, from 20 weeks on, and are able to give a few visits to parents who have been identified as being at risk. They develop a trusting relationship at that stage. They are able to work with the mother on issues around parenting early and they work with a different focus to that of the midwives. The midwives are still going in. The child and family health nurses have a very clear agenda around parenting and they do not really work with mother around her pregnancy. So there are professional boundaries but professional respect between each speciality. The parents stay with the nurse then right through until two years of age. These are the sorts of models that we need. Unfortunately, SNF has not been expanded across the State enough.

Mr DAVID HARRIS: Is that service run across the whole State or only in some local health districts?

Professor FOWLER: There are eight programs.

Mr DAVID HARRIS: That is how they operate on the Central Coast.

The CHAIR: I think there are eight pilot programs. Is that right?

Associate Professor SMIT: There are three pilots underway.

Professor FOWLER: It has been going for five years. The nurses that go into that program, as opposed to many of the other home visiting programs, are doing advanced nurse practise. They are having a year's program that many of the universities now are accepting as credit into the Masters of Nursing program as one subject.

Mr ALEX GREENWICH: One of the concerns I have observed, both in submissions to this inquiry and in things that you have all said, is the Government's approach to funding the sector—that is, it seems to be a spending focus rather than an investing focus. The Karitane submission touched on the return on investment for funding the sector properly and the long-term outcomes for people. Can you expand on your experience or views on shifting from spending on services to investing in outcomes?

Ms O'LOUGHLIN: All the different government departments we talk to are focused on evidence-based programs, which is fantastic. We all agree that we should be delivering evidence-based programs but there are some issues that sometimes we are delivering the incorrect evidence-based programs to parents. So we are not matching the program to the parent. Instead, we are just saying that we have got a bunch of people in social security and that is the only program—I am not saying "us" but other agencies et cetera. The skill level of the people providing them and the integrity of how those programs are delivered are an issue. The longitudinal studies are very low in child and family health in Australia so we do have to look to the United States for some of the longitudinal studies. It is emerging, we are doing a lot of research, but there are some programs that I would say are thinner on evidence that are receiving a significant amount of funding.

The other thing about funding evidence-based programs with known outcomes is that sometimes it can stymie innovation. So where do you get the money to trial and pilot innovative modes of care? People are saying, "We are only going to fund it if it is evidence-based," but we cannot fund the establishment of that evidence and that is somewhat problematic. We do—and the Committee will hear from our Volunteer Family Connect [VFC] program later—look at social return on investment and return on investment studies linked to that longitudinal outcome of parent-child interaction therapy [PCIT] work. We know that has got a significant financial return on investment because it stops a whole pathway for a child if we get that early intervention correct. So there is evidence there but I do not believe that we have done a significant amount of work on return on investment in Australia, and partnering with organisations that can support us in that really is a critical factor in my view.

Associate Professor SMIT: I think outcomes always have to be the focus and I absolutely agree with Ms O'Loughlin that these outcomes are longitudinal. There is definite emerging and significant evidence about the effects of toxic stress antenatally in adulthood; it is profound and absolutely convincing. If the impacts of the parenting interactions, the responsiveness to the infant, is that a secure, resilient child enters school then it can only be worthwhile and we are not then dealing with the extraordinarily expensive cardiac disease, mental health disorders, all of the sequelae in adulthood that was not adequately addressed in childhood. With the intergenerational trauma that is occurring in some communities, working with the communities to help break that story is deeply attachment-based to responsive, positive parenting and that can only make a difference to society.

Professor FOWLER: If we can do randomised controlled trials [RCTs] that is the goal measure and that is fantastic but there are limitations to RCTs. And as John Eastwood mentioned this morning, there are other cheaper ways of getting the evidence and identifying what is needed—like his stepped wedge design—but also his mention of qualitative research needs to be looked at very closely. It gives a voice to the parents, where often RCTs are measuring the pure outcome. It is the interpretation of the statistics, but if you do not have the qualitative integrated with it then it really does not give you a full picture of what is going on.

Ms O'LOUGHLIN: It is really about measuring the dosage of the intervention and the frequency, as well as who is delivering it, what the type of the intervention is they are delivering and who it is to. I really do not think that we have shaped that in a very sophisticated way just yet.

Professor FOWLER: I totally agree with that.

Ms FELICITY WILSON: Just relating to your comment on Sustaining NSW Families, do you have a recommendation that it should be rolled out more broadly?

Professor FOWLER: Definitely more broadly.

Ms FELICITY WILSON: Would you say everywhere or do you think it should be targeted?

Professor FOWLER: That is the difficulty: who do you target it to? As has come through in some of the other submissions, until we have the families with us we do not know that there is a problem. The North Shore has not got a Sustaining NSW Families program and yet from what we are seeing from the research one of my students is doing, and even the research that Tresillian and Karitane have been doing together as an ARC, it identified that over 50 per cent of the clients who come to us have some form of mental illness, and a lot of those parents you would not know that they had a mental illness unless they had developed trust and were able to tell you that.

The CHAIR: We will have to wrap it up because we have some other witnesses waiting. Thank you so much for your time, your input and your expertise in the field—we value that greatly. If the Committee decides at the end of the day that we need to ask you some more questions we will put those to you in writing and ask for a written response and your replies would form part of this evidence and be made public. Would you be happy to do that?

Professor FOWLER: Yes.

Associate Professor SMIT: If I could just say that if you had any questions around future workforce issues—somehow that did not come up—we would be extremely happy to provide you with a written response around that. It is a train on tracks bearing down on us in five years time.

(The witnesses withdrew)

REBEKAH GRACE, Researcher, Volunteer Family Connect, sworn and examined

JAYNE MEYER TUCKER, Champion, Volunteer Family Connect, sworn and examined

JULIE HOURIGAN RUSE, Chief Executive Officer, Fams, sworn and examined

KIM STACE, Capacity Building Consultant, Fams, sworn and examined

The CHAIR: As you have just witnessed some of the proceeding already you will know that we will be asking questions mainly from having read your submissions. Before we do that, we will ask you for a short opening statement to tell us a bit about yourself or your organisation and where you fit in, but you do not need to go over the submissions because we have already seen those.

Dr GRACE: I am a senior research fellow at Macquarie University. I have been part of a collaboration along with three non-government organisations—Save the Children, the Benevolent Society and Karitane—as well as another university, Western Sydney University, and another corporate partner organisation in Ernst and Young. We have been working together on the Volunteer Family Connect project and I lead the research as part of that work.

Dr MEYER TUCKER: I have the absolute joy of being the Volunteer Family Connect Champion, which is having the coordinating role between those three delivery agencies and the two universities. That whole project is funded by FACS, so we are talking about an almost six years randomised control trial and social return on investment to the tune of nearly $8 million in total. This project is a very exciting one to be talking about particularly today as it is National Volunteer Week.

Ms HOURIGAN RUSE: Thank you for the invitation to speak before the Committee. Fams is a FACS-funded peak organisation in the early intervention and prevention space. We have been working since the early 1980s to support traditionally family support services, but as the service sector has changed, services that provide support across the continuum from early intervention through to tertiary services. Our members are diverse in both their size and their geographic location, and one of the things that we have noticed that is a constant challenge for Fams members, they're FACS-funded services, they are not health provider services, but what we have noticed is the definition of early intervention and prevention has become quite contentious as it keeps changing and being pushed further up a continuum toward crisis responses rather than the traditional area that we would see existing. So whilst we know that there is a very large number of kids at risk of significant harm and at crisis who need a response, the concern around a diminishing of early intervention services, particularly for new parents and babies, is a key issue for Fams.

The CHAIR: I will ask a general question but kind of tailored to what I have just heard. We have heard today that much of the field that supports families and parents in particular with young babies is fragmented, that there are many non-government organisations as well as various government initiatives of a patchy kind that operate in some places and not others. Can you tell me how adequate do you think the overall service provision is when it is composed of so many different parts, and how well do they work together?

Dr MEYER TUCKER: I think that the key point you are making there is that you have heard this in just the parts that we were listening to, and I am sure the whole day will have this coming up in conversation, there is fragmentation—and it is not necessarily saying this as a finger-pointing of blame approach. I would probably come from the angle that maybe the kind of world we are living in now is very different to the systems and the way things were structured in, say, the 1970s, 1980s and going onwards—if we look at the twentieth century as opposed to the twenty-first century. So I would suggest, answering your question, maybe it is just that we are not fit for purpose at the moment and, therefore, trying to put structures in place that used to fit is a waste of people's time and we would be better off putting our energies into thinking what are the kinds of systems and processes that we need to fit this twenty-first century?

Ms HOURIGAN RUSE: I would agree with that. I think the thing I would add to that is that some of the historical reporting mechanisms that particularly government-funded organisations face are not a true reflection of the work that they are doing. We have contracting and historical models where people report on outputs, where we have a lot of NGOs doing great work, but they do not have a mechanism to report that to their funder; it turns up in annual reports, it turns up in case studies, it turns up on websites, but there is no consistent way of feeding back the work that is being done that truly works. Fams often talks a lot about innovation being the new black.

We hear that a lot of what we need in this space is innovation. I would challenge that. What we actually need in this space is clean air to identify what is working really well. There is a lot of work going on. Yes, it is fragmented and that is part of the problem. Because it is fragmented we cannot often see the great work being done that we do need to replicate and scale up. We do not necessarily need a whole lot of new stuff. We need to get rid of some stuff that is not working and there is a whole range of reasons why government is continuing to fund programs and initiatives and, dare I say, NGOs that are not delivering outcomes for the communities that they are serving. We need to make sure that we do not throw the baby out with the bathwater in addressing a fragmented system.

The CHAIR: One of the comments I am picking up from that is we are not necessarily measuring the right things or all the right things in terms of reporting. While we are talking evidence-based programs, we are missing some of the dimensions that should be reported.

Ms HOURIGAN RUSE: I think government is not clear about what outcomes it expects to see from what it funds. On the whole we are unclear about what programs and individual NGOs can actually be held accountable for in terms of their role in a system. We all do work that contributes to outcomes; we cannot all be held accountable for every outcome of every family. There are far too many intervening factors when you are talking about family support services that are working in a space with kids nought to 12 to then try and draw a line that says those kids are going to have great educational outcomes and be economically self-sufficient and own a house—it is a bridge too far. We need to be clear that we are not over-claiming what NGOs can be held accountable for in a system. We need to be very clear about how much funding and what resources are in the whole system both from a government's perspective and an NGO's perspective to resource the outcomes we are expecting to see.

The CHAIR: One thing you highlighted is that we have a relatively narrow focus in this inquiry at the early end of your work, but there is a continuum, a spectrum that goes seamlessly onwards, that you have to worry about. We will focus on the front end of that today.

Mr ALEX GREENWICH: Following on from the Chair's question and the answers you provided, in terms of a starting point for that coordination work, where do you see that? In your submission NSW Family Services Inc. [Fams] recommended consideration of the Clear Impact Scorecard. Where do we start? We know what the problem is, where does the solution start?

Ms HOURIGAN RUSE: In community. There are a lot of tools and Results Based Accountability, and the Scorecard is one, but we need to start in community. I completely agree with Dr Meyer Tucker's point, that we have services in places where they were needed in the sixties and the seventies. We need to go into community and have conversations about what success looks like in those communities—what a community is saying is working and what a community is identifying that is missing—and be responsive to that rather than us simply saying we have been funded to deliver Play Group or Circle of Security or triple-P [Positive Parenting Program] or any other myriad of programs that we like to do.

Mr ALEX GREENWICH: Who is the "we" in that when you say, "We need to go into community..." and ask where the services are needed? Is the "we" the sector? Is "we" the government? Is it a specific department? Where does this responsibility lay? Who is the best person to deliver on it?

Dr MEYER TUCKER: Can I jump in, if it is a shared response? I think the "we" is everyone who has a touchpoint in that child's life. It is the future of how we move forward from these kind of conversations; nothing is actually decided upon or actioned upon or funded or even attempted unless it has that remit. That is a very different point from if you are actually working in a program specific way. If it comes from the needs of the family, the child, and then what are the best ways to meet that, we have learnt in our research. I am sure Dr Grace is able to add to that. One of the key things of how volunteering has worked and stood the test of time has been the fact that the way that the volunteer works with the family changes depending on their needs and what service are available in their locality or not. I think it is a fundamental part of working from the needs first and everyone taking that responsibility.

Mr ALEX GREENWICH: Just to clarify, think of it in the context of should this Committee make a recommendation that there needs to be better coordination of services in the sector and where the responsibility for that should lie—how do we define where the responsibility should be lie?

Dr MEYER TUCKER: I am going to be really cheeky and say that is actually falling into the same trap, which is the last thing you should do in a panel. I think we all—and not just yourself in the way you responded—have to change how we think about this. It is no longer about the particular services or particular programs. That kind of language has to be removed and we need to start thinking about the life trajectories and at what ages should those children be expected to have achieved. Once you start having the focus from that point you can then talk about the governance arrangements, about the funding arrangements and organisations who are caught within that. Government and non-government can then start to talk about how they will proceed and be measured.

I am asking for a bit of a check-in here, Bronfenbrenner's ecological theory is a well-renowned model which puts the child at the beginning. It is an ecological model, it is an ecosystem, and it spells out clearly how the responsibilities come out in that circle once you start from the language always being at the child. My plea for the inquiry moving onwards would be that you have a check-in that you do not fall into the trap of services and programs and responsibilities as your dialogue. It is child first language; it is very different.

Ms HOURIGAN RUSE: For me, someone needs to lead it from a position of authority. We get bogged down in agency and if Health lead then FACS will not play or Education and Justice will not play nicely with somebody else and we do get caught in a spiral of people not being able to work out how to move forward. The trap is we spend so much time working out who has to be invited to the table that we never actually get to the table because we never start. We are so concerned about offending somebody because we inadvertently do not invite them that the work becomes setting up the committee. The work becomes identifying who is going to lead the work.

We just need there to be a statement. Ideally, in New South Wales it should be the Department of Premier and Cabinet who lead the work. They should come out from a position of clear authority and say, "The direction for New South Wales that we want to see is" whatever it is, and just name it. Once it is named we can get behind it and we can find ourselves in it. While ever we spend time working out what that model is going to be we are not doing the work that we should be doing to get better outcomes for kids.

Ms FELICITY WILSON: You talked quite a bit about things coming out in other comments around demand and how we manage that organically increasing demand with population growth and additional challenges with demand and pressure on secondary services because of maybe some weaknesses in universal services or additional demand on tertiary services because of a lack of resourcing in secondary services. Can you give a view of what you think needs to change for that to occur? We had comments from the last group about some people being referred to a secondary service because they go through a general practitioner pathway rather than through the child and family health service. Why are people moving into the wrong levels of service so we can look at how to address that?

Dr MEYER TUCKER: When you are in a dysfunctional space, life is not treating you too well and maybe you have more than one child or there are drug issues or mental health issues—I am painting a picture of some of the challenges that many of the families are confronted with—you do not tend to make decisions that are best for you or for your child. Therefore what happens with some of the systems we have, they do not really put a safeguard around people who are making dysfunctional decisions. This is a problem if people do not attend or are not in when a nurse has scheduled a time to visit with them. Then it can be weeks before there is any kind of care.

The reason I am painting that picture is that some of the challenges we have tend to escalate. What we need to think of in the revamp—which is the reason the New South Wales Government is asking, "What can we do different?"—is to think around this step up and step down. That is really important. What are the things that can strengthen our families who may be on a negative trajectory? What can we do to get in early from a prevention measure and then what are those other steps that can be taken for families who have been at the extreme end and still need to have care as they get back into some form of normality. Anyone who has ever had a child would know that life goes up and down those stages all the time—constantly. It is not necessarily that you have to be intensely dysfunctional to be suffering this. There is energy to be put in that step-up and step-down window.

Ms HOURIGAN RUSE: I also think there are two competing challenges with the system. One is the system expects that people know how to engage with it and they have enough self-awareness to know when they should engage with it. They should have enough knowledge to be able to find it geographically. They should know what services are in which area and what they provide. As someone who has been involved in this sector for a very long time, I still struggle to work it out and I still discover things that I did not know existed that I wish I knew existed 10 years ago because I would have made very different choices for some clients that I had worked with at the time. I also think the system is a victim of its own success or failures, in that people's prior experiences with the system impact how they then engage with the system going forward.

There have been conversations that we have heard through our members. Even though they are not health services, they are working with families and mums particularly whose first connection with the hospital was the day they turned up to give birth. That is because they are mums who were children in an out-of-home care system or children who were in families who were affected by family and domestic violence and they do not trust the system because they have their own negative experiences of the system's response to them. That is unfortunate but it is a very big factor in why we have people who make the first contact with the system at a secondary and tertiary level rather than at an early intervention level. We need to make sure that one is an education and awareness raising so that people know what is available to them, but we need to make sure that people feel that the system can be trusted for them to engage with it. For very big chunks of our community that is very difficult.

Dr GRACE: I think if it is okay this is an opportune time to talk about the handout that we provided. Is it okay if I talk through that a little and what it means?

The CHAIR: Yes.

Ms FELICITY WILSON: I was going to ask about information sharing as we have asked some of the other groups. Is there information sharing among different services such access to data, IT systems and things like that. I am not sure whether that would form part of this but that was something in which I was interested.

Dr GRACE: This is really about helping families. I was going to use it to talk about the difficulties that some families can have engaging with formal systems and the sorts of mechanisms that need to be in place to support that kind of engagement. That is probably going back to an original question rather than that build-on question. Is that okay?

Ms FELICITY WILSON: Yes.

Dr GRACE: This is a little diagram that we put together which we think is quite useful. We would argue that for family health and wellbeing there are a number of different but all equally important forms of support. On one side where it refers to "Professional services and relationships" that describes the primary services that are available to help families—the universal and primary services. At the top of the diagram are the secondary and tertiary services—the more intense services. We also know from research that social support and the friends and family who are around to support families are very important. I would like to focus on a square that is rarely discussed, which is about structured social relationships. That is where Volunteer Family Connect fits.

On a continuum of services available to families we know that there are families who struggle to engage with formal services. There are all those sorts of families that Ms Ruse was just describing. They are often lost and then only come into contact with services when the difficulties are so severe that they are hard to ignore and it is tertiary level services that then become involved. A program like Volunteer Family Connect is all about trying to catch people before they reach that stage. It plays such an important role in helping to link them with the other formal services, helping them to become aware of the services that are available in the community but also accompanying them and supporting their engagement with them.

A typical example might be a family that is a new arrival to Australia. They do not have family support around them to help support their wellbeing; they do not understand the service system; language may be a barrier; maybe they have had traumatic experiences that prevent them from feeling comfortable with any sort of professional network. But another community member who speaks the same language who is then connected with and works alongside that family can help them to understand how the service works and can accompany them to the child and family health centre or to the GP and form such an important step-up and step-down role.

It is volunteers who can develop a relationship of trust, or community members who develop relationships of trust, who then may become aware of domestic violence or other issues within the family and then help to link them in with those services. What is really important is the continuum of services that are available from the very pointy end right down to community members who can play such an important role in addressing some of those barriers that lead to the inequities that we see for families in our communities.

Mr DAVID HARRIS: You mentioned that we have to do a remodelling of the sector. Are there any best practice models around the world or interstate—funding models, provision of service models and workforce provision models—that you can share with us?

Dr MEYER TUCKER: I would not be a volunteer champion if I did not say that with the Volunteer Family Connect being a world first, randomised control trial and social return on investment, we have one sitting in Australia and in New South Wales. It is actually the whole of Australia but the main bulk of it is based in New South Wales. I do not say that as "a preciousness" to a program; I say it because it is a great example of where you make major inroads if the delivery service agencies work together. They had to come to an agreement in having one manual so they all had to work to one way of operating. It was difficult as well to get a methodology between a randomised control trial and a social return on investment, and to get that alignment across a couple of universities. I think what I working to hear—because there is some government funding and some non-government funding—is that joint alliance. That joint alliance is fundamental to some of the future models that we are talking about or that we are going to need to encounter. That would be one of my answers.

The topic or the end product is that the best for the child cannot be owned by any one agency—they are all working towards achieving the outcomes. That is another fundamental part of what the future would look like. We all suffer from the case of: What do you do when you need the investment up front and it needs to be long term but the cash flow is getting less and less? I think this is where it comes to some hard decisions and we have mentioned that in our discussion today. There need to be some organisations that do not need to exist. In a previous life, having done a merger in not-for-profit land, it is a very important thing to do.

Those are the kind of conversations that need to be had, and you can have them if the focus is at the core of why we are doing this: It is for the betterment of the children's life, not necessarily to build organisations or to have silos et cetera. We have some fundamentals of what could build the criteria to then help us work around some of those Government decisions. I would be as bold as saying, "Never any funding unless there is a very seriously demonstrated partnership." I know that is a little bit out there but that, for me, is how we nudge this approach and we stop having organisations being, "It is about us."

Ms HOURIGAN RUSE: Our submission speaks to examples internationally that are working. With respect, I am going to be cheeky and go back to the question by the member for North Shore around data and information sharing because that is an issue that Fams is very passionate about. In our experience, particularly in an early intervention and prevention space, we see that issues around privacy and consent are used as a barrier to prevent information sharing. We do not start from a place of information sharing for the benefit of the client. We do not start from a position where, if we get consent about why we need to share data and information, we can work more collaboratively together to get better outcomes. I am aware of some work that the Data Analytics Centre is doing around breaking down some of those legislative barriers to information sharing and being able to facilitate better sharing, not only within and across government agencies but also between government agencies and the community sector.

The other thing that is interesting in the space of information sharing is the debate that is raging at the moment in this Parliament around the release or not of the Tune report. There is a lot of work that happens within Government that either then ends up as a Cabinet-in-confidence process or is informing policy but there is not a full and frank release to the sector that is doing the work around some of the reasoning and rationale behind policy decisions that are made. Whilst we need sharing at a very grassroots level in terms of getting better outcomes for clients, we need to have a very clear understanding of why certain policy directions are being taken. If we are supposed to be changing the way that we are working and operating in a way that is best practice for 2018 and beyond, we need to get much better and much braver in putting information and data out there in the public domain. It just cannot be the responsibility of funded NGOs to be accountable, and to be reporting and releasing data. We need to have much better trust in being able to put data out there, put stories out there, and be able to have a mature conversation about how we use all of that information to build a better and more responsive system. Otherwise, we just keep spinning our wheels and keep being backward-looking, not forward-looking.

The CHAIR: Does any Committee member have a follow-up question?

Ms FELICITY WILSON: Sorry to be quite basic but at that very early point where they are looking at early intervention—and, say, we had our universal services that are identifying risks and would usually refer out to other services—what kind of information is shared at that point? Is it better in different local health districts or with different agencies than others to enable you to do the work that you need to do?

Ms HOURIGAN RUSE: It has been said before that it is patchy, and it is. It is so often reliant on personal relationships between services and across different parts of the system that need to work together. The system should not be solely relying on you and me having a trust relationship and so we share information; but, if one of us leaves, the whole thing falls over because someone new comes into the role and we do not have that connection. We have too many systems that are based on connections that are fragile, at best, rather than on very sound systemic protections for people to be able to share information and understand the barriers. It is definitely patchy but it is mostly based on goodwill, trust and the people in the places where it works well.

Dr MEYER TUCKER: It is a little ironic that at a point in time in life where technology is at its most able and sharing of data systems physically is most able, we have become incredibly risk-averse with our data. I understand all the reasons why.

Ms FELICITY WILSON: Except on Facebook.

Dr MEYER TUCKER: Is that not interesting? That is so interesting in itself, and I am sure Fams will agree with us. Probably one of the most engaging ways that you deal with families—particularly troubled families, who just do not want to engage with anybody—is through things like texting and Facebook where you will be able to engage. I think there is a lot to be learnt in this and to not be too afraid of what we could do with data sharing.

Ms FELICITY WILSON: Are there specific barriers to sharing information in certain circumstances, whether it be around family violence history or a child protection issue? Do your providers and volunteers find circumstances where there is a prohibition of sharing information that stops you from doing your job and you rely upon personal connection to effectively go outside its bounds to help you do your job? Or is it more a case that it is not a rule that prevents it from occurring but that you do not have the right processes, systems, time or resources? Do you understand what I am saying? Is there a prohibition, or is it more that the system does not enable it?

Ms HOURIGAN RUSE: I think the system is just stuck. I do not think it is any more complicated than that the system is stuck. We have privacy legislation, we have become incredibly risk-averse and we are just stuck.

The CHAIR: Thank you so much for your time today and your willingness to answer questions. If, at the end of the day, Committee members decide that we have more follow-up questions for you we might address them to you in writing and ask for a written answer. Are you happy to do that?

Dr GRACE: Yes.

Dr MEYER TUCKER: Yes.

Ms HOURIGAN RUSE: Yes.

Ms STACE: Yes.

The CHAIR: Thank you very much. In those circumstances, those answers would form part of your evidence and be made public. Thank you so much.

(The witnesses withdrew)

(Luncheon adjournment)

KERRY MOORE, Executive Manager, Safety and Prevention, Rural/Regional NSW and ACT, Barnardos Australia, affirmed and examined

The CHAIR: We have been advised that the witnesses from the Winanga-Li Aboriginal Child and Family Centre will not be able to attend today due to a death in their community. We will see what else can be arranged at a subsequent opportunity. We will be hearing from Barnardos for this part of the afternoon. I thank you for coming to talk to us today and to help us understand the Barnardos submission and your perspective. We have all read the submission, so when I ask you to make an introductory statement it will just be for you to tell us a bit about who you are, what you do and how you fit in. Then we will move to questions. Do you have any questions about the process?

Ms MOORE: No, I do not think so. I will see what happens.

The CHAIR: During the day we have been talking to a number of groups. We started off at a more universal service level of support for babies and their parents and then we heard from some more specialised groups. Barnardos fits into that kind of category. We would not mind hearing about the role of Barnardos. Then we will focus on the areas of interest to Committee members.

Ms MOORE: As many people might realise, Barnardos Australia is a fairly large children's charity. Its primary focus is on disadvantaged, highly vulnerable children, young people and families in New South Wales and the Australian Capital Territory. We are largely government funded through State and Federal and have some local government funding. More than half of our funding is for out-of-home care services—that is, children who have been removed from their families. That is in both New South Wales and the Australian Capital Territory. The remainder of our funding is for preventative services across a whole range of family support services, youth services, community development and child care, et cetera, to try to prevent kids from being removed. It really is working very much at the child protection end but also putting in targeted services for the most vulnerable kids and families in the State to prevent that from happening.

The CHAIR: Our focus is on babies rather than the other end of the spectrum. I know your services are directed across childhood. What particular role do you currently fill for babies and how adequate is the system for you to be able to play the part that Barnardos would like to play in providing protection and support for babies and their parents?

Ms MOORE: It is picked up perhaps in some of the aspects of my submission that a number of our services are targeted to babies and also some of the services are targeted primarily to the neonatal phase of a child's development, particularly the Substance Use in Pregnancy and Parenting Service in the Illawarra. We do have services that are targeted to aim to prevent removal of those babies at birth or early in their development. In a number of our services we also work with early childhood or child and family nurses in partnership and with other medical health staff. With our early intervention services, which are a large part of our services, we aim to start as early in life as possible—if that is prenatally, so be it—to try to prevent further harm. That is across all of our early intervention services. I cover the South Coast area, the Illawarra, the Shoalhaven, western New South Wales, the Central Coast, the Hunter area and Canberra. Many of the services I oversee target babies.

The CHAIR: Those are the areas in New South Wales in which Barnardos is active?

Ms MOORE: That is right. And in Sydney.

The CHAIR: Is that an historical development about where Barnardos is active and is not? Is it just how things have grown up?

Ms MOORE: It has developed. Barnardos started in the United Kingdom back in the 1860s and developed here through the Child Migration Scheme. But Barnardos primarily started with children in foster care services. Over the years we have developed considerably and are moving into that early intervention area. With government funding and opportunity we have moved across different areas of New South Wales. We have been in the South Coast area for many years, since 1990, and before that with group homes. But over time with additional funding we have moved into those other areas.

Mr DAVID HARRIS: Particularly in regional and rural New South Wales, how easy is it for new parents to understand that you offer services?

Ms MOORE: I am thinking of some good examples. In western New South Wales we have services from Orange west to Cobar. A large proportion of those services is targeted to young parents. Many of those young parents are Aboriginal young parents and we run services like supported playgroups and home visiting parenting programs. We also run programs in the Wellington Corrections Centre .Our staff are actively working in the commission with health staff, outreaching and actually in the community where families shop and go about their daily lives. We are part of the community. We outreach as well as we can and promote our services.

Mr DAVID HARRIS: The maternity services at hospitals, do they notify you of new births or are you relying on people coming to you?

Ms MOORE: With Wollongong, for example, with the substance use in pregnancy and parenting service, we collaborate with maternal and infant health services and drug and alcohol services. They know all about us. We have a system set up where they notify us as early in pregnancy as possible to assist. We work very collaboratively with them and also with FACS. They know that it has been developed over a number of years.

Mr DAVID HARRIS: On one of our tours we heard evidence that Aboriginal families are sometimes reticent to come forward in case other agencies become involved.

Ms MOORE: That is right; that is definitely true. They are very fearful of coming forward and for good reason. With our services in western New South Wales and in the Illawarra and Shoalhaven we run a lot of supported playgroups out in the community. They are a very user friendly type of service. We run many specific services for Aboriginal families and they are staffed by Aboriginal staff. We have Aboriginal trainees. We do whatever we can to make our services as acceptable and friendly as possible. We are very well aware of that problem.

Ms FELICITY WILSON: Building on the question that Mr Harris asked, we hear from a number of people about the model around co-locating services. You have got your one-stop shops. We have heard evidence of examples where it has been quite successful in Redfern for instance, to co-locate different government services. In your one-stop shops do you do that as well or are there issues with the point Mr Harris raised about the lack of trust if you co-locate with some of those services?

Ms MOORE: We have various ways that we co-locate. When we first built the centre in Warrawong in Wollongong, which is an area of high disadvantage, we co-located with early childhood nurses and the community midwifes, who used to come and run the clinics in our building. They did that for many years until we outgrew our building and we had to gently ask them to leave, which we were not pleased about. We did that for a number of years and continue to have that close relationship. We have also had a child protection worker from FACS co-locate with us, which has been very useful in our child protection work. Then we run other services outside of our centre, such as the housing part of FACS in Wollongong where we oversee a one-stop shop for housing clients. We facilitate that and co-locate with a number of different community and government services. We also do that in the Shoalhaven. We do whatever we can to look for those opportunities so that we are actually working with other services, either in our own facilities or out in the community where it is easier to meet people at their point of need.

Ms FELICITY WILSON: Do you find there are any services or agencies that, if you were to co-locate with, would push other people away? For instance, with parents that are not experiencing substance abuse, they would be less likely to come to a parenting centre if they thought that people seeking support for substance abuse were there; or, if you had a greater level of FACS there, would that prevent some individuals from coming?

Ms MOORE: It has not been our experience because of where we are situated. For example Warrawong is an area of high need. We run playgroups there, which attracts new parents. We try to facilitate their contact with us as early as possible. It is run as a mainstream playgroup but because it is situated in Warrawong, it attracts a high number of families who are in need. We also run a supported playgroup on a public housing estate in Warrawong. Where you situate your services plays a big part. We run a whole range of services that people who need the service will access. People who do not need the service will not come there, usually; they do not need to. When we were co-located with health services, ordinary mums from the community would come into the centre and the way it was set up in the foyer was very friendly. People would not have any idea what is running because most of our services are delivered in people's homes or out in the community.

Our substance use in pregnancy and parenting service is targeted to drug-dependent pregnant women and new mums. We have run playgroups in the community for those mums. Some of them do not feel comfortable accessing that service for themselves, even though they are drug dependent, because they do not want to mix with other drug dependent mums. They would rather go to a mainstream playgroup. We have to be careful about where we run them and how we present them to try to maximise that access. People not wanting to come there because of that sort of a problem has not been an issue for us.

Ms FELICITY WILSON: My next question relates to access to workforce and staffing. You spoke in your submission about the challenges you face in western New South Wales.

Ms MOORE: Yes.

Ms FELICITY WILSON: Is this about a lack of trained staff generally? Is it about the geographic location?

Ms MOORE: All of those things, yes.

Ms FELICITY WILSON: Are there other factors, and how would we overcome it?

Ms MOORE: It is a general workforce challenge for Barnados in western New South Wales.

When I started working out there I could really get the challenges people had with distances. There are huge distances between small communities. For staff driving to those communities, there are all sorts of workforce challenges. Also, attracting skilled staff has been a real challenge. We have got to compete with government services, FACS and other services. We have great trouble attracting skilled staff. We have to look much more flexibly at who we employ and then train them up on the job. We try to attract a lot of Aboriginal staff and probably about 15 per cent or more of our staff out there are Aboriginal. We take on a lot of trainees and train people on the job. There is a lot of flexibility that we have to apply. I talked about early childhood nurses in my submission. We have found that that service has improved out in those communities, but I think it is still very difficult to sustain staff and to try to have Aboriginal staff. It is a big challenge.

Something I did not mention in my submission but that is worth mentioning is that the other big challenge is attracting professional health specialists out to the regional services and communities. That is a big problem and services have had to work very creatively in partnerships with primary health networks and have had to work in all sorts of ways to try to deliver those services out in those communities. There have been some developments and improvements with Medicare and being able to get a Medicare provider number and general practitioners being able to set up specialist appointments with phone or Skype—if they can get it. But one in four still need to have face-to-face appointments and a lot of the time families cannot get to those big centres like Dubbo. We do a lot of transporting and have specialists come to our services to deliver, but it is still a major barrier for health services out there.

Mr ALEX GREENWICH: I thank you for all the work that Barnardos does across the State. My question is about the support for incarcerated mothers. What work does Barnardos do for incarcerated mothers? Have you identified areas where more work needs to be done and supports need to be put in place and what are the benefits of those changes?

Ms MOORE: I gave the example in my submission of the Beyond Barbed Wire service, which was named by the women themselves in the Wellington Correctional Centre. That was set up back in 2013 from Barnardos own fundraising source as a pilot, and then a couple of years ago we managed to attract some housing money within FACS. That is wonderful and we just need to keep developing it. The service has developed a whole suite of services for incarcerated women in that correction service, most of whom are Aboriginal mums. We have just had an evaluation done and a launch of a major report by the Western Research Institute that has shown a huge reduction in the recidivism rate of those mums.

We provide volunteer monitoring when they come out of the prison, parenting programs within the prison and volunteer mentors. We refer them to a range of different services and provide short-term housing for them. We are continuing to build that service and we are actually getting really good outcomes. It has been evaluated. We certainly want to continue to grow that service. It has become very well known and respected in that area. We would like to see it operating in other prisons as well. The program tries very hard to work with mums while they are still in the prison and then continues that work when they get outside the prison to improve their parenting skills and hook them up with some work or volunteer experiences. It has been shown to be effective.

Mr ALEX GREENWICH: I imagine that your support staff take on quite a heavy burden with the vulnerable people that they are supporting. What work is done to look after them and the kind of stresses that they are under? What extra support is needed in that space and how do you cope with that?

Ms MOORE: You are right; they do need a lot of support. Barnardos has a culture and system of looking after our staff as much as possible and as much as our funding allows, I suppose. We have a culture of strong supervision and very good work conditions, particularly for working mothers. I assume it is within the government funding structure to allow and enable us to deliver the face-to-face services while acknowledging what goes on behind that and the support for staff. That sort of infrastructure should be part of funding models. Non-government agencies cannot compete with government with pay rates, and that is a big point. We are continually competing with government. We are able to provide very good work conditions, work satisfaction and support—all the non-monetary things—to help us to attract staff and keep them. We have a very good reputation in some areas for that. But some staff will still walk when they can get a better paid job in government. That is always a challenge for us.

Mr ALEX GREENWICH: I can imagine that for a number of the smaller services that becomes even harder.

Ms MOORE: Yes, definitely, because they are competing with big services such as ours as well as government. It is really tough for them.

Mr DAVID HARRIS: Do you have processes in place to track clients if they are fairly mobile?

Ms MOORE: We are mostly voluntary—we do not have mandatory things in place. Certainly, we would like to be able to have evaluations, for example, of people coming through some of our services to see what has happened three to five years down the track to see whether their children have been removed from their care and how well they are doing in life. But we do not have those sorts of systems because of where we are. A lot of our tracking is through how we are situated and we get to know families. They often come back to us because they have other children later and they come back to us because of the quality of the service. But it is very difficult to track them through data or that kind of thing. It is mostly through continuing to engage them.

Mr DAVID HARRIS: Do you think that starts to become an issue? I was a primary school principal and some of the young people had been to eight different schools and in and out of different services before they were in year 3. We would often have to start from scratch because nothing moves with them and they often move quickly. It would be interesting know whether there was value in setting up an umbrella system that enabled tracking through data sharing and what not.

Ms MOORE: I think you have also got to consider the privacy concerns with that. It is about balancing privacy with trying to keep track. Those families do often turn up in another child protection service through FACS. But sometimes people do just leave and we have no means of tracking them. I think we have to be very careful about monitoring families like that. It is about the safety nets that are delivered across the board that can engage people much better when they do leave. It is important.

The CHAIR: When you talked about the support for mums in prison, you said it had reduced recidivism rates. What is the long-term record of that? Have we got longitudinal data to see how successful some programs are? Are you saying that you could not tell me that?

Ms MOORE: We have only been going since 2013. It is not very long—five years. It is only short term. But we have shown that we have a 7 per cent recidivism rate. I read a statistic that the rate in Australia is 66 per cent.

The CHAIR: That 7 per cent sounds low.

Ms MOORE: It is amazing. We are very pleased with that, but it is only 81 women and 177 kids. We obviously need to be running that service a lot longer. We are keeping good data for that service.

The CHAIR: Would any other agency, such as FACS or the prisons service, have access to that data?

Ms MOORE: Our manager, who runs that, has set it up. She has tried really hard to look at the literature on this. It is very hard to get good data, especially on Aboriginal women in the prison system. There does not seem to be much written on this.

The CHAIR: I think the Committee members would be interested in whether we could put that into context and see how well it is performing and whether it needs to be replicated.

Ms MOORE: I would be very interested in giving you more information.

The CHAIR: That is something we might ask the Government representatives, when they appear before us.

Ms MOORE: Very good. We met a year or so ago. I tried to speak with the then Minister, I think Pru Goward, and her people. She presented a lot of information, because at the time we were very keen to get government support. We ended up getting it for two years, which is marvellous. We are very happy to provide whatever information you want; we can do that.

The CHAIR: Thank you for your very helpful testimony today.

Ms MOORE: I know this is a Commonwealth responsibility, but I would like to raise the new childcare subsidy that is coming in from 1 July. I do not know whether you have had much input from people about this subsidy, but we have big concerns about it as an agency. It is a Commonwealth responsibility, but the New South Wales Government is getting more across it. The unintended consequence is reducing the protective, effective quality of child care. Barnardos, like a lot of services, has used good-quality child care as a way of protecting children: making sure they are getting quality child care each day, making sure they are getting fed properly, connecting the parents with services, making those children visual to services. What this new subsidy is doing—unintentionally, I am sure—is reducing the amount of subsidised care for those families who cannot possibly fulfil the activity test; cutting it by 50 per cent. The new subsidy is also making it much more difficult for services to pay for child care for families through the bureaucracy that is involved. It is a big problem, and we are really concerned about it.

The CHAIR: Thank you for raising that issue; we will make a note of it. If the Committee has any further questions to put to you in writing, would you be happy to provide a written answer?

Ms MOORE: Yes, of course.

The CHAIR: Your written answer would become a record of these proceedings and would be published, as was your submission. Thank you for your time today.

(The witness withdrew)

(Short adjournment)

ALAN HAYES, Director, Family Action Centre, sworn and examined

KYM RAE, Gomerai Gaaynggal Centre, sworn and examined

ZOYA GILL, Project Manager, Australian Research Alliance for Children and Youth, affirmed and examined

SHARON GOLDFELD, Centre for Community Child Health, Royal Children's Hospital Melbourne, affirmed and examined

VIRGINIA SCHMIED, Western Sydney University, affirmed and examined

The CHAIR: Thank you very much for joining us this afternoon and making yourselves available to answer our questions. The Committee has received a large number of submissions. We were particularly keen to follow up on some of them which we thought might be able to shed light on matters of interest to members of the Committee and help us further our understanding of how we should be supporting babies and their parents in New South Wales. I appreciate you making your time available to help us with that. Does anybody have any questions about the process this afternoon?

Today the Committee has been listening to testimony from a number of witnesses from different organisations. This morning we started with a focus on the universal service provision for new babies and their parents, then we heard from other groups with a more specialist focus. We have more hearings next week and the week after when we will continue to look at specialist areas. The group here this afternoon is primarily a research group in the field. We have grouped you together because we hope we can have questions answered on what is good practice, what can we learn from other jurisdictions or from the best in the field, thinking about how to support babies and parents in this State. I hope that is what we can learn this afternoon. I will invite you to make a short statement to tell the Committee who you are or what your organisation is and how you fit into this picture. We have read your submissions and do not need you to go over them again. We would like to spend most of the time if we can with questions from Committee members. Could we have a short statement from each organisation?

Professor HAYES: There are two centres here. The Family Action Centre is a centre within the Faculty of Health and Medicine at the University of Newcastle and the School of Health Sciences. It is an unusual organisation in that for 30 or more years it has been delivering services to support families in the communities of the Central Coast, the Lower Hunter, and, increasingly, also working in the Upper Hunter. It now also has a focus on the traditional university teaching and research as the first organisation in Australia that has a dedicated discipline of family studies. The University of Newcastle is the first university in this country to have it; and of course research, with two research foci on fathers, fathering and families, and also on Strong Families—Capable Communities. Professor Rae is from the Gomerai gaaynggal centre, also in our Faculty of Health and Medicine and I shall allow her to introduce her centre.

Associate Professor RAE: The Gomerai gaaynggal centre is based in Tamworth and we are primarily set up as a research facility to support Indigenous women and their children. We have a research longitudinal cohort where we follow women and their children from pregnancy right through until the kids are 10 years old. We also work very much in partnership and collaboration with the community. We have an Arts Health Program that runs from early childhood through to the age of elders. We take a whole-of-community approach to the Arts Health Program. Many people do not know about arts health. To summarise, it is basically using creative strengths-based approaches in order to connect with communities but also linked to educational outcomes. Our focus area is particularly around health education, building health and interest in health knowledge.

Ms GILL: The Australian Research Alliance for Children and Youth [ARACY] is a nationally focused organisation based in Canberra. Our main aim is to improve all parts of the wellbeing of children and young people from zero to 24, so taking a more holistic approach. We do that by bringing together researchers, practitioners and policymakers to collaborate in order to better achieve our goals. To that end, one of our core projects is right@home, which is a collaboration between Western Sydney University and the Centre for Community Child Health at Murdoch Children's Research Institute. It is a sustained nurse home visiting program. Professor Goldfeld will be able to better explain that.

Professor GOLDFELD: While I am telling the truth, I am not from ARACY. I am from the Centre for Community Child Health, which is a centre of the Royal Children's Hospital and the Murdoch Children's Research Institute, both in Melbourne. As a Victorian I would like to congratulate the New South Wales Parliament on forming this Committee. I think it is a fantastic investigation and I congratulate you on your inquiry. The Centre for Community Child Health is an academic centre and also a clinical centre. Its focus is to work with families, communities and governments to address inequities for Australia's children.

Professor SCHMIED: I am from the School of Nursing and Midwifery at Western Sydney University. Our core business is the education of midwives and child and family health nurses. We have a master level program but people will often exit the child and family health course at graduate certificate level and graduate diploma level, without all of the components that a master program might bring. Our midwifery program is at bachelor level. We have Bachelor of Midwifery, but we also have Graduate Diploma in Midwifery for registered nurses. We pride ourselves very much on the strength of the evidence-base. We have a fairly robust midwifery professoriate for a small group of students. We pride ourselves on the evidence base that those midwives and child and family health nurses receive in their education.

We have a program of research that extends from pregnancy, supporting normal labour and birth. Perinatal mental health is a key area of focus, infant feeding and breastfeeding has been a major focus of our work as well, and system change. Professor Lynn Kemp is one of our faculty members who has been running the sustained home visiting program working nationally and internationally. We have quite a large footprint in that area. Our submission was a little out of left field because since last year we worked with a group of psychologists, social workers and academics at the university focusing on an issue about parenting and the experience of mothers and looking at maternal anxiety. Our agenda was to transform the mothering narrative by trying to look at what this good mother is and perhaps shift the discourse around that.

The CHAIR: I will start with a general question first. What do you think is working well in government support for babies and parents in New South Wales and what is not?

Professor HAYES: The majority of families work well but the services and supports to groups where you have high rates of intergenerationally transmitted entrenched disadvantage are another story. Concerningly, there are parts of the State that have high rates of families that fit that characteristic. What you find is the need for integration, not only of health care but also the sorts of social supports and systems. That is starting to happen, for example, on the Central Coast where there is a focus on integrated care that includes the education system and the family and community services system. That is one of many examples where people are starting to move towards a more integrated, more cohesive, more collectively framed support system for children and their families. It is so important to break the cycle of disadvantage. If you can do that, particularly for young women who are having children in many cases a tad young, a tad early, and you can have pathways for them to return, for example, to educational opportunity, then I think that is a good thing. There are a lot more runs to be made in that area. We have had a long history in this State of services and supports in the perinatal period, antenatally and postnatally. Generally they work quite well, but there are groups that miss out and that is why I was particularly pleased that we could put our submission together because I think Professor Rae's work shows what you can do to provide wraparound supports and services to those who traditionally miss out, or are left out, or are hard to reach, or are hard to maintain in traditional services.

The CHAIR: Professor Rae, do you have something to add?

Associate Professor RAE: I do. In our submission I dealt with Indigenous mothers and children. To my mind, what the State has done well is implementation of the AMIHS (Aboriginal Maternal and Infant Health Strategy). It is an excellent initiative and it is supporting women very, very well. But there are clear gaps in service delivery for many women. To my mind, the one that is the most frightening has come from some of the data we have established from our cohort, and that is the very high rates of mental disease that we are seeing in our cohort. We are seeing 40 per cent of Indigenous women in our cohort with symptoms of PTSD, 30 per cent with anxiety and 33 per cent with depression. In rural and remote communities, we know that mental health services are absolutely inadequate, and particularly culturally appropriate mental health services are increasingly inadequate. That is something we need to address, particularly given poor mental health during pregnancy and the postpartum period has long-term consequences for both the mother and the child. Attachment becomes poorer, engagement with children is not necessarily as strong as we would like, and that leads to a whole lot of other consequences that are very, very important for us to address.

The CHAIR: They are high figures for mental health issues.

Associate Professor RAE: Absolutely.

The CHAIR: It sounds like they are not only applicable to women who are pregnant. It is probably more prevalent in the general population.

Associate Professor RAE: I would say that is exactly right.

The CHAIR: Ms Gill, do you have something to add?

Ms GILL: I will leave it to Professor Goldfeld to talk about.

Professor GOLDFELD: It is a good segue from Professor Rae's comments. I will give you a sense of the morbidity load out there, what are the problems. With right@home, even though it is Victoria and Tasmania, I am not anticipating that women and families are all that different across jurisdictions. One of the important things you have put in your terms of reference is looking at other jurisdictions. Interestingly, we found that children of three, about 35 per cent of women are reporting—and that is reporting—domestic violence, being verbal domestic violence, verbal abuse; 30 per cent of women are still smoking; and the children in general are almost one standard deviation below the mean on language. One of the interesting things with this cohort is that we have not gone for the pointy end. If you look at the submission, you can see the risk factors, which are psychosocial-type risk factors and two or more of those got you into the study.

The prevalence of disadvantage in all its forms is quite high. We tend to default to the very pointy end, the very poor, but if you look at all the elements of disadvantage of those women who have mental health problems—these all coexist, by the way—there is poor health, living alone, being young, or not having a high school education. If you look at that load and the areas of disadvantage, there are a lot of families experiencing some form of disadvantage. The flip side of that is the fact that the social health and education infrastructure across this country is quite strong. It is not like we do not have anything. In fact, we have an enormously good infrastructure. Where we fall down is our ability to deliver it in the way that we need to deliver it, to whom and under which circumstances. What we lack is a level of precision about how to do that.

Programs such as right@home give you a little of that precision because we have a sense of who to deliver it for, in what dose and under what circumstances. The difficulty we have is how do we redistribute what we already have; how do we deliver it to the families we need to without throwing the universal baby out with the bathwater; but what do we build off those universal services; and then where do we find the real gaps and how do we fill those gaps? I think we are extraordinarily lucky to have the infrastructure we have; I am just not sure we deliver it in the way we ought to with the right quality—I think we tolerate a high level of mediocrity—or to the right people.

Professor SCHMIED: In respect of what is working well, we have a very committed workforce across the public sector as well as in non-government services and in lots of instances these groups interact and work well together. In our midwives and child and family health nurses we have a committed workforce that is often overstretched. I am sure you have heard that before. While I was uncomfortable with it when we started the process, and it is now many years ago, the routine identification of women, the psychosocial assessments done in pregnancy and then following birth, that skill level has increased and there is always room for improvement. Also the pathways, but those conversations are happening and the women are aware that they will be asked a range of these questions. So the opportunities are there for them to have a conversation if the clinic and the set-up is organised around the amount of time that they need and they felt comfortable to have those conversations. Whether it always has to be on that very first visit is another question.

The problem with the fragmented system is you do not know if you will see someone again, so you ask those questions. Sometimes there is a strong sense of "I will not ask this now." If I saw that woman again in a continuity model, I would have the opportunity to do that. We have small pockets of excellent models of care—midwifery continuity of care and child and family health services—working in the same home, visiting-type models, so we have evidence-based models in place, but it is a drop in the ocean. We have a lot to learn how we can increase that.

In some places for a long time we have been trying to link our maternity services and child and family health services. We do it at a policy level and it is well documented but in practice that is hard to articulate and funding systems in the local health districts come from different pools, but essentially they should be on the same side and it is not about who is looking after what families. I think we could streamline that transition from one to the other. The use of services such as midwifery services could potentially go a bit longer for people with less need, allowing child and family health nurses to support women with more need.

Local councils in lots of areas where I have been working are stepping up to the mark and engaging well and wanting to build communities that are very supportive of children and families and talk in community hubs. I have always been envious of Victoria's model of maternal and child health. We have done work in Victoria and here. We have facilitated workshops that were set up by the council and the difference in the conversations is because the maternal and child health nurses—the same as our child and family health—are embedded in council in the early childhood platform. It just makes such a difference. Professor Goldfeld is cognisant of that service. That is something we could look towards.

Mr ALEX GREENWICH: Professor Schmied, in your submission you talk about the pressure of judgement and stigma on young parents, young mothers. What early intervention models can government introduce to help reduce or prevent that judgement and pressure on young mothers so they can be supported rather than getting to the stage we are talking about now, which is managing it at crisis point?

Professor SCHMIED: That is a difficult one to answer and we are only just posing it. I am not sure it is a government responsibility specifically. I think it is at a societal level. The pressures and stigmas and the sense of judgement have been there for centuries; just the form that they take changes. They appear to be across cultures. Through modelling and conversations that women and families are able to have with each other and perhaps through services, being able to model how that may happen in communities, we could possibly start to change the discourse. We had one small attempt at that just recently when we ran a Mother's Day's letter initiative. We invited mothers of all ages and varieties, biological or adoptive mothers, whoever wanted to write, to write a letter to a new mother telling her about the things they had found helpful, and who and what had helped them. We have a lot of analysis to do on the messages in those but it was a very positive strength-based type of message. It did not dismiss the challenges and the difficulties; it talked about depression. It talked also about who and what had helped them in a very caring and supportive way. Not the kind of thing you hear about on Facebook and other social media platforms where people are critical of each other. For us it feels a little early days, but how can we start to talk differently? Maybe we need some of the television stuff and—

Mr ALEX GREENWICH: The submission of the Australian Research Alliance for Children and Youth refers to a concern about the Committee's terms of reference referring to new parents. It made the point that you can be a new parent in a new context—namely, having a second child is a new context and a new parenting challenge. Can you take us through that as well as some of the cumulative pressures parents can face beyond their first child?

Professor GOLDFELD: There are a couple of things. The nurse home visiting literature is mainly focused, interestingly, on first-time parents and young parents. We collectively felt that is an unsustainable model for Australia and, in fact, in the United Kingdom they have experienced exactly the same. We are much more interested in parents, with all of the foibles and difficulties that comes with, be it your first child or your sixth child—we did a little bit of homework. In the study we particularly did not focus on first-time parents or young parents, although young parents was obviously a risk factor. We specifically looked at whether there was a differential impact of the intervention on first-time parents versus other parents. In fact, there was not.

So it kind of worked for everyone and, if you know anything about parenting, that is not surprising. It is also important in a society where parents go in and out of disadvantage and in and out of need. And whilst first-time parents are important, it seems to be able to support parents based on a whole range of risk factors of which that particular risk factor did not seem to be one. Certainly we included young but not first-time. It is probably worth noting that that is what the study showed. Our concern about the terms of reference is that by narrowing it you are perhaps boxing yourself into a corner that is not a sustainable model for New South Wales or for anywhere I would suggest.

The CHAIR: It might have sounded like that but we did not mean that. Indeed, we were surprised at how some people interpreted it in that way. We were talking about people who were new to this situation.

Professor GOLDFELD: That is great. A tick then.

Professor HAYES: That is the way we interpreted it—each time is a novel event.

The CHAIR: But we got some responses back that clearly read it the other way.

Professor HAYES: We know now that it is an entirely different intra-uterine environment after the first child is born and, of course, with each subsequent pregnancy each child experiences parents in a different way and in a different context. This notion of novelty is exactly something that has a life course dimension to it. The other thing is—Professor Goldfeld has mentioned evidence-based approaches—we have some exciting developments in the area but I think the public policy problems really are you achieve greater synergy among the many players who are involved with potential relevance to supporting families, particularly those who have a new child. The other two wicked—I do not like the term "wicked"—or difficult problems are how you sustain some of those efforts. The third issue is how you essentially bring those to scale because there are lots of demonstrations of pilot programs in this country—one could almost call us the aviation nation because we are full of pilots—but essentially it is how you sustain those efforts. Problems that have taken a generation or more to manifest do not easily accept a solution that is short term. I think that applies across the board, but particularly to the sorts of high-risk groups.

Professor Rae and I were talking earlier about the fact that one in 25 live births in this country are to a young woman—a teenager. That is a relatively low rate compared to other countries but four times higher in the Aboriginal population and if you think of the health context for Aboriginal mothers then, of course, it is a major concern. When you also think of the average family size, the number of children that women will have, it is not evenly distributed across the population. It is actually a bimodal distribution, with those in the most advantaged group likely to have more children and those basically in the lowest quintile of the population likely to have more children. There is a population dimension to this that is extremely important, including dimensions of what has for a long time been referred to as the new morbidity. We have managed progressively to bring infant mortality down but we have had a growing rate of infant morbidity, and morbidity rates are not evenly distributed across the population either.

Mr DAVID HARRIS: What is your feedback on the quality of educational support for fathers? Does it exist? If so, does it exist well? If it does not exist, should it exist?

Professor HAYES: Our centre has been doing a lot of work on fathers for a long time. Professor Richard Fletcher is probably one of the leaders in this field nationally and internationally. Yes, there is a much greater need for that. Signs of change. I am old enough to remember in another academic life when things were going to change so dramatically that we would find equal co-parenting, we would find fathers doing revolutionary things, and that pace of change has been relatively slow. There are generational changes that are happening for younger fathers but we need to think about how we get parenting messages to fathers—for example, SMS4dads is an initiative of our centre led by Professor Fletcher. Basically that is showing how you can get an uptake in groups as diverse as first-time fathers in the general population, first-time fathers in the Aboriginal population and also groups such as defence force personnel and others. That work is now getting to the point of maturity where it is being looked at internationally and it is looking at different cross-cultural and cross-national uptake. It is an elegantly simple way to deliver messages and it is a very cost-effective way to do that. I think there is a lot of work in that area that could further be supported and developed.

My sense is that there are still big cultural and social gaps in acceptability, for example, of men taking periods of parental leave. It is certainly much lower than the rates you see in Scandinavia and in other parts of Europe. It is a great thing to have access to parental leave but there are also disincentives for some women to take parental leave or pressures to return to work faster, and they differ depending on the occupational position or occupational sector that they work in. I think the father's needs are extremely important because increasingly we see that parenting is not just about mums; it is about a parenting partnership. We also need to be thinking about groups where you need to have better approaches to co-parenting. Dr Chris May from our centre is doing a lot of work on co-parenting, particularly as it relates to parents who have separated or who for some reason are not living together. We know that a lot of couples who separate do so at the point where they have had a child and that the first five years of a child's life, particularly the first two, are where the risk of parental separation and relationship breakdown are very high. But a fair proportion of the population actually separate before the child is born and so this is one of the drivers for some of the issues that confront single parenting.

Mr DAVID HARRIS: Further to that, is enough being done to inform fathers about postnatal depression and how to recognise it and offer support? Often they are in the same household, seeing what is going on, but if they do not recognise postnatal depression, that does not help the mother.

Associate Professor RAE: Personally I would say no. Because of the way society and workloads are balanced now, women tend to go to their many gynaecological and obstetric appointments without their partner. At the moment most information about postnatal depression, or how that may look, is given to the woman herself, not necessarily to the partner. I think there actually does need to be more done in that space. I would be interested to hear what any of the other members felt.

Professor GOLDFELD: There are a couple of things. There are some really nice interventions. There is one by Professor Jane Fisher, the What were we thinking! program, which is just a great title really. It is the idea of couple preparation. Obviously there is an issue because not everyone is in a relationship but for those who are in a relationship, even in disadvantaged families, it made a difference in exactly what you were asking about, which is this kind of preparation for pregnancy, and then preparation for the birth of a child, be it first, second or third. I think there are some interesting and rigorous interventions out there that can be embedded in the current system and can do more about preparing parents, not just mothers, for birth and for children.

I will reflect on a really interesting matter. We have done quite a lot of work in literacy and early literacy. We did a study called Let's Read which is looking at promoting reading to children, working with mothers and fathers. We just happened to collect data from fathers on their reading practices and then did an analysis looking at what the input of fathers did for children's language and literacy. What it looks like is that fathers seem to have an independent impact on children's language outcomes but not their literacy outcomes.

But the fascinating bit of it, and maybe this goes to a point in time, was the media response we got, which was enormous. This was kind of smallish study in the end but we had an enormous response from the media which was mostly from a whole lot of media commentators about this role of fathers in reading to children and being part of the parental process, and this idea that fathers would add value above and beyond what mothers added. It was a really interesting finding. I think there might be a moment in time when there is a whole different approach to the role of fathers in parenting and all that comes with it.

Professor HAYES: There is work that Dr Jennifer St George is doing with colleagues and that is really looking at the role of the different ways in which fathers play with their children. What we see as rough and tumble play has quite important impacts on neurological development of children. So in some senses the partnership between mother and father is extremely important and it has different effects and benefits. But I think your question really goes to the issue of mental health literacy in the population. There is a lot of focus on workplaces, particularly—given that we are in the Hunter—in mining, quarrying and the mining services industry that are now very attuned to this and very attuned to the impacts of having a child on the lives of men and women. But there is a sense that we could do a lot more in terms of that educative effort for the whole of the population.

I think it takes a lot of finesse and skill to design those sorts of public health message programs because we are bombarded with messages daily. We have just had Families Week, we have had Mother's Day, we have had International Families Day and it tends to go over people's minds. But we also know that at critical moments in family life, messages tend to take root better because people are attuned to hear. So thinking about how we do that, that has been the logic of the SMS-based messaging programs. Usually it is the wife, or the mother or the partner. The mother usually is the person who basically tells the father "Maybe it would be good to get onto this website or to pick up these SMS messages".

Professor GOLDFELD: If I might follow, there is one piece of information you might find useful, which is that there has been a look at women's postnatal depression and its correlation with men's postnatal depression, and actually it is quite high. This is a field of Associate Professor Harriet Hiscock's work so she has looked at that. We run a sleep clinic at the Children's and just looking at men's postnatal depression that almost never ever gets looked at, but there is quite a high correlation. Once again a point in time to think about not only the mental health of the woman in front of you but also the men in front of you.

Ms FELICITY WILSON: I will stay on the topic. From what I understand a parent with depression and anxiety affects about one in five women, and one in 10 men. I know that Professor Schmied talked about maternal anxiety. I have read quite a bit now and understand much better now the causal factors which define maternal anxiety. Do we understand what the postnatal depression causes are for men? Considering men are less likely to seek help generally across the population—and there is an overlay of a sense that pregnancy and child birth is about women, so maybe men should not be taking on a sense of pity for themselves—what do you see around men's postnatal depression? How do we identify it? How do we diagnose it and treat it? What causes it?

Professor SCHMIED: A lot of the factors would be quite the same. They are often socio-economic and situational factors that would be impacting on them. The numbers of stressors that they are experiencing. Obviously previous history of mental health problems will also be concerning, and obviously out of the longitudinal study of Australia's parents, and some of the other work, I think others here would also be able to identify. I have looked specifically at the risk factors that come out of literature on men and depression around childbirth, but I would imagine they are very close to the socio-economic factors and other factors for men and depression generally, except there is this circumstance of becoming a father, and the pressures around those. I think it is really interesting that one of the struggles—I mean many men are still having that long commute, no matter where they are living—so they can actually go Monday to Friday without seeing their babies because they leave early for work, living out in the suburbs, and then get home later at night.

Professor GOLDFELD: I am not an expert but interestingly the statistics I just gave you were from a sleep clinic. There have been some very nice studies showing the impact of sleep on postnatal depression. Essentially if you cure sleep you often cure a lot of the other. If you have had babies, that will not surprise you. It is kind of situational. So it is exactly what you are saying: The stressors that are impacting on the woman are the stressors that are often impacting on the man. I do not know why we would think there would be a different response because it is often the same sorts of responses—sometimes short term, sometimes longer term. I think there is a very similar cause or pathways. I am not convinced the interventions are the same; no. I think you can fix sleep and probably do a lot. I think some of the others probably need a lot more thinking about how to address the needs of men versus the needs of women. I am not convinced it would be the same.

Mr DAVID HARRIS: Are there statistics around the birth of the baby and leading to break-ups?

Professor HAYES: There are. Professor Kim Halford at the University of Queensland has done a lot of work on this. It shows that there are peak periods, and it is usually, as I said, in those first two to five years, if people get through that. There are also a lot of supports that come around a family in terms of availability of care that work through a number of things. But, yes, it is. There is a higher risk of relationship breakdown in that early period. Then, of course, the second peak for breakdown of relationships is when children have left the nest. So you get a lot of breakdowns.

Ms FELICITY WILSON: Which is getting later and later these days.

Professor HAYES: Which is getting later and later, exactly. So we are delaying that phenomenon. But it is the case that there are those two peaks. Clearly it is not my area of expertise—having taken an oath I must say that—but hormonal changes occur for men as well with the birth of a child. So there are these complex brain hormonal and situational factors that come to bear. It is not a simple interaction that is involved; it is really a quite complexly determined phenomenon. Like lots of areas of mental health, it is when the load of stresses goes up that you see the manifestation of underlying mental vulnerabilities, which we all have, and when you look at the rates across the population of anxiety and depression they are high and, essentially, it is these triggers.

So there are these points in time that place a lot of stresses on both partners in a relationship and if they are worked through and resolved then so be it, it goes forward. But there are other times—the birth of a child who has a disability or a chronic illness may be another phenomenon, but it is interesting that it is difficult to predict it just on the basis of the characteristics of that event; there are other factors that come to bear. This is why a wraparound of services and supports is extremely important, and we often do not synergise that. We need to move from silos to synergy. We have organised ourselves, as government has, in siloed approaches, but they need to be synergised.

Associate Professor RAE: Further to that, I think one of the big challenges for many women—obviously I am a specialist in Indigenous women's health, but for many women who have preterm infants, and that very definitely has long-term consequences on relationships for many families, but for those families particularly in rural and remote Australia—which a large proportion of the country has that—those infants are generally delivered in metropolitan locations. For our rural residents, that means somebody has to stay and manage a property potentially or look after other children. That becomes a very, very challenging period. But it is not just while the child is in the neonatal intensive care unit [NICU] down at, say, Royal North Shore or wherever it may be. It is also potentially if that child has other health complications that may go for many, many years that those health services and that family are having to go backwards and forwards to see a paediatrician. Some of our towns do not have a paediatrician. It is all of those kinds of things that can have very, very long consequences for families and create a huge burden of stress for them and their siblings.

Ms FELICITY WILSON: We have talked about mothers and fathers and those kinds of relationships. We are going to hear from Rainbow Families in a future session but I am interested from a research perspective the challenges we see with, particularly, mental health. Are you seeing the same causes, the same statistics of prevalence, or are there other ways that it needs to be treated or addressed? Do you have any insights?

Professor GOLDFELD: Professor Stephanie Brown has done the mothers health study, which has been following about 10,000 women in Victoria and South Australia—this is just a community-based study. What is really interesting is that the highest rates of depression are when the children are four and not in the perinatal period. It is a reminder to me to say something today about the importance of longitudinal relationships with families, and the kind of going in and out and bouncing in and out of families is really unhelpful. So having a relationship with a family, usually through a universal service, allows that relationship to build over time and for these things like depression, family violence, to emerge over time.

Even in our home visiting program, which is based on universal but more intensive, even that took time before women disclosed family violence and other things going on. Our children are three and we are seeing now still the higher rates particularly of anxiety. We talk a lot of depression but anxiety is probably more prevalent in our population. It is just a reminder to us that lobbing in and fixing things in the perinatal period is not really a single solution. I think Alan referred to it, but you might want to look at some work from James Heckman—who is a Nobel prize-winning economist—which he has published lately about human capital and this idea of the complementarity and continuity of services, the idea that we are out of silver bullets really.

We have done water and sanitation and immunisation so I think that is about it for silver bullets and now we are up to this kind of idea of reinforcing over time and the continuity of services over time. I think if we do not have that we are just going to lob in and out, not have relationships and not get that sort of disclosure that will allow us to think "What does this person need at this point in time?" That goes to your point about this kind of mental health load that is out there. That is actually the biggest burden of disease for the twenty-first century and will continue to be so. I am not sure there is a single thing to make a difference, but I am pretty sure that it will not be just do one service and we will be done.

Associate Professor RAE: One thing about our project is because we are connected to women and their children for 10 years, every point we see them is a point of contact to intervene to create social change, emotional change, health change. We can develop nutritional interventions that we see delivering over time, those kinds of things often changing our behaviours. We all know we need to lose weight and we need to change things but it is not necessarily as easy as "Okay I am not going to do that anymore". Sometimes having somebody come and see you in a really supportive way to have that change happen gradually and in a very supportive way can make such a difference. I know certainly for us it has been wonderful; we have got women who have come back to us—and this is Indigenous women, so this is women who are generally often very hard to engage with—who are up to having their seventh baby with us now. So that is huge numbers of moments where we can connect with them and their family and create change.

Ms FELICITY WILSON: Could I just clarify again if anyone had a contribution on same-sex couples? That was my specific question. We have focused a lot on nuclear families, mothers and fathers, mothers as individuals and fathers as individuals. Is there anything on same-sex families?

Professor HAYES: It is interesting because there is work that has been done; a lot of it is methodologically arguable—small sample sizes. But some of the studies that are robust basically do not show a lot of difference, that really quality parenting, effective parenting partnerships are effective parenting partnerships and they are supportive.

Professor GOLDFELD: And vice versa.

Professor HAYES: And vice versa. If they are negative they are negative. At the end of the day I think there are many ways, if you look across the globe and if you look across historical time, that people have parented and they look very different. But when it works in terms of security, consistency, safety, those things are part of what has enabled us as a species to adapt and we have done that across a vast range of environmental, social, cultural contexts. So my sense is that people would like to break into that way of thinking, that there are two kinds of people in the world, two kinds of couples in the world or whatever. But the only thing I have ever noticed is that there are two kinds of people in the world and it is those that believe there are two kinds and the rest of us.

Professor GOLDFELD: There was a really wonderful commentary in the *Medical Journal of Australia* about three months ago, "The Kids are OK", which was put together by a number of academics looking at the literature of the impact of same-sex couples on children's outcomes. It essentially concluded the same as Alan, which is the impact of being same sex per se seems to make no difference to children's outcomes; it is more the functionality or otherwise of the relationship.

Ms FELICITY WILSON: I was probably asking a bit more whether same-sex parents have the same risk factors for their own wellbeing and mental wellbeing as other mothers and fathers or if they need different or targeted support services.

Professor HAYES: I do not know the answer to the second part of the question but I suspect, on the basis of the reading I have done, that essentially they have similar risk factors and similar drivers of these things—they are human conditions. My sense of it is that that would be the answer. The second one is an empirical question in terms of when you have got a better and larger database on it. The other thing I thought in your comment about the differences in prevalence rates is the fact that you have got to disentangle them from reporting rates or rates of willingness to report. I would think as time goes on you might find that the rates of depression in men related to things that are related to parenting across life are probably higher than that, half the rate—one in 10 as opposed to one in five—because the overall prevalence of mental health problems is about one in four at any given time. If you do the maths on it, it is likely to be actually close, but you get differential reporting where they report different conditions, which do not get you to the core problem that is driving the phenomenon.

Professor SCHMIED: One of the risk factors that is there is still discrimination. Sometimes the experience of groups that are marginalised in different ways, depending on the services that they encounter, is that they may have a negative experience and that adds to a burden of the experience and adds a risk factor that is not necessarily there for all groups.

The CHAIR: In your field, Professor Rae, I know there are lots of things we have been told in submissions about the disadvantage that Indigenous people experience and the outcomes that is having in their family situations and the lives of children, so there is probably not one magic silver bullet. But what is the most important thing we perhaps should be thinking about to turn that situation around for Indigenous children and their families?

Associate Professor RAE: From my perspective, and I speak both as a researcher in the field but also in my past life as a schoolteacher, it may sound like a strange response but my belief is that the big thing we need to address with Indigenous families, virtually from adolescence, so pre-pregnancy, is nutrition. Because what we are seeing is about 60 per cent of our cohort are overweight to obese. That has an intra-uterine effect, and that intra-uterine effect is that by the time they are two and three years old, 30 per cent of those infants are then also obese. Those children will have long-term consequences of that, whether it is early onset of diabetes, renal disease—all of those subsequent health problems that will very definitely impact on both their ability to live a long and healthy life but also to engage readily in the classroom.

And it may be that they are not having the right kind of nutrition to be able to do that, but it is also really important at a health cost for us to get that right. It is not just true for Indigenous women that we do this; it is probably true for women across the board. Obstetricians are saying that the rates of obesity they are seeing in pregnancy is higher and higher. But we do know the life expectancy of Indigenous Australians is so reduced from what we see that I think nutrition is the one modifiable thing that we can do. It is not an easy thing to change but it is a critically important thing to change.

The CHAIR: Earlier in our process we visited an Aboriginal support service in Rozelle. We heard about this service which reaches out to preschools and community outreach centres around the State. The person telling us about their involvement was saying that in the preschools for Aboriginal communities that they are supporting they are getting reports of huge numbers of people subjected to child abuse. They were saying the majority of the kids in the centre have been victims of child abuse on an ongoing basis. It sounded like it was not resolved. What is the answer to something as traumatic as that and what is the impact that that is likely to play out if there is not an intervention, effectively?

Associate Professor RAE: To be honest, I do not know that that one is something I could answer. There is no doubt we have lots of disadvantaged communities where they are having the same, but there is no doubt there would be enormous mental health consequences for those children, which is what all of us are talking about that we see with disadvantaged communities.

Professor HAYES: The rate of child protection substantiations the last time I looked was nine times for Aboriginal children. The rate at which an Aboriginal woman will be hospitalised as a result of violence is 35 times that of the population.

The CHAIR: Those are extraordinary numbers.

Professor HAYES: They are extraordinary figures. If you think about that, it is also the long-term intergenerational impacts. Going to the nutrition issue, we now know enough about epigenesis to know the epigenetic effects are that it will span generations and actually write onto the genome a code that gets transmitted generation by generation. This is why there is a need to intervene not only, as Professor Goldfeld has said, early in life but early in the pathways to some of these problems, and they emerge over life. A life course perspective is fundamentally important, as is seeing parenting as a life course phenomenon. You are always a parent irrespective of the contact you have with children. What you write onto your children's genome and epigenome but also their behavioural and social characteristics goes on and crosses relationships and time.

There is fascinating work in Berlin. A person at the Max Planck institute had looked at parenting practices across generations. Each generation of new mothers reported to him that they were going to be a very different parent to the parent that their mother or father had been. Basically what you saw was absolutely scary continuity. They would sing the same songs, have the same sorts of admonitions and chastising verbal behaviour. So these things need to be thought about as things that need to be modified in a way that will turn around some of these intergenerational cycles.

Professor GOLDFELD: In right@home we talk about parenting despite everything else going on in your life. That is one of the things: we cannot wait for the external circumstances to be fixed and then see what happens. I would implore you, if you have any opportunity to make a difference, that you need a multigenerational horizon and a multifactorial horizon, because without that it is not even that there are not any silver bullets, there is not even an array of silver bullets. As Professor Hayes has quite rightly pointed out, we know that intergenerational disadvantage now is no longer just about your social circumstances but it probably gets beneath your skin and it is probably epigenetic.

The risks you have to chronic disease are actually transmitted intergenerationally. That chronic disease then manifests as early death and then you see the generations going on. I would hate to sit here and think, "Well, we've got all the answers. Listen to us." I do not think we do. But we definitely know it is going to take a long time, we definitely know it needs focused effort, and we definitely know we need to evaluate as we go along. Because in this country at least we have a history of intervening in ways that have been harmful to populations. I implore any bravery in governments that are able to do that with a sense of rigour and a sense of intent.

The CHAIR: I will finish off by asking a question that raises the tone with a bit of optimism. What are the really good things happening elsewhere that New South Wales should know about, if anybody has something we should know and take away from today?

Professor SCHMIED: In my mind I have been going through the things—there are great things happening and actually not every parent is going to need this level of intensity of services, so we need to work out how we distribute that best so that people come in and out of the system. For better or for worse, families are clearly the major support people around people. That was just one thought going through my mind, which is not to the point you were asking about. In terms of Aboriginal support for families, Professor Rae mentioned the Aboriginal Maternal Infant Health Strategy [AMIHS] program and Building Strong Foundations. Both of those have got a real opportunity to be enhanced and built on in Aboriginal communities.

Elsewhere, I have looked at the universal services across Australia. It is not that the Australian Early Development Census [AEDC] necessarily demonstrates that Victoria with its universal system that is currently in place in maternal and child health shows better outcomes than New South Wales children at their entry to school, but there is something about that delivery. That is an evidence-based service in terms of maternal and child health. The embeddedness of that within the council and the key ages and stages—the number of visits that are available to families and the fact that families are very tuned into that—is different to what we have in New South Wales. I would think that was certainly one good thing I would like to see happening here.

Professor GOLDFELD: It would be remiss of me not to talk about right@home. That was undertaken in Victoria and Tasmania and what you will not have in the submission are the results, which is that it worked. It worked to improve parenting, it worked to improve parent responsivity and it worked to improve the home learning environment. You will be pleased to know that when the children are three it works to decrease mental health problems so women are less anxious and less depressed in the intervention group and have a better sense of their own personal wellbeing and the social, emotional and physical wellbeing of their children. It comes off the universal service in the same way as you have the universal service, but is embedded in it. We talked about stigma earlier. From the parents' point of view, they are receiving what everybody else gets except that it is in their home. So it has been highly acceptable in two jurisdictions, Tasmania and Victoria.

Professor SCHMIED: I think the other important—it has gone, it will come back in a moment.

Professor HAYES: I think that some jurisdictions are further ahead in terms of better utilising data and using data, particularly integrated and linked data, in a way that you do connect the silos. Western Australia led that some time ago. New Zealand as a single jurisdiction has made big advances in this area. In fairness to our State, New South Wales has the Data Sharing (Government Sector) Act 2015 and has a Data Analytics Centre. My sense is that building community data dashboards will actually start to overcome the paradox that there is never enough money to do things, but there is always enough money to do things 15 times over in isolation without synergy.

My sense of it is that what you can do is, it is not an answer in and of itself, but if you can build better community level data dashboards you can have a way to have ongoing monitoring and evaluation of how services and supports are going. So you do not commission a plethora of bespoke evaluations pre and post; you can scrutinise data. The investments that governments make in data collection is a vast investment and that could be better leveraged in ways that other jurisdictions have done it. The start is here, the infrastructure is here in New South Wales, but think what it could do to the area of parenting and understanding of the wellbeing, health and development of children so conceived.

Professor SCHMIED: I have remembered the point. It was to do with right@home. What is also being studied there is how that gets rolled out, not just the feasibility studies or the randomised controlled trials [RCTs], but how you implement and sustain that in the service and the sorts of resources needed to do that. That is often the problem with, as Professor Hayes said, how do you get to scale something that is effective.

Professor GOLDFELD: In eight local government areas.

Associate Professor RAE: Can I mention one global example? An organisation that is doing a lot in the area of women, children and beyond is the Canadian Institutes of Health Research. It has an initiative where they have partnered with a number of international areas. They have cohorts in countries—it is Canada and India, Canada and South Africa, Canada and China—and they are following prior to birth right through to when the children are 25 years. Each of those countries is developing a number of different initiatives depending on the area of need of each of those countries. That is a great learning lesson for a country to be able to basically have the globe at their fingertips to look at what initiatives work, are working really well and in what particular area.

The CHAIR: Thank you for your time this afternoon. It has been valuable for us. If the Committee decides we have any more questions and we want to put them to you in writing, would you be happy to provide a written answer subsequently?

Professor HAYES: Absolutely.

The CHAIR: If that were to occur, it will become part of your evidence and be published in the same way as your submission was.

(The witnesses withdrew)

(The Committee adjourned at 16:05)