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 25 November 2024

The Committee met at 10:00.

PRESENT

Mr Clayton Barr (Chair)

Ms Liza Butler
Mrs Helen Dalton
Ms Donna Davis
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 the stakeholders who have made written submissions. We appreciate your input into this inquiry.

Ms DINA PETRAKIS, Chief Executive Officer, Ethnic Community Services Co-operative, affirmed and examined

Ms MOLLY JACKSON, Communications Manager, Jesuit Refugee Service, affirmed and examined

Mr BEN FIORAMONTE, General Manager, Children, Families and Disability Support, Settlement Services International, affirmed and examined

The CHAIR: I welcome our first 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 social media pages and websites. Please let the Committee staff know if you object to having photos and videos taken. Before we start, do you have any questions about the hearing process?

BEN FIORAMONTE: No.

MOLLY JACKSON: No.

DINA PETRAKIS: No.

The CHAIR: Before we start our questions, would any of you like to make a short two-minute opening statement?

BEN FIORAMONTE: Thank you for the opportunity to speak today. Since 2000, Settlement Services International has supported newly arrived refugees and now serves diverse communities in New South Wales, Victoria and Queensland. We empower vulnerable individuals and families, including those from diverse backgrounds. Annually, we assist about 56,000 people through nearly 60 programs including disability support, out-of-home care, employment, domestic and family violence, and settlement, with around 20,000 of our clients being refugees.

A key area of focus for SSI is the health and wellbeing of families and children aged zero to five years. The Stronger Starts Brighter Futures research by SSI and the University of South Australia 2024 found that socio-economic disadvantage is the largest driver of developmental vulnerability for children, with nearly a third of children from CALD backgrounds in disadvantaged areas being vulnerable compared to one in six in advantaged areas. Early childhood education and care, or ECEC, is crucial to address developmental vulnerability, but CALD families face barriers such as limited knowledge, language and digital literacy challenges, affordability, transport and lack of culturally responsive services.

In 2021 a third of children aged zero to four years in New South Wales were from a CALD background, the highest cultural diversity in Australia. CALD children are more likely to be developmentally vulnerable at school entry than non-CALD children nationally and in New South Wales. CALD children are less likely to attend ECEC, making them 1.7 times more likely to be developmentally vulnerable compared to those who do attend. Early intervention support is underutilised by CALD children, with CALD children in New South Wales half as likely to access these services compared to non-CALD children.

Based on SSI's experience with refugee and migrant families, and recent research, our recommendations include increasing investment in early childhood development checks to ensure they are accessible for all children, especially newcomers, who may have arrived without pre-birth, birth and early health checks; government collaboration with ECEC providers to codesign service models with soft entry points, integrated approaches and wraparound support, as shown to be most effective for disadvantaged families—the National Community Hubs Program funded by the Scanlon Foundation is a really good example of this—scaling up outreach initiatives to enhance community-based linkers or navigators to help disadvantaged families, including CALD families, engage with ECEC; and, finally, ensuring culturally responsive early intervention to address harm and neglect by considering ethnicity, faith, language and settlement and working with interpreters, community leaders and bicultural workers to enhance engagement and relationships. In conclusion, SSI appreciates the Government's efforts in this inquiry and looks forward to collaborating on strategies that enhance access to early childhood 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, serves and advocates for refugees, people seeking asylum and migrants in vulnerable situations in over 60 countries around the world. Here in New South Wales we offer frontline services to over 3,000 individuals and families, mainly here in Western Sydney. Most of the people we serve are seeking asylum and otherwise living here on and off precarious temporary visas, some for over a decade. As a consequence of this visa insecurity, the people we serve face extremely specific and severe barriers to their health and wellbeing. Very often they are ineligible for a number of public services, including Medicare, Centrelink, childcare subsidies, and parents are not often afforded the right to work. As a result, our families, particularly women and children, are on the front lines of financial, housing and food insecurity. Children in these demographics are falling through the gaps and are not afforded the psychosocial conditions that support their healthy development.

Organisations like ours are increasingly struggling to meet the overwhelming demands for emergency assistance. This is the context in which we made our original submission earlier this year, specifically towards points one and two of the terms of reference. What we want to emphasise is that all children in New South Wales, regardless of visa status, should have the right to health care. This should mean not only meeting their basic medical needs but also affording holistic wellbeing that enables them to thrive in our community. Unfortunately, in our experience, this is not the case. Children are missing out on both essential health checks and opportunities for social wellbeing, which impacts their developmental health in the long term. These children are considerably more vulnerable, with more complex healthcare concerns, than the general population. These include historic and ongoing trauma, exposure to violence, childhood stress from financial and housing insecurity, gaps in or absence of healthcare history, comparatively poorer nutritional status and community isolation and loneliness that can follow them into adulthood.

Despite the NSW Health policy directive we referred to in our submission that establishes that people seeking asylum should have access to essential health services, in practice it's prohibitively difficult for the families we serve to access often even basic health care. I've set out the barriers in more detail but I will simply summarise them to say that there are structural and financial barriers, language barriers, knowledge barriers within the health and public sector, and there are cultural barriers This all leads to a sense of uncertainty and fear of the healthcare system amongst the people we serve, particularly on a financial level, which prohibits them from seeking early or even emergency interventions for their children. Do I have time to share a case study to this effect?

The CHAIR: Let's hold that for a second because during the questioning you may well get the chance to give a case study or an example of something working well or not so well, if that's okay.

DINA PETRAKIS: I would like to acknowledge the Dharug people, on whose lands we meet today. I pay my respects to Elders past and present. I really, really appreciate the opportunity to speak before this Legislative Assembly committee on issues of importance to CALD families and children. As a provider of early childhood services since 1979, we are acutely aware of the need to address gaps in outcomes for vulnerable children and families. We work with new and emerging communities, established communities and some refugee families. Lessons we've learned over the past four decades that are pertinent to this inquiry are, first, we need understanding that parenting is a personal responsibility, but parents need prior knowledge to be able to make informed decisions for their families and their children.

Second, early intervention functions have to be built into the system. They must be clear and sustained. Knowledge of such systems is beyond the understanding of a lot of these families. They come from places where they do not have access to any of these services or systems. Third, proactive planning—and this is my soapbox—starting with cultural diversity, instead of retrofitting a solution to a gap, is critical to achieve universal access. Fourth, there is a fragmentation of early years intervention services—we've seen it—for parents, grandparents and carers, particularly for new and emerging communities, who try to navigate a really complex system. Fifth, support for CALD children with particular needs has to be ongoing and culturally appropriate. This requires systemic engagement with families. All of this—again, my little soapbox—needs to be done at the planning stage, not retrofitting solutions, in order to provide strong coordination and maximise universal access. Thank you. We really look forward to any future collaborations.

The CHAIR: I thank you all. It's such a lovely place to start our hearing today because we had especially wanted to come out to the Parramatta community to hear from groups that are working with CALD communities. The member for Parramatta has been a strong advocate for CALD communities and their place in all of our state government systems. We are so lucky to have you to kick it off today. I will start with the first question—a bit of a softball opening one. It goes to all of you. Given all the challenges you have described in your various spaces, what do you see as working really well in terms of a technique, strategy or opportunity, whether it is created by you, government or a not-for-profit organisation? What do you see as working really well in terms of ensuring that these children get the necessary health checks along the way?

DINA PETRAKIS: My organisation has been recognised for providing bicultural and bilingual support since 1979. All the programs we provide are done with bicultural workers. We find that this has been the one ongoing and sustainable matter of importance in terms of engaging families and children. Our bicultural workers come from the communities of these families. Not only do they speak the language; it's about cultural safety. Families feel safe with somebody from their community. They have a lot of trust and they have a lot of buy-in. So having these bicultural workers is critical for the work that we do in terms of engaging vulnerable families to systems that are complex, making them understand what is happening and building that trust.

Because you asked for the main thing, for us it is giving members of that community bilingual and bicultural support in order to support families. That is even greater than language, because you can give somebody a pamphlet in their own language, but what they do with that pamphlet or that flyer is a different matter. Having an actual person there from their community is what gives them access to systems.

MOLLY JACKSON: At the risk of sounding too negative, I do want to hammer home that there is little that works well for clients that are structurally and systemically unable to access healthcare services. What does work well is that there is the directive that requires that people seeking asylum do receive essential health care. However, as we've said, it's the access to and understanding of how to reach those services that's very complex. What we do at JRS Australia is try to bridge that gap. We do that through having lived experience, informed casework and being able to access interpretive services that are trauma informed and culturally safe, echoing what Dina has already said as well.

BEN FIORAMONTE: Similar to Dina's response around building trust, I think one of the key things that we know works is, certainly, when you have that trust. To build that trust in community, you really need to have that strong connection with community. There are a number of different ways you can do that. One of the examples is having a workforce that mirrors the diversity of the communities that you work with, for a start. You will find that there will be natural connections that can more easily be built within a community.

Just being very present within communities, similarly to what Dina was saying in terms of having available information. It might be in language, and to connect people to resources is critical, but unless you've got a guide or someone on the ground who is connected in community and who is going to be able to walk people through, show them and do those warm hand-offs, it will be much more difficult to make that work. I think that is one of the many reasons, but there are actually a number of things that are quite highly effective. Another would be—and I won't go into it now—integrated services as well.

The CHAIR: I am going to throw to my Deputy Chair. She just took a deep breath when you said "integrated services", so I am not sure if that's where she is starting.

Ms TRISH DOYLE: Yes, I was going to, so that is a great segue. First of all, thank you Ben, Molly and Dina for the work that you do, and please pass on our thanks on behalf of the New South Wales Government to your teams. You do such important work, and it is probably not recognised as much as it should be. On that issue of integration between NSW Health and the Department of Communities and Justice working with the community sector, what suggestions do you have? You have talked about cultural safety and you have talked about soft entry points, but what are some really practical suggestions that we can note through this process today and pass on to those agencies and departments to improve services and provide those wraparound services for children and families, particularly those from CALD backgrounds? I will start with you, Molly.

MOLLY JACKSON: As far as training and education, we've suggested that, potentially, orientation sessions be made available to people on temporary visas to ensure information outlining how the healthcare system works and their rights in relation thereto are clearly communicated. What we described in our submission is a situation of a complex map of exceptions that they have to navigate, and clients from culturally and linguistically diverse backgrounds struggle to navigate that alone. Access to advocates that perhaps come from within the 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, Start Strong, the ideas pathway, where they fund playgroups. So we're currently doing 10 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 wraparound 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-hubs type 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 Ability Links 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. Ability Linkers was a concept and a program where it would actually connect people, show people where to go.

A lot of what worked within SSI was most of our staff were culturally diverse and connected to these communities, and we think that that really worked. So we had bases in lots of locations across New South Wales. That was another program that worked. It was what local area coordination within the NDIS was also supposed to do to a large degree. It does to some degree but just never really quite got there. Finally, I just thought I'd mention the Foundational Supports program. I know it's supposed to be under the NDIS, but it's connected to the early childhood and out-of-home care sector and a whole range of other areas. It's another opportunity to create programs like key networks that can be established across the State for specific communities, again with the concept where you've got place-based services or supports.

Ms TRISH DOYLE: Excellent. Thank you.

Mrs HELEN DALTON: Thank you for attending the hearing; it's very interesting. I want to ask Molly a question. You talked about essential health care. Does that extend to the parents? I'll take a step back. We've got a lot of illegal migrants in my area. They come to Griffith to work, and they often go under the radar. Their visa may have expired. They're supposed to go home or extend it, but they don't, and then they end up having children. You talked about having essential health care. I would assume you were talking about for the children that are born here, but what about for the parents? What do they do when they're sick and they're not really wanting to identify themselves as being here?

MOLLY JACKSON: I'm not sure that there's a situation of people not wanting to identify themselves as being here. I think the situation is that they seek asylum and that the process is extremely difficult and takes—we've got clients, like I said, who've been waiting for processing for over a decade. So that's the context. That directive applies to all people seeking asylum, not just children. What happens is that our clients will, depending on the status of their bridging visa, go on and off eligibility for Medicare and have to go through the process of applying for that, and applying for that on behalf of their children. In the interim they can access, for example, a service called Refugee Health, but it's not necessarily clear how they can access that. They won't be able necessarily to access a GP in the interim, so they might have to pay for that out of pocket. Obviously, we've got clients who don't have the right to work, so there is no money for them to do that. This is an issue that, as we've discussed, doesn't only apply to the children but obviously applies for the parents generally, and then there are knock-on effects for the children because of the impacts of the lack of access to health care on the parents and the financial strain.

Mrs HELEN DALTON: I don't think that Refugee Health service would be applicable to our country areas. I wouldn't think so.

MOLLY JACKSON: Yes, I can imagine that people seeking asylum in rural areas are going to be 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's organisations like JRS that try to bridge that gap, inform the sector and offer some advocacy, but it's very difficult. I think that all of the ideas shared by the panellists would be incredibly valuable for our clients. The issue has been that we have no funding for anything beyond absolute emergency services. Thinking of this higher order wellbeing is a privilege that our clients and our services don't often get the opportunity to consider.

Mrs HELEN DALTON: Griffith is a mecca for agriculture. We've got Baiada—they're in the chicken industry—and ProTen. We have Casella Wines and De Bortoli. That's just to name a few. Obviously, people come in to work at these places. The whole situation with care and these kids slipping through the cracks is totally overwhelming. Is there a role for government, or even for other organisations like yourselves, to contact or to be in contact with those employers, such as Baiada or ProTen, and give them the skills or the help to set up preschools to be the point of contact? They seem to be invisible. They're out there. Work is a big thing. Many of them are working two to three jobs in these places, but it would seem that the employers should take a role. What do you think?

MOLLY JACKSON: I agree. Thank you for bringing that up. At JRS we have an employment program that does support people seeking asylum to upskill as well as to partner with organisations in the community. Like I said, one of the main barriers is this inconsistent ability and right to work, which is a huge detriment for clients to be able to access long-term work. We have all discussed integrated services. Another issue, like I've shared, is that people seeking asylum are often ineligible for childcare subsidies or ineligible for access to childcare services in general. I echo what you say that it would be fantastic to integrate access to child care through work. The root cause of all this is a much more structural concern about access in general. As you've said, people we serve have worked in the community for 10 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.

The teachers in primary school are not able to address these if they haven't been assessed because they don't know what the issue is. We are seeing that more and more. It's definitely increasing. That is one of the reasons I thought I would put forward to this assembly that, with universal preschools, there is an opportunity, if you even have a one-day clinic, to get coordination of services and wraparound services around the children and make sure that, when they start school, they are not already behind most of their classmates.

What we have also found is that for families that can access some supports prior to preschool and primary school, often the intervention is so minimal and so quick that by the time they reach primary school, they don't need to have an NDIS package. Not everybody will need to have one. If you have some early intervention—appropriate and relevant intervention—you won't need NDIS for some children. That's huge for the families because then they just carry on with their lives and the child—because a lot of parents want them mainstreamed—can be mainstreamed appropriately. But coordination—and like Molly said, again, we're working with the more privileged. We're not working with asylum seekers that have been waiting for over a decade for some kind of visa to allow them to work and access services.

Ms LIZA BUTLER: Prior to NDIS, I know there was a program called Early Start early intervention, which was basically going into preschools and picking things up. But it didn't just support the child; it supported the whole family to navigate the system, and supported the parents as well, to keep the whole family intact. Is that the piece that I'm hearing that is missing now?

DINA PETRAKIS: Yes. We had Ability Links, but that's no longer there. Now in NDIS we have support coordinators which do that coordination part, which is critical for CALD families. That's changing to navigators. We don't know what that's going to look like. Ability Links is no longer there. The support coordinators are now becoming navigators. That coordination piece is no longer there, and then the other one is sort of changing, so we don't know.

Ms LIZA BUTLER: This might be a question on notice for you. For those coordination roles, can you just come in now? You were saying that often a child doesn't need to go on for further intervention. It might be that they have glue ear and they're not hearing so their speech is affected, and then they exit again. Under NDIS, with that coordination role, are they eligible for that?

DINA PETRAKIS: If you're an Australian citizen, of course you can get NDIS. We're an NDIS provider. We have a two-year-old on an NDIS package. But this is not the case for a lot of these communities. We're talking about new and emerging communities. Even when you offer them the information and what's available, it's building that bond, trust and connection. They see a different face every time they go for a service. They have to repeat what they need. It's all of that. That's why coordination is critical, and that's why I thought bringing it together in the universal preschool model may be one way to minimise the deficit of that.

Ms DONNA DAVIS: One of the common complaints that I have received over a long time is the lack of coordination that is accentuated by the fact that the funding to support our asylum seekers and refugees is Federal funding, and yet the services that they are seeking, such as these basic health services, if it's a new baby born here with the services that connect and flow on from those early childhood checks with the blue book, are all state services. Would you like to elaborate on that, and on your experiences with that, and on what you think we can do to try to address that issue?

DINA PETRAKIS: Go, Molly.

MOLLY JACKSON: Yes, this is a perfect example of the people we serve being caught in the gaps. The Federal Government won't fix it from a visa perspective, and then the State Government is struggling to fix it without having, for example, permanent status. We made a number of recommendations in the submission that can be implemented from a state level. For example, around health care, there is already a directive that New South Wales has to ensure that people seeking asylum, regardless of their permanency, have access to essential health care. It's not necessarily about whether or not they have the right or whether or not there are processes in place to give them those services. It's about the limited access to those services because of the various vulnerabilities that they have. For example, we've talked about in-language services as well as in-language resources. One of the things I wanted to highlight was just the number of available interpreters—there aren't enough interpreters. Health practitioners—

Ms DONNA DAVIS: Sorry, can I just stop you there? We heard this last week. When there are not enough interpreters, are they interpreters for you to access or are they interpreters within the State government systems?

MOLLY JACKSON: I believe we're talking—both. But I'm talking about within the healthcare system when a client goes to a practitioner to have an appointment or to receive a developmental check and they don't necessarily have access to an interpreter.

Ms DONNA DAVIS: It would be good for us to be able to find out who they actually source their interpreter services from. You would think that that would be just a given, wouldn't you?

MOLLY JACKSON: Yes. I can definitely take it on notice to give you a more specific run-down of how that process works.

Ms DONNA DAVIS: Thank you. That would be great.

MOLLY JACKSON: But I want to reiterate that the issue is that particularly there are not enough female interpreters for women's health issues and their appointments are not extended for the length required to accommodate the use of an interpreter. There also may be bimonthly clinics that are offered in language but, again, the lack of regularity is a huge barrier for people being able to access the service.

Ms DONNA DAVIS: Can I give you that question to come back to us—about particular languages that any of you are aware we have a deficit of interpreters in? That would be very good to know.

DINA PETRAKIS: Mongolian.

Ms DONNA DAVIS: Yes, that is a growing population in my electorate, so definitely Mongolian.

BEN FIORAMONTE: More than happy to come back with some more data on that. But the issue around interpreters is quite significant. There are some tertiary healthcare providers—they're not obligated necessarily to use TIS [Translating and Interpreting Services], for example, which may be helpful to some degree, but the other issue with TIS is they don't always have the context. For example, around NDIS, they cannot necessarily translate the context. That's part of the issue. The other issue, too, is a lot of families being asked, "Can a family member interpret for you? Because we are not going to access." But they won't necessarily want the family member to do the interpreting because they don't want them to be across that level of detail. There are a whole multitude of issues here when it comes to interpreting. Happy to provide more detail.

Ms DONNA DAVIS: When a mother has a baby—like an asylum seeker that you're assisting—and then there is a health issue for that baby, where do you go? What do you do to take steps? I know you talked about refugee health, but what do you actually do to get that access? What do you do to help with money? Because we know they don't have a job. I know JRS very well so I know. I'd like you to tell us what you do to be able to fund and help them find a service. Where are you sending them?

MOLLY JACKSON: Often there is nowhere to send them. Particularly, for example, in a housing context, the reality is that both community sector organisations and public services are simply not taking them. The situation is that there are one-day solutions. We also have no funding. We have no funding for emergency casework, so for assistance with emergency medical appointments, payment for emergency medical appointments, payment for rent—we're talking about the broader psychosocial indicators of health here—we don't have that available to us. What we're seeing is an increasing vulnerability within our clients facing primary and secondary homelessness as a result. When a person seeking asylum who is on a bridging visa has a child who is born, there is a process of time involved in order to get them attached to an application, to get them access to Medicare.

I have another case study that we shared of a client who had two children, and for both of those instances they missed out on early childhood developmental checks because they took time to be able to get registered. To do that, we have to refer them to other organisations and we have to try to coordinate, with essentially no resources. So perhaps it would be useful for me to get one of our caseworkers to set out a specific example of the processes involved, but what I can say here is that it's an individualised experience in each instance because there are no solutions actively provided.

DINA PETRAKIS: I just want to reiterate what Molly said. You probably agree, Molly, that where there is a lack of government services for people like the asylum seekers, you find that community often mobilises to help these families. So the community will find them a place to stay. The community will fundraise money for a child for medical services. The community will band together as much as it can to provide what the government will not. But you can't rely on community a lot and you can't rely on it to that extent. By the time asylum seekers—the ones that do—get visas, which takes such a long time, those children will have missed developmental milestones and health checks, and will present later on with more significant issues.

MOLLY JACKSON: Just to reiterate, that's the experience we're in right now. It's a really dire financial situation. This cost-of-living crisis is affecting everybody—obviously the people we serve, but also community members that donate to JRS Australia. So that option is increasingly not available.

Mrs HELEN DALTON: Chair, can I ask another question?

The CHAIR: Is it connected to that line of questioning?

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 2024. 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 out and seeing a GP or someone who can help them navigate it.

Mrs HELEN DALTON: We're hearing a lot about lack of coordination between what's going on in the State and between 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: For this question particularly, I would say it's more than a lack of coordination when you're talking about Commonwealth and State and what gets funded. What we've seen is that if somebody has an NDIS package, obviously that's funded by the Commonwealth. But then there are services that are provided by the State government in terms of health and foundational supports. If you have a package—you're an NDIS recipient—but it doesn't have access to those supports, how easy is it for Australian citizens to access those supports? I think it's more than a lack of coordination; it's an understanding of what's funded by the Commonwealth, what's funded by the State and what you are entitled to.

I know that there have been NDIS recipients who have tried to get State-funded services and they said, "No, that's part of your package. It's going to come through that, not through us." That hasn't always been a seamless piece of information. I think ex-Minister Shorten was trying to put some clarity around that. Just recently I went to Canberra where he spoke, about four or five months ago, at a forum on foundational supports, just trying to get that clarity between what is funded by Commonwealth and what is funded by State, and getting an understanding between all of the providers about what's funded.

BEN FIORAMONTE: Just adding to Dina's point, as we head toward foundational supports and navigators, that's to kick off from July 1 next year as well. So there's an added question mark around all of this as well. What will the Federal Government take carriage of, and what will the States take carriage of as well? With foundational supports, is it a dual responsibility between the States and the Federal Government? If so, how does that look? What services are provided and how do we base that, and all that sort of thing? I think in community, unless we're super clear ourselves, it's going to be very difficult to communicate outwardly as to what's available, who's leading what and then of course how you connect to all of these different components.

Ms TRISH DOYLE: Thank you all. It's been a very interesting discussion. While you are each speaking and answering a range of different questions, and we are identifying gaps and lack of coordination, you're coming up with—through your submissions and through answering some of your questions—some fantastic, practical ideas that would bring about so much change. I'm just mindful of the frustration that the community services sector must feel with different changes and flavours of government coming and going, changes in the bureaucracy, and the way in which we name the work that different people do at different times—whether it's the ability linkers, the foundational support navigators or whatever it is.

People in the bureaucracy seem to think that a one-stop shop is what people need. That's not necessarily the case if there are no caseworkers to follow through once that first contact is made, whether it is soft entry or whatever. I thought it would be good for you, and for our purposes when we share this with departments, to expand a little bit on those issues where cultural barriers are in place, and to take some time to cut through the stigma, mistrust and fear that the families feel in trying to access services for their children. What do we do about that? How do we tell these agencies the model that is needed, keeping in mind all of those issues around stigma, fear and trauma?

DINA PETRAKIS: Develop a multicultural workforce, provide free training: a TAFE Certificate IV in Community Services—so many of our staff want to access that. I know it will be a government commitment financially to provide free training but, my goodness, the return on investment of having a multicultural workforce in the future is immeasurable.

Ms TRISH DOYLE: That's the early intervention that you're speaking about on the other end of the stick—fantastic, Dina. Did you want to make a comment, Ben or Molly, about that?

BEN FIORAMONTE: Absolutely. Sorry, I was running another train of thought and riding that out. I think part of the issue is that a lot of the different government agencies, and even some community organisations—we're saying the same thing. A lot of what we're talking about today, community has communicated through ongoing and consistent consultations out there. We've got the data. We've got the information for many years. You're communicating very similar things.

Ms TRISH DOYLE: You've got all the answers.

BEN FIORAMONTE: That's right. I think that's the key. The answers are there within communities. I love Dina's idea around a multicultural workforce. It's critical for reflecting and mirroring the communities that you're working with. I do think there need to be some consistent frameworks around how we engage with multicultural communities and diverse families. There needs to be something that sits over the top to connect everything together.

MOLLY JACKSON: I like what Dina and Ben have both said. At the moment, clients from culturally and linguistically diverse backgrounds—and specifically people seeking asylum—find it extremely difficult to navigate a public health system that requires individual advocacy. We try to fill that gap, but we're ill-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 $14,000 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 12 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 50 years. We provide 550 playgroups every week. We have 65,000 families and members across New South Wales, across 90 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 35 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 47 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 Centre? What would you say is working well out there at the moment?

BHAVANA SAREEN: In terms of playgroup?

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 10 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 expert help, visit their general practitioners 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 something that Playgroup across New South Wales encourages as part of that process or are you not that specific about it?

EMILY CASKA: We absolutely encourage it. With those 550 playgroups a week that we either run directly or subcontract to organisations, there is no overarching framework or engagement with Health, in this case, of that drop-in service. So it is quite localised, which has its benefits because you do want to tailor it to the local needs. You don't want come out with a curriculum of "At your playgroups, you're going to do this." I do think it's almost like a two-tiered approach. There is an opportunity to have a bit more of a formalised partnership like in the early childhood sector and actually bring the screenings in to the playgroups, but in terms of accessing health educators, even the playgroups we run ourselves, it's very localised. It's almost like we're individually reaching out; there's no systemic way about it, which definitely could be improved.

The CHAIR: It sounds like a good model. What about for you guys? I was going to say EPOCH. Is that how you refer to yourself?

ELIZABETH DENNEY-WILSON: That's our research collaboration, yes. I'd like to talk about the two programs I mentioned in my opening statement. Firstly, Healthy Beginnings is a program that provides additional support for parents around healthy feeding, healthy eating, active play and parent-child interactions. It's currently underway in Sydney Local Health District, South Western Sydney Local Health District and some components in Hunter New England. That program has been shown to be effective in terms of increasing breastfeeding and in terms of BMI or weight-for-length at 12 months. It has, in a research environment, been adapted to Arabic-speaking and Chinese-speaking families and shown to be feasible and acceptable to participants. But that's in a research environment. I guess one of the things that is challenging for groups like ours is that we can show things to be effective, funded by research by NHMRC or someone like that, but then we need a commitment from government to actually roll that out and make it part of routine care. That program is not only effective but also has been shown to be cost effective.

The other program that is underway in Victoria is the INFANT program, which provides training for health professionals. That training, again, is ready to go and has been evaluated, is effective and is very much appreciated by the professionals who do it. That program offers extra parent support at three, six, nine and 12 months, with key messages, again, around infant feeding, active play, sleep and parent-child interactions. That program, too, has been shown to be effective in terms of improving healthy eating and active play, which are all determinants of excess weight gain or weight gain. Again, that program is developed and ready to go and is being rolled out across Victoria. Again, that could be adapted for use in New South Wales. Those are two potential examples of things that are working well.

HEILOK CHENG: Can I add that those programs are embedded into usual care. As Elizabeth said, Healthy Beginnings is in the Sydney and South Western Sydney local health districts, and the INFANT program in Victoria is embedded in the local maternal and child health services, which is slightly different in that the nurses are in local government instead of state government and they have a green book. Also, the INFANT program is being taken up by early childhood educators and community health programs. As mentioned last week, if parents aren't engaged in the health services, we have parenting programs in libraries where this can be talked about by community facilitators.

ELIZABETH DENNEY-WILSON: And obviously it can be adapted to meet the needs of a particular community.

The CHAIR: I have two questions for you. Roughly how long has the INFANT program been rolled out in Victoria?

ELIZABETH DENNEY-WILSON: The INFANT program builds on over 15 years of research but has had widespread rollout for the past three to four years.

HEILOK CHENG: Since 2020, yes.

The CHAIR: Ms Cheng, did you say that the nurses are employed by local government in Victoria?

ELIZABETH DENNEY-WILSON: It's a different model, yes. It's a local government model. Maternal and child health services are provided by local government. It's just a different model of service provision.

Mrs HELEN DALTON: Is it a more effective model? I am a bit confused. Back in the day, 100 years ago when I had my children, I thought the council provided a community nurse. They certainly provided a space, the building. Was it the hospital, back before we had health districts? Can you recall what that service was?

ELIZABETH DENNEY-WILSON: I am pretty old—you are quite right. I think it is really the quality of the service that determines the effectiveness. I don't really think it matters who pays for it.

Mrs HELEN DALTON: But how effective was it 30 years ago?

ELIZABETH DENNEY-WILSON: We had a very different population and we didn't have the problem of rapid weight gain 30 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 3D 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: All of our regional services we auspice with local, well-recognised longstanding organisations, so we don't do the overlay from Sydney. We provide them, we partner locally, we invest locally also with ACLOs as well. We're looking at those partnerships, so we go in local, keep it local. I suppose we're more the peak body governing entity and then we support them with capacity building, practice guidance and some consistency across our playgroups, and also share best practices of, "Hey, this worked here," so we work really well with the local community. Also, the adjunct to that is we're supporting employment in regional and rural areas as well.

Ms LIZA BUTLER: Is it the playgroup itself that decides what kind of service they'd like to help the mums in that playgroup?

EMILY CASKA: Yes, very locally driven. But there is a playgroup facilitator overlaying that that we provide that coordinator and lead, so it's a bit two-way. We will also make soft suggestions of things they might like to think about, because people don't know what they don't know. But it's very locally driven in terms of the demand and the particular nuances of the playgroups. That's the beauty of them. We have some that are very specific to particular language groups, very particular First Nations communities, very particular disability diagnoses, and then that drives what that playgroup does. We certainly don't come at it with a centralised approach. It's really important.

Ms LIZA BUTLER: My next question is to all of the panel. We heard earlier today that there seems to be a lack of coordination between departments, so organisations are working in silos. Could you comment on that and maybe offer ways we can improve that?

ELIZABETH DENNEY-WILSON: Clearly we need more bicultural workers. Clearly we need more translation services that are co-located with child and family health services. We need them to be really specifically tailored to communities where there's a high concentration of migrants from different areas. Again, I guess I'm not an expert on how these services are funded, but it just seems really clear that they need to be available right from the start of a program all the way through to the actual care with the family. They need to be involved in terms of developing the resources, the materials, the language and the interventions because we need to make sure that all of those things are culturally appropriate right from the start—so involvement right from the beginning, not just at the point of consultation.

BHAVANA SAREEN: Can I clarify? When you say the departments are not coordinated, could you just elaborate?

Ms LIZA BUTLER: We heard earlier that there's a lack of coordination between departments and community organisations and the healthcare sector.

BHAVANA SAREEN: Okay, so a lack of coordination?

Ms LIZA BUTLER: So you're working in isolation rather than being a coordinated group.

BHAVANA SAREEN: Every organisation has its own agendas that they are following. To find a common ground is something I believe—sorry, can I take it on notice and get back to you on this?

Ms LIZA BUTLER: Sure. Absolutely.

BHAVANA SAREEN: I have not really come across too much non-coordination as such. I have felt everyone has worked together. But if this has been stated and there is something that I have missed, I would like to take it on notice and get back to you guys.

The CHAIR: It's really good to hear, though, that your experience is that everyone is working together well.

BHAVANA SAREEN: Yes, whenever I've asked for any help or coordination with any other department, they have been very willing and have delivered. I had not come across it, so unfortunately I cannot answer that question, but I'll take it on notice and come back.

EMILY CASKA: We experience the silos across different departments and then across the different levels of government, and that does cause confusion for families. If I particularly narrow down to when the checks are done, if there is a disability, then you go into NDIS land. There is private practice, your local health district and the PHN. There are a lot of people involved. We do find that in regional areas we seem to collaborate a lot better, generally, because of that community approach. Maybe I'm optimistic here but I do think that the new Foundational Supports model coming in with the NDIS reforms will make this area better for children.

I particularly like the proposal of having some sort of navigation coordinator support for children and families, and bringing the departments together a lot more. We've been working on that with Disability, Health and Education at the moment. Even in the consults today, Health is the one that families in these early years have the biggest interface with, so we need to bring down those silos. That presents us with an opportunity, and New South Wales is definitely leading the way in implementing that, from our meetings with the Minister here last year. That was a great start, and I think that that's optimistic. But the barriers are definitely there. Even amongst us as community organisations, we almost play that quasi navigator/connector role, which is great, but it detracts us from our core business, because we do it to support the families. But those silos are there and definitely real.

Ms DONNA DAVIS: I was very excited, Professor Denney-Wilson, when you mentioned the word "breastfeeding", because it's the first time in the inquiry that the word has been mentioned.

ELIZABETH DENNEY-WILSON: I could talk about it all day.

Ms DONNA DAVIS: From my personal experience, it was the early intervention that helped support me to be able to breastfeed my first child, even though all the naysayers told me that it couldn't happen. But I was determined. I thank you all for being here; it's wonderful. I'm very excited about the fact that we're in Parramatta today. Everyone knows I'm always carrying on about Parramatta. But it's great to be able to have you here and to hear all your expertise. I would like to talk about breastfeeding and the connection between what I perceive as a reduction in the number of mums that are breastfeeding and how you think that correlates with the services or lack 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 12 months. I want to talk about that secondly. But if you could talk a little bit about the blue book in relation to breastfeeding, I'd be very appreciative.

ELIZABETH DENNEY-WILSON: NSW Health has, for a long time, had a very strong commitment to encouraging and supporting breastfeeding. We do have very good initiation rates of breastfeeding in New South Wales, but we have very early drop-off in terms of women ceasing breastfeeding. Often parents will stop breastfeeding and commence formula feeding without consulting a health professional. That, I think, speaks to access, and it might be about more than just being able to get an appointment—and it might be about being able to get an appointment in language. Certainly, breastfeeding is front of mind for child and family health nurses. They are often also lactation consultants, but also have access to lactation consultant services within the local health districts in that early establishment stage. There is a whole bunch of things that we need to do as a community to help women to breastfeed for longer and to breastfeed exclusively for longer. Now I've lost my train of thought.

Ms DONNA DAVIS: We can come back to you.

ELIZABETH DENNEY-WILSON: You wanted to know specifically to the blue book, didn't you?

Ms DONNA DAVIS: Yes.

ELIZABETH DENNEY-WILSON: I think there is lots of support within the blue book, but we need more. We need women to be able to access help and support when they need it, rather than popping off to the pharmacy and being told, "Here you go. Here's the solution."

Ms LIZA BUTLER: Can I just interrupt for a question before you go to another topic?

Ms DONNA DAVIS: I was just going to ask the others for their view on that. Bhavana, do you feel that in language is an issue with mums?

BHAVANA SAREEN: Not with the parents that I have been working with, because they're all coming from migrant communities and CALD communities and, usually, breastfeeding is the way to be. But how long would they be doing it, that's a completely different situation, depending on whether the mother has the capacity to breastfeed. I would have to also take up with this lactation consultant and the lack of knowledge. I think that's the biggest challenge. Let's say, for a first-time parent, they don't have a rule book that they're going to follow. What's the first point of contact? It will be the doctors and the nurses that they're coming across when the baby is born. A blue book is given to the parent and they say, "Follow it." A person who is coming from a migrant community, who has just come here, does not have the language and does not understand. For her, the blue book is just another bunch of paper. It's nothing else.

Not having that communication between the health provider and the parent—maybe in their language, maybe a peer support group, a multicultural support worker or whoever there is—to help them understand what this is going to do for them and to be able to follow that—unless they understand why this is important, they're not going to follow. It's as simple as that. That also goes for breastfeeding. For people coming from countries like Syria, Afghanistan or even from India, a lactation consultant is not a thing. Not having the knowledge about these kinds of things and that these health professionals are available, they are not going to go for them. Having that conversation within the community is really important. Involving peer support groups is really important. As I said, breastfeeding is a norm. Within my playgroup, I see mums breastfeeding. It is something which is acceptable and is a norm. But how long would they be breastfeeding—and let's say if they are facing any difficulties and knowing who to approach—that's a completely different thing.

ELIZABETH DENNEY-WILSON: May I also add that in our research and in our experience, starting that conversation antenatally is absolutely vital. You can't wait until the baby is here. Antenatal support tends to help switch mums from "I'll breastfeed if I can" to "I will be breastfeeding." That's absolutely essential as well.

EMILY CASKA: I'm going to take my Playgroup hat off and wear my Down syndrome hat now. It speaks to the point about support and knowledge. We hear from our families—I've been in the Down syndrome world for 20 years—that lactation consultants in general seem to have really dipped off. My mum, who has six kids, has said that too. It speaks to antenatal care as well. All Down syndrome babies are born with hypotonia. They need specific breastfeeding techniques. That support and knowledge isn't there. Again, because they're beholden to what is a relatively generic blue book that doesn't spell any of that out, they come to associations like my former one and try to get that support, but there is no expertise out there. That's really diluted, so we're seeing a lot of babies with Down syndrome not being breastfed.

From my own personal experience of when I was breastfeeding my son and how it intersects with the checks, ceasing breastfeeding doesn't seem to then be a developmental indicator of maybe we need to check in as to why. I was doing all the milk and the oat cookies and the apricots and the fenugreek and all the things and staying up all hours and it didn't work. Literally everyone was like, "Oh, well, you tried, doll." Actually, what we found out 10 months later was that that was a sign of tongue tie. That could have saved us a whole heap of speech investment and other things and I probably could have continued to breastfeed. But it wasn't seen as a developmental check of "Maybe we need to check in."

Ms DONNA DAVIS: We spoke last week about these early checks, like with my own son and his lack of sucking reflex and then that connection with autism later on. If you have these regular checks, people can check this stuff out earlier. Sorry, Heilok, did you have anything you wanted to add?

HEILOK CHENG: No.

Ms LIZA BUTLER: On the same subject, we used to have the Nursing Mothers' Association back in my day.

ELIZABETH DENNEY-WILSON: We still do. The Australian Breastfeeding Association is what it's called now.

Ms LIZA BUTLER: I'm still connected with a lot of those mums that were in the Nursing Mothers' Association when I was. You would sit around and talk about all of these things and then you could get help. There was help on the phone and there was lactation help. Is that still a thing?

ELIZABETH DENNEY-WILSON: The Australian Breastfeeding Association is still going, and going strong. They have, like a lot of places, adapted their model. Certainly, when I was breastfeeding my kids, we met in people's homes.

Ms LIZA BUTLER: Yes, that's what I did.

ELIZABETH DENNEY-WILSON: I trained as a counsellor. That model has changed in that people now meet in libraries and in cafes and in places that are more public.

Ms TRISH DOYLE: You can get a sticker for your office, too, to welcome breastfeeding mothers.

ELIZABETH DENNEY-WILSON: Yes. That would be great—"Breastfeeding welcome here".

Ms TRISH DOYLE: I've got one of those.

ELIZABETH DENNEY-WILSON: The 24-hour helpline is still around. They have a very good website to support mums. It's one of the recommended resources in the blue book.

Ms LIZA BUTLER: The Nursing Mothers' Association used to come around to the hospital and introduce themselves to you when you had just delivered your baby. Now you tend to leave hospital within 24 hours, so you may not be connected with as many of those organisations as we used to be.

ELIZABETH DENNEY-WILSON: That's possible. But they certainly are one of the recommended resources.

Ms DONNA DAVIS: Going back to when you mentioned that there is no recommended blue book check between six and 12 months, can you provide a case study or examples of poor diet and the impact this has on babies and children longer term because of the fact that we don't have those checks?

ELIZABETH DENNEY-WILSON: Absolutely. There are a couple of things I'd like to mention about that six to 12 months of life. One of them—and this is Heilok's area of expertise—is that teeth erupt. We really need to start to emphasise early dental care. There was a really lovely case study in the first group this morning that I would refer you to in terms of teeth. That couldn't have been better. One of the things that is a risk factor for child obesity and is a very sticky risk factor in terms of being difficult to reverse is rapid weight gain in the first year of life. It tends to really present itself in that second six months. That's when a regular growth and development check would identify a child who is crossing growth centiles. That would be an opportunity to really dig into how the child is being fed and how you are feeding them—are you feeding them responsively or are you forcing them to finish that bottle? Are you giving them top-ups after the solids? Are you overfeeding that child? Also, what are you feeding the child? How is the milk being prepared? What kind of solids is the baby getting? How frequently? What portion sizes? All those sorts of things.

A baby that has rapid weight gain is much more likely to be overweight or above a healthy weight as a toddler. The longer you have that excess weight, the more likely you are to keep that excess weight and start to develop the kind of health problems that we see associated with child obesity. These are things that you would typically see in adults: risk factors for cardiovascular disease, type 2 diabetes, and there is a thing called fatty liver. But there are also psychological problems around self-esteem and bullying, and also things like the way the skeleton develops can be affected. We would really strongly advocate that rapid weight gain is identified early and nipped in the bud, because we don't want to see an increase in the approximately 20 per cent of kids who are already above a healthy weight entering school—so in those preschool years.

BHAVANA SAREEN: What I have noticed with the parents is the ease of availability of junk food. The parents are time poor because they have so many commitments. I have to make the statement that in Australia we live by the time, literally, so every minute of our time is dedicated. We have got to do this and we have got to do that. That makes the parents time poor. If the parent is time poor—they have more commitments—they are not going to be sitting down making healthy food. They will give the child whatever is easily accessible to them, and most of it is junk food. There is no nutritional value in that, though it might state on the wrapper, "Yes, it's amazing"—but it's not. That's one of the things I have noticed. The parents are feeding their kids—it's not that they want to, it's just because it's easy.

Also, we talk about the need to have three serves of vegies and everything for the children. Now, if we look at the price of the vegetables that are available, the parents are not really going for it because they can't afford it. It's also the financial aspect of it. I've noticed that the parents are not going in for things that they should be feeding the kids. I do believe, sometimes, parents do overfeed their child, as you mentioned. It's because I'm doing something and the child is bothering me right now because he wants to play and I can't, so let me give him some food with a screen. Again, this is what is causing other things. There are a multitude of things which are causing weight gain—and we're talking a rapid weight gain that is happening. It's a very complex issue. I can't just say, "This is it", or "This is the way that it should go", or "This is the way."

Also, the parents who are coming from overseas do have certain food groups that they tend to go to. Let's say, even if they go to a nutritionist, do they understand their food preferences? There is a gap there, too, where people coming from different countries would have a different way of feeding. I know, from my own personal—when my babies were born, my mum would say, "Give them this" or "Give them that", but when I'm talking to a nurse, she said, "No, that's going to cause more issues." So now I'm stuck between my mum telling me something and I'm thinking, as a first-time parent, "I don't know who to listen to." It is a very hard place to be in for a first-time parent—or any parent. It doesn't matter. Even if you have three kids, you'll still struggle because each and every kid is different.

EMILY CASKA: The only thing I'll add is about the milestones in general and the checks. I think there's a need to properly separate the immunisation schedule from the developmental checks. I reflect, personally, that I did the immunisations and I got followed up if I didn't, but if I missed the developmental checks—sometimes I'd just go in and out of the nurse—they didn't really follow me up on that. But when I look specifically at that six- to 12-month time frame, whether it is obesity or any other risk factor, I think there are a lot of things particularly colliding there. I think we're looking at, obviously, for obesity, the teeth and the combination of solids and milk and/or formula.

But also, if you look at the parental capacity side, I feel like at the six-month mark you're starting to come out of the haze and you're starting to find your normal tempo of life, whereas those early days are just hectic. It's not amazing at times, and you are, I think, in quite a frequent rigour of immunisations and checks. I feel like you're there a lot, and then it dies off. But I think there's almost like that lifestyle check needed in that six to 12 months in particular—I would argue probably more regularly throughout the developmental checks. Sometimes that's where parental leave has started to die off as well. Some parents are considering the return to work. I think we need to separate the developmental check from the immunisation check. I'll be honest, even working in this space, I thought the immunisation was the check as well, and sometimes I wouldn't do the two together.

Ms TRISH DOYLE: I've been listening with interest too. There is so much reference to mums for obvious reasons. We've all been reflecting. I'm sure you have too, Mr Chair, on having little children and health checks and access to services. In the case of my second child, it was dad who went to the playgroup and wasn't particularly welcomed, and dad who went to get some of the checks and was kind of scrutinised. We talked in the previous panel about the fact that there are different cultural understandings of what child development is. But I'm sure that's also gendered understandings or different understandings from mum and dad and families. Can you expand on some of that—where access is limited or there is no access or there are families who refrain from reaching out for whatever reason because there are just different cultural understandings of what child development is? I'm interested particularly to hear from playgroup too about how many dads are involved—just as an aside. But it sort of feeds into that idea of what is healthy child development. I might start with you, Bhavana.

BHAVANA SAREEN: We see very few dads, really. That could be because the CALD community feel that it's not the man's role, that it's something like a gender assignment, that only women or mum is going to be doing this with the child and that dads are not really involved—because being a patriarchal society. But the few dads who have come in were only coming in because the mum was sick. It was not that they wanted to be there. And also the fact that there are no dad groups. That also affects it because, if the majority of people there are women and just one dad in there, they really cannot—it's not that they can't communicate. It's just that they feel really awkward, really weird to communicate with each other. They may not be free or they may not be comfortable talking about things. I have noticed that.

In my own organisation we have been talking about encouraging more dads or maybe having dad groups, so encouraging dads to come in to see, because we have realised that bringing up the child has to be both parents. It cannot be just one parent being involved. Because that's just too much pressure on one. And dad not knowing what's going on with the child, because what I have also noticed is—let's say the child has development delays. If the dad has not seen the child—or, rather, it's not that they are not seeing the child but they're not seeing the issues involved with the child, because they say, "It's a small child. He'll grow out of it"—and they're not understanding or they're not going to a health check or a developmental check, they don't accept it. The non-acceptance of a diagnosis is another issue that I've noticed. Bringing dad into the fold is really important and that is what we have been talking about within our organisation—as to how to encourage dads to come in.

Ms TRISH DOYLE: Have you come across different families and different understandings of what healthy child development is depending on what the cultural background is?

BHAVANA SAREEN: Most of the families that I come across—again, I'll keep referring, because they are all South Asian side of the world. The understanding is dads are not really involved in everyday upbringing of the child. They may be involved in taking them to—I mean, I have only seen mums taking them to parks. I have hardly seen dads involved in that—very few dads. It's quite unfortunate because coming back—again, I'm from an Indian background. My dad was not involved. Even with my husband, I saw that he was not involved even though he had been in Australia for a good 20, 25 years. It's a cultural thing.

Ms TRISH DOYLE: On that point, leaving aside mums or dads, at the migrant resource centre do you often have different families that come in and they have a different understanding to the models and the systems of what is considered healthy childhood checks? Is there a bit of a clash there sometimes with the CALD communities and the system?

BHAVANA SAREEN: I think there is a lack of knowledge, really. They feel if the child is okay, running about, eating—all good. If a child is naughty because he's displaying some behaviours, that's because the child is naughty. They are not really understanding it. Even if it has been conveyed to them in a very soft approach, they still do not want to accept that—"It cannot happen to me". It's as simple as that. So, yes, there is a huge difference.

Ms TRISH DOYLE: Did you want to comment on that question, Emily?

EMILY CASKA: Yes. I think that the gender roles exist. We'd be remiss not to say that, but I do think that there are some levers in place and some things that we're doing to bridge that gap. I do think, as an overarching structural lever, the changes to paid parental leave have helped. Dads tell us, "I can now go to the therapy and support at home." So that has been great. From our service perspective, building parental capacity is that other lever that we as playgroups are trying to influence.

This Saturday, actually, I'm going to Rosehill for a dads' teddy bears' picnic. It's on a Saturday—so that tells you something—out of work hours. Again, it's that soft entry point for dads. I think thrusting them into a check environment or a breastfeeding class might be a big step for some of them. But if we can engage them in a playgroup that's specific to dads—again, localised in their local area—then we're finding that that's great. So that'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 60 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 ALISON WALLBANK, 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. First of 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 usefulness 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. Every day, 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 450 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 20 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 20,000 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 50 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 24 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, with a focus on matters of child and family health, early parenting, perinatal mental health, health promotion and early intervention and prevention.

Tresillian's guiding principle is to deliver the highest quality service to children and families, and to provide children with their right to safety, stability and healthy development. Tresillian also provides a strong framework that ensures the quality of service and care that is provided to children and families of New South Wales, Victoria and the Australian Capital Territory. Our guiding principles focus on available research, literature and best practice, which will continually inform our best service and strength-based approach when supporting families.

The CHAIR: Thank you all so much. What a diverse and experienced group of panellists we have. I start by emphasising that it is us who thank you for your attendance today, because we are in your hands as to your experience and wisdom in helping us to better understand and write the best possible report and set of recommendations for the Government. We sincerely appreciate that. To start on a positive note, in your collective experiences, what do you see as working really well at the moment in this space about making sure that everyone—hopefully all children—have access to the early childhood health and developmental checks?

RITA FENECH: What's working really well is the knowledge base in our sector and the ability to support families in a holistic way. At Tresillian, we have a multitude of professions that work in a supportive way. We also have partners out in the community. I think that not working in silos is really important and that we use what other resources are around in the community, and Tresillian is very good in partnering with NGOs and other health services. We use that in a respectful way for families, and I think that works really well. It is important because of the limited funding that's out there for just one service to do everything for families. We can close that gap when we partner with each other.

The CHAIR: Agreed. We have to be careful with the way that we spend money and who's doing what. We don't want to duplicate things, right? There's only a certain amount of money to go around.

RITA FENECH: Exactly.

The CHAIR: It is important. Thank you for acknowledging that. Ms Wallbank?

ALISON WALLBANK: I think at Tresillian what they do really well is access. When we talk about 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 or have difficulties around health literacy, that's a barrier to accessing service, and I think Tresillian does that really well in terms of having a phone line that's available seven days a week—7.00 a.m. to 10.00 p.m.—where families can ring and get help to navigate the service that they need. Sometimes that's directing people back to their child and family health service. I just think that's done well in Tresillian, if I think about the process. 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 services operate is in business hours—is tricky. So, yes, that's something that I think is good.

The CHAIR: In terms of that phone service, are there multiple languages available?

ALISON WALLBANK: No, there's not—well, in a way, yes, because we can access phone interpreters, just like any other NSW Health service. We can call the phone interpreter and then we can use the phone interpreter with the phone call.

MORGAN FITZPATRICK: When families are connecting in with the child and family health nurse servicing, I think that they're getting a good experience generally. The gap, as we've talked about, is obviously when they don't get followed up or they fall out of that system. But when they're in that system, they're getting a fairly holistic set of supports that's available to them. Insofar as families are able to access that through the barriers, I think they are getting a good-quality service and that's working well.

KYLIE STREATFEILD: I do support what Morgan said there. Particularly from a regional, rural and remote perspective, when families are accessing the child and family health nurses, as well as the Brighter Beginning checks, children are getting a really good holistic assessment, which is great. Particularly from our preschool, the feedback that's given to the parents as well as preschool staff has been good and sufficient to be able to support families.

LAURA FARAJ: I would have to echo those last couple of points. Once a family can access the child health nursing service, they are getting a very supportive assessment. Those blue book checks are really helpful for families who might not have that high parental health literacy. It's a simple way that they can read through. It's a simple yes or no. They may or may not do it at home, but if they did, that's good. If they do it with a nurse, that's a really quality service and a safe place to get that information. Typically, again, they have the pathways 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?

LAURA FARAJ: I think that in our community, there's quite a few. Being quite a challenging geographic 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.

KYLIE STREATFEILD: For myself, being located, again, 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 children get the check, 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 12 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 child care; 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 ninetieth 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 maybe have 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 system at present sits 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 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 10-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 24 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 17 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: SMS4dads.

MORGAN FITZPATRICK: SMS4dads. It was incredible. I would come home from work and he would go, "I got this text today. Did you know that [name redacted] should be smiling today?" He would read it to me. "'Around this time you might start to see the first smiles.' Do you know what? Today we had a smile." For him, it was such a great way for him to connect. It was short and it was bite sized and he loved it. He really came along on that journey because of that. I think, why aren't we doing that with mums? Why aren't we doing that in different languages? I'm sure it would be incredibly easy. Texts are very short. Translate that and get that out.

The CHAIR: Sorry, what was that called?

MORGAN FITZPATRICK: SMS4dads.

ALISON WALLBANK : It's through the University of Newcastle.

MORGAN FITZPATRICK: I think the other thing I would echo, as Alison said, is that involvement of the other parent in the child and family health checks and in the screening about how they are coping. I think we have to recognise that there will be instances where the mother is not the primary caregiver in those early days, so if you're not doing depression inventories and if you're not checking on wellbeing, I think we've got a real risk around how those caregivers are coping and an obligation to make sure we're following that up. I think that's all from me.

Ms DONNA DAVIS: That's great. They were some really good responses.

KYLIE STREATFEILD: I sometimes feel that vulnerable families often need a level of trust and familiarity. I obviously agree with everything that everyone else has said, but I think that sometimes those soft entry points and connections with families in the community are really important for being able to provide information to check in with families to ensure that their children are getting those child and development checks that are needed. For me, it is potentially for allied health staff or early childhood family and health nurses to be available at mainstream community places for children like playgroups. Supported playgroups are a great opportunity to really check in with those vulnerable families and are a way of supporting them and providing information.

I just wanted to echo something that Alison said around the mothers' groups and the availability of those groups for families when they have their children so that they can connect with other parents, they can get information, and they can get that peer support from other parents. If you've got one person saying that they've accessed a child development check, it might encourage others to do the same, but I also think maybe there could be a way where allied health professionals or early childhood nurses are present at those mothers' or fathers' groups. I know for us, in Orange, if you have your first child, you are eligible to attend a mothers' group. If you have your second child, you cannot go; you are not eligible.

So if you've got families moving into regional, rural and remote communities, potentially with their first child—they've just been born—and they want to get access to a mothers' group, they're not eligible to attend. I see this over and over again on social media. Parents are asking, "Where can I go? Where can I link in with families?", particularly in those rural and remote areas. For isolated families, it's really significant and it impacts on children's development and parents' and family wellbeing. I think—being connected and trusted in the community and having that engagement where families are at in their community.

LAURA FARAJ: I submitted in our appendix and referenced throughout our submission that we had done a parental health literacy consultation. I ran focus groups for families that may or may not have had a child with a disability or delay, as well as some interviews with one that had—intentionally—to understand their experiences. So I thought I would just read their ideas of how they would like to get more information, from their perspective, I guess—from a vulnerable cohort. They echoed what has already been very much shared about getting out into community—that often they don't know but that if they saw a nurse in community, if they saw a flyer, or if there was an information session at their local hall, they would attend and really appreciate that. Resource libraries that had different tools that a family could borrow instead of having to buy—so similar to a toy library but maybe there are speech cards or maybe there are different gross motor skill activities.

They might often be aware that there might be a delay, but they don't then know what to do with that or how to address that—really simple how-tos on how to access services. Often the literature that is put out is very word heavy and very dense, and for vulnerable families where maybe there is low literacy—we have already talked about multiculturalism and different languages as well—often our families aren't going to read a big brochure. If it's just a super simple, "Here's what your child should be doing at two", which I know is what's in the blue book check, that kind of information is really easy to see. "Where do I see a child health nurse? This is the number to call." It's simple information.

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 of where to get help, where mums can go to get activities, ask a question 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 Lans 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 day care. 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, 12, 18 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 18 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 day care 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 key worker. A key worker in the best practice field for early childhood intervention is a trans-disciplinary role. It's often an early childhood teacher, but it can be a speechie or an OT or a physio that's trained in key worker. 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 18 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 speechie, physio—key workers 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. But there's going to be a good portion of families that need to go into some initial intervention and support. That will be needs based. Some children might need intensive support; some might need the occasional check-in with a key worker or a speechie or an OT or another discipline.

As you go down that journey, you're going to identify whether or not those functional needs are so severe that they need to go into the NDIS and we need to support them on that pathway, or it may be that that early intervention is all they need. All of this, we would suggest, is done within the best practice guidelines for early childhood intervention—so done in natural settings where children live, learn and play. That's in their schools, their homes and their community settings. I give the example of a three-year-old having sensory meltdowns. We can go into an office, we can help and you can explain what's going on. But if we go home at 5.00 p.m., when that's really happening, and we see that when it's happening, we can get to more effective strategies more quickly.

One of the reasons that we recommend it be in natural settings where the children are living, learning and playing is because we can get to the solutions more quickly. We can really understand what's going on and we can intervene more effectively. It does cost a bit more to send someone into the community, but your return on investment is higher. The other thing with that is that it is working in a transdisciplinary approach. The idea of a key worker and why you use a single key worker is because the evidence shows that reducing the number of relationships that the family needs to manage—you can tell that on this journey that we've mapped out, they haven't had to bounce around five different people to get there—

Ms LIZA BUTLER: And tell their story 10 times.

MORGAN FITZPATRICK: Yes. They're just getting straight to some support and advice. There's no funding for that at the moment.

Ms LIZA BUTLER: That was my next question.

MORGAN FITZPATRICK: There's no funding for this at the moment. With the NDIS and the changes happening there, I think that you have a scenario where children will be coming off the NDIS. In practice, that may or may not be happening. That's going to free up workforce. The last thing you want to do is create a separate workforce alongside the existing early childhood intervention workforce. We have got people delivering these services and supports already. It would be ideal that the same organisations that deliver those services are delivering this at this point. If a family then ends up on the NDIS because they have a longer term need, if they choose, they can continue to use that provider, so you get some continuity for that child and family as well.

It's envisioned that this would work alongside what other additional foundational supports are designed, such as peer support. That's a huge gap at the moment. If your child has a developmental concern, there are not a lot of organisations out there, particularly in New South Wales, funded for peer support for the parents to go, "I have got a child with additional needs. That's a unique experience. I need peer support around that." Some parent training, such as Hanen for a child struggling with speech—Hanen can be fabulous, but there's nowhere funding that right now. Those types of services can sit alongside this and really complement it, but this is about documenting a much more streamlined journey to early intervention for children and families.

Ms LIZA BUTLER: Before I ask about funding, did anybody else have anything to say on this?

KYLIE STREATFEILD: I probably just wanted to add to what Morgan was saying around the key worker model. For vulnerable families, this model is very effective. It builds those relationships and engagements with vulnerable parents. We find that the continuity of support is really good for those families. The other thing is that the key worker model looks at the child and family as a whole and works with the team around the child. We're not just working with the child and, say, the mother. We try to engage the father, or we're working with siblings and looking at the needs of siblings as well. We're also working within the child's other environments, like childcare centres, preschools, long day care and schools. We might go into the community and provide support with that child in the community. We're not only building the capacity of the child and the parents, but we're also building the capacity of community members.

ALISON WALLBANK: I was just going to add that that's very much in line with how child and family health nursing works. It's just that there aren't enough clinicians to do it. We have the safe start policy that identifies families with risk of vulnerability. They are identified as level two or level three. These families are brought to multidisciplinary case review. We don't call ourselves key workers but basically what we are doing is what you are describing. We are working with the family and getting multidisciplinary case review from our colleagues in allied health around what would work with the family. We have an Ages and Stages questionnaire (ASQ).

MORGAN FITZPATRICK: That's what we do, too.

ALISON WALLBANK: And then that has guidance into where you go and whether they need to be referred to allied health, or there are activities that they are given—a little bit like what you are talking about.

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 key worker 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, probably, sufficient for services to be able to provide a really good quality service. We are all using the term 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. Those funding contracts have not changed since 2018, but our communities have changed. It's really difficult to be able to meet the needs of families and communities flexibly in a way that meets their individual needs and community needs.

Ms DONNA DAVIS: Thank you, everyone, for coming today. I'm going to go straight to the Hive to start with. You mentioned the Child Health Linker role. Can you elaborate on the Check-Ups Before School program and the linker role, and how the services can be implemented on a larger scale?

LAURA FARAJ: Absolutely. The Check-Ups Before School—or CUBS—program was basically because we were hearing all the same things that we've been talking about today that our community really wanted. There were such high levels of developmental vulnerability and unidentified delays heading into school. When we were talking to families, they weren't aware of the blue book checks or they had barriers to access them. We knew that the local community health centre was offering these checks, but they just weren't being utilised by the community that needed them the most because of that fear, because of the lack of awareness or the lack of transport to get there.

We got some funding from the New South Wales Government to do a pilot, initially—this was in 2019—to address that. It was like innovate, listen, trial something and see if it works. We partnered—already, what we've been talking about today—with local early childhood and education services to bring out the childhood and family health nurse and be embedded within those services, as well as community centres, because we know that a lot of vulnerable families aren't accessing early learning for various reasons as well. They're often the ones that really need the pick-up before they start school.

The nurse would come into those early learning environments and be able to assess all of the children that were in that service. They would come in for multiple days. They took a really trauma-informed and slow approach. The nurse would be there at pick up and drop off, just to get to know the families. It really focused on leveraging the trust that families had existing with their educators. Once they saw that the educators were vouching for this nurse, and it would be able to happen in that place that was mentioned before that the children really trusted—that they can do the assessment during group time, on the floor, rather than if it happened one-on-one with the family in the traditional assessment sense. We would also then have the same thing available within community centres.

Again, there was a bit more of an outreach model. It was somewhere that maybe families come weekly anyway for community breakfast or playgroup. They could go and they could see that nurse and get that assessment done there. It was essentially the blue book check, but we did the ASQ, which is the next step up in terms of a developmental assessment that assumed that our population had developmental delays going into it, so it was a slightly more thorough assessment. That was run for a period of about 18 months before—I always refer to this program as a bit of a Pandora's box. Once we actually got a nurse in to test the theory of "Do these children have identified delays?", the referrals that came out of it were just huge. We know that the system doesn't have capacity to handle it. Referrals were going for—speech was a huge one and dental was a huge one. And then some families were left with like five referrals that they had to follow up.

To that point before, families are all of a sudden left with, "You've got to talk to six different professionals, plus the NDIS, plus follow up with your early learning centre or school." It was just really overwhelming. The second phase is where that initial trial funding ended and our philanthropic funding came in as an organisation. We were able to keep rolling out that program for a couple more years. We added a speech therapist onto our team. They went with the nurse into the early learning centres. That was the biggest need that we saw coming from all of the referrals. They were then able to work with the children in their early learning centres on some really basic speech and language assessments and support skills that would then also be upskilling the educators, and then they could be catching the parents at pick up and drop off time as well to explain what had been happening.

That's also at the same point we developed that Child Health Linker role. At the time that was myself—so I am social work trained. I was able to understand as well the social challenges the family was going through and support them to navigate that. "Okay, this is what the nurses said after your assessment. These are the next steps for you. I'm going to be here to help you to access a paediatrician if that's what it is. I'm going to explain to you whatever the NDIS is and let's see if we can get on that together and then how you are going to use your funding." Some of that support was really short term. Sometimes it was just to explain what had happened. But sometimes it did go for 12 to 18 months. There was never, ever a time that we said that we would only work with you for X amount of weeks or months, which is quite common. It was kind of an open door of, "Let's make sure that your child is set up for the supports that are needed."

The Hive—we don't want to run services as our nature for the long term. We want to try to test ideas and then we want to see if the system can implement them. All of this was done really closely with the Western Sydney

Local Health District, who were amazing at coming along and provided that nursing staff and the speech therapist. They were within that system already. They knew very well. Then, after a period of time, we had an external evaluation with Western Sydney University and proved the success that we were seeing on the ground with the program of reaching this vulnerable cohort—that they now actually have absorbed that program and have been running it themselves with their own funding as part of their own mainstream child health delivery in that health district just for the Mount Druitt area over the last couple of years, with the Hive still providing that Child Health Linker role and support. Some of those findings did feed up and we gave some information to state government at the time of the Brighter Beginnings rollout for child health and development checks. CUBS was kind of one of the models that they leveraged to inform their funding decision as well.

Ms DONNA DAVIS: We know that there is a high First Nations demographic in that area, but who else predominantly do you have in that area? Pasifika?

LAURA FARAJ: Pasifika is probably our next biggest after First Nations. We often find that, in that, there are a lot of misconceptions of understanding what development is and what is normal, what's not. And obviously normal is—there is no such thing as normal. But being able to understand what are the processes and when do we get help, when do we not. So, yes, there are First Nations, Pasifika, Filipino, different African communities as well.

Ms DONNA DAVIS: One of the discussions this morning touched on the need to do more in antenatal and educating at that stage about the existence of the blue book. What, in your experience, can we do before birth to make these future mums more aware of what they can do and what some of the challenges will be?

LAURA FARAJ: I can start. I'm happy for expertise from the panel. We've really found that there is a really stark gap from when you're in the maternal health system to then when you're transferred into the child health system. In our area as well, we're on the border of two LHDs, so it really depends on how quickly you might get supported then to childhood health—depending on what hospital that you birth at, which is really common for our community. Often then they're trying to follow up. If they do have the ability to be proactive at that time and try to call up and then they're told, "No, you need to call this health district instead"—I think being able to have some education in those later stages of pregnancy around what the blue book is and this is what you should expect.

I know families have said, "Well, I didn't know about it until I was being discharged from the hospital and handed this book and I didn't know where I was meant to go or what to do." If that could be part of the midwifery team or maternal health team of education at that really early stage or in that latter half of pregnancy of what to expect next—I think the idea before of text reminders as well would be really helpful and that is something we've heard from our community too.

Ms DONNA DAVIS: Do you find there is a low take-up of breastfeeding?

LAURA FARAJ: It's not something that we've particularly researched into, so I don't know if I could quite comment on that one.

Ms DONNA DAVIS: Alison, you were nodding your head ferociously there.

ALISON WALLBANK: It's all music to my ears.

Ms DONNA DAVIS: That happened to me when I had my babies. They were born in a different local health district and then not knowing, "Oh, yeah, we'll just ring this number"—we know that, depending on your personal situation, you are or aren't going to do that and if you've got language as a barrier on top of that, could you speak to that a bit? What your experience is and what could be done?

ALISON WALLBANK: In terms of the blue book, do you mean, and that same question?

Ms DONNA DAVIS: Yes, the blue book and future mother's understanding prior to giving birth.

ALISON WALLBANK: In my role two roles ago, I was working in Canterbury in the team and I was a manager of the team. We had a program in there called SNF. I don't know if you've heard about it; it's Sustaining NSW Families. Within that program, part of the structure was that the nurse that would be working—families were identified in the antenatal period if they were going to engage with this program, and they were identified through the SAFE START process. With families who were identified with vulnerability, they'd be referred in.

The first engagement point was at around 36 weeks pregnancy, and the nurse would go and meet with the family. I think it shifted the focus for women. When they're being given information from a midwife, their mind is on the birth. They're having a conversation in their mind about the actual process of giving birth, and it's very difficult for a lot of women to get past that until after they've given birth. But what I saw when we had the child and family health nurse go in was the SNF program is structured so the conversation would be had at that appointment.

I feel like it has shifted the focus for women to, "This is a child and family health nurse. They explained their role; they're not involved with the birth at all." I feel like that's a place, if we had enough nurses for the nurse to engage with the family for a one-off antenatal visit, to talk about things like exactly what you're saying—the blue book and what to expect in the first weeks when the baby is born, after the birth. As much as midwives try to talk about that, I don't think it goes in. I've worked as a midwife, and I just think the focus is on birth when the message is coming from a midwife. Does that answer your question?

Ms DONNA DAVIS: Yes, thank you. I've got so many questions.

The CHAIR: We just have a couple of minutes left. Is there anything we haven't yet touched on that you might want to talk to quite briefly?

RITA FENECH: I think that everyone sitting here today has given a really great overview of the issues that we face on a daily basis in that early childhood, the first 2,000 days of a child's life, and the complexities that come with that and the challenges for both mum and dad. I think that we've got a long way to go, and this is great today. I'm really pleased that you've recognised there is an issue in that period of time. Again, I think if all government departments and NGOs come together and share their resources, we might be able to take a step forward. I think that you've covered most things, but it's a challenging journey. Thank you for taking it up; I hope you do something with it. We will keep in touch, I hope, so we understand what steps are going to be taken. We'd like to come along on the journey because it's very important.

ALISON WALLBANK: I think just two things that I hadn't touched on, in the space of child and family health nursing. I know that this inquiry is into increasing access to early childhood health and development checks, but recognising the competition that's faced by the profession of child and family health nursing in terms of psychosocial screening and domestic violence screening, and all the different things that a child and family health nurse goes through. Mental health screening; relationship difficulties; financial difficulties; that whole-of-family support for older children, as you mentioned earlier about other families; breastfeeding; introducing solids; sleep and settling; sleep safety; drug and alcohol screening; smoking—there's so much competition within the space, when you're seeing a family and you've got half an hour with them, of the things that you're going to discuss with them.

The other thing I was going to talk about was just the workforce changes for the child and family 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 to work with autonomy as a child and family health nurse. That's really changing at the moment. We've got a much more junior workforce coming into our workforce. The frameworks around supporting that more junior clinician also cuts into the support. That kind of mentoring and education support just isn't there. It's important to think about the impact that has on this workforce—that you have more junior clinicians working in this workforce 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: I think the one thing I would draw attention to is that the developmental check is really important, but it's what happens after that that really is where things often fall down. If you have a child who's got a gross motor delay or a speech delay or something identified in that check, it's a fantastic starting 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. The need would be too great for any one of those alone. If we think about them in too siloed of a headspace, I think it's going to be hard to achieve. The other thing I would say is, in solving that, it's thinking about the foundational support discussion, which is live at the moment, because that cuts across education, disability and health. How all those all intersect is what we're talking about.

KYLIE STREATFEILD: I agree with Morgan's thoughts around foundational support and the intersections between those departments. I think we touched on very lightly, but I wanted to elaborate further on, the issues for families who are living in rural and remote areas and having to travel to undertake child development checks, as well as getting supports and services for their families. I think utilising existing workforces, 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 15 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 100 hubs in different areas all over Australia. Within New South Wales, we have up to 25 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 10 years ago. It has been in Rydalmere for the past 10 years. It started in 2014. I came to Australia in 2017. 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 2018. So I have been in my role for the past six years.

The CHAIR: To follow on, you said there were about 25 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 25 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 25 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, 10-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 25 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 $100 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 10 months or 12 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 resources 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 preschool? 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 $3,000 for both the facilitator and the childminders to provide 10 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 preschool?

SEETHA SRINIVASAN: Yes, of course. It's going to help them get into the system. Once they're in the system, it's easier to go back and check with them. For example, parents might not notice that the child is not achieving their milestones, whereas the well-educated preschool teachers would be able to pick that up.

Ms LIZA BUTLER: Do you think that cost is a barrier for CALD families not to send their children to preschool?

SEETHA SRINIVASAN: Yes, of course. Child care is really pricey. Unless both of them are working, it's very difficult to afford child care and go ahead with that.

Ms LIZA BUTLER: With those preschools, they are not necessarily going to be where a community hub is that you offer. Do you think that healthcare workers in general are trained enough in CALD-specific—educated enough to deliver those services?

SEETHA SRINIVASAN: They should be, because most of the schools are community focused. Most of the schools have a P&C which can work with the community. In saying that, I am placed within the school. All the programs are not restricted only to the school families or the school members. Many families who are in and around the school come and participate. We do have four lovely grandmas who come and participate in our cooking program, who want to volunteer for the canteen. We do have a lot of families who do not have children who want to be a part of the school, who want to be part of the community. We have dance fitness every Friday where they come and participate. They want to be healthy. They come and participate.

Through our community hubs we're able to promote the Project Harmony discount that was provided by the Government. Just from my community, we had 25 families who were able to use the First Lap vouchers and get 10 free swimming lessons for their children. All the children are three to five years old, and not all of them are part of our school. Our school has 160 students from K to 6. Just a very small school we're talking about. We have 120 families, that's it, but we don't restrict ourselves because we are already providing these services. We want more people to utilise these services. We also do trips to Ermington library, which is just 800 metres from our school. We walk to Ermington library with our playgroup families. We do Redsee there. We do other programs that the Ermington library is running—the story program. We take them there. We connect them with other organisations so that they have that exposure. They can ask more questions, and they can find out more information from various different places.

The CHAIR: Wow. Every community wants one of you.

SEETHA SRINIVASAN: Thank you.

Ms DONNA DAVIS: Thank you, Seetha. You said that when you first arrived in Australia, you were at Westmead Public School and that there's a community hub there. Even though you weren't there at the beginning, do you know how Rydalmere and Parramatta West—how did it unfold? Just for the other members of the Committee, we know that Parramatta West is a much bigger school, and they are probably the two extremes in the Parramatta electorate.

SEETHA SRINIVASAN: Yes. My child was going to Westmead Public School and, on my first day at school, since I was a migrant, I was introduced to the community liaison officer and hub leader there. She was running English conversation classes. She was also running playgroup. Although I did not have children less than five, I was happy to help them with the playgroup, but they had enough families helping them around. But the issue that she faced was she had English class, but during that time they didn't have funds to have childminding services. So she was asking, "Would you be able to take care of the children while I am doing the English classes?" Eventually, I used to take activities for the children, because that's my forte. I have been a Montessorian. I have been working with children less than six back in my country for six years. I have been training teachers and being their mentor before I came to Australia. I would love to do that. I would always plan what activities to take for the children, and I was able to raise red flags if required.

Eventually, she found an opportunity for me to volunteer in another school, which was Toongabbie East Public School, which was also a very small school. They wanted to run a playgroup, but they didn't have people who could help them with the playgroup. A kindy teacher was running the playgroup, but she wanted a lot of support with set-up and pack-up and help in running it. I was doing that for a year. I was volunteering there in that school as well. I am also a Scripture teacher at Westmead Public School. Eventually, when my community liaison officer and the community hub leader at Westmead saw that there was this opportunity at Rydalmere, she asked me to apply for this role.

Since I did not have any community development background or social work background, I told her I might not be the best fit here. But the main idea was for early education. That was the main area that they were focusing on. They said, "Either you should have experience with early childhood or you should be a social worker." Since I had that, I was able to start. I did have a lot of on-the-job training, like asset-based community development training and a lot of other on-the-job training, which I was taking up on the go.

I started the job in 2018. When I started, we had a parent-run playgroup, but we did not have any English class for the community there. We really required an English class. There were families who would come to me just to fill in an application form. There were families who would come to me and ask me to read their mail for them. Although I was not able to translate—I wouldn't know their language—I would just simplify whatever it was, show the actions and they would be able to go from there. That is how I wanted to start with an English class. We were able to secure a facilitator, and she has been running the English class for the past four years now.

Ms DONNA DAVIS: You said that there are grandparents that attend and that you have people that come from outside of the school as well. Do they come from other local public schools or are they not associated with the school yet?

SEETHA SRINIVASAN: They're not associated with the school. They come to know about my programs through their friends, their acquaintances or through the Facebook page that we have. I always put my term calendar in the Ermington library so they flip the page and they see that there are free dance sessions and think, "Let me go and have chat and find out if I can join." That's how I get more people as well. We do have families whose children are going to other schools. They might have started with our school when they were coming for the playgroup but eventually they are not in the catchment and they would have gone to different public school.

Ms DONNA DAVIS: You mentioned before that your hub plays a role in the delivery of early childhood checks and screening services. To be more involved and to deliver more of that, what supports are needed for your organisation so that you can do that?

SEETHA SRINIVASAN: More people. I'm happy to do as much I can but I want my community to be more confident in approaching the services. So we need someone who can come there quite often—maybe once a term—and show their face and just give them the vocabulary. There is a speech pathologist. There are paediatrics. There is an OT who can help and there is something called NDIS that can provide services. I would like to share one of the experiences that we had in 2019 when there was a total fire ban. We had one whole English lesson on total fire bans because people didn't know what a total fire ban was. So it's as simple as that. Even getting that vocabulary out for people to see, normalising it for them so they do not feel afraid that the child is going to an OT and do not feel afraid that the child requires support—just getting it out there and in front of their face and normalising it.

Ms DONNA DAVIS: Before, when we were talking, you said that you refer people to Ermington, to the early childhood centre clinic there. Did you also say that they come in to the centre? Or they're not at this stage?

SEETHA SRINIVASAN: No, there's one GP clinic just opposite our school, very close by, hardly 300 metres. I did have a chat with them earlier about if they could come in and have an information session but that was not made possible. I don't know what the barrier was for them to come into the school to provide an information session or explain where they are placed, what kind of support they can provide to the families. If those barriers are lessened, it's easier for parents to see "Yes, I can go to this GP and ask for help." The GP need not come. We could have someone—maybe a nurse—from the clinic who can come and visit our playgroup once a term just to show her face and come in for half an hour so we can introduce her. They can ask about some doubts. That would be the starting point for people to understand. Many a time we've had situations where it is difficult for mum to accept that their child might have some issues so more such interactions will provide them a chance to ask more questions and really understand that earlier intervention and support that we can provide to the children at an early stage will really help the child going forward—both for the parents as well as the children.

Ms DONNA DAVIS: Sorry, one more question. What is the visa status and the country of origin of the majority of Rydalmere Public School?

SEETHA SRINIVASAN: To give you an example, in our English class we generally have around eight to 12 ladies who come along, and they're all from eight to 10 different countries or language backgrounds. So in a very small school, we have a boom of various countries. I have a world map in my room. Once, during an event, I asked them to put a dot on the country they come from. We were able to collect 20 different countries that they are coming from. So it's a very varied group.

Ms DONNA DAVIS: That's very much like Parramatta.

SEETHA SRINIVASAN: Many organisations that I go to ask me, "Do you want an Arabic translator? Would you like a Chinese translator?". I say, "Just simple English, please," because it's very hard for me to get one translator for each one of them. But, if required, if I'm providing one-on-one support, then we use interpreter services.

The CHAIR: When you did manage to get a speech pathologist in, for example, did you have to pay for that or was that provided by Health or a private company?

SEETHA SRINIVASAN: I was fortunate enough to get them through SDN Children's Services, who I am running the playgroup with. They have been in this role for a long time. They were able to pay for the speech pathologist to come and visit, but that was just a visit. They do a very basic, initial assessment for the families. We introduce them and then the playgroup is on and we have a separate room where the mum can take the children, have a one-on-one chat with the speech pathologist in private and then they can come out. If there are too many red flags, if the parent says it is all right then the speech pathologist shares that information with us and we follow them up.

The CHAIR: Does the school provide you with a room, a space?

SEETHA SRINIVASAN: Yes.

The CHAIR: Hopefully it is free of charge.

SEETHA SRINIVASAN: Yes. I am part of the school. I am now being paid through the Department of Education, for the past two years, before which I was being paid by SSI, who was paid through CHA. I work with two organisations. I use the framework of Community Hubs Australia and I am being paid by the Department of Education. That is why I have two titles: community liaison officer and community hub leader.

Ms TRISH DOYLE: You're the person who works on the ground. You're the one who is multiskilled here. It sounds like there needs to be some coordination between the federally funded NFP, the Department of Education and NSW Health when you learn about the needs of the different families, what they tell you—and that might change. Like you said, it would be great one term to have a speech therapist or a maternity or children's nurse from the local health district come to talk to the parents. But it sounds like there needs to be a collaboration with NSW Health as well in terms of us looking at the connection that families are making with the early childhood developmental checks—a formal collaboration. Would you agree with that?

SEETHA SRINIVASAN: Yes, I totally agree. In saying that, I have to bring up that we have our WINC [Wellbeing and Health In-reach Nurse Coordinator] nurse in our school. They work with children of the school and their families. They work through referrals through the teachers, and even if the parents have some issues then they can go to the nurse and have a conversation with the nurse. It's more of a wellbeing nurse.

Ms TRISH DOYLE: How often is that WINC nurse there?

SEETHA SRINIVASAN: She is there on Thursdays and Fridays, twice a week.

Ms TRISH DOYLE: Two days a week?

SEETHA SRINIVASAN: Two days a week. I don't work on Thursdays; I work on the other four days. We meet once in a while, although we have our own restrictions. I can't share the parent's details unless the parent says okay to it, and she also has a similar issue. But we are able to introduce the parents to each other if they require any support. If she knows of a family whom I can support, then she introduces the family to me, and likewise on my side.

Ms TRISH DOYLE: I can imagine that you've got a huge referral base and knowledge in your head and all sorts of people that you talk to and connect with. For example, in the previous panel we had Tresillian here. When you learn about what's happening with families, do you connect with a service like Tresillian? Then, once the mums or dads drop off the school-aged children to their classes, is there space for the parent to talk with an organisation like Tresillian about the younger child? Do you do those sorts of things?

SEETHA SRINIVASAN: Yes. We have not connected with her but what we generally do is that we have one-on-one conversations with the families. They come to me and, for example, they ask, "I am looking for a job. I want to find jobs. My child is in preschool. The child is starting kindy next year. I want to find jobs. Can you please help me?" It is that kind of support. Similarly, when they come in and have concerns with the children, we ask them to come to the playgroup because, when they come into the playgroup, they are within the SDN Children's Services. They are within that organisation, which can also provide external help and which also brings in one of the other social workers every week when they come in. That's how I connect them with various other referrals.

For example, we had a family who required a hearing check and eventually a cochlear implant, but the child is still requiring more support in terms of developments. Although they were coming for the playgroup, 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 25 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 15:45.