

REPORT ON PROCEEDINGS BEFORE

COMMITTEE ON COMMUNITY SERVICES

**SUPPORT FOR NEW PARENTS AND BABIES IN NEW SOUTH
WALES**

At Macquarie Room, Parliament House, Sydney on Monday, 28 May 2018

The Committee met at 10:00 am

PRESENT

Mr Kevin Conolly(Chair)

Ms Trish Doyle

Mr Alex Greenwich

Mr David Harris

Ms Felicity Wilson

PROFESSOR MARIE-PAULE AUSTIN, New South Wales Branch, Royal Australian and New Zealand College of Psychiatrists affirmed and examined

The CHAIR: Welcome, Professor Austin. I declare this meeting of the Committee on Community Services open. I thank you for attending this public hearing today. This is the second public hearing for the inquiry into support for new parents and babies in New South Wales. We will hear about a number of issues today including the adequacy of services for new parents and babies and whether they can be improved. We are also looking at support for new parents in other states and how technology can improve support for new parents. I now declare the hearing open. Professor Austin, I thank you for attending and helping the work of this Committee by sharing your thoughts with us. Do you have any questions about the hearing process?

Professor AUSTIN: No, that is all good.

The CHAIR: I am Kevin Conolly, the member for Riverstone and the Chair of the Committee. On my right is the member for Sydney, Alex Greenwich and the member for Blue Mountains, Trish Doyle, and on my left David Harris, member for Wyong, and Felicity Wilson, member for North Shore. We are down two members, but I am sure there will be enough questions for the witnesses today. I invite you to make a brief opening statement summarising your contribution. We have read the submission and do not need that recapped, but is there anything by way of introduction and then we will ask questions.

Professor AUSTIN: I represent the college but you may also know that I have chaired the Australian clinical practice guidelines for perinatal mental health that came out 2011 and at the end of 2017. I have been advocating with a number of my colleagues in New South Wales for at least 20 years to have a mother baby unit set up in the public sector. You may be aware there is a private unit at the Saint John of God but that is only available to the minor proportion of Australian families who have that top level cover required for psychiatric admission. It is a case for inequity.

Just to remind you, maternal mental health problems are highly disruptive and affect the family unit adversely. At worst they may contribute to the breakdown of parental relationships and impact on the development of infant attachment and care also of other children by the primary caregiver. The development of secure attachment in the first two years of life is critical to the offspring's longer term emotional wellbeing and resilience, and that has been shown time and time again in many studies over the decades. In order for this to occur the infant's mother needs to be emotionally well and available and it is essential that we identify and treat mental health illness early in the piece.

New South Wales has been an early and effective adopter of maternal psychosocial screening and early mental health identification and intervention. That has gone really well. That has included the SAFE START program, which has been in existence now for almost 20 years. Overall, our services for parents with mild to moderate conditions are pretty good, especially if you live in urban areas, not great for rural and regional families. However, we have really fallen behind the other States in terms of service provision for parents with severe illness. This is the particular concern that the college has and many of our colleagues around the State.

In particular, we have no public sector mother baby beds, which is, when you compare it to other jurisdictions, quite striking. That is in spite of that long standing advocacy. There have been repeated plans to set up mother baby units. I could give you countless examples in the last 10 years just how many times we have gone to advocate with the Minister, with the department, and so forth, all to no avail. Furthermore, our Australian clinical guidelines concur with international best practice and recommend admission of severely ill mothers and babies to assist with bonding and avoid prolonged separation. What is, in the end, for such severely unwell mothers, inadequate treatment in the community. You can only do so much through outreach teams. People need to understand it is not a magic cure. What we are doing is leaving the families of these severely unwell mothers to care for, not only the mother but the infant, and increase the risk to both.

The extent of severe postnatal psychiatric conditions: Who are we talking about when we are thinking about who might need those admissions and the unmet debt in New South Wales? Just to remind the Committee, severe mental health illness is now the leading cause of maternal death in Western countries. It is no longer haemorrhage or infection, it is psychiatric illness. We know that new mothers will have a 70-fold increase in suicide rate in that first year after birth, greater than any other time of their life. We know that at least two per 1,000 women will need admission for a postnatal psychosis, which is the severe form of mental health episode we see in this population. Currently, none of these women, except the minority with the top level cover, have access to the care that they need.

In New South Wales what are the figures, what is the burden, what is the need? We get about 100,000 births per annum, one-third of all Australian births in proportion to our population, and that is then associated with

a minimum 200 admissions per year for these mothers would be needed in our State. If you do the calculations that means that at a minimum we would need 18 beds and at an optimum we would have 24 beds. That would mean that we would have those units not only in Sydney, which is where the bulk, 70 or 80 per cent of the population live, but also have some in the key regional centres. Those women, as we know, cannot access the centres without being separated from the rest of their families. We know they often do not come in to the mother baby units if they are going to be separated from other children for too long.

Just to highlight the lack of equity in terms of mother baby beds, if we compare it to our neighbour in Victoria which has similar population numbers now, their numbers are growing. They have three mother baby units in Melbourne and two regional units and 28 beds. In Western Australia, a much smaller State, they have two mother baby units and 16 beds; in Queensland they just brought on a new public sector four-bed unit and; South Australia has one mother baby unit in Adelaide of eight beds, and they would be the lowest population of those other states. It is time to look at this.

I will give you a little bit of a case, a woman I looked after. I work at the Royal Hospital for Women as a psychiatrist and I work in the private mother baby unit but I am passionate about having equity for women who cannot afford that unit and we try and admit occasional women who do not have that level of insurance. This woman, I will call her Kate, five days after giving birth developed an intense thought of killing the baby and killing herself. She needed hospital admission, clearly; she had no private hospital cover. She was readmitted to the maternity unit, rather than the psychiatric unit, to avoid separation of mother and infant.

Kate became increasingly sleep-deprived, suspicious of staff, declining sleeping medication as she thought that the staff might be trying to poison her—again, classic persecutory delusions in the context of a peripheral psychosis. She was irritable with the baby, expressing thoughts that the baby might be evil. The next day she was more agitated; she wanted the baby out of her room, saying that she had thoughts of harming the baby. When the midwife gave her the baby to feed and settle, because that is what midwives do when there is a mother with a baby in the postnatal unit, she ended up throwing the baby across the room. Luckily, the midwife caught the baby, who was unharmed. That was just a lucky outcome for her but I think a very near miss that was most striking and distressed, as you can imagine everybody—the staff, the husband, her family, and when she thought about it subsequently and was able to think and remember those events, herself.

Kate was admitted to the locked psychiatric unit at that point; the baby was taken home by his father, who struggled to care for him while trying to run a business. At that stage Kate was so unwell that she ended up being in hospital for a couple of months. That was a most unfortunate event and we feel could have been prevented had we had appropriate facilities for that family in New South Wales. It was not for lack of identification in that case, it was a lack of being able to go to the appropriate unit, with a much worse outcome at the end of the day. I hope this case clearly demonstrates the need and begs the question: Do we wait to lose a mother and baby before the call for public sector mother-baby beds in New South Wales is heard? The case for resourcing is obvious and I am happy to speak to that.

The CHAIR: Thank you, Professor Austin, that has been very helpful. By drilling down to the numbers and comparisons, you have answered some of the questions I might have asked. I will dive straight into that issue with a couple of others. You have described a significant gap you see in relation to severe postnatal depression. Is it only postnatal or in some of these cases that you are describing are they people with pre-existing mental health conditions?

Professor AUSTIN: Yes.

The CHAIR: Therefore, as a lay person in my mind, what is the prognosis of that woman being able to properly care for her baby longer term in any case? Are we dealing with a postnatal problem that can readily be solved or are we dealing with something much more difficult than that?

Professor AUSTIN: That is a great question. I think a substantial proportion have pre-existing conditions, and that is where the early screening, identification of women at risk, already comes into play, and we do that pretty well in New South Wales as per the guidelines. All women coming into the public sector will be asked those very questions. The issue is stigma. Often they will not reveal that past history; they do not want to be seen as someone who may have problems caring for the child because in many cases at the back of the woman's mind is this spectre of "They will see me as a bad mother, take the child away, throw me in the asylum and throw away the key".

The CHAIR: I do not know about the asylum and the key but the other parts may be valid concerns.

Professor AUSTIN: But that is how they think.

The CHAIR: It is from a public point of view a valid concern to say, "Is this child ever going to be safe?" in a certain situation. It is not for us, is it, today to make that determination, but it is a question that is going to arise?

Professor AUSTIN: Exactly. There are those women who will have that pre-existing condition and then those who will become acutely unwell, and we have to care for both. For those who have a pre-existing condition, perhaps of the chronic type such as schizophrenia or bipolar disorder of the very, very severe end of the spectrum, they will need additional assistance in terms of having such an admission, and in some cases the issue of are they able to take this child home safely and care for it will arise, and certainly from mother-baby unit work, which I have done over the last few decades, when that occurs you then need a very expert team to do those kinds of assessments. So we would not ever recommend that a mother be admitted to a mother-baby unit to assess her parenting capacity.

The CHAIR: That is not the focal point.

Professor AUSTIN: Exactly.

The CHAIR: That has been really helpful. Why do you think your lobbying over so long has been unsuccessful? Is it just about dollars or are there are other perspectives involved in government policy that have led to a different outcome?

Professor AUSTIN: I think it is both. The perspectives have been "Well, we have set up the Safe Start program, we have early intervention. The idea is to go for early prevention and therefore these cases will not arise", but, as your question states, many of them are pre-existing and we know that they will stop their medication when they are pregnant, that they will become unwell early postnatally because they are sleep-deprived, and there are all those other stressors as well. Therefore, programs such as Safe Start will never address the issue, and I think that is where there has been a bit of a blind spot perhaps in addition to the fact that the dollars for these sorts of units are very substantial; you are looking after mother and baby, you need a higher nursing-to-patient ratio, there are issues of risk, there are issues of specific training. So there has been a real blind spot in this area because I think part of it was around the policy that was put in place. But they have not put in the other piece of the puzzle, which is the severe end of the spectrum and, yes, that is the pricey end.

Mr ALEX GREENWICH: Following on from the Chair's question, I am interested in what the Government response has been and how they have justified their inaction in this critical space. What assessment has been done of work in the other States with their mother-baby mental health units and in your view, if it is possible to express, what is the long-term cost of continued inaction in New South Wales?

Professor AUSTIN: Taking your first question: their response has been "Oh yes, this is a very big problem. We must do something about it. Let's draw up a model of care for a mother-baby unit". That went round to all of us; we commented on it back in 2014-2015—

Ms TRISH DOYLE: And nothing.

Professor AUSTIN: Yet. We did not hear anymore. It never came out—it was not released, because I guess once you release a report and a policy you have to fund it. So it just was not going to happen. I have been to them personally on, I think, four occasions to the Minister for Health; the Minister for Mental Health twice I think I went to him prior to Tanya Davies coming in; I have been to the Department of Health on at least two occasions; we have had delegations; we have put forward a proposal for a public mother-baby unit—that was back as early as 2009 when I came into my chair at the University of New South Wales. The figures I gave today have been there in front of people for at least the last decade. Your second question was around—

Mr ALEX GREENWICH: An assessment that would have been done in other States.

Professor AUSTIN: Prior to the guidelines, which came out in 2011, I was also leading the national action plan for the care of women and families in the perinatal mental health period, so pregnancy to the end of first year, postnatal. Because I visited all the States to see what resources they had I was able to enumerate those and they were available to the Department of Health at that time, who, when the national action plan was finally signed off by the Commonwealth and then funded by each of the individual jurisdictions to match Commonwealth funding, the head of the Department of Mental Health, Drug and Alcohol knew the exact detail, but again it did not go anywhere. When we were doing it, it was back in 2007. Your third question was what would the outcomes be?

Mr ALEX GREENWICH: The long-term cost of inaction.

Professor AUSTIN: They are multiple and they go from the obvious such as the potential for child demise and maternal demise, and we have seen some of those cases, through to much more subtle outcomes—we

are talking about relationship breakdowns, not uncommon at that time; the strain on fathers is very, very extensive and we know about a third of them will develop their own depression and anxiety disorder.

Professor AUSTIN: They often just have to carry on because in our day in age with nuclear families women are very much reliant on their partners. They often do not have parents and extended family. There is a strain on them and their financial situation, such as with the father I gave the example of whose business was affected by him having to be at home with the baby for two months to care for it entirely. There can be an impact on developmental outcomes for the infant. I cannot emphasise enough the critical need for the attachment to form. Luckily, there is a certain period over which secure attachment can form—it is not only over the first month, but over the first one to two years. But that is often when women remain unwell. They are grumbling, their condition is partly but not fully treated, they are staying at home and they are struggling with caring for a baby. They are not able to engage appropriately with the baby and give it the adequate stimulation for cognitive development and, in particular, emotional development, which then leads on to building a resilience in healthy adults.

It is trans-generational and moves onto the next generation. We now have a very good study, the Avon Longitudinal Study of Parents and Children [ALSPAC], from the United Kingdom of approximately 10,000 mums who have been studied from mid pregnancy, with their offspring now in their early 20s. It is the same. As they grow, you can test those offspring and they have ongoing higher rates of mental health conditions. Of course, you have to consider what the genetic factors are there. But over and above that, they do have higher rates of poor emotional outcomes in terms of relationships. You can then see them going into the next generation. When they become parents they may not have had the adequate parenting experience that you would hope for.

Ms TRISH DOYLE: Thank you, Professor Austin, for being here today and for articulating so clearly the need to support mothers, families and children with mental ill health. Before I ask you a question around services and agencies working together, I will say that I have had mental ill health in my own family, as a young mother with a husband who had a chronic mental illness. A lot of what you said rang true on a very personal level.

Just recently, a playgroup and family support service reached out to me about a young mother, who I took to see some of the management at Nepean Hospital. As you would be aware, they are looking at planning for a rebuild of the hospital. This young woman felt that her experience as a new mother and parent, and the family's experience, was awful enough to contribute to the feedback that the hospital was collecting as part of its planning. She had an experience with the neonatal intensive care unit at Nepean Hospital, which is where changes are actually happening. She was separated from her baby and there was no room at the hospital for her. I am from the Blue Mountains and she is from the upper Blue Mountains, and the distance that people have to travel to access services is a huge part of the problem. She did not have diagnosed mental health issue—mental illness was not part of her experience until post birth. But since then, she has certainly had to reach out to a number of different agencies. I think it was important for her to provide feedback about what she needed at the time, when there was early detection that there might be something wrong with her baby.

I really want to acknowledge that there is a need for specific services for families in our public health service. Her telling of her story, where those services were not available, was quite sad for everyone involved. How do we improve? How can we have the inter-agency collaboration working with you to support your call for that mother and baby set up? Has that been part of submissions in the past? I would like to feed some of these stories, particularly this one, into the work you are doing and hopefully a recommendation might come out of our Committee for such a set up. How do we improve that sort of coordination of working together and have a number of agencies calling for the same support?

Professor AUSTIN: That is a really apt point because the issue with these families is that they are invariably complex. There can often be mental health issues, domestic violence, substance misuse and a need to monitor the safety of the baby with the family when they go home. I would see the mother and baby units, if they were adequately networked—I will give you the example of Victoria. Victoria's three urban units have specific catchment areas and within those catchment areas they work with that complexity of services to coordinate the services. It is not only about looking after the mother and the baby and that being the end of the story. It is much more than that. I know that from working in the private mother and baby unit in Sydney. That is just as important as caring for the mother and child.

That is at the severe end. In the more intermediate area that you are talking about, we have started to set up in the big maternity hospitals, such as the Royal Hospital for Women in Randwick, mental health services to ensure that that kind of coordination occurs antenatally. The idea is for continuity of care, but that is really hard to achieve, as you know. But that is one of the big aims that we have. Again, that is reflected in the guidelines. The other thing we need to think about is not only the units themselves and the staff that work within the units, but also how we develop a body of expertise for our future psychiatrists. How do we train our junior psychiatrists to get the experience in this very complex space, which interfaces with a number of different speciality areas?

Part of the submission that the college made to the inquiry was around how we can have a more structured network set up to train those registrars.

My fellow psychiatrists are often afraid of caring for mothers and babies. It is frightening. They have to ask, "Do I give her medication in pregnancy? Will I be sued for treating her in the way that she needs? Do I give her medication when she is breastfeeding? Do I have the right information? Am I up to date? What if there are issues around maternal self harm or maternal harm of the infant? How do I deal with that? How do I deal with Family and Community Services [FACS]?" People stay away. They turn to us as the experts but there are not enough of us. We need to train up our junior staff to gain the confidence and skills to work in such a complex multi-disciplinary setting. We need to network it and we need to have rural, regional and remote families cared for as well. We are very aware of that. Recently, I did a national study that looked at that and there were no surprises around where the highest needs but least amount of access were.

Ms FELICITY WILSON: Thank you very much, Professor Austin. I am a fairly new member of Parliament, but in my time here I have been working with the Gidget Foundation on mother and baby beds and have been speaking with the Minister about it as well. One of the pieces of information I have been given is that the mother and baby beds might be introduced to the Professor Marie Bashir Centre. I understand it is a slightly different model to the mother and baby units we would see in other jurisdictions. Could you comment on that introduction?

Professor AUSTIN: It has been a secret well kept. That is the first I have heard of it. There has been a lot of talk of that, but it all went quiet again at the end of last year and I have not heard anything since. I cannot comment on the detail. I know there has been talk of it. It was getting more and more possible and likely in the middle of last year, and I am in regular contact with NSW Health mental health department, but we have not been told anything. That would be fantastic, that would be a start, but it can only be a start. We are talking about 20-plus beds for the whole of New South Wales. I would be very glad to hear that, but I would be concerned if that was going to be the only unit.

Ms FELICITY WILSON: I have a question about screening and identifying the risks. One point you made is that mothers might have stigma and shame about acknowledging any past or pre-existing conditions. Recently I met with a mother who had had twins. She had had a psychotic episode about 10 years ago and it was not identified as a risk factor during her pregnancy. She was hospitalised at Royal North Shore a few days after the twins were born. Do you think the current screening processes are adequate? Is that an example of someone falling through the cracks? Can you reflect on private versus public so far as identifying those risks? In my area, more than half of births happen in private hospitals.

Professor AUSTIN: Thanks for raising that. That is a good point. We can only ask the question. By asking the question, "Do you have past history? Do you have any of these risk factors that would put you at greater risk?" we show that we want to know, that we are interested, that it is part of holistic care. It is not just about your blood pressure and your weight and fontal height, and whatever else could happen for the woman physically in pregnancy or the postnatal period. We ask the questions and we rely on them to respond with the information that they have. For sure, women are missed, and we know that.

In our maternity hospital, which has led the way in many respects, around the public sector screening, we ask some of those questions more than once because you have to engage the woman, you have to gain trust. She is not necessarily going to tell you about her past history the first time she meets you as her midwife or obstetrician. You have to do it more than once. You have to do the screening antenatally and postnatally. Things can occur in between. You are looking at building that rapport. Having said that, it is not uncommon for those things to occur, for us to see that, but we often get a gestalt. We get a bigger picture of how somebody is looking: how they are coping, are they struggling, what strengths, supports and so forth they have, and that gives us a better idea who we might want to monitor. We monitor those women, even though they might say, "No, I am fine", and score zero on all the questionnaires. We will want to know a bit more to make sure they are okay. That is one aspect.

The other aspect you have raised is around women delivering in the private sector. When we did the national action plan, we found one in three women will deliver in the private sector, which is fine and good, but that one-third of women do not have any screening. That has been a major failing that we identified in 2007 when the plan came out, and that we again lobbied on quite strongly. I am happy to say that towards the end of last year a number of us were able to—through the advocacy that had been going on for some time, the Commonwealth decided to extend the antenatal assessment item for obstetricians and general practitioners [GPs].

Therefore, those women in the private sector who were not being asked those questions by their midwives in the public sector, that would be part of what we would strongly recommend that they did, as well as domestic violence and substance abuse. That was a first. A new item was introduced postnatally to be done in the first few

weeks after birth when the obstetrician or the GP checks the woman out, again asking those questions. That has been a great development, but, again, that will take time. It will require more training and confidence at the college level for our obstetrician and gynaecological colleagues. Many of them will probably ask their practice midwife to do it for them. That is fine, as long as it gets done and the referral pathways are in place.

Ms FELICITY WILSON: At my local private hospitals, Royal North Shore Private and the Mater, the Gidget Foundation has a program where midwives are doing some of that screening.

Professor AUSTIN: Yes.

Ms FELICITY WILSON: Forgive my ignorance in not having had children, but are obstetricians and GPs the right people to be doing that screening? One of the points you made was about building rapport and trust in the relationship?

Professor AUSTIN: They can because they will build rapport, they will know these families over the longer term. I think they should be. It is a generational change. The folk that I trained with, that is a Pandora's box. As I said before, it is scary. If you start asking those questions you may not want to know what the answers really are. You do not want to be asking the questions with that in mind, because that is really quickly conveyed to the woman that you are asking the questions of. There needs to be support and training in place for those specialists, but I believe it is part of the holistic care. The highest cause of maternal death nowadays, thankfully it is very uncommon, is due to mental health issues, so they need to be in there. They need to get in and get dirty—ask the questions.

Ms FELICITY WILSON: On medical history and records, you say you ask the question and rely on the woman to provide the information. Are we at a point where that information should be shared between medical practitioners?

Professor AUSTIN: That is a vexed question, the issue of confidentiality. You always have to ask the woman, "Are you willing to share this information?" Or if you need to because there is a significant risk, that is duty of care. That is another matter altogether, but you have to be respectful of that woman and ask for that. With the increase in electronic medical records [EMR] that information will become increasingly available to relevant clinicians, but that is a space we need to work around.

Mr DAVID HARRIS: Professor Austin, in your submission you talk about a centralised hub to coordinate data for research and service enhancement. What might that look like and who should operate it? Should it be independent university-based or should it be government-based?

Professor AUSTIN: I am also an academic at the University of New South Wales and have done research for many years now. I am aware that sometimes if the information, the data bases, are with government agencies, the conclusions that can be drawn from the information may not always be made available. I am well aware of that at a national level. That has happened to me and colleagues a couple of times. It is a shame, but it is too hot for that to be out there, so it does not get released. It should be with the universities. We certainly have the capacity for safe storage, which is a critical issue, especially if you are working with linked data. You have probably all heard about "big" data; that is what linked data is. It is consumer data that is identifiable, has to be de-identified and has to be very carefully handled. Universities have the capacity for that. Beyond universities, I would not be so much in agreement. I would have great problems, because I would be very concerned about the capacity for private service to be holding that sort of information.

Mr DAVID HARRIS: You have talked about the need to locate resources into regional areas. Are you aware of hotspots? If those resources became available, where would you place them? How would you work that out?

Professor AUSTIN: You would have to go for the population number, so they would be, I imagine, somewhere around Newcastle and Wollongong—north and south of Sydney. We know there are a lot of disadvantaged families around there anyway, those who cannot afford the private sector, but, also, that is where the great family population growth is, and as people cannot afford to live in Sydney, they are going to those hubs. Something in the western sector of the State would also be important if there was sufficient capacity for that. As I said before, Victoria has two of those centres regionally. We are a bigger State.

Mr DAVID HARRIS: If you located those services in those places, what other medical support service would have to be co-located there as well?

Professor AUSTIN: We have perinatal infant mental health outreach teams. They are slowly being created across the State. Their remit is to care for the more unwell mums but obviously they are not able to do that for those who need an admission. They would need to be in place—you cannot have a mother and baby operating independently. The number of beds you need depends on what it is embedded into. That range between

18 and 24 is very much about: What else do we have in the community? In those regional centres there tend to be less of those resources as well. We need to consider telepsychiatry, and that is something that some of us are doing now. For those with milder conditions you can also do online courses—cognitive behavioural therapy [CBT] counselling therapy-type approaches—and that is good too. That all needs to be embedded. We need to have those registrar numbers.

I think I may have mentioned before that we have about four dedicated perinatal psychiatry registrar positions in New South Wales. They are uncertain in their funding, which is reviewed every three years. They are Commonwealth-funded positions. If I compare that to the other States—again, I hate to say it—Victoria has 11 of those positions and they are State-health funded. They are therefore permanent; they are not going to be potentially phased out at the next triennium. Those people would then go out to those regional centres and provide that expertise with supervision from the psychiatrists in Sydney, if needs be.

Mr DAVID HARRIS: Are they advanced training positions?

Professor AUSTIN: That is right.

Mr DAVID HARRIS: Your submission says a "more coordinated and equitable approach". Does that mean the current ball lines are not in the right places or does "equitable" mean that there should be more of them?

Professor AUSTIN: Do you mean the current training positions are not in the right places?

Mr DAVID HARRIS: Yes.

Professor AUSTIN: There certainly needs to be more of them. We have got this tiny number that are at risk at the moment because the Commonwealth scheme is being reviewed in terms of its goals. Perinatal does not fit the goals, so it is very much at risk of those positions being lost—that is right now. Yes, more of them. They also need to be rotating out and they need to be doing that with adequate support from the Sydney-based mother-baby units is the way I would see it, so that they are not on their own, and with consultants such as me, fly-in, fly-out consultants, would also be an important aspect for those trainees.

The CHAIR: Professor Austin, your evidence has made a valuable contribution to this inquiry. Thank you.

(The witness withdrew)

NICOLE BRIDGES, New South Wales Branch President, Australian Breastfeeding Association affirmed and examined

LOUISE DUURSMA, Senior Manager, Consumer Services, Australian Breastfeeding Association, sworn and examined

The CHAIR: Thank you for appearing before the Committee today. Before we proceed, do either of you have any questions about the process that will be followed today?

Ms BRIDGES: No.

Ms DUURSMA: No.

The CHAIR: I invite you both to make a short opening statement, if you wish. The Committee would like to spend the majority of its time today asking questions. We have read your submission so it is not necessary to go over that information again but if you would like to say something in particular by way of an opening statement now is your chance.

Ms DUURSMA: I have been involved in this community for more than 20 years as a volunteer breastfeeding counsellor, a mother and a lactation consultant in private practice. I see that breastfeeding rates are just not getting better and there is a lot of inequity in the support that mothers can be given. Mothers want to breastfeed and we need to do more to give them the support they need. We are very grateful for this opportunity to make a submission, to answer the Committee's questions and also to know that the inquiry was started in the first place because it is so important. These are the children and the health of our country that we are looking into today. The Committee has seen the information about the Australian Breastfeeding Association. We have been around for 54 years now providing support services. Each day we have 22,000 hits to our website so mothers are coming to us for that support. We also have about 80,000 calls to our 24-hour breastfeeding helpline each year.

The CHAIR: You made two statements at the outset—that breastfeeding rates are not improving but that mothers want to breastfeed. Clearly to put those two together implies there are some blockages in the way that are preventing mothers from doing what they want.

Ms BRIDGES: That is right. When you look at our initiation rates of 96 per cent Australia wide, breastfeeding rates are dropping off rapidly. You are right, there is some sort of disconnect between what mothers want and know is the right thing and the services we provide for them.

The CHAIR: Can you name some of those blockages or what the problems in the way may be?

Ms DUURSMA: I think mothers need timely access to support. They go home from hospital very early, which in itself is not a bad thing if they have access to support but sometimes that support can be a long time coming and sometimes when they get that support it is not the optimal support. We really have a crisis in education for health professionals around breastfeeding. I decided, as part of my role as Senior Manager Consumer Services for the Australian Breastfeeding Association, to monitor some of the online breastfeeding support groups, and Ms Bridges has done a PhD into this as well. I would say that two out of three of the things that mothers post in that group are the result of poor health professional education around breastfeeding—basically being given bad breastfeeding advice.

Ms BRIDGES: And I dare say that calls to our national helpline would have similar figures as well.

Ms DUURSMA: The poor advice is really amazing sometimes, the things that mothers are told. Even if they can find the right support, getting the right support and the right help are very difficult. Sometimes they will go home from hospital and may not see someone for weeks. If you have a breastfeeding problem, if you have a baby that you have to feed every couple of hours and your nipples are cracked and bleeding, you do not want to wait to see someone and you are not going to wait to see someone. Rates are dropping so quickly.

Ms BRIDGES: Of course the other pressures mothers are having at that critical stage is the really aggressive and unethical marketing by formula companies and that is a whole other issue altogether. You get these issues together and you have the perfect storm for women to wean prematurely.

The CHAIR: Can I explore that first one? Our universal system of support for mothers is that the frontline is midwives in public hospitals and child and family nurses attending home visits after birth. That is intended at least to be offered to everybody and ideally to reach everybody but certainly to be available to everybody. Are those professionals—the midwives and child and family nurses—capable of giving the kind of support that you say is required?

Ms BRIDGES: Not all of them.

Ms DUURSMA: Not always. For a lot of them, if we look at their pre-service education, the breastfeeding content is very small and not enough to give really capable support. Often it will rely on the fact that they are interested enough to go and educate themselves and I know that the Ministry of Health has been increasing the breastfeeding education that they are providing but it still requires individuals being motivated enough to do it and having that culture there.

Ms BRIDGES: And depending on when they were trained they may have breastfeeding information that is extremely dated. Also, breastfeeding is one of those really emotive issues that often we find that health professionals will give their recommendation based on their own personal experiences as well and depending on what those personal experiences may or may not have been, that influences the type of help they give those mothers.

The CHAIR: What kind of training would be involved for someone who is already a midwife or a child and family nurse to upskill to the level that they could give that advice?

Ms DUURSMA: If we look at the requirements of the Baby Friendly Hospital Initiative, they require 20 hours of education in the three years prior to accreditation and then eight years of education within those three years, so it is not massive amounts of education that is required.

The CHAIR: So it would be achievable, one would think, if there was the will to have everybody involved in that universal level service to be upskilled to that level?

Ms DUURSMA: Yes. We cannot just draw on midwives and early child health nurses here; the medical profession has even lower rates of breastfeeding education and the general practitioner and the paediatrician are the people that the mother may first turn to for support, especially if she is having significant problems. In my practice I do not have a single paediatrician that I know a mother can go to where I feel confident that their breastfeeding will be supported and that is pretty damning. Mothers will say, "Who should I go to?" and I cannot think of anyone.

Ms BRIDGES: I remember with my most recent experience having my youngest child going into a paediatrician's office and seeing boxes of formula stacked up behind his desk, so again it comes back to that really aggressive marketing by the formula companies that are influencing these health professionals.

Ms DUURSMA: I also want to pick up the point about universal home visiting. Universal home visiting is a fantastic idea and I have been around for a long time and I have seen the before and after. The problem is that we have gone from a nurse sitting in a clinic being able to see multiple mothers in a day to being able to see two or three mothers in a day. We did not get a proportionate increase in staffing in community health services to be able to provide universal home visiting in a timely manner for all mothers and in some areas it is much worse than others and maintaining staff in those areas, I have been told, can be difficult as well, so there is often a shortage of staffing to provide that visiting. It is a great concept if, first, it is timely, and, second, the person who comes out is well educated in breastfeeding support.

Mr DAVID HARRIS: I am interested in the Baby Friendly Health Initiative. Why has only one service been accredited? Who does that accreditation?

Ms DUURSMA: The accreditation is done by the Baby Friendly assessors in Australia. Baby Friendly Australia is run by the Australian College of Midwives. I would say predominantly there are a few reasons why there is only one service. Firstly, it is having that top-down support for Baby Friendly, both in a hospital and a community. It is not prioritised within the service and therefore resources are not allocated to the service to do that. All facilities do their general accreditation but when it comes to Baby Friendly accreditation it is seen as not as important and it is vitally important. If those steps are followed, they are evidence-based steps that should make a difference to rates in the community. But the resources have to come with it. There is no point paying lip-service to it if there are not resources to support the mothers.

Mr DAVID HARRIS: Are there differences in the rates between metropolitan New South Wales and regional rural New South Wales?

Ms DUURSMA: I think it is very hard for us to know that because the other problem we have is that we do not collect significant breastfeeding statistics. The last time breastfeeding statistics were collected was in 2010. We do the Mothers and Babies Report NSW, that collects breastfeeding rates on discharge. Discharge could be anything from a few hours to a few days and although discharge rates have been getting shorter periods of time, breastfeeding rates are falling on discharge. They are the only significant numbers of results that we really have because we are not collecting them nationally or on a State level.

Mr DAVID HARRIS: Finally, from a community point of view, every now and again you see stickers on windows, "This is a breastfeeding friendly area". Is there still community stigma associated with this and does there need to be a better education program for the community, for businesses and places like that to maybe become accredited?

Ms BRIDGES: Absolutely. When you look at the research into why mothers wean prematurely, one of the biggest reasons stated, particularly for younger mothers, is breastfeeding in public. There is still that stigma attached. You look at the media and even calls to our helpline, we have so many calls from mums who have been evicted from a public pool or their local café. It happens all the time; it happens a lot more than we know about. We only know about the times that we do hear about it. It is happening all the time. There needs to be more awareness amongst the community and business owners about what women's rights are and definitely destigmatising breastfeeding in public.

Ms DUURSMA: Some years ago Shoalhaven council did a "Breastfeeding welcome here" project and they got 200 businesses to sign up to the project and display the stickers. They then created a card for mothers with all the places listed on them where they could go and feed their babies. It is not just about health services; it is about everybody providing that support, and being in a community where you know you can breastfeed anywhere any time. What those stickers need also to say to people: Not only should you feel comfortable breastfeeding here—and Trish Doyle had said that she has a sticker in her office for mothers to come in and feed—it is about telling everybody else that "You will see breastfeeding here and that's okay and that's normal".

Ms BRIDGES: And it is important.

Ms FELICITY WILSON: You talked about the reasons women are weaning early, within that first six months. In my area a lot of women return to work quite early, within that first six months. There are many reasons for that, probably the cost of living and the requirement of retaining their income, or the professional pressures. Not having had children, what is the daily scenario of a family where the mother is returning to work? Is it trying to express milk? Will the early childhood centre then feed the baby with the expressed milk? What happens during the day?

Ms BRIDGES: It can be so many different scenarios. That could be one of them. For me, returning to work with each of my three children was different. For my first, I resigned from my position and had a few years off. For my second, I was working as a casual and was very fortunate that my workplace—I work in a university—was like, "Let's come back to work." I took my three-week-old back to work and lectured and tutored my students carrying a baby and breastfeeding as I went. That is how it worked for me for my second, but for my third I had a full-time position and I had paid maternity leave. By the time he was eight months old, I went back to work and it was child on campus, me having a big lunchbreak in the middle of the day, rushing to child care, breastfeeding him to sleep, going back to teach some more.

For other mothers it can be that scenario. It can be leaving a baby for 12 hours when it comes to commuting into the city and back and expressing several times a day. For some breastfed babies they will not accept breastmilk in a bottle, so mothers have that conundrum of what to do with their baby in the middle of the day. Sometimes they have carers bringing them up to work. There are so many different scenarios. It is difficult. It is a real added stress for mums. That is why paid maternity leave and support in the workplace for breastfeeding mothers is very important.

Ms DUURSMA: We have our breastfeeding friendly workplace program that we run from the Australian Breastfeeding Association, which gives businesses guidance on how to support breastfeeding mothers. We have very few government organisations that are breastfeeding friendly workplaces in New South Wales. The Department of Health is, but we do not have any other health facilities that are breastfeeding friendly workplaces. It is very important that we support all mothers returning to work to continue breastfeeding, but also particularly we support health workers to return to work breastfeeding. That will then influence their interaction with mothers.

Ms BRIDGES: Anecdotally, when I have spoken to mums about returning to work, I have found that it tends to be the female-centred professions where it is most difficult to return to work and breastfeed. I know lots of people who are teachers and nurses and they find it extremely difficult to combine work and breastfeeding. I have had colleagues who are nurses who have had to sit in broom closets with breastpumps at their workplace. They work in a hospital and these are the types of scenarios they are dealing with. It is ludicrous that a hospital does not have facilities for their staff to be able to combine breastfeeding and work.

Ms DUURSMA: If you are an executive in a company, it is a lot easier to organise facilities to be feeding your baby or to express milk, but if you are an assembly line worker who does 10-hour shifts, it can be very difficult. There is a huge inequity in that and their right to ask for provisions within their workplace.

Ms FELICITY WILSON: My question relates to when advocating for breastfeeding can go too far. Most of the new mothers that I know and all the professionals that I have met have been strong advocates for breastfeeding. Quite a few mothers I know have found that regardless of the levels of support they get, including some of the secondary services, there is a sense of shame amongst women who may develop mastitis or who may have to discontinue breastfeeding early and they persist regardless of the impacts on their physical, emotional and mental wellbeing. Is that something that your organisation looks at, or is that something for which you have an answer?

Ms DUURSMA: Yes, certainly, both in my work with the Australian Breastfeeding Association and in my work as a private lactation consultant. I work with a lot of mothers for whom breastfeeding does not work out. The most important thing is that we support them through that process. When you see mothers who feel shame and guilt, they have not been supported properly. Every mother that rings the breastfeeding helpline is asked: How do you feel about continuing breastfeeding? Do you want to keep going? Often a mum will say, "No, I think I want to wean." We say, "That is fine. Did you want any suggestions about how to continue?" and a mum might say, "No, I want to wean." That is fine; you give her the information she needs to wean. Then I say, "Aren't you fantastic; you have breastfed this baby for six weeks. That is six weeks of breastmilk, and it has been so hard for you. You should be so proud of that achievement." Often a day or two later the mum will say, "I have been thinking about what you said. Could you give me a few more suggestions?" or, "Could you send me to someone who might be able to help?"

This comes down to education. Not everybody in Health is educated to communicate with mothers. An Australian Breastfeeding Association counsellor is educated to listen to a mother, to meet her where she is at and to give her the support that she needs. Counselling skills is what our counsellors work on most of the time. We role play them to death. They hate role plays. We make them role play and it is unconditional positive regard. The mothers that I support in both my roles, if they do wean, and in fact I had a mother message me the other day who never got her baby to the breast at all was saying, "Whilst I feel sad, I feel like you were with me along the way and I got to that point." She does not feel guilty. She knows she did everything she could and gave her baby the best start that she could. This is so important. Those of us that are mothers in the room, we feel guilty all the time—from the day we conceive for the rest of our lives, we feel guilty about our children. What we need to do is to help mothers feel the best they can about whatever they achieve with their babies. That is so important. Sorry, that was a bit of a rant.

Ms TRISH DOYLE: Thank you both for the important work that you do. As my eldest son is about to turn 21, I think about some of that very early support I received as a new mother. It was from the Australian Breastfeeding Association. I encourage all members of Parliament who receive promotional material in their electorate offices to put up the sign "Breastfeeding welcome here". It is incumbent upon members of the community and businesses in local communities to provide safe and welcoming places for women to get off the street if it is something with which they feel uncomfortable. I acknowledge a lot of women with children and partners want to have a quiet space to sit down and breastfeed. There are sections of society reacting to seeing a breastfeeding mother. The work that the Australian Breastfeeding Association does and the support the association receives from communities is imperative in women continuing to breastfeed their children.

Not all mothers feel comfortable, as I once did, in challenging someone who stops them at a café and says, "Do you have to do that here? Can't you go to the toilet?" My response was, "Mate, why don't you take your muffin and cup of coffee and go to the toilet?" It is important to challenge that negative stigma. As Ms Duursma said, it is important to encourage the positives in breastfeeding. I frame my question around the association's submission where this Committee is called on to provide support for new parents and babies. My question relates to the 10 steps for successful breastfeeding being promoted and adhered to, particularly the sixth and the tenth steps—to ensure health professionals are educated and to ensure there are well-informed referrals by health professionals to organisations.

I wanted you to comment on that second point, which is the incidents that you might hear about from women who are perhaps in the health system, having just had their baby, and they are handed a brochure or a sticker is popped on to the baby book and off they go. But they are actually a little afraid and sleep deprived and they might need to ask, and they are not sure how, for some advice around breastfeeding. I am the eldest of six children, my youngest sister has just had a baby and she rang me from the hospital. She said, "What is the question I have to ask if my nipples are really sore and it is just not working?" I said, "Ask for a lactation consultant, ask for the social worker, ask for someone from ABA, ask one of the nurses to call someone from ABA and get them there." She did not know. In your view how do we ensure that well informed referrals take place and the steps are adhered to?

Ms DUURSMA I cannot count the number of mothers I see that call me and say, "Every feed is painful. It is just awful. I cannot bear to do it. They told me at the hospital the baby is feeding fine."

Ms BRIDGES: It looks okay.

Ms DUURSMA It looks okay. Again it is about having enough people there and appropriate support. For a couple of years the Australian Breastfeeding Association ran a drop-in breastfeeding support service and I have just been presenting some research at a conference that I did on that. The mothers that came to that service, in the research we did not ask them how long they fed for but they nominated because they were so proud of what they achieved, they fed for 18 months to two years. That is well beyond what we would ever expect mothers to do. It was because they had timely skilled breastfeeding support. This is the thing, there are some people that can afford to pay for a private lactation consultant if they have a very complex problem but most people cannot do that. There are no Medicare rebates and health insurance rebates, if there are any, are very small. A service that we ran we had to stop because we were too busy and we could not fund it. Even though most of us were working as volunteers we could not even pay for the premises that we were having it in.

Nine out of 10 mothers who attended that service said that they met their breastfeeding goals because they had been to the service. We know that timely good breastfeeding support is really important. Ringing the help line is important. Understanding what ABA is about and I think we said in the submission, it is not just putting a sticker in the book, it is saying to the mothers: This is Australian Breastfeeding Association, they can be your village. They can be the people that get you through your parenting journey. It is not just about breastfeeding problems, it is being around parents role modelling loving parenting that happens within our groups. We know in communities where health professionals refer mothers to ABA groups those groups are thriving. In areas where health professionals do not refer the mothers the groups struggle to keep going and have enough volunteers to run. That working together is really important

We have a great relationship with NSW Health and we work together on lots of projects but we need to do more to get the word out to mothers. We are capacity building for health services. Even in my professional role as a lactation consultant I want all my mothers to go to the Australian Breastfeeding Association because that is less work for me then as well. On the train on the way here I have been answering text messages from mothers I am seeing. It is capacity building for the service. A lot of the things mothers worry about are normal infant behaviour. At ABA they come to a group meeting and say, "Oh, my baby is doing this." And someone says, "My baby did that but it only took this long and it will pass", and we are on to the next thing.

Mr ALEX GREENWICH: Thank you for the submission and the great work you are doing across the community. I have two questions. The first question is around Medicare coverage of lactation consultants. What justification has the Federal Government given for not providing it, and the second is whether the New South Wales government has previously advocated for Medicare coverage of lactation consultants?

Ms DUURSMA I am not aware that the New South Wales Government has advocated. There have been a number of submissions that I have not been involved with that have gone to try and get provider numbers and there has been stumbling blocks over lactation consultants being registered with Australian Health Practitioner Regulation Agency because not all lactation consultants are health professionals -- I am a registered nurse as well -- nor do they need to be to give good support. I think that is one of the stumbling blocks, which we should be able to get past. Lactation consultants who are international board certified have to show evidence of a lot of hours of education and experience before they receive the qualification.

Mr ALEX GREENWICH: The benefits of having that Medicare coverage for young mothers, what are those positive impacts?

Ms DUURSMA: It allows for more equity of access. There are some complicated problems that need more specialised services and that is what a lactation consultant can provide. If there had been Medicare rebates for lactation consultants we might not have had to close down our breastfeeding centre.

Ms BRIDGES: Also the fact that it is the lower socioeconomic groups where breastfeeding is lowest. It is a double inequity, they need the support so that if there are complicated issues they can get the timely lactation support. It is beyond the scope of what the Australian Breastfeeding Association can do over the phone.

Mr ALEX GREENWICH: The New South Wales breastfeeding policy, when was that last updated and how has the implementation gone?

Ms BRIDGES: It is in the process of being re-updated.

Ms DUURSMA: The policy is in draft and going through the approval process. This is the third policy we have had. I have been involved in writing every one of them. A few times I have said, "Can we not please implement the previous policy?" But that did not go down too well. I think there are so many priorities within health services that it just keeps getting pushed down. When we sat in a room deciding what we were going to do

with the pot of money that came out of the obesity summit many many years ago we talked for a long time about what can we do to make a difference.

What we realised is that there are many clinicians doing a really good job and doing their utmost to help mums. But what they do not have is top down support to do that. We wrote that first policy using those funds. We thought about advertising, we thought about this and we thought about that. We do not need to tell mothers that breastfeeding is important, they know that. But, what we need to do is have that top down support so the whole of the health service provides the community that is going to support breastfeeding. NSW Health work tirelessly to get the policies done and the policies are very good, it is getting the health services to implement them and make them a priority, which is very difficult.

The CHAIR: I thank you both very much for coming in today and answering questions and contributing to the work the Committee is doing. If it happened that a Committee member has a subsequent question they think of later and send it to you in writing, would you be happy to answer in writing?

Ms BRIDGES: Sure.

The CHAIR: I would point out that if you did so it would be considered part of your evidence in the Committee and published in the same way.

MS DUURSMAN: Absolutely, we would be happy to do so. (The witnesses withdrew)

(Short adjournment)

ZOE ROBINSON, Chief Executive Officer, Yfoundations, affirmed and examined

ANDREW JOHNSON, Advocate for Children and Young People, affirmed and examined

The CHAIR: Thank you for joining us today to help with the work of the Committee on Community Services of the Legislative Assembly in our inquiry into support for new parents and babies in New South Wales. We are partway through an inquiry into support for babies and parents in New South Wales and we have heard from a number of witnesses already today and we look forward to hearing briefly from you in an opening statement about any key points you would like to make. We have read your submissions and the key purpose today is for members of the Committee to ask you questions that have arisen for them in that process. Would each of you like to make a short opening statement?

Ms ROBINSON: First I would like to acknowledge the traditional owners of the land on which we meet today, the Gadigal people of the Eora nation, and pay my respects to elders past, present and emerging and any amongst us today.

We thank you for the opportunity to appear before the Committee on Community Services in relation to the inquiry into support for new parents and babies in New South Wales. I am the CEO of Yfoundations. Yfoundations is the New South Wales peak body for youth homelessness. We represent young people at risk of and experiencing homelessness and those services that provide direct support to these young people. Importantly, we advocate for the youth who are homeless, at risk of homelessness and who have experienced it.

We represent services across New South Wales. Our members provide direct services to young people including young parents. Our services provide early intervention support, crisis support, housing and rental support. They run in four areas: out-of-home care services and medium-term housing providers, they work with children and young people aged 12 to 24 years old, and they work with families around family restoration. At all times our members provide services that are in the best interests of the children and young people and they put these children and young people at the centre of all they do.

We believe that young people have the right to safety and stability, home and place, connectedness and participation, education, employment, health and wellness. We know these are the foundations for the prevention and pathways out of homelessness and all are relevant to young parents and their babies. As the Committee will be aware, youth homelessness has increased at a rate of 92 per cent since 2006. On census night there were 9,048 people aged between 12 and 24 who were homeless. We also know that young parents are disproportionately represented; for example, young people experiencing homelessness are 10 times more likely to be single parents than the general youth population.

Census data shows that the proportion of young people aged 15 to 24 in the general population who are single parents is 1.4 per cent. The Australian Institute of Health and Welfare shows that the proportion of young people 15 to 24 being assessed by specialist homelessness services who are single parents is 15 per cent.

Yfoundations is committed to providing advocacy support for new parents and babies and for the services that support them. There are very specific needs for this cohort, including appropriate and adequate housing, new parent support and training. We need to ensure that each child has every opportunity to thrive and achieve and that we provide adequate support to both the parent and the new baby in the first early days.

Mr JOHNSON: I would also like to thank the Committee for the invitation to appear before this important inquiry. I also would like to acknowledge the traditional owners of the land, the Gadigal people of the Eora nation, and pay my respects to elders past, present and emerging.

The Advocate for Children and Young People [ACYP] is an independent statutory appointment overseen by the Parliamentary Joint Committee on Children and Young People. Our mandate is to advocate for and to promote the safety, welfare and wellbeing and, importantly, voice of all children and young people aged 0 to 24 in New South Wales, with a focus on the needs of those who are vulnerable or disadvantaged.

In my role as Advocate I have been privileged to hear directly back from over 17,000 children and young people from across the State. This includes children and young people in out-of-home care and juvenile justice and specialist homeless services. These are the settings where we most often come into contact with young parents. We have also spoken to the parents of young children participating in playgroups, as well as adults who work with or on behalf of children and young people in regional New South Wales. We are also about to commence a poll of parents across the State to determine the information they need to assist their goals of ensuring that their children survive and thrive.

What we have heard back from children and young people themselves is summarised in the following: that Aboriginal children and young people require services that are connected to culture; young parents faced obstacles including socio-economic stress and social stigma, which can limit their opportunities to access education, employment and housing; young parents face barriers in accessing safe and stable, affordable accommodation, particularly within the private rental market; there is a lack of programs for homeless young couples and families that would allow a family to stay together, including more programs for young fathers; young parents need help to find affordable housing and learn life skills; and intervention programs are most effective when they are consistent, respectful and positive and have links to health, education, housing and employment pathways.

A common theme throughout our consultations with any young person was their ability to get easily accessible information, particularly in the digital space. On that, ACYP, along with 10 other government departments, is right now creating a new digital platform to provide that information, I do not really like the term "youth friendly", but in a youth-friendly, child-friendly kind of way. We sincerely thank you for this very important topic to be raised. We are taking your lead with doing the parenting poll, which will be going out in the next couple of weeks, and we hope that our discussion can be of assistance to you here.

The CHAIR: I will start with you, Mr Johnson—if I can say, you have got a broader remit than our other witness here at the moment, and that gives you a challenge in respect of some of these difficult cases that we are going to hear about because you obviously have a focus on both the baby and the young person who is the parent of the baby, a kind of dual responsibility. At some point do those conflict? Is it a real challenge in order to protect the welfare of the baby that at times your natural inclination to support the parent, which most of the time you would be able to do holistically, you reach a point where that is not possible?

Mr JOHNSON: Sure. We always work from a child's rights perspective, and I think what people often forget is that in the Convention on the Rights of the Child it talks about how we need to give parents the maximum support possible to the financial capabilities of each jurisdiction. We think it is very important for a young person who has had a baby to support both, and in supporting both you are getting the maximum outcomes for both the mother, the father and the child itself. I think what we need to get better at is ensuring and understanding that the assumption is that a young person may not be a good parent because they are young. So there is a stigma against them. They are often telling us that they are worried about losing their children, so they are often highly motivated individuals. I think we need to do all we can to ensure that they are getting the supports that they need, particularly—and I am sure my colleague will talk more about it, but the housing needs are often at the forefront, particularly for those young people doing it tough who are having children.

The CHAIR: Are we doing that or anything like that at the moment? Are we providing the focus that would keep those young people in safe, secure positions with their babies?

Mr JOHNSON: There are a lot of good services that are run around the State, both in the city and in regional New South Wales. It works well when they are able to attach themselves to a youth service of family service that looks holistically at their problems, including their psychosocial needs, drug and alcohol issues and educational needs. Many of our Yfoundations members are doing a great job in that particular area. I think we

need to make best practice common practice and have an always-open-door policy for young people with difficult needs. There are some great programs out operating around the State. I think where we come to a problem is when we butt up against the issues that relate to homelessness. That is a priority for the State, and we are very excited about the fact that New South Wales has made it one of the Premier's Priorities and there is work being done to ensure that, particularly for young people. You can imagine how difficult it is in an already difficult housing market for someone who is low income and disadvantaged and also has a young child. Trying to navigate a private rental market is incredibly difficult.

The CHAIR: I want to hone in on the practicality of that. You quoted some numbers from census statistics and so on. How many young people who are parents are homeless at the moment in New South Wales? Is it possible to estimate that?

Ms ROBINSON: I would not want to give an under representation or over representation on that. I will take that on notice and give you exact figures. But we do know that there are cohorts where the numbers are much larger. We do know that children leaving out-of-home care are two to three times more likely to be parents. One in three young women were either pregnant or had given birth soon after leaving care, and several years later 57 per cent of the same group had become parents. We know that there are particular cohorts of young people who are highly represented in this group. But to give you an exact figure of what it is on any given night would be difficult.

The CHAIR: If you can give us your best estimate that would be helpful.

Ms ROBINSON: I give what the Australian Institute of Health and Welfare data says in terms of young people presenting who were single parents. I read—and I am going to make sure that I find this figure properly—that there were 22,000 in 2016. But I do want to make sure that I get you the right figure.

The CHAIR: That would be scary number of people who have children but no roof over their heads.

Ms ROBINSON: To Mr Johnson's point on things that are working well, there are programs that work well. There are certainly programs that engage young people to learn parenting skills and to thrive. There are areas in New South Wales where accommodation is the biggest and most fundamental problem. To give you a living example of that, there is a young family in regional New South Wales who were being brokered to couch surf because that was the only accommodation that could be found for them—there was no other appropriate accommodation. A service had enabled for them to couch surf with friends and had provided financial support for that. That relationship broke down, because it can over time, and now the father is living in a male refuge and the mother and child are continuing to couch surf.

It is often not appropriate to put a young parent and child in an all-women refuge because there are various other issues that are being faced there. If there is no appropriate accommodation, they have to do what they can with the resources that they have. That is not an uncommon problem in regional parts of New South Wales. Then there is also the lack of two bedroom or one bedroom apartments. It is not always appropriate to have a mother and child in the same room and apartments often do not meet the adequate living standard. We do not have a lot of apartments that are available for young parents and their babies. That is a reoccurring problem in the cities as well.

The CHAIR: Is it an indicator for priority on the public housing list if you are a young parent with a baby? Does that provide you with a level of priority access?

Ms TRISH DOYLE: No.

Ms ROBINSON: No, it does not.

Mr DAVID HARRIS: That is quite alarming. One of the Committee's site visits was to the Young Parent's Hub in the electorate of Wyong, which seems to be doing a pretty good job. I have concerns around out-of-home care and wards of the State. Is there a reason why they are—I do not like to say higher risk, because it often by choice—over represented in young parent statistics?

Mr JOHNSON: They are children with multiple disadvantages. You would be aware of the fact that these children are cycling through homelessness, out-of-home care and juvenile detention centres. We have just finished visiting every detention centre in New South Wales. Young people who do not necessarily get the supports and services that they need throughout their lifetime are exposed to many different elements. That is one of the key factors. Having that in mind, it means that the services need to be more holistic. When a young person presents who is a young parent people often see that as the problem; that is not the problem. The problem is that the person may be homeless, does not have the levels of education that they have the right to have, and does not have a safe and supportive place to live. It is working well at the Young Parent's Hub in your area, which won the NSW Youth Service of the Year award last year with Youth Action. That service is an example of looking at

young people in totality and what assistance they need for themselves and to capacity build them to be the best parents they can be.

Mr DAVID HARRIS: Do you think there should be a policy of trying to keep both parents and baby together in terms of housing etc.?

Mr JOHNSON: That is really important, and that is what young people are saying to us. When we spoke to young parents, many of whom just happened to be on the Central Coast, they often talked to us about how what they really wanted was to be with each other and be with their child. What Ms Robinson raised was that it is sometimes incredibly difficult to maintain that. You can imagine that for someone who had a pretty stressful life to begin and who was suffering multiple disadvantages, having a child and not being able to live together is incredibly difficult. But it is important to understand that the young people are telling us that they want to be good parents and want to be together. I say once again that contrary to the stereotype, more often than not, these young parents are highly motivated to do the right thing.

Mr DAVID HARRIS: Your submission talked about the fact that young parents are often able to only get a youth allowance. Whilst it is out of remit, because it is a Federal policy, it does seem to be a ridiculous situation when they are most at need they cannot find support for accommodation and things. The youth allowance is obviously not enough to pay rent and all those sorts of things.

Mr JOHNSON: In our consultations we had to be real with young people and say, "Look, my job is to listen to you, but we can only report back to the New South Wales Government. But across the board all children who were doing it tough, and specifically young parents, were saying that of all the other stresses in their lives, accommodation and the lack of financial resources made their lives incredibly difficult.

Mr DAVID HARRIS: Do you think it is a societal thing? In the past, some of the newspapers etc. have criticised payments to young parents because they see that as incentivising having children. Is that the reality or is the reality that we actually disadvantage babies and children right from the very start if we do not acknowledge that it is a time when resources are most necessary?

Mr JOHNSON: It is a stereotyping of young people that goes back millennia. Part of that is understanding the lived reality of having multiple disadvantages and multiple stresses. It is a difficult choice for them, given their circumstances, to commit to raising a young child. They are still wanting to. It is hard for many of us to raise a child in easier circumstance, but for young people who do not have safe accommodation, have incredibly low financial resources, and have a lack of supporting services, it is difficult. I am not sure that young people are making that choice—it is an incredibly hard choice.

Ms ROBINSON: Perhaps take the financial side of it. If they are a young parent and they do not have access to their own Medicare card because they have been attached to somebody else's Medicare card, that becomes very difficult as well in terms of accessing health services and bulk-billing. Those are the additional hurdles that we do not always consider but they are a reality for these young people.

Ms TRISH DOYLE: I want to begin by thanking you for the work you do throughout the State, especially where there is dysfunction, vulnerability and disadvantage. It is tough work. Recently I came across a young couple with a young baby living in the bush in the Blue Mountains. The first thing they expressed was their shame in needing to have to ask for help. The stigma that you have talked about and the issues around accommodation I see all the time, as you do. I want to say thanks. It is pretty tough when we are dealing with children having children. Ms Robinson, you referred to a substantial increase in the percentage of youth homelessness in the last little while. I think it was more than 90 per cent, is that right?

Ms ROBINSON: The rate of youth homelessness is 92 per cent. It has increased since the 2006 Census.

Ms TRISH DOYLE: That is an incredible statistic. That is worth noting when considering the recommendations that come out of this Committee inquiry. On that point, I acknowledge the 10 sensible recommendations that you have put forward, especially No. 2 and No. 3. I want to highlight those. I presume when there is consultation and conversations around youth homelessness and needs of young people with children, the number one factor is accommodation?

Ms ROBINSON: Certainly. That is what our members would be hearing and that is what we are seeing, yes.

Ms TRISH DOYLE: We have a situation where housing demand is outstripping supply across the board and then you have this added disadvantage. I would like you to talk, if you can, to recommendation No. 2 and No. 3 in your submission about what you are hearing in respect of young parents needing priority accommodation,

especially the accommodation that is near essential services such as public transport, shops, medical services, childcare centres.

Ms ROBINSON: Often we would be dealing with young parents who are homeless and nearing giving birth. As you can imagine, that is a stressful time because they might be aware that the service in which they are in is not the appropriate service that they will continue to be in once they have had their baby. A lot of work is done by services and our members to try to advocate for someone. I need to note that we can make you a priority if you are nearing birth or have a young baby. A lot of that advocacy will be done by member services around the transitional properties that they have or the housing relationship that they have.

There is a priority to be next to essential services because adding an additional burden on a person who may already be from a low socio-economic background of having to travel to services, such as health for their babies, will make it difficult for them to attend those services. Obviously they have to weigh up the costs. They will have costs for the accommodation that they may be in, for health and for food. If you add distance and cost of transport to that, it is making it harder and harder for those young parents to achieve those things for their babies, but also for themselves, importantly, because they need to maintain their own health. We all know that child care is expensive, so ensuring that you have the ability to get there—car, transport—it is the everyday costs that are piling up.

Our submission talks to this as well. If you are talking about that, for example, the new minimum income for healthy living budgets for low paid and unemployed Australians, a single adult would require \$600 a week to have a reasonable standard of living while a couple with two children would need close to \$1,200. Currently people are receiving \$800 a week. It does not leave much. At the very least, finding accommodation closer to these services is important. The recommendation states that the accommodation models for young parents should give them control over their decisions. They should be voluntary to allow young parents to maintain both their sense of autonomy and their ability to make their own decisions. We hear that a lot.

We hear a lot from young people that they have a fear of losing their children, having their children taken away from them. We also hear from young people talking about the kinds of ways that they are being engaged with and communicated with. That is important for Aboriginal and Torres Strait Islanders as well, respecting community and culture, and ensuring that the practices that they are engaging with respect community and culture. Also, we have young people, as Mr Johnson pointed out, who are very committed to and enthusiastic about being good parents so we need to empower and enable them to do so and we need to develop programs. Successful programs are the ones that give them autonomy. They enable young parents to engage with their communities and it provides them with access to material that is relevant and appropriate for them.

Ms TRISH DOYLE: Whilst I acknowledge all of the 10 recommendations are very sensible, it is good to highlight where that greatest need is. Mr Johnson, you make note in your submission to the Committee of the importance of providing new and expecting parents, and in this case children themselves, the opportunity to engage in life skills preparation. As a former teacher, that jumped out at me. I often have a lot of young people in the Mountains Youth Services Team who stop and talk to me about where they feel the biggest disconnect is in respect of some of the difficulties they are facing in their lives now and education, and they feel there were no life skills preparation as part of their formal education. I am wondering whether you might like to talk to that a little. If I was to say to the Department of Education that as a teacher and a parent this is something we need to address because kids are coming out of formal education feeling like they do not have any life skills, it would be felt far more intensely for those who, all of a sudden, find themselves with a need for those skills.

Mr JOHNSON: It is important to also acknowledge whether we are talking to kids who are doing it tough or kids who are doing it not so tough. They are all saying they want life skills, which goes to the fact that this is the digital generation, so what is the impact that has had on young people about getting information? Some of it is that they think that we, as adults, know what we are doing about certain things. Often it will be taking the time to say, "I am an old guy and I do not know how to do that still." It is as much about empowering but we have had lots of consultations with children across the spectrum. Interestingly, they all come back with similar answers: It is about paying rent, what do they do to pay taxes. We are putting a lot of time in researching how can people get that information? It has to be done in schools, but not everything can be put on a school. It is whether you take it outside in non-formal settings, whether it is youth groups and others.

We know that many youth services provide some training in life skills. We probably need to get better at collating how we are doing that so young people can find the information that they need more easily. In our research, and it is not rocket science, a lot of young people will get their information from three-minute videos on YouTube. They are more likely to find that information on YouTube than a website. So government information, we would say if you are trying to target young people, they will go to YouTube before they go to a website. It is about tailoring the information for young people in an accessible way, but it is a worry across the board, whether it is children in out-of-home care, children in detention, or young parents—often there is a population cycling through all of those—when they are calling out for life skills.

Ms TRISH DOYLE: Navigational skills?

Mr JOHNSON: That is right.

Ms ROBINSON: The services do a very good job in providing that, as you would know, and they often bring education and real estate to the table with the young people to have that conversation. What I would say also in relation to the Education department is that one of the difficulties for a lot of young parents is going back to school and being welcomed back into school. There are other ways that we can deliver the life skills training that should be invested in.

Ms TRISH DOYLE: I want to acknowledge that the community services sector not only in my community but also across this State do incredible work with all sorts of vulnerabilities, but what I am hearing is that they are having to do more with less. That sort of resourcing of our community services sector, those unique services that can work in collaboration with one another and provide the support, are finding it really tough at the moment. That is why I specifically wanted to talk about some of the feedback I have heard from the Mountains Youth Services Team and some of the young people who access that service. I think they could do with double the amount of staff.

Mr ALEX GREENWICH: Ms Robinson, you commented on the growing number of people who are homeless; there is an ever larger number of people at risk of homelessness and that includes new parents and their babies. Can you give the Committee some examples of the types of private rental market discrimination that new parents may face? Can you also give the Committee some examples of the types of concerns new parents may have in dealing with FACS? Finally, what do you see as potential solutions to the impossible situation that many young parents with babies find themselves in?

Ms ROBINSON: I will deal with private rentals first. It is a competitive market. Again, as Mr Johnson said, whether one is struggling or not struggling it is a competitive market. We understand that agencies have a duty to the people who own the properties to get the best tenants for those properties. They will also have a way of listing and prioritising those tenancies. We are currently in discussions—and we know that it works quite well in some areas like Lismore—where you bring the real estate agencies in early and in your conversations with them you explain to them a bit about the tenant. You also explain to them that there is a service around this young person that is supporting them and there is a willingness to engage with that—for example, a trauma-informed tenancy course is being run up in Lismore with one of the services. That is being well received and it is something that we are in conversations with the Real Estate Institute of New South Wales to have further conversations about what we can be doing with that.

It is part of the education piece in how you bring everyone to the table to understand the kinds of young people who are being put forward for private rentals are those who have been seen by the service and by our members as being an appropriate outcome for them. We also know that the earlier the real estate agents engages with the service the young person is 80 per cent more likely to maintain that tenancy. It is about bringing that community around that young person and people being aware of it. In our submission we spoke about the relationship with FACS and some of the concerns that young people have there. If we look at what we represent there in the out-of-home care numbers, there is a nervousness and a concern that that young person who has had their own experiences with out-of-home care may also subsequently lose their child.

I think, again with the willingness of the table, when people have the early conversations and everyone is engaged, there is a willingness by the agencies and the services to continue to keep that young person with their child as well but there is a highlighted risk—certainly in the services we have spoken to—of that. I have heard from a particular service on the mid north coast where there have been experiences of a child being removed from a parent in the hospital and some very strict requirements being put on that young person. That person achieved those requirements and they were reunited after nine months with their child. That person is now a thriving, excellent mother. Young people hear stories like that and they do get concerned about what will happen to their

baby and that relationship. But I would say that it works really well when agencies, education and health and everyone is sitting at a table talking about the best interests of that new parent and baby.

Mr ALEX GREENWICH: Is there an advocate in place to support that mother at risk of homelessness with a new baby through her journey to housing? Is there somewhere she can safely turn knowing that she is not going to be discriminated against and that she is not at risk of her child being taken away?

Ms ROBINSON: If they have been presented to a service previously I would say that service would absolutely advocate for them and that it would be doing everything it could to maintain that relationship and the housing. There is obviously government lines such as Linked to Home, which a young person can call and they will receive advice on where there is potential availability for services. But, again, it would be services that advocate for housing priority.

Mr ALEX GREENWICH: Obviously it is linked to the increasing number of people who are homeless, but there is obviously not adequate social and affordable housing available in New South Wales for this cohort.

Ms ROBINSON: There is not and there are not appropriate alternatives. If it is not that, there are none or limited single-bed parent units. There are limited spaces that are appropriate for a young family who can co-locate with another young family. We have seen that co-location works really well where there is a service wrapped around it. So there is not enough affordable housing but there are also not enough alternative pathways.

The CHAIR: In talking about the risk of homelessness are most of these situations where a mother and father are together or is it more often the mum on her own with the baby?

Ms ROBINSON: We certainly see a number of situations where it is a mum and her baby. There is a lot of work being done trying to keep the family unit together. We certainly make a recommendation about the need for father-specific courses as well around that to try and keep the unit together.

Mr JOHNSON: That is not a scientific approach but it has been very interesting in our direct consultations with these young people. Our experience with the services has been that it is more common that the issues are around the two parents staying together, rather than single parents—that is not to say that does not exist. What we are seeing is that once you are attaching yourself to a service, or when a service is good—interestingly the five or six examples going through my head were all couples trying to stay together—because of the way emergency accommodation and refuges work there is a large gap, not enough. Specifically for young parents trying to stay together, that was a significant problem.

The CHAIR: Is there something specific needed to help the dads to stay in the picture?

Mr JOHNSON: Ensuring that there is more safe, supported accommodation available that takes into account a young family's needs. So more resourcing would need to go into that to ensure that there were places available. We talked about when you see the model working, you could have young families with young families. But, of course, in regional New South Wales, let alone Sydney, that capacity is not there yet.

Ms ROBINSON: The example I gave in rural New South Wales was a family who wanted to be together but because of the circumstances there was not an opportunity for them to stay together. There was room for the father to go to a male refuge but there was not room elsewhere.

The CHAIR: Ms Robinson, could you take on notice to provide the Committee with some extra detail around the Lismore example? We would be interested to know a little more about the process involving the real estate agents and services. That may lead the Committee down a path that has some light at the end of the tunnel.

Ms ROBINSON: Absolutely.

The CHAIR: There was also the issue around the statistics that I asked about earlier?

Ms ROBINSON: Would you like them now?

The CHAIR: Oh, you have got them?

Ms ROBINSON: This is from the Australian Institute of Health and Wellbeing and it says that the report on the number of homeless young people who are single parents—it is not necessarily clear on that specific data—but overall numbers of homeless, single parents have increased by 7 per cent to 22,172, representing 30 per cent of those seeking assistance from Specialist Homelessness Services [SHS]. The difficulty we do have is sometimes obtaining the specific young parent data, as you can imagine and often they are grouped in other circumstances but that is the specific number I can give you.

The CHAIR: Thank you. If there are questions that members of the Committee think of later, would you be happy to answer those in writing, if we deliver them to you?

Ms ROBINSON: Absolutely.

Ms JOHNSON: Yes, we would.

The CHAIR: In that case they would become part of the record and published in the same way as the rest of the evidence. I thank you very much for your time and for contributing to the work of the Committee.

(The witnesses withdrew)

(Short adjournment)

VANESSA GONZALEZ, Co-Chair, Rainbow Families, affirmed and examined

The CHAIR: Welcome to the Committee. Thank you for making your time available to give evidence and assisting the Legislative Assembly Committee on Community Services inquiry into support for new parents and babies in New South Wales. Do you have any questions about the process?

Ms GONZALEZ: No, thank you.

The CHAIR: Before we commence, would you like to make a short opening statement? We have read the submission that your organisation has made so you do not need to repeat that but we will be asking you questions. Is there something you would like to say?

Ms GONZALEZ: I just really want to thank you for inviting us. It is really special for us to be talking about particularly new babies and new parents. Our community is certainly growing in terms of the numbers of members in our community who are having babies and becoming parents. I am the Co-Chair of Rainbow Families. Our organisation is the main peak organisation supporting lesbian, gay, bisexual, transgender and intersex [LGBTI] parents and their children in New South Wales, and prospective parents as well. We offer a network of support. We are community-led and volunteer-led. We offer things like playgroups; we do lots of parenting, resourcing, social events and advocacy on issues affecting parents. As I said, we are a growing community, definitely after marriage equality and the changes to adoption in New South Wales, with more interest in fostering as well. We are growing in terms of being able to be parents.

New parents need support and services that are inclusive and are able to meet their needs. On the whole our community has said that they experience very positive things when they seek care and support but there are times when there are lots of barriers and some of those are structural barriers—simple things, as mentioned in our submission, like gay dads not being able to change a nappy because there are no change tables in male toilets; forms, when the computer says "No", when I tell them that my children have two mums; attitudes and awareness when people are a bit confused or sometimes awkward around different types of families or do not have the language around trans parents or gender-diverse parents. Sometimes those things can delay the help that new parents get and might have an impact on the newborn and their baby or it might create a stigma and be a barrier to the support that they so much need. In some ways they are simple things that this Committee, I am sure, can look at and help change. That would make a lot of difference. I will stop now because you have read the submission but I welcome questions.

The CHAIR: Can you elaborate on how some of those things you have said might delay support, I think you said, reaching parents and babies? What would cause that delay?

Ms GONZALEZ: I can give you two examples. Where there is some stigma or where trans parents feel that they have not been understood or they feel in some way discriminated, it could mean, for parents who spoke to us, that they would not seek the support of that service; they would not be out or they may choose not to get the support they might need. For example, we run an antenatal class and we have quite a lot of trans parents come to that antenatal class. We self-fund it, we fundraise for that because they do not feel that they could attend mainstream antenatal classes, for example.

The other thing is simple language for gay dads. A lot of the literature that is around, particularly about simple things like perinatal depression and anxiety, mostly assumes it is an issue that affects mothers. Even the imagery is often very mother, mother, so a lot of dads have said to us, "We didn't think it related to us until I was depressed for six months and then I mentioned it to my GP and my GP said, "I should have screened you", and by then it was probably too late. Even the parent thought, "It probably doesn't affect me" because the information was a barrier to getting support so it did delay help for that particular dad, for example.

Mr ALEX GREENWICH: Thank you for the great work that Rainbow Families does. You mentioned stigma and discrimination and you touched on the fact that we now have marriage equality. But last year was a

particularly difficult time for LGBTI parents. Can you take us through the experience of LGBTI parents during the marriage equality postal survey?

Ms GONZALEZ: That was a very distressing and difficult time where certainly there was a lot of public debate, to say it nicely, or negative commentary or abusive statements made about our children and our families. I have spoken to quite a few people in our community who have said during that time they felt unable to come out, unable to tell people about their sexuality again, being very secretive about who they are, and having experiences of depression and anxiety again. People who had experiences prior to babies were saying: I cannot believe I am back on antidepressants. Quite a few parents told me that story, of going back seeking that type of help. A lot of people would say if you have families that are not accepting, once you have children there is a new wave of love and acceptance. A baby fixes a lot of things. But during the survey a lot of people naively, including myself, decided to ask family members how they were going to vote.

You then learnt those that decided they were not going to vote or found out for the first time they had an issue with your relationship. Out and proud people then had to have an awkward Christmas, had to question their worth and their value as a family, and that of their children. It gave permission for people very close to us—where it hurts us most—to say: I think I accept you both but I really do not think this child is both of yours, it is only hers because she had it. Lots of very negative things that occurred during that time, within the family space and the outer space. It certainly impacted on people's mental health as parents and ability to seek support from the people who offer the first lot of support, who is your family and people around you. If you cannot rely on that, that is a very hard time. A lot of families are healing through that.

Mr ALEX GREENWICH: Do you feel the "No campaign" specifically targeted LGBTI parents and their children?

The CHAIR: Sorry, I am going to intervene. Is this leading us somewhere Mr Greenwich?

Mr ALEX GREENWICH: It is. The inquiry is about the experience of new parents and babies. Before you interrupted me the questioning was going to is there adequate support given the way in which the specific cohort was targeted, and as we have heard, had a very distressing experience.

The CHAIR: The question should be focused on the prospective part of is there adequate support, rather than make assumptions about what experience people may or may not have had.

Mr ALEX GREENWICH: I was asking the question and I think it is completely in line. I will stick to the question and then ask about whether there is adequate support in place for this cohort.

The CHAIR: As I say, I ask you to ask the question about the support rather than make judgements about people.

Mr ALEX GREENWICH: I am not making a judgement, I am asking our witness who is appearing, to express the situation of the cohort that she is representing, just as the Committee has asked every other group here.

The CHAIR: I have no drama with that, if you phrase it in a way that is doing that.

Mr ALEX GREENWICH: I think you understand what I am getting at, which is the way in which LGBTI families were specifically targeted. What was your experience in terms of the adequacy of consideration of that by the Federal Government and whether there is adequate support in place for LGBTI families who do have this extra burden of discrimination and targeted attacks?

Ms GONZALEZ: I feel there is not adequate support. As a small incorporated organisation that fundraise, we are trying to meet a lot of that support, as much as we can, providing things like help to gay dads access a Blue Book for example or get the Statewide Infant Screening – Hearing [SWISH] test or the newborn screening done for their babies. Those are the sorts of things that we do all the time to offer support. Even though there have been lots of changes in policy like gender-neutral forms and lots of inclusion policies, it does not follow the case that there is always the staff awareness or training.

It is not ill-intentioned. Sometimes people are confused and want to know what does a cisgendered man mean and what does a transwoman mean? Can you breastfeed if you have transitioned and you are on hormones? Sometimes even health workers do not know that. It would be basic and important to not only have some training and education so there is correct language, support and understanding to make those services accessible to everyone. That would be a very important thing.

At the moment, particularly health information assumes a heterosexual couple. It is not only imagery that excludes, but it is often the information as well. I gave the example if it is two dads not being able to access simple support or assuming that that support is not available to them. Things like mothers' group. It is called mothers'

group. They will tell you mothers' group is mothers' group, you'll be a brave dad—even a straight dad—to go to a mothers' group. There is very little for fathers. The gay dads I spoke to said: If you can help dads altogether—straight dads as well—get more support in terms of looking after their babies, you would be helping gay and straight dads. You would also be helping mums that have straight husbands who also want the dad to change the nappy, to go to parent education. Some straight dads want to stay at home and look after the children. Certainly with gay dads, one of them is going to stay home and want to be able to go to a mothers' group, if it is not called a mothers' group and if it allows them to participate. I feel there is a lot to be done in terms of access and equity, and to be very thoughtful about that. We cannot just offer universal services and think people will rock up.

Mr ALEX GREENWICH: It is all that practical support, but also emotional support is what I was eluding to.

Ms GONZALEZ: Yes, absolutely.

Ms TRISH DOYLE: Thank you for attending Ms Gonzalez to assist the Committee in our work around what is needed to provide support to new parents and babies in this State. I thank you for the work that you and Rainbow Families have done and will continue to do into the future. Following on from Mr Greenwich's questions, acknowledging that practical measures are needed to be put in place to support parents. In noting the recommendations Rainbow Families has put forward in its submissions, to look at some of those—providing specialist training to medical professionals and health workers on family diversity, where the role that people will play with new babies is spoken about. Mother, father, what-have-you rather than gender. One example is reviewing the Blue Baby Book or the personal child health record and other key publications. What sort of position is Rainbow Families in to assist with transitioning some of these universal services to be better equipped to support you?

Ms GONZALEZ: It is something that we already engage with. We have had a lot of conversations with NSW Health and they have been really wonderful in that they were very interested to hear about our experiences with the blue book and sent one of their policy workers to come to our Rainbow playgroup in Erskineville. They gave them lots of advice. So I understand the latest edition of the Blue Book will be changing as a result of that. They were keen to support that.

We have spoken to the local health district as well and they are very keen to support particularly gay dads who are not accessing services with their babies. They are rewriting some information that we can offer about the services that are available that will be specifically targeted for them. Where we can we have worked with services and we have been able to offer that support. As you know lots of services that are funded for new parents are sometimes religious services and those religious services are exempt from discrimination and choose not to support our families. That is sometimes a significant barrier with a lot of the services and that is why we run our own parenting programs and seek funding to run those programs.

Ms TRISH DOYLE: You are positioned quite well. You are engaged with a number of departments and organisations in that transition to acknowledge diverse families in this State and you can offer further support to different government agencies or community organisations. You would be able to offer continued support. How could you do that?

Ms GONZALEZ: That would be something we would need funding for. We have a talented committee and beautiful people but we are a parent group essentially and we fundraise and do what we can. We are very keen. We get invited a lot. Community nurses invite us, the breastfeeding association invite us, and we go where we can, but without funding it is not something we can do at a reasonable scale.

Mr DAVID HARRIS: Does your organisation engage with local councils on design specifications for public toilets and things like that?

Ms GONZALEZ: We have a good relationship with Inner West Council and the City of Sydney and have done some work in terms of libraries and inclusions, having diverse books in libraries in Parramatta and the Blue Mountains. We have not had that conversation about design of public space and that would be something that is on a to do list as an important thing. Until we were consulted it is something that I personally, as a woman, was not aware of and most dads went, "Yes, we change nappies anywhere but we cannot in a toilet in privacy in the park". It is on the floor somewhere because as a dad there is nowhere unless you go to a supermarket or shopping centre.

Mr DAVID HARRIS: Do you think that is an area where the Committee could make a recommendation in terms of having a mandated specification in terms of public spaces?

Ms GONZALEZ: I think if you have that power.

The CHAIR: We can recommend anything we want.

Ms GONZALEZ: It would be really lovely if fathers could participate just as much and be able to do those things. It gives a strong message, even to straight couples, if you can go with your baby and change a nappy, it is a very simple public design fix.

Mr DAVID HARRIS: Most major shopping centres now have baby change rooms.

Ms GONZALEZ: They do.

Mr DAVID HARRIS: But I had not thought of parks.

Ms GONZALEZ: And playgroups.

Mr DAVID HARRIS: It might be something to have a look at. In terms of the forms, in your submission it says that the Commonwealth is going to gender neutral forms. I know as an ex-primary school principal our enrolment forms were "parent one" and "parent two" and now all of our newsletters are "parents" and "guardians" rather than being specific.

Ms GONZALEZ: Yes.

Mr DAVID HARRIS: Are there any other areas in State responsibility where that is not transitioning?

Ms GONZALEZ: In schools you sometimes have individual school forms that still say "mother" and "father". I had one last year. It might be for a camp.

Mr DAVID HARRIS: In public schools?

Ms GONZALEZ: Yes. You have a little word to the principal if they have never had that. They might have their form for something else. The other thing is hospitals on the whole do "parent one", "parent two", but there are lots of parts of hospitals which is a bit of a nightmare for changing forms and computer systems that still have "father" and "mother". Recently, last year, I had to have my child admitted to hospital. It was for a day surgery and it had "mother" and "father" on the form. There are lots of instances like that where there is still an assumption that there is a mother and a father. Sometimes it is the paper form and sometimes it is the computer that does not want to let you say.

I have been to hospital and said, "Look me up under 'father'." And they sure enough found me under "father". I am very assertive, I can do that, but I think it is trickier and harder for other parents to have to do that negotiating of systems. With Births, Deaths and Marriages you have to ask for a special form. You have a new baby and you get given a form and you go, "No, no, that is not for you." Right, ring them up, get a new form, get a different form. We often have to get special forms. It was the same with the census if you were a transperson you had to ask for a special form. I am assertive and lots of people would not be assertive and write that they are not in a relationship or not include both parents and make a decision about that excludes someone.

The CHAIR: What you are looking for is something respectful to people in the language it uses. Can you appreciate that some people would find it less respectful not to be called "mother" or "father" because that is an important part of their identity. Would it be a better outcome if the computer is smart enough to give options within the drop-down boxes that accommodate people's respectful preferences?

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

The CHAIR: If we, as Committee members, think of any other questions later that we would like to put to you would you be happy to respond to them in writing?

Ms GONZALEZ: Absolutely.

The CHAIR: They would become part of your evidence and be published.

(The witness withdrew)

(Luncheon adjournment)

KERRY DOMINISH, Board Member, Early Childhood Intervention Australia, sworn and examined

MARGIE O'TARPEY, Chief Executive Officer, Early Childhood Intervention Australia, sworn and examined

LEONIE HAZELTON, Advocate, People with Disability Australia, sworn and examined

The CHAIR: I welcome each of the witnesses here this afternoon to share their wisdom with the Legislative Assembly Committee on Community Services inquiry into support for new parents and babies in New South Wales. Before we proceed, do any of you have any questions about the process?

Ms DOMINISH: No.

Ms O'TARPEY: No.

Mrs HAZELTON: No.

The CHAIR: As you are aware, there are three different groups here today. We have tried to group witnesses with similar themes of evidence to give together. It has not always been exactly possible, but in our exploration of this issue we have discovered many more dimensions to this inquiry than originally anticipated when we wrote the terms of reference. It is great to hear from people in the field who have that particular expertise to share with us. I invite each of you to make a short opening statement to tell us what you would like us to know. We have read each of your submissions, so we do not have to go over that territory again. We are hoping that most of the session will be question and answer time. But if you would like to make a short opening statement, now is the opportunity.

Ms O'TARPEY: My name is Margie O'Tarpey, I am the Chief Executive Officer of Early Childhood Intervention Australia for New South Wales and the Australian Capital Territory. I thank you very much for the opportunity to present today. With me is my colleague Kerry Dominish, who is an Early Childhood Intervention Australia board member and the Chief Executive Officer of EarlyEd. There are two things we want to say in terms of identifying the cohorts that we think the inquiry should focus on and a number of key recommendations. I respect that you have read our submission. We would also like to table a white paper that we have developed that is with the Department of Premier and Cabinet at the moment—we hope to meet with the Premier shortly—which identifies the gaps in services for children with developmental delays and disabilities post June 2018, when Ageing, Disability and Home Care [ADHC] closes and the National Disability Insurance Scheme [NDIS] is in full transition and reform.

For the purposes of this inquiry we would like to identify two things. First, is that children who have a diagnostic disability need a more rapid referral pathway to NDIS, and Ms Dominish will outline that in more detail. Secondly, is that for babies who have developmental delay, there is a lack of assessment, referral and identification. They are the two groups that we think are critical and at risk. Our principal position is that early intervention matters. The earlier you intervene, the higher likelihood you have of improved physical, mental, emotional health for both the child and family. If we can get the mechanisms right for early intervention it will save huge and enormous costs to community and families as children move through the spectrum of early childhood development and beyond.

In terms of the recommendations we are making, they are essentially that, like with many of the issues around early childhood at the moment, we need: a whole-of-government approach to early childhood and early childhood intervention; greater support and resourcing in skills and education for child and maternal health nurses, as community health is critical if we are going to support work with babies early on; and some improved referral pathways and work with early childhood partners—we can come back to that. I would like to hand over to Ms Dominish. We very much welcome your questions and the opportunity to address any comments, concerns or issues that you have as Committee members.

Ms DOMINISH: I bring the experience of being an early childhood intervention provider, which I have been doing with ADHC for many years and am now rolling out into NDIS. We are also Early Childhood Early Intervention [ECEI] partner until 30 June—we do not quite know what is going to happen then. I bring that practical experience, as well the global knowledge of practitioners that I have gained from being on the ECEI board. I want to talk about the two groups in a bit more detail. The first group we have includes the child who has a diagnosed disability at birth or is premature. The second group includes the child who has an emerging disability that comes from the awareness that the child has a developmental delay that is not identified after birth. The two groups are similar but have distinct features that we could probably use to advantage them, in terms of looking at support for them.

Since the roll out of the NDIS things have changed. What we feel that there is a critical need for a clear priority pathway for families to access NDIS if they have a diagnosis or if the child is born prematurely. This is the one time, apart from when a child starts school, when the family touches with official formal services—we have a captive group. If there is a diagnosis then it is very easy for them to be supported through a pathway to access NDIS. I think this is particularly important for our groups such as our culturally and linguistically diverse [CALD] families and our Aboriginal and Torres Strait Islands families who do not typically connect with services. This is the one time that they are connected and we can form relationships.

In all hospitals, we have NDIS liaison staff and we feel that it should be really important for those staff to immediately look at referring that child into an NDIS pathway and connecting them up with a service that the family chooses. That service is then able to commence and build a relationship for their ongoing requirements over time. We know that the earlier it happens—research is quite clear—the better the outcomes. At the moment we have an absolute decrease in referrals—we do not know where the babies have gone. There are very long waiting lists for the babies to get their NDIS packages, and in the mean time they are actually not getting any services. This gap has turned up because of the roll out of NDIS. They are an identified cohort that we can support to get that early referral going. We know that if we can get that referral happening it will decrease the impact of disability and decrease the likelihood of vulnerable family situations eventuating. That is the first group.

The second group includes the child with the developmental delay. What we are finding is that this group typically would have been identified by the Early Childhood Early Intervention services that were funded by ADHC. Because they are not there anymore, that identification process is falling down. We need to think about how to put that back in. It may be through an increase in funding for maternal and child health nurses and community nurses and to up skill them to be able to fill that gap or it may be through looking at how the Early Childhood Early Intervention provider partner when they come in can be looking at the role and working to support good collaborative practice around supporting the maternal nursing groups.

We need to make sure they are fully resourced, they have the skills and they also understand that best practice and early intervention is a holistic, family-centred and collaborative approach and an all-organisation approach for that child. We need to see rapid assessment processes and referrals rather than waiting. So once a child is identified, they get to the early childhood early intervention partner, that we get quick referral, and that means that we can put in place some intensive supports. It is having requirements about what that support looks like, and if that child needs to be referred to NDIS that that referral is activated quickly and the baby and their families are not sitting, waiting for a long period of time.

Mrs HAZELTON: I am from People With Disability Australia. We are a cross-disability organisation providing rights-based advocacy services. My role is an individual advocate. I work a lot with parents who are experiencing involvement with the child protection system, so whose babies have either been removed or are at risk of being removed. The majority of those parents have an intellectual or psychosocial disability. Our organisation is run for and by people with disability. We know from the research that we have seen, and it is noted in our submission, that parents with intellectual disability and particularly psychosocial disability are 10 times more likely to have their children removed by State-based child protection services.

The recommendations we have made in our submission are about providing better disability awareness to FACS workers, but also improved information provision to the parents with disability, including parenting resources and other skill-building resources in an accessible way which accommodates a person's specific disability needs, such as information in easy English, information in alternative formats, or modifications to known parenting programs such as the positive parenting program to ensure that parents with disability are able to participate in those programs fully and effectively to ensure that the child remains in the family environment, if it is safe to do so.

The other thing we have seen recently is an increased trend in the involvement in child protection services with parents who are receiving access to services through the NDIS. There seems to be a divide between the support that the NDIS provides and that provided by the child protection services, so we have seen a massive gap in that area. I guess the recommendations we have made are for strategies to improve the NDIS for parents with disability and also to improve the knowledge that child protection workers have about what the NDIS can do to support parents with disabilities to have children remaining in their care, if it is safe.

The CHAIR: Around the time of intervention, much of your theme was the earlier the better and, therefore, we need to identify. A couple of things I took from what you said is that we used to have services or

staff in the public health system who would identify these needs earlier and the NDIS arrangements means we no longer have those people there. Am I hearing that correctly?

Ms DOMINISH: Yes. There has been a disruption because the early childhood early intervention partners were established in New South Wales in this transition period over the past 18 months. Because that focus has been on supporting planning and access to NDIS, there has been less ability to focus on those early referrals. Even so, even if we have identified that a child is a priority for NDIS, the whole process is taking a long time for that to happen because of the amount of work.

The CHAIR: Is that a temporary problem, that ought to settle and those people should be able to refocus their efforts on assessment and identification?

Ms DOMINISH: I guess we are now waiting for the next phase, which is the ECEI partner. Hopefully that will be announced in the next few weeks. We are not sure what that is going to look like. We are concerned there is still a long way to go and a whole lot of delays in place. Also, we have identified that there needs to be a new forming of relationships with child and maternal health to ensure that whatever this looks like in the future, it has covered the areas that we were able to cover before. As Mrs Hazelton was saying, early childhood early intervention services would often have done some of the things that NDIS is not doing around child protection. We would do all of that wraparound support for that family whether they had a disability or not. There is an uncertainty as well.

The CHAIR: Some of which may be transitional?

Ms DOMINISH: It might. We do not know what we are in for, really.

Mrs HAZELTON: Following on from Ms Dominish's point, we do not know if it is transitional but, at the end of the day, there are still families at significant risk because of the issue that is happening with this transition across to NDIS. The babies are missing out and the parents are missing out on being provided that support. That has long-term consequences. You are looking at intergenerational trauma, a long-term involvement with other government sectors that we do not want children involved with as they get older. I support the point: the earlier the better and needing to have something concrete as soon as possible because we have a whole generation of kids who are falling through the cracks.

Ms O'TARPEY: If I can add to that. I agree with Mrs Hazelton's and Ms Dominish's comments. There are two aspects. Yes, there are transitional issues and we all agree with that. We welcome the ECEI partner and we hope that once they are established—and that will take six to 12 months to roll out that intervention—that they will be able to build the capacity of the family, the community and in partnership with NDIS and maybe all these problems will go away, but that could take six to 12 months.

The other side is this systemic issue. The systemic issue is notwithstanding what the ECEI partner does, you need to build the capacity of the family—our principal position is that it is the family that is with the child 24/7—build the information, education and skills of the family. That has to be done now. It has to be ongoing and it has to be early. You need to support the resources within the health system that are currently not there. Even though child and maternal health and community health do excellent work, it is our observation that there are longer waiting lists, less services, and, therefore, the intervention and support for babies is not happening at that very critical stage of birth—prenatal and birth. That does not change with NDIS, that is just a secondary issue.

The CHAIR: That is where I was going. I am no expert in the field of some of these issues, but I understand that some challenges can be diagnosed prior to birth, some immediately at birth and others do not become apparent for a year or two, or even longer. The ideal time to test for vision impairment or hearing impairment is at different ages. Who in Health is doing that at the moment? What is supposed to happen? How are we supposed to identify these needs? Before we respond to them, how do they get picked up?

Ms DOMINISH: A lot of times it is the parent. If the child moves out of the health system—they have had their baby, they have moved on, they have seen the child nurse—

The CHAIR: Some tests are done in hospital, though?

Ms DOMINISH: Yes, absolutely. That is when a diagnosis might be identified or it might be that the child is identified as being at risk. That is what we are seeing. If that is occurring now, we should be

using that opportunity to make sure we keep connected with those families and streamline it. If they then have to move on to another department, where is that continuity going to be?

The CHAIR: It strikes me that some physical disabilities will be immediately apparent at birth. Developmental delay may not be apparent for sometime?

Ms DOMINISH: No. It will start occur at about six months, or even earlier. Baby may not be feeding properly or moving properly, or is too sleepy. Sometimes you pick it up. In the first six months you start to get some really clear signs.

The CHAIR: In respect of the health service systemic approach, who is supposed to pick it up if it happens six months or 12 months later?

Ms DOMINISH: That would be your early childhood nurse, but the family has to connect with that early childhood nurse, which means you must go there. A lot of times it might be the Aboriginal women's network that is relating to a family and is trying to encourage them to connect with Health. It might be the families that are running a play group. It is very much an informal system. There is no formality around that and it needs that on-the-ground relationship building and community that will get that support.

Mrs HAZELTON: With regards to the parents who are at-risk, often it is not picked up until something terrible has happened or if there are children with previous history or if those parents are experiencing domestic and family violence or substance abuse or anything like that. I work with families who have had previous involvement with child protection, they have then had another baby and that baby has been removed because there has not been the capacity building done early on in the piece. The family does not have the skills. They are sitting there in hospital saying, "What the hell do I do?" There has not been that foundation or building work done prenatally and they do not have any of those skills. They are not empowered and supported to be able to parent effectively in those early months should the child have disability or anything like that.

Ms TRISH DOYLE: I begin by thanking each of you for appearing before the Committee today. I thank you not only for the work that has gone into your submission but also for the work that you do with the vulnerable, at times dysfunctional, and the disadvantaged. That is critical work which often goes unrecognised; it is quite tough. You have already articulated so many important points, which this Committee needs to take on board, but from asking around there are obvious barriers to accessing services that parents need to support their families and their children who may have developmental delays or disabilities. Since being elected I have held three quite substantial forums—two on the NDIS and one on community services.

What I am hearing from people who work on the ground, supporting the families that you advocate for, and from people with disability and their families is that there is so much uncertainty, frustration and need at the moment from the huge reforms impacting our communities. Indeed, there is a great need for people to troubleshoot and connect with one another and support one another. At the community services forum I held a number of organisations from the disability sector participated. They talked about the disconnect and the problems around targeted earlier intervention [TIE] and NDIS reforms. That disconnect between Health and disabilities, on top of what are already tough times, is creating huge problems. We have particular families and people who have added disadvantage and a lot of those might be in rural, regional, remote areas as well. You have outlined in your submission some practical measures that we can take to address those barriers but I thought you might like to talk to them.

Mrs HAZELTON: I will go first. As the Committee is aware I am work primarily with parents whose children—well, the parents themselves have disability. There is a stigma attached particularly to parents who have intellectual and/or psychosocial disability like "You should not be having children." There is a lot of judgement and that perceived stigmatisation or judgement leads to parents not wanting to access service land. The other major barrier that we have noticed is the lack of access to information, skills development and resources for basic things such as—the blue book is not really accessible for parents with disability. It is probably not accessible for most parents but for parents with disability it is a minefield. It is big, it is blue and there is a lot of information in very small print. I guess I can use the blue book as my starting block and in order to facilitate greater interaction it needs to be more accessible.

It is all very great to have the big numbers on the back for Karitane, Tresillian and places like that but as a parent you are not empowered to look at the child's percentile charts and look at the child's developmental milestones that are printed in the blue book and go, "Hang on a minute, this child is not actually developing. He is six or seven months old and he's not even rolling. This is not right." It is that kind of basic tool and resource that needs to be accessible. Another thing that we come across a lot in our work with parents is parenting courses.

There are a few known ones like Triple P—Positive Parenting Program, 1-2-3 Magic and Circle of Security. All those well-known and well-respected programs really are not accessible for people with disability. I have looked at Triple-P and a lot of these programs for the parents that I work with and none of the information is available in alternate formats; it is all print.

If you have a parent with a vision impairment, they cannot access it and they cannot participate in that course. A lot of the stuff is easy for most people to read but if you have a cognitive or a psychosocial disability you are not necessarily going to be fully able to participate or understand the tools and techniques that are being taught to you, so therefore you are not going to be able to effectively parent that child. I think probably the final thing I wanted to mention around the barriers is that there are a lot of people with disability who are socially isolated. They cannot connect with the likes of playgroups and things like that. For some parents it is not easy to access them because they cannot get support to do that. That is because—and I am going to hark back to the NDIS—the NDIS basically says, "That is not in our role so you have got to find it somewhere else." So therefore it puts them at risk of moving into child protection and child protection is like, "NDIS should be doing this." It is that disconnect between NDIS and State bodies.

Ms TRISH DOYLE: Do either of you want to make a further comment on barriers?

Ms DOMINISH: I have got some thoughts on that. I think in a way the barriers are not things that are a surprise.

Ms TRISH DOYLE: There are obvious ones.

Ms DOMINISH: Particularly if you are a family that is not connecting with your community, you are the "unconnecting". You need to have someone connecting with you. A lot of times we are waiting for the family to come to the service and we will give them some help, but if you do not know that you need that support or you are not in a position because of your family needs or whatever to be able to come then you are not going to get that support. From things that have worked in the past—we are actually FACS' funded and have supported playgroup funding so I do know a bit about what you are talking about there—we know that you need to be a presence in the community, to be known. Particularly with our culturally- and linguistically-diverse families and with our Aboriginal families you need to build trust and connection. You need to be just hanging around. You need to be part of the furniture. So it is not just like I am going to some disability place over there. We are here and we come to you and support you.

My first point is that we need to be part of the community and we need to walk beside them. Giving resources often is not enough either. We need to be able to walk with them, to take them through that, to help them through the journey. That is one area in which there is a barrier. We all know that some cultural groups are unsure about connecting up with an agency because first of all you do not want to be doing that. If you think there is something wrong with your child then you do not want to be there. You have to be supported in that journey.

The other part is really reiterating what Mrs Hazelton is saying. Under the NDIS, as a provider our role with our block of funding is to look after that child's developmental needs and who is looking after the family. We used to do that. We used to be able to nurture a family that we knew was at risk and to support the whole family—the brothers and sisters, the dad, the grandma, whoever is involved—but we do that out of our own pocket now because we know that if we do not do that, that family is going to fall apart or we are not going to get the outcomes we need anyway. The family is not going to choose to spend their money on looking after themselves. They want to use it on their occupational therapist, their physiotherapy or their speech. Some families at that point are not even able to make a decision about where they need to spend their funding. They are the two barriers but they also create solutions as well.

Mrs HAZELTON: Following on from Ms Dominish's point, with the introduction of the NDIS, case management has become a really dirty word. That was the word that popped into my head when she was talking about walking beside you on the journey. That is what case managers did. They looked after the mum when she was cracking it because the child had a really hard day and she needed someone to talk to because otherwise she was going to end up in a screaming heap on the floor. That does not happen anymore and no-one does that case management approach anymore, as Ms Dominish said, of looking after the family as a unit. In my case, you have the NDIS that looks after mum who has a disability and you might have the early intervention services that looks after the child with disability but never the twain shall meet. That is why we are seeing so many families ending up in a big hole.

Ms O'TARPEY: I concur with all the barriers. I have probably more of a solution-focus about how we actually address some of these issues but what Mrs Hazelton and Ms Dominish have said very clearly articulate the issues and the barriers. Ms Doyle is very well aware of them and that is very impressive as well.

Mr DAVID HARRIS: I thank all of you. It is a very complex area. I will start with two points. First, are we making the right decisions around workforce capabilities in order to identify young people with disabilities? You talked about waiting lists. In my former employment as a primary school teacher trying to get psychologists in some areas was just impossible and that is if the parents could afford it. The NDIS may help there but you tend not to be able to access the NDIS until someone is diagnosed?

Ms DOMINISH: Not under six; under six you do not need to necessarily.

Mr DAVID HARRIS: Do you think we are heading in the right direction workforce wise or are there severe gaps in being able to meet future needs?

Ms O'TARPEY: Again, as you say, that is a very complex issue. In terms of early childhood intervention services, New South Wales was quite unique in a way. We had over 100 early childhood intervention services that were non-government organisations that worked in a collaborative, multidisciplinary approach that were funded to run playgroups and to do wraparound family centred, family and child coordinated intervention activities and it was a model of service delivery, which is not to say that there were not challenges around workforce, particularly in regional and rural areas, and in some occupational groupings, whether that was speech pathologists, occupational therapists or psychologists. That varies across regions and metropolitan regions.

The issue is that that is all changing because early childhood intervention services now are registered providers under the NDIS and that has opened it up to the market, which means encouraging a whole lot of private therapists and, with the greatest respect, paediatric and private therapist interconnections, which we do not necessarily believe is best practice. So there is a question mark around the quality skills and skills in profile of the workforce as we move forward and I think it is just too early to say how that is going to pan out over the next months with the rollout of the NDIS.

We hope that the Early Childhood partners will be multi-collaborative and skilled in early child intervention, connected with their communities, engaged in community development, supportive of mainstream services but it is too early to tell that yet. In terms of mainstream community services and targeted early interventions, as Ms Doyle highlighted, there are no more resources for targeted early interventions through the Department of Family and Community Services—and I think FACS committed to inclusion in disability—but again it is too early yet. To be frank, FACS has been emasculated in terms of funding, so to get more skills and resources even for that department, let alone Health and Disability, is a huge issue in terms of government resourcing and community service resourcing. That is yet to be determined.

There are simply going to be areas in the far north-west, for example, to use the case of telehealth and other activities will have to be put in place, so there are going to have to be creative ways of managing the workforce shortage in areas where there simply are not the professional capabilities. This is a very complex issue and a lot of scoping work needs to be done on workforce capacity over the next 12 to 18 months to really identify how this will pan out and therefore the services for families, but a really critical area of need and investigation is support for the early childhood education sector, as you would know.

There is a great willingness for the early childhood education sector to be inclusive but they need skills, resources and support to do that. That is where the rubber hits the road really, children coming into the preschool environment and then into the school environment. How that is going to work—I know there is a lot of commitment from government at the moment to support that but we think that needs a lot more support and resourcing as well.

Mr DAVID HARRIS: In your recommendations to talk about a taskforce headed up by the New South Wales Government on the most effective way of identifying families in need. Is that in relation to how families are going to interact with the NDIS and if there is a gap analysis around services that might be missing or is it around having a look at whether there needs to be an agency that we are getting rid of that actually has some sort of oversight role?

Ms O'TARPEY: Again, I just refer to our white paper and Ms Dominish and Mrs Hazelton can add comment to this. We are really saying that there needs to be a whole-of-government integrated approach in supporting children and families with developmental delay and disability because we do not have Ageing, Disability and Home Care anymore so part of that is for Premier and Cabinet to provide some coordinating role. That is even down to disability policy, bilateral agreements, appropriate Commonwealth-State relationship negotiations and so on. You would have more understanding of around that political interface than I would but there is going to be a gap. There is a gap in government policy and programs.

There needs to be a whole-of-government approach that can link Family and Community Services, Health, particularly child health and community health—the no longer existing Disability—Environment and Justice in terms of the older having gone, and child protection of course and child safety. We are making a plea

for us to have some coordinated integration around policy and programs. Part of that analysis and integration is to look at a number of things. First is the waiting lists; second is the gaps, which you have alluded to—culturally and linguistically diverse [CALD] communities, Indigenous communities, rural and remote communities, disadvantaged, complex communities and families that have really complex needs and profiling. They are the sorts of groups that need particular targeted intervention. Disability and disadvantage often go together and we need to be able to have an integrated approach to that, with some mapping.

To some extent, ECIA has done a lot of work on mapping. There is a sense of what is out there. How are all the NDIS services, the early childhood partners, the community services and health services coming together to meet the needs of children? I think there should be a Minister for Children for example, where children and their families—to take your point, Leonie—what a different intervention approach we would have.

Mrs HAZELTON: Off the back of Margie's point, we need to make sure that any service providers are disability aware. When a parent has had a child removed—that child may be removed at birth, so there is the whole baby issue—they are interacting with services and those services may not necessarily be disability aware. Even if a parent has a child with a disability, that service provider might know how to work with the child with the disability, who is the one that is receiving the service, but that parent is going to be the one to put the child to bed at night. That service provider needs to know how to support that parent to put that child to bed at night and to be able to maintain that family unit.

The big thing that needs to be across everything, across everywhere, is that disability awareness and disability inclusion. Treating parents with a child with a disability like they are still that primary focus of that child's care and not the carer that might be supporting them to drive to the appointment or something like that. That is something that is across health, child protection, everywhere. I think disability awareness inclusion must be in every service, in every program, in every policy.

Mr DAVID HARRIS: Mrs Hazelton, I have worked with several parents who had disabilities. One parent was blind, another one was deaf. What I see in the system at the moment is that when services interact with those families, it is learn as you go. There is no-one to advocate on their behalf, so a lot of mistakes are made.

Mrs HAZELTON: Usually then they come to us to try to help scrape it up.

Mr DAVID HARRIS: In one of the cases, the Department of Community Services [DoCS] as it then was, became involved, simply through a lot of misunderstandings. Is there some mechanism that you can see that would make that easier in terms of that advocacy from when the child first comes into contact with a pre-school or something like that rather than those misunderstandings occurring? If people have not dealt with a disability before, as I said, they are learning as they are going on both sides of the equation.

Mrs HAZELTON: As I said before, any service provider that a family comes into contact with should be disability aware. It should be part of the social work degree or early childhood education degree because at the end of the day, these families are going to roll through your door. There is only so much learning on the job you can do before the children are missing out because you are still making it up as you go along or before the parents get so frustrated that they do not want to deal with you, they disengage because you are making it up as you go along.

A disability aware focus needs to be in every aspect of training for every service provider because you are dealing with it more on a day-by-day basis. It is not just the children, it is the parents as well. I also add the importance of organisations like People with Disability Australia that do that disability advocacy support. Usually we have become involved when it has all gone south. The parents hate the DoCS worker and the DoCS worker hates the parents. It is our job to come in, sit down and I might say to the parents, "This is not appropriate, the way you are speaking to DoCS." I might say to the DoCS worker, "You're being condescending, or whatever." I have been known to do that. It is very important to have independent disability advocates and also for children. The NDIS is a prime case in point. I am working with a four-year-old at the moment who is struggling to get the support she needs through the NDIS. We are going through the Administrative Appeals Tribunal at the moment and the mother is at her wits' end because of the amount of time the NDIS has taken.

I have another four-year-old in a similar situation. The fact that I know the system and I know how to play is beneficial for them, but the fact that they have had to come in at the end of it all, when it has all gone south is not good. The advocacy and support organisations need to be brought in at the get-go. Welcome to this place. If you need help, here is A, B and C advocacy agency or support agency that might be able to help you and help us, particularly now that we do not have that case management approach to providing support. It was not originally my job, but as an advocate, I do a lot of that now.

The CHAIR: I am going to have to move things along as it is after 2.30 p.m. but there is probably time for one question.

Mr ALEX GREENWICH: My question follows on this topic of professional development that is needed in supporting parents with a disability. Are there any models that have worked that we could base a model in New South Wales on? Does government interact proactively with the advocacy groups in building these policies or has it just been at the crisis end?

Mrs HAZELTON: Can I take that on notice?

Mr ALEX GREENWICH: Yes.

Ms O'TARPEY: Can I quickly respond to a couple of things that relate to that? There are a lot of resources out there and I think it is important that they be disseminated and known through a range of community environments. To give you a couple of examples—ECIA has many resources on inclusion, has many resources on early child intervention designed and written by families for families. ECIA has a family centre project at the moment working with Plumtree, where families work with families to set goals and do developmental work.

You have a bit of a tsunami where families can support families, that can support families, that can support families, that can support families around goal-setting and identification. I think it is important that the Committee is aware there are resources and supports out there through the advocacy organisations, through the peak bodies such as ECIA. We do support agencies such as FACS and the early childhood partners to work in partnership to provide the information and resources around in our field best practice for service providers. Yes, we can give you plenty of examples of that.

Ms DOMINISH: Can I add that education needs to be ongoing. Inclusion is very topical at the moment. It is more than attitude. Everyone has the attitude, the right attitude, but they do not know how to do it. To change behaviour, you need to support that all the way. The Ready Together funding from Ageing, Disability & Homecare started that capacity building support. Then once NDIS has come in, that has been left a little bit. We cannot just capacity build and expect a community to continue to have that strength and knowledge. New people come in, you lose the skills; you lose the impetus. It needs to have that ongoing structure. The only way to do that is to not work in silos but work together and use the expertise that you have and disseminate it across all agencies that need that support.

The CHAIR: I thank you all for appearing here this afternoon. If the Committee decides there are follow-up questions for you, it will send those to you in writing and your replies would form part of the evidence and be made public in the same manner as your testimony has been here today. Would you be happy to provide replies in those circumstances?

Ms DOMINISH: Sure.

Ms O'TARPEY: Definitely.

Mrs HAZELTON: Yes.

The CHAIR: Thank you for your contribution today.

Ms O'TARPEY: Thank you for the opportunity and good luck with your deliberations.

(The witnesses withdrew)

SUE KINGWILL, Chief Executive Officer, Contact Inc., affirmed and examined

The CHAIR: Thank you for contributing to the Legislative Assembly Committee on Community Services inquiry into support for new parents and babies in New South Wales. Do you have any questions about the process of today's hearing?

Ms KINGWILL: No.

The CHAIR: To commence this afternoon, I invite you to make a few opening comments and observations. We have read your submission, so there is no need to go over that. I hope most of the time is spent with questions from Committee members.

Ms KINGWILL: I congratulate the Committee on the inquiry being held. Our experience is around helping to address the impacts of isolation for children and families and communities. What we do know is that no matter where parents are they want the best for their children. In terms of isolation the greatest challenges are being able to access the most appropriate supports and resources for you when you are a parent. When you are a parent with a young child and you do not know where to turn to for that support, that can be a real challenge. Our evidence draws upon our experience in the rural and remote context and I am sure the inquiry is cognisant that access to specialised parenting supports and resources and programs in that environment are few and far apart.

The CHAIR: That is where I am going to dive in: What models of support work best? There is more than one layer to that depending on what support is required. We know that health services are in specialist facilities in big cities and you have the local general practitioner, but to go up the pecking order you have to go further and further away. Some services can be in regional centres but not in every single town. What model of support for parents do you think can work best?

Ms KINGWILL: That is the million dollar question. I do not think there is one answer to that. The reality is that often technology is touted as the solution about where to access information but I truly believe it is the people to people contact that is the most lasting solution to address the issues that we are talking about. In a rural and remote context the reality is that there often are not necessarily the maternal child and family nurses which are often the first point of contact for those families to be referred to. What we do know is that when people seek out supports they turn to the people they trust within the community. I believe that certainly there are multiple layers that we need to think about. Certainly access to maternal and child health nurses is one option.

I equally believe we need to support and skill the people that have the trusted relationship with children and families so they are more confident certainly to know about what is available and to talk through where else and guide the families about where to get the best help for them. We have made attempts to take some more specialised agencies with us in the past times to try and explore solutions, but what we have found is that often they see themselves as a second layer of intervention after the maternal nurses may have come into play. What I would like to see, ideally, is the support for the families, but also a way that those agencies could ring in to a specialised agency to get the information targeted for what their needs are and translate that information for the families and guide them through so they start to define what is best for their situation. That is a generic response.

The CHAIR: It is a good one. I was wondering what sort of phone-in service there is for someone in a small, remote town with a baby who will not sleep or who has feeding issues.

Ms KINGWILL: Yes.

The CHAIR: Is there a service available, even located in Sydney, that can address that issue for a remote-located parent?

Ms KINGWILL: There are. Tresillian and Karitane have specialised help lines, but you do not know to call them if you do not know who they are.

The CHAIR: This is part of the dilemma, is it not? Who is the local trusted person you were talking about who should know that for you in each little town, who is the right person?

Ms KINGWILL: My experience is that there are multiple players. It could be a women's health service, it could be a neighbourhood centre, it could be a mobile children's service that is facilitating supported playgroups acting as a catalyst, it could be the Royal Flying Doctor Service—it is all those different players. It is the fabric of the players that are out in those communities. We have been exploring. I had a conversation just recently with someone from the Parent Infant Research Institute and they have some fabulous resources and I was thinking is there a way we could tap into that train-the-trainer model and use that as a resource to skill up and take out into communities to help people to understand what supports are available and start to provide a layer of threads to connect people together would be one option. I cannot answer that as a direct answer.

The CHAIR: It sounds like that model of somebody in the local community as a contact point or go-to person, but they need the backup and the systems behind them to give out the information that is needed.

Ms KINGWILL: That is correct. My organisation used to produce a resource called the "who to contact" sheet, which was large. It got longer and longer but it was the listing of major agencies that related to children and families in New South Wales, the support agencies. The reverse were the major agencies related to children with disabilities. Thousands of those were produced and sent out to those community agencies and they were designed to be pinned up on the noticeboards and offices so when these families were connecting with people if the conversation turned to those more personalised needs and requirements they could look up this list and at least have a starting point about who might be out there. What we found was that it was really the trigger and those people in the community, if they felt sufficiently confident, would then ring us as the intermediary and say, "Look, I am looking for something and I am not sure if this is the right person on the list or the right agency" or, "There is nobody on that list related to what we are really looking for. Who do you know that might be able to assist?" It is that trigger point or catalyst to connect people together.

Mr DAVID HARRIS: I have two questions. What role do GPs play in rural and remote communities in terms of accessing this sort of information?

Ms KINGWILL: They are an enormously valuable resource. As you would appreciate, GPs are a very valuable and trusted source. But I would comment that they are under so many demands in a rural and remote context to have a knowledge of everything. Unless they know, once again, it is very hard for them to pinpoint specifically where to send people. We have a lot to do with the Royal Flying Doctor Service¹ and it also recognises that there is a real gap around maternal and child health. It is not necessarily the intermediary of that first medical intervention, but the people connected in a health system who know how to put those layers together. Some of the GPs are very well connected with their community, but the reality is that a lot of GPs in rural and remote contexts are not necessarily there for the long term. There are a lot of doctors moving in and out. I feel like I am saying things and then saying, "Yes, but...", but the reality is that there is not only one solution and it does depend on the personality, skillset and longevity of the person in the region.

Mr DAVID HARRIS: In your submission you talked about mothers having to travel to bigger centres to give birth. Does that create complications in that the immediate contact they have with the system is far away and when they come back home there is no-one locally that knows what has happened while they have been away?

Ms KINGWILL: Yes, in general, but it depends on the personal circumstances of that person. There is often no tracking through of what supports the person is going back to when they are released from the hospital or birthing centre. But that is not always the case. For example, in the Western Division, they are working really hard through the local health system to have a coordinated plan around the first 2,000 days of a child's life. The remote birthing options recognise that there is a different way of looking at it. In that context, there will be a greater continuity and sharing of information. But as a general statement, I do think there are huge gaps between exiting one service to the other and where the family ends up.

Mr DAVID HARRIS: Is that made worse if they travel inter-state? I would think a lot of people would travel to Melbourne or Brisbane.

Ms KINGWILL: Yes. In the main, people will want to go, if they can, to a family connection. Where people start from and where their family are might be completely removed from where they are living now. That case study gives you a great challenge around how you could ever trace that so that the person engages with the system and talks about those things. It is a challenge when people are away.

Mr ALEX GREENWICH: Thank you very much for your submission. I have two questions. First, given the challenges that new parents in rural and regional communities face, has it been your experience that when people are expecting a baby they will move from their community to another area on a more permanent basis? We hear a lot about people moving out of rural and regional areas to major centres. Do you think this is a potential contributor to that?

Ms KINGWILL: It is not my experience that people are moving away because they are going to have a baby, unless it has been identified that the child may have a particular health issue that they may need more specialist supports for beyond the actual birthing.

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

Mr ALEX GREENWICH: In terms of your interaction with Government, in your submission you talked about the lack of birthing centres across rural and regional centres. What has been the response to you advocating to Government on the great need for them?

Ms KINGWILL: It has recognised that it is an issue. But, equally, I can see the other side of the fence. Many women will leave the birthing to the last minute because they do not want to leave their local area in a more remote context, and that is totally understandable. They are moving away from their security, sense of belonging and the supports that they have around them in the community. But there is a slow shift in that system. Giving the example of the Western NSW Local Health District, I can appreciate the desire to have the baby in the area, but when something goes wrong it becomes a really complicated issue because most of the multi-purpose centres or small hospitals do not have the specialised assistance to intervene, so it becomes an evacuation.

I believe that there is a genuine shift in the system to try to address that complication and I know, for example, that there is a plan of action and confirmation with the families about what the process will be to get them back to their community as soon as possible. From an Aboriginal context, there are supports after the birth to connect the child back to their country. I think that is a very respectful approach. There is a slow shift in the system. I am certainly not here to criticise the system. It is the reality that there are not the specialist staff and supports to be able to handle that.

Ms TRISH DOYLE: I want to thank you for the work that you have put into the submission. It is really comprehensive and you are speaking to some of those points today and are articulating the concerns and needs of communities and families in rural, regional and remote areas. I think it is really important to inform our deliberations as a Committee. Having said that, I grew up on the outskirts of Wagga Wagga on a big farm and as I heard you talk, I remembered what it was like for my poor mother birthing six children, especially when they arrived during shearing season. Those sorts of needs around the work that happens in communities outside of metropolitan areas where there is easier access to services are important for us to note.

I also want to acknowledge the work over many years that Contact Inc has done. You reminded me again of that fabulous referral list. I thank you. Contact has been a respected referral point for many years and people still talk about that list in terms of the collaborative approach and different communities and organisations in the community services sector always checking in with each other. The Contact list has always been an essential part of the referral triage system. I acknowledge that. I think the list in your submission is fantastic. It is a solution-focused list of information around where there are service gaps and what some communities are doing to address those gaps, such as the community approaches and some of the research that you refer to. Is there anything in particular in terms of prioritising some of the recommendations that you feel is central or should be highlighted for some of those communities? I know it is hard to pick one over the other, but is there something that particular communities are doing together to address the needs of supporting new parents and babies in those areas?

Ms KINGWILL: Thank you for commenting on your experience in the Riverina as a young child and then growing up. I think it is important that the Committee understand that what I am sharing with you, it is not necessarily the vast plains and the red dirt that are characterised by these issues that we are talking about. I was approached by the Junee community recently, which, in essence, may not be characterised by huge geographic isolation—it is in close proximity to Wagga. The community centre had read our submission and they were talking to me about the challenges they were facing. They are wanting to search out a solution to evolve their own local approach and maybe train up volunteers and others who could be an aunties connection or a resource to move around the community to help their particular needs. What I would say is just as I am saying that families do not know where to turn to, the agencies do not know, so there is a real role for a clearing house, or a sense of knowledge about the programs that are really working to help people to evolve their local models.

It is inappropriate for me to be sitting up here responding to say this is the way I think it would go as a solution out in the community, because there is no one answer to all of this. The realities of different distances, cultural backgrounds, social issues mean that communities need to have control over designing something that will meet their particular circumstances. I would have to give a pitch for sharing of the information and a broadcasting of that information. I believe there is a place for a specialised—if I could put in a pitch—Tresillian or Karitane bed in regional hospitals so that when there is a critical incident and a parent and their child needs that assistance that there could be somewhere where they could be relocated to start to have those interventions.

The CHAIR: Thank you very much for your contribution today and your assistance with your submission. I think we have all gained from that and it will help us in our work on reporting on this issue. If any

member of the Committee has subsequent questions, which we would put to you in writing, would you be happy to provide an answer to those?

Ms KINGWILL: I would be delighted.

The CHAIR: That will become part of your testimony in evidence, as what you have said today will be.

Ms KINGWILL: Thank you.

(The witness withdrew)

(Short adjournment)

ASHLEE TENBERGE, Chairperson, Board of Directors, Australian Multiple Birth Association, sworn and examined

JOANNE O'KEEFFE, NSW State President, Australian Multiple Birth Association, sworn and examined

The CHAIR: Thank you for appearing before the Committee today. Before we commence do you have any questions about the process this afternoon?

Ms TENBERGE: No.

Ms O'KEEFFE: No.

The CHAIR: We have read your submission, and we hope that most of the afternoon will be spent with Committee members asking you questions. Do either of you wish to make a brief opening statement?

Ms TENBERGE: Thank you for inviting us to appear before the Committee today. I would like to introduce our organisation a little bit, and Ms O'Keeffe will refer mostly to the content of our submission. The Australian Multiple Birth Association [AMBA] is 99.99 per cent run by volunteers, all parents of multiples themselves. Ms O'Keeffe and I are both parents of twins. We work full-time separate to AMBA and we are volunteers within AMBA. We have taken some annual leave this afternoon to come here and talk to the Committee. AMBA was formed as a national organisation 44 years ago and it has been run through the community by families of multiples. We have not had the support of the health system or anything like that in how we continue to support families. It is the dedication and devotion of families that has kept it going. That is pretty much our opening statement today.

The CHAIR: In your submission you speak of the financial impact of multiple births on families. Clearly with different multiples of children you have different issues. Can you give the Committee a brief outline of what financial support is available and how it works?

Ms O'KEEFFE: Obviously we do not collect data or anything like that; it is only voluntary information that our members have provided to us. Obviously we are not capturing all multiple families. From my experience and from my conversations with our members it can be anywhere from when a female has to remove herself from the workforce if there are any medical complications or when the babies are delivered, at how many weeks and so forth. If they are preemie that will change again. Their experience may be through neonatal intensive care [NICU] or special needs. It would come down to how the children are delivered and also with the hospital experience, if there is a NICU experience or if it is an extended experience with triplets.

Most babies are born at 32 weeks, so their time within the hospitals and the family resources around them is quite limited as well—you go down to a single-income family. Depending on the gestational date the baby is born as well could impact on physical and developmental delays or disabilities. Just from a mental health and care perspective for families as well, if you have gone down to a single-income family, if you have additional children at home—I am a parent of four children and they were my last so that was different for us as well—returning back to the workforce and trying to look at child care options and costs and stuff. Sometimes the financial costs will impact where you sit in society: Do you return to work? Do you go to child care? Do you go to social activities like swimming or anything like that? Obviously the development side of it for children is also impacted with that.

The CHAIR: If I can weigh up on one hand the extra costs and on the other hand what the Government might give in childcare benefits, I know that the costs can vary dramatically—for example, someone who already has a couple of children and is about to have triplets suddenly will need a new car.

Ms O'KEEFFE: Yes.

The CHAIR: Those sorts of trigger points come into play. The costs can be significant because people have to buy multiples of everything that a new parent normally buys—whether it is prams, cots, child car seats and all sorts of stuff.

Ms O'KEEFFE: Nappies and formula.

The CHAIR: What assistance does the Federal Government give to multiple birth families?

Ms TENBERGE: At the moment there is something called the Multiple Birth Allowance but the Government only defines a multiple birth as triplets or more, which is what we refer to as higher order multiples [HOM]. Twins are not categorised in that currently. There is financial assistance for HOMs from birth up until they are 18 years old.

The CHAIR: For what sort of support is that?

Ms TENBERGE: I believe it is just a financial—

The CHAIR: Just an amount?

Ms TENBERGE: Just an amount of money that is determined per child. I am not sure of the frequency of the payment.

The CHAIR: Is it the same for a one-year-old as it is for a 17-year-old?

Ms TENBERGE: That is a good question as well and I do not know the answer to it. We can certainly look into it and come back to the Committee.

The CHAIR: I imagine there are some set-up costs that are pretty significant.

Ms TENBERGE: Yes, there are. If you do not already have children then the set-up costs are all at once, as opposed to being able to hand things down—like using cots for a second time or reusing child seats and things like that.

Ms O'KEEFFE: It is \$155 a fortnight or it is \$206 a fortnight for quadruplets. That is based on the family tax benefit part A, which I know is also changing. It is means tested.

Ms FELICITY WILSON: I actually have twin nieces who are 10 now and when they were born my sister, as I think is fairly common, had to have an emergency caesarean. My question is more about the birthing experience, and the medical care leading up to birth and immediately postnatally. How does the experience differ for multiple birth mothers to single birth mothers?

Ms O'KEEFFE: We can talk about our own personal experiences. I worked to 36 weeks and had them at 38 weeks but I had medical complications and my medical expenses were \$1,000 a week, which made me continue with work. Obviously it was a financial decision trying to go and health-wise I was impacted through that. My delivery was a C-section and my girls were in the special care nursery. I was lucky enough to bring them home after seven days.

Ms TENBERGE: Experiences can differ greatly. I went into spontaneous labour at 30 weeks and had them the same day. I was still working at the time. I called my boss and said, "I am not coming in today" and then I had them that afternoon. My girls were in the NICU for 10 weeks. As to how the experience differs for a singleton, a multiple birth is automatically classified as higher risk for a number of factors. There is greater risk of preterm birth, gestational diabetes for the mother, pre-eclampsia—those types of things. Your health professional, if you go through an obstetrician, will monitor you much more closely for a multiple birth but if you are not under the care of an obstetrician who is particularly experienced with multiple births, they will not be looking out for those risk factors; they might not know what to look for or have a lot of experience with that.

Ms FELICITY WILSON: One of the things you mentioned was that they can all be managed differently by different medical professionals through different birth plans, et cetera. Do you know whether there is any specialist training or anywhere that medical professionals or allied health workers can become more upskilled, particularly in diverse geographic areas?

Ms O'KEEFFE: Currently to our knowledge the only prenatal courses that are offered within New South Wales are at Royal North Shore and Westmead. Most prenatal courses or support are based on singleton births. The feedback we received from our members is that it does not actually explain the experiences, what they may go through, or an understanding that when you deliver or have your babies that they can be separated, they have their own individual health needs and stuff like that or they will have their own health providers on hand. The experience is quite different.

Ms TENBERGE: That is from the family perspective. In terms of medical professionals themselves getting specialist training, I do not believe there is anything currently. There are professionals out there. Our patron for AMBA is Dr Mark Umstad based at the Royal Hospital for Women in Melbourne. He has a special interest in twins and has done a significant amount of research around that. It is basically up to professionals who have a special interest in multiples to then further their own knowledge and attend conferences, that type of thing, to further themselves and their own knowledge as opposed to there being anything standardised.

Ms FELICITY WILSON: I appreciate that you are all volunteers so I am not sure what level of research you are capable of doing but I have a question about the progressing age of first births and the increase in the use of IVF and other measures to fall pregnant and the view that there is a greater likelihood of multiple births under both those scenarios. Are you seeing an influx in multiple births?

Ms TENBERGE: No. The rate of multiple births has actually remained steady over the past decade or so and the rate of multiple births through IVF has decreased actually because there was a change in the legislation to implant only one embryo as opposed to more than one to increase chances of a successful birth or pregnancy.

Ms FELICITY WILSON: One of the references in your submission talks briefly about how to reduce the risk of perinatal anxiety or depression. Is there a higher prevalence across multi-birth parents and are there different ways to successfully treat it or is it the same as everybody else?

Ms O'KEEFE: From the statistics we have received and the knowledge we have gained through people talking to us in our conventions and seminars, we have been advised that 25 per cent of multiple families experience postnatal depression. That would be equivalent to one in five for twins, 27 per cent for triplets and 25 per cent for multiple families. With postnatal depression and the births of babies, that can also depend on the experience, the health conditions and the family support. With us, because we are only volunteers, we probably would not have the correct data, skill set or knowledge base to actually know unless someone comes to us and tells us that they are going through hardship, receiving counselling, there is depression or something like that.

Ms TENBERGE: Anecdotally, there tends to be some negativity around finding out that you are expecting multiples—because there is financial burden, logistics, how am I going to cope with raising two or more babies? Unless you are connected with a group or organisation such as AMBA who can talk you through that it is not the end of the world, we have coped, are surviving, are kind of normal and are doing okay, then you will have that negativity around it. In terms of what that support for perinatal depressions looks like, you have probably got more likelihood of families needing to access that service before the babies are born, connecting with an organisation like the AMBA that can support them through that experience from a peer perspective, which is what we are all about—offering the peer support, connecting with other people who have been there, done that and understand the challenges.

Ms FELICITY WILSON: Thank you for taking your annual leave to speak to us today.

Ms TRISH DOYLE: Thank you both for coming in. It sometimes can be a little intimidating sitting in front of people and talking about what you know best. Remember, you are the experts here, the Committee is learning. I acknowledge, as did my colleague, that you have taken time to report to us. Congratulations on doing amazing things with lots of children. I acknowledge also that our colleague Ms Jo Haylen, who is on maternity leave at the beginning of the year gave birth to Dylan and Elliott. When I told her about this inquiry she said, "You've got to make sure that you hear from the AMBA". It is good to see you here.

The AMBA might not be able to collect statistics, which are always useful for committees and for committee deliberations in recommendations that go to government, but the personal stories, the anecdotal stories are a profound avenue of communicating the needs—in particular, the plea from the Bruzzano family, which is also touched upon by others in your submission around in-home care and the fact that there are systemic problems that need to be addressed. That juggling exercise is incredibly intense. When I am reading about people's experiences, it goes without saying that no individual or even two parents can look after two or more newborns by themselves 24 hours a day, seven days a week without support. Can you talk to that particular aspect of a system that many have alluded to here and the need to adapt, change, amend or improve the in-home care component in order to make people's lives a little easier?

Ms O'KEEFE: Not many people know about it and I think it is just not understood at all. Some people might think "I have got three, four or five children; I am entitled to it." I understand it is needs based and it has to go through certain criteria, but I also think some opportunities are being missed, especially with the higher multiples when it becomes triplets or quads. Their support is so much more than what even a parent of twins would be. In saying that, if there is a medical condition or a diagnosis in a twin family, there would also be an extra need. My experience has been more with the triplet families, where they feel the only way they can get assistance is through mental health. They are already struggling and with that struggle they have to put their hand

up further and say "I have got a mental health condition as well". They may be sleep deprived; there might be multiple issues relating to them and the short-term adjusting going from a family of two to five or more, the transition period.

With that, we do miss a lot of people because it is not well advertised or promoted. There is an opportunity in hospitals if there is a resource or a brochure, something where there can be a connection to community nurses so things like that could be screened. We all have our community health checks when our babies are delivered. That probably could go into a component of the nurse checking when we have just come home with babies. There are avenues to look at how it can be used and how it can be communicated. I do understand that it might not be accessible to everyone, it has to be means tested, but probably a review on how that is done.

Ms TRISH DOYLE: It is alarming to read here that two families, who have provided their personal stories, have had to wait until there is a breakdown. It could be a preventative service to assist new parents who have had multiple births. The application that the Bruzzano family put in was rejected. They had to wait until the mother had had a breakdown before that support was offered. That is an alarming gap that needs to be noted.

Ms TENBERGE: They felt that they had to be at a point of "I emotionally cannot cope anymore and I am almost going to harm my children" before the application was anywhere near being successfully received, yes.

Ms O'KEEFE: We also have some families that are not willing to put in the application because they do not want to think that they are going to have a cross against their name for saying that their children are at risk. We do miss people in that area as well. That is where we come in as a peer support and try to assist and do things locally for them.

Ms TRISH DOYLE: Please thank those families who were brave enough to share their story. It takes a lot of courage to admit that.

Ms TENBERGE: Further to the Bruzzano application, when they were successful and they had someone come into their home to offer the in-home care, the person that came into their home was not sufficiently trained to be there. The carer was dealing with triplets and she had never changed a nappy before. Yes, they were successful in having someone come in to offer support but they were not trained.

Mr ALEX GREENWICH: Thank you very much for the important volunteer-based advocacy that you provide. As you said in response to questions, the number of multiple births are remaining at a consistent level but I imagine the cost-of-living pressures are increasing. Could you take us through what you are experiencing and the feedback from your membership about cost-of-living pressures, the direction they are going in and what support can be provided, what support people need and where the gaps are?

Ms TENBERGE: That is a very good question.

Ms O'KEEFE: That is a good question. I am in the Nepean area and we are a very diverse area. We also cover a large area—from the Blue Mountains to Blacktown, Narellan to Richmond. The needs of our individual members are quite different in that group. A lot of issues that we have locally is one-income family childcare and starting school is a big issue for a lot of our multiple families because they feel their children are not ready for school. They want to send their children to school because they cannot afford to stay at home. School readiness, screening and speech are issues that we have been trying to focus on at a local level. From the feedback I have received, that is something we can improve on as well. As you said, cars, prams, cots, nappies, formula, they are essentials. Anything else I consider a luxury. The isolation and trying to integrate and socialise children and families can sometimes be a barrier as well.

Ms TENBERGE: Sydney is a very expensive place to live, so you potentially have people who are choosing to move out of Sydney into more regional areas. When you get out into more regional areas there are not as many multiple birth families, so you do not have the volunteers putting their hands up to say "Yes, we will form a club or offer support for families in that area". They tend to be even more isolated, from a multiple birth support perspective. There are some technology options available to us and we are using those where we can, things like video conferencing and webinar technology. That is making a little bit of difference but we are a long way away from offering a fully integrated support network in that way. That is a reality too.

Mr ALEX GREENWICH: I imagine parents sharing experiences and stories and you facilitating that is a critical part of counselling.

Ms TENBERGE: It is, yes, that is pretty much why we exist, for peer support from those who have been there and done that. Interestingly, membership based organisations are, for the most part, experiencing a decline, because there is things like Facebook where people can go to access support. AMBA's membership has been steadily increasing over the past five years and we now have more member families than we have had in a long time.

Mr DAVID HARRIS: You have said that additional support is not automatic and it often has to be pursued. Is there anywhere else in Australia or overseas that is doing it better that you are aware of?

Ms TENBERGE: I would say in the international multiple birth community our equivalent in the United Kingdom is called Twins and Multiple Births Association [TAMBA]. They are the pinnacle that other multiple births organisations look up to in terms of what they are offering. They have about 30 paid staff and the programs and support that they offer is significant. They have a chief executive officer who comes from a policy research background, so he is able to take a different perspective on what the organisation can offer and his skill allows them to apply for grants and engage with organisations and the community in a different way. We definitely take a lead from TAMBA and look to them in terms of where we could be in terms of an organisation. We are a long way away from that.

Mr DAVID HARRIS: How are they funded?

Ms TENBERGE: They are funded through grants, memberships, subscribers, that type of thing. I do not believe they have government funding.

The CHAIR: Thank you for your time this afternoon in assisting the Committee with its work. If we think of any subsequent questions we would like to ask would you be happy to answer those in writing?

Ms TENBERGE: Yes.

Ms O'KEEFFE: Yes.

The CHAIR: Those answers would become part of your evidence.

(The witnesses withdrew)

KAREN VAN WOUDEMBERG, Manager, Programs and Quality, Playgroup NSW, sworn and examined

The CHAIR: Thank you for being here this afternoon and participating in the Legislative Assembly Committee on Community Services' inquiry into support for new parents and babies in New South Wales. Do you have any questions about the process of today's hearing?

Ms VAN WOUDEMBERG: No.

The CHAIR: My name is Kevin Conolly, I am the member for Riverstone and the Chair of the Committee. I am joined by the member for Sydney, Alex Greenwich, the member for Blue Mountains, Trish Doyle, the member for Wyong, David Harris and the member for North Shore, Felicity Wilson. In a moment I will ask you to make an opening statement on behalf of Playgroup NSW. We have read your submission and you do not need to go over it again. Committee members will be asking questions about various aspects that have caught their eye.

Ms VAN WOUDEMBERG: Thank you for the opportunity to address the Committee today on behalf of Playgroup NSW. Playgroup NSW represents over 13,000 families with young children, many with children under two years. Parents come to playgroup from all walks of life to play, share knowledge and support each other. The memory of playgroup experience is one shared across generations from our 45-year history. A playgroup involves a group of mums, dads, grandparents and/or caregivers meeting regularly with their young children to engage in fun and learn through play, and for parents and carers to share ideas and information in a supportive environment. The many benefits of connecting new mothers in local communities has led to recent increases in membership to Playgroup NSW, demonstrating that new parents are keen to connect into their community and are looking for ways to meet with other families with children of the same age.

Play is serious business for children. It is how they make sense of their world, navigate their learning and understand possibilities and limits within a peer group. Play is also one of the means by which parents build emotional connections to their child. A supportive social environment such as playgroup can help develop a sense of what is normal in parenting. When parents need to seek additional support there are other parents there to support them as friends and offer community stabilising influences. Playgroups take families along the pathway from mothers' group through until they move into education. It builds friendships in local towns and communities and these connections are often sustained into adulthood. I would like to share Joe's story in closing comment:

I know myself I struggled to find other parents around to get out of the house and I think it is really beneficial for new mums especially. I was such a hermit when my mums' group meetings finished and it took me years to build confidence to leave the house again. It helps new mums to get out of the house so they do not feel so alone and isolated.

Thank you.

The CHAIR: I will start with a pragmatic question: At what age typically do children start going to a playgroup?

Ms VAN WOUDENBERG: It varies depending on the parents' capacity to get out of the house. We have had children as young as four weeks attend playgroup. Generally, once parents feel the need to engage in a social conversation, once their child becomes a little bit more mobile and once their mothers' group finishes they will seek social opportunities and playgroup is one of the first places they will go to. It could be from six months onwards.

The CHAIR: The focus of this Committee started out to be on babies, but we have realised as we delved into the issues that it has lots of dimensions and support for mums in particular but for grandparents and other family members who participate is an important part of what your group does. I would ask, is playgroup a welcoming experience for dads?

Ms VAN WOUDENBERG: It really depends on the group. Every group has its own personality. There are groups I have seen that are very welcoming and open to dads and there are groups that are a bit uncertain because there may be an established friendship in that mothers' group and if a dad tries to come in outside of the group it can take a while to get settled in. We have some fantastic dads facilitating playgroups acting as volunteer coordinators and we have dads' groups that are just dads that are meeting. What we try to do in our conversations with playgroup volunteers is engage them in a conversation about how to make it open and welcoming. Every group has its own personality, so it will depend. We always suggest if you do not like one playgroup look for another playgroup, because they are so different.

The CHAIR: We heard from a previous witness about the difficulty in country areas for people to find knowledge about who to ask for what. Often framing the question is hard enough let alone finding who has the answer. Do playgroups operate in many small country towns? Do they get right out into the more remote parts of New South Wales?

Ms VAN WOUDENBERG: We have playgroups in about 60 per cent of postcodes. Because they are run by volunteers, it will depend very much on the capacity. For example, in Tucabia we have a playgroup with three families. It is very small town just south of Grafton. But we have massive playgroups in places such as Wagga Wagga and Deniliquin, where there are 10 to 15 families that attend because they are probably the only thing happening in the local community.

Mr DAVID HARRIS: Playgroups are run by volunteers. How do they occur?

Ms VAN WOUDENBERG: Normally people hear about playgroup from either their community health nurse or a parent who has been to a playgroup. A lot of mothers tell their daughters to go to playgroup. Then they will phone our hotline and ask, "How can I find a playgroup?" We have a "find a playgroup" option on our website, but we also identify that if a person has a group of friends and wants to set up a playgroup and be covered by our insurance and be affiliated with us, we can help them set up a playgroup. We send out a starter pack, we have manuals and tools and all sorts of things, and a closed Facebook page for people who are running playgroups to seek advice and support from each other. It is fairly easy to set up; it is just a matter of filling out a form and ensuring that everyone is a member, because that is the critical thing around maintaining insurance cover.

Mr DAVID HARRIS: Do they have an educational role? While the parents are together, are there guest speakers or people who can talk on particular topics that have been identified through the group as a need?

Ms VAN WOUDENBERG: Yes. Again, it depends on the personality of the group. We have facilitators that will intentionally seek out speakers to have support on certain things. Certainly, for some of our facilitated playgroups, part of our core deliverable is to provide guest speakers on important things such as immunisation, dental health and speech therapy. Those guest speakers are always very popular and are usually chosen by the members so they can get information about important things that they are trying to do. We do have a lot of professional organisations that like to solicit business through playgroups, and we try to channel that through the parents' choice, rather than open slather for businesses to come and engage with the parent group.

Mr DAVID HARRIS: Finally, have playgroups traditionally had a referral role? If they have a member who has a child with disability, is facing difficulty, or may have mental health issues, is there a tradition of referring to other agencies, or is that outside the purview?

Ms VAN WOUDENBERG: It is not normally considered what volunteers would undertake, however, we do have many volunteers who are very confident—they are usually professionals on maternity leave who seek a volunteer position in a community—and they will make referrals. We get a lot of inquiries to our head office and someone will say, "I have got a mum at our playgroup who I am a bit worried about. Who can I talk to?" We try to connect local playgroups to local services, such as the family support services and family referral service,

so they have a local contact. Often, we will encourage that family referral service worker to drop in, say hi, this is who we are, hand out a few brochures, and see if anyone wants to have a conversation—really just an informal social relationship. That happens in towns across New South Wales, but not so much in the smaller communities. I think they are more disadvantaged because they are very isolated. Branxton is a tiny town with a very active playgroup, but it relies on our head office to make referrals for it.

Ms FELICITY WILSON: Thank you very much, Ms van Woudenberg. In your submission, you mentioned that you have a range of different funding sources. I am interested in understanding more about your funding and the recommendation you made for funds provided by the State Government. What quantum is that and how would that be utilised?

Ms VAN WOUDEMBERG: We have a base grant that is provided by the Department of Social Services through our federated leader, Playgroup Australia. We currently receive funds to the tune of perhaps \$12 per family per year to provide a Playgroup support service. That funds our head office, social media platform, starter packs to set up playgroups and the development of resources. It is a base grant. We have been successful in attracting a number of grants to support specialist programs. Currently one of our favourite programs is the Indigenous Advancement Strategy, which funds supported playgroups for Aboriginal families in combination with Aboriginal communities in Wagga Wagga and Grafton. That has been quite successful in attracting a large number of Aboriginal families to come together and receive support. They are one of the ones that has a lot of services visit the playgroup to interact with the families.

Ms FELICITY WILSON: You asked for additional government funding. What level of funding are you asking for and how would it be utilised?

Ms VAN WOUDEMBERG: Currently we are able to fund 4½ full-time Playgroup support workers for the 650 playgroups that we have across the State. It is not a lot when you compare it to some of the other States. Maternal and Child Health Services in Victoria funds approximately 10 workers—do not quote me on that figure, but I know there is a large number. Every local council has a Maternal and Child Health Services funded playgroup worker. We feel that 4½ full-time staff is not enough to support the number of running playgroups that we have.

Recently, we are noticing that there has been an increased number of inquiries coming through head office from playgroup volunteers who are struggling with some of the responsibilities. Some of the difficulties they are experiencing include a higher number of mental health issues that are not being flagged by professionals and children with additional needs who do not fit in to other supported playgroup programs for disability services. We have two postnatal depression playgroups; we could probably run another 15 across the State. They do require support. We could probably run another 20 Aboriginal family playgroups but they require a high level of support, just because of the individual needs of the families that are coming through. That is the sort of funding that we need—the targeted, supported funding.

Mr ALEX GREENWICH: Thank you very much for the work that you do across the State. In your submission you highlight some really powerful statistics from your member survey about the importance of playgroups to parents and the connection that they create. Given the amount of families that participate in playgroups, do you have the capacity to go to your membership and those who participate to find out different trends in terms of the cost of living or mental health to help give a picture of what is happening for parents with young children?

Ms VAN WOUDEMBERG: It is possible to take the tone of sentiment on certain issues, bearing in mind that they are volunteer members, so they may not see that as relevant to their participation in playgroup. It would depend on how the survey was structured and the types of questions that we were asking. But certainly on our closed Facebook page for committee members, we see a lot of conversations running through that pick up on themes around levels of parenting stress and the difficulty in getting enough people to volunteer to help out—often it is one or two people who are carrying the whole load of the playgroup. We try to develop support for those particular members.

People who are concerned about particular issues do come to the Facebook page to ask questions about, for example, how to manage the behaviour of a difficult child or how to refer a family that has stress or has lost a house in a fire or something like that. There is a good conversation of support, but there is so much more that we can do to tap into that support network. Our helpline and phone line often have a number of people calling about particular issues that they are facing and who want to know how Playgroup can support them.

Mr ALEX GREENWICH: I ask because it would probably be immensely powerful information for government to have because of the trust that people have in the service. We have heard plenty of stories about the lack of trust in some government agencies. Hopefully that is something that government could interact with Playgroup a bit better on to capture some of that data and identify some of those trends.

Ms VAN WOUDEMBERG: I think the advantage is that we are a universal platform. There is no stigma in going to playgroup; it is just what you do with your kids. There are a group of parents that are engaged in the messages that we are able to send out.

Ms TRISH DOYLE: Thank you for being here this afternoon and for the submission. It is really wonderful to acknowledge that play is serious business for young people. There is no greater thing to watch than your young children playing and enjoying themselves. There is something that is quite settling about that. Playgroup, as has been captured here in the quote by a member, changes lives. In acknowledging that playing is an important role for development for families and little people, it is also important to acknowledge that, as you have identified, there is a soft entry point to capture the greater needs that exist between families and communities.

On the back of Mr Greenwich's question, it would be wonderful to capture and gather further information to support your call for more funding to support those playgroups across the State. It seems that funding is required straight up to support the request for extra funding for playgroups generally. You talked about the engagement with Facebook and people asking questions. Would you say anecdotally that playgroups are dealing more and more with the need to assist vulnerable new parents and the impact on volunteers in doing so?

Ms VAN WOUDEMBERG: Yes. We get a lot of comments from our volunteers about managing tricky situations in playgroup. Playgroup is a very low-cost way for parents to get out. Often it will be suggested to a mum to attend a playgroup with their children if the nurse identifies that the mother is feeling vulnerable and may be at risk of mental health. They will come to playgroup and if they are exhibiting behaviours of anxiety or stress or inappropriate parenting styles, we will often get a call: I have this mum in the playgroup and I am really not sure what to do because I am a volunteer and I am not skilled in this sort of thing. We are managing those conversations on the phone.

Because we are low cost—\$2, \$3 to attend a session—it is often the only thing you can attend if you are on a low income. For some of our country members, it is the only thing that exists for parents to get together. It places a huge burden on our volunteer facilitators and we try to give them the resources we can. Having more play group support staff on the ground that are skilled in postnatal depression indicators, managing tricky conversations, all those sorts of things, and mentoring volunteers, it not only skills up the volunteers to feel more capable and in control of what they are trying to do but it also provides them with a face to support them in doing the volunteering that they want to. Most of them are happy to volunteer, they are just overwhelmed with the burden of the tasks that are involved.

One of our strategies now is to actively recruit volunteers who are seeking work skills recognition for the work that they do so there is a pathway into employment for those people who want to learn a certain skill such as coordinating, treasury, or retirees may want to give back to the community and are happy to facilitate a session. We have a number of grandmothers who run sessions across New South Wales. So we have a number of people who are experienced in different ways of managing groups and using that skill to their benefit. A lot of people want to give back to the community by volunteering, but it is a bit of a burden when you are out there on your own and we are only a phone support for most of the regions.

The CHAIR: Do most groups operate out of council facilities? Is that where you hold the play groups?

Ms VAN WOUDEMBERG: We try. We have found over the past five years that we have been increasingly priced out of council facilities; the rent is too high for playgroups. Most councils will charge between \$15 and \$20 an hour and when you have five parents who do not attend regularly it is a huge cost burden. We are finding increasingly we are being asked to subsidise rent from our reserve funds because they cannot afford them. We are looking for low-cost, no-cost venues wherever possible but councils are also charging for parks now. It means the number of venues available for us is reducing considerably. Scout halls, again, they are now starting to charge.

Schools are running their own playgroups, churches are running their own playgroups, or charging a premium rate for hire of their services. We are being squeezed out of venues. When we find a venue, we might run five play groups a week because that is the only option. We also have a number of older buildings across rural New South Wales that were built by playgroups but are now owned by councils that playgroups use for next to nothing, but they are old and we are constantly applying for grants to refurbish, provide access and clean them up. It is a constant difficulty to find accessible venues, particularly in Sydney, that are affordable for families.

The CHAIR: What physical resources do you require to put on a playgroup?

Ms VAN WOUDEMBERG: A room, a toilet, a cupboard and a kitchenette.

The CHAIR: In terms of things to play with?

Ms VAN WOUDENBERG: We provide a starter kit of toys, and we are very lucky that we are sponsored by Lego Duplo and a couple of other agencies that provide us with donations of toys to start our playgroups. We also encourage them to fundraise, so many playgroups run Bunnings barbecues, chocolate raffles, those sorts of things to raise money to buy toys and we share across New South Wales where we can. When a playgroup is closing or has surplus toys, they will post it and we will get someone to check out the toys to see if they want something from that resource. One thing we have had success with lately is running playgroups in aged care facilities, which has been a really nice intergenerational experience. We are finding more and more aged care facilities are keen to open their doors to playgroups. We are just figuring out the parameters around insurance cover and storage and things like that. We started about 13; I think we have seven currently running in New South Wales.

The CHAIR: Thank you for your time and support. That has really helped us understand that part of the picture. There are many parts to this picture of supporting babies and families. If we have any other questions that come to mind afterwards, are you happy to answer them in writing?

Ms VAN WOUDENBERG: Absolutely.

The CHAIR: If that happens they will form part of your evidence and be published in the same way that your evidence here today will be. Thank you for your attendance.

Ms VAN WOUDENBERG: Thank you for your time.

(The witness withdrew)

The committee adjourned at 16:04