Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF ANNE HOLLONDS

I, Anne Hollonds, Director of the Australian Institute of Family Studies', of 6 William Street Roseville 2069, say as follows:

1 I am authorised by the Australian Institute of Family Studies' **(AIFS)** to make this statement on their behalf.

2 This statement relies on AIFS' work to date. We acknowledge that there are emerging issues around how the COVID-19 pandemic will affect the economic, physical and mental well-being of Australians, now and into the future; and that this statement does not cover the mental health impacts of the situation that Australians are currently facing.

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

4 Attached to this statement and marked 'AH-1' is a list of references referred to in this statement.

Professional Background

1 I am currently the Director of the AIFS and have been in that role since September 2015. In this role I am the agency head of a statutory authority of the Australian Government, established under the Family Law Act 1975.

2 My current advisory group roles include: NSW Domestic and Family Violence and Sexual Assault Council (being Co-Chair from 2013-2016), Queensland Family and Child Commission Advisory Council since 2015, National Children's Mental Health and Wellbeing Strategy Steering Group since 2019 and the Bouverie Centre Advisory Committee, La Trobe University since 2019.

3 My previous positions include:

(a) Director of Development Partnerships, Our Watch (2014-15);

(b) Chief Executive Officer, The Benevolent Society (2011-14); and

(c) Chief Executive Officer, Relationships Australia NSW (1998-2011).

4 I hold the following qualifications:

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

(a) Master of Business Administration from the Macquarie School of Management;

(b) Bachelor of Social Studies, University of Sydney;

(c) Bachelor of Arts (Psychology), Macquarie University; and

(d) Psychologist Registration, AHPRA.

5 Attached to this statement and marked 'AH-2' is a summary of my curriculum vitae.

The Australian Institute of Family Studies

6 The AIFS is the Australian Government's key family research body and advisor on family wellbeing. Our purpose is to create and communicate knowledge to accelerate positive outcomes for families. Because when families thrive, Australia thrives.

7 Our research increases understanding of the factors that help or hinder the wellbeing of Australia's families. We build evidence about 'what works for families', which can be translated into action on the ground. We play a critical role in closing the gaps between research, policy and practice. Everything we do is designed for impact on policy and practice.

8 We are a statutory authority of the Australian Government, established under the Family Law Act 1975. We commenced operation in February 1980 and are based in Melbourne.

9 We undertake and publish primary research into a broad range of issues affecting Australian families. Our research involves a range of data collection and analytic methods, including quantitative, qualitative and mixed methods.

10 We also manage a number of major, large-scale longitudinal studies which track participants' lives through time at different ages and stages. These studies contribute to a robust evidence base to equip policy makers, researchers and stakeholders with data that help them make progress on some of Australia's most pressing issues.

11 We impact policy and practice by: providing advice on the design and implementation of policies and services, evaluating policies and programs (to discover what works for families), build the capability of policy and service-delivery agencies to design and deliver evidence-informed services for children, families and communities.

12 AIFS operates within the portfolio of the Department of Social Services **(DSS),** and is responsible to the Minister for Social Services. We conduct research across numerous Australian government departments, states and territories.

13 Our stakeholders include the Australian Government and state, territory and local governments, people who provide services to families and children, researchers, policy makers, families and community members.

14 AIFS acts as a bridge between the worlds of research, policy and practice, and this is reflected in the breadth of our relationships. We work in partnership with our stakeholders to provide evidence, translate knowledge and build capability to address complex social problems and contribute to the design of human-centred policy and services.

15 We understand the challenges that policy makers and practitioners face, and we bring a real-world lens to our research. Our work is built on strong foundations of academic excellence, however, we are not confined to traditional academic outputs. Our work is designed to meet the needs of end users, and ultimately to benefit families.

FAMILY AND COMMUNITY STRUCTURES

The changing characteristics of Australian families over time

16 In relation to the characteristics of Australian families, data from the 2016 Census (ABS, 2019)[1] showed the following:

(a) In 2016, 49% of Australians lived in a couple family with children, compared to 54% in 1996.

(b) People living in couple-only families (without children) increased from 19% in 1996 to 21% in 2016.

(c) People living in single-parent families increased from 11% in 1996 to 12% in 2016. In 2016, 18% of single parents were male (15% in 1996).

(d) In 1996 and 2016, 4% of Australians were living in a group household – in 2016, 20% of group household members were aged 50 or over – up from 12% in 1996.

(e) People living alone increased from 9% in 1996 to 10% in 2016. Under age 55, most people living alone were men (57% in 2016, 60% in 1996), but over age 55 most people living alone were women (62% in 2016, down from 69% in 1996).

17 AIFS research (Qu, 2019a-e)[2] shows how other aspects of family life in Australia have changed over the last few decades:

(a) Fertility rates have declined – the 2017 total fertility rate of 1.74 (births per woman) was the lowest on record, down from a peak of 3.55 in 1961.

(b) The percentage of women having their first child over the age of 30 has risen from 23% in 1991 to 48% in 2016.

(c) In 1971 only 7% of births were ex-nuptial, compared to 35% in 2017.

(d) Since 1970, the marriage rate has fallen steadily, until 2000, when it stabilised for a decade before falling again. In 2017 the rate was 4.6 marriages per 1,000 Australian residents, the lowest rate ever recorded.

(e) Among those who do marry, men and women have been waiting longer before getting married for the first time. In 1971 the median age for men was 23 for men and 21 for women. In 2017 the median age was 30 for men and 29 for women.

(f) Most couples now live together before getting married: 81% in 2017 compared to 16% in 1971.

(g) An increasing number of couples are turning to a civil celebrant to conduct their marriage. In 2017, 78% of marriages were performed by civil celebrants.

(h) The divorce rate started trending down in the 2000s. In 2016 it was 1.9 (divorces per 1000 people), the lowest rate since 1976.

(i) The largest proportion of couples separating and then divorcing are those who have been married nine years or less.

(j) The proportion of divorces involving children under 18 years has fallen since the 1970s, from 68% in 1975 to 47% in 2017. This is partly due to the rise in divorces of long-term marriages where children have grown up.

(k) More young people living with their parents in early adulthood: In 2016, 43% of 20–24 year olds and17% of 25–29 year olds lived with their parents; compared to 36% of 20-24 year olds and 10% of 25-29 year olds in 1981.

Key issues affecting how Australian families live and function

18 Families are a powerful driver of social and economic health and wellbeing. To do their job well, families need the right supports at the right time. At every stage of life, and at major transitions, families face a range of issues, challenges, and external influences that shape their relationships and their social and economic participation.

19 AIFS (2019)[3] has identified the following broad trends that are affecting the lives of Australian families:

(a) **Work and family balance:** Views about the division of labour in the care of children are becoming more progressive. Women are enjoying greater access to

education and employment opportunities and are increasingly occupying leadership roles in the workplace. However, in the home, traditional gender roles for men and women persist, with little shift in the caring responsibilities taken on by men. This is most apparent at the transition to parenthood, at which time women tend to take a period of leave from work, change to part-time work, or withdraw altogether from the workforce, while men's workforce participation generally does not change. These gender divisions persist even after children move through school and beyond.

From a policy perspective, the gendered nature of caring means women with children may be more vulnerable when relationships end, which also has flow on effects for their retirement living standard as their superannuation contributions are often lower. Single mothers who have never married or remarried face similar challenges. As a result, we see higher rates of poverty among single women, particularly single-parent women and elderly single women, than we see for men.

(b) **An ageing population:** This is a testament to the advances in health, education, employment and living standards over the last century. The aging population presents social and economic challenges for individuals, families, communities and governments, with implications for lower workforce participation and a declining tax base with which to fund public services and amenities. It is also a good news story, with increased educational standards, enhanced knowledge economies, increased volunteering and caring capacity, and strengthened intergenerational bonds.

However, the benefits and challenges of our ageing population are not distributed equally. The social determinants of health and wellbeing play a large role in contributing to outcomes for older Australians. There are opportunities to respond to these challenges with policy and system reform to reduce ill-health, isolation and disability among some segments of our older population.

(c) **Interpersonal violence over the lifespan:** The last decade has seen increased awareness and commitment of governments to address the complex and overlapping nature of child abuse and neglect, family and domestic violence and sexual violence. Interpersonal violence and associated trauma can have negative impacts on mental and physical health, family and other relationships, economic participation and social connectedness. The needs of families experiencing these issues can be complex. Increasingly, the imperative is to develop integrated co-ordinated and appropriately tailored support systems to improve the long-term outcomes for survivors, as well as facilitate the prevention of family and interpersonal violence and child abuse.

(d) **Intergenerational inequality:** Intergenerational equity issues have emerged as key drivers in current economic policy debates. Low wages growth, job insecurity,

under-employment and increasing costs of housing affect the wellbeing of families - particularly poorer families, given continuing inequalities across the income and wealth distribution within society.

(e) **Greater acceptance of diverse family types:** There are increasing levels of community support for marriage equality rights for gay and lesbian people, and the right of LGBTI people to adopt or foster children. There is an increasing prevalence of same-sex couple families with children. At the same time, the trend is for greater proportions of single-person households and those without children, with childless couples on track to be Australia's most common family type by 2023. The proportion of young people remaining in (or returning to) the family home when they are aged in their 20s and 30s is also increasing.

(f) **The increasing role of technology**: Developments in information and communication technologies affect how we interact with one another, where we work and how we socialise. For example, recent studies indicated digitisation and the greater use of artificial intelligence is likely to replace about half of known jobs within 20 years. Technology is also blurring the distinction between work and home, and greater flexibility in work patterns, with a rise in working from home. One of the side effects is that technology is contributing to the expectation that workers will be available outside of traditional business hours.

(g) **Mental health:** It is well recognised that mental illness is a significant issue across the life course in Australia, with approximately one in five people aged between 16 and 85 experiencing a mental illness in any year. The effects on families can be significant, and high-quality support and services to families and affected family members is crucial. Mental illness impacts not just the individuals affected but also the family relationships around them, including parents and children.

Poor mental health has a range of personal, social, economic, health and productivity impacts. The complex interplay of the impacts of mental illness on individuals and families means coordination of policy and services across sectors, systems, levels of government and portfolios is crucial to delivering timely and appropriate support to individuals and families. Reducing discrimination and the stigma of mental illness are also important as these are often barriers to individuals seeking support for mental health.

The changing environments in which families are raising children in Australia

The physical environment:

20 Over the last decade, higher density housing, such as apartments and townhouses, now makes up a quarter of Australian housing. However, analysis of 'Growing up in Australia:

The Longitudinal Study of Australian Children' **(LSAC)** data (Warren, 2018a)[4] shows that four out of five Australian children still live in a separate (detached) housing, presumably due to a preference for more (indoor and outdoor) living space among families with children.

21 Increasing student numbers in schools in metropolitan areas, and the need for additional classrooms has meant that the amount outdoor play space has decreased. This makes the need for access to safe parks and playgrounds and community recreational organisations all the more important.

The economic environment:

22 Low wages growth, job insecurity, under-employment and increasing costs of housing affect the wellbeing of families - particularly poorer families, given continuing inequalities across the income and wealth distribution within society.

23 AIFS' work using the LSAC shows that experiences of poverty and disadvantage for families and children are dynamic, with a relatively small proportion of children in the study remaining in poverty throughout their childhood. For example, almost 30 per cent of children in the LSAC had lived in a household with combined parental income below 50 per cent of the median at some stage between 2004 and 2012.[5]

24 It is widely agreed that poverty is not only about low income, but also about deprivation. Family disadvantage means, more generally, a lack of access to resources enabling a minimum style of living and participation in the society within which one belongs (Capellari and Jenkins, 2007). Data from LSAC shows that approximately 50 per cent of children experienced disadvantage in one of the five domains of family-level disadvantage (material resources, employment, education, health and social support) in any particular wave; and around 18 per cent experienced disadvantage in two or more of the five domains in the same year.[6]

25 In addition to disadvantage at the family level, disadvantage at the school and neighbourhood level are also important factors to consider. AIFS research has shown that children who experienced family, neighbourhood or school disadvantage, or a combination of the three, are likely to have poorer cognitive and social outcomes; and that this effect is stronger the longer that children experience these forms of

disadvantage.[7]These complex issues require policy and service responses which are tailored to the experiences and aspirations of families themselves.

26 While encouraging greater workforce participation is one way of addressing poverty and disadvantage, the story around families and joblessness is not straightforward. While many jobless households with children are lone parent households, mothers' employment rates are even lower in two parent families where fathers are also not employed. AIFS research on mothers' employment patterns by age of youngest child for different family forms, from 1991 to 2016 shows the highest rates of maternal employment are found when mothers have an employed partner. Single mothers have lower employment rates than these mothers. However, mothers' employment rates are lower still for mothers who have a jobless partner (Baxter et. al, 2018).

27 Analysis of LSAC data shows that, in 2014, around one-third of families with children living in private rental accommodation were experiencing housing affordability stress, compared to one in 10 families with children who were paying off a mortgage. For some children, changes in housing are a result of parental separation and, in these cases, housing affordability is more likely to be an issue. Of children who moved house around the time of their parents' separation, 41% moved into a situation of housing affordability stress (LSAC).

28 A study of housing conditions and children's developmental outcomes (using LSAC data) has shown that, while overcrowding had the largest negative impact for learning outcomes, frequent moves, renting (versus owning), and housing affordability stress were shown to be negatively associated with children's social and emotional wellbeing.[8] (Dockery, Ong, Colquhoun, Li, & Kendall, 2013). The creation of stable and safe accommodation options in Australia would likely lead to positive mental health outcomes, especially among vulnerable and disadvantaged groups. Providing secure housing early in life could lead to better development and wellbeing outcomes.

The social environment:

29 The increasing use of electronic media, may negatively affect health by facilitating sedentariness and reducing physical activity and also impacts on mental health, particularly for adolescents and young adults, for whom where online bullying has become an increasingly significant issue.

30 There is a growing understanding of the interconnections between violence against women and increasing rates of homelessness and mental health problems, and negative later life outcomes for children has resulted in domestic and family violence becoming

centre stage in policy reform across Australian jurisdictions. The AIFS report, Children's Exposure to Domestic and Family Violence (Campo, 2015), further recognised children's experiences by highlighting that domestic violence and child abuse are often seen as separate problems, obscuring the multi-victimisation experienced by children that is often poorly understood.

31 The 2012 family violence amendments to the Family Law Act 1975 included strategies aimed at supporting better identification of family violence and safety concerns by family law professionals. AIFS research[9] has shown some positive changes regarding the efficacy of the family law system and its ability to protect the safety of children, with:

(a) Significant increases in the proportions of people who reported being asked about family violence and safety concerns when using a formal pathway (FDR/mediation, lawyers and courts) for resolving parenting arrangements. The findings also suggest small increases in the proportion of parents who disclosed concerns.

(b) Slightly higher levels of endorsement relating to "whether the family law system meets the needs of mothers, fathers and children".

(c) Higher levels of agreement to the question about whether the family law system protects the safety of children, particularly among those who had safety concerns involving children and those who did not have contact with the other parent.

(d) There are significant numbers of Australian children who live in out-of-home care. At 30 June 2016, there were 46,448 children aged 0-17 years who were in out-of-home care (8.6 per 1,000 Australian children), compared to 37,648 children at 30 June 2011 (7.3 per 1,000 children) (AIHW, 2017, 2012)[10]. The majority of these children were living with foster or relative/kinship carers in home-based care arrangements (AIHW, 2017).

Predicted changes to the environments in which families are raising children in Australia

32 Many of the gradual changes that have been taking place in OECD countries are likely to continue and in some cases intensify, with higher rates of female participation in the labour market, higher divorce rates, more single parents, rising and longer enrolment in education, growing numbers of elderly, higher numbers of foreign-born population and increased ethnic diversity (OECD, 2011).[11]

33 The OECD (2011) suggests that time may see family relations reconfiguring on new foundations: "we may increasingly see networks of loosely connected family members from different marriages, partnerships and generations emerging, who devise fresh approaches to cohesion and solidarity. Intergenerational transfers could take on a new, different life, with important consequences for social services, welfare and fiscal management. Growing, better-integrated ethnic communities may help to instil their family values into mainstream society. And medical progress, such as in remote health monitoring, may help alleviate the strains on families of caring for elderly dependants."

34 Also, new potentially disruptive factors, such as Information and Communication Technologies are now firmly embedded in everyday life. Recent innovations in social networking give an idea of their power to revolutionise social interaction - it remains to be seen how these technologies will play out in the future in shaping people's involvement in education, work and, more generally, society (OECD, 2011).

35 ABS projections (2019) indicate that, in 2041, family structure will be quite similar to the way families live today:

(a) The Australian population will grow by 40% – from 24.2 to 34.0 million.

(b) Average household size will remain stable (2.6 people per household).

(c) Family Households will remain the most common household type in Australia (69% to 71% of all households).

(d) Couples with children will remain the most common family type (43% of all families), followed by couples without children (39%) and single parent families (13%), with very little change in the percentage of families in each family type over the next 25 years.

(e) Single-male-parent families are projected to increase the fastest of any family type.

(f) Nearly one-third (30% to 31%) of Australia's population are projected to live with their parents in 2041 (31% in 2016).

(g) People living with other relatives are projected to potentially increase for 50–59 year-olds, from 11% in 2016 to between 10% and 15% in 2041.

36 In Australia, there are diverse contexts and situations in which families interact and care for each other, such as grandparents caring for young children and young children being carers of family members (Baxter & Warren, 2016[12]; Warren & Edwards, 2017[13]). It is important to consider mental health in the context of families and the intergenerational

effects on mental health between grandparents, parents, children and siblings. Young carers have been identified as a priority group for policy makers. Estimates indicate that over 60% of young carers will be receiving income support in 10 years. AIFS research has shown that, in 2014, 9% of 14–15 year-olds had caring responsibilities for a household member, and approximately 20% of those were caring for a household member on a daily basis; and that being a young carer has a significant and substantial detrimental effect on school outcomes, particularly for those with a high burden of care (Warren & Edwards, 2017).

The influence of family environments to infant and child health outcomes

5 Using data from LSAC, Mullan and Higgins (2014) identified three broad family environments:

(a) **Cohesive:** average or above-average levels of parental warmth and parent–child shared activities, and below-average levels of hostile parenting and parental relationship conflict (most common).

(b) **Disengaged:** below-average levels of parental warmth and parent–child shared activities, and above-average levels of hostile parenting (a small group).

(c) **Enmeshed:** average levels of parental warmth, but higher than average levels of conflict in the relationship between parents (a relatively small group).

6 LSAC examined differences in children's developmental outcomes according to the above family types and found the following impacts:

(d) *Health Outcomes:* At age 2-3, (but not at older ages): Children in families tending toward enmeshment were more likely to be underweight than normal weight; and Children in families that were relatively more disengaged were more likely to have one or more injuries per year. No significant differences for children aged 2-3 in single parent households or older children (4-11)

(e) *Social and Emotional Wellbeing:* Children in families indicating disengagement had significantly lower levels of prosocial behaviour and higher levels of problem behaviour. Children in families indicating enmeshment had significantly lower levels of prosocial behaviour and higher levels of problem behaviour (not significant for children 4–5 and 10–11 years old in families with a parent living elsewhere).

(f) *Cognitive Development:* In families with two resident parents, children in families scoring relatively high on disengagement averaged lower Year 5 NAPLAN reading and numeracy scores.

(a) *Changes in the family environment:* Children in families with two resident parents whose family environment became more cohesive showed improved social and emotional wellbeing. Children whose family environments became relatively more problematic (less cohesive) exhibited increased social and emotional problems. In families with two resident parents, children gained higher NAPLAN reading scores if their family environment became relatively more cohesive.

37 These findings suggest policy may be more effective if it is attuned or sensitive to different family environments, targets behaviours rather than groups of people and recognises that families can both change for the better, and draw on their own prior (positive) experiences.

38 The results linking family environments to key child outcomes provide a clear impetus for a public health approach promoting safe and supportive family environments.

RESEARCH

Mechanisms and approaches that strengthen the role of research and evaluation in the design of policies and service reform

39 There is a sustained, high need in Australia for the creation, maintenance and dissemination of quality research on mental health. This evidence is crucial for high-level decision making and policy development. More specifically, there is a need for:

(a) A more informed and evidence-based understanding of the intergenerational effects of mental health.

(b) A greater focus on recognising, and adjusting for, the unique experiences and mental health needs of disadvantaged and marginalised children and families.

(c) Improvements to the employment and education participation and outcomes of children and families experiencing mental ill-health.

(d) A reconsideration of the current mental healthcare system and its accessibility for all Australians (including improvements regarding the mental health literacy of the general community, and accessibility and affordability of mental healthcare services, especially for disadvantaged Australians)

(e) Improved understanding of the intersections between gambling, mental ill-health, and other co-occurring issues (e.g. drug and alcohol misuse) to inform integrated prevention and harm reduction approaches

(f) Continued and expanded investment into Australian research with a focus on mental health.

40 Meeting these needs will require improvements in the following areas:

Research Capacity

41 Expansion of Australia's research capacity and expertise is an important step to addressing research/knowledge gaps and to improving mental health and wellbeing in Australia (AIFS, 2020)[14].

Longitudinal Studies

42 In Australia there are a number of longitudinal datasets that are used to examine issues related to mental health, including LSAC, BNLA, the Australian Longitudinal Study on Women's Health, TTM and HILDA. Overall, these data assets are under-utilised in relation to mental health research for numerous reasons, including: limited funding and resources to maximise use of the data, including promotion and user support, a lack of 'discoverability' of the data and absence of centralised infrastructure and limited utility; for example, due to a lack of data linkage. (AIFS, 2020).

Data Linkage

43 Prioritising data linkage with pertinent datasets would be a step towards addressing the under-utilisation of data in the mental health field in Australia. Health data linkage provides the opportunity to transform data (including census, survey and administrative sources) into more robust and comprehensive data assets that enable, enhance and inform research and policy development (AIFS, 2020).

44 While there have been notable developments in arrangements and procedures for data linkage in Australia, there is still room to implement more effective and efficient data linkage processes. Currently, cross-jurisdictional data linkage, in particular, requires protracted approval and data release processes and can be prohibitively expensive. While advances are being made towards establishing national data infrastructure (e.g. early developments in formulating linked Commonwealth and state/territory health data), the emerging federated data system is not yet operational. It is essential that the eventual national linkage system is accessible, efficient and cost-effective.

45 This can be achieved through the following mechanisms:

(a) a scoping activity to identify current projects related to mental health and suicide prevention;

(b) formalised processes to report on findings including data to one central agency;

(c) the establishment of a data management; and

(d) surveillance monitoring agency to oversee the proposed monitoring and reporting role.

46 Such a data linkage system would enable researchers to optimise the benefits of Australia's rich data assets. Linked datasets will afford opportunities to answer novel questions and explore issues of particular policy and governance concern to much greater specificity, drawing on administrative and self-reported data.

Co-design and Knowledge Translation

47 While the research currently available is undoubtedly important, a systematic analysis of the environmental, individual and family factors that affect the mental health of humanitarian migrants and their families is warranted to understand the particular needs of this group, and to inform approaches to supporting and enhancing their wellbeing. Co-design at the front end of study development and implementation (e.g. in consultation with humanitarian migrants and people with mental ill-health) is fundamental to creating good research; while providing resourcing for Knowledge Translation activities can maximise dissemination and the impact of research at the back end.

Specific Areas of Research / Knowledge Gaps

48 We would also support expanded research capacity in Australia to more comprehensively study intergenerational mental health effects within families. It is essential to better understand the experiences and needs of children and families where someone in their environment (i.e. other family members) is experiencing mental ill-health. Important groups to focus on include young carers, refugees and Indigenous communities (AIFS, 2020).

49 Understanding patterns of healthcare use, help seeking and the factors that affect these health behaviours is crucial to identifying knowledge gaps and addressing barriers to professional support. A significant body of research exists on mental healthcare use; however, there is still a paucity of knowledge about patterns of mental healthcare use and factors affecting service access over time. Longitudinal studies such as LSAC, BNLA and Ten to Men: The Australian Longitudinal Study on Male Health (TTM) collect data on healthcare use and mental health literacy among certain sub-populations. Data linkage (e.g. with MBS datasets) offers opportunities for exploring complex usage behaviours and translating these findings for policy makers, service providers and other key decision makers.

50 Despite the growing evidence base regarding the intersections between mental ill-health, gambling and other co-occurring issues, gambling-related harm is not currently mentioned in Victorian public health, mental health or suicide prevention plans; as noted in the VRGF's (2019) Submission to the Royal Commission into Victoria's Mental Health

System. To reduce the harms associated with the co-occurrence of gambling, related behaviours and mental health conditions, and contribute to appropriate policy responses, better understanding of the causes, interactions and long-term effects of such co-morbidities is required.

The role of government in supporting partnerships in research

51 An important avenue for increasing understanding of the key issues related to mental health is continued funding of research that investigates issues relevant to mental ill-health and the needs of diverse populations.

52 Longitudinal studies afford unique opportunities to detect, monitor and learn about diverse health issues at different ages and over the life course to create a robust evidence base for informing appropriate service delivery and policy improvements in response to dynamic social environments. These studies provide researchers with the ability to explore causal processes and relationships and changing patterns over time, which aids in identifying optimal 'window' periods for the timely implementation of prevention and intervention efforts.

53 There is a rich set of Australian longitudinal datasets, which can be used to detect, monitor and investigate mental health issues. These include studies undertaken by AIFS (e.g. LSAC, BNLA and TTM) and other projects targeting different sub-populations such as the Australian Longitudinal Study on Women's Health and the Household, Income and Labour Dynamics in Australia (HILDA) Survey.

54 The creation and maintenance of studies such as these requires secure, ongoing funding and resourcing investment to collect and monitor data quality, in addition to supporting stakeholders and data users to make the most of collected data. We therefore recommend funding to establish new cohorts of LSAC at regular intervals. As the majority of those who develop mental ill-health experience symptoms before the age of 25.

55 LSAC has been used to identify early childhood risk factors for self-harm and suicidality in teenage years, such as early childhood temperament, parent–child conflict and a poor sense of belonging at school (Daraganova, 2017)[15]. Further, childhood is punctuated by a range of significant life events and transitions, such as puberty and changing schools, that can be particularly challenging to navigate. Mental ill-health is not uncommon during these periods and a significant proportion of children experience on-going difficulties (Maguire & Yu, 2015; Mullan, 2014; Warren & Yu, 2016)[16]. To identify, prevent, manage

and treat such issues effectively and in a timely manner, longitudinal research is vital for informing our understanding of the development and progression of mental ill-health to identify early risk and protective factors, and to highlight what services and supports do – or do not – work for young children and their families.

56 Regular LSAC cohorts will allow for the inclusion of emerging generations and evolving communities in Australia. This is necessary for the in-depth investigation of specific trajectories and any changes over time that affect diverse sub-populations. It also allows us to study generational shifts that affect the development and wellbeing of all Australians. To improve our capability to detect and monitor issues related to mental health that affect certain sub-groups, we suggest expanding this recommendation to include other studies, such as BNLA and TTM.

57 In addition to continued and expanded investment in longitudinal studies, we would welcome governmental support for other research approaches to improve our understanding of – and address – mental ill-health and poor wellbeing in Australia. This could include the mapping and evaluation of existing services for people with mental ill-health, qualitative research to enhance our understanding of barriers and enablers to professional support for mental health, and the piloting of new approaches developed in consideration of the best available evidence (AIFS, 2020).

Continual learning for workforces about emergent research and evidence and translation into practice

58 Knowledge translation is the transfer of research into policy and practice that minimises the gap between knowledge and action. AIFS uses an integrated knowledge translation approach to ensure that our work meets the needs of our policy and practice partners and funders by building strong relationships between our researchers, stakeholders and decision-makers. This is an inbuilt, fundamental approach to our work to identify policy problems, research gaps, or practice challenges. We turn these into questions and work collaboratively with our stakeholders to identify ways in which we might be able to answer these questions. These become our research methods which are implemented alongside our stakeholders to ensure that our work has relevance beyond a research process. To operationalise this, AIFS holds strong capabilities in knowledge translation, impact and strategic communications.

59 At AIFS, knowledge translation is delivered through the KTI Lab. The role of the Lab is to build the capability of AIFS' research teams to create and communicate knowledge to accelerate positive outcomes for families. The Lab also tests innovative ideas about how to better translate our knowledge and delivers funded projects that build the capability of

service providers and policy makers so that they can better meet the needs of families and children. We have learnt that growing and enhancing the capability of researchers in knowledge translation and impact is paramount to policy and practice relevant research and increasing evidence-informed decision making. We have also learnt that embedding human-centred design principles and activities into research study design can improve the quality and relevance of our research findings.

60 AIFS manages the Child Family Community Australia **(CFCA)** information exchange and Families and Children Expert Panel projects. These projects are funded by the Department of Social Services to build the capability of the child, family and welfare sector to improve evidence-informed practice. These projects provide resources and support for professionals working in the sector via online publications, including papers, resource sheets, practice guides, webinars, newsletters and short articles as well as tailored one-on-one support for individual service provides who are seeking advice about how to plan and evaluate their programs. These publications draw on evidence from the research and practice domains to guide policy and practice decisions. Priorities are driven by stakeholder feedback, sourced through surveys, interviews and online polling. This ensures relevant and timely support for the sector to build capability in evidence-informed decision making through the uptake and use of research. In 2019, AIFS conducted a scoping study to investigate the user experiences of the two projects. This study used a human-centred design approach to reconsider how we could improve ways of translating and communicating evidence and creative ways of capability building.

61 Insights from the sector include:

(a) practice wisdom is valued as much as research evidence in decision-making;

(b) evidence-based programs can be seen as too rigid;

(c) existing collaborations and networks in the sector are considered as a key structure for practitioners to source, access and use evidence;

(d) exchange strategies to support the use of evidence are preferred over more traditional push and pull strategies;

(e) the more localised and tailored the evidence is to the practitioner, the more likely they are to use it; and

(f) practitioners value up-to-date free to access research.

OPPORTUNITIES FOR EARLY INTERVENTION

Identifying infants and children living with, or at risk of developing, mental illness?

62 A key challenge for the Australian Government is a service system that leads to early identification of children and families who may be at risk of mental health problems before these problems escalate.

63 Recent AIFS research using linked LSAC and Medicare data allowed in-depth investigation of health service use among LSAC children and their families (Warren, Quinn and Daraganova, 2020)[17]. The results showed that children at increased risk of social-emotional problems had higher rates of contact with various health and support service providers, including psychiatric and behavioural therapy services, general practitioners **(GPs),** paediatricians, speech therapists, and hospital outpatient and emergency services. These findings highlight the need for adequate knowledge among any frontline service providers engaging with families to identify early symptoms of adverse social-emotional outcomes among children. They also point to a need for robust connectivity and referral mechanisms between health and support services throughout Australia.

64 In summary, Warren, Quinn and Daraganova, 2020 found that:

(a) GPs were the most commonly accessed health service type at every age. This highlights the crucial role that GPs occupy in meeting the immediate needs of Australian children and families and as gatekeepers to the wider health care system; and also the importance of GPs being sufficiently knowledgeable about the unique and dynamic needs of children, and appropriate referral mechanisms to services that address specific psychosocial and health concerns.

(b) Non-health care professionals (e.g., juvenile justice authorities, teachers) are also integral to engaging at risk children with suitable services, given their regular contact with such children. Our findings demonstrate that the odds of accessing a School Guidance Counsellor are higher among children at elevated risk of experiencing social emotional problems.

(c) Families with children at risk of social-emotional had a higher rate of contact with mental health support services, and this may be an opportunity for identifying and assisting with social-emotional outcomes for children – intervening early before issues become more serious. For example, a relationship counsellor may provide support or advice for dealing with their child's emotional issues or behavioural problems, or recommend appropriate services for the child.

(d) At the family level, use of counselling and other mental health support services (Parenting Education, Counselling (Relationship Counselling and Adult Mental Health Services, and Family Support Groups, was more common in families where the study child had an increased risk of social-emotional problems. These

> results suggest that families with children at risk of social-emotional problems generally have a higher rate of contact with mental health support services, and this may be an opportunity for identifying and assisting with social-emotional outcomes for children – intervening early before issues become more serious.

65 However, the percentage of parents who reported that they had needed health services for their child in the previous 12 months, but were not able to get them, was significantly higher among parents whose children had elevated levels of risk of social-emotional problems; and there were differences in service access among children in low-income households and in non-metropolitan areas of the country.

66 In recognition of the serious impacts of child mental health difficulties, and the fact that children who experience or are at risk of experiencing mental health difficulties often go unrecognised, lack access to adequate assessment, and they and their families often don't access appropriate support services, the National Workforce Centre for Child Mental Health – led by Emerging Minds, was launched in late 2017. The Centre assists professionals and organisations who work with children aged 0–12 years and their parents to more effectively help children at risk of mental health conditions. The National Workforce Centre aims to build the capacity of organisations and professionals who work with children and families to identify, assess and support children at risk of mental health conditions.

67 AIFS research using LSAC data (Warren, 2018b) has shown that while most parents do attend the first few maternal and child health nurse visits, attendance rates drop substantially over the first 3 years of childhood. In Victoria, for example, participation rates in 2015–16 dropped from 99% for the initial home visit to 95% when children were two weeks old to 63% for 3.5 year-olds (Department of Education, 2017). Still, maternal and child health nurses are another point of contact with the health service system and an opportunity to identify early symptoms of adverse social-emotional outcomes among young children and their parents.

68 AIFS welcomes the recommendation by the Productivity Commission (2019) to extend existing physical development checks on children aged 0–3 to include social and emotional wellbeing. We also support the recommendation to expand information programs for parents on children's social and emotional development. Based on the evidence, we think these interventions have great potential to improve children's social-emotional wellbeing and prevent mental health illness later in life by considering the family context (AIFS, 2020).

69 AIFS is currently working with the Northern Territory Department of Education on an evaluation plan for the Families as First Teachers **(FaFT)** program - an early learning and family support program for remote Indigenous families. The aim of FaFT is to improve

developmental outcomes for remote Indigenous children by working with families and children prior to school entry. The FaFT program involves early learning activities with an emphasis both on child and parent/carer learning and include quality child-centred early learning experiences; facilitated adult-child interactions; adult learning opportunities; nutrition, health and hygiene and linking families with support services and agencies.

Improving support for infants and children who are at risk of developing mental illness

70 AIFS research highlights the need to understand the pathways of intergenerational mental health, and underline the important interconnectivity between socio-demographic, economic, social, physical, biological and psychological factors that influence mental health and wellbeing outcomes. It is also important to understand how, when and where people engage with mental healthcare and what types of barriers impede access to professional support in Australia.

71 Our research at AIFS repeatedly demonstrates the multifaceted effects that disadvantage, especially when cumulative, can have on a range of outcomes, including mental health. For example, LSAC findings indicated that Aboriginal and Torres Strait Islander children experience additional risks due to adverse educational, occupational, social and health outcomes experienced throughout childhood (Baxter, 2013[18]; Forrest & Edwards, 2015[19]; Priest, Baxter, & Hayes, 2012[20]). The unique needs of such groups should be considered when designing, implementing and modifying mental health policies and programs.

72 For some communities, strong religious or spiritual beliefs about mental health may prevent them from seeking professional help (May et al., 2014; Slewa-Younan et al., 2014)[21]. Increased awareness of mental health conditions and effective treatments among migrant families and communities, as well as improved access to culturally appropriate services, is therefore required.

73 Low levels of mental health literacy among humanitarian migrants (May, Rapee, Coello, Momartin, & Aroche, 2014; Slewa-Younan et al., 2014), together with a high incidence of mental health problems among this group, highlights scope for improvement. The latest wave of BNLA shows that 38% of respondents who met the criteria for likely PTSD[22] and 26% of those with probable serious mental illness[23] reported they 'did not need help for emotional problems'. Help seeking for emotional problems is relatively low among humanitarian migrants. In the BNLA sample (at Wave 5), only 51% of those meeting the

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[22] PTSD symptoms were assessed with the PTSD-8, which is derived from the Harvard Trauma Questionnaire (HTQ).
[23] Measured with the Kessler Screening Scale for Psychological Distress (K6). Respondents with high levels of distress (scores of 19 or above in a 6 to 30 scale) were classified as likely to have a serious mental illness

criteria for PTSD and 59% of those who were likely to have a serious mental illness received help for emotional problems in the last 12 months (Slewa-Younan, Rioseco, Guajardo, & Mond, 2019[24]). Language barriers are likely to play an important role here - after most BNLA respondents had lived in Australia for four years or longer, one-third reported being unable to read English well, and 18% reported being unable to read English at all.

74 Healthcare use among those from disadvantaged backgrounds is generally low. Analyses of LSAC data have shown that there are significant differences in children's use of healthcare services depending on household income (Warren, 2018b). For example, in early childhood and also in the primary school years, children in families in the top half of the equivalised income distribution were more likely to have seen a GP in the previous 12 months than those in households in the lowest 25% of equivalised household income. In the primary school years and in adolescence, the likelihood of having been to a specialist was also higher among those from families in the top quarter of equivalised household income, than those in the lowest quarter. Further, compared to families in the lowest quartile of equivalised household income, the odds of reporting difficulties accessing health services were significantly lower for those in the top half of the income distribution. This difference was especially evident for adolescents.

75 For children of school age, school transitions can be very challenging and this can affect their engagement with school. LSAC data have shown that children who report experiencing social-emotional difficulties before or during the transition from primary to secondary school are significantly more likely to also experience problems in secondary school (Maguire & Yu, 2015). LSAC data have also indicated that substantial numbers (40%) of children aged 10–11 years felt 'fairly worried' or 'very worried' about starting high school (Vassallo & Swami, 2019)[25]. If not addressed, these worries may exacerbate mental health problems and lead to disengagement from school.

76 In addition to expanding the pathways for identifying and supporting those with mental health difficulties, it is important to preventatively foster resilience in adolescents; for example, by facilitating social connectedness and reducing loneliness. Research using LSAC data showed that resilience was higher among adolescents who had at least one close friend that they could communicate with or trust in relation to problems and also among those who had family support or who had a greater sense of belonging at their school (Evans-Whipp & Gasser, 2019a.) Resilience-building programs could therefore include components to improve social skills and school engagement.

77 To assist these efforts, it is recommended that holistic preventative approaches be considered that take into account physical activity, diet and sleep, given that these factors have also been shown to be related to mental health and wellbeing among young people (LSAC 2019b[26]; Gasser, Evans-Whipp, & Terhaag, 2019[27]). For example, in LSAC, insufficient sleep (i.e. not meeting recommended sleep guidelines) was associated with symptoms of anxiety and depression, as well as unhappiness at ages 12–17 (Evans-Whipp & Gasser, 2019b). Diversified approaches to fostering wellbeing and resilience might result in better outcomes and take pressure off already over-burdened mental healthcare systems.

Assistance when parents separate

78 With parental separation becoming increasingly common, a wide variety of supports and services are vital in supporting children and families to cope with these changes, helping parents to cope with the emotional and economic changes, and helping children to process their thoughts in relation to parenting arrangements, and develop confidence in their ability to communicate their views. Research using LSAC (Qu & Weston, 2014[28]) shows that children tended to be aware of their parent's separation and were able to report on how they felt about it. Most wanted to have a say in their living arrangements: almost half believed that they did have a say, and around two in five both wanted a say and believed that they had been given this opportunity. These findings are a reminder to separated parents of the difficulties their children can face when the parents themselves remain locked in acrimonious conflict.

79 AIFS research using data from the Survey of Recently Separated Parents (SRSP) (Kaspiew et. al, 2015) has shown that while most parents provided positive reports of their child's wellbeing and physical health after separation, parents reports of their child's wellbeing were noticeably less favourable where family violence had occurred, especially where the child had been exposed to violence or emotional abuse.

80 The 2014 Survey of Recently Separated Parents (Kaspiew et. al, 2015) showed that around 1 in 6 separated parents reported holding safety concerns for themselves and/or their children because of ongoing contact with the other parent, with some parents reporting they tried to stop or limit contact because of these concerns, which included mental health issues. It found that:

(a) Emotional abuse was also commonly reported by separated parents, both before/during separation (67% of mothers, 57% of fathers) and post-separation (61% of mothers and 55% of fathers).

(b) Mothers also reported experiencing physical violence in greater proportions than fathers before/during separation (23% for mothers, 16% for fathers).

(c) Mothers reported that the behaviour of the focus parent was affecting their mental health, eating and sleeping habits, and household tasks, as well as contributing to feelings of lower confidence and security, and feelings of intimidation, in greater proportions than that of fathers.

81 The Domestic and Family Violence and Parenting project (Kaspiew et. al, 2017[29]) highlighted the ongoing physical and emotional consequences of children being exposed to domestic and family violence, including high levels of stress and anxiety, and impaired social, emotional and educational functioning.

82 Interviews with children and young people in separated families (Carson et al, 2018[30]) indicated that most children wanted parents to listen more to their views in relation to parenting arrangements and separation and to communicate with them so that they could understand more about what was going on in the post-separation context. The majority of young participants said that they had limited say or that their views had limited to no impact on the decision-making process about parenting arrangements. When interacting with family law professionals, some participants felt that their views were not sufficiently acknowledged or listened to. Some children and young people also described their distress or disappointment at not being believed by family law system professionals in relation to safety concerns. This reinforces the need for the development of service models designed to specifically address the multiple needs of families affected by concerns relating to family violence/abuse, safety concerns, conflicted and/ or fearful relationships, and their frequent correlates: mental ill health and/or substance misuse (AIFS 2014).

83 A wide variety of supports and services are vital in supporting children and young people to cope with changes during the time of their parents' separation, process their thoughts in relation to parenting arrangements, and develop confidence in their ability to communicate their views.

84 Interviews with children and young people whose parents had separated (Carson et al, 2018) showed that they had relied on support from their family and friends, as well as formal services such as mental health services, which were accessed by nearly two-thirds of participants. Young people in the study also spoke about the potential barriers to

getting help, such as the difficulties in finding or accessing services, or a lack of awareness about services.

85 A lack of awareness of existing family law system services and mental health services among children and young people emerged as a primary practical challenge, as well as referral processes and waiting lists to access services once located. Participants also identified the following as key components of effective engagement by service professionals:

(a) effective listening;

(b) providing them with a space to speak;

(c) acting protectively and addressing and responding to their concerns;

(d) building a relationship of trust (which includes qualities such as patience;

(e) empathy and respect providing information; and

(f) keeping children and young people informed about issues affecting them.

Integration or coordination of mental health and other social services for better overall health outcomes

86 Addressing the issues faced by families in accessing mental health and other support services is challenging because of the fragmentation of service delivery and the multiple layers in service systems. Despite the challenges of mental health assessment and response within the family relationship services sector, there is an undoubtable public health opportunity within the sector for mental illness prevention and early intervention.

87 In Australia we need a system of support for families that can provide a little or a lot - depending on need - using evidence of what works to scale up effective programs. This kind of universal proportionate system needs to be interdisciplinary (across health, education and social services) and innovative (using flexible modes of delivery including new technologies), and designed according to the needs of kids and families, not the requirements of professionals or funders. This is not necessarily about spending more money, but rather shaping existing investments to achieve better results (Hollonds, 2016)[31].

88 As a community we sometimes fear interfering in the "privacy" of family life or being perceived to be "blaming" parents. However, support for effective parenting is about empowering parents, not blaming them. By shaping existing investments to build an evidence-based service system, we have an opportunity to empower parents to be the best mum or dad they can be. The research indicates that these earlier investments are

more economically efficient and more effective. And research indicates that these earlier investments are likely to be the best investment in future human capital that we can make (Hollonds, 2016).

89 Effective programs need to be accessible and delivered in a systematic way, on scaffolding that connects the critical interdependencies across policy domains and jurisdictions. We need system reform to enable smart investment in human capability development, drawing on knowledge from across the disciplines (Hollonds, 2016). Quotes from current and previous directors of AIFS highlight the importance of coordinating services and supports for families:

> "*One of the big challenges families face is the need for better co-ordinated and integrated services and supports, especially for children entrenched in "complex" families spanning health and social services terrain. We're making real progress in integrating aspects of health care but it's the wraparound of all the other social services that's still needed.*" (Alan Hayes, AIFS, 2018).
>
> "*Another emerging issue for families is the complexity of the problems they face while services remain largely siloed around, for example, drug and alcohol issues or family violence - it would be better if the first worker did the running around to help them, instead of expecting clients in distress to actually manage the complexity of the service system*". (Daryl Higgins, AIFS, 2018).
>
> "*There is a need to shift attention from just "policing" to the "prevention" of complex social problems - such as domestic and family violence, substance abuse issues and to the systems and supports needed to keep children safe. This new thinking builds on evidence of the social and economic benefits of investment in prevention and early intervention, and the higher costs of reacting too late.*" (Anne Hollonds, 2016).

Appropriate and accessible services for vulnerable groups

90 Given high levels of stigma experienced by CALD communities and a high prevalence of mental illness among humanitarian migrants, online treatments could potentially increase the use of services among disadvantaged and marginalised groups such as these. As outlined in the Productivity Commission's Draft Report, supported online treatments have helped thousands of Australians improve their mental wellbeing (AIFS, 2020)

91 There is a need for online treatments that are accessible to a diverse audience (e.g. by eliminating language and cultural barriers), and for additional research to identify the specific mental health needs, including online mental health treatment, of a new cohort of recent humanitarian migrants to Australia. (AIFS, 2020). BNLA findings indicated that the majority of humanitarian migrants have access to the internet and over half of

respondents with access to the internet went online on a daily basis. But despite high access to the internet, their uptake of online services is low. Any online treatment would therefore require extensive development in terms of ensuring the use of suitable language and cultural appropriateness. In addition to language and cultural barriers, work needs to be done with CALD communities to improve mental health literacy and their navigation of Australia's healthcare systems (AIFS, 2020).

Family and carer engagement in the delivery of effective care to infants and children

92 Family and carer engagement are critical for the delivery of effective care for infants and children. Families are where the most important prevention and early intervention occurs. AIFS has conducted extensive research into the impact of parenting practices on children's developmental outcomes.

93 Recent AIFS research commissioned by Emerging Minds: National Workforce Centre for Child Mental Health (NWCCMH) (Rioseco et al, 2020[32]) examined children's social-emotional adjustment using LSAC data, with a particular focus on mothers' parenting behaviours, parents' mental health and parents' health behaviours and showed that:

(a) Mothers' positive parenting behaviours including warmth, consistency and low frequency of hostile parenting had a significant positive effect on children's social-emotional outcomes, with the largest effect observed for conduct problems.

(b) Of all parenting behaviours, mother's hostile parenting was associated with the largest differences in children's social-emotional outcomes at all ages.

(c) Children whose mothers experienced moderate or high levels of psychological distress were more likely to be at an increased risk of social-emotional difficulties at every age.

(d) Even after taking into account later psychological distress experienced by mothers, the early experience of mental health problems in pregnancy showed a small but significant effect on the level of children's total difficulties at age 4-5.

(e) Increases in the frequency of warm and consistent parenting behaviours at later stages, as well as a reduction in the frequency of hostile parenting behaviours, led to better social-emotional outcomes.

94 These findings reinforce the importance of engagement with health professionals as a key opportunity to identify both parents and children who are experiencing poor mental health. Health professionals and other service providers also have an important role to play in supporting parents to achieve and maintain good mental health, and to implement warm and consistent parenting practices, especially during difficult circumstances. To

support parents in both their own wellbeing and in their parenting, health professionals and other service providers need to be able to both identify when parents and children are at risk of poor mental health and be equipped to provide appropriate referrals and/or supports. This means individual practitioners need the knowledge to do this and the systems they work in need to be both prevention and early intervention focused and to work in integrated ways.

95 Similar indicators of intergenerational mental health effects have been found using data from BNLA to explore the effects of refugee parents' mental health and behaviours on their children's wellbeing in the first years after arriving in Australia. Specifically, the mental health and parenting behaviours of refugee parents (Bryant et al., 2018)[33], and their prolonged grief (Bryant et al., 2019)[34], directly affected their children's wellbeing. These findings again demonstrate the universal pathways in which mental health difficulties can be passed through generations.

96 Other evidence also suggests that parents' mental health and wellbeing and behaviours affect children's wellbeing, and that there can be differential effects for mothers and fathers. For example, parent drinking and adolescent drinking are strongly related (Homel & Warren, 2017)[35]. Specifically, for resident mothers and fathers who were current drinkers, consuming alcohol at a risky level was associated with increased rates of adolescent drinking.

97 In terms of family and carer engagement, it is important that support be "family-centred", that is, supporting the family and the child. We know that domestic and family violence, parental mental health difficulties and child abuse and neglect are the main contributors to poor mental health for children. Early intervention to support parents and children, and families as a whole, is one of the most important steps in improving the mental health of Australians into the future. The Child Family Community Australia **(CFCA)** at AIFS offers a free research and information helpdesk for child, family and community welfare practitioners, service providers, researchers and policy makers, with the aim of being a key source of quality, evidence-based information, resources and interactive support for professionals in the child, family and community welfare sectors.

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print name Anne Hollonds

date 25 August 2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT AH-1

This is the attachment marked 'AH-1' referred to in the witness statement of Anne Hollonds dated 20 August 2020.

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ATTACHMENT AH-2

This is the attachment marked 'AH-2' referred to in the witness statement of Anne Hollonds dated 20 August 2020.

Name:	Anne Hollonds
Present position:	Director, Australian Institute of Family Studies *Commencing as National Children's Commissioner in Nov 2020*
Educational and professional qualifications:	Master of Business Administration, Macquarie University, 2005 Certificate IV Quality Management, Australian Quality Council, 1997 Psychologist Registration, AHPRA, 1992 Bachelor of Social Studies, University of Sydney, 1984 Bachelor of Arts (Psychology), Macquarie University, 1979
Relevant experience:	2015-present: Director, Australian Institute of Family Studies 2014-2015: Director of Development Partnerships, Our Watch 2011-2014: Chief Executive Officer, The Benevolent Society 1998-2011: Chief Executive Officer, Relationships Australia NSW 1995-1998: Deputy CEO/Director of Services, Relationships Australia 1992-1995: Regional Manager/Clinical Supervisor/Lecturer, Marriage Guidance NSW 1989-1992: Child/Family Therapist, Marriage Guidance NSW (P/T) 1985-1989: Child/Family Counsellor, Community Health NSW 1980-1985: Child Protection Social Worker, NSW Department of Community Services