Playgroup nsw

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Legislative Assembly Committee on Community Services Hearing Transcript: Improving Access to Early Childhood Health & Development Checks

REPORT ON PROCEEDINGS BEFORE

LEGISLATIVE ASSEMBLY COMMITTEE ON COMMUNITY SERVICES

IMPROVING ACCESS TO EARLY CHILDHOOD HEALTH AND DEVELOPMENT CHECKS

At Silver and Gold Room، Mantra Hotel، Parramatta، on Monday ٢٥ November ٢٠٢٤

The Committee met at ١٠:٠٠.

PRESENT

Mr ClaytonBarr (Chair)

Ms LizaButler
Mrs HelenDalton
Ms DonnaDavis
Ms Trish Doyle(Deputy Chair)

The CHAIR: Thank you, member for Parramatta, for having us here. Before we start, I would like to acknowledge the Dharug people, who are the traditional custodians of the land we are meeting on here at Parramatta. I also pay my respects to Elders, past and present, of the Eora nation, and extend that respect to other Aboriginal and Torres Strait Islander people who are present here or watching proceedings online.

Welcome to the second hearing for the Committee on Community Services inquiry into improving access to early childhood health and development checks. My name is Clayton Barr. I'm the Committee Chair. I am joined by my colleagues Ms Trish Doyle, the member for Blue Mountains and Deputy Chair of the Committee; Mrs Helen Dalton, the member for Murray, and recently a grandma again; Ms Donna Davis, the member for Parramatta; and Ms Liza Butler, the member for South Coast. We do have two apologies from two other members who couldn't be here today, and they send their regards. We thank the witness who are appearing before us today and thestakeholders who have made written submissions. We appreciate your input into this inquiry.

Ms DINA PETRAKIS, Chief ExecutiveOfficer, EthnicCommunityServicesCo-operative, affirmedand examined

Ms MOLLY JACKSON, CommunicationsManager, JesuitRefugeeService, affirmedandexamined

Mr BEN FIORAMONTE, GeneralManager, Children, FamiliesandDisabilitySupport, SettlementServices International, affirmed and examined

The CHAIR: I welcomeourfirstwitnesses. Thankyouforappearingbeforethe Committeetodayto give evidence. Please note thattheCommitteestaffwillbetakingphotosandvideosduringthehearing. The photos and videos may be usedforsocialmediaandpublicengagementpurposesontheLegislativeAssembly social media pages and websites. PleaselettheCommitteestaffknowifyouobjecttohavingphotosandvideos taken. Before we start, do you haveanyquestionsaboutthehearingprocess?

BEN FIORAMONTE: No.

MOLLY JACKSON: No.

DINA PETRAKIS: No.

The CHAIR: Beforewestartourquestions, wouldanyofyouliketomakeashorttwo-minuteopening statement?

BEN FIORAMONTE: Thankyouforthe opportunitytospeaktoday. Since٢٠٠٠, SettlementServices Internationalhassupportednewlyarrivedrefugeesandnowservesdiversecommunitiesin NewSouthWales, Victoria andQueensland. Weempowervulnerableindividualsandfamilies, includingthosefromdiverse backgrounds. Annually, weassistabout٥٦,٠٠٠peoplethroughnearly٦٠programsincludingdisabilitysupport, out-of-homecare, employment, domesticandfamilyviolence, andsettlement, witharound٢٠,٠٠٠ofourclients being refugees.

A keyareaoffocusforSSIisthehealthandwellbeingoffamiliesandchildrenagedzerotofiveyears.

The StrongerStartsBrighterFuturesresearchbySSIandtheUniversityofSouthAustralia٢٠٢٤foundthat socio-economicdisadvantageisthelargestdriverofdevelopmentalvulnerabilityforchildren, withnearlyathird of childrenfromCALDbackgroundsindisadvantagedareasbeingvulnerablecomparedtooneinsixin advantagedareas. Earlychildhoodeducationandcare, orECEC, iscrucialtoaddressdevelopmentalvulnerability, but CALDfamiliesfacebarrierssuchaslimitedknowledge, languageanddigitalliteracychallenges, affordability, transport and lack of culturally responsive services.

In٢٠٢١athirdofchildrenagedzerotofouryearsinNewSouthWaleswerefromaCALDbackground, the highestculturaldiversityinAustralia. CALDchildrenaremorelikelytobedevelopmentallyvulnerableat school entrythannon-CALDchildrennationallyandinNewSouthWales. CALDchildrenarelesslikelytoattend ECEC, makingthem١.٧timesmorelikelytobedevelopmentallyvulnerablecomparedtothosewhodoattend. Early interventionsupportisunderutilisedbyCALDchildren, withCALDchildreninNewSouthWaleshalfas likely to accessthesecomparedtonon-CALDchildren.

BasedonSSI'sexperiencewithrefugeeandmigrantfamilies, andrecentresearch, ourrecommendations include increasinginvestmentinearlychildhooddevelopmentcheckstoensuretheyareaccessibleforallchildren, especially newcomers, whomayhavearrivedwithoutpre-birth, birthandearlyhealthchecks; government collaboration withECECproviderstocodesignservicemodelswithsoftentrypoints, integratedapproachesand

wraparound support، asshowntobemosteffectivefordisadvantagedfamilies—theNationalCommunityHubs Program funded bytheScanlonFoundationisareallygoodexampleofthis—scalingupoutreachinitiativesto enhance community-basedlinkersornavigatorstohelpdisadvantagedfamilies، includingCALDfamilies، engage with ECEC؛ and، finally، ensuringculturallyresponsiveearlyinterventiontoaddressharmandneglectby considering ethnicity، faith، languageandsettlementandworkingwithinterpreters، communityleadersand bicultural workerstoenhanceengagementandrelationships. Inconclusion، SSIappreciatestheGovernment's efforts in this inquiryandlooksforwardtocollaboratingonstrategiesthatenhanceaccesstoearlychildhood health and development checks for all families in New South Wales.

MOLLY JACKSON: I've also prepared a longer statement, and I'll just attempt to summarise as best I can. Good morning, Committee members. Thank you for the opportunity to appear today. JRS is an international organisation that accompanies، servesandadvocatesforrefugees، peopleseekingasylumandmigrantsin vulnerable situationsinover٦٠countriesaroundtheworld. HereinNewSouthWalesweofferfrontlineservices to over٣،٠٠٠ individualsandfamilies، mainlyhereinWesternSydney. Mostofthepeopleweservearseeking asylum and otherwiselivinghereonandoffprecarioustemporaryvisas، someforoveradecade. Asaconsequence of this visa insecurity، thepeopleweservefaceextremelyspecificandseverebarrierstotheirhealthand wellbeing. Very oftentheyareineligibleforanumberofpublicservices، includingMedicare، Centrelink، childcare subsidies، andparentsarenotoftenaffordedtherighttowork. Asaresult، ourfamilies، particularly women and children، areonthefrontlinesoffinancial، housingandfoodinsecurity. Childreninthese demographics are fallingthroughthegapsandarenotaffordedthepsychosocialconditionsthatsupporttheir healthy development.

Organisationslikeoursareincreasinglystrugglingtomeettheoverwhelmingdemandsforemergency assistance. Thisisthecontextinwhichwemadeouroriginalsubmissionearlierthisyear، specificallytowards points oneandtwoofthetermsofreference. WhatwewanttoemphasiseisthatallchildreninnewSouthWales، regardlessofvisastatus، shouldhavetherighttohealthcare. Thisshouldmeannotonlymeetingtheirbasic medicalneedsbutalsoaffordingholisticwellbeingthatenablesthemtothriveinourcommunity. Unfortunately، in our experience، thisisnotthecase. Childrenaremissingoutonbothessentialhealthchecksandopportunities for socialwellbeing، whichimpactstheirdevelopmentalhealthinthelongterm. Thesechildrenareconsiderably more vulnerable، withmorecomplexhealthcareconcerns، thanthegeneralpopulation. Theseincludehistoricand ongoingtrauma، exposuretoviolence، childhoodstressfromfinancialandhousinginsecurity، gapsinorabsence of healthcarehistory، comparativelypoornutritionalstatusandcommunityisolationandlonelinessthatcan follow them intoadulthood.

DespitetheNSWHealthpolicydirectivewereferredtoinoursubmissionthatestablishesthatpeople seekingasylumshouldhaveaccesstoessentialhealthservices، inpracticeit'sprohibitivelydifficultforthe familiesweservetoaccessoftenevenbasichealthcare. I'vesetoutthebarriersinmoredetailbutIwillsimply summarisethemtosaythattherearestructuralandfinancialbarriers، languagebarriers، knowledgebarrierswithin the healthandpublicsector، andthereareculturalbarriersThisallleadstoasenseofuncertaintyandfearofthe healthcaresystemamongstthepeopleweserve، particularlyonafinanciallevel، whichprohibitsthemfrom seekingearlyorevenemergencyinterventionsfortheirchildren. DoIhavetimetoshareacasestudytothis effect؟

The CHAIR: Let'sholdthatforasecondbecauseduringthequestioningyoumaywellgetthechance to giveacasestudyoranexampleofsomethingworkingwellornotsowell، ifthat'sokay.

DINA PETRAKIS: Iwouldliketoacknowledgetheوharugpeople، onwhoselandswemeettoday.

I pay myrespectstoElderspastandpresent. Ireally، reallyappreciatetheopportunitytospeakbeforethis LegislativeAssemblycommitteeonissuesofimportancetoCALDfamiliesandchildren. Asaproviderofearly childhoodservicessince١٩٧٩، weareacutelyawareoftheneedtoaddressgapsinoutcomesforvulnerable childrenandfamilies. Weworkwithnewandemergingcommunities، establishedcommunitiesandsomerefugee families. Lessonswe'velearnedoverthepastfourdecadesthatarepertinenttothisinquiryare، first، weneed understandingthatparentingisapersonalresponsibility، butparentsneedpriorknowledgetobeabletomake informed decisionsfor their familiesand their children.

Second، earlyinterventionfunctionshavetobebuiltintothesystem. Theymustbeclearandsustained. Knowledgeofsuchsystemsisbeyondtheunderstandingofalotofthesefamilies. Theycomefromplaceswhere they do nothaveaccesstoanyoftheseservicesorsystems. Third، proactiveplanning—andthisismysoapbox—starting withculturaldiversity، insteadofretrofittingasolutiontoagap، iscriticaltoachieveuniversalaccess. Fourth، thereisafragmentationofearlyyearsinterventionservices—we'veseenit—forparents، grandparentsand carers، particularlyfornewandemergingcommunities، whotrytonavigateareallycomplexsystem. Fifth، support for CALDchildrenwithparticularneedshastobeongoingandculturallyappropriate. Thisrequiressystemic engagementwithfamilies. Allofthis—again، mylittlesoapbox—needstobedoneattheplanningstage، not

retrofitting solutions, inordertoprovidestrongcoordinationandmaximiseuniversalaccess. Thankyou. Wereally look forward to anyfuturecollaborations.

The CHAIR: Ithankyouall. It'ssuchalovelyplacetostartourhearingtodaybecausewehadespecially wanted to come outtotheParramattacommunitytohearfromgroupsthatareworkingwithCALDcommunities. The member for Parramattahasbeenastrongadvocateforcaldcommunitiesandtheirplaceinallofourstate government systems. Wearesoluckytohaveyoutokickitofftoday. Iwillstartwiththefirstquestion—abitof a softball openingone. Itgoestoallofyou. Givenallthechallengesyouhavedescribedinyourvariousspaces, what do you seeasworkingreallywellintermsofatechnique, strategyoropportunity, whetheritiscreatedby you, governmentoranot-for-profitorganisation? Whatdoyouseeasworkingreallywellintermsofensuring that these childrengetthenecessaryhealthchecksalongtheway?

DINA PETRAKIS: Myorganisationhasbeenrecognisedforprovidingbiculturalandbilingualsupport since ١٩٧٩. Alltheprogramsweprovidearedonewithbiculturalworkers. Wefindthatthishasbeentheone ongoingandsustainablematterofimportanceintermsofengagingfamiliesandchildren. Ourbiculturalworkers come fromthecommunitiesofthesefamilies. Notonlydotheyspeakthelanguage, it'saboutculturalsafety. Familiesfeelsafewithsomebodyfromtheircommunity. Theyhavealotoftrustandtheyhavealotofbuy-in. So havingthesebiculturalworkersiscriticalfortheworkthatwedointermsofengagingvulnerablefamiliesto systemsthat are complex, making themunderstand what ishappening and building that trust.

Becauseyouaskedforthemainthing, forusitisgivingmembersofthatcommunitybilingualand biculturalsupportinordertosupportfamilies. Thatisevengreaterthanlanguage, becauseyoucangivesomebody a pamphletintheirownlanguage, butwhattheydowiththatpamphletorthatflyerisadifferentmatter. Having an actualpersontherefromtheircommunityiswhatgivesthemaccesstosystems.

MOLLY JACKSON: Attheriskofsoundingtoonegative, Idowanttohammerhomethatthereis little thatworkswellforclientsthatarestructurallyandsystemicallyunabletoaccesshealthcareservices. What does workwellisthatthereisthedirectivethatrequiresthatpeopleseekingasylumdoreceiveessentialhealth care. However, aswe'vesaid, it'stheaccesstoandunderstandingofhowtoreachthoseservicesthat'svery complex. WhatwedoatJRSAustraliaistrytobridgethatgap. Wedothatthroughhavinglivedexperience, informedcaseworkandbeingabletoaccessinterpretiveservicesthataretraumainformedandculturallysafe, echoing what Dina has already said as well.

BEN FIORAMONTE: SimilartoDina'sresponsearoundbuildingtrust, Ithinkoneofthekeythings that weknowworksis, certainly, whenyouhavethattrust. Tobuildthattrustincommunity, youreallyneedto have thatstrongconnectionwithcommunity. Thereareanumberofdifferentwaysyoucandothat. Oneofthe examplesishavingaworkforcethatmirrorsthediversityofthecommunitiesthatyouworkwith, forastart. You will findthattherewillbenaturalconnectionsthatcanmoreeasilybebuiltwithinacommunity.

Justbeingverypresentwithincommunities, similarlytowhatDinawassayingintermsofhaving availableinformation. Itmightbeinlanguage, andtoconnectpeopletoresourcesiscritical, butunlessyou'vegot a guideorsomeoneonthegroundwhoisconnectedincommunityandwhoisgoingtobeabletowalkpeople through, showthemanddothosewarmhand-offs, itwillbemuchmoredifficulttomakethatwork. Ithinkthat is oneofthemanyreasons, buttherareactuallyanumberofthingsthatarequitehighlyeffective. Anotherwould be—and I won't go into it now—integrated services aswell.

The CHAIR: Iamgoingtothrowtomy DeputyChair. Shejusttookadeepbreathwhenyousaid "integrated services", so I amnot sure if that'swhere she isstarting.

Ms TRISH DOYLE: Yes, Iwasgoingto, sothatisagreatsegue. Firstofall, thankyouBen, Molly and Dinafortheworkthatyoudo, andpleasepassonourthanksonbehalfoftheNewSouthWalesGovernment to yourteams. Youdosuchimportantwork, anditisprobablynotrecognisedasmuchasitshouldbe. Onthat issue ofintegrationbetweenNSWHealthandtheDepartmentofCommunitiesandJusticeworkingwiththe communitysector, whatsuggestionsdoyouhave? Youhavetalkedaboutculturalsafetyandyouhavetalked about softentrypoints, butwhataresomereallypracticalsuggestionsthatwecannotethroughthisprocesstoday and passontothoseagenciesanddepartmentstoimproveservicesandprovidethosewraparoundservicesfor children and families, particularly those from CALD backgrounds? I will start with you, Molly.

MOLLY JACKSON: Asfarastrainingandeducation, we'vesuggestedthat, potentially, orientation sessionsbemadeavailabletopeopleontemporaryvisastoensureinformationoutlininghowthehealthcaresystem worksandtheirrightsinrelationtheretoareclearlycommunicated. Whatwedescribedinoursubmissionisa situationofacomplexmapofexceptionsthattheyhavetonavigate, andclientsfromculturallyandlinguistically diversebackgroundsstruggletonavigatethatalone. Accesstoadvocatesthatperhapscomefromwithinthe system, rather than external advocates, would also be helpful.

As far as this training, it could also help ensure trauma-informed care, teach practitioners more specifically how to use interpreters, for example, increasing the length of appointment times, and how to manage cultural parenting dynamics and be more familiar with the identification and assessment of the specific healthcare concerns that affect children seeking asylum, as well as women and children who have experienced gender-based violence—specifically, the application of the directive teaching general practitioners in the healthcare sector how to interact with that, how to explain to clients, and how to refer clients within that. I think that's probably enough of the summary.

Ms TRISH DOYLE: Excellent, Dina.

DINA PETRAKIS: I'll just talk about three things. The first one is playgroups. The Department of Education has a fabulous program, StartStrong, the ideas pathway, where they fund playgroups. So we're currently doing ١٠ playgroups in Western Sydney, and each one is based on a different new and emerging community. At the moment, we're doing Afghani. We're doing Cambodian. We're doing Vietnamese, which is not so new. It's quite established, but there are still new migrants coming out. And we've done many in the past: Tibetan, Nepali, Hindi playgroups, Syrian playgroups, Iranian playgroups. And it is a brilliant project.

We have our bicultural, bilingual workers, and they work with these mums. This is important because working in playgroups with mums, when you have a bicultural, bilingual worker, gets rid of the stigma and shame of having a child that you think has a disability or a developmental delay, and that's why I first said that parents need to make informed decisions. Often what we hear from these playgroups is members of the community saying, "You're a parent. It is your responsibility to look after your child. There's no need for you to take it to services." And so trying to break through that stigma and shame communities have of accessing services, that "As a parent, I'm not doing the right thing. I should be doing it all on my own", is really huge, and that's where playgroups work. They work brilliantly. I want to acknowledge the Government's support for this initiative and hope that it can be sustained.

The second thing is—oh, my goodness, what a wonderful opportunity! New South Wales universal preschools—yes! Let's go, let's plan, let's get it right. This is what I was saying about not retrofitting. With the rollout of the universal preschools, you have such a good opportunity to plan them well. Let's have a clinic once a week in the preschools where we have providers coming in, talking to families and looking at all this stuff. We also work with bicultural workers in preschool, and I'll tell you the biggest issue for us. Our bicultural workers are educators. Although they speak the language of the cultural group that they're working with, the children in preschool, they are not disability assessors. And more and more teachers from preschools are saying, "Excuse me. This little boy—we think that he might have a developmental delay. Can you assess him?" Our bicultural workers are educators. They don't have the specific knowledge and training to assess disability, but they're continuously being asked to do this, which leads me to the third point.

As Ben and Molly know very well, trauma often manifests as a developmental delay, in terms of chronic health, language delay and sensory perception, but you need experts. So we put our bicultural workers with experts that are disability assessors to be able to assess a child. Playgroups—let's keep them going, make them stronger. Universal preschools—let's start planning for a fabulous universal preschool system and putting in place what we need to do for these. And trauma-informed—we cannot stress enough how important it is, because trauma and developmental delay are not the same, but they're often put in the same bucket. That's it.

Ms TRISH DOYLE: Thank you, Dina. Thanks for your passion. Ben, did you want to add to that what suggestions you have about integrating that work between NSW Health, Department of Communities and Justice and the community sector to improve wrap around services?

BEN FIORAMONTE: Yes, please. I'd just like to point out I thought that Dina's idea around looking at universal preschools as an opportunity is a really great idea for that. Some additional ideas could be building that community-hub style model, which you could tie in with the universal preschools concept but having those community hubs where you do have that ongoing connection. I think one of the challenges for CALD communities, and therefore for all communities, is when you have a one-off engagement-type approach with specific communities where you engage once, they see you, but then you disappear for six months and they no longer know that you're there. Having those types of models will make sure that people are aware that there's always someone to connect them to other services.

The other one too—I thought this was worth mentioning because it was specific to New South Wales—was the AbilityLinks program, which was a program that was funded prior to the NDIS coming into play. Ability Linkers—SSI was one of the partners for that program—operated across New South Wales and connected people to a range of different services. These are people with disability, or family members who may have disability, who also have children that need various supports who are impacted by a range of intersectionality-based issues, whether it be mental health issues, whether it be people struggling with employment, people from gender-diverse

communities, for example. AbilityLinkerswasaconceptandaprogramwhereitwouldactuallyconnectpeople, show people where to go.

A lot of what workedwithinSSIwasmostofourstaffwereculturallydiverseandconnectedtothese communities, and we think thatthatreallyworked. Sowehadbasesinlotsoflocationsacross NewSouthWales. That was another program thatworked. ItwaswhatlocalareacoordinationwithintheNDISwasalsosupposed to do to a large degree. It doestosomedegreebutjustneverreallyquitegotthere. Finally, IjustthoughtI'd mention the Foundational Supportsprogram. Iknowit'ssupposedtobeundertheNDIS, butit'sconnectedtothe early childhood and out-of-homecaresectorandawholerangeofotherareas. It'sanotheropportunitytocreate programs like key networks thatcanbeestablishedacrosstheStateforspecificcommunities, againwiththe concept where you've got place-basedservicesorsupports.

Ms TRISH DOYLE: Excellent. Thankyou.

Mrs HELEN DALTON: Thankyouforattendingthehearing; it'sveryinteresting. IwanttoaskMolly a question. Youtalkedaboutessentialhealthcare. Doesthatextendtotheparents? I'lltakeastepback. We'vegot a lot of illegalmigrantsinmyarea. TheycometoGriffithtowork, andtheyoftengoundertheradar. Theirvisa may haveexpired. They'resupposedtogohomeorextendit, buttheydon't, andthentheyenduphavingchildren. You talkedabouthavingessentialhealthcare. Iwouldassumeyouweretalkingaboutforthechildrenthatare born here, butwhataboutfortheparents? Whatdotheydowhenthey'resickandthey'renotreallywantingto identify themselves asbeinghere?

MOLLY JACKSON: I'mnotsurethatthere'sasituationofpeoplenotwantingtoidentifythemselves as beinghere. Ithinkthesituationisthattheyseekasylumandthattheprocessisextremelydifficultandtakes— we've gotclients, likeIsaid, who'vebeenwaitingforprocessingforoveradecade. Sothat'sthecontext. That directive applies to all peopleseeking asylum, not just children. What happens is that our clients will, depending on the statusoftheirbridgingvisa, goonandoffeligibilityforMedicareandhavetogothroughtheprocessof applying for that, and applying for that on behalf of their children. In the interim they can access, for example, a servicecalledRefugeeHealth, butit'snotnecessarilyclearhowtheycanaccessthat. Theywon'tbeable necessarily to access a GP in the interim, so they might have to pay for that out of pocket. Obviously, we've got clients whodon'thavetherighttowork, sothereisnomoneyforthemtodothat. Thisisanissuethat, aswe've discussed, doesn't only apply to the children but obviously applies for the parents generally, and then there are knock-oneffectsforthechildrenbecauseoftheimpactsofthelackofaccesstohealthcareontheparentsandthe financial strain.

Mrs HELEN DALTON: Idon'tthinkthatRefugeeHealthservicewouldbeapplicabletoourcountry areas. I wouldn't think so.

MOLLY JACKSON: Yes, Icanimaginethatpeopleseekingasyluminruralareasaregoingtobe facing these challenges to an even greater extent than in the city. Something that we highlighted was that the application of the directive and the application of billing policies vary across different local health districts. For example, in Western Sydney, we find that people seeking asylum often are billed for services, whereas in the eastern suburbs, they potentially aren't. It depends where you live as to how you're going to get treated. Like I said, it'sorganisationslikeJRSthattrytobridgethatgap, informthesectorandoffersomeadvocacy, butit'svery difficult. Ithinkthatalloftheideassharedbythepanellistswouldbeincrediblyvaluableforourclients. Theissue has beenthatwehavenofundingforanythingbeyondabsoluteemergencyservices. Thinkingofthishigherorder wellbeing isa privilege thatour clientsandour services don't often get the opportunity toconsider.

Mrs HELEN DALTON: Griffithisameccaforagriculture. We'vegotBaiada—they'reinthechicken industry—andProTen. WehaveCasellaWinesandDeBortoli. That'sjusttonameafew. Obviously, peoplecome in to work attheseplaces. Thewholesituationwithcareandthesekidsslippingthroughthecracksistotally overwhelming. Is there a role for government, or even for other organisations like yourselves, to contact or to be in contact withthoseemployers, suchasBaiadaorProTen, andgivethemtheskillsorthehelptosetuppreschools to be the pointofcontact? Theyseemtobeinvisible. They'reoutthere. Workisabigthing. Manyofthemare working two tothreejobsintheseplaces, butitwouldseemthattheemployersshouldtakearole. Whatdoyou think?

MOLLY JACKSON: Iagree. Thankyouforbringingthatup. AtJRSwehaveanemploymentprogram that does support people seekingasylumtoupskillaswellastopartnerwithorganisationsinthecommunity. Like I said, one of the main barriersisthisinconsistentabilityandrighttowork, whichisahugedetrimentforclients to be able to access long-termwork. Wehavealldiscussedintegratedservices. Anotherissue, likeI'veshared, is that people seeking asylum areofteneligibleforchildcaresubsidiesorineligibleforaccesstochildcareservices in general. I echo what you saythatitwouldbefantastictointegrateaccesstochildcarethroughwork. Theroot cause of all this is a much morestructuralconcernaboutaccessingeneral. Asyou'vesaid, peopleweservehave

worked in the community for ١٠ years, pay tax and then often don't get even a small portion of the services that are afforded to other citizens in New South Wales.

Ms LIZA BUTLER: Thank you, all, for attending today. It's really appreciated. I know how busy you are, coming from a community services background myself. Molly, you spoke of improvements around coordinating between departments and community organisations. Would you have a case study so that we could better understand it?

MOLLY JACKSON: Sure. Thank you for the opportunity to share a case study. The one that I'd like to share evidences a number of the different barriers that we've set out. This one concerns a client, Rowan. Obviously, we've changed her name to protect her privacy. Rowan arrived in Australia on a partner visa with her two young daughters. She experienced domestic violence here in New South Wales, which led to separation from her partner. Ultimately, that put her visa at risk, which meant that she and her children faced financial, food and housing insecurity. They did not speak English, so interactions with support services were very complex without our engagement. Amidst these challenges, her youngest daughter suffered from severe dental decay. This went unnoticed and unaddressed throughout their stay, despite multiple visits to medical practices for routine appointments and immunisations. Like many parents from Rowan's background, Rowan believed that because her daughter's milk teeth would naturally fall out, there was no need for intervention.

A JRS caseworker met Rowan and her daughter and was able to schedule an appointment for a dentist, which, as we've discussed, is already a complex process. The situation had escalated to the point where her daughter required emergency surgery out of hospital to remove all her teeth. This was a really severe consequence of medical neglect, ultimately, and it led to far-reaching impacts on her diet and mental wellbeing. It really highlighted the need for a robust healthcare support system that ensures that wellbeing is protected and early interventions aren't missed. As far as integration, what we are trying to explain is that when people seeking asylum only have intermittent access to health care and not consistent GPs et cetera, they don't have anyone taking accountability for their ongoing health. They are also siloed, for example, in a developmental check, checking only certain issues. No-one is taking responsibility for the overall health and wellbeing of the family.

We also have a further case study about a client whose son required psychological services. They were both victims of domestic violence again. Although the care was still shared between the son and the father, the father didn't want the son to be receiving any psychological support, which has obviously left the son's mental health concerns to get worse and has caused the son to become violent against the mother. We have lots of instances of this. We have discussed clients with trauma backgrounds who really need tailored and specific support. In this case, the DCJ and healthcare services and services like ours are not interacting in a way that really safeguards the wellbeing of that child, which is often the case for the people we serve. They're falling through the cracks and no-one is taking accountability. In the long term, we see more interactions with the public sector and increased-cost emergency services as opposed to proactive health care.

Ms LIZA BUTLER: You're saying that you tend to all work in silos rather than together, is that what I'm hearing?

MOLLY JACKSON: Yes, that's right, and different perspectives taken from different sector organisations. There is so much advocacy that goes on, individual advocacy that takes a lot of work and effort. At the moment we have one caseworker at JRS Australia. What we see is they're always put in the too-hard basket and there is always someone they can pass onto. In fact, that person doesn't exist and we end up with extremely poor health outcomes for children.

Ms LIZA BUTLER: Dina, you spoke of screenings in preschools and, Ben, you spoke about prior to NDIS. Have you seen a decline in services for the nought to six age group, specifically, since NDIS came in?

DINA PETRAKIS: That's a good question. Definitely within our playgroups and the work that we do with preschools, I don't know if it's a decline since NDIS but, certainly, every year we see more and more need. The CALD families that we work with don't access NDIS. A lot of them don't even know it exists. They don't know what it is. Even if they are told what it is, they would have no clue how to access it. To echo Molly's point, where there is a lack of coordination, there is a lack of access to services.

I don't know if there is more of a lack of service provision since NDIS, but definitely every year we are getting more and more requests to look at children with the perception that there is a developmental delay. These children are even going into primary school with no assessments. We know from primary schools that teachers often—because the parents don't know what they don't know, they enrol their children in a primary school. They may or may not have gone to a preschool previously, so these children are presenting in kindergarten with quite significant developmental delays in their milestones.

Theteachersinprimaryschoolarenotabletoaddresstheseiftheyhaven'tbeenassessedbecausethey don't knowwhattheissueis. Weareseeingthatmoreandmore. It'sdefinitelyincreasing. Thatisoneofthe reasonsIthoughtIwouldputforwardtothisassemblythat, withuniversalpreschools, thereisanopportu nity, if you evenhaveaone-dayclinic, togetcoordinationofservicesandwraparoundservicesaroundthechildrenand make surethat, whentheystartschool, theyarenotalreadybehindmostoftheirclassmates. Whatwehavealsofoundisthatforfamiliesthatcanaccesssomesupportspriortopreschoolandprimary school, oftentheinterventionissominimalandsoquickthatbythetimetheyreachprimaryschool, theydon't need to haveanNDISpackage. Noteverybodywillneedtohaveone. Ifyouhavesomeearlyintervention— appropriateandrelevantintervention—youwon'tneedNDISforsomechildren. That'shugeforthefamilies because thentheyjustcarryonwiththeirlivesandthechild—becausealotofparentswantthemmainstreamed— can be mainstreamedappropriately. Butcoordination—andlikeMollysaid, again, we'reworkingwiththemore privileged. We'renotworkingwithasylumseekersthathavebeenwaitingforoveradecadeforsomekindofvisa to allow themtoworkandaccessservices.

Ms LIZA BUTLER: PriortoNDIS, Iknowtherewasaprogramcalled EarlyStartearlyintervention, which wasbasicallygoingintopreschoolsandpickingthingsup. Butitdidn'tjustsupportthechild; itsupported the wholefamilytonavigatethesystem, andsupportedtheparentsaswell, tokeepthewholefamilyintact. Isthat the piecethatI'mhearingthatismissingnow?

DINA PETRAKIS: Yes. WehadAbilityLinks, butthat'snolongerthere. NowinNDISwehave supportcoordinatorswhichdothatcoordinationpart, whichiscriticalforCALDfamilies. That'schangingto navigators. Wedon'tknowwhatthat'sgoingtolooklike. AbilityLinksisnolongerthere. Thesupportcoordinators are nowbecomingnavigators. Thatcoordinationpieceisnolongerthere, andthentheotheroneissortof changing, so we don'tknow.

Ms LIZA BUTLER: Thismightbeaquestiononnoticeforyou. Forthosecoordinationroles, canyou just comeinnow? Youweresayingthatoftenachilddoesn'tneedtogoonforfurtherintervention. Itmightbe that theyhaveglueearandthey'renothearingsotheirspeechisaffected, andthentheyexitagain. UnderNDIS, with thatcoordinationrole, aretheyeligibleforthat?

DINA PETRAKIS: Ifyou'reanAustraliancitizen, ofcourseyoucangetNDIS. We'reanNDIS provider. Wehaveatwo-year-oldonanNDISpackage. Butthisisnotthecaseforalotofthesecommunities. We're talkingaboutnewandemergingcommunities. Evenwhenyouofferthemtheinformationandwhat's available, it'sbuildingthatbond, trustandconnection. Theyseeadifferentfaceeverytimetheygoforaservice. They havetorepeatwhattheyneed. It'sallofthat. That'swhycoordinationiscritical, andthat'swhyIthought bringing ittogether in theuniversal preschoolmodel maybeone way tominimise the deficitof that.

Ms DONNA DAVIS: OneofthecommoncomplaintsthatIhavereceivedoveralongtimeisthelack of coordinationthatisaccentuatedbythefactthatthefundingtosupportourasylumseekersandrefugeesis Federal funding, andyettheservicesthattheyareseeking, suchasthesebasichealthservices, ifit'sanewbaby born here withtheservicesthatconnectandflowonfromthoseearlychildhoodcheckswiththebluebook, are all state services. Wouldyouliketoelaborateonthat, andonyourexperienceswiththat, andonwhatyouthink we can do to trytoaddressthatissue?

DINA PETRAKIS: Go, Molly.

MOLLY JACKSON: Yes, thisisaperfectexampleofthepeopleweservebeingcaughtinthegaps. The Federal Governmentwon'tfixitfromavisaperspective, andthentheStateGovernmentisstrugglingtofix it without having, for example, permanentstatus. Wemadeanumberofrecommendationsinthesubmissionthat can be implemented fromastatelevel. Forexample, aroundhealthcare, thereisalreadyadirectivethatNewSouth Wales has to ensure thatpeopleseekingasylum, regardlessoftheirpermanency, haveaccesstoessentialhealth care. It's not necessarilyaboutwhetherornottheyhavetherightorwhetherornottherearepro cessesinplaceto give them those services. It'saboutthelimitedaccesstothoseservicesbecauseofthevariousvulnerabilitiesthat they have. For example, we'vetalkedaboutin-languageservicesaswellasin-languageresources. Oneofthe things I wanted to highlightwasjustthenumberofavailableinterpreters—therearen'tenoughinterpreters. Health practitioners—

Ms DONNA DAVIS: Sorry, canIjuststopyouthere? Weheardthislastweek. Whentherearenot enough interpreters, are they interpretersforyoutoaccessoraretheyinterpreterswithintheStategovernment systems?

MOLLY JACKSON: I believewe'retalking—both. ButI'mtalkingaboutwithinthehealthcaresystem when a client goes to a practitioner to haveanappointmentortoreceiveadevelopmentalcheckandtheydon't necessarily have access to an interpreter.

Ms DONNA DAVIS : Itwouldbegoodforustobeabletofindoutwhotheyactuallysourcetheir interpreter services from . Youwouldthinkthatthatwouldbejustagiven ، wouldn'tyou؟

MOLLY JACKSON : Yes . Icandefinitelytakeitonnoticetogiveyouamorespecificrun-downof how that process works .

Ms DONNA DAVIS : Thankyou . Thatwouldbegreat .

MOLLY JACKSON : ButIwanttoreiteratethattheissueisthatparticularlytherearenotenough female interpreters for women'shealthissuesandtheirappointmentsarenotextendedforthelengthrequiredto accommodate the use of aninterpreter . Therealsomaybebimonthlyclinicsthatareofferedinlanguagebut ، again ، the lack of regularityisahugebarrierforpeoplebeingabletoaccesstheservice .

Ms DONNA DAVIS : CanIgiveyouthatquestiontocomebacktous—aboutparticularlanguagesthat any of you are aware we haveadeficitofinterpretersin؟Thatwouldbeverygoodtoknow .

DINA PETRAKIS : Mongolian .

Ms DONNA DAVIS : Yes ، thatisagrowingpopulationinmyelectorate ، sodefinitelyMongolian .

BEN FIORAMONTE : Morethanhappytocomebackwithsomemoredataonthat . Buttheissue aroundinterpretersisquitesignificant . Therearesometertiaryhealthcareproviders—they'renotobligated necessarilytouseTIS ﷺ TranslatingandInterpretingServices ﷺ ، forexample ، whichmaybehelpfultosomedegree ، but theotherissuewithTISistheydon'talwayshavethecontext . Forexample ، aroundNDIS ، theycannot necessarilytranslatethecontext . That'spartoftheissue . Theotherissue ، too ، isalotoffamiliesbeingasked ، "Can a familymemberinterpretforyou؟Becausewearenotgoingtoaccess ." Buttheywon'tnecessarilywantthe familymembertodotheinterpretingbecausetheydon'twantthemtobeacrossthatlevelofdetail . Therearea whole multitudeof issues herewhen it comes to interpreting . Happy toprovide more detail .

Ms DONNA DAVIS : Whenamotherhasababy—likeanasylumseekerthatyou'reassisting—and thenthereisahealthissueforthatbaby ، wheredoyougo؟Whatdoyoudototakesteps؟Iknowyoutalkedabout refugeehealth ، butwhatdoyouactuallydotogetthataccess؟Whatdoyoudotohelpwithmoney؟Becausewe knowtheydon'thaveajob . IknowJRSverywellsoIknow . I'dlikeyoutotelluswhatyoudotobeabletofund and helpthemfindaservice . Whereareyousendingthem؟

MOLLY JACKSON : Oftenthereisnowheretosendthem . Particularly ، forexample ، inahousing context ، therealityisthatbothcommunitysectororganisationsandpublicservicesaresimplynottakingthem . The situationisthattherareone-daysolutions . Wealsohavenofunding . Wehavenofundingforemergency casework ، soforassistancewithemergencymedicalappointments ، paymentforemergencymedicalappointments ، paymentforrent—we'retalkingaboutthebroaderpsychosocialindicatorsofhealthhere—wedon'thavethat availabletous . Whatwe'reseeingisanincreasingvulnerabilitywithinourclientsfacingprimaryandsecondary homelessnessasaresult . Whenapersonseekingasylumwhoisonabridgingvisahasachildwhoisborn ، there is a processoftimeinvolvedinordertogetthemattachedtoanapplication ، togetthemaccesstoMedicare .

Ihaveanothercasestudythatwesharedofaclientwhohadtwochildren ، andforbothofthoseinstances they missedoutonearlychildhooddevelopmentalchecksbecausetheytooktimetobeabletogetregistered . To do that ، wehavetoreferthemtootherorganisationsandwehavetotrytocoordinate ، withessentiallynoresources . So perhapsitwouldbeusefulformetogetoneofourcaseworkerstosetoutaspecificexampleoftheprocesses involved ، butwhatIcansayhereisthatit'sanindividualisedexperienceineachinstancebecausethereareno solutionsactively provided .

DINA PETRAKIS : IjustwanttoreiteratewhatMollysaid . Youprobablyagree ، Molly ، thatwhere there isalackofgovernmentservicesforpeopleliketheasylumseekers ، youfindthatcommunityoftenmobilises to helpthesefamilies . Sothecommunitywillfindthemaplacetostay . Thecommunitywillfundraisemoneyfor a childformedicalservices . Thecommunitywillbandtogetherasmuchasitcantoprovidewhatthegovernment will not . Butyoucan'trelyoncommunityalotandyoucan'trelyonittothatextent . Bythetimeasylumseekers—the onesthatdo—getvisas ، whichtakessuchalongtime ، thosechildrenwillhavemisseddevelopmental milestones and health checks ، and will presentlater on withmore significant issues .

MOLLY JACKSON : Justtoreiterate ، that'stheexperiencewe'reinrightnow . It'sareallydirefinancial situation . Thiscost-of-livingcrisisisaffectingeverybody—obviouslythepeopleweserve ، butalsocommunity membersthat donate to JRS Australia . So that optionis increasingly not available .

Mrs HELEN DALTON : Chair ، canIaskanotherquestion؟

The CHAIR : Is it connectedtothatlineofquestioning؟

Mrs HELEN DALTON: No, not really.

The CHAIR: I'll come back to you.

Ms DONNA DAVIS: If a young mother and asylum seeker presents at the children's hospital with an emergency, what happens?

MOLLY JACKSON: I think I'll need to speak to a caseworker to be able to articulate that particularly.

Ms DONNA DAVIS: Yes, if you can. I know that it's hard for you to—

MOLLY JACKSON: No, it's a good example of how it's unclear how the directive applies in practice. I would imagine that, depending on the hospital, they will get different treatment.

Ms DONNA DAVIS: We know the process is that when you have a baby in New South Wales, you get the blue book. But if you are not actually in the system as the mother then how does that work for you? I think that might be a question that we can send to a few different organisations, perhaps, Chair. We haven't really had an answer to that question yet.

The CHAIR: No, we haven't.

MOLLY JACKSON: I'll take that on notice to provide a case study about a woman's maternal experience in hospital.

Mrs HELEN DALTON: Do you think that navigating the health system is made unduly complicated because you've got to deal with State and Federal health systems? Would each of you like to make a short comment on that, please?

BEN FIORAMONTE: Yes, sure. I'm happy to kick things off. I think, absolutely, it's highly complex, especially when you're talking about navigating the healthcare system as well as if you've got those intersectionality issues—if you've got people in the family with disability, for example, as well—navigating health care and disability or going across from housing to, again, it could be employment; it could be hospitals. The issue for a lot of families is that they could be struggling with a multitude of issues—so it could be financial constraints, for a start. I'm sure you've talked more about transport issues getting to services and coordination of services. All of that is quite difficult.

When you've got newly arrived migrants, for example, who also are struggling with trauma and mental health issues, as we've spoken about earlier, that adds an extra layer to what's already quite a complex healthcare system. That's where I know, within some of the programs that I've operated over the years, families are very close and connected. For example, we know that Vietnamese communities in the south-west Sydney region will make a really close connection within our program to someone who's from that community. That's the only person they'll refer people to, because they will help them to navigate a range of these different complex services. Sometimes it's a bit of an over-reliance because the information provided, even when it is in language, can be really comprehensive, so they'll just move away from that and go straight to the individual. In some cases, if that individual is not available, then they're trying to navigate these sorts of things and get answers.

Mrs HELEN DALTON: So they've got to navigate between the State and Federal health bureaucracy?

BEN FIORAMONTE: Yes. Also sometimes they're relying on Google, believe it or not—digital platforms. We know there was a study—and I'm happy to provide this as well afterwards—around Mongolian communities, specifically mothers from Mongolian-speaking communities. This was ٢٠٢٤. I can provide that.

They spoke about a reliance on these digital platforms. What they would do is cross-reference to get the correct answer. They will look at a variety of different websites to work out what's truth and what isn't, as opposed to going directly to a GP or someone who could help make a quick comment.

Mrs HELEN DALTON: We're hearing a lot about lack of coordination between what's going on in the State and Federal levels. I think there's an enormous amount of money put into health, yet we're not really getting the outcomes. Molly, would you like to make a quick comment?

MOLLY JACKSON: I'll echo everything that Ben has shared. Obviously, for the families that we serve, Federal solutions have always been off the table as far as our organisation is concerned. One piece is obviously our advocacy around requiring much more structural support for refugees and people seeking asylum. That comes at a Federal level as far as access to permanency and safety here in Australia. But I think it's also important to remember that a lack of coordination from State and Federal doesn't need to be an immediate barrier to the health of children seeking asylum. There are a number of practical recommendations that we've all made that, from the state level, can help to bridge that gap.

DINA PETRAKIS: Forthisquestionparticularly, Iwouldsayit'smorethanalackofcoordination when you're talking aboutCommonwealthandStateandwhatgetsfunded. Whatwe'veseenisthatifsomebody has an NDIS package, obviouslythat'sfundedbytheCommonwealth. Butthentherearesservicesthatareprovided by the State governmentintermsofhealthandfoundationalsupports. Ifyouhaveapackage— you'reanNDIS recipient—but itdoesn'thaveaccesstothosesupports, howeasyisitforAustraliancitizenstoaccessthose supports? I thinkit'smorethanalackofcoordination; it'sanunderstandingofwhat'sfundedbythe Commonwealth, what'sfunded by the State and whatyou are entitled to.

I knowthattherehavebeenNDISrecipientswhohavetriedtogetState-fundedservicesandtheysaid, "No, that's partofyourpackage. It'sgoingtocomethroughthat, notthroughus." Thathasn'talwaysbeena seamless pieceofinformation. Ithinkex-MinisterShortenwastryingtoputsomeclarityaroundthat. Justrecently I went to Canberrawherehespoke, aboutfourorfivemonthsago, ataforumonfoundationalsupports, justtrying to get that claritybetweenwhatisfundedbyCommonwealthandwhatisfundedbyState, andgettingan understanding betweenall of the providersabout what's funded.

BEN FIORAMONTE: JustaddingtoDina'spoint, asweheadtowardfoundationalsupportsand navigators, that'stokickofffromJuly١nextyearaswell. Sothere'sanaddedquestionmarkaroundallofthisas well. WhatwilltheFederalGovernmenttakecarriageof, andwhatwilltheStatestakecarriageofaswell? With foundationalsupports, isitadualresponsibilitybetweentheStatesandtheFederalGovernment? Ifso, howdoes that look? Whatservicesareprovidedandhowdowebasethat, andallthatsortofthing? Ithinkincommunity, unless we'resuperclearourselves, it'sgoingtobeverydifficulttocommunicateoutwardlyastowhat'savailable, who's leadingwhatandthenofcoursehowyouconnecttoallofthesedifferentcomponents.

Ms TRISH DOYLE: Thankyouall. It'sbeenaveryinterestingdiscussion. Whileyouareeachspeaking and answeringarangeofdifferentquestions, andweareidentifyinggapsandlackofcoordination, you'recoming up with—throughyoursubmissionsandthroughansweringsomeofyourquestions—somefantastic, practical ideas that wouldbringaboutsomuchchange. I'mjustmindfulofthefrustrationthatthecommunityservices sector must feelwithdifferentchangesandflavoursofgovernmentcomingandgoing, changesinthebureaucracy, and the way inwhichwenametheworkthatdifferentpeopledoatdifferenttimes—whetherit'stheabilitylinkers, the foundationalsupportnavigatorsorwhateveritis.

Peopleinthebureaucracyseemtothinkthataone-stopshopiswhatpeopleneed. That'snotnecessarily the case iftherearenocaseworkerstofollowthroughoncethatfirstcontactismade, whetheritissoftentryor whatever. Ithoughtitwouldbegoodforyou, andforourpurposeswhenwesharethiswithdepartments, toexpand a little bitonthoseissueswhereculturalbarriersareinplace, andtotakesometimetocutthroughthestigma, mistrust andfearthatthefamiliesfeelintryingtoaccessservicesfortheirchildren. Whatdowedoaboutthat? How do wetelltheseagenciesthemodelthatisneeded, keepinginmindallofthoseissuesaroundstigma, fear and trauma?

DINA PETRAKIS: Developamulticulturalworkforce, providefreetraining: aTAFECertificateIVin CommunityServices—somanyofourstaffwanttoaccessthat. Iknowitwillbeagovernmentcommitment financiallytoprovidefreetrainingbut, mygoodness, thereturnoninvestmentofhavingamulticulturalworkforce in the futureisimmeasurable.

Ms TRISH DOYLE: That'stheearlyinterventionthatyou'respeakingaboutontheotherendofthe stick—fantastic, Dina. Did you want to make a comment, Ben or Molly, about that?

BEN FIORAMONTE: Absolutely. Sorry, Iwasrunninganothertrainofthoughtandridingthatout.

I think part oftheissueisthatalotofthedifferentgovernmentagencies, andevensomecommunity organisations—we'resayingthesamething. Alotofwhatwe'retalkingabouttoday, communityhas communicatedthroughongoingandconsistentconsultationsoutthere. We'vegotthedata. We'vegotthe information formanyyears. You'recommunicatingverysimilarthings.

Ms TRISH DOYLE: You'vegotalltheanswers.

BEN FIORAMONTE: That'sright. Ithinkthat'sthekey. Theanswersaretherewithincommunities. I love Dina's idea around a multiculturalworkforce. It'scriticalforreflectingandmirroringthecommunitiesthat you're working with. I do thinkthereneedtobesomeconsistentframeworksaroundhowweengagewith multicultural communities anddiversefamilies. Thereneedstobesomethingthatsitsoverthetoptoconnect everything together.

MOLLY JACKSON: IlikewhatDinaandBenhavebothsaid. Atthemoment, clientsfromculturally and linguistically diverse backgrounds—andspecificallypeopleseekingasylum—finditextremelydifficultto navigate a public health systemthatrequiresindividualadvocacy. Wetrytofillthatgap, butwe'reill-equipped

to fill that gap. So that's one core cultural barrier. There are obviously other specific health literacy cultural barriers that could be addressed through training of the workforce.

Ms TRISH DOYLE: I think it's important for us to acknowledge the degree of frustration when you've got the answers, you see what works and what doesn't, and you've spoken to people for probably many years.

Ms LIZA BUTLER: Dina, you just spoke about the cert IV in community services through TAFE. Does that fall under the Federal Government's announcement of free TAFE courses or is that still paid?

DINA PETRAKIS: I'm not sure. I would have to take that on notice. But it would be great if it did.

Ms LIZA BUTLER: Because I can see, just having a quick look, that it's nearly $١٤,٠٠٠ for a one-year course.

DINA PETRAKIS: Yes, that's right.

Ms LIZA BUTLER: But can you get that back under the fee-free TAFE?

Ms TRISH DOYLE: It would be good for us to find out too, actually. We should ask the Minister.

Ms DONNA DAVIS: Ben, for settlement services, I know one of the big roles that you play is first settling people into our communities. As a part of that, I know much of that is practical. A lot of us take for granted how to navigate daily life in Australia. How do you go about explaining things like the blue book and the taxation system? Do you rely on community organisations? So if people are from a Nepalese background, do you get assistance from the Nepalese community—the same with the Mongolian and Afghani? How do you go about that?

BEN FIORAMONTE: That's a great question. All of the above. There is a range of different strategies that are used, so it depends. I'm obviously giving an overarching view, or comment, here. It depends on the community you're working with, so what's available in terms of that community, in terms of resources and in terms of community supports. It could be that there could be a Nepalese community out there. It could be a community from Sai centre, so practising Hinduism. They may have those sorts of connections or programs that are going on internally that you can refer to. In other circumstances we're providing certain programs. It could be around digital literacy. I was thinking of cultural competence, but when you're working with some communities, it could be around how to navigate the NDIS, for example. That's another really big one. So, in short, it really depends on the specific community that you're referring to.

If we were to go a little bit more broadly, I know that one of the things that SSI has been pushing, along with a number of other groups—and I am not the person to speak on behalf of this—is the national multicultural centre for children's health and wellbeing. That's something that's being pushed at the moment that I can provide to this Committee. That also gives some additional ideas on how communities and organisations can work together to connect people to appropriate services.

DINA PETRAKIS: Through our playgroups, our bicultural workers talk to the mums about the blue book and milestones, health clinics and weight clinics, and all of that. That seems to work. But we work at a much smaller level than, of course, SSI. So the initiative of that centre I think would be a game changer.

The CHAIR: We might end it there, which is another complicated layer to this inquiry. Thank you for appearing before us today. You will be provided with a copy of the transcript of your evidence for correction. Committee staff will also email any questions you have taken on notice today, so you don't need to worry about remembering those. You will get those sent to you, and the context around those. The Committee may also develop some supplementary questions that we will seek to send out to you. I thank you sincerely again for the work that you do every day but also for taking time out of your important lives to be with us here this morning.

(The witnesses withdrew.)

Professor ELIZABETH DENNEY-WILSON, Chief Investigator, Centre of Research Excellence in Translating Early Prevention of Obesity in Childhood (EPOCH-Translate CRE), affirmed and examined

Ms HEILOK CHENG, PhD candidate, Centre of Research Excellence in Translating Early Prevention of Obesity in Childhood (EPOCH-Translate CRE), affirmed and examined

Ms BHAVANA SAREEN, Early Intervention Family Worker, CALD Early Intervention and Perinatal Program, Community Migrant Resource Centre, affirmed and examined

Ms EMILY CASKA, Chief Executive Officer, Playgroup NSW, sworn and examined

The CHAIR: I welcome our next witnesses. Thank you for appearing before the Committee today to give evidence. Please note that the Committee staff will be taking photos and videos during the hearing. The photos and videos may be used for social media and public engagement purposes on the Legislative Assembly's social media pages and websites. Please let Committee staff know if you object to having these photos and videos taken. Before we start, do any of you have any questions about the hearing process today?

ELIZABETH DENNEY-WILSON: No.

The CHAIR: Would you like to make a brief opening statement before we begin questions?

ELIZABETH DENNEY-WILSON: Thank you for giving the Centre of Research Excellence in Translating Early Prevention of Obesity in Childhood an opportunity today. Our collaboration conducts research focusing on early prevention of obesity, which means promoting healthy growth and development, especially in the first year of life. We work with child and family health nurses and other primary care providers to develop, trial and implement interventions.

I am holding the blue book for my granddaughter, Georgia. For the past year, my daughter, Louisa, as a first-time parent, has relied on the services provided in her local child and family health centre. Like many first-time parents before her, she accessed parenting sessions available in her neighbourhood. She was supported to breastfeed and was referred to lactation consultants when she needed further help. In this first year, her child and family health nurse, Stephanie, made sure my granddaughter was meeting milestones like talking, crawling and walking, and made sure she was growing well. She assessed her length, her weight and her head circumference, her vision and her hearing. She provided enormous reassurance that my granddaughter was growing and developing well. Child and family health nurses are the cornerstone of this care. They offer health, development and wellbeing checks for children, and support, education and information on parenting for all families.

Rapid weight gain, or excessive weight gain, in the first year of life is one of the stickiest risk factors for child obesity. Child and family health nurses are one of the first health professionals who can spot health and development issues and refer on to specialist support as needed. In our research with nurses, they've told us that their work in promoting health and preventing unhealthy weight gain is challenged by limited time and staffing to see families and to have enough time to work through the barriers in promoting healthy growth, eating and play. Importantly, there are no routine visits between six and ١٢ months, a time when unhealthy weight gain can occur and when early intervention to assess what and how a baby is being fed is crucial in preventing excess or rapid weight gain.

Research by our team has shown that child and family health nurses are best placed to deliver two effective obesity prevention programs: the Healthy Beginnings program in New South Wales and the INFANT program in Victoria. But these programs aren't reaching all families. Families from culturally and linguistically diverse populations face challenges that could be overcome with more translators and bicultural workers, culturally appropriate messages and resources, and improved accessibility. The EPOCH-Translate CRE emphasises the importance of early intervention to ensure healthy growth and identify risks for excess weight gain in the universal health model across the entire first year of life. This will require an investment in child and family health nurses, bicultural workers and translators to offer this vital public health service, especially for vulnerable families.

BHAVANA SAREEN: First of all, thank you for giving me an opportunity to put forward my views—actually, it is the organisation's view, alongside. I work as an early intervention family worker at the Community Migrant Resource Centre in Parramatta. My organisation has not made any submission to this inquiry, but we work with migrant, refugee and culturally and linguistically diverse communities, supporting them to adjust and integrate within Australia. As a family worker, I have the opportunity to work with families with children from zero to eight years of age. From professional as well as personal experience, I recognise the importance of early

childhood health checks alongside development checks. I have seen how early detection of development delays and early intervention improves quality of life for both children and families.

EMILY CASKA: Thank you for the opportunity to present on behalf of Playgroup NSW. I am six days into my new role—thrown in at the deep end, right? But I've been following the organisation for a long time and I have a big history in the disability sector, so it all crosses over. In terms of Playgroup NSW, we've been around for ٥٠ years. We provide ٥٥٠ playgroups every week. We have ٦٥,٠٠٠ families and members across New South Wales, across ٩٠ per cent of postcodes, so our reach is there. In terms of this inquiry, we've provided a bit of a multifaceted perspective on early childhood health and development broadly, and to the checks. Playgroups by design also enhance early childhood development and health. There is plenty of research, which I'll quickly touch on, that shows that.

We also play a role in helping families understand what the checks are and also help them access them, and I'll touch on that. Also, where those checks happen, where delays or concerns might be identified, we then also provide the follow-up service through either community playgroups, but we also have First Nations specific, CALD-specific and supported disability specific playgroups. We also have some awesome intergenerational playgroups with grandparents as well. We have a real focus on regional and rural communities, which I know is part of the terms of reference here. We know that, naturally, a really critical prevention and early intervention measure in those early years is access to these formal checks, but I just wanted to give context about what happens before and after those checks because they don't sit in isolation.

Probably at a high level, the five key recommendations from us—we didn't make a submission, I'm afraid—are that, firstly, developmental screening and checks need to happen in places where families are, in the spaces and models that they trust and are familiar with. Naturally, playgroups provide that. Families really need to feel safe and supported in that space. I am sure, from all that I have been listening in from last week and today, everyone agrees with that. Peer support is so critical to the journey. It can't be a transactional checks approach. Again, that's where we see the strength in playgroups. Families learn from families. It is so powerful.

I think what my colleagues have touched on in their submissions, and the ones before us, is that families that are already facing systemic barriers or issues need really soft entry points. For example, we have a play van here in Parramatta. We can't keep up with demand so we take the services to the people in their local community that have particularly high CALD and isolated family access. With this model we then provide screening. We bring in health educators into that model. It's consistent, regular and mobile. That's something that is working. Investment is needed to make that process a lot smoother—that's probably not surprising—for everything, from apps to transport to get to the checks and interpretation for the checks.

The blue book is great, I know. I was part of a consult last year with NSW Health to digitise the blue book. We couldn't support that more because where a delay or a diagnosis might be found—my background is in Down syndrome—it would be great to have those developmentally specific birth charts access to support, which the current print version of the blue book doesn't do, and it can obviously isolate those families. Lastly, something to note is that families often need access to checks outside regular business hours. That is something that we hear a lot. The only other things I'll touch on, just specific to playgroups, is that data demonstrates that around ٣٥ per cent of children attend a playgroup before they start school. Interestingly, in relation to the terms of reference, we find that children in regional and remote communities are more likely to attend playgroups than they are in metro. I think that's interesting from an access point of view. Not surprisingly though, but necessary to note, is children from First Nations populations, and from CALD populations, and boys, are less likely. That is something we're really focusing on and, again, is an access point for this terms of reference.

Notwithstanding that, we do have a wide reach. We impact one in four disadvantaged children. There are some key indicators around playgroups, and something to note is that where a child has not gone to a playgroup they are ٤٧ per cent more likely to have developmental delays when they reach school. That's telling us that something in this playgroup model is working. Something that we really like, and I think that there are some green shoots, is the collaboration between the Department of Education and the health department to put the early childhood checks in those settings. One of our recommendations today is to look at the playgroup ecosystem as another way because a lot of our families aren't accessing early childhood education and, if they are, sometimes it's a bit later in life, whereas we're capturing children right from zero so we have that ecosystem and, as I said, that reach across the whole State definitely.

What we know is that playgroups, by their very nature, inherently—we enhance child development by our design, we enhance parent capacity. That is a key recommendation that we would make to the inquiry, that building and supporting parent capacity is key and their confidence and connection with the system. The fact that we are locally present drives that connection and the engagement. Then there's that universality of our playgroup

ecosystem that we think could really enhance and complement the very focus of this inquiry, which is how do we get more children and more families accessing these early childhood checks as early as possible?

The CHAIR: The first question by design is a softball, easy one. I think I might have just heard the answer to this question from Playgroup, but what do you see working well out there? What methodology is being used out there that you think works well in terms of these young people getting access to all these health checks along the way during their development and progress?

EMILY CASKA: The agreement that's been reached in the early childhood setting is definitely something we would like replicated across the playgroup ecosystem. Data shows that playgroups do tend to get in earlier. We have more reach. Not all children go into the formal early childhood space, so we would like to see that as a fairly quick win. It's a model that could just extrapolate out further. Secondly, our supported playgroup and community playgroup, First Nations, CALD, that's a great thing that is working. Some of it is state funded, some of is federally funded, but I think more investment in that. Like I've said, we know that in place, local support works. I think some more investment, and maybe some more formalisation of the ability to bring health practitioners and NSW Health into that ecosystem would only strengthen it further. Absolutely.

Like I said, another green shoot was the consultations by NSW Health to digitise the blue book. I do think that just helps us allow for more developmental nuance, and it gets people the targeted information that they need. Speaking for Down syndrome, there are completely different growth charts, weight charts, developmental milestones. In the current hard copy form those families are left behind. They would be some green shoots at the moment that I'd recommend.

The CHAIR: Ms Sareen, what about Community Migrant Resource Centres? What would you say is working well out there at the moment?

BHAVANA SAREEN: In terms of playgroups?

The CHAIR: No, in terms of these young children getting access to these developmental health checks in the first five years.

BHAVANA SAREEN: Okay. As a part of Community Migrant Resource Centre we do have supported playgroups. What I have seen in the playgroups is that the parents—it's the comfort level that the parents get. That's the first thing. Because most of them are from CALD communities, meeting people from a similar community—let's say I have a playgroup, and there are ١٠ people coming from Afghanistan, five of them are coming from Indian communities, the subcontinent. First of all, making that community connection is quite helpful. Sorry, can I just come back to the question?

The CHAIR: Sure. Can I emphasise we are here at the great privilege of tapping into your incredible knowledge. You do us great service by sharing anything that you can with us, so we thank you in advance for everything.

Ms DONNA DAVIS: Maybe I can help rephrase it? In that environment of bringing mums together, does it make it easier for them to talk about all the things—how to access services—because they've got the comfort of—

BHAVANA SAREEN: Absolutely. Yes, thank you for helping me out there. That's true. When the parents are in that space where they feel safe and they're able to communicate in their own language, it is quite helpful. Being a migrant myself, it is easy for me to connect to the parents and everything, and tell them. I do tend to notice because I run a playgroup personally. I do bring a wealth of knowledge by bringing in experts and having information sessions in the playgroup. So I might get people from Service NSW coming in or from the health department coming in, talking about very specific topics. Recently I had people coming from the health department talking about mental health and stress managing kids if the kids are having any issues. It was more focused on the mothers but at the end of the day, it would be helping the kids. Basically educating the mothers and the parents or the grandparents who are there in the playgroup is quite helpful to be able to detect any issues with the children at a very early age.

Let's say we are having an activity going on and we can actually see what each child is doing. Let's say we see there are some delays in a particular child. The easiest way is to have a conversation with the mother and see what's going on at home—what's happening and what is she noticing. This is where the conversation starts, as we can then encourage the parents to seek experthelp, visit their general practitioner or see a nurse. That, I feel, is really great because it's basically really going to the grassroots level and engaging with the community at that point.

The CHAIR: Ms Caska, can I go back to you for a second? That sounds like a wonderful model but I'm wondering, have you chosen through your playgroups that you facilitate to try to bring in those external services?

Is this somethingthatPlaygroupacrossNewSouthWalesencouragesaspartofthatprocessorareyounotthat specific about it?

EMILY CASKA: Weabsolutelyencourageit. Withthose٥٥٠playgroupsaweekthatweeitherrun directlyorsubcontracttoorganisations, thereisnooverarchingframeworkorengagementwithHealth, inthis case, ofthatdrop-inservice. Soitisquitelocalised, whichhasitsbenefitsbecauseyoudowanttotailorittothe localneeds. Youdon'twantcomeoutwithacurriculumof"Atyourplaygroups, you'regoingtodothis." Ido thinkit'salmostlikeatwo-tieredapproach. Thereisanopportunitytohaveabitmoreofaformalisedpartnership likeintheearlychildhoodsectorandactuallybringthescreeningsintotheplaygroups, butintermsofaccessing healtheducators, eventheplaygroupswerunourselves, it'sverylocalised. It'salmostlikewe'reindividually reachingout; there'sno systemic way about it, which definitely couldbe improved.

The CHAIR: Itsoundslikeagoodmodel. Whataboutforyouguys? Iwasgoingtosay EPOCH. Isthat how yourefertoyourself?

ELIZABETH DENNEY-WILSON: That'sourresearchcollaboration, yes. I'dliketotalkaboutthe two programsImentionedinmyopeningstatement. Firstly, HealthyBeginningsisaprogramthatprovides additional supportforparentsaroundhealthyfeeding, healthyeating, activeplayandparent-childinteractions. It's currentlyunderwayinSydneyLocalHealthDistrict, SouthWesternSydneyLocalHealthDistrictandsome componentsinHunterNewEngland. Thatprogramhasbeenshowntobeeffectiveintermsofincreasing breastfeedingandintermsofBMIorweight-for-lengthat١٢months. Ithas, inaresearchenvironment, been adapted toArabic-speakingandChinese-speakingfamiliesandshowntobefeasibleandacceptableto participants. Butthat'sinaresearchenvironment. Iguessoneofthethingsthatischallengingforgroupslikeours is that we canshowthingstobeeffective, fundedbyresearchbyNHMRCorsomeonelikethat, butthenweneed a commitmentfromgovernmenttoactuallyrollthatoutandmakeitpartofroutinecare. Thatprogramisnotonly effective butalsohasbeenshowntobecosteffective.

Theotherprogramthatisunderway inVictoriaistheINFANTprogram, whichprovidestrainingfor health professionals. Thattraining, again, isreadytogoandhasbeenevaluated, iseffectiveandisverymuch appreciatedbytheprofessionalswhodoit. Thatprogramoffersextraparentsupportatthree, six, nineand١٢ months, withkeymessages, again, aroundinfantfeeding, activeplay, sleepandparent-childinteractions. That program, too, hasbeenshowntobeeffectiveintermsofimprovinghealthyeatingandactiveplay, whichareall determinantsofexcessweightgainorweightgain. Again, thatprogramisdevelopedandreadytogoandisbeing rolled outacrossVictoria. Again, thatcouldbeadaptedforuseinNewSouthWales. Thosearetwopotential examples of thingsthat are working well.

HEILOK CHENG: CanIaddthatthoseprogramsareembeddedintousualcare. AsElizabethsaid, HealthyBeginningsisintheSydneyandSouthWesternSydneylocalhealthdistricts, andtheINFANTprogram in Victoriaisembeddedinthelocalmaternalandchildhealthservices, whichisslightlydifferentinthatthenurses are in localgovernmentinsteadofstategovernmentandtheyhaveagreenbook. Also, theINFANTprogramis being takenupbyearlychildhoodeducatorsandcommunityhealthprograms. Asmentionedlastweek, ifparents aren't engagedinthehealthservices, wehaveparentingprogramsinlibrarieswherethiscanbetalkedaboutby communityfacilitators.

ELIZABETH DENNEY-WILSON: Andobviouslyitcanbeadaptedtomeettheneedsofaparticular community.

The CHAIR: Ihavetwoquestionsforyou. Roughlyhowlonghastheinfantprogrambeenrolled out in Victoria?

ELIZABETH DENNEY-WILSON: TheINFANTprogrambuildsonover١٥yearsofresearchbuthas had widespreadrolloutforthepastthreetofouryears.

HEILOK CHENG: Since٢٠٢٠, yes.

The CHAIR: MsCheng, didyousaythatthenursesareemployedbylocalgovernmentinVictoria?

ELIZABETH DENNEY-WILSON: It'sadifferentmodel, yes. It'salocalgovernmentmodel. Maternal and child health services areprovidedbylocalgovernment. It'sjustadifferentmodelofserviceprovision.

Mrs HELEN DALTON: Isitamoreeffectivemodel? Iamabitconfused. Backintheday, ١٠٠years ago when I had my children, Ithoughtthecouncilprovidedacommunitynurse. Theycertainlyprovidedaspace, the building. Was it the hospital, backbeforewehadhealthdistricts? Canyourecallwhatthatservicewas?

ELIZABETH DENNEY-WILSON: Iamprettyold—youarequiteright. Ithinkitisreallythequality of the service that determines theeffectiveness. Idon'treallythinkitmatterswhopaysforit.

Mrs HELEN DALTON: But how effective was it ٣٠ years ago?

ELIZABETH DENNEY-WILSON: We had a very different population and we didn't have the problem of rapid weight gain ٣٠ years ago. When I first started in the business of obesity prevention, we really worried about people formula feeding who were diluting formula because we were worried that they wanted to make it last longer. Now we worry about them over-concentrating it because they think it'll help their baby grow bigger or might help the baby sleep. Things have changed in the time that I've been working in this area.

Mrs HELEN DALTON: At these hearings, we have been hearing about a lack of coordination. If you had the ability to change the system, what would you do?

ELIZABETH DENNEY-WILSON: I think you would have co-location of services like multicultural workers, like interpreters and like childhood family health nurses who would, with the local community, help to co-design programs or work together to adapt programs like Healthy Beginnings and INFANT that have shown to be effective. You would get those to be made culturally appropriate because we know that different cultural groups might have different attitudes towards growth and development, especially around the size of a baby. Some cultural groups really do like a bigger baby because they think it's a sign of health and wellbeing.

Mrs HELEN DALTON: The state is divided up into health districts. Is there a need or a requirement for every health district to provide the rudimentary services, or can they cut corners? Do you know how it works?

ELIZABETH DENNEY-WILSON: I would take some of that on notice. But as a general principle, I think we do need to provide services and not cut corners when it comes to healthy growth and development because this is our future. Even though we underinvest in prevention, it really pays enormous dividends. I guess, as a prevention person, I would really like to see us doing as much work on preventing conditions as we can.

Mrs HELEN DALTON: For us in rural areas, the idea of centralisation of services to a bigger regional centre is not working. With the tyranny of distance, we can have people who are four or five hours from that service. Is that good enough?

ELIZABETH DENNEY-WILSON: If I may just plug one other part of the research work that we've done, the INFANT program in Victoria is accompanied by an app called My Baby Now. That app has been designed in collaboration with healthcare professionals. It uses the best available evidence. It matches Ages and Stages-type health checks. That is a good adjunct to face-to-face care. I'm not suggesting for a moment it should be necessarily a standalone service, but it could be of assistance to people who work in resource-poor areas. But I guess there are greater experts on the provision of healthcare services than I who would be better placed to discuss how a healthcare service is provided in rural and regional areas. But, of course, I believe that all of our citizens deserve the best possible health care.

Mrs HELEN DALTON: I am going to have to leave, Chair. I have to catch a plane.

The CHAIR: All right. Go and get on the plane.

Ms TRISH DOYLE: I hope you enjoy meeting your new granddaughter.

Mrs HELEN DALTON: I hope so.

Ms DONNA DAVIS: The member for Murray has a new granddaughter.

ELIZABETH DENNEY-WILSON: Congratulations!

EMILY CASKA: I was just going to add a comment to Mrs Dalton's very valid points about our regional and rural health access and delivery. Rudimentary services, yes, they are okay and fairly equitable. But as soon as there is any hint of a delay or an ongoing diagnosis, everything falls out the window. It is not just the tyranny of distance; it is the accommodation cost to the families and all of the stress that comes with being out of place. So I think we need to shift from people having to go to the services to the services coming to them, because it's also the timeliness of it. We see a degradation of the diagnoses and the development because of the delays, the travel and all of those things to get to the centralised places.

Ms TRISH DOYLE: Before I ask my question, which segues well into the point you just made there, Emily, I thank you all for the fantastic work and research that you do. It is a privilege for us to hear from you today to inform the work that we do. On that point is something that I've been actually following closely on another committee that I'm on: regional, rural and remote healthcare access. Is telehealth an appropriate way to deliver these early childhood checks for CALD communities particularly? Do you have some commentary? Anyone have any commentary on that, whether you've heard feedback that would help inform the work that we're doing?

ELIZABETH DENNEY-WILSON: I can comment on that. Certainly, that was a model that was instigated during the COVID pandemic. Sydney Local Health District did deliver those checks over Zoom or Teams, and my recollection of the research was that it was doable, it was feasible but it wasn't as—

Ms TRISH DOYLE: Ideal.

ELIZABETH DENNEY-WILSON: It's not ideal, and what you lose is that potential for creating community. As you know, with any sort of health promotion, you tend to get an amplification of the effects of that health promotion if you get people together, from community, who discuss that particular intervention. So you lose all of that.

Ms TRISH DOYLE: Ms Sareen, do you want to make a comment on that?

BHAVANA SAREEN: Yes. I think, as a first point of contact, it's amazing to have telehealth because it can be reached right at the home. But, in the long run, it would not be adequate, because assessing a child in person, to just the parents saying what's going on—and the health practitioner is unable to see, or an expert unable to see the child, exactly what's happening at that point—would not give an adequate picture of what's going on with a child. So, as a first point of contact, amazing, because it had helped during COVID, where we just could not go, to a point where right now the parents may not be able to go because of family commitments, because they can't travel, whatever—amazing. But eventually it has to be face to face. It has to be where the practitioner is seeing the child.

Ms TRISH DOYLE: Not standalone.

BHAVANA SAREEN: Yes. It can't be standalone. For the rural community, I understand it would be amazing, but eventually it would have to be where either the health practitioner is going to this community or somehow the community is able to come to the practitioner.

Ms TRISH DOYLE: Fair enough. Emily, did you want to make a comment?

EMILY CASKA: Probably just echoing that. We have feedback from our regional and rural families, through our PlayConnect program: "If it's telehealth or nothing, we'll take telehealth." And I'd probably go further, not just even as a first step. It is good there as part of a complementary ecosystem, but the other three prongs I'd probably add to it, not surprisingly, is connection with a playgroup, some sort of mobile servicing of that area, absolutely, and then, potentially, if travel is needed, how can we support those families to travel to the centre—if you take the four together. But I do think that telehealth—our families tell us it is a really powerful resource in regional and remote because they are getting at least some sort of timely access. But agree with the points too: There are some caveats around that, about the depth and, probably, reliability of that assessment and also, if you think about it, a potential unintended consequence could be then, in that local area, if telehealth does become the main, then the expertise of that workforce in the area would, by virtue, be depleted over time as well because they wouldn't be seeing those families because they're going to the telehealth option.

Ms TRISH DOYLE: I'm just interested in this not only from the sort of professional perspective and how it impacts what we're looking at and access to childhood checks and the development and the monitoring of that development, but my son works with Ambulance, and he's just been developing a sort of a telehealth virtual health model for his colleagues out in rural and remote areas. The feedback initially is how positive it's been with children. On one hand, I think, "Is it because they're always looking at screens?" Or is there something in the model that we can pinpoint to say this works well? But I think the point that you made, Bhavana, is it has to be supplemented with the face-to-face and that ٣D viewing of a child. And, particularly with communication with CALD communities, it would be a bit tough if you only relied on the telehealth model.

BHAVANA SAREEN: Because you can't make connections over the telehealth, and the connection is really important to understand what's going on with a child.

EMILY CASKA: And our families tell us that it works for children in some ways because they're in the home environment. They're not being taken to the doctor's surgery, so they're a bit more relaxed. In some ways you can get a deeper assessment seeing them in place, and also our families like it because, to my earlier point, they can access it out of the traditional hours, particularly for working families. It does give that, which generally in regional and rural communities do have the shorter hours.

Ms LIZA BUTLER: Thank you, everyone, for giving up your time today. I know how valuable that is. Ms Caska, you spoke about soft entry points and taking services to families in a mobile service, and that people living in regions are more likely to be connected to a playgroup. How are you currently doing that? How are you currently taking those services to the regions?

EMILY CASKA: Allofourregionalservicesweauspicewithlocal, well-recognisedlongstanding organisations, sowedon'tdotheoverlayfromSydney. Weprovidethem, wepartnerlocally, weinvestloca lly alsowithACLOsaswell. We'relookingatthosepartnerships, sowegoinlocal, keepitlocal. Isupposewe're morethepeakbodygoverningentityandthenwesupportthemwithcapacitybuilding, practiceguidancea nd someconsistencyacrossourplaygroups, andalsosharebestpracticesof, "Hey, thisworkedhere, sowew ork reallywellwiththelocalcommunity. Also, theadjunctto thatiswe resupportingemploymentinregionala ndrural areasas well.

Ms LIZA BUTLER: Isittheplaygroupitselfthatdecideswhatkindofservicethey'dliketohelpthe mumsin that playgroup?

EMILY CASKA: Yes, verylocallydriven. Butthereisaplaygroupfacilitatoroverlayingthatthatwe providethatcoordinatorandlead, soit'sabittwo-way. Wewillalsomakesoftsuggestionsofthingstheymight like tothinkabout, becausepeopledon'tknowwhattheydon'tknow. Butit'sverylocallydrivenintermsofthe demandandtheparticularnuancesoftheplaygroups. That'sthebeautyofthem. Wehavesomethatarevery specifictoparticularlanguagegroups, veryparticularFirstNationscommunities, veryparticulardisability diagnoses, andthenthatdriveswhatthatplaygroupdoes. Wecertainlydon'tcomeatitwithacentralisedapproach. It's reallyimportant.

Ms LIZA BUTLER: Mynextquestionistoallofthepanel. Weheardearliertodaythatthereseemsto be a lackofcoordinationbetweendepartments, soorganisationsareworkinginsilos. Couldyoucommentonthat and maybeofferwayswecanimprovethat?

ELIZABETH DENNEY-WILSON: Clearlyweneedmorebiculturalworkers. Clearlyweneedmore translationservicesthatareco-locatedwithchildandfamilyhealthservices. Weneedthemtobereally specificallytailoredtocommunitieswherethere'sahighconcentrationofmigrantsfromdifferentareas. Again, I guess I'mnotanexpertonhowtheseservicesarefunded, butitjustseemsreallyclearthattheyneedtobe availablerightfromthestartofaprogramallthewaythroughtotheactualcarewiththefamily. Theyneedtobe involvedintermsofdevelopingtheresources, thematerials, thelanguageandtheinterventionsbecauseweneed to makesurethatallofthosethingsareculturallyappropriaterightfromthestart—soinvolvementrightfromthe beginning, not just at the point of consultation.

BHAVANA SAREEN: CanIclarify? Whenyousaythedepartmentsarenotcoordinated, couldyou just elaborate?

Ms LIZA BUTLER: Weheardearlierthatthere'salackofcoordinationbetweendepartmentsand community organisationsandthehealthcaresector.

BHAVANA SAREEN: Okay, soalackofcoordination?

Ms LIZA BUTLER: Soyou'reworkinginisolationratherthanbeingacoordinatedgroup.

BHAVANA SAREEN: Everyorganisationhasitsownagendasthattheyarefollowing. Tofinda common ground is somethingIbelieve—sorry, canItakeitonnoticeandgetbacktoyouonthis?

Ms LIZA BUTLER: Sure. Absolutely.

BHAVANA SAREEN: Ihavenotreallycomeacrosstoomuchnon-coordinationassuch. Ihavefelt everyone has worked together. Butifthishasbeenstatedandthereissomethingthat Ihavemissed, Iwouldlike to take it on notice and get backtoyouguys.

The CHAIR: It's reallygoodtohear, though, thatyourexperienceisthateveryoneisworkingtogether well.

Yes, when we asked BHAVANA SAREEN: anyhelporcoordinationwithanyother department, they have been verywillingandhavedelivered. Ihadnotcomeacrossit, sounfortunatelyIcannot answer that question, but I'll takeitonnoticeandcomeback.

EMILY CASKA: Weexperiencethesilosacrossdifferentdepartmentsandthenacrossthedifferent levels of government, and that doescauseconfusionforfamilies. IfIparticularlynarrowdowntowhenthechecks are done, if there is a disability, thenyougointoNDISland. Thereisprivatepractice, yourlocalhealthdistrict and the PHN. There are a lot ofpeopleinvolved. Wedofindthatinregionalareasweseemtocollaboratealot better, generally, because of thatcommunityapproach. MaybeI'moptimisticherebutIdothinkthatthenew Foundational Supports model cominginwiththeNDISreformswillmakethisareabetterforchildren.

I particularly like the proposalofhavingsomesortofnavigationcoordinatorsupportforchildrenand families, and bringing the departmentstogetheralotmore. We'vebeenworkingonthatwithDisability, Health

and Education at the moment. Even in the consultstoday, Healthistheonethatfamiliesintheseearlyyearshave the biggest interface with, so we need to bringdownthosesilos. Thatpresentsuswithanopportunity, and New South Wales is definitely leading the wayinimplementingthat, fromourmeetingswiththeMinisterhere last year. That was a great start, and I think thatthat'soptimistic. Butthebarriersaredefinitelythere. Evenamongst us as community organisations, we almost playthatquasinavigator/connectorrole, whichisgreat, butitdetracts us from our core business, because we do it tosupportthefamilies. Butthosesilosarethereanddefinitelyreal.

Ms DONNA DAVIS: I was very excited, Professor Denney-Wilson, whenyoumentionedtheword "breastfeeding", because it's the first time in theinquirythatthewordhasbeenmentioned.

ELIZABETH DENNEY-WILSON: Icouldtalkaboutitallday.

Ms DONNA DAVIS: Frommypersonalexperience, itwastheearlyinterventionthathelpedsupport me tobeabletobreastfeedmyfirstchild, eventhoughallthenaysayerstoldmethatitcouldn'thappen. ButIwas determined. I thank you all for being here; it'swonderful. I'm very excited about the fact that we're in Parramatta today. Everyoneknows I'm alwayscarryingonabout Parramatta. But it'sgreat to be ableto haveyou here and to hear all your expertise. I would like to talk about breastfeeding and the connection between what I perceive as a reductioninthenumberofmumsthatarebreastfeedingandhowyouthinkthatcorrelateswiththeservicesorlack of services being provided with the blue book now. I know that, Professor, you mentioned that there is no requirement or encouragement to attend a service between six and ١٢ months. I want to talk about that secondly. But if you could talk alittle bit about theblue bookin relation to breastfeeding, I'd be veryappreciative.

ELIZABETH DENNEY-WILSON: NSWHealthhas, foralongtime, hadaverystrongcommitment to encouragingandsupportingbreastfeeding. WedohaveverygoodinitiationratesofbreastfeedinginNewSouth Wales, but wehaveveryearlydrop-offintermsofwomenceasingbreastfeeding. Oftenparentswillstop breastfeeding and commence formula feeding without consulting a health professional. That, I think, speaks to access, and itmightbeaboutmorethanjustbeingabletogetanappointment—anditmightbeaboutbeingable to get an appointmentinlanguage. Certainly, breastfeedingisfrontofmindforchildandfamilyhealthnurses. They are oftenalsolactationconsultants, butalsohaveaccesstolactationconsultantserviceswithinthelocal health districtsinthatearlyestablishmentstage. Thereisawholebunchofthingsthatweneedtodoasa community tohelpwomentobreastfeedforlongerandtobreastfeedexclusivelyforlonger. NowI'velostmy train of thought.

Ms DONNA DAVIS: Wecancomebacktoyou.

ELIZABETH DENNEY-WILSON: Youwantedtoknowspecificallytothebluebook, didn'tyou?

Ms DONNA DAVIS: Yes.

ELIZABETH DENNEY-WILSON: Ithinkthereislotsofsupportwithinthebluebook, butweneed more. We need women to beabletoaccesshelpandsupportwhentheyneedit, ratherthanpoppingofftothe pharmacy and being told, "Hereyougo. Here'sthesolution."

Ms LIZA BUTLER: CanIjustinterruptforaquestionbeforeyougotoanothertopic?

Ms DONNA DAVIS: Iwasjustgoingtoasktheothersfortheirviewonthat. Bhavana, doyoufeelthat in language is an issue withmums?

BHAVANA SAREEN: NotwiththeparentsthatIhavebeenworkingwith, becausethey'reallcoming from migrant communitiesandCALDcommunitiesand, usually, breastfeedingisthewaytobe. Buthowlong would they be doingit, that'sacompletelydifferentsituation, dependingonwhetherthemotherhasthecapacity to breastfeed. I wouldhavetoalsotakeupwiththislactationconsultantandthelackofknowledge. Ithinkthat's the biggest challenge. Let'ssay, forafirst-timeparent, theydon'thavearulebookthatthey'regoingtofollow. What's the first pointofcontact? Itwillbethedoctorsandthenursesthatthey'recomingacrosswhenthebabyis born. A blue book isgiventotheparentandtheysay, "Followit." Apersonwhoiscomingfromamigrant community, who hasjustcomehere, doesnothavethelanguageanddoesnotunderstand. Forher, thebluebook is just another bunchofpaper. It'snothingelse.

Not havingthatcommunicationbetweenthehealthproviderandtheparent—maybeintheirlanguage, maybe a peer supportgroup, amulticulturalsupportworkerorwhoeverthereis—tohelpthemunderstandwhat this is going to doforthemandtobeabletofollowthat—unlesstheyunderstandwhythisisimportant, they're not going to follow. It'sassimpleasthat. Thatalsogoesforbreastfeeding. Forpeoplecomingfromcountrieslike Syria, Afghanistanorevenfrom India, alactationconsultantisnotathing. Nothavingtheknowledgeaboutthese kinds of things andthatthesehealthprofessionalsareavailable, theyarenotgoingtogoforthem. Havingthat conversation withinthecommunityisreallyimportant. Involvingpeersupportgroupsisreallyimportant. As I said, breastfeedingisanorm. Withinmyplaygroup, Iseemumsbreastfeeding. Itissomethingwhichis

acceptable and is a norm. Buthowlongwouldtheybebreastfeeding—andlet'ssayiftheyarefacingany difficulties and knowingwhotoapproach—that'sacompletelydifferentthing.

ELIZABETH DENNEY-WILSON: MayIalsoaddthatinourresearchandinourexperience, starting that conversationantenatallyisabsolutelyvital. Youcan'twaituntilthebabyishere. Antenatalsupporttendsto help switchmumsfrom"I'llbreastfeedifIcan"to"Iwillbebreastfeeding." That'sabsolutelyessentialaswell.

EMILY CASKA: I'mgoingtotakemyPlaygrouphatoffandwearmyDownsyndromehatnow. It speakstothepointaboutsupportandknowledge. Wehearfromourfamilies—I'vebeenintheDownsyndrome worldfor٢٠years—thatlactationconsultantsingeneralseemtohavereallydippedoff. Mymum, whohassix kids, hassaidthattoo. Itspeakstoantenatalcareaswell. AllDownsyndromebabiesarebornwithhypotonia. Theyneedspecificbreastfeedingtechniques. Thatsupportandknowledgeisn'tthere. Again, becausethey're beholdentowhatisarelativelygenericbluebookthatdoesn'tspellanyofthatout, theycometoassociationslike myformeroneandtrytogetthatsupport, butthereisnoexpertiseoutthere. That'sreallydiluted, sowe'reseeing a lotofbabieswithDownsyndromenotbeingbreastfed.

FrommyownpersonalexperienceofwhenIwasbreastfeedingmysonandhowitintersectswiththe checks, ceasingbreastfeedingdoesn'tseemtothenbeadevelopmentalindicatorofmaybeweneedtocheckinas to why. Iwasdoingallthemilkandtheoatcookiesandtheapricotsandthefenugreekandallthethingsand stayingupallhoursanditdidn'twork. Literallyeveryonewaslike, "Oh, well, youtried, doll." "Actually, whatwe foundout١٠monthslaterwasthatthatwasasignoftonguetie. Thatcouldhavesavedusawholeheapofspeech investmentandotherthingsandIprobablycouldhavecontinuedtobreastfeed. Butitwasn'tseenasa developmental checkof"Maybe we need to checkin."

Ms DONNA DAVIS: Wespokelastweekabouttheseearlychecks, likewithmyownsonandhislack of sucking reflexandthenthatconnectionwithautismlateron. Ifyouhavetheseregularchecks, peoplecancheck this stuff out earlier. Sorry, Heilok, didyouhaveanythingyouwantedtoadd?

HEILOK CHENG: No.

Ms LIZA BUTLER: Onthesamesubject, weusedtohavetheNursingMothers'Associationbackin my day.

ELIZABETH DENNEY-WILSON: Westilldo. TheAustralianBreastfeedingAssociationiswhatit's called now.

Ms LIZA BUTLER: I'm still connectedwithalotofthosemumsthatwereintheNursingMothers' Association when I was. You would sit aroundandtalkaboutallofthesethingsandthenyoucouldgethelp. There was help on the phone and there was lactationhelp. Isthatstillathing?

ELIZABETH DENNEY-WILSON: TheAustralianBreastfeedingAssociationisstillgoing, andgoing strong. They have, like a lot of places, adaptedtheirmodel. Certainly, whenIwasbreastfeedingmykids, wemet in people's homes.

Ms LIZA BUTLER: Yes, that's whatIdid.

ELIZABETH DENNEY-WILSON: Itrainedasacounsellor. Thatmodelhaschangedinthatpeople now meet in libraries and in cafes and in placesthataremorepublic.

Ms TRISH DOYLE: You can get astickerforyouroffice, too, towelcomebreastfeedingmothers.

ELIZABETH DENNEY-WILSON: Yes. Thatwouldbegreat—"Breastfeedingwelcomehere".

Ms TRISH DOYLE: I've got one ofthose.

ELIZABETH DENNEY-WILSON: The٢٤-hourhelplineisstillaround. Theyhaveaverygood website to support mums. It's one of the recommendedresourcesinthebluebook.

Ms LIZA BUTLER: The NursingMothers'Associationusedtocomearoundtothehospitaland introduce themselves to you when you had justdeliveredyourbaby. Nowyoutendtoleavehospitalwithin٢٤ hours, so you may not be connected with as manyofthoseorganisationsasweusedtobe.

ELIZABETH DENNEY-WILSON: That'spossible. Buttheycertainlyareoneoftherecommended resources.

Ms DONNA DAVIS: Going backtowhenyoumentionedthatthereisnorecommendedbluebook check between six and ١٢ months, can you provideacasestudyorexamplesofpoordietandtheimpactthishas on babies and children longer term because ofthefactthatwedon'thavethosechecks?

ELIZABETH DENNEY-WILSON: Absolutely. ThereareacoupleofthingsI'dliketomentionabout that six to ١٢monthsoflife. Oneofthem—andthisisHeilok'sareaofexpertise—isthatteetherupt. Wereally need to starttoemphasiseearlydentalcare. Therewasareallylovelycasestudyinthefirstgroupthismorning that I wouldreferyoutointermsofteeth. Thatcouldn'thavebeenbetter. Oneofthethingsthatisariskfactorfor child obesityandisaverystickyriskfactorintermsofbeingdifficulttoreverseisrapidweightgaininthefirst year of life. Ittendstoreallypresentitselfinthatsecondsixmonths. That'swhenaregulargrowthand developmentcheckwouldidentifyachildwhoiscrossinggrowthcentiles. Thatwouldbeanopportunitytoreally dig into howthechildisbeingfedandhowyouarefeedingthem—areyoufeedingthemresponsivelyorareyou forcing themtofinishthatbottle? Areyougivingthemtop-upsafterthesolids? Areyouoverfeedingthatchild? Also, whatareyoufeedingthechild? Howisthemilkbeingprepared? Whatkindofsolidsisthebabygetting? How frequently? Whatportionsizes? Allthosesortsofthings.

Ababythathasrapidweightgainismuchmorelikelytobeoverweightoraboveahealthyweightasa toddler. Thelongeryouhavethatexcessweight, themorelikelyyouaretokeepthatexcessweightandstartto developthekindofhealthproblemsthatweseeassociatedwithchildobesity. Thesearethingsthatyouwould typicallyseeinadults: riskfactorsforcardiovasculardisease, type٢diabetes, andthereisathingcalledfatty liver. Buttherearealsopsychologicalproblemsaroundself-esteemandbullying, andalsothingslikethewaythe skeletondevelopscanbeaffected. Wewouldreallystronglyadvocatethatrapidweightgainisidentifiedearly and nippedinthebud, becausewedon'twanttoseeanincreaseintheapproximately٢٠percentofkidswhoare already above ahealthy weight entering school—so in thosepreschool years.

BHAVANA SAREEN: WhatIhavenoticedwiththeparentsistheeaseofavailabilityofjunkfood.

Theparentsaretimepoorbecausetheyhavesomanycommitments. Ihavetomakethestatementthatin Australia welivebythetime, literally, soeveryminuteofourtimeisdedicated. Wehavegottodothisandwehavegotto dothat. Thatmakestheparentstimepoor. Iftheparentistimepoor—theyhavemorecommitments—theyarenot goingtobesittingdownmakinghealthyfood. Theywillgivethechildwhateveriseasilyaccessibletothem, and mostofitisjunkfood. Thereisnonutritionalvalueinthat, thoughitmightstateonthewrapper, "Yes, it's amazing"—butit'snot. That'soneofthethingsIhavenoticed. Theparentsarefeedingtheirkids—it'snotthat they want to, it'sjust because it'seasy.

Also, wetalkabouttheneedtohavethreeservesofvegiesandeverythingforthechildren. Now, ifwe lookatthepriceofthevegetablesthatareavailable, theparentsarenotreallygoingforitbecausetheycan'tafford it. It'salsothefinancialaspectofit. I'venoticedthattheparentsarenotgoinginforthingsthattheyshouldbe feedingthekids. Idobelieve, sometimes, parentsdooverfeedtheirchild, asyoumentioned. It'sbecauseI'mdoing somethingandthechildisbotheringmerightnowbecausehewantstoplayandIcan't, soletmegivehimsome foodwithascreen. Again, thisiswhatiscausingotherthings. Thereareamultitudeofthingswhicharecausing weightgain—andwe'retalkingarapidweightgainthatishappening. It'saverycomplexissue. Ican'tjustsay, "Thisisit", or "Thisisthe way that it shouldgo", or "Thisisthe way."

Also, theparentswhoarecomingfromoverseasdohavecertainfoodgroupsthattheytendtogoto. Let's say, eveniftheygotoanutritionist, dotheyunderstandtheirfoodpreferences? Thereisagapthere, too, where people coming fromdifferentcountries wouldhave adifferent way offeeding. I know, from my ownpersonal—whenmybabieswereborn, mymumwouldsay, "Givethemthis"or"Givethemthat", butwhenI'mtalkingtoa nurse, shesaid, "No, that'sgoingtocausemoreissues." SonowI'mstuckbetweenmymumtellingmesomething and I'mthinking, asafirst-timeparent, "Idon'tknowwhotolistento." Itisaveryhardplacetobeinfora first-timeparent—oranyparent. Itdoesn'tmatter. Evenifyouhavethreekids, you'llstillstrugglebecauseeach and everykidisdifferent.

EMILY CASKA: TheonlythingI'lladdisaboutthemilestonesingeneralandthechecks. Ithink there'saneedtoproperlyseparatetheimmunisationschedulefromthedevelopmentalchecks. Ireflect, personally, thatIdidtheimmunisationsandIgotfollowedupifIdidn't, butifImissedthedevelopmentalchecks—sometimes I'djustgoinandoutofthenurse—theydidn'treallyfollowmeuponthat. ButwhenIlookspecificallyatthat six-to١٢-monthtimeframe, whetheritisobesityoranyotherriskfactor, Ithinktherearealotofthings particularlycollidingthere. Ithinkwe'relookingat, obviously, forobesity, theteethandthecombinationofsolids and milk and/orformula.

Butalso, ifyoulookattheparentalcapacityside, Ifeellikeatthesix-monthmarkyou'restartingtocome outofthehazeandyou'restartingtofindyournormaltempooflife, whereasthoseearlydaysarejusthectic. It's notamazingattimes, andyouare, Ithink, inquiteafrequentrigourofimmunisationsandchecks. Ifeellikeyou're therealot, andthenitdiesoff. ButIthinkthere'salmostlikethatlifestylecheckneededinthatsixto١٢months inparticular—Iwouldargueprobablymoreregularlythroughoutthedevelopmentalchecks. Sometimesthat's whereparentalleavehasstartedtodieoffaswell. Someparentsareconsideringthereturntowork. Ithinkwe

need to separatethedevelopmentalcheckfromtheimmunisationcheck. I'llbehonest, evenworkinginthisspace, I thoughttheimmunisationwasthecheckaswell, andsometimesIwouldn'tdothetwotogether.

Ms TRISH DOYLE: I'vebeenlisteningwithinteresttoo. Thereissomuchreferencetomumsfor obviousreasons. We'veallbeenreflecting. I'msureyouhavetoo, MrChair, onhavinglittlechildrenandhealth checksandaccesstoservices. Inthecaseofmysecondchild, itwasdadwhowenttotheplaygroupandwasn't particularlywelcomed, anddadwhowenttogetsomeofthechecksandwaskindofscrutinised. Wetalkedinthe previouspanelaboutthefactthattherearedifferentculturalunderstandingsofwhatchilddevelopmentis. But I'm surethat'salsogenderedunderstandingsordifferentunderstandingsfrommumanddadandfamilies. Canyou expandonsomeofthat—whereaccessislimitedorthereisnoaccessortherearefamilieswhorefrainfrom reachingoutforwhateverreasonbecausetherearejustdifferentculturalunderstandingsofwhatchild developmentis? I'minterestedparticularlytohearfromplaygrouptooabouthowmanydadsareinvolved—just as anaside. Butitsortoffeedsintothatideaofwhatishealthychilddevelopment. Imightstartwithyou, Bhavana.

BHAVANA SAREEN: Weseeveryfewdads, really. Thatcouldbebecausetheculturalcommunityfeel thatit'snottheman'srole, thatit'ssomethinglikeagenderassignment, thatonlywomenormumisgoingtobe doingthiswiththechildandthatdadsarenotreallyinvolved—becausebeingapatriarchalsociety. Butthefew dadswhohavecomeinwereonlycominginbecausethemumwassick. Itwasnotthattheywantedtobethere. Andalsothefactthattherearenodadgroups. Thatalsoaffectsitbecause, ifthemajorityofpeoplethereare womenandjustonedadinthere, theyreallycannot—it'snotthattheycan'tcommunicate. It'sjustthattheyfeel reallyawkward, reallyweirdtocommunicatewitheachother. Theymaynotbefreeortheymaynotbe comfortable talking about things. I havenoticed that.

Inmyownorganisationwehavebeentalkingaboutencouragingmoredadsormaybehavingdadgroups, so encouragingdadstocomeintosee, becausewehaverealisedthatbringingupthechildhastobebothparents. It cannotbejustoneparentbeinginvolved. Becausethat'sjusttoomuchpressureonone. Anddadnotknowing what'sgoingonwiththechild, becausewhatIhavealsonoticedis—let'ssaythechildhasdevelopmentdelays. If the dadhasnotseenthechild—or, rather, it'snotthattheyarenotseeingthechildbutthey'renotseeingtheissues involvedwiththechild, becausetheysay, "It'sasmallchild. He'llgrowoutofit"—andthey'renotunderstanding or they'renotgoingtoahealthcheckoradevelopmentalcheck, theydon'tacceptit. Thenon-acceptanceofa diagnosisisanotherissuethatI'venoticed. Bringingdadintothefoldisreallyimportantandthatiswhatwehave been talkingaboutwithinourorganisation—astohowtoencouragedadstocomein.

Ms TRISH DOYLE: Haveyoucomeacrossdifferentfamiliesanddifferentunderstandingsofwhat healthy childdevelopmentisdependingonwhattheculturalbackgroundis?

BHAVANA SAREEN: MostofthefamiliesthatIcomeacross—again, I'llkeepreferring, becausethey are all SouthAsiansideoftheworld. Theunderstandingisdadsarenotreallyinvolvedineverydayupbringing of the child. Theymaybeinvolvedintakingthemto—Imean, Ihaveonlyseenmumstakingthemtoparks. Ihave hardly seendadsinvolvedinthat—veryfewdads. It'squiteunfortunatebecausecomingback—again, I'mfrom an Indianbackground. Mydadwasnotinvolved. Evenwithmyhusband, Isawthathewasnotinvolvedeven though hehadbeeninAustraliaforagood٢٠, ٢٥years. It'saculturalthing.

Ms TRISH DOYLE: Onthatpoint, leavingasidemumsordads, atthemigrantresourcecentredoyou often havedifferentfamiliesthatcomeinandtheyhaveadifferentunderstandingtothemodelsandthesystems of what isconsideredhealthychildhoodchecks? Isthereabitofaclashtheresometimeswiththe CALD communitiesand the system?

BHAVANA SAREEN: Ithinkthereisalackofknowledge, really. Theyfeelifthechildisokay, running about, eating—allgood. Ifachildisnaughtybecausehe'sdisplayingsomebehaviours, that'sbecausethechildis naughty. They arenotreallyunderstandingit. Evenifithasbeenconveyedtotheminaverysoftapproach, they still do not want toacceptthat—"Itcannothappentome". It'sassimpleasthat. So, yes, thereisahugedifference.

Ms TRISH DOYLE: Didyouwanttocommentonthatquestion, Emily?

EMILY CASKA: Yes. Ithinkthatthegenderrolesexist. We'dberemissnottosaythat, butIdothink that there are some leversinplaceandsomethingsthatwe'redoingtobridgethatgap. Idothink, asanoverarching structural lever, the changestopaidparentalleavehavehelped. Dadstellus, "Icannowgotothetherapyand support at home." So thathasbeengreat. Fromourserviceperspective, buildingparentalcapacityisthatother lever that we as playgroupsaretryingtoinfluence.

This Saturday, actually, I'mgoingtoRosehillforadads'teddybears'picnic. It'sonaSaturday—sothat tells you something—outofworkhours. Again, it'sthatsoftentrypointfordads. Ithinkthrustingthemintoa check environment or abreastfeedingclassmightbeabigstepforsomeofthem. Butifwecanengagethemina playgroup that's specifictodads—again, localisedintheirlocalarea—thenwe'refindingthatthat'sgreat. Sothat's

an emerging area for us, definitely. As part of that, we will bring in things like 'What does healthy childhood development look like?' They're not just sit-and-learn sessions.

I think the other lever that we can pull, not necessarily just at Playgroup NSW, but systemically, is that attitudinal barrier—things like putting dads in more of the campaigns around early childhood development checks. I'd love to see a bit more research into showing the benefits of dads being involved in that space, not just for the child but for family capacity, mental health, getting women back into the workforce and the benefits to the dads themselves as well. I think that's a lever that I'd like to see some investment in, and we would love to help with that, given our reach. I also think that, again, probably speaking to that antenatal stage, self-reflecting as well—the language that we give, which parent we speak to about these things, and engaging dads nice and early in that space as well, and just being conscious of that.

Ms TRISH DOYLE: Did you want to comment, Elizabeth?

ELIZABETH DENNEY-WILSON: There is certainly longstanding research around the importance of the support of the other partner around breastfeeding. There's a real emerging area of interest around the role of fathers, in research, in infant feeding activity, sleep and play. That's an area of research that's really taking off.

HEILOK CHENG: I also wanted to add, on your question about cultural expectations of health, child and family health nurses are working in culturally sensitive ways. For example, some cultures might not expect the child should be crawling around on the ground because the ground is dirty and cold. Nurses will be working with parents to engage them in terms of what a child should be doing at that age, but that does need more engagement time. If they do want more time to work outside those scheduled checks, it works on an individual basis within their local health service in terms of can you have those extra checks. That's related to staffing and time.

Ms TRISH DOYLE: That's a good point, Ms Cheng—staffing and time to actually explore a little bit further, rather than just tick boxes.

ELIZABETH DENNEY-WILSON: Indeed, yes.

The CHAIR: We literally have just a couple of minutes left. In ٦٠ seconds or less, is there any final comment that anybody would like to make?

HEILOK CHENG: There's a shortage of child and family health nurses in the Australian workforce, noted by the Federal Government. Improved staffing in local health districts would help with addressing health and development checks locally.

ELIZABETH DENNEY-WILSON: We need more bicultural workers. We need more support on the ground so that we can deliver evidence-based obesity prevention programs that would also incorporate healthy growth and development checks.

BHAVANA SAREEN: I feel that training people who are working with the families—they may not be health professionals. But training them up to be able to identify things, to be able to talk—and obviously more multicultural people in the workforce—would be really great.

EMILY CASKA: I think my thing is probably just repeating that peer-to-peer support and capacity building is critical—delivery in place and maybe some flex around out of hours, because it also helps to address the engagement of dads and others in that space. I definitely think that soft entry points—not a surprise—are really key, not just in playgroups but in anything. Like I said at the start, this inquiry's looking at the checks themselves, but looking at the before and the after of that check, and the support and the knowledge that sits around that. Then to my earlier point regarding the milestones within those checks, I would advocate for those to be reviewed so that we are getting in a bit more frequently and a bit earlier, even if some of those are a quick telehealth call—even for metro, it's great for us metro ones too—so just reviewing those softer touch points.

The CHAIR: Thank you all sincerely for appearing before us today. You will be sent a copy of the transcript for correction. We will also email to you any questions that have been taken on notice, so you don't need to worry about that. We will send those questions out to you. The Committee may also develop some supplementary questions that we will send to you in addition to that. My sincere thanks for spending some of your precious time with us today. Your expertise has been greatly appreciated and entirely enlightening.

(The witnesses withdrew.)

(Luncheon adjournment)

Mrs RITA FENECH , Executive Support Manager, Tresillian, sworn and examined

Ms ALISONWALLBANK , Clinical Nurse Consultant, Child and Family Health, Tresillian, sworn and examined

Mrs MORGAN FITZPATRICK , Co-Chair, Early Childhood Intervention Best Practice Network, sworn and examined

Ms KYLIE STREATFEILD , Co-Chair, Early Childhood Intervention Best Practice Network, sworn and examined

Mrs LAURA FARAJ , Partnerships and Policy Lead, The Hive Mount Druitt, United Way Australia, affirmed and examined

The CHAIR: I welcome our next set of witnesses. Thank you so much for appearing before the Committee today and agreeing to give evidence. Please note that the Committee staff will be taking photos and videos during the course of the hearing. The photos and videos may be used for social media and public engagement purposes on the Legislative Assembly social media pages and websites. Please let the Committee staff know if you have any objections to having photos and videos taken. Before we start, do any of you have any questions about this hearing process we are about to embark on?

RITA FENECH: No.

ALISON WALLBANK: No.

MORGAN FITZPATRICK: No.

KYLIE STREATFEILD: No.

LAURA FARAJ: No.

The CHAIR: Before we start with our questions, would any of you like to make a brief opening statement?

LAURA FARAJ: I'll make a brief statement. Firstof all, thank you to the Committee for the invitation to be present at this inquiry today. I am the Partnerships and Policy Lead at the Hive Mount Druitt. I have been part of the team in that community for eight years, and I have taken the lead role in implementing and advocating for our child health initiatives. At the Hive Mount Druitt, we're a small, place-based early years initiative. We are hyper-focused on the Mount Druitt postcode in Western Sydney. We take a collective impact and ecological approach, aiming to shift outcomes for children in an area of long-term developmental delay and disadvantage. We focus on supporting families to access early education and child health services while also working with the early education and child health systems to advocate that they work differently for long-term changes for vulnerable families who face barriers in accessing the services as they currently stand.

Compared to some of the other larger organisations that have put in brilliant submissions in this inquiry, I hope our small but deep engagement with families in a vulnerable area of New South Wales and our innovative approaches, through child health-linker roles, in delivering two innovative, place-based child health programs will provide some useful ness to the inquiry in regard, particularly, to the first two points in the terms of reference surrounding understanding the barriers families face and some changes needed to address gaps and outcomes for vulnerable families. Everyday, we see that our families want the absolute best for their children. We really welcome the interest by the New South Wales Parliament to make these child health and development checks more equitable and accessible for those who stand to benefit the most.

KYLIE STREATFEILD: Thank you very much for having me at this inquiry. I am the CEO of the Orange and District Early Education Program. We're located in the Central West, regionally, of New South Wales. We service the three local government areas of Orange, Blayney and Cabonne. We provide early childhood intervention services and a mainstream preschool in those areas. We provide supportive playgroups and parent support groups as well. We see over ٤٥٠ children in those three local government areas. I am also the co-chair of the Early Childhood Intervention Best Practice Network. I'm going to hand over to Morgan Fitzpatrick, who is my co-chair, to give another introduction.

MORGAN FITZPATRICK: Thank you, Kylie, and thank you to the Committee and to the Chair. We appreciate the opportunity to appear today before the Committee. I would like to start by acknowledging the traditional owners of the land on which we are meeting as well and pay my respects to Elders past and present, including any First Nations people attending today. As Kylie said, we're attending on behalf of the Early Childhood Intervention Best Practice Network. We're a network of over ٢٠ early childhood intervention providers

that operate primarily in New South Wales but also have a footprint in Victoria and the ACT. Collectively, as not-for-profit providers, we represent over ٢٠,٠٠٠ children and young people a year.

I'm also the CEO of Koorana Child and Family Services. We operate in the inner west, south-west and southern Sydney areas. We've been providing services for nearly ٥٠ years, and that includes early childhood intervention, supportive playgroups and two inclusive preschools, soon to be a third inclusive preschool, which focuses on supporting children with additional needs. Personally, I'm a mother of two young children who have developmental concerns, at one and three. We're going through the system currently and have been through it in recent years, so I've got some personal experience that I'm happy to speak to today.

In terms of our submission, we have obviously put that in. We do have a couple of additional documents that we'd be happy to table at the appropriate time today. Our submission focuses on, as you know, access and gaps for vulnerable communities, in line with the terms of reference, and several recommendations around how to improve access in rural and remote areas, as well as for Indigenous and CALD families. We speak about barriers to routine checks and recommend a number of solutions in that space as well. Underpinning all of that is an emphasis on the importance of access to early intervention, particularly using the best practice guidelines, which are currently under review nationally for early childhood intervention.

We have recently put out a paper, which I can table now, if you'd like, to get it on record. We've got copies for the Committee. This is a paper that our network put out in May regarding the foundational support system that is currently under design nationally. It focuses on the needs of families that we see and the barriers to access and what the gaps are within the system. It's obviously relevant because things have evolved quite substantially since the time of our original submission.

I will also offer to table a model that our network has been working on to recommend access to a key worker under the transdisciplinary approach as soon as developmental concerns are raised. As you know, and as we talk about in our paper, there are so many families that are missing out, particularly those that aren't eligible for the NDIS or whose concerns are early on in that process who are missing out. We believe as a network that it would be incredibly valuable for those families to get immediate access to key worker and transdisciplinary support so they don't miss out on that early childhood intervention at that early point. I'm happy to take questions on that or talk through that in more detail as we go through questions today.

The CHAIR: Thank you. Over to Tresillian.

ALISON WALLBANK: I'm coming from a different lens, maybe. I'm the clinical nurse consultant for child and family health at Tresillian. I've worked with families for the last ٢٤ years as a midwife and a child and family health nurse. I've worked as a nursing unit manager in difficult or complex areas in the Sydney Local Health District, and I've also worked in Tresillian for last two years as their clinical nurse consultant. Working with families in that space gives me a lot of insight into what some of the challenges are around your inquiry on child health and development checks.

Also in my role I'm the vice-president of the NSW Child and Family Health Nursing CNC Network, which gives me a real insight into issues across the State for the child and family health nursing service. I also attend reflective supervision with some of my colleagues in regional and rural areas, which also gives me insight into the challenges that they face in those regional areas. I feel like I'm coming from a different viewpoint but I have some real understanding of what's happening on the ground in the child and family health nursing profession Thank you for the opportunity to come here. I have a very different perspective, I feel. Rita is going to talk about Tresillian as a service.

RITA FENECH: Tresillian's goal is ensuring that children get the best start. Improving access to early childhood health and development checks is only a small part of what we do. Tresillian would like to thank the Committee for the opportunity to respond to the inquiry and to platform the work of Tresillian for children and families across New South Wales. Our response is made on behalf of the Royal Society for the Welfare of Mothers and Babies, also known as Tresillian family care centres. We're a public health organisation, operating under an Act of New South Wales Parliament, which is positioned in a strategic area to influence long-term health outcomes.

Tresillian's brand is known as a national and New South Wales centre of excellence, operating within a larger health and welfare service context. We're well positioned to address critical state and national policy goals—in particular, early intervention and prevention services—to support healthy attachment relationships, provide tailored family support for optimum development in early childhood, and the delivery of wraparound parenting support. Today's families are indicating early difficulties to prevent problems from occurring or escalating to the need for protective action. Tresillian's objectives, first and foremost, are about children and their

best interests, withafocusonmattersofchildandfamilyhealth, earlyparenting, perinatalmentalhealth, health promotion and earlyinterventionandprevention.

Tresillian's guiding principle is to deliver the highest quality service to children and families, and to provide children withtheirrighttosafety, stabilityandhealthydevelopment. Tresillianalsoprovidesastrong framework that ensuresthequalityofserviceandcarethatisprovidedtochildrenandfamiliesofNewSouth Wales, Victoria and theAustralianCapitalTerritory. Ourguidingprinciplesfocusonavailableresearch, literature and best practice, whichwillcontinuallyinformourbestserviceandstrength-basedapproachwhensupporting families.

The CHAIR: Thankyouallsomuch. Whatadiverseandexperiencedgroupofpanellistswehave.

I start by emphasisingthatitisuswhothankyouforyourattendancetoday, becauseweareinyourhandsasto your experience andwisdominhelpingustobetterunderstandandwritethebestpossiblereportandsetof recommendations fortheGovernment. Wesincerelyappreciatethat. Tostartonapositivenote, inyourcollective experiences, what doyouseeasworkingreallywellatthemomentinthisspaceaboutmakingsurethat everyone—hopefully all children—have accessto the earlychildhood health anddevelopmental checks?

RITA FENECH: What'sworkingreallywellistheknowledgebaseinoursectorandtheabilityto support families in aholisticway. AtTresillian, wehaveamultitudeofprofessionsthatworkinasupportiveway. We also have partnersoutinthecommunity. Ithinkthatnotworkinginsilosisreallyimportantandthatweuse what other resourcesarearoundinthecommunity, andTresillianisverygoodinpartneringwithNGOsandother health services. Weusethatinarespectfulwayforfamilies, andIthinkthatworksreallywell. Itisimportant because of the limitedfundingthat'soutthereforjustoneservicetodoeverythingforfamilies. Wecanclosethat gap when we partnerwitheachother.

The CHAIR: Agreed. Wehavetobecarefulwiththewaythatwespendmoneyandwho'sdoingwhat. We don't want to duplicatethings, right? There'sonlyacertainamountofmoneytogoaround.

RITA FENECH: Exactly.

The CHAIR: Itisimportant. Thankyouforacknowledgingthat. MsWallbank?

ALISON WALLBANK: IthinkatTresillianwhattheydoreallywellisaccess. Whenwetalkabout child and family health services in general, families need to go through a really quite complex process to get access to our service. They have to ring a certain number, press a button. If you've got a family who don't speak English orhave difficultiesaroundhealthliteracy, that'sa barrier toaccessing service, and IthinkTresillian does that reallywellintermsofhavingaphonelinethat'savailablesevendaysaweek—٧.٠٠a.m.to١٠.٠٠p.m.—wherefamiliescanringandgethelptonavigatetheservicethattheyneed. Sometimesthat'sdirectingpeopleback to theirchildandfamilyhealthservice. Ijustthinkthat'sdonewellinTresillian, ifIthinkabouttheprocess. There's a lot of phone tag. Families are busy. People work. People are going back to work earlier than they were because of financial struggles in the home. Answering a phone call when they're at work—when, traditionally, our servicesoperateisinbusinesshours—istricky. So, yes, that'ssomethingthatIthinkisgood.

The CHAIR: Intermsofthatphoneservice, aretheremultiplelanguagesavailable?

ALISON WALLBANK: No, there'snot—well, inaway, yes, becausewecanaccessphoneinterpreters, just like any other NSWHealthservice. Wecancallthephoneinterpreterandthenwecanusethephoneinterpreter with the phone call.

MORGAN FITZPATRICK: Whenfamiliesareconnectinginwiththechildandfamilyhealthnurse servicing, I think that they're gettingagoodexperiencegenerally. Thegap, aswe'vetalkedabout, isobviously when they don't get followed uportheyfalloutofthatsystem. Butwhenthey'reinthatsystem, they'regettinga fairly holistic set of supports that'savailabletothem. Insofarasfamiliesareabletoaccessthatthroughthebarriers, I think they are getting a good-qualityserviceandthat'sworkingwell.

KYLIE STREATFEILD: IdosupportwhatMorgansaidthere. Particularlyfromaregional, ruraland remote perspective, when familiesareaccessingthechildandfamilyhealthnurses, aswellastheBrighter Beginning checks, children are gettingareallygoodholisticassessment, whichisgreat. Particularlyfromour preschool, the feedback that's giventotheparentsaswellaspreschoolstaffhasbeengoodandsufficienttobe able to support families.

LAURA FARAJ: I wouldhavetoechothoselastcoupleofpoints. Onceafamilycanaccessthechild health nursing service, they are gettingaverysupportiveassessment. Thosebluebookchecksarereallyhelpful for families who might not have thathighparentalhealthliteracy. It'sasimplewaythattheycanreadthrough. It's a simple yes or no. They may ormaynotdoitathome, butiftheydid, that'sgood. Iftheydoitwithanurse, that's a really quality service and asafeplacetogetthatinformation. Typically, again, theyhavethepathways

internally within NSW Health to be able to refer to speech therapy or occupational therapy. There are challenges with waitlists and things like that, but I think what is available is actually quite a holistic wraparound service, though it does have some barriers in that case.

The CHAIR: To ask that question in the opposite way—and we'll go back around—what is the glaring gap preventing families and children from accessing these health checks along the way?

I think that in community, there's quite a few. Being quite a challenging LAUREN FARRAH

geographical and social space, we often see just awareness of the checks, that they exist and they're not just for immunisations. You might remember your blue book when you first come home from the hospital, and then it goes in a cupboard somewhere and you forget about it. You might go to your GP to get your immunisations done, but the GP might not then do that thorough developmental check, so that then gets missed. There might be a lack of awareness of what that community health service can provide, as well as then there's trust barriers, particularly for communities of disadvantage, like the one that I'm representing today. There's a lot of fear about accessing a service, as well as practical challenges, such as transport, to be able to get there and bringing multiple kids along at the same time if you don't have any other care arrangements. They're some of the biggest barriers, I think, in getting in the door to that very first appointment.

For myself, being KYLIE STREATFEILD Aboriginal, in that regional, rural and remote, it's

around workforce challenges. In western New South Wales, there's very limited staff available, particularly allied health staff and early childhood nurses, to actually carry out the checks. Then, once child rengetthecheck, if they need to be referred on, there are very few allied health staff to be able to provide the services. Waiting length times, for some children, can be well over ١٢ months. Even to get on a waiting list is very tricky because a lot of services have actually closed their books.

MORGAN FITZPATRICK: I would echo what's been said so far. If I speak from a personal point of

view—having my first child in a metro Sydney area and then having my second child in a regional area—the thing that has been consistent for me in my own personal observation is great follow-up for that initial check in the first four weeks and then the six-week check. After that, it is very dependent on the parents initiating and following up and staying connected. Obviously there are many families who would prioritise that for all sorts of reasons: health, education and literacy, all the way through to that being a value of theirs. But there are many families where natural barriers will then come into that: They're back to work; they don't have the support; they don't have the childcare; they don't even just get the reminder. Maybe they're struggling in those early days and keeping up with even the appointment—at a very basic level, not having a reminder system can be a huge barrier.

The thing that has been consistent for me, both in my personal experience and observing professionally, is that follow-up after that six-week check—particularly for children and families where there are concerns identified. You presume through the questions that are asked that there's a risk assessment being undertaken. Even when you have children dropping down in terms of growth—both my children dropped from the nine tieth percentile, roughly, to fifth for one, tenth for the other, and we didn't have that follow-up after that point in time. You would think when you do have growth issues or developmental issues that there would be follow-up. I think the resourcing potentially doesn't allow for that, so I think at-risk families are falling off the radar of health services after that that point in time.

ALISON WALLBANK: I've got a lot to say, and I agree with everything you've all said so far. A couple

of things. Firstly, having a title. We don't have a standard national title for our profession. We're maternal child and family health nurses in Victoria and the ACT, and a child and family health nurse in New South Wales. We're often confused with midwives. It's a difficulty maintaining a profile in the community. So, number one, for families that may never have engaged with a service—if you think about families that may behave gone through the private health system to give birth, they might just drop off the system. They might never answer their phone and never connect with child and family health nursing at all.

No standardisation—I know this is changing, but our documentation systems at present sit within each LHD (Local Health District), which makes it difficult when families move to communicate with our colleagues in different LHDs. It's a problem for us in Tresillian when we sit across a multitude of LHDs, with that communication. Services being different within each LHD for child and family health nursing—so families without Medicare in some LHDs do have access to child and family health services. Others don't. They have to pay. That's difficult for vulnerable families. If you think about people who've come from overseas, they're fruit picking in regional areas, they have no Medicare, and then they have no access to health services, so no child and family health. Or they can pay for it, but it's not prioritised.

As you mentioned, the age of families being seen—despite the services supposed to be being seen from

zero to five, I've noticed in my role in Tresillian, in some regional areas, they've had to limit the age they can see families based on availability of staff. They are focusing on younger children and then the older children are being

culled or dropped out of the service. Some services offer immunisation; some LHDs don't. That's also something that is really valuable for families. When we think about GP services now charging for immunisation or appointments for children, that's a really great way to get families back into child and family health nursing.

Also, the changing role of the child and family health nurse—when you think about 'what did it use to look like', it used to look like focusing on keeping the well, well. There was lots of that anticipatory guidance around supporting families to stay at a certain level. But now we pick families up when things are not going well. They drop off and they come back in when things are really not going well. We have a decrease in universal service focus—that means our focus is really on what's happening with vulnerable families. That all takes more time. If you think about increasing case planning and management time, often holding families where the more specialised services just can't pick up families, there's lots of holding due to that lack of resources and lack of ability. They're at their capacity to support families.

Increased documentation and consultation—so case planning with external stakeholders. It all takes additional time and planning. Obviously, the more complex a family is, the more you need to document that, and that all does take time. Groups have been cut out in lots of the LHDs over prioritising vulnerable families. We know how valuable the new parents' group or mothers' group are. Most people recognise them as being important as part of child and family health nursing, but they've been culled in lots of LHDs because of—I think COVID happened. Groups were culled, and lots of the LHDs have not brought them back.

Multiculturalism—if you think about cultural and language demands, access to assessments and resources in other languages is a challenge at times. There are lots of people with low literacy or lack of knowledge. If you've got a child born overseas and you come to Australia with a two-year-old, how do you find out about the services that are available for your family to access if you're socially isolated? Difficulties collaborating with other services like GP services—child and family health services are sometimes seen as undervalued or maybe seen as competition in some LHDs.

The CHAIR: Ms Wallbank, that's an excellent list. Thank you so much. I'm going to have to interrupt there because I'm mindful of my other Committee members getting a chance to ask questions. By all means, if there's more of that list that you want to share with us at the end—or table it or email it through—that would be great because it's a comprehensive list.

ALISON WALLBANK: Yes, I'd be happy to.

The CHAIR: Ms Fenech, was there anything you wanted to add?

RITA FENECH: I think that was fabulous, don't you? They're all the things. What I would like to add is they're all the things that Tresillian highlight about what's difficult for families across our work across New South Wales, the ACT and Victoria. Very briefly, what we did do is we lobbied government and we received some funding for some early parenting mobile vans. We're taking our service for access to those families that cannot access services. We're parking in front of community health service centres and we're parking in front of preschools in those areas—for example, Kempsey—and they do a ١٠-kilometre drive for those families that have difficulty accessing. That's one of our strategies for transportation and access to our services. We are trying to address that long list.

The CHAIR: We have certainly heard about this mobile van/bus model being present in communities to build some of that connection—soft entry and all that.

RITA FENECH: It's purpose built—it has a cot in there—to work through with the goals of the families and whatever their needs are. They do those very important physical checks on the children—developmental checks.

Ms TRISH DOYLE: Thank you all for the work that you do. It's often not recognised unless you are connecting with those families that need it the most so, on behalf of the Committee, I thank you so much. A number of you talked about parental health literacy. What do you think we need to do to increase that parental health literacy, the understanding of the need for those early childhood checks and the uptake of different tools? Whether its the blue book, the steps before that or something that's wrapped around the blue book, what do you think we need to do?

RITA FENECH: Education's the key. Information-sharing is the key. How you get that out to families is so very important.

Ms TRISH DOYLE: Especially with vulnerable families and CALD communities.

RITA FENECH: Yes, antenatally and postnatally, there's your captive audience. In one of the jobs that I had, we trained volunteers to go into the antenatal clinics and the postnatal clinics and hand out paper bags. There was nothing untoward in them—

Ms TRISH DOYLE: A little show bag of information.

RITA FENECH: A little show bag. Mostly the dads were sitting in the waiting rooms because they're excluded from some of the actual checks and the important information they're asking the female carer about what's happening in their life, like DV screening et cetera. You capture the dads in the antenatal waiting rooms, and postnatally as well. That's important.

Ms TRISH DOYLE: So the whole family is engaged.

RITA FENECH: Yes, and if you capture them at that point in time—antenatally and postnatally—and they get that information of what services are out here, at least it's a start.

ALISON WALLBANK: I think we need to recognise the changing face of families. I don't think we've caught up in child and family health nursing with the way that families function. We talk about being father inclusive but I don't feel like we truly are father inclusive in the care that we provide. It's not recognising that dads play such a big part in families now—much more than they did traditionally. Yet, we still exclude them from services. We just don't take advantage. We are funded for one child and one parent. Actually, truly being father inclusive would be looking at 'What was your experience in childhood and what sort of a parent do you want to be?' We don't fully immerse them in that experience. We focus on mums. I think that is something that could change.

We need to recognise how families operate as well. They are on social media and they want access to that ٢٤ hours a day, seven days a week. I am sure all of you are on your local Facebook groups for where you live. I'm on my local mums group. They are always asking for parenting advice from each other—always. Sometimes someone will recommend accessing their child and family health service. Sometimes they'll go down a rabbit hole critiquing that, or encouraging it and supporting it. But I don't know how we in health get that social media presence so that we can be more available to families in the way that they are interacting these days. People have feedback fatigue, so we don't often get that feedback and true engagement with families.

Also, they're a parent of a young child for a very short period of time. They kind of move on. If you have a group in a hospital that's your community group that you are looking for feedback from, that changes rapidly in this area that we are talking about. Also, we need to recognise that some of our policies don't align with multiculturalism and the way families operate. If you think about the safe sleeping government policy, we don't recognise the fact that in the huge multicultural society we live in, co-sleeping happens. Yet, our policy doesn't support a discussion around co-sleeping at all. There is that trust building and transparency in working with families.

MORGAN FITZPATRICK: I think to increase that parental or developmental knowledge, it starts prenatally. Having had two children in the past few years, my capacity to absorb new information and really focus on that in those first early months of life, when we had other complications to focus on, was quite restricted. And I come from the sector. I have had ١٧ years in the sector. I've got a good level of developmental knowledge already. But having a prenatal course not only means that I come along but also, to your point, the fathers can come along, or the other parent can come along—reflecting the diverse nature of families these days. It is really important that both caregivers, or the primary caregivers, in that child's life have that opportunity prenatally.

That also breaks down some of the barriers to access child and family health afterwards. If you've had someone from child and family health come along and do that course through the hospital, or have a local podcast or go live on Instagram or Facebook or something, you've got a little bit of familiarity with the system. That will help to build a bit of trust and knowledge about who these people are and what they're doing to hopefully increase the follow-up after birth. To Alison's point, I think we need to come along with how we give that information. Facebook is fantastic, but my generation is on Instagram. I think the younger generations are on TikTok.

The CHAIR: Bragger.

MORGAN FITZPATRICK: I don't even know. We know that our attention span these days is much shorter. How can we make the information bite sized? We could have a NSW Health Instagram thing that is for the first three months that has little bite-sized bits of information. I am sure there would be a huge cost to develop it, but I am sure the impact would be phenomenal. The other thing that I would say is that my husband was the primary caregiver after six weeks for both our kids—definitely for our first child. After six weeks he was a full-time stay-at-home dad and I went back to work. He was getting the dad texts. I don't know what the program is called—

ALISON WALLBANK : SMS dads .

MORGAN FITZPATRICK : SMS dads . Itwasincredible . Iwouldcomehomefromworkandhe would go , " I got this text today . Didyouknowthat nameredacted shouldbesmilingtoday ? " Hewouldreadit to me . " 'Around this time you mightstarttoseethefirstsmiles . 'Doyouknowwhat ? Todaywehadasmile . " For him , it was such a great way for himtoconnect . Itwasshortanditwasbitesizedandhelovedit . Hereallycame along on that journey because of that . Ithink , whyaren'twedoingthatwithmums ? Whyaren'twedoingthatin different languages ? I'm sure it wouldbeincrediblyeasy . Textsareveryshort . Translatethatandgetthatout .

The CHAIR : Sorry , what wasthatcalled ?

MORGAN FITZPATRICK : SMS dads .

ALISON WALLBANK : It'sthroughtheUniversityofNewcastle .

MORGAN FITZPATRICK : IthinktheotherthingIwouldecho , asAlisonsaid , isthatinvolvement of the other parent in the child andfamilyhealthchecksandinthescreeningabouthowtheyarecoping . Ithink we have to recognise that there willbeinstanceswherethemotherisnottheprimarycaregiverinthoseearlydays , so if you're not doing depressioninventoriesandifyou'renotcheckingonwellbeing , Ithinkwe'vegotarealrisk around how those caregivers arecopingandanobligationtomakesurewe'refollowingthatup . Ithinkthat'sall from me .

Ms DONNA DAVIS : That'sgreat . Theyweresomereallygoodresponses .

KYLIE STREATFEILD : Isometimesfeelthatvulnerablefamiliesoftenneedaleveloftrustand familiarity . Iobviouslyagreewitheverythingthateveryoneelsehassaid , butIthinkthatsometimesthosesoft entry pointsandconnectionswithfamiliesinthecommunityarereallyimportantforbeingabletoprovide informationtocheckinwithfamiliestoensurethattheirchildrenaregettingthosechildanddevelopmentchecks that are needed . Forme , itispotentiallyforalliedhealthstafforearlychildhoodfamilyandhealthnursestobe available atmainstreamcommunityplacesforchildrenlikeplaygroups . Supportedplaygroupsareagreat opportunitytoreallycheckinwiththosevulnerablefamiliesandareawayofsupportingthemandproviding information .

Ijustwantedtoechosomethingthat Alisonsaidaroundthemothers'groupsandtheavailabilityofthose groups forfamilieswhentheyhavetheirchildrensothattheycanconnectwithotherparents , theycanget information , andtheycangetthatpeersupportfromotherparents . Ifyou'vegotonepersonsayingthatthey've accessedachilddevelopmentcheck , itmightencourageotherstodothesame , butIalsothinkmaybetherecould be a wayherealliedhealthprofessionalsorearlychildhoodnursesarepresentatthosemothers'orfathers' groups . Iknowforus , inOrange , ifyouhaveyourfirstchild , youareeligibletoattendamothers'group . Ifyou have yoursecondchild , youcannotgo ; youarenoteligible .

Soifyou'vegotfamiliesmovingintoregional , ruralandremotecommunities , potentiallywiththeirfirst child—they'vejustbeenborn—andtheywanttogetaccesstoamothers'group , they'renoteligibletoattend . Isee this over andoveragainonsocialmedia . Parentsareasking , " WherecanIgo ? WherecanIlinkinwithfamilies ? " , particularlyinthoseruralandremoteareas . Forisolatedfamilies , it'sreallysignificantanditimpactsonchildren's developmentandparents'andfamilywellbeing . Ithink—beingconnectedandtrustedinthecommunityand having thatengagementwherefamiliesareatintheircommunity .

LAURA FARAJ : Isubmittedinourappendixandreferencedthroughoutoursubmissionthatwehad done a parentalhealthliteracyconsultation . Iranfocusgroupsforfamiliesthatmayormaynothavehadachild with a disabilityordelay , aswellassomeinterviewswithonethathad—intentionally—tounderstandtheir experiences . SoIthoughtIwouldjustreadtheirideasofhowtheywouldliketogetmoreinformation , fromtheir perspective , Iguess—fromavulnerablecohort . Theyechoedwhathasalreadybeenverymuchsharedabout gettingoutintocommunity—thatoftentheydon'tknowbutthatiftheysawanurseincommunity , iftheysawa flyer , oriftherewasaninformationsessionattheirlocalhall , theywouldattendandreallyappreciatethat . Resourcelibrariesthathaddifferenttoolsthatafamilycouldborrowinsteadofhavingtobuy—sosimilartoatoy library butmaybe there are speech cardsormaybethere aredifferentgrossmotorskillactivities .

Theymightoftenbeawarethattheremightbeadelay , buttheydon'tthenknowwhattodowiththator howtoaddressthat—reallysimplehow-tosonhowtoaccessservices . Oftentheliteraturethatisputoutisvery wordheavyandverydense , andforvulnerablefamilieswheremaybethereislowliteracy—wehavealready talkedaboutmulticulturalismanddifferentlanguagesaswell—oftenourfamiliesaren'tgoingtoreadabig brochure . Ifit'sjustasupersimple , " Here'swhatyourchildshouldbedoingattwo " , whichIknowiswhat'sin the bluebookcheck , thatkindofinformationisreallyeasytosee . " WheredoIseeachildhealthnurse ? Thisis the numbertocall . " It'ssimpleinformation .

A timetable of in-person activities to take children to; local services being available again in the community, instead of families having to go out—in our area, public transport's really poor, and a lot of our families
don't have access to cars; mothers' groups, which has already been mentioned, with the purpose to have fun,
share common experiences, get information and have some time out; information sessions, as I said, at the
community hall, on certain topics, such as speech, occupational therapy, and to get tips and tricks; a one-stop
location or service where to get help. Where mums can go to get activities, ask questions or support and an app and social media was also mentioned as well.

Ms LIZA BUTLER: Thank you all for giving up your time to be here with us today. I am interested in this document in relation to building stronger partnerships between Health and community service providers and early intervention services. I work closely with Alice Lins from Noah's Ark, and I have for many years. It was when I worked for Addict, one of my organisations that I looked after. Alice and I are trying to set up a program where Noah's can go into the hospital to see new mums and maybe make those connections and have that so the parents know where to reach out to. Is that something that you would be—is that what this document is about, about building partnerships with all those organisations?

MORGAN FITZPATRICK: Yes. I can speak to that and explain, and Alice has talked about that
program and how valuable that would be. And, having been someone recently through the system, I think that would be incredibly valuable. What we've documented here is—this has been developed in the context of the
foundational support discussions that are happening between the Commonwealth and the States at the moment and, effectively, how we fill that gap for children with developmental concerns that have been identified, who then may eventually end up on the NDIS. But that's a long journey, and what happens in between and what happens for children who might not be eligible for the NDIS but who do genuinely have a developmental delay?

So what we've documented here is that you'll have all sorts of places where a concern might be identified.
It might come from the GP when you get your immunisation, and they do a bit of a blue book check. It might come from the child and family health nurse. It might come from daycare. It might come from the parent themselves. It doesn't matter. Wherever it comes from, we are recommending that we simplify that process because right now the journey for families is very complex. You might go to the GP, and then they might send you to the child and family health nurse, who then might say, "Go back to the GP. Get a paediatrician referral", and then you wait three, four, five, ١٢, ١٨ months to get to the paediatrician, and then they might go, "Actually, go to the sleep doctor." It's such a journey. So really what we see in the early childhood intervention best practice network and within the field is that that gap for children at such a critical development window is a concern. So this is designed to try to fill that gap and get children to the development support they need quicker.

So what we've recommended is it would be great to have some type of call centre, and I understand this
exists in Victoria. They've got a child and family health number that you call and say, "Listen. My child's ١٨ months. They haven't said a word yet. I don't even have 'mamma'. What should I do?" And they can give some initial advice over the phone, help point them in the right direction. So they don't have to go to an office. They don't have to go have a full check. They can get pointed in the right direction, over the phone or through an online chat feature, online resources, if you prefer to do it that way. The daycare staff could also do that. So, if you've got a daycare program that's really struggling to know what to do to support a child—potentially, the child's got some behavioural concerns, and they don't know what this means: "What do we do? How do we support this child?"—they could also call the number and get some advice.

If developmental concerns exist, what we're recommending is that that child and family should be
immediately referred to a keyworker. A keyworker in the best practice field for early childhood intervention is a trans-disciplinary role. It's often a early childhood teacher, but it can be a speech or an OT or a physio that's trained in keyworker. That initial stage of support is some emotional support with what's going on, identifying what might be going on and giving some initial advice: "We're not talking at ١٨ months. Are they mirroring your facial expressions? Are they gesturing? Are they making any sounds at all? Can we help strengthen some of the muscles? What are they eating? There are lots of initial strategies that you can be pointing the family in the direction of doing immediately. So they walk out of that first appointment with some ideas of things they could be doing that will actually help the development immediately. And then they can pull in the trans-disciplinary team. So, if they need to get some input from an OT or a speech, physio—keyworkers work as part of trans-disciplinary teams—they can get that advice, get the family on the way.

Now, there is going to be a handful of families that—I use this example, and Kylie's going to laugh that I'm doing this here—"When I peel a banana the wrong way, we get a meltdown and I don't know what to do." You're going to do some education around toddler tantrums. That's going to make them feel a lot more confident, and then they're going to go on their way and all is going to be fine. We've all been there. I had one this morning. There's going to be a handful of families where that's all they need. They just need a little bit of support, advice and assurance that there's nothing else going on and they can kind of go on their way. They can always come back

if needed. Butthere'sgoingtobeagoodportionoffamiliesthatneedtogointosomeinitialinterventionand support. Thatwillbeneedsbased. Somechildrenmightneedintensivesupport; somemightneedtheoccasional check-in with akey workerora speechie or an OT oranother discipline.

Asyougodownthatjourney, you'regoingtoidentifywhetherornotthosefunctionalneedsaresosevere that theyneedtogointotheNDISandweneedtosupportthemonthatpathway, oritmaybethatthatearly interventionisalltheyneed. Allofthis, wewouldsuggest, isdonewithinthebestpracticeguidelinesforearly childhoodintervention—sodoneinnaturalsettingswherechildrenlive, learnandplay. That'sintheirschools, their homesandtheircommunitysettings. Igivetheexampleofathree-year-oldhavingsensorymeltdowns. We can go intoanoffice, wecanhelpandyoucanexplainwhat'sgoingon. Butifwegohomeat٥.٠٠p.m., when that's reallyhappening, andweseethatwhenit'shappening, wecangettomoreeffectivestrategiesmorequickly.

Oneofthereasonsthatwerecommenditbeinnaturalsettingswherethechildrenareliving, learning and playingisbecausewecangettothesolutionsmorequickly. Wecanreallyunderstandwhat'sgoingonand we can intervenemoreeffectively. Itdoescostabitmoretosendsomeoneintothecommunity, butyourreturn on investmentishigher. Theotherthingwiththatisthatitisworkinginatransdisciplinaryapproach. Theideaof a key workerandwhyyouuseasinglekeyworkerisbecausetheevidenceshowsthatreducingthenumberof relationshipsthatthefamilyneedstomanage—youcantellthatonthisjourneythatwe'vemappedout, they haven't hadtobouncearoundfivedifferentpeopletogetthere—

Ms LIZA BUTLER: Andtelltheirstory١٠times.

MORGAN FITZPATRICK: Yes. They'rejustgettingstraighttosomesupportandadvice. There'sno funding for that at the moment.

Ms LIZA BUTLER: Thatwasmynextquestion.

MORGAN FITZPATRICK: There'snofundingforthisatthemoment. WiththeNDISandthechanges happeningthere, IthinkthatyouhaveascenariowherechildrenwillbecomingofftheNDIS. Inpractice, that may or maynotbehappening. That'sgoingtofreeupworkforce. Thelastthingyouwanttodoiscreateaseparate workforcealongsidetheexistingearlychildhoodinterventionworkforce. Wehavegotpeopledeliveringthese services andsupportsalready. Itwouldbeidealthatthesameorganisationsthatdeliverthoseservicesare deliveringthisatthispoint. Ifafamilythenendsupontheindisbecausetheyhavealongertermneed, ifthey choose, theycancontinuetousethatprovider, soyougetsomecontinuityforthatchildandfamilyaswell.

It'senvisionedthatthiswouldworkalongsidewhatotheradditionalfoundationalsupportsaredesigned, such as peersupport. That'sahugegapatthemoment. Ifyourchildhasadevelopmentalconcern, therearenota lot of organisationsoutthere, particularlyinNewSouthWales, fundedforpeersupportfortheparentstogo, "I have gotachildwithadditionalneeds. That'sauniqueexperience. Ineedpeersupportaroundthat." Some parent training, suchasHanenforachildstrugglingwithspeech—Hanencanbefabulous, butthere'snowhere funding thatrightnow. Thosetypesofservicescansitalongsidethisandreallycomplementit, butthisisabout documenting a much more streamlined journey toearly interventionfor childrenandfamilies.

Ms LIZA BUTLER: BeforeIaskaboutfunding, didanybodyelsehaveanythingtosayonthis?

KYLIE STREATFEILD: Iprobablyjustwantedtoaddtowhatmorganwassayingaroundthekey worker model. Forvulnerablefamilies, thismodelisveryeffective. Itbuildsthoserelationshipsandengagements with vulnerableparents. Wefindthatthecontinuityofsupportisreallygoodforthosefamilies. Theotherthing is that the keyworkermodellooksatthechildandfamilyasawholeandworkswiththeteamaroundthechild. We're not justworkingwiththechildand, say, themother. Wetrytoengagethefather, orwe'reworkingwith siblings andlookingattheneedsofsiblingsaswell. We'realsoworkingwithinthechild'sotherenvironments, like childcarecentres, preschools, longdaycareandschools. Wemightgointothecommunityandprovidesupport with that childinthecommunity. We'renotonlybuildingthecapacityofthechildandtheparents, butwe'realso building thecapacityofcommunitymembers.

ALISON WALLBANK: Iwasjustgoingtoaddthatthat'sverymuchinlinewithhowchildandfamily health nursingworks. It'sjustthatthereare'tenoughclinicianstodoit. Wehavethesafestartpolicythatidentifies families withriskofvulnerability. Theyareidentifiedasleveltwoorlevelthree. Thesefamiliesarebroughtto multidisciplinarycasereview. Wedon'tcallourselveskeyworkersbutbasicallywhatwearedoingiswhatyou are describing. Weareworkingwiththefamilyandgettingmultidisciplinarycasereviewfromourcolleaguesin allied health aroundwhatwouldworkwiththefamily. WehaveanAgesandStagesquestionnaire(ASQ).

MORGAN FITZPATRICK: That'swhatwedo, too.

ALISON WALLBANK: Andthenthathasguidanceintowhereyougoandwhethertheyneedtobe referred to allied health, or there are activitiesthattheyaregiven—alittlebitlikewhatyouaretalkingabout.

MORGAN FITZPATRICK: Yes.

ALISON WALLBANK: We just need more of it. There is a limit on how many families each nurse can see. When we have a lack of staff, that's limited.

Ms LIZA BUTLER: You have touched on the funding, so you are obviously not getting funded to plug those gaps now. That would require block or brokerage funding attached to that to be able to deliver that properly, wouldn't it?

MORGAN FITZPATRICK: Within our network, we've spent a lot of time talking about that. I think where we have landed is that it's probably a bit of a mix. You probably have a baseline of funding to coordinate it and to do those initial checks. But then, once you get down to the ongoing support stage, that would be on a needs basis because you don't want to take funding that's not needed. It would be some type of Ages and Stages or some other similar assessment model that would let you know how much the needs are and how much support is required, and that would be based on an individual needs basis. I think, to your point, Alison—exactly. We work in similar ways. The reality is, if we put it on child and family health nurses, there is not enough capacity, nor would the early intervention sector have enough capacity. But if we leverage both, we probably could fill the need with existing workforce. Currently, we are just not aligning the two. They are operating in silos. You've got your NDIS world over here and you've got community health over here.

ALISON WALLBANK: True.

Ms LIZA BUTLER: Did anyone else have a comment about funding?

LAURA FARAJ: Maybe just a short comment about brokerage. We have a Child Health Linker role, which is slightly different to the keyworker role that has been talked about already. We utilise brokerage as well for families who need to access that initial paediatrician appointment or speech assessment in order to get that paperwork to then be able to access the NDIS or disability supports in school. We are very lucky that we are philanthropically funded.

Ms LIZA BUTLER: I was about to ask who gives you that brokerage funding.

LAURA FARAJ: Yes, we are primarily philanthropically funded, with a little bit of Federal government funding for overall of the Hive. But, yes, that would be something to note—that there is possibly extra brokerage and funding that would be really beneficial to those families to overcome the barriers to then access that mainstream system as well.

RITA FENECH: Can I just make a comment about funding? The age-old issue is that it's so competitive and lots of services are buying into the same grant. I spend a lot of my day looking for them—philanthropic as well as government funding—and it's so competitive it's ridiculous. If we can find a way to stop working in silos and share our resources, maybe we will take a few leaps forward in servicing families where it's respectful and meaningful and supportive.

Ms LIZA BUTLER: Do you have any ideas on how you break those silos down?

RITA FENECH: I'm ready for retirement soon. I have sat around a lot of round tables, and it's really difficult. People are difficult. Each government department thinks that they are doing everything that they can, and it's quite difficult to bring people together. You might be able to get one or two government departments working with you, but the whole kit and caboodle is quite difficult.

Ms LIZA BUTLER: Was it better prior to NDIS, where ageing, disability and home care had the bucket of money so they knew all those services they brought together? Was that better, instead of all these little bits like DCJ and Health?

RITA FENECH: Yes.

KYLIE STREATFEILD: Yes, I would say that's correct. But, unfortunately, the level of funding was not sufficient for services to be able to provide a really good quality service. We are all using the term probably, at the moment, 'pay what it takes' in relation to funding. If we want families and children to be supported sufficiently and at a good quality level, then services do need to be funded in a way that supports and allows that.

RITA FENECH: And not for one year or two years.

KYLIE STREATFEILD: And not for one year. I think there also needs to be some flexibility in contracts for funding. At the moment, funding can be over a period of time, but it's not flexible enough to meet the needs of the community. You might be funded with particular KPIs for one year, and then you're re-funded for the year after that and the year after that, but the KPIs don't change. The way you provide the service doesn't change. For us in regional areas, we've been providing a service funded by the Department of Education and

Training. Thosefundingcontractshavenotchangedsince٢٠١٨, butourcommunitieshavechanged. It'sreally difficulttobeabletomeettheneedsoffamiliesandcommunitiesflexiblyinawaythatmeetstheirindividual needs andcommunityneeds.

Ms DONNA DAVIS: Thankyou, everyone, forcomingtoday. I'mgoingtogostraighttotheHiveto start with. YoumentionedtheChildHealthLinkerrole. CanyouelaborateontheCheck-UpsBeforeSchool program and the linker role, and how the services can beimplemented on a larger scale?

LAURA FARAJ: Absolutely. TheCheck-UpsBeforeSchool—orCUBS—programwasbasically becausewewerehearingallthesamethingsthatwe'vebeentalkingabouttodaythatourcommunityreallywanted. There weresuchhighlevelsofdevelopmentalvulnerabilityandunidentifieddelaysheadingintoschool. When we weretalkingtofamilies, theyweren'tawareofthebluebookchecksortheyhadbarrierstoaccessthem. We knew thatthelocalcommunityhealthcentrewasofferingthesechecks, buttheyjustweren'tbeingutilisedbythe communitythatneededthemthemostbecauseofthatfear, becauseofthelackofawarenessorthelackoftransport to get there.

WegotsomefundingfromtheNewSouthWalesGovernmenttodoapilot, initially—thiswasin٢٠١٩— to address that. Itwaslikeinnovate, listen, trialsomethingandseeifitworks. Wepartnered—already, whatwe've been talkingabouttoday—withlocalearlychildhoodandeducationservicestobringoutthechildhoodandfamily health nurseandbeembeddedwithinthoseservices, aswellascommunitycentres, becauseweknowthatalotof vulnerablefamiliesaren'taccessingearlylearningforvariousreasonsaswell. They'reoftentheonesthatreally need thepick-upbeforetheystartschool.

Thenursewouldcomeintothoseearlylearningenvironmentsandbeabletoassessallofthechildren that wereinthatservice. Theywouldcomeinformultipledays. Theytookareallytrauma-informedandslow approach. Thenursewouldbethereatpickupanddropoff, justtogettoknowthefamilies. Itreallyfocusedon leveragingthetrustthatfamilieshadexistingwiththeireducators. Oncetheysawthattheeducatorswerevouching for thisnurse, anditwouldbeabletohappeninthatplacethatwasmentionedbeforethatthechildrenreally trusted—thattheycandotheassessmentduringgrouptime, onthefloor, ratherthanifithappenedone-on-one with thefamilyinthetraditionalassessmentsense. Wewouldalsothenhavethesamethingavailablewithin communitycentres.

Again, therewasabitmoreofanoutreachmodel. Itwassomewherethatmaybefamiliescomeweekly anywayforcommunitybreakfastorplaygroup. Theycouldgoandtheycouldseethatnurseandgetthat assessmentdonethere. Itwasessentiallythebluebookcheck, butwedidtheASQ, whichisthenextstepupin termsofadevelopmentalassessmentthatassumedthatourpopulationhaddevelopmentaldelaysgoingintoit, so it wasaslightlymorethoroughassessment. Thatwasrunforaperiodofabout١٨monthsbefore—Ialwaysrefer to thisprogramasabitofaPandora'sbox. Onceweactuallygotanurseintotestthetheoryof"Dothesechildren haveidentifieddelays?", thereferralsthatcameoutofitwerejusthuge. Weknowthatthesystemdoesn'thave capacitytohandleit. Referralsweregoingfor—speechwasahugeoneanddentalwasahugeone. Andthensome familieswere left with like five referrals that theyhad to follow up.

Tothatpointbefore, familiesareallofasuddenleftwith, "You'vegottotalktosixdifferent professionals, plustheNDIS, plusfollowupwithyourearlylearningcentreorschool." Itwasjustreally overwhelming. Thesecondphaseiswherethatinitialtrialfundingendedandourphilanthropicfundingcamein as an organisation. Wewereabletokeeprollingoutthatprogramforacouplemoreyears. Weaddedaspeech therapist ontoourteam. Theywentwiththenurseintotheearlylearningcentres. Thatwasthebiggestneedthat we saw comingfromallofthereferrals. Theywerethenabletoworkwiththechildrenintheirearlylearning centres on somereallybasicspeechandlanguageassessmentsandsupportskillsthatwouldthenalsobeupskilling the educators, andthentheycouldbecatchingtheparentsatpickupanddropofftimeaswelltoexplainwhathad been happening.

That's also at the same point we developed that Child Health Linker role. At the time that was myself—so I amsocialworktrained. Iwasabletounderstandaswellthesocialchallengesthefamilywasgoingthrough and supportthemtonavigatethat. "Okay, thisiswhatthenursessaidafteryourassessment. Thesearethenext steps foryou. I'mgoingtobeheretohelpyoutoaccessapaediatricianifthat'swhatitis. I'mgoingtoexplainto you whatevertheNDISisandlet'sseeifwecangetonthattogetherandthenhowyouaregoingtouseyour funding." Someofthatsupportwasreallyshortterm. Sometimesitwasjusttoexplainwhathadhappened. But sometimesitdidgofor١٢to١٨months. Therewasnever, everatimethatwesaidthatwewouldonlyworkwith you for Xamountofweeksormonths, whichisquitecommon. Itwaskindofanopendoorof, "Let'smakesure that yourchildissetupforthesupportsthatareneeded."

TheHive—wedon'twanttorunservicesasournatureforthelongterm. Wewanttotrytotestideasand then wewanttoseeifthesystemcanimplementthem. Allofthiswasdonereallycloselywiththe WesternSydney

Local HealthDistrict, whowereamazingatcomingalongandprovidedthatnursingstaffandthespeechtherapist. They werewithinthatsystemalready. Theyknewverywell. Then, afteraperiodoftime, wehadanexternal evaluationwithWesternSydneyUniversityandprovedthesuccessthatwewereseeingonthegroundwitht he programofreachingthisvulnerablecohort—thattheynowactuallyhaveabsorbedthatprogramandhavebeen runningitthemselveswiththeirownfundingaspartoftheirownmainstreamchildhealthdeliveryinthathe alth districtjustfortheMountDruittareaoverthelastcoupleofyears, withtheHivestillprovidingthatChildHeal th Linkerroleandsupport. Someofthosefindingsdidfeedupandwegavesomeinformationtostategovern ment

Ms DONNA DAVIS: Weknowthatthereisahigh First Nations demographic in that area, but who else at the time of the Brighter Beginnings rollout for child health and development checks. CUB Swas kind of one o f the models that they leveraged to inform their funding decision as well.

predominantly do you have in that area, Pasifika?

LAURA FARAJ: Pasifikaisprobablyournextbiggestafter First Nations. Weoftenfindthat, inthat, there are a lotofmisconceptionsofunderstandingwhatdevelopmentisandwhatisnormal, what'snot. And obviously normalis—thereisnosuchthingasnormal. Butbeingabletounderstandwhatarethe processesand when do wegethelp, whendowenot. So, yes, thereare First Nations, Pasifika, Filipino, different African communitiesas well.

Ms DONNA DAVIS: Oneofthediscussionsthismorningtouchedontheneedtodomoreinantenatal and educatingatthatstageabouttheexistenceofthebluebook. What, inyourexperience, canwedobeforebirth to make thesefuturemumsmoreawareofwhattheycandoandwhatsomeofthechallengeswillbe?

LAURA FARAJ: Icanstart. I'mhappyforexpertisefromthepanel. We'vereallyfoundthatthereisa really starkgapfromwhenyou'reinthematernalhealthsystemtothenwhenyou'retransferredintothechild health system. Inourareaaswell, we'reontheborderoftwoLHDs, soitreallydependsonhowquicklyyou might getsupportedthentochildhoodhealth—dependingonwhathospitalthatyoubirthat, whichisreally commonforourcommunity. Oftenthenthey'retryingtofollowup. Iftheydohavetheabilitytobeproactiveat that timeandtrytocallupandthenthey'retold, "No, youneedtocallthishealthdistrictinstead"—Ithinkbeing able to havesomeeducationinthoselaterstagesofpregnancyaroundwhatthebluebookisandthisiswhatyou should expect.

Iknowfamilieshavesaid, "Well, Ididn'tknowaboutituntilIwasbeingdischargedfromthehospital and handedthisbookandIdidn'tknowwhereIwasmeanttogoorwhattodo." Ifthatcouldbepartofthe midwiferyteamormaternalhealthteamofeducationatthatreallyearlystageorinthatlatterhalfofpregnancy of what toexpectnext—Ithinktheideabeforeoftextremindersaswellwouldbereallyhelpfulandthatis something we've heardfromour community too.

Ms DONNA DAVIS: Doyoufindthereisalowtake-upofbreastfeeding?

LAURA FARAJ: It'snotsomethingthatwe'veparticularlyresearchedinto, soIdon'tknowifIcould quite comment on that one.

Ms DONNA DAVIS: Alison, youwerenoddingyourheadferociouslythere.

ALISON WALLBANK: It'sallmusictomyears.

Ms DONNA DAVIS: ThathappenedtomewhenIhadmybabies. Theywereborninadifferentlocal health district and then not knowing, "Oh, yeah, we'lljustringthisnumber"—weknowthat, dependingonyour personal situation, you are or aren'tgoingtodothatandifyou'vegotlanguageasabarrierontopofthat, could you speak to that a bit? What yourexperienceisandwhatcouldbedone?

ALISON WALLBANK: Intermsofthebluebook, doyoumean, andthatsamequestion?

Ms DONNA DAVIS: Yes, thebluebookandfuturemother'sunderstandingpriortogivingbirth.

ALISON WALLBANK: InmyroletworolesagoIwasworkinginCanterburyintheteamandIwas a manager of the team. We had a programintherecalledSNF. Idon'tknowifyou'veheardaboutit: it'sSustaining NSW Families. Within that program, partofthestructurewasthatthenursethatwouldbeworking—families were identified in the antenatal periodiftheyweregoingtoengagewiththisprogram, andtheywereidentified through the SAFE START process. Withfamilieswhowereidentifiedwithvulnerability, they'dbereferredin.

The first engagement pointwasataround٣٦weekspregnancy, andthenursewouldgoandmeetwith the family. I think it shifted the focusforwomen. Whenthey'rebeinggiveninformationfromamidwife, their mind is on the birth. They're havingaconversationintheirmindabouttheactualprocessofgivingbirth, andit's very difficult for a lot of women togetpastthatuntilafterthey'vegivenbirth. ButwhatIsawwhenwehadthe

child and family health nurse goinwastheSNFprogramisstructuredsotheconversationwouldbehadatthat appointment.

I feel like it has shiftedthefocusforwomento،"Thisisachildandfamilyhealthnurse.Theyexplained their role؛ they're not involvedwiththebirthatall."Ifeellikethat'saplace،ifwehadenoughnursesforthenurse to engage with the family foraone-offantenatalvisit،totalkaboutthingslikeexactlywhatyou'resaying—the blue book and what to expectinthefirstweekswhenthebabyisborn،afterthebirth.Asmuchasmidwivestry to talk about that، I don't thinkitgoesin.I'veworkedasamidwife،andIjustthinkthefocusisonbirthwhenthe message is coming from a midwife.Doesthatansweryourquestion؟

Ms DONNA DAVIS: Yes، thankyou.I'vegotsomanyquestions.

The CHAIR: Wejusthaveacoupleofminutesleft.Isthereanythingwehaven'tyettouchedonthat you might wanttotalktoquitebriefly؟

RITA FENECH: Ithinkthateveryonesittingheretodayhasgivenareallygreatoverviewoftheissues that we face onadailybasisinthatearlychildhood،thefirst٢،٠٠٠daysofachild'slife،andthecomplexitiesthat come with thatandthechallengesforbothmumanddad.Ithinkthatwe'vegotalongwaytogo،andthisisgreat today. I'm reallypleasedthatyou'verecognisedthereisanissueinthatperiodoftime.Again،Ithinkifall government departmentsandNGOscometogetherandsharetheirresources،wemightbeabletotakeastep forward. I thinkthatyou'vecoveredmostthings،butit'sachallengingjourney.Thankyoufortakingitup؛Ihope you do somethingwithit.Wewillkeepintouch،Ihope،soweunderstandwhatstepsaregoingtobetaken.We'd like to come alongonthejourneybecauseit'sveryimportant.

ALISON WALLBANK: IthinkjusttwothingsthatIhadn'ttouchedon،inthespaceofchildandfamily health nursing.Iknowthatthisinquiryisintoincreasingaccesstoearlychildhoodhealthanddevelopmentchecks، but recognisingthecompetitionthat'sfacedbytheprofessionofchildandfamilyhealthnursingintermsof psychosocialscreeninganddomesticviolencescreening،andallthedifferentthingsthatachildandfamilyhealth nurse goesthrough.Mentalhealthscreening؛relationshipdifficulties؛financialdifficulties؛thatwhole-of-family support forolderchildren،asyoumentionedearlieraboutotherfamilies؛breastfeeding؛introducingsolids؛sleep and settling؛sleepsafety؛drugandalcoholscreening؛smoking—there'ssomuchcompetitionwithinthespace، when you'reseeingafamilyandyou'vegothalfanhourwiththem،ofthethingsthatyou'regoingtodiscusswith them.

The other thing I was going totalk about was just the workforce changes for the child andfamily health nursing profession. In the past، a child and family health nurse generally came in as an older clinician who had worked in midwifery، maybe working in paediatrics. They came with a lot of experience، so really ready to go and toworkwithautonomyasachildandfamilyhealthnurse.That'sreallychangingatthemoment.We'vegota much more junior workforce coming into our workforce. The frameworks around supporting that more junior clinicianalsocutsintothesupport.Thatkindofmentoringandeducationsupportjustisn't there.It'simportantto thinkabouttheimpactthathasonthisworkforce—thatyouhavemorejuniorcliniciansworkinginthisworkforce with really complex families when our focus has gone to vulnerability. That takes time to train and learn and become confident in working in that space.

MORGAN FITZPATRICK: IthinktheonethingIwoulddrawattentiontoisthatthedevelopmental checkisreallyimportant،butit'swhathappensafterthatthatreallyiswherethingsoftenfalldown.Ifyouhavea childwho'sgotagrossmotordelayoraspeechdelayorsomethingidentifiedinthatcheck،it'safantasticstarting point but now the journey's starting. The cost to get a diagnosis، the number of people you need to be involved with، the time delay to get access to the speech or the OT or whatever intervention you need—that's where we're hitting real barriers. The checks are critical، but we've got to focus on the whole system and what happens after that.

Some of the discussion today about how we can leverage both the child and family health nurse workforce، as well as the existing ECI workforce within the sector—I think، if we work together، we can solve that. Theneedwouldbetoogreatforanyoneofthosealone.Ifwethinkaboutthemintoosiloedofaheadspace، I think it'sgoingtobehardtoachieve.TheotherthingIwouldsayis،insolvingthat،it'sthinkingaboutthe foundational support discussion، which is live at the moment، because that cuts across education، disability and health. Howallthoseallintersectiswhatwe'retalkingabout.

KYLIE STREATFEILD: IagreewithMorgan'sthoughtsaroundfoundationalsupportandthe intersectionsbetween those departments. I think we touchedon very lightly، but I wanted to elaboratefurther on، the issues forfamilieswhoarelivinginruralandremoteareasandhavingtotraveltoundertakechilddevelopment checks، as wellasgettingsupportsandservicesfortheirfamilies.Ithinkutilisingexistingworkforces،and collaboration with health and early childhood intervention services is one solution there، but I think there is an

untapped workforce in early childhood teachers who have that experience and knowledge of childhood development. I think if we can look at ways that they can be utilised in these areas to undertake, as well as support children after the checks, that would be one solution.

LAURA FARAJ: I want to reiterate the importance, particularly for vulnerable communities, of getting into the community and really being place based and out of those community health centres, whether that's in a community centre, whether that's in the early learning space or schools. Also, echoing what Morgan was saying around that linker support and what's next—that issue of brokerage that comes up: the waitlist, where do I go next that practical and emotional support, the education. It's what happens after the check because the check, if it's anything like ours, is going to be a Pandora's box. That is what we found from our program.

Two things we've touched on very briefly was just looking at the issue of transport. That's something that we see a lot. If you can't get out into community—I understand there is a lot of resourcing that needs to happen for that. I know that some community health centres or hospitals have community buses to be able to get to appointments, but often they're only for adults and not children, and they don't have the car seats. So transport is just one that we see is a really big barrier. The health centre is maybe only ١٥ minutes away, but our public transport is shocking. That's going to be an hour away in this Western Sydney heat, which some families do walk. It's just impossible.

Just considering the ineligibility for Medicare and NDIS for some families who might be on visas and different things, they will have to again pay out of pocket for a child health check, which might not be the biggest priority for a vulnerable family at that time. If they're ineligible for NDIS and they can't access or afford private speech or occupational therapy, what else could be offered through community health centres as well—recognising the resource issue, but just not wanting to forget that cohort in there as well.

The CHAIR: Thank you all so much for sharing your wisdom and expertise with us today. You will be provided with a copy of the transcript of evidence that you have been a part of today. Feel free to make any suggestions for corrections around that. Committee staff will also email to you any questions taken on notice from today. If there were any questions taken on notice, they will be emailed out to you. The Committee may also develop some supplementary questions that we'd like to send to you, if you could please be open to getting those. Again, I thank you for taking precious time out of the valuable contribution you make every day.

(The witnesses withdrew.)

(Short adjournment)

Ms SEETHA SRINIVASAN, Community Liaison Officer and Hub Leader, Rydalmere Public School Community Hub, affirmed and examined

The CHAIR: We now welcome our next and last witness from Rydalmere Public School Community Hub, who I'm very much looking forward to hearing from. Please note that the Committee staff will be taking photos and videos during the hearing. The photos and videos may be used for social media and public engagement purposes on the Legislative Assembly social media pages and website. Please let us know if you object to having the photos and videos taken and used. Before we start, do you have any questions about this hearing process?

SEETHA SRINIVASAN: No. I'm all right.

The CHAIR: Would you like to make a short opening statement before we begin with questions?

SEETHA SRINIVASAN: Yes, just to make sure you understand what I do.

The CHAIR: That was going to be our first question, so you can beat us to it.

SEETHA SRINIVASAN: First and foremost, I want to acknowledge and pay my heartfelt respects to the Dharug people and traditional custodians of the land we gather on today. I extend my gratitude to their Elders past, present and future, and any Aboriginal community members joining us today. I would also like to take this opportunity to express my sincere thanks to the Committee for allowing me to share my insights during this important hearing on early childhood development and health checks. It is both an honour and privilege to represent Community Health Australia and Rydalmere Public School. In my role as a community liaison officer at the school, I am deeply committed to the national initiative through Community Hubs Australia. Each week, I coordinate a few engagement programs, in collaboration with various organisations, to support families in and around the school area.

My work focuses on four key areas. One of them is early childhood development. The other ones are adult English education, employment opportunities and community development or community engagement. I basically work with new migrants, but I'm not restricted to working only with new migrants. It can be anyone who wants to engage with us. Many families involved with the hub come from migrant backgrounds. I strive to ensure they receive the support they need. I also provide referral services tailored to each family's unique requirements. I am proud to say that all the programs we offer in the hub are free of charge. Most of them have no visa requirements or restrictions, making them accessible to everyone in our community.

The CHAIR: You've just ended there on a couple of really interesting points that have been raised throughout today. But can I go to why do you exist, how did you come to exist, when was it set up, who funds it and takes responsibility for it. Can you give us a bit more detail about that, because what you are doing is fascinating.

SEETHA SRINIVASAN: Community Hubs was mainly started in Melbourne. It is funded through the Scanlon Foundation.

Ms LIZA BUTLER: Who was it, again?

SEETHA SRINIVASAN: Scanlon Foundation. You can look it up on the Community Hubs Australia website. We also work closely with the communities and justice department. We are close to ١٠٠ hubs in different areas all over Australia. Within New South Wales, we have up to ٢٥ hubs. All of the hubs are placed within primary school premises. Our main focus is to provide support for new migrants, because school has been an area where they come but they don't engage. That's the first meet-up point for many of the migrant families, because their children start schooling and then they don't know how to connect or where to go. There was a niche area, and that's how this was started more than ١٠ years ago. It has been in Rydalmere for the past ١٠ years. It started in ٢٠١٤. I came to Australia in ٢٠١٧. I was able to meet up with one such hub leader at Westmead Public School. I was volunteering there. Eventually, I got a job at Rydalmere Public School with a similar position in ٢٠١٨. So I have been in my role for the past six years.

The CHAIR: To follow on, you said there were about ٢٥ across New South Wales?

SEETHA SRINIVASAN: Yes.

The CHAIR: All in primary schools?

SEETHA SRINIVASAN: Yes.

The CHAIR: Are they all in Sydney?

SEETHA SRINIVASAN: There are some in Coffs Harbour, Liverpool, Bankstown and Fairfield.

The CHAIR: How big is your team? It sounds like you cover a lot of area. How many people do you work with in this hub environment? As an add-on to that, what are the rough hours of operation?

SEETHA SRINIVASAN: Within the Parramatta LGA, Parramatta West Public School also has a hub leader like me. We work around ٢٥ hours a week. That's our work schedule.

Ms TRISH DOYLE: Is that what you're paid for?

SEETHA SRINIVASAN: Yes, we are paid for ٢٥ hours a week.

Ms TRISH DOYLE: You probably do a lot more.

SEETHA SRINIVASAN: That's up to us. Although we have the same framework, the work is very different, depending on the community. My peer at Parramatta West will have much different tasks when compared to what I'm doing with my community. What we generally do is ask our community what kind of support they want from us. We keep in mind that we are working with multicultural communities. We don't want any single community to have advantage over the others, so we make sure that the programs we are providing are equal for everyone.

At the same time, we ask them what they want us to provide. For example, I run adult English conversational classes. Although we have AMEP and various other programs that the Government provides, we provide this as just a conversational English class for them to gain some confidence to go to these classes. When they are ready, we shift them to the mainstream classes. If they are on a visa then we provide an opportunity for them to develop their English. These are conversational English classes that are open for everyone to come along. This has been funded by Community Hubs Australia. So every hub leader, depending on whether she wants to run the English classes in the hub, depending on the requirement of the community, can apply for funding from

CHA, which is Community Hubs Australia, and run those classes. Most of our programs are during school hours and during the school term.

The CHAIR: Earlier today we heard from some of our multicultural service providers that one of the barriers to fulfilling these early development checks is that back in the home country, wherever they came from, there was potentially nothing like this available.

SEETHA SRINIVASAN: Yes.

The CHAIR: In terms of what you deliver, is a part of your delivery in your service to talk specifically to families about what's expected or what's typically done, and this is why it's important to work through these checks?

SEETHA SRINIVASAN: Yes. As part of my job we run playgroup once a week for families with children less than five years. We run this in partnership with SDN Children's Services. I say "we" because it's just me in my role. I run it from my school in partnership with SDN Children's Services. We get a social worker and a playgroup facilitator to run this every week. In this process, we have chats with the family and find out what they are interested in, what they want and what they have been doing. If they have a small baby, we ask them, "Do you know what a blue book is? Have you been to immunisations? Have you met a doctor?" If you see any red flags, we raise those red flags with them on a personal note. Since they're coming every week, they have that trust. We have to really build that trust before we can ask these questions.

Eventually, once a term, we try to connect them with such services. We used to bring in speech pathologists to have a chat. Twice, earlier, we've had speech pathologists come and do individual one-on-one, ١٠-minute initial assessment with the families and provide them with—mums ask questions, grandmas ask questions, and they answer. They provide them with all the information that is required. Also, we do a follow-up after six months, trying to find out where the child is, what kind of support they require and how we can provide more support in this area.

I could see that there are a lot of barriers. The main issue that I faced initially, when I started with the job, was I wanted the local GP to come into the school and have a chat with the families—just an information session or just a casual chat over a coffee. That really gives them an idea and also gives them comfort to go and ask questions: "My child is not talking. My child is not walking. What should I do next?" or "When can I start schooling for my child? Can the child go to child care? How do I toilet-train them?" We do answer those questions when they came to our playgroup. Sometimes the consistency is a bit of an issue, but when people are not going to the places we want them to go, the places or the organisations have to come to them. I am happy to provide a space for anyone who wants to come in and have information sessions or chats with my families, maybe during playgroup or I can also provide a small room for them to have one-on-one chats with the families about the concerns that they are facing, and provide them a pathway of what will work for their children. In this process, I can provide them a space. They can do it once a month, once a term, whatever suits for the organisations to come in and provide this information session.

The CHAIR: All in ٢٥ hours a week.

Ms TRISH DOYLE: Thank you so much, Seetha, for being here and sharing a little bit about what you do and the huge impact that must have in your community. It's quite amazing to learn of all the different elements. There's a huge array of issues that come under those things. Early education and all the services there, health, connecting families—that's a huge amount. It sounds like there needs to be more of you, rather than just you, in these hubs. It's good to see it's formalised. If I think back to when my children were little, I was teaching at the same school, and we knew that there were some transient families at that time. So we organised Rotary to come in and do breakfasts. That was a time that all the other services could talk to the families. It sounds like what you're doing is a more formal model. Have you noticed that there are fewer children from multicultural communities that are connecting with the early childhood checks, the health checks and the development checks? We've heard that that is the case. If so, how can we change that? How can we improve that? What are the some of the barriers? Why aren't people taking up these checks, in your view?

SEETHA SRINIVASAN: I would focus on my experience, when I came to Australia first. I have two children. When we enrolled them into the schools, we were asked for their immunisation history, which we got from our country, but we had a few of the immunisations which they needed to tick. We took them to a GP, and I was charged $١٠٠ each to get the immunisations done. When I started the job, then I came to know that we do have immunisation clinics where it's provided free of cost. The barrier is—we knew English. We knew the process, but we still didn't know where to go for information. We didn't know we could ask if it was free; we didn't know. Only if we know, can we ask those questions.

So I would say the information—or maybe we need to promote these things a bit more. Maybe the information should be out there in their faces, for people to see that it's available. I would really suggest some of the information to be put out in the GP clinics where people go for immunisation clinics, the nearby immunisation clinics or their scheduled—or the developmental and health check clinics that's available closest for people to see that it is available and it is available for them to use. What's happening in this process is when we all come from various backgrounds, there are a few things which are not—if you're a local, you will know that this is available and this is the process. But when you're a migrant coming into Australia, if it's not followed in their country, we don't know about it. So that's why we have these conversations during our groups. Whenever we are all having those group programs, we have these kinds of conversations. Those casual conversations get them to go in.

Beyond all of this, there are still barriers where they find it difficult to get their appointments, especially with early childhood. Before coming to Australia, I had been a Montessorian back in my country. I have six years of experience being a Montessorian. The gap can be bridged earlier; that's why we need early intervention—earlier in the age of the child. For example, if the child is not walking by ١٠ months or ١٢ months and they're in constant touch with the GP or a nurse, they'll know what to do. They have a path. But if they don't have that intervention, the gap of the child getting into a normal position would be further away. Before the age of six, they should have that support; they should have that intervention. It may be physical or mental developments. That barrier—for example, if the appointment to a speech pathologist is delayed by six months, that really hampers the growth or it needs more intervention later on. If it's earlier, the intervention is less. So I think we need more—I don't know, maybe students who are doing speech pathology, who want to become a speech pathologist, helping us out here and providing more opportunities for people to share their concerns or problems and getting some support.

Ms TRISH DOYLE: Excellent. That was going to be my next question. It sounds like these hubs could provide even more. You're working on the ground with these families. We have heard a lot of people talk about the need to improve parental health literacy and build their knowledge base and their trust in services and their connections with each other. The organisations and roles like the one you're in could probably do more. You've just named one resource, like having some students in OT, for example, or speech pathology. What other resource or supports would you need in a hub to offer that support to the families and the children to encourage them?

SEETHA SRINIVASAN: We also have a preschool in our school. Once a term, we take our playgroups into the preschool for them to see that environment and connect them with the preschoolers. Eventually when the parents are able to get into that system, they are provided with a vision check, hearing check and dental check through the preschools as well.

Ms TRISH DOYLE: Through the preschools? Great!

SEETHA SRINIVASAN: Yes, through the preschools. We are doing that already. In this process during the English class, we provide them with free childminding through the funds that we're getting from Community Health Australia, which is very less. We get $٣,٠٠٠ for both the facilitator and the childminders to provide ١٠ weeks of two-hour lessons and take care of the children. We need at least two childminders to take care of the children, and we need one facilitator to do the lessons, so it's way, way, way less. Since we are individual within the school, we can't apply for any grants by ourselves. We have been having those barriers.

In saying that, we could have more visitations through the GP, or speech, or any developmental checks. That could be done within our playgroup or preschool or within the school campus. Many times, what happens is many of these families have not gone to any other organisation except for the school, because they come to drop off children at the school. The school is a safe space for them to go and come back. But they're not allowed to go anywhere else without every member of the family. So it becomes difficult for them to go out on their own to explore.

Ms TRISH DOYLE: Especially if there is domestic violence involved.

SEETHA SRINIVASAN: Yes. School has always been the safe space for them to come and drop in. When they are having concerns about the child's development, they have someone whom they are seeing every day. They can trust them and share their problems that they are facing. That's how we are able to tailor our referral depending on what they want.

Ms TRISH DOYLE: Thank you, Seetha. That's a huge amount of work you do.

Ms LIZA BUTLER: Thank you for your time today and for the work that you do. We've heard that CALD children are less likely to attend preschool. I think what you've just told us about playgroups taking children to preschools is fabulous. Do you see the rollout of preschools collocated within schools that are free for children four to five—that the Government's committed to—as helping get children into preschools?

SEETHA SRINIVASAN : Yes , ofcourse . It'sgoingtohelpthemgetintothesystem . Oncethey'rein the system , it's easier to go back andcheckwiththem . Forexample , parentsmightnotnoticethatthechildisnot achieving their milestones , whereasthewell-educatedpreschoolteacherswouldbeabletopickthatup .

Ms LIZA BUTLER : Doyouthinkthatcostisabarrierfor CALDfamiliesnottosendtheirchildrento preschool ?

SEETHA SRINIVASAN : Yes , ofcourse . Childcareisreallypricey . Unlessbothofthemareworking , it's very difficulttoaffordchildcareandgoaheadwiththat .

Ms LIZA BUTLER : Withthosepreschools , theyarenotnecessarilygoingtobewhereacommunity hub is thatyouoffer . Doyouthinkthathealthcareworkersingeneralaretrainedenoughin CALD-specific— educated enough todeliver those services ?

SEETHA SRINIVASAN : Theyshouldbe , becausemostoftheschoolsarecommunityfocused . Most of theschoolshaveaP&Cwhichcanworkwiththecommunity . Insayingthat , Iamplacedwithintheschool . All the programsarenotrestrictedonlytotheschoolfamiliesortheschoolmembers . Manyfamilieswhoareinand aroundtheschoolcomeandparticipate . Wedohavefourlovelygrandmaswhocomeandparticipateinour cookingprogram , whowanttovolunteerforthecanteen . Wedohavealotoffamilieswhodonothavechildren who wanttobeapartoftheschool , whowanttobepartofthecommunity . Wehavedancefitnesseveryfriday where theycomeandparticipate . Theywanttobehealthy . Theycomeandparticipate .

Throughourcommunityhubswe'reabletopromotetheProjectHarmonydiscountthatwasprovidedby the Government . Justfrommycommunity , wehad ٢٥ familieswhowereabletousetheFirstLapvouchersand get ١٠ free swimminglessonsfortheirchildren . Allthechildrenarethreetofiveyearsold , andnotallofthem are part of our school . Ourschoolhas ١٦٠ studentsfromKto٦ . Justaverysmallschoolwe'retalkingabout . We have ١٢٠ families , that'sit , butwedon'trestrictourselvesbecausewearealreadyprovidingtheseservices . We want more peopletoutilisetheseservices . WealsodotripstoErmingtonlibrary , whichisjust ٨٠٠ metresfrom our school . We walktoErmingtonlibrarywithourplaygroupfamilies . WedoRedseethere . Wedootherprograms that the Ermingtonlibraryisrunning—thestoryprogram . Wetakethemthere . Weconnectthemwithother organisations so thattheyhavethatexposure . Theycanaskmorequestions , andtheycanfindoutmore information from variousdifferentplaces .

The CHAIR : Wow . Everycommunitywantsoneofyou .

SEETHA SRINIVASAN : Thankyou .

Ms DONNA DAVIS : Thankyou , Seetha . Yousaidthatwhenyoufirstarrivedin Australia , youwere at Westmead PublicSchoolandthatthere'sacommunityhubthere . Eventhoughyouweren'tthereatthe beginning , do youknowhowRydalmereandParramattaWest—howdiditunfold ? Justfortheothermembersof the Committee , weknowthatParramattaWestisamuchbiggerschool , andtheyareprobablythetwoextremes in the Parramattaelectorate .

SEETHA SRINIVASAN : Yes . MychildwasgoingtoWestmeadPublicSchooland , onmyfirstday at school , sinceIwasamigrant , Iwasintroducedtothecommunityliaisonofficerandhubleaderthere . Shewas running Englishconversationclasses . Shewasalsorunningplaygroup . AlthoughIdidnothavechildrenlessthan five , I washappytohelpthemwiththeplaygroup , buttheyhadenoughfamilieshelpingthemaround . Butthe issue thatshefacedwasshehadEnglishclass , butduringthattimetheydidn'thavefundstohavechildminding services . Soshewasasking , "Wouldyoubeabletotakecareofthechildrenwhile Iamdoingthe Englishclasses ?" Eventually , Iusedtotakeactivitiesforthechildren , becausethat'smyforte . IhavebeenaMontessorian . Ihave been workingwithchildrenlessthansixbackinmycountryforsixyears . Ihavebeentrainingteachersandbeing their mentorbeforeIcametoAustralia . Iwouldlovetodothat . Iwouldalwaysplanwhatactivitiestotakefor the children , andIwasabletoraiseredflagsifrequired .

Eventually , shefoundanopportunityformetovolunteerinanotherschool , whichwasToongabbieEast PublicSchool , whichwasalsoaverysmallschool . Theywantedtorunaplaygroup , buttheydidn'thavepeople who couldhelpthemwiththeplaygroup . Akindyteacherwasrunningtheplaygroup , butshewantedalotof supportwithset-upandpack-upandhelpinrunningit . Iwasdoingthatforayear . Iwasvolunteeringthereinthat schoolaswell . IamalsoaScriptureteacheratWestmeadPublicSchool . Eventually , whenmycommunityliaison officerandthecommunityhubleaderatWestmeadsawthattherewasthisopportunityatRydalmere , sheasked me toapplyforthisrole .

SinceIdidnothaveanycommunitydevelopmentbackgroundorsocialworkbackground , Itoldher I mightnotbethebestfithere . Butthemainideawasforearlyeducation . Thatwasthemainareathattheywere focusingon . Theysaid , "Eitheryoushouldhaveexperiencewithearlychildhoodoryoushouldbeasocial

worker. "SinceIhadthat, Iwasabletostart. Ididhavealotofon-the-jobtraining, likeasset-basedcommunity development traininganda lotof other on-the-job training, which I was takingup on thego.

Istartedthejobin٢٠١٨. WhenIstarted, wehadaparent-runplaygroup, butwedidnothaveanyEnglish class forthecommunitythere. WereallyrequiredanEnglishclass. Therewerefamilieswhowouldcometome just to fillinanapplicationform. Therewerefamilieswhowouldcometomeandaskmetoreadtheirmailfor them. AlthoughIwasnotabletotranslate—Iwouldn'tknowtheirlanguage—Iwouldjustsimplifywhateverit was, showtheactionsandtheywouldbeabletogofromthere. ThatishowIwantedtostartwithanEnglishclass. We wereabletosecureafacilitator, andshehasbeenrunningtheEnglishclassforthepastfouryearsnow.

Ms DONNA DAVIS: Yousaidthattherearegrandparentsthatattendandthatyouhavepeoplethat come fromoutsideoftheschoolaswell. Dotheycomefromotherlocalpublicschoolsoraretheynotassociated with theschoolyet?

They're not associated with the school. Theycometoknowaboutmy SEETHA SRINIVASAN programsthroughtheirfriends, theiracquaintancesorthroughtheFacebookpagethatwehave. Ialwaysputmy term calendarintheErmingtonlibrarysotheyflipthepageandtheyseethattherearefreedancesessionsand think, "Letmegoandhavechatandfindoutif Icanjoin." That'showIgetmorepeopleaswell. Wedohave families whosechildrenaregoingtootherschools. Theymighthavestartedwithourschoolwhentheywere coming fortheplaygroupbuteventuallytheyarenotinthecatchmentandtheywouldhavegonetodifferent public school.

Ms DONNA DAVIS: Youmentionedbeforethatyourhubplaysaroleinthedeliveryofearlychildhood checks and screeningservices. Tobemoreinvolvedandtodelivermoreofthat, whatsupportsareneededforyour organisation sothatyoucandothat?

SEETHA SRINIVASAN: Morepeople. I'mhappytodoasmuchIcanbutIwantmycommunitytobe more confidentinapproachingtheservices. Soweneedsomeonewhocancometherequiteoften—maybeonce a term—andshowtheirfaceandjustgivethemthevocabulary. Thereisaspeechpathologist. Thereare paediatrics. ThereisanOTwhocanhelpandthereissomethingcalledNDISthatcanprovideservices. Iwould like toshareoneoftheexperiencesthatwehadin٢٠١٩whentherewasatotalfireban. WehadonewholeEnglish lessonontotalfirebansbecausepeopledidn'tknowwhatatotalfirebanwas. Soit'sassimpleasthat. Even gettingthatvocabularyoutforpeopletosee, normalisingitforthemsotheydonotfeelafraidthatthechildis goingtoanOTanddonotfeelafraidthatthechildrequiressupport—justgettingitoutthereandinfrontoftheir face andnormalising it.

Ms DONNA DAVIS: Before, whenweweretalking, yousaidthatyoureferpeopletoErmington, to theearlychildhoodcentreclinicthere. Didyoualsosaythattheycomeintothecentre? Orthey'renotatthis stage?

SEETHA SRINIVASAN: No, there'soneGPclinicjustoppositeourschool, verycloseby, hardly ٣٠٠metres. Ididhaveachatwiththemearlieraboutiftheycouldcomeinandhaveaninformationsessionbut thatwasnotmadepossible. Idon'tknowwhatthebarrierwasforthemtocomeintotheschooltoprovidean informationsessionorexplainwheretheyareplaced, whatkindofsupporttheycanprovidetothefamilies. If thosebarriersarelessened, it'seasierforparentstosee"Yes, IcangototthisGPandaskforhelp." TheGPneed notcome. Wecouldhavesomeone—maybeanurse—fromtheclinicwhocancomeandvisitourplaygrouponce a termjusttoshowherfaceandcomeinforhalfanhoursowecanintroduceher. Theycanaskaboutsomedoubts. Thatwouldbethestartingpointforpeopletounderstand. Manyatimewe'vehadsituationswhereitisdifficult for mumtoacceptthattheirchildmighthavesomeissuessomoresuchinteractionswillprovidethemachance to askmorequestionsandreallyunderstandthatearlierinterventionandsupportthatwecanprovidetothe children at anearly stage willreally help the child goingforward—both for theparentsaswell as the children.

Ms DONNA DAVIS: Sorry, onemorequestion. Whatisthevisastatusandthecountryoforiginofthe majority ofRydalmere PublicSchool?

SEETHA SRINIVASAN: Togiveyouanexample, inourEnglishclasswegenerallyhavearoundeight to ١٢ladieswhocomealong, andthey'reallfromeightto١٠differentcountriesorlanguagebackgrounds. Soin a verysmallschool, wehaveaboomofvariouscountries. Ihaveaworldmapinmyroom. Once, duringanevent, I askedthemtoputadotonthecountrytheycomefrom. Wewereabletocollect٢٠differentcountriesthatthey are comingfrom. Soit'saveryvariedgroup.

Ms DONNA DAVIS: That'sverymuchlikeParramatta. SEETHA SRINIVASAN: Manyorganisationsthat Igotoaskme, "DoyouwantanArabictranslator? Would you like a Chinese translator?". Isay, "Justsimple English, please," becauseit'sveryhardformetoget

one translator for each one ofthem. But, ifrequired, ifI'mprovidingone-on-onesupport, thenweuseinterpreter services.

The CHAIR: Whenyoudidmanagetogetaspeechpathologistin, forexample, didyouhavetopay for that or was that providedbyHealthoraprivatecompany?

SEETHA SRINIVASAN: IwasfortunateenoughtogetthemthroughSDNChildren'sServices, who I am running the playgroupwith. Theyhavebeeninthisroleforalongtime. Theywereabletopayforthespeech pathologist to come and visit, butthatwasjustavisit. Theydoaverybasic, initialassessmentforthefamilies. We introduce them and thentheplaygroupisonandwehaveaseparateroomwherethemumcantakethechildren, have a one-on-one chat withthespeechpathologistinprivateandthentheycancomeout. Iftherearetoomany red flags, if the parent saysitisallrightthenthespeechpathologistsharesthatinformationwithusandwefollow them up.

The CHAIR: Doestheschoolprovideyouwitharoom, aspace?

SEETHA SRINIVASAN: Yes.

The CHAIR: Hopefullyitisfreeofcharge.

SEETHA SRINIVASAN: Yes. Iampartoftheschool. IamnowbeingpaidthroughtheDepartment of Education, for the pasttwoyears, beforewhichIwasbeingpaidbySSI, whowaspaidthroughCHA. Iwork with two organisations. IusetheframeworkofCommunityHubsAustraliaandIambeingpaidbytheDepartment of Education. That is whyIhavetwotitles: communityliaisonofficerandcommunityhubleader.

Ms TRISH DOYLE: You'rethepersonwhoworksontheground. You'retheonewhoismultiskilled here. It sounds like thereneedstobesomecoordinationbetweenthefederallyfundedNFP, theDepartmentof Education and NSW Healthwhenyoulearnabouttheneedsofthedifferentfamilies, whattheytellyou—andthat might change. Like yousaid, itwouldbegreatonetermtohaveaspeechtherapistoramaternityorchildren's nurse from the local healthdistrictcometotalktotheparents. Butitsoundslikethereneedstobeacollaboration with NSW Health as wellintermsofuslookingattheconnectionthatfamiliesaremakingwiththeearlychildhood developmental checks—aformalcollaboration. Wouldyouagreewiththat?

SEETHA SRINIVASAN: Yes, Itotallyagree. Insayingthat, IhavetobringupthatwehaveourWINC ﷺWellbeing and HealthIn-reachNurseCoordinatorﷺnurseinourschool. Theyworkwithchildrenoftheschool and their families. Theyworkthroughreferralsthroughtheteachers, andeveniftheparentshavesomeissues then they can go to thenurseandhaveaconversationwiththenurse. It'smoreofawellbeingnurse.

Ms TRISH DOYLE: HowoftenisthatWINCnursethere?

SEETHA SRINIVASAN: SheisthereonThursdaysandFridays, twiceaweek.

Ms TRISH DOYLE: Twodaysaweek?

SEETHA SRINIVASAN: Twodaysaweek. Idon'tworkonThursdays; Iworkontheotherfourdays. We meetonceinawhile, althoughwehaveourownrestrictions. Ican'tsharetheparent'sdetailsunlesstheparent says okaytoit, andshealsohasasimilarissue. Butweareabletointroducetheparentstoeachotherifthey requireanysupport. Ifsheknowsofafamilywhom Icansupport, thensheintroducesthefamilytome, and likewise on my side.

Ms TRISH DOYLE: Icanimaginethatyou'vegotahugereferralbaseandknowledgeinyourhead and allsortsofpeoplethatyoutalktoandconnectwith. Forexample, inthepreviouspanelwehadTresillian here. Whenyoulearnaboutwhat'shappeningwithfamilies, doyouconnectwithaservicelikeTresillian? Then, once themumsordadsdropofftheschool-agedchildrentotheirclasses, istherespacefortheparenttotalkwith an organisationlikeTresillianabouttheyoungerchild? Doyoudothosesortsofthings?

SEETHA SRINIVASAN: Yes. Wehavenotconnectedwithherbutwhatwegenerallydoisthatwe have one-on-oneconversationswiththefamilies. Theycometomeand, forexample, theyask, 'Iamlookingfor a job. I want tofindjobs. Mychildisinpreschool. Thechildisstartingkindynextyear. Iwanttofindjobs. Can you please helpme?' Itisthatkindofsupport. Similarly, whentheycomeinandhaveconcernswiththechildren, we ask them tocometotheplaygroupbecause, whentheycomeintotheplaygroup, theyarewithintheSDN Children's Services. Theyarewithinthatorganisation, whichcanalsoprovideexternalhelpandwhichalsobrings in one of the othersocialworkerseveryweekwhentheycomein. That'showIconnectthemwithvariousother referrals.

For example, wehadafamilywhorequiredahearingcheckandeventuallyacochlearimplant, butthe child is still requiringmoresupportintermsofdevelopments. Althoughtheywerecomingfortheplaygroup, they

were not able to consistently come for the playgroup. But we do keep in touch, depending on if they are interested, and provide them with more support in terms of things like, "There is a speech pathologist visit coming up. Would you be available this week to come and have a chat?" It depends on what the family requires. Once they have got into the referral system, then I will be focusing on other families. That's the pathway.

Ms TRISH DOYLE: I can't believe there's just one of you, Seetha. You're a wonder woman extraordinaire.

SEETHA SRINIVASAN: It's more of the community coming and having a chat with us. We are just there to provide them with a launchpad, show them various opportunities that they have and provide them with a legitimate person whom they can speak with.

The CHAIR: Seetha, thank you so much. We are going to finish up a bit early, but what a wonderful place to finish up. Thank you so much for your time this afternoon and everything that you do every single day in helping the community. You will be provided with a copy of the transcript for corrections. Committee staff will also email to you any questions taken on notice—I don't think there were any. We as a Committee may develop some supplementary questions that we want to send out to you, and we ask you to be available to respond to those please. That concludes our public hearing for today. I would like to thank all of the witnesses who appeared today. I also thank my Committee members, Hansard, Committee staff, the audiovisual team who help make today possible and, of course, our hosts here at the Mantra Hotel. I wish everyone safe travels on their way home this afternoon. Thank you so much, Seetha.

Ms DONNA DAVIS: It's amazing what you do—just you in that little space for ٢٥ hours a week.

SEETHA SRINIVASAN: I want to let you all know, if you know any organisations that are within the Parramatta LGA and want to provide these services but don't have a space, I can provide them with space and also people to come and have a chat with them and get it out there. I'm happy to provide that.

The CHAIR: Thank you. Well, you have a wonderful local member. Thank you, Seetha.

(The witness withdrew.)

The Committee adjourned at ١٥:٤٥.