FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Melbourne — 18 September 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

Witnesses
Dr Nicole Milburn, Perinatal Psychologist and Chair, and
Ms Kirsty Evans, Director of Clinical Services/Nursing, Tweddle Child and Family Health Service.
The CHAIR — Welcome to these public hearings, Dr Nicole Milburn, chair of Tweddle and perinatal psychologist, and Ms Kirsty Evans, director of clinical services and nursing. Thank you for attending today. All evidence at this hearing 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 this hearing will not be afforded such privilege. It is a contempt of Parliament to provide false evidence. These hearings will be recorded, and then you will be sent a proof copy to look at yourselves. Welcome. That is pretty much the boring stuff out of the way. We would love to hear you talk about your service for 10 to 15 minutes, and then if we can ask you some questions, that would be great too.

Visual presentation.

Dr MILBURN — Thank you for giving us the opportunity to come and talk to you. I think what we are going to talk about is going to follow on really nicely from some of the things that Louise spoke about in terms of parenting capacity, supporting parents and focusing on the infant. Some of the questions that I heard were about what support there is for parents in this space that is not just in the mental health system, and we will be talking about that.

Ms EVANS — Thank you for allowing us the time to present today. Tweddle Child and Family Health Service is able to provide a range of intensive services for families that concentrate on the whole family unit, whatever that configuration of family may be. We are able to span the health, family services and specialised health service spectrum and provide wraparound services for the family unit with an emphasis on the health, safety and wellbeing of the infant or toddler, recognising that this occurs in the context of the whole family dynamic. Our presentation this afternoon will briefly demonstrate how we are able to achieve this. Equally we are limited in our capacity to provide services due to the ageing nature of our buildings and the lack of a truly joined-up service system, and we will speak to some of these challenges also.

Victoria has a strong history of providing a range of parenting and early childhood services to support families with infants and young children. EPCs, day-stay residential groups and home-based services are pivotal services due to the expertise and focus on infant health and development and the promotion of family wellbeing and parent-infant attachment. The services are focused primarily on providing early intervention and prevention through the delivery of intensive parenting support for vulnerable families from pregnancy through to the baby and toddler phase of development, and now we are very much focusing on the first 1000 days. The aim of the service is to build family resilience and parenting capacity, to reduce and prevent the need for further specialist or tertiary-level services and to assist in the engagement of child protection services when significant wellbeing and/or protective issues arise.

Early parenting centres are unique organisations within the service system. Tweddle is recognised as a registered public hospital under the Health Services Act, but we are also a community service organisation. This means we are a ‘well’ facility that enables families to reside in an environment that replicates the home environment as much as possible and allows the family to receive therapeutic education and support. A significant component of the work we undertake is linking the families with the appropriate supports they require back in their own community, so we have strong links with maternal and child health, other family support services and other specialised services such as mental health, drug and alcohol and family violence services. However, because we sit across both service systems, we have the compliance requirements of both — accreditation against hospital standards as well as DHHS standards. We have reporting requirements to the department of health and to the department of human services, but then we fall through the cracks for many of the funding opportunities and service delivery opportunities out there.

A child and family health organisation such as Tweddle cannot help but evolve over the years, responding to the changing needs of the community. This has meant 90 years-plus of evolution for Tweddle and the families it serves. We have previously had a reputation as a sleep school, but now we work with some of the most vulnerable families within our community and provide a pivotal link across universal, secondary and tertiary services. This diagram indicates where the universal secondary and tertiary levels sit and the sorts of services that are providing those services. We sit very much in secondary and tertiary-level service provision.

The CHAIR — Kirsty, what is PASDS?

Ms EVANS — Parenting Assessment and Skills Development Service. That is the child protection program that is provided where a parenting capacity assessment is undertaken.
Government policy direction has moved us towards providing direct to those families more at risk and vulnerable in our community. We target families from across the state with children from birth to three years of age and prioritise our referrals according to the level of vulnerability experienced. Over 95 per cent of our referrals are from health professionals, with about 60 per cent being from maternal and child health, about 20 from general practitioners and paediatricians, and the remainder coming from a variety of family services and other service providers, including mental health, drug and alcohol, and family violence. It is vital that the early parenting centres are recognised as an integral part of the broader service system as the reforms associated with mental health, family violence and the Roadmap to Reform are rolled out.

We know that the complexity of our clients is increasing. We have an assessment and intake process that requires families to answer approximately 80 questions that look at risk and protective factors. Each question scores between negative three and positive three, with negative relating to protective factors and positive scores to risk factors. When this program — the assessment and intake program — was designed with as much evidence incorporated into it as was available at the time so that it had some rigour and validity, the profile of the clients that were coming into the residential program was scoring about a 12. On this graph that you have got — it scores across the bottom with numbers obviously going up the side — the blue graph is our data from 2013–14 and the orange data is representing the information from the clients that came in in the last financial year. You can see that the profile of a client that is coming into the residential program now is sitting at a risk score of around 20, 21 — a shift to the right of about five risk factors, five points, so very clearly demonstrating that shift in acuity that we know has been happening, but this clearly demonstrates it.

Ms McLEISH — Kirsty, can I just ask a quick question: at what point do you do this assessment?

Ms EVANS — A referral document is sent into the service. We look at that within the first three days of that referral coming in, and then this assessment is done within about a week of having received the referral.

Ms McLEISH — And does that determine your priority?

Ms EVANS — It does assist in us making a decision, yes. The needs of the most vulnerable in the family are at the heart of Tweddle’s service practice. In times of stress and adversity the most vulnerable is always the youngest member of the family. Tweddle’s work is orientated towards simultaneously building family strengths and reducing risk because we know that adverse childhood experiences have far-reaching and long-lasting effects and that prevention and intervention at this age can save lives. At this point I will hand over to Nicole.

Dr MILBURN — I want to talk about the theoretical foundation for a shift in the practice of Tweddle. I have been on the board for 10 years, and when I started the practice was much more traditional parenting capacity building. Over the years, based on infant mental health science and the evidence that has come out from the Decade of the Brain and those sorts of things, the practice has shifted much more to focus on the needs of the baby or toddler. The reason for that is that we understand the crucial period of brain development from conception to about the age of three. The brain develops hierarchically from the most primitive functions to the most complex. All of the emotional and regulatory systems in the brain are largely developed between conception and age three. So all those foundations that we need to be functional children, adolescents and adults are pretty much laid down between conception and age three. That means that we really need to get it right in those years. If I could wave a magic wand, I would shift a whole lot of funding right to that area, because then we would not have to do quite so much in adolescence and adulthood.

We know that normal development requires specific input at specific times, and if we do not get the right stimulation at the right time critical brain functions will not develop. This we need to think about in terms of what our families are facing. Our families are facing more and more isolation as time goes on. For example, in the 1850s the average size of the family was seven or eight in a family home, and now it is about three. There just are not as many relationships available to the baby. We know that the number of words a baby hears in the first three years of life is directly correlated to their language development, and it has got to be through conversation. It cannot be through television. If you have got a family where there is a single mum or a single dad and only one child, and the TV is on all the time and they are not talking, that baby will develop a language delay. It is as simple as that — usually not knowingly; obviously parents do not want to do that to their children.

We know the relationships that a baby has are really, really important. This is just a really simple slide to show the different types of experiences that babies might have with mums. The one on the bottom right is the one that we really want. It is a good interaction. You can see mother and baby gazing at one another — same parts of the
brain being stimulated. The one on the top left is more like a depression that we might see in the mother, where the baby is looking to the mother but the mother is looking away. We think about, well, what does that baby see when they look to a mother who is flat and depressed? That baby might internalise a sense of ‘I’m not very interesting’, for example.

The angry, violent one is self-explanatory. Infants get very hyper-developed stress response systems when they experience a lot of anger and frightening things.

The one on the bottom left — I always think of that at the moment because it is what we see so much when we see babies look to their mum and they are looking at their phone. We see that a lot. We see that way too much.

This is important because these experiences of not having enough development or having too much of something — too many scary things or too much anger — really affect how the infants develop their sense of themselves, their sense of being able to regulate their own world and their environment and their expectation of relationships. The reason why this is really important to the work of Tweddle is that Tweddle really helps parents and babies get it together and understand these patterns and shift them. If we can do that in the first three years of life, then we can prevent a whole lot of problems in later childhood, adolescence and adulthood.

In my other life I work a lot with child protection clients, and I think you would be hard-pressed to find any child protection client still in the system who had a good infancy. It just does not happen.

Ms EVANS — Tweddle has a framework that we work towards. It is underpinned by evidence and it certainly looks at attachment, child development and trauma. Normal growth and development is underpinning all of what we do. We are able to design services that meet the needs of individual families. We work with the service system and ensure that we are crossing universal and specialist services.

We are trying to build our service delivery by improving our site at Footscray. We have a pod in development as we speak, which will house an additional four families, and we have really looked at the changes in the legislation around family reunification and family preservation in designing that pod, which will enable families to come and live as a family unit — cook, clean, sleep and interact as much as you can emulate in an institution — in a family environment. We are tapping that into wraparounds from other service providers — mental health, drug and alcohol, and family violence.

But we are certainly faced by some challenges, and one of those is workforce. These have become increasingly concerning. It is difficult to attract maternal and child health nurses as they tend to want to work standard hours, and our work involves shiftwork. It is also difficult for them to transfer entitlements such as long service leave across from local government to state government positions. The nature of the work that we undertake is multifaceted and requires a multidisciplinary workforce.

We were significantly impacted by the withdrawal of the NPDI funding at the end of 2015, which resulted in us having to make four specialist psychologists redundant. Although we are grateful that some of these dollars have been reinstated by the government, the redundancies affected our reputation and there have been some challenges in again attracting suitably qualified and experienced psychologists to our team.

Our early parenting practitioners need to be upskilled to work with the complexities and multiple challenges our families present. The work is very different to that experienced in a childcare centre. Our workers require additional training and competencies to undertake the specialised work, and currently there is no specific course available.

We are currently funded predominantly through the DHS component of DHHS, and maternal and child health is funded through DET. Although the majority of our referrals come from maternal and child health nurses, we are not always recognised as part of that service system, and the specialised nature of the work we undertake in supporting maternal, paternal and infant health and wellbeing is not supported financially or in the service system reforms.

As the service system moves more towards place-based services this also places additional strain on our capacity to be at all the appropriate tables. As a statewide service our resources do not stretch far enough to always have a relevant presence to ensure other service providers are aware of the specialist therapeutic
interventions we can offer to families to support the physical and bio-psycho-social development of all family members.

Our recommendations are: that any further service developments be joined up with existing early parenting centres in order to ensure consistent, high-quality, evidence-based service delivery; that consideration is given to supporting attraction and retention strategies for maternal and child health nurses to work within public health settings; that consideration is given to support increased funding that is targeted at professional development of the early parenting services, and this relates to but is not limited to trauma-informed care; that consideration is given to the development of an advanced diploma in early parenting and that this course includes working with families with mental health issues and issues associated with alcohol and other drugs; that Tweddle’s concept for property redevelopment for a centre of excellence for early parenting in the west be progressed; that there is further development of the capacity of early parenting services to provide an increased response to perinatal, infant and early childhood mental health difficulties by strengthening the existing mental health services within these services; that there be the provision of overt recognition of maternal health knowledge and intervention skills in the perinatal infant and early childhood periods as specialist skills; and, finally, that there be a qualitative shift towards prioritising the first thousand days to receive additional funds to support current and future mental health needs in the perinatal period.

Our final message: infants’ brains matter, and all efforts should be directed at giving infants the best possible start in life. To do this we need the first thousand days prioritised, joined-up services, a specialised workforce and a specialised centre for early parenting. Thank you for your time.

The CHAIR — You very much hit the nail on the head, I think, with early investment at an early stage, without doubt. Do you mind if we ask you some questions now? I have just got one relating to the first graph and that shift of acuity. I was just wondering which questions were asked that made that change. Where are the hotspots where we have seen increases — even if it is off the top of your head and it is just broadly.

Ms EVANS — I cannot tell you the specific ones — I think it is across the board. The questions look at obviously some demographic information, they look at the pregnancy information and they look at the maternal health through the pregnancy, after the perinatal period and beyond. They look at the birth history of the child and their growth and development, and we have underpinned that, as I said, with as much evidence as possible. Then we are looking at the enjoyment of parenting and any health needs more broadly of the parent and the child, and then we ask questions specifically around mental health. We ask specific questions around drug and alcohol use. We ask specific questions around family violence. Across 80-odd questions we get varying responses.

I think, anecdotally, for the questions around family violence, back when we were first asking in 2013 the respondents were saying there was no problem, whereas today with the greater focus on family violence they are now starting to articulate that they are having some challenges in the family environment. That graph actually — the highest risk score was up in the 50s, so it is significant.

The CHAIR — Thank you. I just would like some clarification on two terms that were in your presentation, which was great by the way. Early parenting centres — I had not heard of them.

Ms EVANS — There are three here in Victoria. So there is Tweddle Child and Family Health Service in Footscray, there is the Queen Elizabeth Centre out in Noble Park and there is Mercy O’Connell Family Centre in Canterbury. All three services started in a similar sort of fashion over 90 years ago as hospitals for unwell babies and mother-baby centres to care for mothers in the postpartum period, to give them a rest — oh, for the day. There has been an evolution over the 90 years with government moving all three early parenting centres more into the vulnerable space over the last 15 or so years. Sleep school is probably what we were more commonly known as back 15 or 20 years ago, but over the last 15 years we have really moved much more to working with vulnerable families.

Sleep and settling are still legitimate reasons for families to access the service, and we deal with that because that is what the families are presenting with, but then we are dealing with the additional complexities that those families are presenting, as indicated by those scores that are shifting up.

The CHAIR — That might lead to my left next question. Enhanced maternal and child health services, again, I have not heard of that term before.
Ms EVANS — So maternal and child health is our universal platform for all families, and I think it is about 98 per cent of new babies that are seen by maternal and child health for at least a first visit. Enhanced maternal and child health is the home visiting extended service provision from maternal and child health, which has had some additional investment from the minister in the last budget in relation to being able to do some additional home visits. It has gone from, I think, 15 hours to 20 hours. I may not be —

Dr MILBURN — And it is high risk.

Ms EVANS — Yes, it is very much aimed at the more high-risk families. We think that is a great investment — to have additional hours and dollars into that — but we also think that that is going to increase our workload as well, because that 20 hours is not going to be sufficient with the complexity that is out there in the community, and the maternal and child health nurses are going to be looking at where to send those families next.

Ms EDWARDS — Thank you for coming in, by the way, and for your submission. I was really interested in the prison program, particularly in relation to the challenges that women face in our women’s prisons — and we have two, Dame Phyllis Frost and Tarrengower — and what supports are available for women who are pregnant in prison and for women who have their babies in prison. Do we have any data on how many there are going through the system? Also is there any data on background — so is there any data on how many of those women would be from Aboriginal or Torres Strait Islander backgrounds, for example? I am just interested in the program, what the challenges are and how these women are supported while they are in the corrections system. I assume you work with Corrections Victoria to run the program.

Ms EVANS — Yes.

Ms EDWARDS — And once they are ready for release, what happens then?

Ms EVANS — We only work at Dame Phyllis; we do not work currently at Tarrengower, and the program is —

Dr MILBURN — But would like to.

Ms EVANS — Absolutely, we would like to.

Ms EDWARDS — I would like you to as well, given that Tarrengower is in my electorate.

Ms EVANS — Our program is a parenting support program. We are not doing a lot in the antenatal period; we are really coming in as a parenting support education program. We run a group program with mothers that either are parenting children in jail or, obviously, have children outside and are wanting to re-establish relationships with those children, particularly once they have been released. We do some one-on-one consultations as well. I am having to rack my brain in terms of the report that came across my desk earlier this week in terms of numbers, but I am sorry, I do not —

Ms EDWARDS — That is okay. You can provide it to us later if you like.

Ms EVANS — Yes, I can certainly provide it to you. We have just done a report for the last 12 months.

Ms EDWARDS — That would be really helpful.

Ms EVANS — Yes. We are very much constrained by the prison system. They tend to manage the referral of the women in and out of the program, and so we come each week and the clients that are allocated to the program are there for us. We are not having a lot of additional contact with the prisoners outside of the group or the individual consultation.

Ms EDWARDS — So it is basically a parent education program?

Ms EVANS — It is parent education but across the greater age spectrum because technically as an early parenting centre we work with nought to three but we will work in the prison environment with any parenting mother — so those with older children and teenagers as well. Our staff member that goes in there has got that additional skill set.
Ms McLEISH — Have you got any demographics that you can share with us — the number of people, certain age groups, for example, different backgrounds?

Ms EVANS — We can certainly provide all of that information. Off the top of my head I can tell you that the greater cohort of children is around that seven to eight-month period when they come in. We get more boys than girls. The age group is generally older; the highest demographic would be older mums.

Ms McLEISH — Single mums? New arrivals? A mix of everything?

Dr MILBURN — There are not many new arrivals.

Ms EVANS — There are not many new arrivals and there are not many Indigenous families coming through, as much as we are trying to make our way into that.

Ms McLEISH — How wide do you cast your net in terms of referrals?

Ms EVANS — Statewide.

Dr MILBURN — Forty per cent are from the local LGAs, though, but 60 per cent are from elsewhere.

Ms McLEISH — When you say local LGAs, what does that mean? How many?

Dr MILBURN — Brimbank, Melton, Maribyrnong — and the other one.

Ms EVANS — Hobsons Bay.

Ms McLEISH — That is very narrow.

Dr MILBURN — So that is 40 per cent from those LGAs.

Ms McLEISH — When you think about the number of LGAs in the state, that is not many.

Ms EVANS — We are based in Footscray and those immediate LGAs surround us. We absolutely have got that data right through all of our services.

Dr MILBURN — There is a service in Geelong that Tweddle runs as well.

Dr MILBURN — But the service has not matched the pace of the population development in the region by any means — nothing like it.

Ms EVANS — We have 450 families come in for the residential program — Monday to Friday — for the year. That is what we are funded for. That is our service agreement target. We can do double that, but we would have to hang them off the chandeliers.

Ms McLEISH — Earlier you mentioned that you prioritised by vulnerability. I have a question about how you do this. When you showed us the risk score assessment tool, you said that that assists. So what else do you use in determining?

Ms EVANS — We have got clinicians that are on the phones. They obviously use their —

Ms McLEISH — So who do they speak to?

Ms EVANS — They speak to the family themselves. They are speaking to the mothers. They have got the written referral from a health professional, and then they contact and have a phone conversation that lasts 40 to 45 minutes generally with the client. It is based on the data they get from asking those 80-odd questions and the score that comes up but also just that experienced, practised ear hearing what the story is —

Ms McLEISH — And knowing likely outcomes.

Ms EVANS — Yes, so we are not just basing our decisions on a score alone. We are very much using the expertise of the clinicians to determine what they think is the best option for that family.
Dr MILBURN — Which comes back to the importance of a specialised workforce, because there is a big requirement on the staff in that first assessment call because they need to attend to what is being said, obviously, but also what is not being said and they can pick up some of the nuances, which does require some specialised training.

Ms McLEISH — What are the skills and qualifications of the person that is doing an assessment?

Ms EVANS — We have got our maternal and child health nurse as the team leader, and then we have got early parenting practitioners that are mothercraft nurses originally and/or childcare trained and then skilled up in relation to the breadth of the work we undertake. So they are doing further education around maternal-infant attachment, trauma, growth and development — all of those things. They are our more senior clinicians.

Ms McLEISH — Finally, if you would like to share with me, I would really be interested in a case study. If there was somebody who was high risk and they came in, what were the sorts of factors and things that they were experiencing, what did you do and how did it end up for that person? You will have thousands of them. It is just so we really can get a feel of what you do.

Dr MILBURN — I had a case that I referred into Tweddle. It was a case where the reunification was on the cards with child protection. There was a lot of anxiety about sending this baby home. There was a good reunification plan and good supports, but the anxiety was really about how the parents were going to manage overnight because the baby had been injured before. The parents had done a whole lot of capacity work in the year that the baby had not been with them. So I referred them to Tweddle. They came in for a five-day stay — the mum and the dad. That afforded the whole system the comfort of knowing that there were going to be eyes on the baby the whole time, so the baby was going to be safe. It also gave the parents the knowledge that someone was going to be there if and when they needed it, because they were really worried as well about getting too stressed. The five-day stay at Tweddle — you can talk a bit about what happened and then I can say what happened at the end of it.

Ms EVANS — The general program is that they come in, they are allocated to a primary worker so somebody is following them as best as we can through the course of the week. They will sit down and develop up their care plan that is looking at the goals that the family want to achieve. We are looking at what the risk factors and the information that we have obtained from the referral information, and we are marrying that with what the family are wanting to achieve. So, as I was saying earlier, we still do a lot of work around sleep and settling, because that is the primary reason that most referrers will contact us on behalf of the family. But then you are looking at all that additional complexity that is happening, so you will work on that one-on-one but also in group work.

There is a lot of benefit in the clients being able to experience what is happening for others in the environment; they see that they are not alone. That goes for the child protection families as well as the families who are not involved with child protection. We put them all together. We do not separate them at all. We do not stigmatise in any way. Everybody is there to help one another. So looking at the specific requirements, we bring in the additional supports we might need, such as psychology and social work, to do some individual work with the families. We are looking at depression and anxiety stress scales. We look at that for both the mother and the father so that we are really looking across that breadth of challenge they are having, so not just an Edinburgh postnatal depression score; we have got the anxiety and stress in there as well and then being able to do the work that needs to happen to start them on the journey that they need to go on and linking them into the referral sources that they need back in their local community.

Dr MILBURN — My case was a case where they lived 3 hours drive away from Melbourne. They came in for their five-day stay, they went home and they continued the transition for the baby to be returned to their care — so gradually. From their stay at Tweddle there were a few outcomes. The mum had had mental health problems.

Ms McLEISH — Diagnosed or undiagnosed?

Dr MILBURN — Both, and she had been seeing a psychiatrist for some of those. There was trauma, and she had had other children removed as well. She found after her stay at Tweddle that she did not think she was up to full-time parenting of this baby, so she relinquished. The dad actually found that he was up for it, and with the help and the understanding of the expectations of full-time parenting, he took the baby on, and they are still...
together. The outcome for the baby was, because the mum was able to say, ‘It’s actually too hard’, she could then have a relationship with her child that was within her capacity as opposed to what had been happening with the adversarial system, where she had been saying, ‘Yes, I can; yes, I can’, and fighting with it. She was sort of helped through the intensive 24-hour-a-day support for five days at Tweddle to really say, ‘I can’t do it all. I can do this much’. So she has an ongoing relationship with her baby. She just does not have full-time care. He is in the full-time care of the dad.

**The CHAIR** — I promise we will finish on a high note, but I just wanted to ask you how prevalent in your view is the incidence of maternal suicide? What are the risk factors, and how can these be reduced?

**Dr MILBURN** — I would not have — —

**Ms EVANS** — I do not know.

**Dr MILBURN** — I work with injured babies not injured mothers.

**Ms EVANS** — We certainly get a number. There is a high percentage of parents that are coming through that score high on the depression, anxiety and stress scale, across those three domains. There is certainly a question in relation to self-harm in the last seven days/five days, and we certainly act on that very seriously. In terms of actual suicide and death we work very hard to get them involved with the right sort of resources. That is why it is really important that we have a mental health team around the clients that are coming in. About 60 per cent of the clients articulate a mental health issue. It may not be diagnosed, but they are articulating that they have a mental health issue before they even come in the door. So, yes, it is a challenge.

**Dr MILBURN** — I think the work really helps bring to the fore the relationship between the baby and the parent in a way that can really get them connected and motivate them to really work on those depression and wanting-to-die issues but also give them real meaning to live and keep going with that, so it is a direct intervention in that way.

**The CHAIR** — Thank you.

**Ms EDWARDS** — I just wanted to know if there was a waiting list for your residential and day programs?

**Ms EVANS** — Yes, there is a waiting list, but at the moment we are running at about four weeks before we can get a family in. It does fluctuate, and in the past it certainly has been out to three or four months, but we work really hard to try and get families in as soon as possible.

**Ms EDWARDS** — How many do you accommodate at a time?

**Ms EVANS** — We have the capacity to take 11 families into our residential program at the moment. I am hesitating because it gets a bit complicated. Currently we have the two programs, so the five-day residential — come in Monday, out Friday — and then we have got the PASDS child protection program, and those families are in for 10 days. Western region has just increased their targets there, so we now have two of those families every fortnight, and southern metropolitan in this financial year has purchased 12 beds. We are running between eight and nine families coming into the five-day program each week to then accommodate the child protection of families, and we have been able to shift that knowing that we have got our pod coming into the new year, and I will be able to put more families through the five-day program then.

**Dr MILBURN** — And day stay?

**Ms EVANS** — We have got six day-stay programs around Maribyrnong; Kings Park, which is Brimbank; one out at Whittlesea; Geelong; Mortlake; and with Djerriwarrh. They generally have four families coming in for a day, and we run that between one and two times a week, depending on the site.

**The CHAIR** — Thank you so much for coming in and giving us your time today. It has been invaluable. Thanks for your submission.

**Ms EVANS** — A pleasure.
The CHAIR — That is the end of our proceedings for today. Thanks, everyone in the gallery for coming along, and thank you to Hansard and our secretariat too.

Committee adjourned.