

TRANSCRIPT

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Warrnambool — 11 October 2017

Members

Mr Paul Edbrooke — Chair

Ms Cindy McLeish — Deputy Chair

Ms Roma Britnell

Dr Rachel Carling-Jenkins

Ms Chris Couzens

Ms Maree Edwards

Mr Bernie Finn

Witness

Ms Maryanne Purcell, maternal and child health nurse coordinator, Warrnambool City Council.

The CHAIR — I welcome to these public hearings Ms Maryanne Purcell, the maternal and child health nurse coordinator from Warrnambool City Council. Thank you for attending here today and giving us your time. All evidence at this hearing is taken by the committee and 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.

Again, welcome. Out of the 80-odd members of Parliament they put the friendliest people on this committee. It is amazing.

Ms PURCELL — I am glad to hear that.

The CHAIR — So feel welcome, do not be nervous and if you would like to give us a 10-minute introduction to your service and your stakeholders, that would be fantastic, and we will follow up with some questions.

Ms PURCELL — I would just like to say thank you, first up, to the committee for inviting me to contribute to your inquiry. It is a good opportunity to represent maternal and child health. I have not done a written submission for you, but I thought I might just give a brief overview of the service. Is that something that you would like to hear?

The CHAIR — Absolutely. That would be ideal.

Ms PURCELL — So the maternal and child health service is a universal primary care service for Victorian families with children from birth to six years of age. The service is provided in partnership with the MAV, local government and the department of human services. It aims to promote health outcomes for children and their families. The services provide a comprehensive and focused approach for the promotion, prevention, early detection and intervention of the physical, emotional and social factors affecting children and their families in contemporary communities.

The service is delivered through a schedule or what we call a framework — a key age and stage framework — and there are also activities including groups and groups for parents as well. There are a few components to the service. There is the universal service, and there is additional support also available through the enhanced maternal and child health service. That is available to families with children at risk of poor health outcomes, so it is provided for families that require more intensive support from the service. Then we are also backed up with the maternal and child health 24-hour line.

The Warrnambool City Council service has a staff of 2.8 EFT for the universal service and 0.7 for the enhanced part of the service. I do the coordination of the service, so 15.2 hours of coordination, and I also do some practice work as well with vulnerable families in enhanced. Our workload currently can be up to 135 new births per one EFT. Generally, along with everybody else, we have had a reduction in births over the previous financial year, but generally we sort of sit roughly around 400. We would average in the last five or so years 400 births for Warrnambool city.

I was just going to highlight a couple of challenges that seem to be prominent at the minute for maternal and child health. One of the principles underlining the maternal and child health service is that we are a family-centred service. This is a segue into the fact that I feel support for fathers is fairly underwhelming in Warrnambool. It could be statewide as well; I am not sure. But I find that we do not have access to fathers, which is not in their best interest, for their own wellbeing.

I just want to read to you quickly. I think there is a lot of research out there at the moment about the benefits of engaged fathers, and I just want to do a quick list of something that I found. So this was from a systemic review by the University of Western Australia:

... high levels of father involvement have been linked to:

this is by research —

higher levels of cognitive and social competence

- increased social responsibility and capacity for empathy
- positive self-control and self-esteem
- more positive interactions with siblings
- fewer school adjustment difficulties and better academic progress.

I guess in comparison you are looking at, even to start with, Beyondblue's numbers for depression and anxiety in men and women: so for men, one in eight for depression and one in six for anxiety; for women you are looking at one in three for depression and one in five, I think, for anxiety.

Women seem to intersect in the perinatal period a lot with professionals. We do have this screening system as has already been talked about this morning. They have at least two to three times they are screened for any anxiety or depression through some screening — the Edinburgh Postnatal Depression Scale. I guess we do not have the same access to men, but given the numbers that are put out there by Beyondblue, do we need to consider more that we would like to have more access to fathers given that their role is so important and it has been a bit underwhelming, I think, the way we have supported fathers?

I often think by name 'maternal and child health' almost sounds a bit dominant to mothers and babies. The term 'perinatal' often conjures up that it is just about mothers and babies, but we are forgetting that fathers are an important part of the family dynamic. Even titles of lots of other support services, like we have got the new Healthy Mothers, Healthy Babies, again it is dominantly by title — it talks about mothers and babies. I guess it would be easy for fathers to think that they are not privy to these services, that they are not relevant to them, because even by that title — are they part of the actual family dynamic?

I had a couple of quick case stories that highlight the need for men's support and more assertive engagement with men. A couple that I visited recently were having their first baby and the mum had a little bit of anxiety, which can be a little bit normal, around parenting for the first time, but as I talked to her, a lot of her anxiety was exacerbated by the fact that her partner is disengaging, a little bit withdrawn, a little sulky, a little cranky, for want of better words, and that is just making her feel worse. We were discussing with her ways that we can help and support him, and really when it comes down to it it seems that there was not a lot that I could do to somehow get him support and someone to talk to as well. She said straightaway, 'He's not going to go through the normal channels of going to a GP, getting healthcare plans and going to seek assistance'. Maybe he lacks understanding, or he seemed to lack understanding from what I hear, of the emotions of pregnancy and early childbirth — the dynamic change once there is a third person in this little dynamic, the communication breakdown, the stresses that he is feeling about providing for his family, so his little father worries as well: how is he going to best support his partner, which is part of his job as well? I started to think there is really not much around. We are not offering anything really for dads.

The other little case scenario was an antenatal consultation — a mum and a dad; his second baby, her first baby. He had quite an extensive history with domestic violence with his previous partner and with the previous baby — child protection involvement, even intervention orders from his own parents and own family. Sorry, the important part was very strong illegal drug use as well. So he presents now having his second baby, and how do we provide supports to him? In discussions with that couple, the young woman said to me, 'There's lots of support out there for women'. I was trying to get a bit of an idea of what sort of supports they have in place so that these circumstances do not need to be like the previous ones. She acknowledged that there is lots of support for women, and when I turned to him and said, 'Who's supporting you in your trying to be better?' — he had been off drugs for 12 months, but he is trying to make it better this time — his answer was: his solicitor. I thought that is really sad, and it is expensive as well — that the only person that he can think of to support him is his solicitor.

Often men do not have a good role model for a father, or they do not have brothers that they can share things with — just father stuff. Friends, networks — there is all sorts of isolation for men. They do not get the opportunities that women are having with support around that perinatal period.

The other challenge for us is the tightness of the framework from which we work. The framework really comprises 10 basic key age and stage consultations. What we are finding currently and have found in the last few years is that the additional visits that we need to have on top of those scheduled consultations have increased substantially in the last couple of years. In asking my team, and in reflective practice thinking to

myself, ‘What is the relationship here with the increased need for additional consults with our service?’, the correlation that I am making — and this is certainly not research proven; it is just my anecdotal thoughts — is that it does coincide with the early discharge policy implementation at South West Healthcare, a two-night stay.

I just find there is a lot of need for support, particularly for first-time mums, and even though the domiciliary service itself is fantastic, I guess you cannot compare it to having someone there 24/7 to back you up with any anxieties or worries that you have with newborn babies. When I looked at the numbers for the additional visits, it also seemed predominantly that the reasons for additional visits were feeding difficulties, breastfeeding support, parent support in general and then what we call ‘failure to thrive’, which is a bit of an old term, but it really basically means babies are not putting on weight, so there is more intensive need for looking at their weight gains, their growth and their development.

I guess the other thing that I would like to highlight is that when I am thinking about including fathers — a more inclusive and assertive engagement of fathers — we do not seem to have a lot of room for innovative practice. We can see lots of need, and I see a lot of need in our community, but that framework is so tight for us that there is just not a lot of room for having innovative practice.

When I talked about the key ages and stages I wanted you to have an example of our practice guidelines to show you what we would cover within those 10 key age and stage visits. It just gives you a brief look at the sort of content that they are asking us to cover in probably half an hour, or an hour sometimes. It is an enormous amount of health promotion, education and surveillance of children and families. That tends to be our core business; we do not seem to have a lot of room for innovative practice.

The third challenge for us at the moment is recruitment. It sounds like it is a bit of a common theme for today. Our current team of six has an average age of 50-plus, and we currently have no student maternal and child health nurses despite the fact that we are quite happy to offer preceptorships and support for students. We did not have a student last year, and when I look back we have had one student complete her maternal and child health studies in probably the last eight years, so recruitment is becoming quite an issue for us with an ageing workforce. I guess some of the barriers for that are open for discussion, about why people are not training for maternal and child health, but certainly we struggle even with casual staff to do backfill for sick leave and holidays, and they are within that bracket of 50-plus as well, and even older.

The CHAIR — Do you mind if we ask some questions?

Ms PURCELL — No, go for it.

The CHAIR — I might begin. You were talking about the complexities of support for fathers. I just wanted to take that to the optics of a family violence perspective, and this is only anecdotal — my opinion — but I think that, and maybe Bernie can chime in, a lot of men have trouble reconciling what it is to be a bloke or a male with the transition to being a father and a caring person and how their perception of themselves probably changes a bit, and what role they take in the family unit. Sometimes I think that men in this process are probably feeling like they are bystanders. I wonder if there are some preventative things that are fairly easy that we could be doing which could assist in that area and might actually affect the incidence of family violence down the track. Have you got anything to —

Ms PURCELL — I definitely make the same connection as you. Again with reflection, there is the correlation of the fact that there is not a lot of support in that perinatal period and the fact that family violence is at its height or there is a higher risk in that perinatal period as well. Are we addressing their frustrations, the changes and all of those things? I do not know about minimal sorts of changes. As I said, we can probably do those as a community, but there is not a lot of scope for driving some innovation sometimes. We work privy to the Baby Makes 3. Is that something that is familiar to you all?

The CHAIR — Yes.

Mr PURCELL — I found that it was a fabulous bonus for our community, because we had never had anything before. We had never had access to fathers in that antenatal period, even though it was a postnatal program, but even if it was adapted to that prenatal/antenatal phase as well. But it was threefold, so its underlying messages were about gender equality, so there was a lot of focus on communication for couples — respect and responsibility. Gender equity is one of the primary underlying things with domestic violence. On

top of that, it also gave men access to other men, and it normalised things for other couples. When you spend time, as women do in first parents groups, it normalises for you, you are making social connections and you are getting information at the same time, so it has a threefold benefit. We are not privy to the program anymore because it was a three-year funded program. Even adapting that to the period before couples have babies would be fantastic.

I think it has to be a universal education program too. Probability and statistics will tell you this as well. I read on Beyondblue that men, by research, are not good at reaching out to services to ask for help and assistance.

The CHAIR — We are absolutely prehistoric at that.

Ms PURCELL — General universal education programs would have more appeal to me, and even a peer support program where you have really good role modelling from members of your community — just normalising those things that become a struggle during those early days of parenting. We never get an opportunity to give them a screening for their mental health, even though the statistics are saying that men are almost as badly off as women with mental health — anxiety and depression.

Ms BRITNELL — Thank you. I am very impressed that you have brought up the male aspect of this. It seems we have forgotten men —

Ms PURCELL — A little bit.

Ms BRITNELL — and we have prioritised to the point that we actually have shoved them aside too much. You are absolutely right; there is real opportunity to culturally shift that, because we are actually as a community culturally shifting a lot of our thinking at the moment around the sexes, I suppose.

There are certain ways, I suppose, we would have to actually do the whole thing. I remember clearly years ago — I have always been a working mum — Glenn, my husband, doing the kinder mum role. I was just thinking about it then and thought, ‘The kinder mum role. Why did I say Glenn was doing the kinder mum role?’. Men have never been really that welcome, and it was really extraordinary that a man was doing the kinder mum role, let alone the playgroup job.

Years ago we used to have antenatal sessions in the evening, and men were encouraged — does that still happen?

Ms PURCELL — That is run through the maternity services. I am not sure how much it covers. It covers a lot about birth, but the actual coming home — the father support — it covers a little bit of that as well.

Ms BRITNELL — And what about the maternal and child health services? Involving men in that would be another way, but they are usually from 8 till 5 or 9 till 5.

Ms PURCELL — There are certain barriers to men. We are always thinking inclusively, even though our title of ‘maternal and child health’ does not indicate that that is the case. We did a survey back a few years ago about how often men were attending appointments. We had about a 30 per cent attendance, which was really pleasing. I thought that that was really good, so we are sort of a little way there. I think they think it is not their business to be attending appointments. They are run during the day, which can be a barrier for them, the same as groups are often run during the day — support groups, playgroups. Yes, that can be a bit of a barrier for men’s attendance. And not to bag the men, but sometimes communication can be a barrier in itself for a lot of men.

The CHAIR — Prehistoric at that too, sorry.

Ms BRITNELL — Early mothers groups — you talked about those groups helping normalise. Do we run early fathers groups locally?

Ms PURCELL — No. We do not have the human resource in our team, and that is why I wanted to give you an idea of what we cover in our framework. It is core business, but it takes up all of our time. On top of that now we have got all these additional visits that we are somewhat funded for, but they are increasing at a really high rate. What is the cause for that? My team feed me back information all the time about the complexities of families — every family that comes through even the universal doors. There are marriage breakups and a lot of

relationship issues. There is just a mountain of complexities to families. This is the way society is now. It is just very complex.

Ms BRITNELL — I worked in a low socio-economic group in my health days towards the end. I often had unemployed people that I was working with, but the fathers were not that included either or intending to be interested as much as the women were forced to be. They go through that phase of having to mature up because they are going to have to get up at night or they are going to have to look after somebody else, but the fathers did not go through those milestones that getting work and becoming a father took them through; they sort of stayed on the edge of that.

Ms PURCELL — There is a shift in thinking, and I think that they have not considered it to be part of what they do. In the community engagement that we did when looking at men's attendance and appointments, we were actually evaluating through women. It would be more ideal to go directly to the men, but they are the people that we have access to. Would they like their husbands or partners to attend appointments? A lot of the answers were really ambivalent, as in, 'I don't care; if he wants to'. Even women themselves are not drawing men into that, which I know is a very complex issue in itself. We find their own partners are perhaps not drawing them and encouraging them into playing the father role.

Ms BRITNELL — You talked about not having one person in the last eight years. What is the cost for the individual? Is that one of the reasons we are not getting people training and moving into that area?

Ms PURCELL — I would imagine it is the major barrier for people not to be become trained. On the cost itself, I am not sure. How much is a year at uni?

Ms BRITNELL — Midwifery is 16, isn't it?

Ms PURCELL — I am guessing it is pretty much around the same. It is a postgraduate course. On top of that, the prerequisites for maternal and child health in Victoria are that you have general training with some experience, you have midwifery training with experience and then you are doing a postgrad on top of that. People get into the rhythm of earning money and then taking time away from an income, and paying out \$16 000 or \$17 000 for a uni course probably does not look that attractive, maybe. I am not sure.

Ms BRITNELL — But also when you are in a stable situation like we are — we have got all our doctors retiring almost in their fifties and sixties at the moment, and then the same with our — if you were training, you have already got the job and there are only five jobs, why would you spend the money?

Ms PURCELL — The retention for maternal and child health is actually really good. You tend to stay in jobs. Looking at it regionally, we are definitely an ageing workforce, and it does worry me a little bit about how that is going to look in five, six or 10 years time.

Ms BRITNELL — It is a bit of a conundrum there.

Ms PURCELL — It is a worry Victoria wide.

Ms BRITNELL — I was really interested that you brought up that early discharge is coinciding with —

Mr PURCELL — With the additional for need for visits, yes.

Ms BRITNELL — During the 1990s it is my understanding that we stopped women being able to just drop in as much as they used to. It was always a plan, so many checks over the 18 months, whereas women would often go in every week or two weeks for that support and guidance. The funding changed then. Is that a similar period to the —

Ms PURCELL — I think some councils through the funding that they get are still offering drop-in sessions. We do not currently offer one, but we possibly should look at whether women would like it to happen — I am falling into the same trap — whether families would like to have options for drop-in. But certainly it is part of the scope of our practice, for sure.

Mr FINN — Can I thank you for finally recognising after all these years that fathers are actually important —

Ms PURCELL — My pleasure.

Mr FINN — because we have been told for decades and decades and decades that we are not, and it is really nice to hear somebody say that we are, even to the point where a few weeks ago, on Father's Day, it became in certain quarters, 'Special person's day', so we were abolished altogether. What a marvellous thing that was! That was a great feeling.

Ms PURCELL — We are bringing it back now.

Mr FINN — That is wonderful. It is good to see that the swing is back on. That is very good indeed. I am just wondering what the reaction is to this new embracing of fathers by the fathers themselves. That must be a hell of a culture shock to a lot of them.

Ms PURCELL — That I am not sure about. Baby Makes 3, and this is the only information we have from our community, indicates that it was well received. The anecdotal feedback was that men enjoyed hanging out together, and they even had a session on their own where they could talk about the sorts of things that were particular to them. I think it is like everything; when you are making a change, people do not always embrace it as much as you would like them to. But I think it is a slow shift. Then there is opportunity and having something to access.

Mr FINN — The early discharge — we keep getting back to that. It is creating its own set of problems. What support is there exactly available to mothers who are struggling with a new bub at home, having been sent home after a day or two?

Ms PURCELL — How it works now with the continuity of care model is that women have their babies, the discharge is after two sleeps, and they will be discharged home, preferably. That is mostly the case. The domiciliary service from maternity services — South West Healthcare — provide about three visits for women that have had babies. Then sometimes with a slight bit of overlap we pick up women from there, because by law we are notified of births in your local council. Then we make contact with the family and offer them our services. So hopefully they are getting periodic visits.

I cannot explain exactly what is happening, but I think for the purposes of supporting breastfeeding as well, they need to have someone that is a bit more constant perhaps. This is all speculation, because all I know is that there is a correlation between the time that the early discharge started and the need for us to do a lot more additional visits. So if a baby was struggling to put on weight or a woman was struggling with breastfeeding, we would just have to slot them in as additional visits. So other than the 10 key age and stage visits that we are set to have, we would be putting in additional visits. Sometimes that can be twice a week or weekly visits for four or five weeks to make sure that the baby is thriving.

Mr FINN — One of my portfolio areas is autism. There has been much discussion even on this committee about the role of maternal and health care nurses as to early signs or diagnosing early signs of autism and directing families to a paediatrician or somebody like that. What is the attitude of yourselves to taking that on in a more formal way with extra training and, as I said, a more formal role in diagnosis or at least in detecting those early signs?

Ms PURCELL — I do not know; it is a good question. I have not thought about it much. I would be confident that maternal and child health nurses certainly have the capabilities to do a little more extensive screening. As it is now we certainly do secondary screening, which would indicate, but diagnosing has not been part of our scope of practice.

Mr FINN — I am not suggesting diagnosis, but just detecting early signs and then sending the family off to see somebody who might be able to diagnose.

Ms PURCELL — That is actually part of our job.

Mr FINN — You are doing that now?

Ms PURCELL — So it is part of our current scope. We do early detection, so surveillance of the child's physical growth and development. If we see that there is something wrong, we would immediately do a referral

to another service that specialises in diagnosis. So we would actually probably do a secondary screening before we sent them. So there is concern, secondary screening and referral.

Ms BRITNELL — It was mentioned earlier — I think Dr Uren said she thought it might be a good idea — or it might have been Julianne — that isolation might be an issue for maternal and child health nurses, and it might be better to have them in the community health setting. What is your opinion on that comment?

Ms PURCELL — I would partly agree with that. It has never been delved into too intensely, but there have been a few things. I think Peter Logan, the previous unit manager, said it is a better fit that we work from hospitals, and that might seem the case. I think over the history of maternal and child health it has gone to and fro. We were working from hospital and then it went back to local government. I would agree that there is a little bit of isolation. As nurses we are a very small contingent of a big workforce with Warrnambool City Council, and that produces lots of different issues, as you can imagine. There perhaps can be some lack of understanding about what we do and our different needs as opposed to other sectors of Warrnambool City Council.

Ms BRITNELL — You mentioned that you take on some case load for vulnerable individuals. The safety issue around staffing and your safety, has that been an issue?

Ms PURCELL — Ours is a little similar. There would be a small amount of cases where you would be concerned. We have the option to dual up and do a double visit. We have recently looked into some safety options. There is a SafeTCARD. I do not know if you are familiar with that, but it is a little card that you wear around your neck. If it disconnects, it goes directly to a call centre, and then there is an emergency process that follows after that. My team at the time did not feel that they needed anything that intense, but what we are looking at is working with phones and GPS monitoring or alarms from phones. But it happens. It is not a huge concern, but there are possibilities that you are unsafe, because we do a lot of isolated visits, especially in enhanced.

Ms BRITNELL — And out in the district — like half an hour or three-quarters of an hour from —

Ms PURCELL — No. It would have been nice if Jodie had been here, because she can probably talk more about the rural isolation. We are restricted to the Warrnambool area, and for us that does not probably entail a lot of that geographic isolation.

Dr CARLING-JENKINS — Thank you for coming in, Maryanne; I really appreciate your time and your efforts.

Ms PURCELL — My pleasure.

Dr CARLING-JENKINS — I will not take up too much time because I am just watching the clock. I appreciate the recommendation you have around a holistic approach, where you are valuing fathers and you are valuing mothers, because it is all about the best interests of the baby. It does not seem like that would be an easy add-on to a service. It seems like that is a new model that needs to be thought through more and developed. Would you agree with that?

Ms PURCELL — Yes, you are reading it exactly right, Rachel. It would be an add-on, but I think it is an important add-on and something to be considered.

Dr CARLING-JENKINS — Yes, absolutely. You mentioned that part of your case load is working particularly with vulnerable families. One of the examples you gave was around the drug and alcohol issue being involved in the family. Are you seeing anecdotally that a lot more as a factor in creating these vulnerable families?

Ms PURCELL — Yes, I would say so, probably in trend with statistics that you read about. I think there is an increasing amount of, certainly, ice use, and it causes havoc with families. You tend to find a lot of the vulnerable families would have those clusters of vulnerabilities, where there is domestic violence, there is illicit drug use or alcohol use, and then they are socially and economically disadvantaged as well. So they do tend to cluster together.

Dr CARLING-JENKINS — Sure. We talk a lot about ice, I guess, and the increasing incidence, or maybe we are just increasingly aware of it. Are you seeing an increase, or is that something that has been fairly steady over the last few years?

Ms PURCELL — I think it is relatively steady. It is hard to answer that honestly. I am not too sure. We do not have a lot of statistics that would indicate that that is the case. But certainly it is steady. I do not know —

Dr CARLING-JENKINS — But it is certainly not declining?

Ms PURCELL — No, no decline and probably a bit of a steady increase.

Dr CARLING-JENKINS — And I guess your service works on that reactive end more than the proactive; would that be —

Ms PURCELL — I think we are probably more proactive because we do consider ourselves to be early intervention. So because we are a universal service we are doing very generalised care, and in that sense we are proactive. Like I said to Bernie before, we are surveilling families and children, and when we see that there is something wrong we are getting in as early as possible. So, say for the example of autism, as soon as you see things that might concern you or parents have seen things that concern them, the earlier the intervention, the better the outcomes. So I would say we are more proactive.

Dr CARLING-JENKINS — Okay, excellent. And do you find — because I would think some of that would be by a referral service as well —

Ms PURCELL — Yes. Referrals are really heavy on our —

Dr CARLING-JENKINS — So you are referring out for drug and alcohol issues or for autism et cetera?

Ms PURCELL — Yes.

Dr CARLING-JENKINS — Do you find in Warrnambool that you have enough services to support that referral?

Ms PURCELL — I certainly would stand behind and support the services that are represented today. We do not seem to have a lot of services for emotional health support. Let alone I am trying to pump up —

Dr CARLING-JENKINS — I am looking for the gaps, I guess.

Ms PURCELL — Yes, and there is a gap for emotional health support not just for women, but now I am finding that that gap is there for men very much so as well.

Ms BRITNELL — On the last point that Rachel has just raised, can you elaborate more on the demand on CAMHS? Are you familiar with —

Ms PURCELL — The demand for CAMHS?

Ms BRITNELL — Yes, the demand on CAMHS. When you refer, are you finding they are overwhelmed or waiting lists —

Ms PURCELL — I know just from discussions around other services and agencies that they are quite overwhelmed. We probably would not directly refer a lot of —

Ms BRITNELL — Young mums?

Ms PURCELL — young mums to CAMHS, no. We would do a lot of other referrals for emotional stuff, like GPs, emotional health services and general counsellors and psychologists, but probably very little directly related to parenting emotional support.

The CHAIR — Thank you so much for your time, Maryanne.

Ms PURCELL — You are most welcome.

The CHAIR — It is a great example, your submission, of why we are here, to hear from the coalface about the gaps we should be looking at, especially in regional areas. Thank you so much.

Witness withdrew.