FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Bairnsdale — 7 December 2017

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Ms Ailsa Carr, executive manager, family, youth and children’s services, Gippsland Lakes Community Health.
The CHAIR — I welcome to these public hearings Ms Ailsa Carr. Thank you for attending here today. All evidence at this hearing taken by the committee is protected by parliamentary privilege as provided by the Constitution Act 1975 and is subject to the provisions of the Parliamentary Committees Act 2003 and other relevant legislation. Any comments you make outside the hearing will not be afforded such privilege. It is a contempt of Parliament to provide false evidence. These proceedings will be recorded and you will be sent a proof copy of the transcript. Now that that is over with, let us relax. Let us hear from you. If we could have a 10 to 15-minute presentation, then we would love to ask you some questions.

Ms CARR — No worries; not a problem. I do not have a PowerPoint, but I did do a bit of a paper and I have made some copies. I do not know whether you would like that. I was anticipating just highlighting some of the key points and then leaving it for questions, if that is all right. I am the executive manager of the family, youth and children’s services unit at Gippsland Lakes Community Health, which is where the maternal and child health nursing service operates out of. Gippsland Lakes Community Health is a significant community health service provider within the East Gippsland shire, providing an extensive range of programs.

Some of the programs are locality based, but a large number are actually provided across the whole of the shire, which is 21,000 square kilometres and has a population of about 43,000 — so a small population, large distances. We have a particular focus on service provision and support to the most disadvantaged communities and individuals, families and young people. We have developed close links with local Aboriginal communities and also our local Aboriginal controlled organisations.

The organisation is divided into five units: aged and disability, clinical, community health, corporate, and the unit that I manage. Obviously that is the unit that I am going to talk about because that is where we provide most of the services to both antenatal and postnatal mums and families. The family, youth and children’s services unit has an extensive range of services that focus predominantly on clients presenting with a range of social, emotional and welfare issues, and within that unit over the last 14 years we have developed a fairly comprehensive integrated model with a strong service coordination and case management focus. That is from initial contact right through to case closure and it is across all the programs. It is based on a team structure. The unit is divided into five teams.

Maternal and child health nursing sits in our early years team, which has the universal maternal and child health nursing program and the enhanced home visiting service. It has Healthy Mothers, Healthy Babies. It has Cradle to Kinder, our 0 to 2 program and Bumps to Bubs. I guess the benefit we see of that for maternal and child health nursing is that the team sits in is quite a comprehensive team. It is not an isolated program, which can sometimes happen when they are working outside of something like a community health service, and the unit covers a whole range of programs, everything from alcohol and drug counselling, family violence, homelessness — I am trying to think what else I have in my unit — a whole range of programs.

Maternal and child health nursing, because of it sitting in the unit and sitting within the early years teams, means that they work very closely with all the programs, so they do not just have, I guess, a universal focus; they actually have quite a strong focus on dealing and working with high-risk families. When I talk about high risk, it is probably different to how you were talking about it just before. For us, we are talking about high risk in relation to drug and alcohol issues in families, family violence, child protection involvement, homelessness — those sorts of things.

The maternal and child health nursing focus is to actually provide a program, and by being in the early years as a team, that scales up and scales down the level of support provided to families. So we have everything from our universal service, which would be predominately provided to those families that are low risk and have very few social and welfare issues right up to our Cradle to Kinder program and our 0 to 2 program, which works with quite high-risk families where there is considerable child protection involvement or family violence issues.

Placing those programs within a universal service has meant that we have had quite significant gains in engagement of those families and being able to work with those families long term, mainly because there is less stigma seen as being attached to working with someone like a maternal and child health nurse, who then might have a welfare staff member or social worker attached with that work.

We use evidence-based early intervention, trying to get in as early as we possibly can so that we can try and ameliorate some of the risks that might occur. We have very close links to the hospital, to the GPs, but also to child protection and a range of other services, and we have quite a clear antenatal referral pathway for those
families that are assessed as being at, I will call it, social and welfare risk and might need more of the other programs that we have. So the midwives will screen for those families when they meet with them, as will the GPs, and they can make antenatal referrals to our service so that the maternal and child health nurses in the other programs can engage with those families early and develop a relationship and then hopefully continue that through to post-delivery.

We have some targeted programs, particularly for young women under 25. We have quite a high rate of teenage births in this area, and so we have created particular programs to support them, and also for women where there is increased anxiety and depression. We also have specific supports where we work with our local Aboriginal controlled organisations. We also now, more recently over the last 12 months, have established a program for dads that are looking after their children.

Our strength we say is that the maternal and child health nursing service is sitting within a community health service and within a whole range of supports so that it allows us to provide an actual integrated service. We are able to identify things such as family violence, and then we are able to link the women or whoever it may be to the appropriate other supports that they might need. We have very much a partnership approach with our clients and also our other workers. It is about being client driven — family driven — and focusing on what their needs are and what they would see as the supports that they would require to help them address any of their issues.

I guess the other strength is that our maternal and child health nurses are now, I would say, highly skilled in a whole range of frameworks, so they have a very good understanding of the best interest principle, which is the one that is used by child protection, along with the common risk assessment framework for family violence and harm minimisation for drug and alcohol. Being established in the one unit with all of those programs around means that we are able to do quite a large amount of inter-program education and support and that we are able to have staff work together to be able to support in the understanding of the different frameworks each of the programs work under.

The main challenges we probably have are access to specialist services, particularly in the more remote areas. Certainly I note that it was part of the inquiry to look at the reduction in funding around the mental health supports for perinatal. We saw a reduction. That position was reduced by half, and that impacted quite considerably on the work that we were doing, particularly with women in the postnatal period around anxiety and depression.

**The CHAIR** — Are you referring to reduction in federal funding?

**Ms CARR** — Yes. What we have done to try to ameliorate that is we have actually created some group work which is particularly focused on supporting those women, and we have done that in conjunction with the perinatal emotional mental health clinical practitioner — I think that is her official title. We run that group work, and she does provide some one-on-one support, but obviously having been reduced in funding has meant that her capacity to do one-on-one support is quite limited.

The other main challenge we have is that there are quite significant levels of child protection involvement with our families down here, and also there are high levels of family violence. Until recently we were sitting at fifth in the state for episodes of family violence. We have improved. We are now 13th out of 79 shires, so that is an improvement, but it is still a considerable amount of families that are being impacted. Obviously those have high-risk issues for infants, and of all the child death inquiries we have been involved in, most of them have been children under 12 months — obviously because they are at greater risk in those sorts of situations.

Our other challenge is that because of high levels of child protection involvement, child protection has huge workload demands, and sometimes there are challenges in respect of their capacity. They will always respond in an emergency, but I guess it is that ongoing case management. The benefits around that, which Bernadette also mentioned, are that we do have a monthly high-risk infant meeting. That has been working extremely well. It has been around for quite some period of time, but I would say certainly in the last 12 to 18 months it has really started to function at a high level with quite a bit of comprehensive planning happening pre-birth so that plans can be put in place for when the baby is born along with the supports that the mum might need. As Bernadette mentioned, that is a multidisciplinary meeting with representation from ourselves and child protection.

I am happy to leave it there. I am happy to answer any questions. I know there was a question about breastfeeding. I can comment on that if you are interested.
The CHAIR — Yes, please do.

Ms CARR — We had quite low rates of breastfeeding. If you go back about three or four years — and I do have the figures back to three years — we were sitting, at about six months, at 43, which is not very good. We would average about 400 to 460 registrations with the maternal and child health nursing service, because obviously not all births occur at Bairnsdale Regional Health Service. Last year it was up to 188, and we saw that the increase has been quite significant. That is at six months, but then if you look at over the whole period — three months and then six months — the numbers have actually increased quite remarkably.

The CHAIR — Thanks for the submission and presentation. I might start off. I am just wondering how many maternal and child health nurses there are in your catchment under your management and, as opposed to that, what the ideal number would be for your workload.

Ms CARR — We have eight maternal and child health nurses within my team. There are two maternal and child health nurses located at Orbost Regional Health service, but they are managed and supported through Orbost Regional Health service. What would be ideal?

The CHAIR — Yes. You have obviously got a high workload. What would be ideal?

Ms CARR — That is a difficult one to answer. I guess being in the unit we are actually able to manage quite a significant workload because of the way we have structured the team and because they are supported quite extensively by the other 60 staff I have in my unit — not that they would do maternal and child health nursing, clearly. It is difficult because, as everybody would know, births do not come in regularly. We have 400 or 460 a year but we do not get three or four a day. They come when people have them, and there tend to be peak times and low times. When there are peak times, it is quite challenging to meet that demand. Probably another couple of EFT would be nice. I do not have any data around that, really.

The CHAIR — No worries. Anecdotally I just wanted an idea. Obviously your nurses would follow the family violence risk assessment framework.

Ms CARR — Yes.

The CHAIR — I have just got a really unclear picture of how this works when family violence is seen to be a factor in a household, but you have still got to get a nurse out there. How do you manage that?

Ms CARR — We have a home visiting risk assessment process that we would use. If there is perceived to be an increased risk, we would have two staff attend. I have to say for maternal and child health nurses it can be quite risky. They are well trained on how to read circumstances. We have clear policies around when to enter a home and when not to enter a home. We have a policy around where you should park your car — you do not park it in the drive, you park it on the street. If you get to a house and there is a whole heap of people there and you were not expecting that or you do not know who they are, you would not enter. You would reschedule an appointment.

As I said, if we are thinking there are concerns, we might do two up, or we would see the family in another venue, which would depend upon the family. It could be in the clinic for our Aboriginal clients. We will often make arrangements to see them in our Aboriginal controlled organisation. It might be in another family member’s home or wherever they are actually comfortable that also ensures privacy and security for them.

The CHAIR — So you are quite flexible.

Ms CARR — Yes, we are extremely flexible. Our maternal and child health nurses are very flexible. We will see people wherever it is most appropriate to see them, obviously being respectful of the need to respect people’s privacy and confidentiality. They may catch up with some mums for a coffee somewhere down the street if that is seen as appropriate. Obviously it would be a limited catch-up in that sort of environment. We will catch up at kindergartens and at childcare centres. Basically the premise for the intensive home visiting which we provide or our home visiting support, if that is required, is that the nurses will go wherever is most appropriate to meet that client.
Ms COUZENS — Thank you for coming in today. We appreciate it. I note that you have a partnership with the Lakes Entrance Aboriginal Health Association. Can you give us an idea about what that partnership involves?

Ms CARR — It has been quite a comprehensive partnership. We helped, I guess, support that community to establish LEAHA in the very, very early stages when the local Lakes Entrance Aboriginal community had identified that they felt they needed their own Aboriginal controlled organisation at Lakes Entrance and there was not anything there. Clearly there is the Aboriginal controlled organisation at Lake Tyers Aboriginal Trust and GEGAC here in Bairnsdale. From an early stage Gippsland Lakes Community Health was very supportive of the community and our previous CEO was actually quite active in supporting that community to lobby for the initial funds. When it was initially established we auspiced it, and we still do auspice some of the supports for LEAHA. We provide corporate services, HR, those sorts of things. We have continued to strongly support that organisation to grow and develop and access funding as they have identified to provide programs for their local community, whilst also hopefully supporting them in a way that is about having them get to a place where — I sort of want to say they do not need us, do you know what I mean? — they can move to a space where our support has become less and less as they have been able to establish their role and processes in place.

The executive officer at LEAHA is supported by our current CEO. She joins the executive management team that I am a member of for meetings. We have reciprocal board arrangements now, so our CEO sits on their board and a member of their board sits on our board. That has been of huge benefit to us as an organisation in being able to be able to connect that community with their needs and also ensure that our staff are supported to access cultural training. We have got a cultural resource there that we can tap into at any time. Certainly I know that the maternal and child health nurses will often see clients at LEAHA. We will work with them and the Aboriginal health workers if that is what the client feels is the most appropriate way to support that family. We are supporting LEAHA at the moment around Aboriginal health worker training in partnership with VACCHO.

Ms COUZENS — You mentioned Aboriginal cultural training. Is that happening across your service?

Mr CARR — Absolutely. We have generic Aboriginal cultural training that is offered to all staff members. Then we have a tiered approach, I would say. When those staff are going to be working with clients we have a more in-depth process for training. Everyone, including our accounts payable people, will do some level of training, but then we have more comprehensive training for those staff that are actually working out with clients. Then we have a supported program through our scholarship program for those staff that might want to go on and do a higher level qualification or experience around Aboriginal culture, working with Aboriginal communities. That is supported through the organisation’s scholarship fund.

Ms COUZENS — Do you have a focus on mental health as well in a general sense, not just with the Aboriginal community but mental health for mums?

Ms CARR — Yes, absolutely. Within the unit I manage a counselling program. We have family violence counselling, but one of the group programs we have established is called FAB Tuesdays, which is families and babies and it is held on a Tuesday. That was particularly established for mums with babies that were identified often antenatally as being at risk but also having anxiety and depression issues. We run that as a 12-week program.

Ms COUZENS — Has that been successful, do you think?

Ms CARR — It has, actually. We do pre and post Edinburgh postnatal scores. That is not the only measure. I do not necessarily think numbers are always a concrete measure, but we have seen those reduced. We found that being able to bring mums together in that environment has allowed them then to create their own supports and networks as well. Initially we tried to create it with child care, because we felt they needed to have some freedom to just be there without the babies. That proved extremely difficult. But what we have actually found is that having the babies there has not been a disadvantage. That, like our Bumps to Bubs program which is focused on under 25s, is very much client driven. Whilst we have a framework and a structure we use, it is basically dependent upon the group that is presenting and what they identify or see as the important issues they would like to address, so there is flexibility within that.

Ms COUZENS — Do you see any glaring gaps in the perinatal services?
Ms CARR — I think mental health is the difficult one. We have more recently had Agnes ward established down at Latrobe Regional Hospital. That has been a huge advantage for us. Prior to that for mums and babies who were having difficulty postnatally — with parenting or those sorts of issues — it was really Melbourne or there was not anything else. Obviously you can imagine. We provide services up to Omeo. It is hard enough for families coming to Bairnsdale, I think as Bernadette mentioned. You might have your family here, so having to go to Melbourne is horrendous. Having access to Agnes ward has made a huge impact, and we work really closely with them. They have a particular focus on mental health as well, because obviously they are closely connected to Latrobe mental health.

As with anything that is really useful, what has happened with that is it can now become difficult to get someone in. You can obviously plan those things and book them in, but sometimes we do have situations where it would be of benefit to be able to get someone in relatively quickly, and that is becoming increasingly difficult. We work closely with them, and they always work really hard to try and get someone in if it is seen as being quite urgent, but the demand on that service has increased to the point where there is often a wait. It is like all of those resources. They are really beneficial, but now there are not enough of them.

Added to that, with our Cradle to Kinder funding we are now looking at establishing a day-stay program here in partnership with BRHS. Because we will not have huge numbers, it will focus across a whole range of things, whether it be parenting, providing a bit of play therapy or for those mums and babies who are struggling with feeding. We are doing that in partnership with the hospital, and it will be using one of their rooms and facilities to do that.

Ms McLEISH — Thank you for coming, Ailsa. Roma and I were actually just down at Gippsland Lakes Community Health visiting LEHA and Paula Morgan and her team earlier today. They spoke extremely highly of you. In fact they spoke very highly of the program that we had today and the speakers. She was unable to be here today because of something else, but it was really good to get down and to see your set-up and to have a good understanding of what LEHA does down there. I have got a couple of questions around the maternal and child health nursing model. Are they still paid for out of local government?

Ms CARR — Universal services are paid 50 per cent by local government with 50 per cent by the Department of Health and Human Services, but the other programs that are sitting in there — our Enhanced Maternal and Child Care Service, our Cradle to Kinder, our Health Mothers, Healthy Babies — come from the Department of Health and Human Services.

Ms McLEISH — A couple of people mentioned that last week — that level of funding.

The CHAIR — Funding streams are a bit curly and convoluted.

Ms CARR — Our big thing is that when you get out to rural areas you get little bits of money that come through based on obviously a statistical formula, which is fair enough, but they come down in independent streams with their own individual reporting. What we end up having to do in organisations like ours, which is what we have done in our early teams, is bundle it all up together to be able to provide service that is viable and able to be provided. So, our Health Mothers, Healthy Babies is basically just a little bit under one EFT. If we ran it as an independent program as a single EFT, it would not be viable; you would not be able to cover sick leave and annual leave, those sorts of things. You would have the service coming in and out.

By combining it all with our maternal and child health nursing and our Cradle to Kinder, we now have 11 staff in that team who understand all the programs and therefore will respond to the needs of the client based on the needs of the client, not based on the label of a program or a funding stream that they might fit under. The challenge for that is then staff have multiple programs they need to come back to to say, ‘So that visit was which program?’ and ‘What do I need to report for the minimum dataset for that program so that the department has its required data?’

Ms McLEISH — So do you have much to do with the LGA, with the local government?

Ms CARR — Yes, we do. We meet with them on a regular basis, I would say, because we have a number of programs. We also manage their HACC programs. We have regular meetings with the local government, though they are fully contracted out services to that.
Ms McLEISH — Do you feel like they are your boss, I suppose, with maternal and child health?

Ms CARR — Not at all, no.

Ms McLEISH — That is okay. We are looking for honest answers here.

Ms CARR — I do not know what I should say — maybe I need to be politically correct here. I do not mean it in a negative way. I guess it is what I said before. Having the maternal and child health nursing sitting in a community health service has had huge benefits for that program, because they are not isolated within a council that has limited other health and welfare services, so they have been able to be connected to a whole range of other things.

Ms McLEISH — That is a great answer. You mentioned the vast services that they offer and different things that they do and that you and your organisation do. With the Healthy Mothers, do they do a lot of mental health screening? Because you did say that it is one of the big gaps in mental health. Are the maternal and child health nurses equipped to be able to pick up anxiety or depression in new mums?

Ms CARR — We would use a range of tools, and they would have had a range of training provided to them. We use the Edinburgh Postnatal Depression Scale, we use the K10. Because we have a counselling team and a number of other things, we do training on a regular basis in what is called a mini-mental assessment. So the maternal and child health nurses would have been part of all of that training, and they would use those where appropriate. We would not necessarily do that with every client, but where they are starting to sense that there might be issues that they would want to further assess, then they would use one of those tools.

Ms McLEISH — And what method of accreditation do you guys have to undertake?

Ms CARR — We are under the QIC, the Quality Improvement Council, which is what most community health services would be accredited under. And because we are a Child First —

The CHAIR — We have not heard of that one before.

Ms McLEISH — No, no-one has mentioned that before.

Ms CARR — Okay.

Ms McLEISH — Keep going.

Ms CARR — The Quality Improvement Council — they are the accreditation standards that most community health services would operate under. Also because we have Child First and integrated family services, which also sits within my unit and which the maternal and child health nursing team work really closely with, we have to be accredited under the Children, Youth and Families Act, and so we have to meet the Department of Health and Human Services standards that are required for accreditation under that. Because the Cradle to Kinder program is incorporated into that team, that team is assessed under those standards too, as well as the maternal and child health nursing quality framework.

Ms BRITNELL — Again I just reiterate, going down and seeing LEAHA this morning and meeting the team, they spoke very highly of the relationship between your community health service and the Aboriginal-controlled health service there that we visited. It was really good to actually see it firsthand before coming today. I just wanted to ask you about staffing and access to staffing and any concepts that you imagine would work to attract staff out into the regions, if that is something you see as a challenge.

Ms CARR — It has been a challenge, particularly for maternal and child health nursing. It takes a bit of training to get to be a maternal and child health nurse. By the time you have done your nursing and midwifery.

Ms BRITNELL — They are highly skilled.

Ms CARR — Yes. I mean, we have a scholarship program at GLCH, and what we have done that has helped us in that space is we have supported and we have tried to target local people, because they are much more likely to stay. The hospital might kill me here — sorry, that will go in the transcript. I am just thinking who is behind me! We sometimes target — well, not target —
The CHAIR — There are plenty of witnesses!

Ms CARR — I guess we offer support to midwives, to nurses that might be interested in maternal and child health nursing as a pathway.

Ms BRITNELL — They’re poaching.

Ms CARR — Yes. And we will support them to do that training. But it is a challenge because it is quite a commitment. I think, particularly in rural areas, without that sort of support, we did have a period where we really struggled. If you are living in a rural area, it is a large commitment even from a study point of view, regardless of the financial point of view, to actually be able to go on and do that. We have found that by focusing on people who are already here and established with their families we are much more likely to retain them. We have a really good retention rate.

I think the other thing that we do at GLCH is as well as being very client focused, we are very staff focused, and we are very strong on ensuring staff have very good regular supervision. We are family friendly. We will, I suppose, do everything we possibly can within the funding and what we have available to attract staff, but then retain them in order to maintain the services that we are providing.

Ms BRITNELL — Another question: the program you talked about, bubs to —

Ms CARR — Bumps to Bubs.

Ms BRITNELL — And that was for clients under 25. What is the demand like for that service? Is it growing? Is it stable?

Ms CARR — It has been relatively stable. We have about 10 per cent of deliveries — I am thinking that about 30 to 40 of the 400 births would be under 21. That program goes up to under 25. It has not increased, but we have not seen a decrease in those pregnancy rates. We have consistently run regularly between 36 and 40 young mums in that group.

Ms BRITNELL — And so does that support them up to just the birth, hence Bubs to —

Ms CARR — Bumps to Bubs.

The CHAIR — Say that five times quickly!

Ms CARR — Yes. It used to be called ‘pregnancy and parenting’, but the young mums did not like pregnancy and parenting, so they came up with ‘Bumps to Bubs’. Sorry, what was your question again?

Ms BRITNELL — I asked if it just went till when the child was —

Ms CARR — We support them usually up to the baby being two years of age, but sometimes they will go back for another one. It is more supported until we feel they are comfortable to move to another group if we can. A bit like our Fab Tuesdays group, what we have found has tended to happen is over the period of 12 months to 24 months that they might be there we have been able to support them to then move out into running the group themselves and continuing on themselves as a network supporting each other, and I guess that is our aim — that they will move to a space where they do not need us to facilitate that group and they can facilitate it themselves.

Ms McLEISH — I have a couple of areas that I just want to drill down a little bit more on. First of all, you mentioned the monthly high-risk infant meetings that have been talked about. Can you give me a bit of an understanding about how they began? What was the impetus to put those meetings together, and what outcomes are you seeing specifically?

Ms CARR — They originally, if I go back a number of years, came out of child protection, and I think initially that probably led to why there were some struggles to have the momentum. They were very much about the high-risk infant position at that time within child protection, so that is around unborn notifications to child protection and those unborn notifications then being managed appropriately for when the baby is born.
Because they were being driven originally by child protection, the workload demands on child protection made that really hard for them to facilitate that. I think what it then moved into was that it was seen as a real benefit by some key people — so I would certainly say the maternity ward; my manager of the early years team, Linda Brown; and one of the other key staff at child protection. I guess then there was more ownership by more people to actually pull it together and make it work, including by the social work department at the hospital. So now it is held at the hospital usually, and it will happen I guess regardless of the demands on child protection.

I think it has improved because it is being driven more by the group themselves, because they have actually seen it as a benefit. I think the benefit is that we have got services like ours that can offer a lot of support. We have got unborn notifications being made. The clients might be identified in other ways, and it is really around the professionals being able to come together and talk about what the risks are and what the supports are that might be able to be put in place for that family, and then it is working with the family around how we might do that so that hopefully child protection then does not need to be involved. But it has also meant that we have developed plans for those where it is deemed as still at risk for when the baby is born, for child protection to then potentially open it as an actual case and be part of that.

**Ms McLEISH** — So just to help me understand, if you have an unborn notification, would those families have had other children already, or would they be at high risk of family violence or something like that?

**Ms CARR** — It could be any of those. They could have had other children. They could have been already in the child protection system or they might not ever have been in the child protection system. It could be a first-time mum. Child protection is not actually able to open an active open child protection case until you have actually got a child, so they are limited in what they can do under the Children, Youth and Families Act —

**Ms McLEISH** — So they are just worried about the child being born into that family?

**Ms CARR** — Yes, so there might have been a call to child protection about significant drug and alcohol use, or it might have come through a police L17. Pregnancy is a very high-risk time often in family violence situations, and we know that from the statistics, so that might be the first time they have surfaced. Police might have been called and there will be an L17. That will go through to child protection. There is a limit to what child protection can do antenatally, so that allows those families to be talked about in a multidisciplinary way before the baby is born, and then assessments continue to be made so that when the baby is born we can determine what is the most appropriate pathway. Hopefully that is for them to go home with supports, but obviously that is not always the case.

**Ms McLEISH** — Do you see many women from out-of-home care that are pregnant and struggle?

**Ms CARR** — Yes, we see those.

**Ms McLEISH** — Is it a high or low incidence?

**Ms CARR** — I do not have hard data. Anecdotally I would say that we see a very high incidence of situations where they have been in out-of-home care or they have been brought up in families where they have been involved in child protection. We see a very high incidence of intergenerational high-risk factors. They might have been in child protection often as children themselves, and then they go on.

**Ms McLEISH** — I wondered that.

**Ms CARR** — We have some staff who are now seeing grandchildren in those situations. Those families take a lot of support because they have not had good experiences of how to parent because they have not been parented that way themselves. My only other comment around that would be that often the programs we put in place have short-term funding for those sorts of things, and my experience of intergenerational trauma, whatever the cause, is that it is not fixed quickly. It takes a lot of long-term work, a lot of support and a lot of client-focused, client-directed support. That is why programs like Cradle to Kinder, which has funding to stay with a family for four years, is actually quite unique and therefore has more likelihood of achieving good outcomes.

**The CHAIR** — Thanks so much, Ailsa. We appreciate your time today. We know it is valuable. Thank you for your submission and for everything you have been able to pass on today.
We might just take a 5-minute break, because I think Ailsa wants to talk to Bernadette about some interagency employment issues. Maybe we will have a Tim Tam and a cuppa. Maybe there are some opportunities there.

Ms CARR — I was just wondering if there were some arrows coming into my back!

The CHAIR — We will take a 5-minute break.

Witness withdrew.