Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF DR ROBYN MILLER

I, Robyn Miller, Chief Executive Officer of MacKillop Family Services of 237 Cecil Street, South Melbourne VIC 3205, say as follows:

1 I make this statement on the basis of my own knowledge, except where otherwise stated. Where I make statements based on information provided by others, I believe that information to be true.

2 I am giving evidence to the Royal Commission in my personal capacity and not on behalf of my employers or organisations of which I am a member.

Background

3 I am a social worker and family therapist, with over thirty five years' experience in the community sector, local government and child protection.

4 I have a Bachelor of Social Science (Social Work) from R.M.I.T, a Graduate Diploma in Family Therapy from La Trobe University, a Masters of Family Therapy, and a Doctor of Philosophy from La Trobe University. My doctoral thesis examined cultural reform in Victorian Child Protection and Family Services and the Best Interests Case Practice Model.

5 I am the Chief Executive Officer of MacKillop Family Services, which is one of the largest providers of specialist services to vulnerable and disadvantaged children, young people and their families in Victoria, New South Wales and Western Australia. I have held this role since July 2016.

6 I currently serve on the Boards of Catholic Social Services Australia, Catholic Professional Standards and the Association for Child Welfare Agencies.

7 Prior to my current roles, I was:

(a) the Chief Practitioner within the Department of Human Services in Victoria between 2006 and 2015;

(b) a senior clinician and teacher at the Bouverie Family Therapy Centre at La Trobe University between 1992 and 2004;

Please note that the information presented in this witness statement responds to matters requested by the Royal Commission.

(c) a consultant to the Royal Commission into Institutional Responses to Child Sexual Abuse between 2015 and 2016; and

(d) a member of the Victorian Child Death Review Committee between 2002 and 2013.

8 Attached to this statement and marked 'RM-1' is a copy of my curriculum vitae.

Services provided by MacKillop Family Services

9 MacKillop Family Services provides out of home care (including foster, kinship and residential care), family support, youth support, alternative education, disability, and heritage and information services across New South Wales, Western Australia and Victoria.

10 Over the past year MacKillop's foster care and residential care programs have cared for over 1,200 children, young people and their families who have experienced loss and trauma beyond most people's understanding. MacKillop's homelessness and education services have reached a further 800 young people and MacKillop has also provided counselling and support to over 6,000 families nationally.

11 MacKillop currently operates 40 residential homes in Victoria. These residential homes are predominantly four-bed therapeutic residential care homes, four-bed general residential care and two-bed residential care models.

12 The therapeutic residential care model includes additional supports to improve outcomes and life trajectories for children and young people with complex needs who have experienced abuse or neglect related trauma. The therapeutic residential care model includes funding for a 0.5 equivalent full time therapeutic practitioner attached to each therapeutic residential care house, and additional hours on the roster to support higher levels of client support, staff supervision, therapeutic care planning and practice and group reflective practice.

13 Other residential homes operated by MacKillop include:

(a) homes funded by Targeted Care Packages (**TCP**), which can have varying numbers of young people (for example, one TCP home was developed for a sibling group);

(b) at times, one-to-one contingency homes where a staffing group cares for one young person in a residential home; and

(c) MacKillop's 'specialised' three-bed house called Morgan House, which provides support to young mothers, who are involved in the Child Protection system.

14 Some homes provided by MacKillop are single sex (female) homes due to their program focus, with other homes operating as single sex at various times depending on referrals and/or placement matching issues.

Responsibilities as Chief Executive Officer

15 As the CEO of MacKillop Family Services, my role is to lead and influence our 1,450 staff members and 800 foster carers and volunteers to achieve optimum outcomes for the children and families MacKillop serves, and to deliver on our strategic plan. I am accountable for the work health and safety of employees and volunteers, and to the complex regulatory requirements for the children and young people we care for.

16 It is my duty to embed the learnings from the Royal Commission into Institutional Responses to Child Sexual Abuse and foster a culture of continuous improvement and excellence, whilst advocating for the rights of children.

17 My prior experience working as a consultant to the Royal Commission into Institutional Responses to Child Sexual Abuse has fuelled my dedication to improving MacKillop's practice culture so that it is more centred on reunifying families, and genuinely listening to the feedback of families and the voice of children.

18 As CEO for the past three and a half years, I have led unprecedented growth in our services whereby we have more than doubled in size from an operating budget of $65 million to $156 million per annum, and our staff has increased from 800 to 1,450 dedicated professionals. Despite the unprecedented growth, our employee engagement (independently evaluated) has increased by 10% and is 17% above industry standards.

19 I have been very hands on and present as a leader, travelling widely and focused on the essence of our work, the children and families. Embedding more therapeutic and evidence-based approaches, developing our staff, our systems, and nurturing the carers has been my strong focus. My approach has been one of strengthening the culture of best practice that 'walks the talk' of child safety and the learnings from the Royal Commission into Institutional Responses to Child Sexual Abuse.

MacKillop Family Services' Outcomes 100

20 In July 2018, I began a new strategy at MacKillop, known as 'Outcomes 100' to improve our residential care program. Outcomes 100 is a comprehensive case review for each young person in MacKillop's residential care homes in Victoria. Between 9 July 2018 and May 2020, a total of 100 young people in Victoria have had their cases reviewed as part of this initiative. In total, the number of reviews completed across MacKillop nationally is 125.

21 The Outcomes 100 case review process involves collaboratively engaging the key professionals and carers in a young person's life through a panel discussion with a view to:

(a) critically analysing the young person's experience of living in out of home care, which includes having regard to extensively prepared and developed case files, which synthesise all relevant assessment reports, incident reports and a survey completed directly by the young person;

(b) developing a joint understanding of the key issues, achievements, views and wishes of the young person and their family;

(c) promoting information sharing across key agencies and the Department of Health and Human Services; and

(d) developing an action plan with agreed tasks and responsibilities to address any identified issues or blockages.

22 Having the right people participating in the panel has been key to the success of the initiative. Each panel is chaired by myself, with panel members typically including:

(a) senior MacKillop operational staff with line management responsibility to ensure congruent practice;

(b) senior Child Protection staff, who have access to information, decision making capacity and can assist to address system issues and blockage;

(c) the young person's direct carers, who can provide day-to-day information and insight into the view of the young person;

(d) the house supervisor or managers, who can provide a perspective on day-to-day issues, including what has been tried, what works well and what needs to change;

(e) case managers and therapeutic specialists, as well as external mental health and educational personnel; and

(f) in the case of Aboriginal children and young people, the General Manager, Aboriginal and Torres Strait Islander Service Development is invited to attend.

23 The panel review is one part of a thoughtful process of critical reflection. Supporting case workers, therapeutic specialists and carers to be able to formulate the current issues in the context of each young person's lived experience has been a rich and instructional process.

24 This review has provided invaluable insight not only into the needs of each individual, but into the out of home care system, and has guided our approach to providing targeted and

individualised support to young people in care. As a result of Outcomes 100, decision making has been reviewed and behaviour management responses have been reflected upon and either endorsed, at times respectfully challenged or sometimes directly altered.

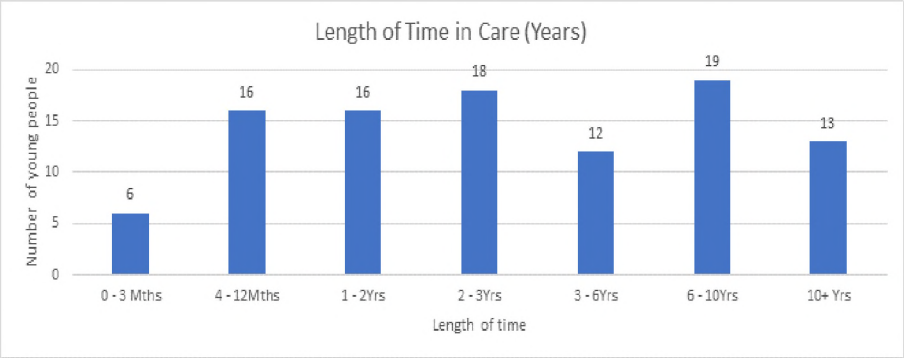
Outcomes 100 data results

25 A full report detailing the results of the Outcomes 100 data is expected to be published in late 2020. Notable key findings from the analysis of Outcomes 100 data include:

(a) The young people in our homes were primarily older adolescents: 65% were aged 15 years plus, 25% were aged 12 to 14 years and 9% were under 12 years old. Most of the young people under 12 years old were male – possibly reflecting both the difficulty in placing young boys in foster care along with the complex issues and needs of these young children which have led to their placement in residential care.

(b) Of the young people reviewed, 16% were Aboriginal or Torres Strait Islander.

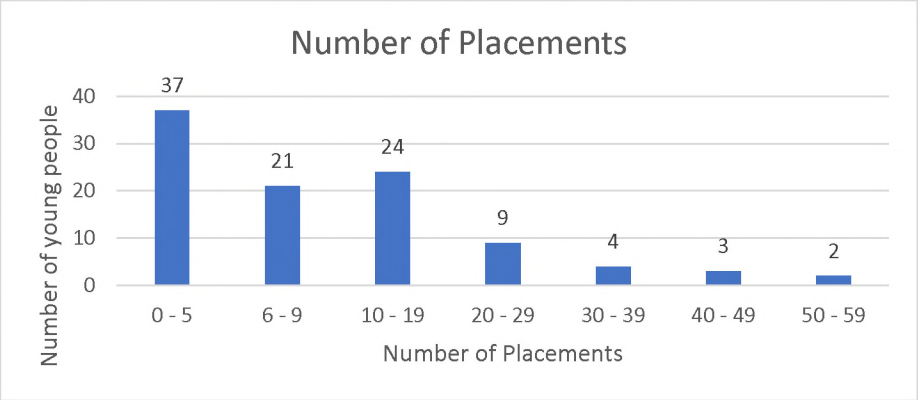
(c) Of the young people reviewed, 62% had been in care for over two years. Significantly, 32% had been in care for over six years and 13% had been in care for ten years or more. This sadly highlights the lack of permanency for many young people who have come to live in residential care.



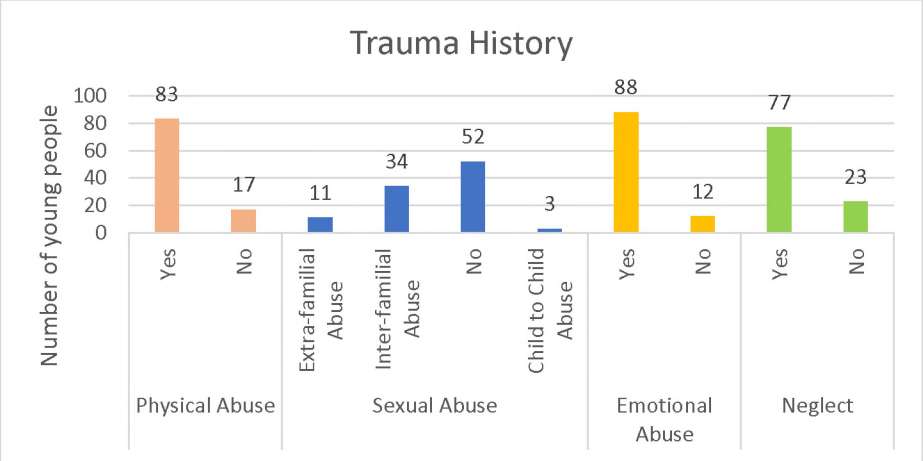
(d) Of the young people reviewed, 82% had resided in their current residential placement for under 12 months, including 55% having resided in their current placement for under six months. Only 18% had resided in their placement for over a year.

(e) Of the young people reviewed, 63% had experienced six or more placements, 42% had lived in ten or more placements and 18% had lived in over 20 different placements. One young person had experienced approximately 55 placements. In contrast, 37% of young people had experienced between one and five placements. 14% were new to out of home care, having had only one or two placements, with the current residential care placement being the first placement for 5% of the young people reviewed. This paints a picture of the

high level of placement instability in young people's lives. It also shows the high level of client turnover in homes and that young people are often residing with other young people who have also only been in the home for a short period. This has an impact on their stability and capacity to build relationships.

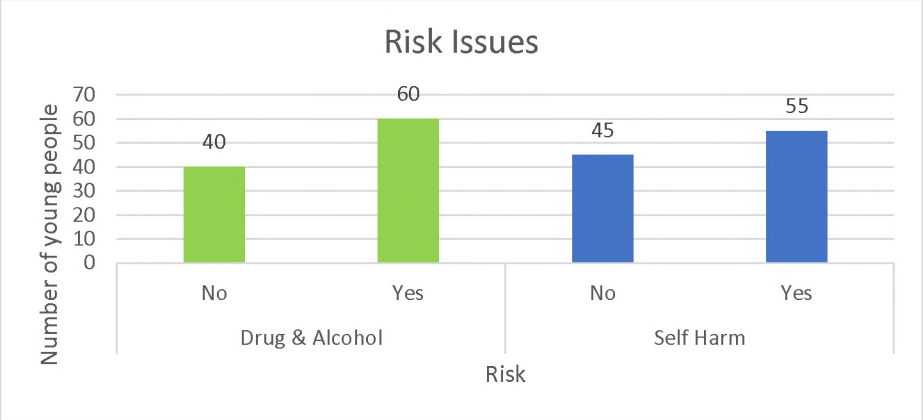


(f) Most of the young people reviewed had experienced multiple forms of abuse that led to their removal from their parents' care. Approximately 83% had experienced physical abuse, 88% had experienced emotional abuse, 77% had experienced neglect and 48% had experienced some form of sexual abuse.

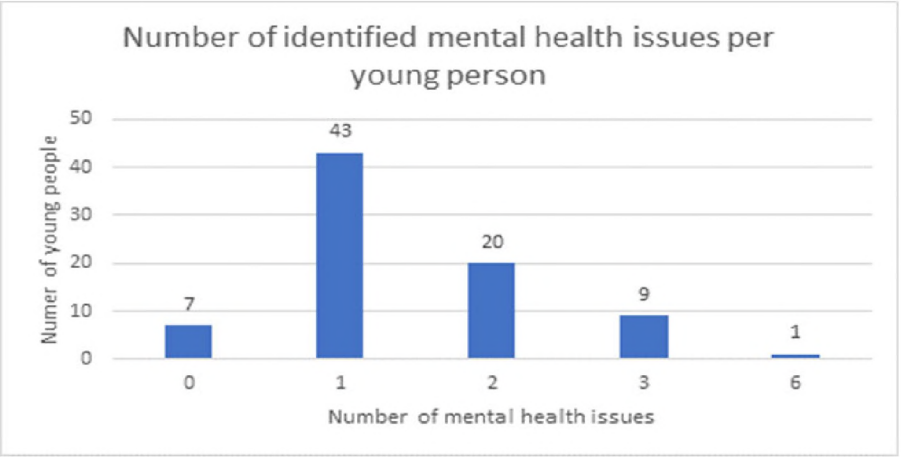


(g) The prevalence of family violence in the young person's childhood histories was very high, with at least 87% known to have experienced severe family violence in their childhood.

(h) Drug and alcohol use and self-harm are significant issues for young people in residential care and place these young people at very high risk. Of those reviewed, 60% experienced problems with drug and alcohol misuse and 55% were known to have self-harmed. Many of these young people had self-harmed and attempted suicide on multiple occasions and this remains an ongoing issue. The matching of children and young people to placements and to each other is a complex issue given that most young people in residential care experience or display these significant risks.

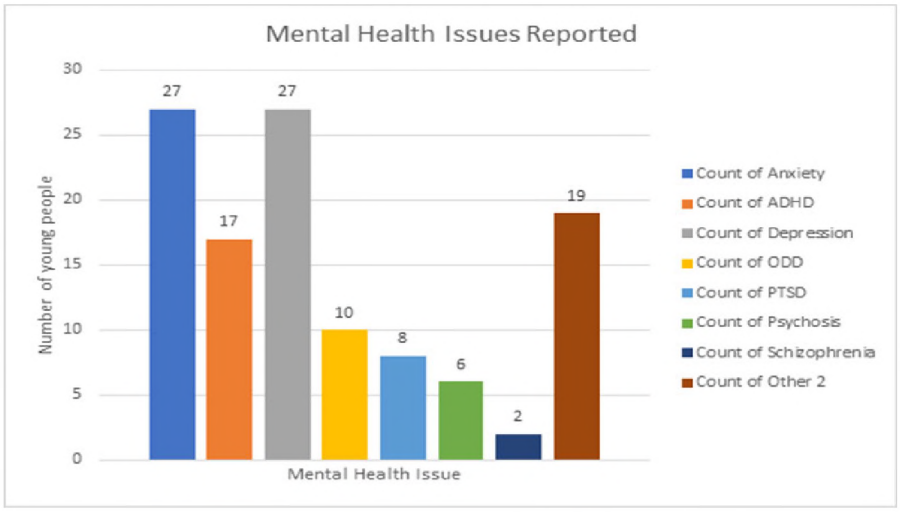


(i) Most of the young people reviewed suffer from poor mental health, with many having multiple identified mental health issues and diagnoses. There are also some young people who have obvious mental health issues that have not been formally diagnosed. A formal diagnosis can be difficult to obtain due to the child's age and also when a young person is not stable, does not access placements, is missing from placement, is affected by drugs or does not attend or engage in assessments or appointments. Of those reviewed, 80% were noted as having mental health concerns, with some having multiple mental health issues and diagnoses. 7% were noted as having mental health issues but were yet to be assessed.



(j) The below table outlines the range of mental health issues that the young people reviewed were reported as having been diagnosed with (these may not all be formal diagnoses). Prevalent mental health issues identified include Anxiety (27 people), Depression (27 people), Attention Deficit Hyperactivity Disorder (17 people), Oppositional Defiance Disorder (10 people), Post Traumatic Stress Disorder (8 people), Psychosis (6 people), Schizophrenia (2 people). The range of mental health issues categorised as 'Other' (reported by 19 people) include personality disorder, severe attachment disorder, Developmental Trauma Disorder, Conduct Disorder and attachment issues,

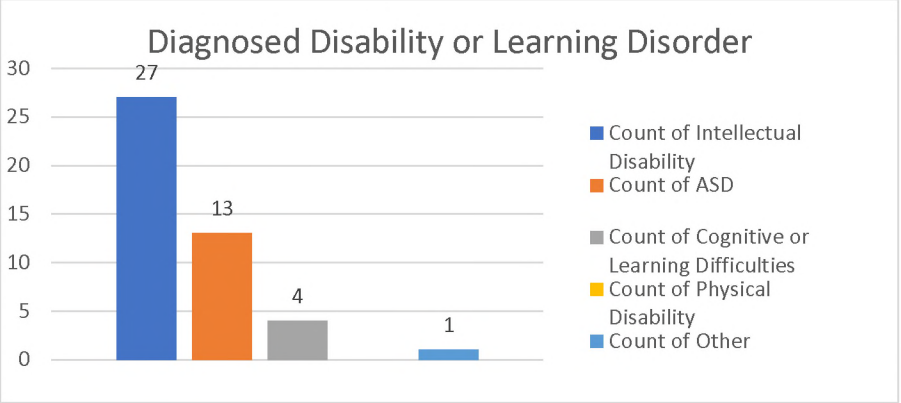
Mania, early onset bipolar or traits of bipolar disorder, reactive attachment disorder, adjustment disorder, panic attacks, hearing voices and grandiose sense of self.



(k) Of the young people reviewed, 39% were reported as having a disability or a learning disorder. This proportion is significantly higher when compared to the Australian Institute of Health and Welfare (**AIHW**) data regarding the disability status of children in out of home care, which indicated that overall 15% of children in out of home care at 30 June 2017 were reported as having a disability.[1] The report noted that "[a]s disability is a multidimensional and complex concept, differences may exist across jurisdictions in how disability is defined, including which health conditions are classified as a disability. There are also differences in how information about disability is captured in jurisdictional processes and client information systems.".[2]

(l) The below table outlines the most prevalent diagnosed disability or learning disorders among the young people reviewed in the Outcomes 100 panels. 27% of young people reviewed had a formally diagnosed Intellectual Disability and 13% had a diagnosis of Autism Spectrum Disorder which includes young people with Aspergers. The 4% listed as having 'cognitive or learning difficulties' includes young people noted to have a suspected intellectual disability that has not been formally diagnosed, a cognitive impairment and speech delay, learning and cognitive difficulties, or considered to be low functioning. The 'other' category includes a young person with Foetal Alcohol Spectrum Disorder (**FASD**). This figure is likely to be under-reported as FASD data was not specifically collected for this report.

[1] Australian Institute of Health and Welfare 2018. Child protection Australia 2016–17. Child welfare series no. 68. Cat. no. CWS 63. Canberra: AIHW, page 46.
[2] Australian Institute of Health and Welfare 2018. Child protection Australia 2016–17. Child welfare series no. 68. Cat. no. CWS 63. Canberra: AIHW, page 46.



Worries and wishes revealed by Outcomes 100 data

26 Young people's views were presented in the case review reports and were central to the panel discussion. The key worries and wishes of each young person were thematically analysed. In terms of what young people worried about, some prominent themes were:

(a) **Family**: Most young people worry about family and often it is noted that in particular they worry about their mother (where she is, her safety, mental health, drug use, financial situation); they were also concerned about their siblings, including their safety; family generally; contact with family and wanting to return home. In contrast, some young people were concerned about returning home, not wanting to return home or fear that it would not work.

(b) **The Future**: Young people worry a lot about their future; transition to independence; housing and where they will live; turning 18.

(c) **Safety**: Their safety and fear of the dark was noted for many young people; being bullied; fear of co-residents.

(d) **Other**: Pending court and charges; concerns for their baby/child; lack of Child Protection worker contact.

(e) **Health and wellbeing**: Health and weight; their mental health and anger issues; pregnancy.

(f) **Education**: Wanting to go to school; worried about school.

(g) **Being heard**: Not being listened to or involved in plans.

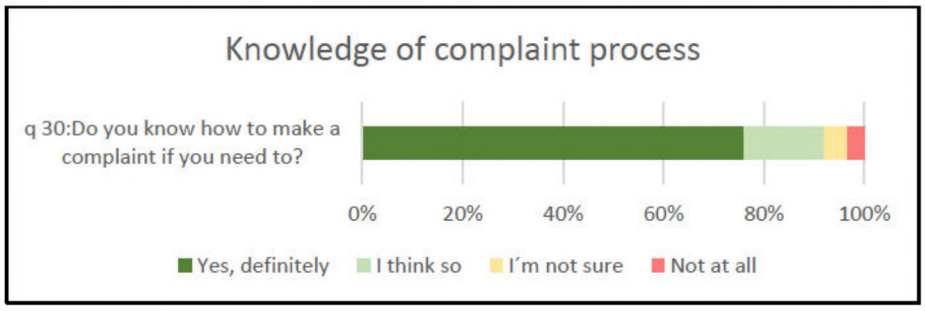
27 In terms of young people's wishes, overwhelmingly the most prominent theme was young people wanting to live with family and wanting connection and contact with family. The other main areas included wanting to have an education (either returning to school, undertaking vocational training or employment) and assistance in moving towards independence.

Views revealed by Outcomes 100 data

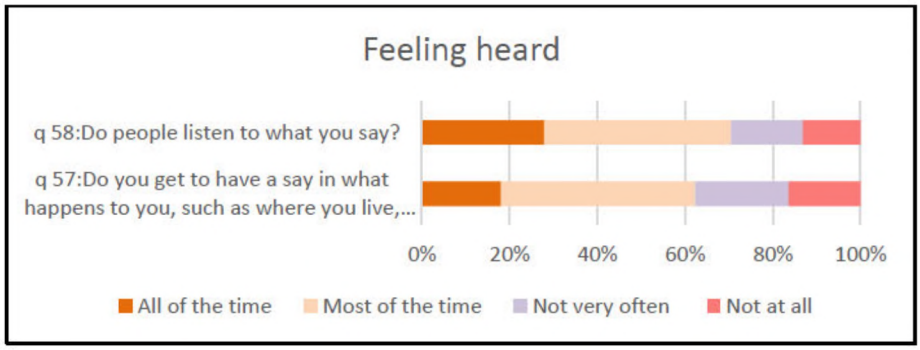
28 64% of young people reviewed in the Outcomes 100 panels completed a Viewpoint Survey. The Quality and Compliance Manager manages and monitors all Viewpoint Surveys and follows up any adverse responses or areas of concern with the areas and case managers.

29 Key findings from the Viewpoint Surveys included:

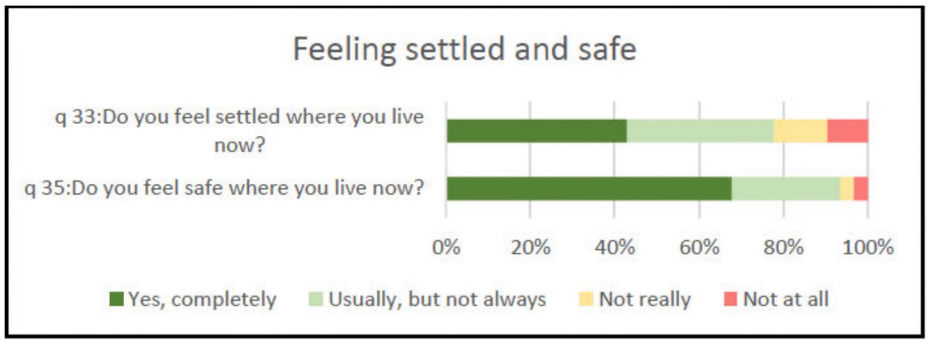
(a) The majority reported that they knew how to make a complaint, with around 75% reporting that they definitely knew how to do so. Young people also reported that they knew who they could approach to make a complaint.



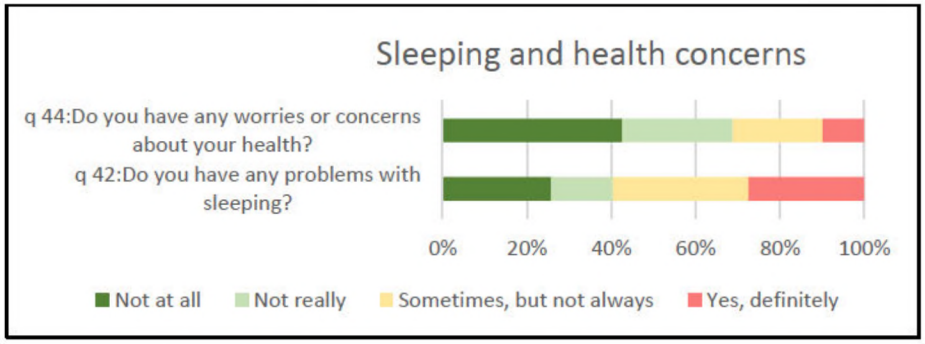
(b) Approximately 62% of the young people surveyed felt that they have a say about what happens to them all or most of the time, and approximately 70% felt that people listen to what they say all or most of the time.



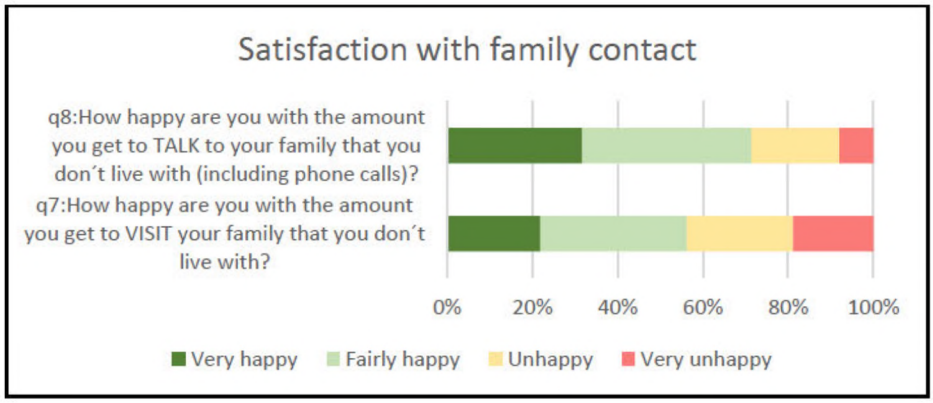
(c) The majority of young people surveyed reported feeling settled and safe. It is interesting to note that more young people felt *safer* where they lived rather than *settled*. The high number of placements experienced by young people is likely to contribute to this feeling.



(d) Over a third of the young people surveyed reported having worries or concerns about their health. Furthermore, the majority reported having problems with sleeping. Sleep patterns and how to support young people were also often discussed in the Outcomes 100 panels and it is noted that night time is often a time when young people feel most unsafe. This is consistent with having experienced extreme trauma.



(e) Approximately 44% reported not feeling happy with the amount of time they get to *visit* their family, however approximately 72% were happy with the amount of time they get to *talk* their family. This is line with the views of young people gathered in the Outcomes 100 panel discussion that noted many of our young peoples' strong desire to be more connected with and live with their families. MacKillop is very committed to positively engaging with families and being strengths based and family focused in our work.



Prevention and early intervention

30 There are well established long-term social benefits of preventing children from entering care. There is an increased risk of poor social, educational and health outcomes (including homelessness, mental illness, unemployment, substance misuse, early parenthood and low educational attainment) for young persons who have left care.[3] There is a strong overlap between the Youth Justice System and Child Protection, with up to 38% of children sentenced in the Children's Court known to Child Protection.[4] Children known to the Child Protection system or who have been in care are more likely to use social services and incur higher service costs. [5] These outcomes can transition into a young care leaver's adulthood and perpetutate inter-generational cycles of disadvage. This is particularly acute for the Aborginal and Torres Straight Islander families, where there is inter-generational trauma of child removal from colonisation.

31 Notably, the children of care leavers are more likely to be placed in out of home care compared to the general population. In New South Wales children of care leavers have been shown to be more than ten times more likely to be placed in out of home care and in Victoria about two in three children of care-leavers are known to children protection. [6]

32 It is therefore critical that the reform of the mental health system dedicates resources to the most vulnerable group where transgenerational patterns can be disrupted, and positive, resilient parenting can be supported. Infant mental health evidence-based therapeutic approaches combined with family therapy outreach to our most at risk families can prevent mental illness.

33 The implementation of additional early intervention programs needs to be purposeful and planned by both government and the child and family services sector for it to be set up for success. This includes coordinated planning of recruitment, training, and capacity building of the workforce, ramping up of service delivery, and putting in place robust monitoring and evaluation mechanisms. It also requires support for Aboriginal organisations and communities to shape how early intervention is approached and

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[3] See for example, evidence summarised by Campo, M., & Commerford, J. (2016). Supporting young people leaving out-of-home care (CFCA Paper No. 41), for the Australian Institute of Family Studies.
[4] Sentencing Advisory Council 2019, "Crossover Kids: Vulnerable Children in the Youth Justice System Report 1: Children Who Are Known to Child Protection among Sentenced and Diverted Children in the Victorian Children's Court".
[5] See for example: Deloitte Access Economics (2016), Raising our children: Guiding young Victorians in care into adulthood, commissioned by Anglicare Victoria; Forbes, C. and Inder, B (2006), Measuring the cost of leaving care in Victoria; Taylor, P., Moore, P., Pezzullo, L., Tucci, J., Goddard, C. and De Bortoli, L. (2008), The Cost of Child Abuse in Australia, Australian Childhood Foundation and Child Abuse Prevention Research Australia; KPMG (2016), An evidence-based continuum of care and support for child and family services, Final Report.
[6] Taylor Fry report for the NSW Office of Social Impact Investment 2019, "Analysis of future service usage for Out-of-Home-Care leavers". Victorian Department of Health and Human Services, unpublished data.

implemented for Aboriginal children and families, and investment towards building the evidence base for the application of cultural healing approaches to help families to stay safely together.

34 The COVID-19 pandemic strengthens the existing case for additional investment in early intervention to keep families together, building on the foundational reforms made by the Victorian Government in recent years. The needs of vulnerable families are even greater as a result of COVID-19, requiring additional supports from government to keep families together and children safe.

35 Early intervention programs such as MacKillop's Cradle to Kinder program and Multi-Systemic Therapy Psychiatry program are currently being delivered with promising outcomes by MacKillop. They have been effective in supporting vulnerable children and families at different key points in the system, including preventing children from entering out of home care and/or building the capacity of parents and families. Learnings from implementation are showing that while the Multi-Systemic Therapy Psychiatry program was developed and evaluated overseas, it has applicability to the Australian setting. In my view, smart government investment would invest in early intervention programs such as these.

MacKillop Family Services' Cradle to Kinder program

36 Cradle to Kinder is MacKillop's specialist early intervention intensive family support program for vulnerable young mothers, fathers and their children. The program aims to prevent children entering the out of home care system, and to provide families with the skills to raise healthy children in positive and loving environments.

Users of Cradle to Kinder

37 Cradle to Kinder is a voluntary program available to women aged 25 years and under who are pregnant or have recently (within six weeks) given birth, who have received a report from Child Protection or exhibit indicators of vulnerability (such as poverty, homelessness or domestic violence). Priority is given to those who are under 18 years of age, are Aboriginal, have an intellectual disability or who are or have been in out of home care.

38 All referrals to Cradle to Kinder are made through Child FIRST, Child Protection, antenatal staff (such as obstetricians and midwifes) and other family service programs.

39 The Cradle to Kinder program is currently offered by MacKillop in Melbourne's metropolitan inner east (through a partnership with Mercy Health O'Connell Family Centre), in Bendigo (through a partnership with Bendigo Community Health Service and Catholic Care Sandhurst) and in Wangaratta and Wodonga (through a partnership with

Gateway Health). These local partnerships have enabled greater access to universal health services and other community and parenting resources that have enriched our service delivery.

40 Since June 2017, MacKillop's Cradle to Kinder programs have worked with 149 children in 115 families. Across the areas of Loddon, Inner East Metropolitan Melbourne and Ovens Murray there are approximately three to four times more unborn reports annually received by Child Protection than what our program can support. The serious unmet demand has resulted in upwards of 80 referrals for which we have been unable to progress into the program.

Support provided by Cradle to Kinder

41 As part of the program, each family is allocated a Cradle to Kinder practitioner who visits the family home at least weekly from pregnancy until the child is four years of age. The practitioner provides integrated and coordinated support to facilitate positive family outcomes. This model is underpinned by a multi-disciplinary team, including maternal children health nurses and early childhood parenting workers, who are often call upon for their specialist skill sets.

42 The aim of the home visitation sessions is for the practitioner to successfully bring about lasting positive change in the area most pertinent to the family. The key areas of focus of the program include; strengthening parenting skills and confidence (for example feeding practices and developing routines), supporting healthy infant development (for example removing harms from the environment and safety in the home), encouraging healthy lifestyle behaviour change (for example drug and alcohol reduction and healthy nutrition), enhancing connection to culture, addressing wider psychosocial challenges (for example financial and housing instability and connection to community and culture), and promoting positive parent-child relationships and attachment (for example, Circle of Security and the Wait, Watch and Wonder technique).

43 Cradle to Kinder adopts a tailored approach to support, whereby each vulnerable family is provided with an individual plan of core interventions and the focus is on integrating an outreach, family support program with evidence-based family therapy and infant mental health interventions.

Independent evaluation by Monash University

44 The Cradle to Kinder program has been independently evaluated by Monash University over a duration of four years.[7]

[7] This report has not been published online.

45 The independent evaluation identified that of the families reviewed in the program:

(a) 100% were identified to have three or more complex issues. For example, the co-existence and interrelated complexity of alcohol and other drug use, mental health issues and family violence;

(b) more than 50% had Child Protection reports for other children, some of whom were in their care;

(c) almost half of the families had a member with a disability. In Loddon, over two thirds had a member with a disability;

(d) over 90% of families in the inner east metropolitan area and approximately 75% of families in the other areas had a parent with Child Protection or an out of home care experience; and

(e) the mean age of mother was 19.5 years old.

46 The independent evaluation examined the statistically significant positive outcomes for children and families in the program over two years. At the three year mark, of the 149 children in the Cradle to Kinder program, approximately 89% remained safely at home with their parents three years later, with the other 11% of children residing in out of home care.

47 This placement prevention statistic is outstanding, particularly given the program selected and prioritised infants who were most at risk of imminent placement into care, with parents historically unlikely to engage other services.

48 Victorian data which tracked all of the unborn reports to Child Protection in 2014 showed that 28% of them were in care within two years;[8] all of the 2016 South Australian unborn reports to South Australian Child Protection authorities were tracked by the University of South Australia and by two years later in 2018, the same figure – 28% of the children – were in care.[9]

49 75% of the children within the program were subject to Child Protection unborn reports (we have been told this would likely have been 100% had the family not voluntarily engaged in the Cradle to Kinder program), and as a result of the program's limited capacity and high demand, the referrals received were the most high-risk unborn cases.

[8] Department of Health and Human Services, unpublished data 2020.

[9] Identifying early intervention and prevention pathways for child protection concerns raised in pregnancy: Preliminary Findings from Child Protection Departmental Case File Reviews, South Australian Early Intervention Research Directorate (EIRD) Case File Review Research Policy Brief #1, University of South Australia, Australia Centre for Child Protection (2014).

Experienced Child Protection practitioners have commented that the likelihood of entering the out of home care was 90% for those children that were selected.

Economic impact of Cradle to Kinder

50 In addition to significantly improving the safety and wellbeing of children, and stopping the transgenerational pattern of child abuse, trauma and removal, the Cradle to Kinder service avoids significant 'downstream' costs and has saved the government money.

MacKillop calculates the cost of a child entering out of home care over four years as an estimated $202,400 (or $50.6K per annum).[10] This cost assumes a 20/80% split between foster care (which costs $70,000 per annum) and kinship care (which costs $44,000 per annum).[11]

51 The 20/80% foster care to kinship care split reflects the small number of actual placements into out of home care that have occurred in families that have been referred to MacKillop's Cradle to Kinder program, which is 17 out of 149 children (11.4%).

52 Based on the conservative assumption that, in the absence of the Cradle to Kinder program, a minimum of 50% of the 149 children would otherwise have been placed in care (74.5 children), this would have cost government $15 million over four years and resulted in 75 more children in out of home care. In comparison, the cost to government of the three MacKillop Cradle to Kinder programs has been $1.72 million per year, which to date equates to $5.2 million over the three years.

53 Funding is only guaranteed for Cradle to Kinder until the end of September 2020, as unlike Child First and Integrated Family Services, the funding is not recurrent. The outcomes data and independently evaluated outcomes need to inform government decision making.

Impact and the urgent need for early intervention

54 The Cradle to Kinder findings are consistent with the plethora of peer-reviewed literature, which show that the delivery of intensive family support and parenting interventions can greatly improve both parenting outcomes and infant development.[12]

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[10] MacKillop has calculated this cost using the Social Ventures Australia modelling and methodology as a base. The economic case for early intervention in the child protection and out-of-home care system in Victoria, Social Ventures Australia (2019).

[11] The economic case for early intervention in the child protection and out-of-home care system in Victoria, Social Ventures Australia (2019), page 42.

[12] Coates, D., & Howe, D. (2016). An evaluation of a service to keep children safe in families with mental health and/or substance abuse issues. Australasian Psychiatry, 24(5), 483-488; De la Rosa, I. A., Perry, J., Dalton, L. E., & Johnson, V. (2005). Strengthening families with first-born children: Exploratory story of the outcomes of a home visiting intervention. Research on Social Work Practice, 15(5), 323-338;

55 Effectiveness of parenting programs is defined by experts from the Parenting Research Centre as demonstrating maintenance of positive parenting effects at 12 months post program.[13] It is therefore remarkable that the Cradle to Kinder data has found significant and positive findings in terms of parental and infant outcomes after 18 months (Monash University evaluation) and 36 months (MacKillop data).

56 It is known that investment in primary prevention and early intervention to strengthen families can provide long-term social and economic benefits by disrupting trajectories that lead to adverse adult outcomes and that, in particular, effective parenting programs are cost effective. It is also known that the implementation of home-visiting programs, without the provision of practical parenting-type intervention, have been found to result in non-significant effects across both parental outcomes and infant development. For example, Rayce, Rasmussen, Klest, Patras, and Pontoppidan (2017) performed a systematic review and meta-analysis on 16 parenting interventions delivered using home-visitation strategies.[14] Their findings revealed that there was no significant improvement in the infant's cognitive development or parental internalising behaviour at follow up, after the home visiting intervention was implemented.

57 In light of the Cradle to Kinder findings, coupled with the peer-reviewed literature, there is a clear and established link between delivering intensive parenting interventions and significantly improving both parental and infant outcomes, among the most marginalised and disadvantaged in our community. There is no evidence of any other early intervention program that has produced such rigorous and effective outcomes during the most formative years of a mother-child dyad development, and reversing the intergenerational trajectory of infants born into vulnerability and disadvantage.

58 Cradle to Kinder offers a preventative, intensive and effective family support intervention that is well received by the parents, families, the Cradle to Kinder staff and communities involved; it builds the protective community around the child that would otherwise be missing. Unlike other parenting and infant mental health programs that deal with the less at risk cases where there is not family violence or parental drug use, and that screen out the most vulnerable women, MacKillop's Cradle to Kinder program's cohort includes the

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Fernandez, E. (2007). Supporting children and responding to their families: Capturing the evidence on family support. Children and Youth Services Review, 29(10), 1368-1394; Iván, A., Perry, J., & Johnson, V. (2009). Benefits of increased home-visitation services: exploring a case management model. Family & Community Health, 32(1), 58-75.

[13] Macvean et al. (2013). An analysis of the evidence for parenting interventions for parents of vulnerable children. Parenting Research Centre.

Iván, A., Perry, J., & Johnson, V. (2009). Benefits of increased home-visitation services: exploring a case management model. Family & Community Health, 32(1), 58-75.

[14] Rayce, S. B., Rasmussen, I. S., Klest, S. K., Patras, J., & Pontoppidan, M. (2017). Effects of parenting interventions for at-risk parents with infants: a systematic review and meta-analyses. BMJ open, 7(12), e015707.

most difficult and complex cases and as such breaks the intergenerational cycle of disadvantage.

Family Focus Multi-Systemic Therapy Psychiatry

59 Multi-systemic Therapy (**MST**) is an evidence-based family and community-based treatment for young people with complex clinical, social, and educational problems (such as violence, drug abuse and school expulsion). MST Psychiatry (**MST-Psych**) is an adaption of MST created to serve families with young people at risk of out of home placement due to serious behavioural problems and co-occurring mental health problems such as thought disorder, bipolar affective disorder, depression, anxiety, impulsivity and substance use or abuse.

Service provided by Family Focus MST-Psych

60 MacKillop in partnership with the Victorian Aboriginal Child Care Agency is the lead agency delivering MST-Psych in Victoria through its 'Family Focus MST-Psych' service, which has been in operation in Western Metropolitan Melbourne and Geelong since May 2018.

61 Family Focus MST-Psych involves a treatment team of therapists, crisis case managers, psychiatrists and on call support workers, working within the young person's home, school and community, and hand in hand with the family to provide intensive treatment as well as 24/7 face-to-face crisis response. In addition, the program actively treats the parent's mental health and substance abuse problems (if any), which frequently underpin the young person's behaviours.

62 The program aims to improve behavioural problems (including anti-social and violent behaviour), mental-health symptoms, suicidal behaviours and family relations, while increasing the amount of time youth spend going to school and living in home-based placement. It also emphasises preventing psychiatric hospitalisation or re-hospitalisation and entry or re-entry into out of home care services.

63 On average the length of each treatment is between four and seven months, with the treatment team providing between 25 and 30 hours per week of face to face contact with the young person and their family.

64 There has been a significant investment by MacKillop in training and supervision to enable the treatment team to provide the 24/7 flexible, therapeutic response which has required a minimum of three outreach visits per family, per week, often out of traditional working hours.

65 MST-Psych therapists receive standard MST training and ongoing quality assurance support as well as supplemental training designed to address:

(a) safety risks associated with suicidal, homicidal and psychotic behaviours in youth;

(b) the integration of evidence-based psychiatric interventions for youth and caregivers;

(c) treatment of adolescent and caregiver substance use or abuse utilising an evidence-based treatment, and contingency management; and

(d) evidence-based assessment and treatment of youth and caregiver mental illness including anxiety disorders, depression, bipolar affective disorder, thought disorders, attention deficit hyperactivity disorder, impulse control difficulties and symptoms of borderline personality disorder.

Service users of Family Focus MST-Psych

66 The Family Focus MST-Psych program works intensively with 16 families at any one time. Over the past two years, the program has worked with a total of 49 young people and their families. This is not including the siblings of these young people, who are often at risk and overlooked by traditional programs. If they were included in the count, the number would be much higher.

67 The majority of the young people the program has worked with were on the cusp of entering out of home care, with 12 having already been in care, hospital or incarcerated at the time of referral. Of the 49 young people, 19 identified as Aboriginal/Torres Strait Islander.

68 Family Focus MST-Psych receives its referrals from Principal Practitioners within the Department of Health and Human Services, with each of the families using Family Focus MST-Psych having previously failed to engage with multiple services or having not experienced successful outcomes using other services.

Outcomes of Family Focus MST-Psych

69 Evaluations have determined that the ecological approach of the MST-Psych model reduces self-harm, problem behaviour and criminal justice interactions.[15]

[15] Rowland, M.D., Halliday-Boykins, C.A., Henggeler, S.W., Cunningham, P.B., Lee, T.G., Kruesi, M.J.P., & Shapiro, S.B. (2005). A randomized trial of multisystemic therapy with Hawaii's Felix Class youths. Journal of Emotional and Behavioral Disorders, 13 (1).13-23; Henggeler, S.W., Rowland, M.D., Randall, J., Ward, D.M., Pickrel, S.G., Cunningham, P.B., Miller, S.L., Edwards, Zealburg J.J., Hand, L.D., & Santos, A.B. (1999). Home based Multisystemic Therapy as an Alternative to the Hospitalization of Youths in

70 Over the past two years that the program has operated in the Western suburbs of Melbourne and Geelong, the program has achieved the following outcomes:

At closure:	**At 6 months post closure:**
80% were at home	72% were at home
64% were engaged in school or work	61% were engaged in school or work
90% had not been arrested	78% had not been arrested

71 In New South Wales, the Department of Communities and Justice has recently announced the continuation of funding of the MST programs due to the successful outcomes achieved.

Seasons for Growth and Stormbirds

72 Good Grief joined MacKillop in 2017 and provides tailored and age appropriate evidence-based loss and grief education programs designed to support the mental health and wellbeing of children, young people and adults following major loss experiences.

73 The programs invite children, young persons and adults to learn and practice ways of thinking and responding to change in their families, with an emphasis on understanding the effects of change, loss, and grief, whilst developing skills in communication, decision-making, and problem-solving. The programs strengthen the resilience and preparedness of children, young people and adults to manage and overcome trauma in the likely event of tough times ahead in their communities.

74 Good Grief's key programs include Seasons for Growth and Stormbirds, and Good Grief provides training to support appropriately skilled professionals to facilitate each of these programs.

<u>Seasons for Growth</u>

75 Seasons for Growth is an early intervention, evidence-based loss and grief education program that builds the capacity of children, young people and adults to understand the links between the change or loss event and their reactions, as well as developing support networks for them.

Psychiatric Crisis: Clinical Outcomes. Journal of the American Academy of Child & Adolescent Psychiatry 38,1331-1339; Schoenwald, S.K., Ward, D.M., Henggeler, S.W., & Rowland, M.D. (2000). MST vs. hospitalization for crisis stabilization of youth: Placement outcomes 4 months post-referral. Mental Health Services Research, 2, (1), 3-12; Huey, S.J., Jr., Henggeler, S.W., Rowland, M.D., Halliday-Boykins, C.A., Cunningham, P.C., Pickrel, S.G., & Edwards, J. (2004). Multisystemic therapy effects on attempted suicide by youth presenting psychiatric emergencies. Journal of the American Academy of Child & Adolescent Psychiatry, 43, 183-190.

76 Seasons for Growth has supported local communities to support more than 300,000 children in seven countries. The program helps children and young people experiencing change, loss and grief; builds participants' understanding and skills and enables them to express their views, thoughts and feelings; strengthens participants' social and support networks and improves participants' emotional wellbeing. The most recent evaluation of Seasons for Growth showed that the average ratings of children and young people's wellbeing increased over time. The program has been adapted to support young people who have experienced suicide, forced migration or terrorist activity, and is currently being adapted to support children and young people living in care. This allows for trained facilitators to respond to additional and likely ongoing local community needs following the immediate response that comes with disasters.

77 Seasons for Growth is endorsed through BeYOU (a national initiative for educators, aimed at promoting and protecting positive mental health in young people) and referenced in the Evidence-Based Programme Guidebook by the Child Family Community Australia at the Australian Institute of Family Studies. The program has received a 'high impact' rating in Australian Research Council's Engagement and Impact Assessment 2018–19 National Report. Further, Seasons for Growth was selected as part of the NSW Parliament Showcase on 19 September 2019 by the Deputy Vice Chancellor Department at Southern Cross University. Attached to this statement and marked 'Attachment RM-2' is a copy of a report summary setting out the impact of Seasons for Growth.

Stormbirds

78 Stormbirds is an immediate response program (developed from Seasons for Growth) for children and young people who have experienced a natural disaster. It provides an opportunity to share experiences of change and loss in safe and creative ways, understand and attend to feelings and learn skills for adapting and recovering. Since it was developed in 2009, Stormbirds has successfully supported many communities following natural disasters and has been adopted by schools, including in response to the bushfires in Victoria, South Australia, New South Wales and Western Australia, the floods and cyclones in Queensland and the drought in New South Wales. It was also used extensively in Christchurch, New Zealand following the earthquakes, with in excess of 1,000 children participating in the program.

Power to Kids: Respecting Sexual Safety

79 Children and young people living in out of home care are at significant risk of experiencing harmful sexual behaviour, sexual exploitation and dating violence.[16] MacKillop is

[16] McKibbin, G., Bornemisza, A., Humphreys, C. (2020) *Power to Kids: Respecting Sexual Safety Evaluation report,* Melbourne, VIC, [not yet published].

committed to addressing these issues through its Power to Kids: Respecting Sexual Safety program, delivered in partnership with the University of Melbourne.

80 Following my work at the Royal Commission into Institutional Responses to Child Sexual Abuse, and cognisant that there was no evidence-based program of prevention of sexual exploitation for children in care, I initiated a partnership with the University of Melbourne to develop Power to Kids: Respecting Sexual Safety. This action research project began in 2017.

81 The Power to Kids program aims to increase young people's understanding about healthy and respectful relationships and sexual safety and strengthen their capacity to keep themselves safe. It was designed in consultation with an expert advisory group of key researches, policy makers and practitioners working in the field of sexual abuse and was informed by the research of Dr Gemma McKibbin, which involved asking young people what they think could have been different in their lives so that they did not develop sexually harmful behaviour.[17]

82 The Power to Kids program consists of three prevention strategies:

(a) Whole-of-house respectful relations and sexuality education. This involves training and coaching workers and carers in recognising an responding to harmful sexual behaviour, sexual exploitation and dating violence, as well as educating children and young people about respectful relationships and sexual health and safety.

(b) Missing from home strategy. This involves establishing practice partnerships between each child or young person and their carers to counter grooming, assertively engaging the children and young people in safety planning, staying in touch (through social media) especially when missing from home, and working consistently with the Enhanced Response Model and Sexual Exploitation Protocol.

(c) Sexual safety response. This involves early identification, safety planning, advocacy and therapeutic treatment for harmful sexual behaviour and dating violence, proactively supporting exit strategies for sexual exploiting, strengthening relationships with family of origin and joining-up of MacKillop workers with local sexual abuse professionals and police.

[17] Gemma McKibbin (2017) 'Preventing Harmful Sexual Behaviour and Child Sexual Exploitation for children & young people living in residential care: A scoping review in the Australian context', *Children and Youth Services Review*, 82 (2017) 373–382; Gemma McKibbin, Nick Halfpenny & Cathy Humphreys (2019) 'Respecting Sexual Safety: A Program to Prevent Sexual Exploitation and Harmful Sexual Behaviour in Out-of-Home Care', *Australian Social Work*.

83 Evaluation of the Power to Kids program has suggested that the program has been successful in decreasing risk levels associated with harmful sexual behaviour, sexual exploitation and dating violence.[18] Part of this reduction relates to the improved ability of carers to identify the sexual abuse and swiftly and appropriately respond. The evaluation also revealed some evidence that young people were missing less as a result of the program and that there was improvement of relationships between carers and young people as a result of the brave conversations had about sexual health and safety.[19]

84 The program is currently implemented in four of MacKillop's residential houses, although it will soon be implemented in a further 20 MacKillop foster care homes.

Consequences of trauma from childhood abuse and/or family violence for an individual's mental health

85 Children will demonstrate their distress in different ways depending on their age, developmental stage and the quality of care available. There may also be gender differences, with boys more likely to show externalising behaviours like aggression, and girls more likely to have internalising symptoms such as depression or anxiety, however this is variable. The Child Development and Trauma Specialist Practice Resource summarises the symptoms of trauma in children and gives advice for parents and professionals.[20]

86 The development of a child's brain is highly influenced by the child's environment. Secure attachment contributes to the development of neural pathways that build the child's capacity to soothe, regulate emotions and contribute to healthy growth and development. Overwhelming stress, such as the trauma of violence, leads to neural pathways being established in the brain that are highly responsive to threat. Because children's physical, social, emotional and cognitive development is a cascading process that interacts with each domain in a complex and dynamic way (Tronick 2007), family violence interferes with the basic building blocks of development.[21]

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[18] McKibbin, G., Bornemisza, A., Humphreys, C. (2020) *Power to Kids: Respecting Sexual Safety Evaluation report,* Melbourne, VIC, [not yet published].
[19] McKibbin, G., Bornemisza, A., Humphreys, C. (2020) *Power to Kids: Respecting Sexual Safety Evaluation report,* Melbourne, VIC, [not yet published].
[20] Child development and trauma specialist practice resource, 2010. Published by the Victorian Government, Department of Human Services, 2007, <https://www.cpmanual.vic.gov.au/our-approach/best-interests-case-practice-model/child-development-and-trauma>.
[21] Tronick E 2007, The neurobehavioural and social-emotional development of infants and children, WW Norton, New York.

87 Learning is not just a cognitive process. It relies on and builds on the child's developing ability to form secure relationships, regulate their emotions, and explore their world.[22] Children need stable, sensitive, loving, stimulating relationships and environments in order to reach their potential. They are particularly vulnerable to experiencing violence, abuse and neglectful circumstances and do not 'witness' violence in a detached way. Abuse and neglect at the hands of those who are meant to care is particularly distressing and harmful for infants, children and adolescents.

88 Given that an infant's primary drive is towards attachment, not safety, they will accommodate to the parenting style they experience. They have no choice given their age and vulnerability, and in more chronic and extreme circumstances, they will show a complex trauma response. Infants, children and adults will adapt to frightening and overwhelming circumstances by the body's survival response, where the autonomic nervous system will become activated and switch on to the freeze, fight or flight response. Immediately the body is flooded with a biochemical response which includes adrenalin and cortisol, and the child feels agitated and hyper-vigilant. Infants may show a 'frozen watchfulness' and children and young people can dissociate and appear to be 'zoned out'.

89 Prolonged exposure to these circumstances can lead to 'toxic stress' for a child, which changes the child's brain development, sensitises the child to further stress, leads to heightened activity levels or withdrawal and affects future learning and concentration. Most importantly, it impairs the child's ability to trust and relate to others. When children are traumatised, they find it very hard to regulate their behaviour and soothe or calm themselves. They often attract the description of being 'hyperactive'.

90 Infants and toddlers who have witnessed or experienced prolonged family violence are likely to develop disorganised attachments to their mothers.[23] This means an infant will find it difficult to obtain comfort when needed and that they are frequently frightened by the presence of their mother as well as by the presence of the perpetrator of the violence. These babies and their parents require skilled and empathic therapists. Indicators of disorganised attachment could include the infant avoiding eye contact, an inability to be soothed or displaying unusually high anxiety when separated from caregivers.

91 Babies are particularly attuned to their primary carer and will sense their fear and traumatic stress; this is particularly the case where family violence is present. They will become unsettled and therefore more demanding of an already overwhelmed parent. The

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[22] Centre for Early Childhood Mental Health Consultation 2012, Tutorial 6: Recognizing and supporting the social and emotional health of young children birth to age five, viewed 15 June 2014, <http://www.ecmhc.org/tutorials/social-emotional/mod1_0.html> [accessed 30 July 2020].

[23] Zeanah CH, Danis B, Hirshberg L, Benoit D, Miller D, Heller SS 1999, 'Disorganized attachment associated with partner violence: a research note', Infant Mental Health Journal, vol. 20, no. 1, pp. 77–86.

first task of any service is to support the non-offending parent and to engage the family in safety.

92 Traumatic memories are stored differently in the brain compared to everyday memories. They are encoded in vivid images and sensations and lack a verbal narrative and context. As they are unprocessed and more primitive, they are likely to flood the child or adult when triggers like smells, sights, sounds or internal or external reminders present at a later stage. These flashbacks can be 'affective', meaning intense feelings that are often unspeakable; or 'cognitive', that is vivid memories or parts of memories which seem to be actually occurring. Alcohol and drug abuse are the classic and usually most destructive attempts to numb out the pain and avoid these distressing and intrusive experiences.

93 Children are particularly vulnerable to flashbacks at quiet times or at bedtimes and will often avoid both, by acting out at school and bedtimes. They can experience severe sleep disruption, intrusive nightmares which add to their 'dysregulated' behaviour and limit their capacity at school the next day. Children may eventually make meaning of their circumstances by believing that the abuse is their fault and that they are inherently bad.

94 In addition to the behaviours outlined above, adolescents may demonstrate behavioural changes and interpersonal difficulties such as running away from home, risk taking, problematic sexual behaviour and sexual exploitation, suicidal and self-harming behaviours and mental health problems, and may attempt to manage overwhelming feelings with substance use, 'numbing out' and other avoidant behaviours. Adolescents will often stay up all night to avoid the nightmares, and sleep in the safety of the daylight.

95 Children who have experienced violence have been shown to have significantly poorer outcomes on 21 child psychosocial, developmental and behavioural dimensions, compared with those who do not witness abuse. Behavioural problems include acting out, violence and aggression towards others. Outcomes for child witnesses were similar to those where children were also directly physically abused.[24]

96 The range of negative effects of living with violence are not always well recognised, including the association between family violence and:

(a) young people involved in the youth justice system;[25]

[24] Kitzmann KM, Gaylord NK, Holt AR, Kenny ED 2003, 'Child witnesses to domestic violence: a meta-analytic review', Journal of Consulting and Clinical Psychology, vol. 71, no. 2, pp. 339–352.

[25] Greenwald R 2002, 'The role of trauma in conduct disorder', Journal of Aggression, Maltreatment, and Trauma, no. 6, pp. 5–23.

(b) those who exhibit sexual behaviour problems;[26] and

(c) an increase in the risk of psychosis in child victims of sexual abuse who have also been exposed to family violence.[27]

Coping, recovery and resilience in children who have experienced family violence

97 Despite the negative effects, children demonstrate remarkable resilience after family violence, and professionals must be careful not to pathologise them.[28]

98 Research supporting the evidence of children's recovery and resilience includes the following:

(a) Kitzmann et al. (2003) noted that while a significant proportion of children who witnessed family violence fared worse, one-third of these children fared as well as or better than children who had not witnessed violence.[29]

(b) Martinez-Torteya et al.'s (2009) study found that more than 50 per cent of children aged two to four years showed positive adaptation and resilience despite witnessing violence against their mothers.[30]

(c) Edleson (1999) reported that several studies found that as more time passes since the experience of domestic violence, children demonstrate fewer problems. He also discusses the reframing of perceived behaviour and psychosocial problems as coping strategies in a traumatic and complex environment. For example, it is very adaptive to be on alert and hypervigilant in a chaotic and violent environment.[31]

(d) Edelson et al. (2004) reported that children's recovery improves the longer the period they are free from violence.[32]

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[26] Duane Y and Morrison T 2004, Families of young people who sexually abuse: Characteristics, contexts and considerations. In: G. O'Reilly, W. L. Marshall, A. Carr and R. Beckett (Eds), The handbook of clinical intervention with young people who sexually abuse (pp. 103–127), Brunner-Routledge, Hove.

[27] Cutajar MC, Mullen PE, Ogloff JR, Thomas SD, Wells DL, Spataro J 2010, 'Psychopathology in a large cohort of sexually abused children followed up to 43 years', Child Abuse and Neglect, vol. 34, no. 11, pp. 813–822.

[28] Humphreys C, Houghton C and Ellis J 2008, Literature review: better outcomes for children and young people experiencing domestic abuse, Scottish Executive Domestic Abuse Delivery Group, Scottish Government, Edinburgh.

[29] Kitzmann KM, Gaylord NK, Holt AR, Kenny ED 2003, 'Child witnesses to domestic violence: a meta-analytic review', Journal of Consulting and Clinical Psychology, vol. 71, no. 2, pp. 339–352.

[30] Martinez-Torteya C, Bogat GA, von Eye A, Levendosky AA 2009, 'Resilience among children exposed to domestic violence: the role of protective and vulnerability factors', Child Development, vol. 80, no. 2, pp. 562–577.

[31] Edleson JL 1998, 'Responsible mothers and invisible men: child protection in the case of adult domestic violence', Journal of Interpersonal Violence, no. 13, pp. 294–298.

[32] Edleson JL 2004, Should childhood exposure to domestic violence be defined as child maltreatment under the law? In: P. Jaffe, P.L Baker and A. Cunningham (Eds), Protecting children from domestic violence: strategies for community intervention, (pp. 1–17) Guilford Press, New York.

Cumulative harm in children who have experienced family violence

99 Cumulative harm refers to the effects of patterns of circumstances and events in a child's life, which diminish a child's sense of safety, stability and wellbeing. The continuing daily impact on a child can be profound and exponential, covering multiple dimensions of a child's life. Cumulative harm is experienced by a child as a result of a series or pattern of harmful events and experiences that may be historical or ongoing, with the strong possibility of the risk-factors (such as family violence and neglect) being multiple, inter-related and co-existing over critical developmental periods. Family violence is a common factor in the lives of children who experience cumulative harm. Violence in this context includes not just physical violence but also emotional violence - humiliation, coercion, degradation and the threat of abandonment or physical assault.

100 Family violence is frequently accompanied by other problems that are detrimental to children's safety and development. These may include parental substance abuse or mental health problems, neglect, disrupted living arrangements and direct abuse.

101 The term 'complex trauma' is also used to describe the complicated set of responses often observed in people subject to prolonged, multiple and/or chronic traumatic events such as persistent family violence at key developmental stages.

How sectors working with trauma can collaborate, exchange lessons and good practices

102 MacKillop's commitment to child focused/family centred practice is critical. Children have a hunger for family connection. There is a great gap in the mental health system where clinicians do not have training to think systemically or to think family. If you can engage family members to be believing and bear witness to the suffering of the child, the child will get better faster. It is so simple, but it is complicated to do and frequently in mental health and in residential care, clinicians are much more focused on the placement and the child as an individual, rather than recognising that physical separation from family does not equate with emotional separation for the child or young person.

103 MacKillop has adopted a big training focus on family centred practice even though the children are not living with their families as they are in foster care or in out of home care. For Aboriginal children it is also important to promote cultural identity and cultural connection back to country. We have implemented training around therapeutic life story work to help the child make sense of the disruption, trauma and separation from family and reconnect with safe family members.

104 MacKillop does a lot of work with children's families and our work has unsurprisingly increased reunification rates, because we are working not just with the child but with the child's relationship with their family and supporting the family.

Supports that can be provided to workers to assist with wellbeing and retention[33]

105 As our work at MacKillop involves regularly working with trauma, it requires our staff to repeatedly listen to and empathically respond to painful and disturbing stories. This can place staff at risk of being traumatised themselves; this is often referred to as 'vicarious trauma'[34] or 'secondary trauma', a closely related phenomenon.[35] Recognition is needed that the achievement of a 'truly trauma-informed' service system requires no less than a "process of reconstitution within our organisations top to bottom"[36] and involves all stakeholders in an organisation, from coalface staff to the upper echelons of management.

106 When working in mental health or with families where there is violence, assault, abuse or neglect, the evidence is that it impacts the practitioners. Indeed, it can permeate the organisation so that the organisation's staff at times can very easily start to parallel some of the unhelpful and negative behaviours that we are trying to support to change within families. When working with children with significant levels of distress and mental illness, like that identified by Outcomes 100, staff need to be trained and supervised in a way that manages the impact of the work on them.

107 To have a trauma informed or a trauma responsive organisation you need a shared language and to put in place rituals or patterns of organisational behaviour that mitigate the impact of vicarious trauma.

The Sanctuary Model

108 As part of its trauma-informed and relationship based practice, MacKillop began implementing the Sanctuary Model in 2012. The Sanctuary Model, which attends to the group dynamics of out of home care and other service contexts, uses trauma-informed, organisational change strategies to support better practice.[37] It is designed to help the organisation and its staff safely manage the impact of the trauma they are working with by better understanding trauma and its impact. It is an organisational change model which pays attention to implementation and the need to have a shared language and tools

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[33] In order to respond to this section, I have drawn on my previous work on a draft chapter entitled 'Whole-of-culture Support – Introducing the Sanctuary Model for vicarious trauma' which I prepared for a Catholic Social Services Australia publication.

[34] Pearlman, L. A., & Saakvitne, K. W. (1995). Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors. New York, NY, US: W W Norton & Co.

[35] Dunkley, J., & Whelan, T. (2006). Vicarious traumatisation: Current status and future directions. British Journal of Guidance and Counselling, 34(1), 107-116.

[36] Bloom, S (2006). Human Service Systems and Organisational Stress – Thinking & Feeling our way out of existing organisational dilemmas. CommunityWorks. <www.sanctuaryweb.com>

[37] Bloom, S.L. (1994) The sanctuary model: Developing generic inpatient programs for the treatment of psychological trauma. In M.B. Williams and J.F. Somme (Eds.), Handbook of posttraumatic therapy: A practical guide to intervention, treatment, and research (pp. 474–491). Westport, CT: Greenwood Publishing.

across the whole organisation – top down, bottom up, for front-line staff and for all back of house and support staff.

109 As a Sanctuary Model organisation, MacKillop intentionally works to create a space where the people we work with feel safe, heard and empowered to respond to the challenging trauma that faces our workers every day and night, and to experience growth, rather than harm.

110 From an organisational perspective, factors which reduce the impact of vicarious trauma include: healthy organisational work environments, training of employees, social support from colleagues and managers, and evidence based follow-up after a critical incident. [38]

111 In that context, MacKillop embeds the Sanctuary Model by training everyone in the organisation to understand trauma and its impacts – both on individuals and organisations; providing social supports in the form of peer supports facilitated by frequent meetings; and providing supervision and training.

Training

112 The Sanctuary Model enables practitioners and carers to conceptualise difficult behaviour of the children as a normal response to abnormal traumatic events, and remain stronger in their ability to remain compassionate. Instead of the staff being really reactive, which can escalate children's behaviour, MacKillop trains its staff to understand where the child is coming from and to deescalate. It is about giving children a language for how they feel and understanding that trauma has a very predictable pattern. Reactive responses can trigger unprocessed memories that children have from times of trauma and can result in that child's fight, flight or freeze response being activiated, with the child respectively acting out violently, absconding or disassociating. We train everybody to understand that pattern and help the children feel safe, to embed an emotionally intelligent organisation.

Supports

113 The Sanctuary Model has some very simple ways of connecting groups. For example, at MacKillop, we hold regular team meetings called community meetings (at least one or two a week) to check in with how team members are feeling, what their goals are for the day and who is going to help them. It is a really powerful way of checking in with everyone. The essence of the meetings is to establish safety. Everybody has their own proactive safety plan and their own self-care plan. Every single team holds community meetings

[38] Skogstad, M. Skorstad, A. Lie, H. S. Conradi, T. Heir, L. Weisæth, Work-related post-traumatic stress disorder, Occupational Medicine, Volume 63, Issue 3, April 2013, Pages 175–182.

and if there is a real problem or something is not getting fixed there is the option to call a red flag meeting.

Supervision and further training

114 In the residential care setting, there is additional training and supervision provided – beyond that which is provided to all staff. There is stringent induction and ongoing professional development. MacKillop has self-funded Principal Practitioners, who are clinically trained, and provide supervision – one-on-one, in team meetings and in a group setting (called reflective practice, which occurs fortnightly with the team that helps to embed therapeutic understanding).

115 In addition to other more frequent meetings, residential carers and house supervisors gather every quarter for a day that is nurturing, professionally enriching and celebrates good practice.

116 The use of Principal Practitioners has had the effect of embedding mental health expertise into the residential homes in a more integrated way. It not only helps the carers with managing children and their behaviours, but the Principal Practitioners can quickly pick up on early warning signals for staff fatigue, secondary post-traumatic stress disorder or compassion fatigue.

117 MacKillop has also integrated into its practice other therapeutic modalities that have made a real difference – for example, other trauma treatment approaches such as Eye Movement Desensitisation and Reprocessing (**EMDR**) and Therapeutic Crisis Intervention (**TCI**). EDMR is one of the World Health Organization's two treatment approaches to trauma and is used very effectively with MacKillop's residential care staff. TCI is an evidence-based program that originates from Cornell University and has been used by MacKillop to teach a therapeutic approach to case workers and carers who do not have clinical training. It teaches the essential elements of clinical training (which often takes years of training) in a way that is accessible for frontline workers who often have the longest time with the families and children.

118 I am passionate about getting funding to run more programs like EDMR, TCI training and Sanctuary Model training because I know they work.

Quality assurance and accountability

119 The Sancturary Model has been in place for a number of years and has provided a terrific foundation. Getting the knowledge into practice has taken some extra strategic processes that have to be led top down and embraced bottom up.

120 To really get a child-safe culture, there needs to be work on leadership and systems to hold people accountable. MacKillop has been assertive in developing champions at every level and openly directive that as this is the culture we want at MacKillop there is a collective duty of care to speak out if there is punitive practice or unprofessional behaviour. If someone is not right for the team and is doing the wrong thing that will impact the whole team and residence.

121 Performance management is important. We promote strong feedback and a culture of appreciation, as well as having really clear complaint systems as poor behaviour from staff is not tolerated.

122 MacKillop has also introduced state-wide quality committees and supervision requirements. We have done this so that there are more structures around the focus on practice quality. We have introduced templates that insist supervision notes are documented and we audit those to ensure the supervision is being done. We have driven a much stronger emphasis on supervision because that is the main form of quality assurance. We insist that everyone at MacKillop has at least one session a month of individual uninterrupted supervision for an hour before filling out the template form.

The effectiveness of the Sanctuary Model

123 MacKillop has experienced the benefits and positive impacts of the Sanctuary Model in assisting to prevent and respond to vicarious trauma. MacKillop has had this approach for a number of years now and there is a growing body of evidence as to the difference it is making. In terms of WorkCover, 100% of our staff are back to work within six months, compared with the industry average of 75% and the like agency average of around 60%.[39]

124 As a whole, what MacKillop has embedded is quite sophisticated, novel and progressive. I do not believe many others are doing what we are doing.

sign here ► _____

print name Dr Robyn Miller

Date 7 August 2020

[39] MacKillop Family Services unpublished data, 2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT RM-1

This is the attachment marked 'RM-1' referred to in the witness statement of Dr Robyn Miller dated 7 August 2020.

ROBYN MAREE MILLER PhD
— CURRICULUM VITAE —

QUALIFICATIONS

2014 PhD - Latrobe University
Thesis Title: 'Walking the Same Talk: Promoting cultural reform in the Victorian Child Protection and Family Services through the Best Interests Case Practice Model.'

1997 Masters of Family Therapy - La Trobe University
Thesis Title: 'Exploring an innovative therapeutic technique: Confrontative interviews with perpetrators of sexual abuse.'

1991 Graduate Diploma of Family Therapy - La Trobe University

1979 Bachelor of Social Science (Social Work) - R.M.I.T.

EMPLOYMENT HISTORY

July 2016 - present Chief Executive Officer, MacKillop Family Services

January 2015 – June 2016 Specialist Consultant
Policy and Research (vulnerable children)
Royal Commission on Institutional Responses to Child Sexual Abuse

2006 - 2015 Chief Practitioner Department of Human Services
Director Office of Professional Practice
Community and Executive Services
Department of Human Services Victoria [2013 – January, 2015]

Chief Practitioner Child Protection & Youth Justice
Community and Executive Services
Department of Human Services Victoria [2012 – 2013]

Principal Practitioner
Office of the Principal Practitioner
Children, Youth and Families Division
Department of Human Services Victoria [2006 – 2012]

In my roles at the Department of Human Services ("DHS") between 2006 and 2015 I performed the following functions:

- Professional leadership across the state and regional programs of child protection, family support, out of home care, sexual assault services, family violence services, Aboriginal Community Controlled Organisations and disability services.
- The completion of formal reviews of practice for the Minister for Community Services and Secretary of the Department of Human Services
- Development of evidence informed practice and trauma informed practice models
- Strengthening innovative partnerships with the police, courts, education, health and mental health
- Representation of the Department in a range of media, statewide, national and international forums.

2004 - 2006 PhD Candidate
PhD research and Private Practice and Consultancy

1992 - 2006 Individual, Couple and Family Therapist
Private Practice (half time)

Supervisor/Trainer/Consultant
Private Practice

1992 - 2004 Senior Clinician
The Bouverie Centre
Victoria's Family Institute
La Trobe University

- The Bouverie Centre was originally part of state-wide psychiatric services and was mainstreamed to become part of La Trobe University, School of Health Services in 1998.

Lecturer/Supervisor
Graduate Diploma and Masters of Family Therapy Courses
La Trobe University, Faculty of Health Sciences, School of Public Health
The Bouverie Centre.

The role included:

- Providing therapy to vulnerable children and families, consultations to other agencies, and teaching of advanced practice to post graduate, experienced professionals. I lectured and provided clinical supervision in the Masters of family therapy course.
- I was a member of the Sexual Abuse Team at the Bouverie Centre for twelve years. The team developed trauma informed models of practice with families who had suffered sexual abuse, including perpetrators and trained widely and interstate. I co-ordinated the team from 1998-2002.

Whilst at Bouverie, I also undertook the following roles:

1992 - 1994 Intake coordinator – Bouverie clinical program

2003 Trainer
Lifeline, Suicide Line, Men's Counseling Line
Training on understanding and responding to trauma

2000 - 2003 Consultant
MH Sky, Intensive Mobile Youth Outreach Service, Child and Mental Health Services

1994 - 1996 Consultant Supervisor
DHS Western Region, Child Protection Service,

1999 - 2003 Consultant and Trainer
DHS Child Protection Statewide Induction Training,
Quarterly statewide workshops on Family Violence and the engagement of violent offenders.

1993 - 2003 Clinical Supervisor
City of Darebin, Maternal and Child Health Nurses

2001 - 2002 Consultant
Parkville Youth Training Centre
DHS Juvenile Justice Section

2000 - 2002 Trainer
DHS

- Professional development statewide program on Domestic Violence and Child Abuse
- Professional development statewide program on High Risk Adolescents.

1997 - 2000 Consultant
Wodonga, Child and Adolescent Mental Health Service

1998 - 2000 Consultant
MH Sky Older Adolescent Service

1996 - 1999 Sessional Lecturer
La Trobe University

Masters in Education (Counseling) Course
Counseling for families and individuals where there has been sexual abuse and family violence.

Employment History Prior to The Bouverie Centre

1991 - 1992 Child Protection Practitioner
DHS, Child Protection.

After Hours Child Protection Service (Part-time).

1988 - 1992 Family Counselor
City of Fitzroy

This position included:

- The provision of counseling and family support services to families in Fitzroy, with a particular focus on those considered "at risk", and the development of community networks with other agencies, schools, child care centres, medicos, kindergartens and D.H.S.

1987 Adoption Assessment Social Worker
Catholic Care

1986 Travelled overseas (Europe, U.K. and Middle East).

1985 - 1986 Resumed former position as Co-manager at North Carlton Children's Centre after maternity leave (described below).

1983-1984 Co-manager and Family Counsellor
North Carlton Children's Centre.
Emergency Residential Unit.
(Melbourne City Council and Catholic Family Welfare Bureau).

- This position involved developing an innovative service which targeted 'at risk' families in the Carlton High Rise Flats, providing counseling and respite care for vulnerable children.

1980-1982 Family Counsellor and Pregnancy Counsellor.
Catholic Family Welfare Bureau, Carlton;

- This position included co-ordination of Family Support Workers outreaching to children at risk of harm.

1980 Community Development Consultant
Brotherhood of St. Laurence SPAN project, Northcote.

PRIVATE PRACTICE HISTORY

2001 - 2008 Lecturer
Melbourne University Graduate Diploma in Child and Adolescent Mental Health (Mindful Program).

2003 - 2006 Supervisor to counselling team
Eltham Community Health Centre
Reconnect Program - Eltham CHC

2002 - 2006 Consultant/Supervisor
City of Moreland:
Maternal and Child Health Nurses and Enhanced Home Visiting Nurses

2002 - 2006 Consultant/Supervisor
Gatehouse Centre, Royal Children's Hospital

2002 - 2006 Consultant, Debriefing and Training
Bendigo Community Health Service,

2001 - 2006 Consultant/Trainer
Whitelion Program, Juvenile Justice Mentor, Role Model and Employment Program

2001 - 2006 Consultant/Supervisor
City of Yarra:

Family Counseling and Family Support Team [2000 – 2006]
Early intervention program [2000 – 2002]
Maternal and Child Health Nurses [2000 – 2006]
Enhanced Home Visiting Nurse [2002 – 2006]

1998 - 2006 Consultant/ supervisor
Methodist Ladies College school counselling team (fortnightly).

2002 - 2005 Consultant
Alfred Hospital, Management Executive Team, social work department

1996 - 2003, 2004, 2005 Consultant/Supervisor
Northern CASA

2004 Independent Reviewer/Investigator
Office of the Child Safety Commissioner

- Lengthy investigation and Report into sexual exploitation in Out of Home Residential Care.

2003 - 2004 Consultant/Lecturer
Baptist Union Sexual Abuse Response Team,

2003 - 2004 Independent Reviewer/Investigator
DHS Child Protection and Juvenile Justice Branch

1996 - 1998, 2002, 2004 Consultant/Supervisor
Eastern CASA (Centre Against Sexual Assault)

2003 Consultant/Trainer
Department of Family and Community Services,

2003 Consultant/Supervisor
City of Booroondara. Sept.

1996 - 1998, 2000, 2003	Consultant/Supervisor Western CASA
2002	Consultant and therapist DHS Permanent Care Team Fitzroy
2001 - 2002	Consultant and trainer Social Work Department at the Alfred Hospital, Team building and Vicarious Trauma.
1993 - 1996	Consultant/Lecturer/Therapist Pastoral Response Office. Catholic Archdiocese of Melbourne.

- This office preceded "The Melbourne Response" and provided counselling and support to victims of clerical sexual abuse. I lectured at large parish meetings about the experience of children and the reasons they don't generally disclose sexual abuse, in order to promote understanding and support within the community. I also provided long term therapy to adult survivors of childhood clergy sexual abuse and clinical supervision to the staff of the office.

VOLUNTEER ROLES

1976 -1977 and 1977 - 1988	Community Development Worker Joint venture of Catholic Archdiocese of Melbourne and Australian Volunteers Abroad Papua New Guinea, Kanabea (highlands). 2 assignments x 3 months each
1976 - 1979	Weekly Volunteer Brotherhood St Laurence Children's program, Fitzroy High rise.
1976 - 1982	Weekly volunteer Soup Van, Inner Melbourne St Vincent de Paul Matthew Talbot conference.
1978 - 1980	President Soup Van, Inner Melbourne. St Vincent de Paul Matthew Talbot conference
1992 - 2006	Consultant Supervisor Sisters of Mercy Regina Ceoli Home for Homeless Women, North Melbourne
1998 - 2004	Loyola College, Watsonia School Council, soc welfare committee

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MEMBERSHIPS

Member Victorian Child Death Review Committee, (VCDRC) 2002-2013 (Ministerial appointment)

Member of Therapeutic Treatment Board 2007-09 (Ministerial appointment)

Member of the Australian Association of Social Workers (AASW)

Clinical Member of the Victorian Association of Family Therapists (VAFT)

Member of VAFT Committee of Management Board (1992-96)

BOARD MEMBERSHIPS

Association for Child Welfare Agencies (NSW) (2018 – current)
Catholic Social Services Australia (2017 – current)
Catholic Professional Standards Ltd (2017 – current)
CREATE (2008 – 2015). CREATE is the national peak body for children in out of home care.
Victorian Institute of Forensic Medicine (VIFM). Council member (2012-2015)
White Lion (Youth Justice Community Service Organisation) (2006 – 2011)
Siena College, Camberwell (2006-2008)

AWARDS

Recipient, Harvard Club of Victoria Non-Profit Fellowship 2017 (to attend Strategic Perspectives in Nonprofit Management Program at Harvard Business School, Boston US)

Nominated and finalist for the Nancy Millis, PhD academic award, La Trobe University 2014 (criteria for nomination: thesis must be outstanding and in the top 5% of those marked by examiners)

Winner of the Robin Clark Inspirational Leadership Award 2010

Finalist in the Telstra Business Women of the Year award, 2006

Winner of the Inaugural Robin Clark Memorial PhD Scholarship 2004

Winner of the Australian Association of family therapists' best journal article award, 1996

PUBLICATIONS

Frederico, M and Miller, R (2018)	The ever changing context of Child and Family Practice (in Leadership in Child and Family Practice. Edited by Margarita Frederico, Maureen Long and Nadine Cameron)
Miller, R (2018)	Excellence in caring for vulnerable clients: Going beyond the rhetoric and compliance to explore excellence in care (in Hearing, Healing, Hope. The Ministry of Service in Challenging Times. Edited by Gabrielle McMullen, Patrice Scales and Denis Fitzgerald)
Miller, R. (2015)	Engagement with Families involved in the Statutory System. In Maidment, J. and Egan, R., (eds), Practice Skills in Social Work and Welfare. Second Edition
Miller, R. (2015)	Stories from the Field – positive leadership in child protection (in Press:Beyond the Risk Paradigm: Current debates and new directions in child protection. Palgrave Publishers Editor: Prof Marie Connelly)
Miller, R. (2015)	Embedding Critical Social Work in child protection practice. (In press: Doing Critical Social Work, Allan and Unwin. Editors B. Longe, J. Allen, S. Goldingay)
Dwyer, J. and Miller, R. (2014)	Best Interests Case Practice Model, Specialist Practice Resource Working with families where an adult is violent
Robinson, E. and Miller, R. (2012)	Best Interests Case Practice Model, Specialist Practice Resource Children and their families
Helen Skouteris, Marita McCabe, Matthew Fuller-Tyszkiewicz,	Australian Social Work, Obesity in Children in Out-of-home

Adele Henwood, Sheree Limbrick and Robyn Miller (2011)	
Bromfield, L. and Miller, R. (2010)	Best Interests Case Practice Model, Specialist Practice Resource: Cumulative Harm
Robinson, E. and Miller, R. (2010, 2012)	Best Interests Case Practice Model, Specialist Practice Resource: Adolescents and their families
Pratt, R. Miller, R. (2010, 2012)	Best Interests Case Practice Model, Specialist Practice Resource: Adolescents with sexually abusive behaviours and their families
Evertsz, J and Miller, R. (2010-12)	Best Interests Case Practice Model, Specialist Practice Resource: Children with problem sexual behaviours and their families
Miller, R. (2009)	Engagement with Families involved in the Statutory System. In Maidment, J. and Egan, R., (eds), Practice Skills in Social Work and Welfare.
Dr Brigid Jordan, Robyn Sketchley, Dr Leah Bromfield, Robyn Miller (2009, 2012)	Best Interests Case Practice Model, Specialist Practice Resource: Infants and their families
Miller, R. (2008, 2012)	Best Interests Case Practice Model- Summary Guide (DHS)
Miller, R. (2007, 2012)	Child Development and Trauma Guide Best Interests Series (DHS)
Miller, R. (2007)	The Best Interests Principles: a Conceptual Overview (DHS)
Miller, R. (2007)	Cumulative Harm: a Conceptual Overview (DHS)
Bromfield, L. and Miller, R. (2007)	Specialist Practice Guide: Cumulative Harm
Dwyer, J and Miller, R. (2006)	Lighting the Path - Reflections on Counseling Young Women and Sexual Assault - pgs: 57-71
Sutherland, K.J and Miller, R. (1999)	Partners in Healing: Systemic Therapy with Survivors of Sexual Abuse and their Partners. Journal of Family Studies, Vol. 5, No 1, April 1999, pp97-lll. Training Manuals, Bouverie Centre, La Trobe University.
Miller, R. and Dwyer, J. (1997)	Reclaiming the Mother-Daughter Relationship after Sexual Abuse. A.N.Z.J. of Family Therapy, Vol. 18, No. 4, pp194- 202.
Dwyer, J and Miller, R. (1996)	Disenfranchised Grief after incest. The Australian and New Zealand Journal of Family Therapy, 17(3), 137-145.

ROBYN MAREE MILLER
PhD
ATTACHMENT A: LECTURES AND PRESENTATIONS

INTERNATIONAL

London School of Economics, London UK. Research Forum presentation 'Understanding trauma and sexual abuse and the place of family therapy- the work of the Bouverie Sexual Abuse Team' *August, 2002*

Queens University, Belfast. Guest lecturer in the Family Therapy Master's course, *August-September 2002*. 'Trauma and sexual abuse in the southern hemisphere – working systemically' one week intensive.

International Society of Behavioral Development, 'Relevance of Developmental Science for Practice and Policy in Child Protection', Conference Presentation, *Melbourne, July 2006.*

Positive Futures 2006, Achieving wellbeing for children & families, Association of Children's Welfare Agencies Conference Incorporating the International looking after Children Conference, S*ydney, August 2006.*

World Congress of the International Association for Child and Adolescent Psychiatry and Allied Professionals (Joint presentation with Dr Anne Smith), *September 2006.*

11th Australasian Conference on Child Abuse & Neglect, Gold Coast, guest speaker: 'Effective responses to Chronic Neglect & Cumulative Harm' (joint presentation with Office of the Child Safety Commissioner), *Brisbane, October 2007.*

International conference, Eusarf 2008 (European Scientific Association on Residential & Foster Care for Children and Adolescents) "Assessing the "Evidence-base" of Intervention for Vulnerable Children and their Families - Cross National Perspectives and Challenges for Research, Practice and Policy held in *Padova, Italy, March 2008.* Presentation on the 'every child every chance' reforms in Victoria.

Congress of the World Association for Infant Mental Health (WAIMH) Congress, J*apan, 31 July - 6 August 2008.* Joint presentation with Associate Professor Campbell Paul "Responding to intrafamilial sexual abuse."

Queen Elizabeth Centre's *Biennial International Conference*, Melbourne. Keynote: "Promoting Positive Outcomes For All Children - A Best Interest Case Practice Model"

UK and Ireland. March 2008. 17 Presentations on the Victorian child and family services system and child protection, to social workers and other UK and Irish professionals. The tour was part of a recruitment drive to attract practitioners to work in the Victorian Department of Human Services child protection program, over a two week period in nine different locations.

USA and Canada. April 2008. Presentations on Victorian reforms of children and family services to: New York State Dept. social services executive; Los Angeles Department of child protection; Sanctuary Institute, Andras Children's Centre, New York; Vancouver Department of child and family services executive; Vancouver Adolescent Mental Health Services; Boston children's hospital mental health 'No to violence' program. Biennial International Social Work Conference, joint presentation with Mick Naughton, 'Promoting positive outcomes for all children - a best interest case practice model', November 2008.

PRATO Conference 2011, Italy 'Working within the Forensic Paradigm: Developing effective responses across the health, helping and legal professions' Tuscany Italy, 12-14 September 2011. Robyn's keynote speech was titled 'Cumulative harm and its impact on child development: The Victoria, Australia reform process.'

Oxford, UK. 2012 The 'Celebrating Social Work' Conference – *Keynote address in* 'The value of social

work: evidence based practice developments and the role of Principal Social worker in Victoria'.

Oxfordshire County Council Child Sexual Exploitation Team, Oxford, UK. 2012. 'The Victorian Best Interests Case Practice Model and the Specialist Practice Resources' to the staff of the Two day workshop.

International Social Work Conference, Melbourne 2014 'Reforming the Victorian Child and Family Services'.

Myanmar National Health and Welfare Conference, Yangon, Myanmar; January, 2015. 'Protecting children and supporting families in Victoria, Australia'. Keynote Address.

2018 Anglophone Safeguarding Conference, Gregorian University, Rome; 'Trauma Culture: Meanings and Learnings'

NATIONAL

Australian Centre for Child Protection & Government of South Australia presentation, 'Family Reunification from Out of Home Care: Implementing a collaborative research program Forum', Keynote speaker and panel member, *Adelaide; November 2006.*

National Family Alcohol and Drug Network Conference, Facilitator of workshop - 'Keeping it real - holding the child in mind when working with families struggling with substance abuse,' *June 2007.*

Australasian Statutory Child Protection Learning & Development Group Forum - (joint presentation with Dr Leah Bromfield) - Keynote address focusing on practice reforms & respondent following Raymond Lemay Forum "Measuring our success by the outcomes for the children in our care," *September 2007.*

Australian Association of Spiritual Care & Pastoral Counseling Professional Development Evening - Guest speaker: 'Trauma and its effects on children and their families.' *September 2007.*

National Foster Care Conference, 'Turning Breakdowns into Breakthroughs, ' *October 2007.*

Immigrant Women's Domestic Violence Service National Seminar: Blaming and Reclaiming Culture, Panel member, *October 2007.*

Parenting Helpline National Meeting, guest speaker: 'Best interests/cumulative harm through to vicarious trauma'. Eastern Region, *October 2007.*

Australian Institute of Family Studies Conference, presentation with Mick Naughton, focus on the new legislation and theoretical frameworks, *November 2007.*

Victorian Offender Treatment Association Conference, Victim led therapy with intrafamilial sex offenders: a pathway to healing a joint presentation with Jenny Dwyer, *November 2007.*

Child Protection Advisor's Workshop - Brisbane conference, Guest Speaker: Effective Responses to chronic neglect and cumulative harm A Victorian Perspective, *November 2007.*

Victorian Aboriginal Child Care Agency Conference *4-6 June 2008* 'The River of Culture Runs Deep - Learning from Old Ways, Creating a New Approach'. Workshop exploring the impact of cumulative harm on Aboriginal children and their families and samples of services that enhance wellbeing.

Community Child Health Conference *Brisbane 2008*, keynote speaker: 'Celebrating good practice and good self-care', *October 2008.*

Queensland Department of Child Safety Practice Leaders, *Brisbane,* Presentation on child protection, trauma and good self-care, *October 2008.*

Australia Wide Resilient Families Symposium, presentation 'Early Intervention & Placement Prevention' - Best interests practice framework challenges of embedding the practice and cultural change, *June 2009.*

Centre for Excellence in Child and Family Welfare - Panel discussion: Searching for Certainty in an Uncertain World, Do lessons from evidence-informed practice in the health sector help or hinder the

search for evidence-informed practice in the child and family welfare sector? *June 2009.*

Association of Child Welfare Agencies biennial conference (2-4th August, Sydney), School of Social Sciences and International Studies, *The University of New South Wales*, Discussant/respondent presentation to one of the international keynote addresses Dr Marion Brandon, *August 2010*.

Chaired sessions at the 31st Australian Family Therapy Conference, Diversity: Context, Culture and Community. *October 2010*.

Round Table Discussion on Undersupply of Social Workers in Victoria and Nationally - Linda Martin: facilitator; member of the panel of expert social workers and workforce managers, *February 2011.*

AIC /AIFS/Victoria Police "Truth, Testimony, Relevance" Conference, Child sexual abuse and children's resistance strategies, *May 2012.*

Best Interest Case Practice series, Working with Children & Families who have experienced Cumulative Harm/Multiple & Complex Needs, *May 2012*.

'Mindful' Conference - Keynote speaker: young people who sexually offend; family issues and the context of treatment orders, *August 2008*.

Victorian Legal Aid Youth National Law Conference, Keynote address, *April 2009.* 'Young people and coping with court processes'

Integrated Family Support Service Program, Tasmania. Two day workshop, 'Working with Families: Practice Wisdom',*July 2009.*

NAPCAN NCPW Breakfast - 'Keeping children safe is everyone's responsibility' and questions, *September 2010*.

National Conference for the Finding Solutions program, Uniting Care Harrison - keynote address regarding trauma in particular 'Understanding the needs of young people who have experienced trauma'. *September 2010.*

Australasian Conference of Trauma, *Gold Coast*. 'Working with children and families recovering from trauma in the child protection system,' *July 2012.*

Rising to the Practice Challenge - The Cumulative Impact of Family Violence On Child Development, Robyn presented a workshop on skills/practice on Adolescents with Sexually Abusive Behaviours, *Adelaide, September 2012*.

Dept of Justice Child Protection Legal Conference - theme of "Holistic approaches in the child protection legal system: Family drug treatment courts", *October 2012.*

lOth Australian Adoption Conference. Panel discussion from people affected by adoption and permanent care. Keynote summation, October 2012.

Keynote speaker National Out of Home Care conference, Sydney 2013. "Therapeutic out of home care – the Victorian experience"

Member of the Royal Commission into Institutional Sexual Abuse, Round Table on Out of Home Care, Sydney April 2014.

Vic Police Sex Offender Registry Asia Pacific Conference - CP interface with sex offender registry, Victorian Police 2014.

Keynote: NSW FACS Conference, 'Inspiring good practice' Sydney September, 2015

Australian Youth AOD Conference, 'Embracing trauma-informed practice as an organisation…challenging risk-adverse practice' Melbourne, August 2016

Keynote: NSW FACS Conference, 'Ethics practice in child protection – Sanctuary: A trauma informed approach' Sydney September, 2016

ANZATSA Symposium 2016 - Collaborations in Practice: Sexual Safety in Out-of-Home Care. 'Dilemmas and innovations in promoting and achieving sexual safety for young people in out-of-home

care', *Sydney November 2016*

AAIMHI National Conference 2017 – 'How to foster a culture of critical reflection in an overwhelmed system', *November 2017*

Shine a Light Foster Care Conference – 'Who knew?.. Responding to children in foster care with sexualized beahviours', September 2017

NSW FACS Case Specialist Conference 2018 – 'A culture of critique', *February 2018*

Catholic Social Services Conference 2018 – 'Excellence in caring for vulnerable clients', *February 2018*

Childhood Trauma Conference 2018 - '"I reckon you should get back in your car and piss right off": Workers reflect on the problem of Harmful Sexual Behaviour and Child Sexual Exploitation for children & young people in residential care' (joint presentation with Dr Gemma McKibbin)

Catholic Social Services National Conference 2018 – Hearing, Healing, Hope 'Excellence in caring for vulnerable clients: Going beyond the rhetoric and compliance to explore excellence in care'

Building Opportunities, Building Communities Conference, Hobart – Implications of Royal Commission into Institutional Responses to Child Sexual Abuse, December 2018

Mission: One Heart Many Voices Conference – Living and leading Mission Together, May 2019

Carroll O'Dea Not for Profit Charity Law Day, Newcastle, September 2019

VICTORIAN STATEWIDE PRESENTATIONS

Statewide Forum Take Two - 'Working Clinically with Families where Children are both Victims and Sexually Abusive', May 2006.

Community - Based Child Protection Worker Forum - Child Protection Discussion, May 2006.

Child Protection Workers Forum - Assessing & responding to cumulative harm in children and young people, 1Cumulative Harm',June 2006.

Robin Clark Memorial Awards, Federation Square, Robin Clark Memorial Lecture1 Keynote speaker, September 2006.

Trauma and Sexual Abuse Presentation, CASA Forum, October 2006.

Presentation regarding Child Protection Changes for Maternity Services, Royal Women's Hospital, October 2006.

Case Planning Tool Presentation, October 2006.

Agenda Writers Workshop1Underpinning messages from the new legislation', Swinburne University of Technology TAFE, November 2006.

Strengthening Resilience to Meet Diversity: Maternal Child Health Services Conference, Keynote speaker: Children's Best Interest Principals', November 2006.

Every Child Every Chance, Department of Human Services Leadership Group Forum. Keynote speaker:

Cumulative Harm, practice implications, what needs to be built into SAG', December 2006.

Vulnerable Children within the Health Sector: Information and Planning Forums, Principles and facts associated with Children, Youth and Families Act', December 2006.

Violence in medical practice "Your safety is in your hands" medical practitioners - Monash GP'S panel guest speaker: 1Family Services1 March 2007.

Presentation to Child Psychiatry trainees from Mindful, 1Protective services issues', March 2007.

Melbourne University, Graduate Diploma Seminar in Mental Health Sciences, Keynote speaker: Working Systemically with Families Following Trauma, Part 1," April 2007.

University of Melbourne, Practice with Families Lecture, Keynote speaker: "The family as a locus of trauma and healing: integrating trauma theory with family practice," April 2007.

CASA Workers Forum - Keynote speaker: The new legislation', Royal Children's Hospital, April 2007.

Looking After Workers Lecture - Keynote speaker: 1integrating trauma notions with family practice\ University of Melbourne, May 2007.

Berry Street Victoria in partnership with La Trobe University, Austin CAMHS & Mindful launch of the second evaluation report of the Take Two program, Keynote Speaker, May 2007.

Community Child Protection Quarterly Forum - 1The Art of Consultation' with Banu Moloney, June 2007.

Best Interest Practice Group for Children in SAAP & Family Violence Services, Guest Speaker - Cumulative harm, changes to the legislation and practice implications,' July 2007.

Practice forum - Working together to respond to children and young people affected by family violence - Keynote speaker: Collaborative practice to enhance safety and healing for women and children,' July 2007.

DHS Student Placement Introductory Seminar - Keynote speaker: Legislation, Principles of practice & characteristics of families we work with,' August 2007.

Monash University Clinical Doctoral Psychology Students - Guest Lecturer: Productive ways to interact with protective services/governmental bodies in their work with clients,' August 2007.

CASA Forum, Keynote speaker: Cumulative Harm,' August 2007.

Take Two Forum - Keynote speaker: Working Clinically with Families where Children are both Victims of Abuse and Sexually Abusive. August 2007.

Child First & HRI Forum - A team based approach to working with vulnerable families. Recognising the team that is, The CDU Resource Group, High Risk Infant Program & Child First. Royal Women's Hospital, August 2007.

Celebrating Good Practice in the context of the ecec reforms - capturing case study examples. Release of the case practice publication, DVD launch,regional examples of practice that reflects key directions under the every child every chance reforms, August 2007.

Professional Development Day Child Protection for Centacare' - Keynote speaker: The new legislation, the concept and principles of Best Interests of Children & Cumulative Harm',September 2007.

Training at Bouverie Centre, October 2007. Understanding responses to child abuse trauma

The Child Safety Commissioner & Platform Youth Theatre in collaboration with the CREATE Foundation - 2007 Youth Advisory Group on Out-of-Home Care, participation in Q & A's, October 2007.

Foster Care Association of Victoria Inc., Keynote Speaker: discussion around permanent care decision making in terms of attachment, November 2007.

Residential care, therapeutic way forward, Trauma, Neglect Resilience and a therapeutic response to kids, November 2007.

Follow-up Professional Development Child Protection on Clinical Issues Staff have Experienced, Centacare, December 2007.

Child and Adolescent Psychiatry Training program, February 2008.

Panel Discussion for Children's Services Leadership Training, March 2008. Learning Circle at the Bouverie Centre, presentation, May 2008.

VCC Experts' Roundtable on Out of Home Care - presentation on lessons from overseas, May 2008

Social Work and Psychology Student Seminar, 'An overview of Child Protection', May 2008. MacKillop

Family Services Out of Home Care Workshop - Keynote speaker: presenting on overseas learnings and further work on the service model, June 2008.

Department of Human Services, Interdepartmental Committee - Review of Out of Home Care, lessons from overseas, June 2008.

Whitelion Board Meeting keynote speaker: presentation on overseas learnings, July 2008.

2008 'Coalition For Change', the next horizon, Keynote address - How is Victoria stacking up? & The Best Interest Case Practice Model - Implications for leaders and partnership, July 2008.

Family Services, Child Protection, and Out of Home Care Best Interests Case Practice Forum, Keynote speaker: "Best Interests case practice model", July 2008.

Student Orientation Workshop - Child Protection Workforce Planning and Development, July 2008. Young

People and Sexual Exploitation Forum, Working towards a shared agenda: responding to young people involved in commercial sexual exploitation. Keynote speaker: DHS analyse & panel discussion - Case Scenario, July 2008.

Early Childhood Programs for at risk children Program Planning workshop, centre based early childhood programs, August 2008

Launch of Breaking the Cycle Facilitator's manual,Anglicare - Contribute to a panel discussion, August 2008.

Professional Development Day, Centacare, Focus on engagement and practice with couples and families who have experienced family violence, September 2008.

Protecting Children Awards, Keynote, September 2008.

Cumulative Harm: Practice implications of the new legislation, workshop conducted with Cathy Humphreys for Centre for Excellence, 2008-12.

CPS Team Day, La Trobe Uni, presentation on Best Interests of the Child, Professional Development Session, October 2008.

Aboriginal Child & Family Services Network Meeting, Facilitator and speaker on Best Interests Case Practice Model, October 2008.

St Luke's Youth Connection Forum, October 2008

Anglicare Victoria, Placement Support & Family Services Joint PPF, October 2008. Best Interests Case Practice Model Challenges for Implementation.

DHS, Court Advocacy Unit, presentation on good practice stories & infant development, October 2008.

La Trobe University, CP Family Violence & Sexual Abuse, October 2008.

Centre for Excellence, Cumulative Harm Workshop with Professor Cathy Humphreys, November 2008.

DHS, Child Protection Careers Open Day What do Child Protection Practitioners do? December 2009.

UK social workers, Reflections on practice from the Principal Practitioner, February 2009.

Launch of Adolescent Cautioning and Referral (ACAR) Program Keynote speaker, 'Snap shot of young people at risk categories', March 2009.

Launch of the Immigrant Women's Domestic Violence Service, The Voices of Culturally and Linguistically Diverse Children affected by Family Violence, guest speaker, April 2009.

Melbourne University, lecture on family Child abuse & trauma, April 2009.

Mindful, University of Melbourne, lectures to graduate diploma students on Family Therapy, April 2009.

Anglicare Pillars of Practice Launch - presentation on Family Resilience and Best Interests Case Practice Model, April 2009.

Graduate Certificate in Child and Family Practice Workshop, May 2009.

Monash University, Clinical Doctoral Candidates, Lecture on working with trauma and risk, May 2009.

Maternal Child Health, Key Ages and Stages Residential Workshop, presentation 'What makes for good leadership in Maternal and Child Health', May 2009.

Healthy Mothers Health Babies Program, presentation on Child Protection & Family Services, June 2009.

Kinship Care Forum, Keynote address: 'The Heart of the Matter - the need to belong' Celebrating kinship families and the difference they make for children, June 2009.

Seminar to Reconnect Workers, presentation on cumulative harm, trauma attachment & youth homelessness, June 2009.

Launch of educational resource for health regarding vulnerable children, OHS, Keynote address, July 2009.

Centre for Excellence in Child and Family Welfare, Cumulative Harm Training, joint presentation with Cathy Humphries, July 2009.

OHS Family Decision Making Convenors Statewide Forum, facilitator, August 2009.

Royal Children's Hospital Mental Health Service, Professional Development Session - 'Clinical practice with children and families involved in the child protection system - best practice in working with children and families recovering from trauma,' August 2010.

Chisholm Institute Conference 2010- chatterbox: Community conversations, training and partnerships - Keynote speaker & presentation. Keynote: Family inclusive practice - How do we walk the talk? Workshop: Effectively engaging with vulnerable children and families - The role of practitioner self care and reflective practice, October 2010.

The Good, The Bad & The Ugly Conference - Workshop & keynote address. Workshop: 'Practise with Young people with sexually abuse behaviours ', Keynote address: 'Engaging Adolescents and their Families in Healing from Trauma',October 2010.

Victorian Police SOCIT Leadership forum - Child Protection Framework, NGO (Child First roles and responsibilities), Collaboration - effectiveness of case conferencing, Child Death Inquiries, March 2011.

Victoria Police presentation to Compliance Managers DHS, in particular risk assessment and police powers under the CYFA (Protective Intervener) from OHS perspective inclusive of what OHS expect or want from VICPOL members, May 2011.

Statewide Forum for Infant Mental Health Services in CAMHS MINDFUL - Child and adolescent mental health service clinicians about their role in working with protective services and infants and families, December 2010.

VLA Training, Build relationships between OHS and ICL's so that there is a greater level of understanding and co-operation, March 2012.

CSSS Catholic School Counsellors Conference 2012 - Workshop 4 - "The Impact on Adolescent Development of trauma, abuse & violence" May 2012.

EES Combined Schools Curriculum Day, 'Complex Childhood Trauma," May 2012.

CP & VJ Training - Working with High Risk Adolescents and their Families & Working with Children & Adolescent and their families where there are sexualised behaviours. The impact of cumulative harm & families with multiple & complex needs on young people May 2012.

Launch of Richard Rose's new book "Life Story Therapy with Traumatized Children - A Model for Practice" - The importance of taking a therapeutic approach to OoHC, June 2012.

The Salvation Army Westcare Inaugural general managers' awards 2012 - 'What it means to work in the field', July 2012.

CPLO training "Working with families where there is family violence and sexual abuse - best practice and considerations for access", July 2012.

Maternal Child Health Services in the Northern Metropolitan region - Keynote address on Child Protection and the role and relationship of Child Protection within OHS and Maternal Child Health & Vulnerable Children's Report, August 2012.

Training session for START to carers and workers in the NW region - Working with Children and Families who have experienced trauma - engaging and leading, August 2012.

Child Protection Careers Open Day - Child Protection Practitioners: Protecting Children Changing Lives, October 2012.

The No To Violence 2012 Australasian Conference on Responses to Men's Domestic and Family Violence: Experience, Innovation and Emerging Directions - plenary session, November 2012. Royal

Children's Hospital conference - focus on workforce implications 2014.

Melbourne School of Health Sciences - Integrating theory and practice: The Best Interests Case Practice Model, 2014.

Kinship Carer's Victoria - launch of Kinship Carer's handbook 2014.

Royal Women's hospital - Keynote: Psychiatric disorders in women using substance and or alcohol, 2014.

Australian Institute of Family Studies - Webinar - sexual abuse & exploitation: prevention & effective responses 2014.

Melbourne University - Book launch: the importance of social work scholarship to practice 2014. Kildonan

Leadership Forum - Seminar presentation, 2014.

Centre for Excellence - Resi-rocks forum - Keynote address: Mindfulness in residential care: Building a hopeful future 2014.

Women's health West - Trauma Informed Practice, 2014.

Better regulation, better regulators: Reform challenges and opportunities forum - Panel topic Professionalising regulation, 2014.

YHARS - OHS trauma-informed care model, role of the Office of Professional Practice & resource, 2014.

OzChild panel discussion - Children with a disability in OoHC, 2014.

Catholic Education Office Melbourne - Keynote address: Child safety, personal safety, Child Protection, 2014.

Responsive Pathways for Vulnerable Children Conference, Promoting cultural reform in practice with vulnerable young people, 2014.

Royal Children's Hospital - Grand round keynote presentation: Reforming Victorian services: Focus on workforce implications, 2014.

Magistrates Court Conference day - Keynote: Protection of Children in the context of Family Violence, 2014.

DHS State wide conference: Joint presentation with James Anglin - Sexual exploitation of young people in residential care & Aboriginal young people in residential care, 2014.

Centre for Excellence in Child & Family Welfare forum on the Royal Commission into Institutional responses to child sexual abuse, 2014.

Children OoHC Symposium, Sexual exploitation, 2014.

Annual meeting of the Australasian Association of Parenting & Child Health (AAPCH) Attachment & trauma within CP context, 2014.

Statewide CASA Forum Conference Presentation, Trauma and Attachment – engaging the family in healing following sexual abuse, October 2015.

Presentation to Children's Court of Victoria - Ethics in Child Protection, August 2016

University of Melbourne, Len Tierney Lecture 2017 – 'Working with Families: Then and Now', August 2017

Catholic Secondary Schools Support Network Conference – Working with families & schools when there has been a disclosure of abuse (physical & sexual), June 2019

Catholic Social Ministry Conference – The opportunities and challenges facing Catholic Social Service Organisations, November 2019

Royal Commission into
Victoria's Mental Health System

ATTACHMENT RM-2

This is the attachment marked 'RM-2' referred to in the witness statement of Dr Robyn Miller dated 7 August 2020.

Details of the Impact

EXPERIENCES OF LOSS AND GRIEF FEATURE IN THE LIVES OF MANY CHILDREN AND YOUNG PEOPLE. Almost one in four Australians aged 18-24 experience divorce or separation of their parents (Australian Bureau of Statistics, 2010) and 6% experience the death of a parent during childhood (Australian Bureau of Statistics, 2013).

PROFESSOR ANNE GRAHAM, Director of the Centre for Children and Young People (ccyp) at Southern Cross University, authored *Seasons for Growth* (is an evidence-based, small-group, psychosocial education program providing children and young people (6-18 years) with knowledge and skills to adapt to significant changes following death, separation, divorce and other loss experiences. Launched in 1996, it is the only such program developed in Australia that is nationally and internationally available.

***SEASONS FOR GROWTH* IS STRUCTURED AROUND THE METAPHOR OF SEASONAL CHANGE**, Worden's task theory and contemporary evidence about what children need to know and do to adapt to loss. The program emphasises agency: accepting the reality of the loss, working through the pain of grief, adjusting to the new situation and emotionally relocating the person or thing. It promotes resilience and self-esteem, normalises grief, builds peer support and fosters positive coping strategies.

***SEASONS FOR GROWTH* (3RD EDITION) CHILDREN AND YOUNG PEOPLE WAS LAUNCHED IN 2015.** This edition synthesised and integrated the findings of much of CCYP's research from the preceding decade, including contemporary interdisciplinary understandings of childhood (emphasising children's agency as well as vulnerability), children's rights, grief theory, understandings of wellbeing (subjective wellbeing grounded in children's conceptualisations) and Honneth's recognition theory.

SUICIDE IS THE LEADING CAUSE OF DEATH FOR 15-24 YEAR OLDS IN AUSTRALIA (24% of male and 15% of female deaths, respectively). In 2015 headspace National Youth Mental Health Foundation requested a trial of *Seasons for Growth* as a suicide post-vention in schools. CCYP researchers modified the program, and having conducted a successful trial, trained 72 companions and rolled it out into communities across Australia identified as youth suicide hotspots.

BETWEEN 2011 AND 2016 81,993 PEOPLE (91% of them children or young people) participated in *Seasons for Growth* in its various adaptations in Australia, New Zealand and Scotland. Since its development in 1996, the program has delivered significant social benefits to over 260,000 children, young people and adults in Australia, New Zealand, Scotland, England and Republic of Ireland.

UPTAKE IN SCOTLAND HAS BEEN SPECTACULAR. The Scottish Government funded a National Coordinator for the program from 2008 resulting in training of 2,204 companions and participation of 24,210 children and young people in the period from 2011-16. *Seasons for Growth* won a City of Edinburgh Council Children & Families Award in 2011. There is solid evidence that it has made a very positive contribution to the social and emotional well-being of Scottish children and young people.

***SEASONS FOR GROWTH* ALSO PROVIDES THE AUSTRALIAN GOVERNMENT WITH AN EVIDENCE-BASED,** credible program to support children and young people facing loss. While schools were previously the major sites for *Seasons for Growth* in Australia, 27% of programs are now run through community agencies. In 2005 Professor Graham gifted the intellectual property in the *Seasons for Growth* program to the newly-established non-profit organisation Good Grief Ltd, which was established to administer *Seasons for Growth* programs across Australia and coordinate mandatory training. From 2011-2016, Good Grief trained 3,098 companions who delivered the suite of *Seasons for Growth* programs and seminars to 50,280 people (85% of them children or young people).

IN 2009 ACCESS ECONOMICS REPORTED THAT NEARLY A QUARTER OF YOUNG PEOPLE IN AUSTRALIA AGED 12-25 HAD SOME MENTAL HEALTH DIFFICULTY. The direct financial cost of this mental illness was estimated at $10.6 billion. Proven intervention programs such as *Seasons for Growth*, which raises self-confidence, self-respect, self-esteem, and lowers depression and anxiety, provide economic benefit to Australia by lowering health costs. However, any economic benefits that may flow from *Seasons for Growth* are overshadowed by the social benefits that have accrued from this program in its many forms. *Seasons for Growth* has given thousands of children, young people and adults a new start, a chance to transform their experiences of change and loss and move forward with confidence and hope.

NOTE: report summary only. The full report is located at https://dataportal.arc.gov.au/EI/NationalReport/2018/

MacKillop Family Services

good grief

Seasons for Growth