Grace Homestead Recovery Centre

During the past two decades, the only rehabilitation centre in Queensland which allowed mothers to bring their children to treatment, Fresh Hope, closed in early 2018 (Janetzki, 2018; Morrisey, 2018), and only two more, (including Grace Homestead), have since opened. Referral sources for mothers include Child Protection services, DV Connect, Drug Arm, Sisters Inside, Courts and Prisons, family members and mothers enquiring to the centre directly. Grace Homestead remains the only long-term residential treatment program for parenting mothers in Queensland.

Our mission is to eliminate the treatment barriers for mothers, change the narrative, keep families together, restore lives by empowering independence and reducing the intergenerational impact of substance use and Domestic Violence on individuals, families and communities. Grounded in evidence-based methodologies and delivered by trained clinicians within a trauma-informed practice framework, the Grace Homestead program is holistic, and includes a blend of group and individual therapy, case management, parent training, and rediscovering living skills across a twelve-month program.

100% of women who remained abstinent have acquired work or study and continue to care for their children.

1. Abstract: Pilot Study

Operating from August 2018 to January 2022, Grace Homestead's trauma-informed treatment outcomes are proof-of-concept for the parent-child model of recovery. The aim of the current research was to identify the effectiveness of keeping mothers and children together during residential rehabilitation, based on outcomes of a two-year pilot study. Data was collected to monitor craving levels, mental health ratings including anxiety and depression, trauma symptom ratings, parent stress, parent-child attachment, and social and emotional development of the child. It was hypothesised that long-term residential parent-child treatment would be effective in treating SUD's (6+ months abstinence post-graduation), improving parenting skills, improving parent-child bond, managing distress, and providing skills to enter employment/study.

2. Parent-Child Model: International Research

Outcomes for residential and parent-child residential treatment settings indicate effective treatment outcomes for parenting women who undertake rehabilitation in parent-child SUD treatment centres. Connors, Whiteside, Bradley and Crone (2001) examined outcomes of 72 families who participated in the Arkansas CARES mother-child rehabilitation program. They found that graduates of the program were significantly more likely to remain abstinent, with an 85% recovery rate, compared to non-graduates who had a 50% recovery rate (p = <0.01). Exodus Rehabilitation Centre in Los Angeles provides a 12 to 24-month program with an 81.2% completion rate (USA national average 25%), and family reunification rates of 85% with an average of 646 days in treatment (USA national average is 90 days) (Einbinder, 2010; Icenhower, 2010). Blakey (2012) reported that 50% of women retained custody of their children following a parent-child residential intervention. Another positive benefit of parent-child residential intervention is a higher level of motivation for

program engagement and program completion when a mother has her children in her care (Baird, 2008; Villegas et al., 2019; Sword et al., 2009; Williams et al., 2017; Wong, 2006), which is significant given that length of stay and program completion is predictive of a sustainable recovery (Conners et al., 2006; Greenfield et al., 2007; Mendez, 2008; Prendergast et al., 2011; Villegas et al., 2019). Choi, Huang and Ryan (2012) found that the mothers in residential treatment who were more likely to make treatment progress and not relapse were those who were engaged in the program and were internally motivated.

While the number of women seeking treatment has increased (Greenfield et al. 2007; Schori, Sapir & Lawental, 2012), globally, the number of women presenting for treatment is low and only 1 in 5 are mothers (Fernandez-Montalvo et al., 2017). Not only are women less likely to enter treatment compared to men (Greenfield et al., 2007) they frequently only do so to improve the likelihood of retaining custody or reunifying with their children (Grella, Hser & Huang, 2006; Hills et al., 2002; Traube et al., 2015) or, when ordered to by the courts, child protection systems, or mental health services (Allen, Flaherty & Ely, 2010; Grella, Hser & Huang, 2006; Jenner et al., 2014; Pagliaro & Pagliaro, 2017; Rivera, Dueker & Amaro, 2021; Traube et al., 2015; Villegas et al., 2019). The most commonly cited reason explaining this phenomenon is that women face additional help-seeking barriers than men (Fernadez-Montalvo et al., 2017; Fernández-Montalvo & López-Goñi, 2020; Jenner et al., 2014; Schori, Sapir & Lawental, 2012) and have lower levels of education and employment (Hser et al., 2011; Messina et al., 2006) contributing to substance-using women feeling stigmatised and marginalised.

Treatment models that encompass AOD and the physical and psychological trauma of DFV for mothers and their children will help break the cycle of intergenerational consequences for families and communities. While the research is not categorical in terms of whether

women achieve better outcomes in gender-specific centres than in mixed-gender centres, it is clear that some women either prefer or will only consider women-only centres (Green, 2006). A review of the research establishes that not only do women respond better to residential rehabilitation than in outpatient programs (Greenfield et al., 2007) specifically designed centres are highly desirable to women as they feel safer removed from male expectations and perceptions and are therefore more likely to remain in treatment (Prendergast et al., 2011). Other benefits are that women value actively assisting and contributing positively to each others recovery journey (d'Arlach et al., 2008; Fallot & Harris, 2002; Greenfield & Grella, 2009; Kruk & Sandberg, 2013; Nelson-Zlupko et al., 1995; Prendergast et al., 2011; Rhodes et al., 2018; Rossiter et al., 2013; Schori, Sapir & Lawental, 2012; Sword et al., 2009; Werner et al., 2007). Legler et al. (2015) claimed that the bonds that the mothers developed within women-only recovery centres may contribute to a reduced likelihood of substance-use relapse.

Barriers to Treatment

There are a range of complex physical, social, parenting and psychological barriers that contribute to the reasons why women avoid treatment. For example, researchers have noted that a woman's substance-using network could be influential in her choice to not seek treatment (Martin, 2011; Tuchman, 2015). However, research has established that fear of losing their children is the foremost barrier to treatment with up to 75% of women reporting they were not prepared to seek any form of support or treatment as it may alert child protection services to their substance use (Elms, Link, Newman, & Brogly, 2018). Another significant barrier is fear they will be perceived as unworthy or unfit mothers (Martin, 2011). Fear is a pervasive and significant barrier to women entering residential treatment. Research demonstrates that they feared reprisal from intimate partners, the

content of treatment programs, that the treatment would be unsuccessful, that clinicians would not empathise with gender-specific issues and that the facility would not be child friendly (Elms et al., 2018; Lal et al., 2015). Additional barriers are the lack of facilities that accept children or pregnant women, lack of comorbid or gender-appropriate treatment models, economic costs, opposition of family and friends, mistrust of service providers, marginalisation caused by prostitution and entrenched stigma associated with substance use (Canaway & Merkes, 2010; Elms et al., 2018; Kruk & Sandberg, 2013; Lal et al., 2015; Marel et al., 2016).

3. Parent-Child Model: Trauma-Informed Care

Adjunct Professor Warwick Middleton stated that failure to acknowledge the reality of trauma and abuse in the lives of children, and the long-term impact this can have in the lives of adults, is one of the most significant clinical and moral deficits of current mental health approaches. Trauma in the early year's shapes brain and psychological development, sets up vulnerability to stress and to a range of mental health problems (Kezelman & Stavropoulos, 2012). Middleton states that despite the wealth of evidence delineating the kinds and extent of abuses of children and that even though the mental health problems experienced by abuse victims have been accurately and repeatedly documented, and that their negative well-being is completely understandable in the context of the duration and sorts of trauma they experienced, "… our mental health and child safety systems can rebrand or invalidate to an extent that maintains collective silence" (as cited in Kezelman & Stavropoulos, 2012, p. x).

Trauma-Informed Care: It's evidence informed & rights-based

Trauma-informed care (TIC) is based on the premise of "What has happened to you?" rather than the common paradigm when dealing with substance use, "What is wrong with

you?". This means that a non-stigmatising and marginalising approach to accessing substance-use treatment options is essential to preventing ongoing harm to the mother and negative intergenerational impacts for their children.

Australian researchers have advanced the world's understanding of trauma-informed care and practice (TICP). Trauma theory is evidence-based and practice-informed, within the sociopolitical context of human well-being that helps clarify the way individuals and families have responded to trauma. Trauma can disrupt how children bond with their parents and siblings and can interfere with their developmental progress. TICP is a means of discovering the origins of trauma and the individual, and extended family factors that contributed to or caused the traumatising events. The treatment focuses on improving family connections that will alter patterns of behaviour and moderate symptoms and thus interrupt the cycle of trauma (Ewald et al., 2019; Kezelman & Stavropoulos, 2012).

Trauma: It's Intergenerational

The connectedness of trauma based in childhood abuse and consequential intergenerational outcomes such as parenting stress, child maltreatment, poverty, DFV and homelessness is well established. Maltreated and abused children grow up in chaotic environments dominated by unpredictable adults. They experience uncertainty, fear of violence from adults, sexual assault, sibling violence and adult to adult violence most often occurring within the privacy of the family home (Marshall, Ey & Goddard, 2019).

Middleton describes their world as one where they "... never felt safe growing up, were endlessly entangled in the double-bind communication patterns of their families, and despite fearing abandonment, had learned how risky it was to trust. Despite ongoing abuse, they were instinctually driven to maintain some form of attachment, frequently to the very people most responsible for abusing them" (Kezelman & Stavropoulos, 2012, p.

x). Further, Collins, Strieder, Depanfilis, Tabor, Clarkson, Linde and Greenberg (2011) described the lives and scale of adversities confronting some children and their families as ones they believe are "... filled with misery and hopelessness" (p. 32).

Treatment: Parenting Skills

Changing outcomes for parenting women with SUDs requires a new approach to parenting skills provision. Scientific evidence suggests that there is significant overlap in the neural circuitry and brain pathways involved in substance use and parenting (Suchman et al., 2017). Further, as substance-using women move into the childbearing age range and parenthood, they simultaneously experience heightened distress and diminished reward. Consequently, it is crucial that parenting training supports women from a dependency's perspective. That is, that women learn stress-reward systems relevant to parenting as a means of dependency treatment and relapse prevention (Suchman et al., 2017). Kilty and Dej (2012) emphasise the need for substance using women to form new self-identities that are neither hierarchical or binary and that do not view substance use treatment as redemptive. In other words, using motherhood as an 'anchor for change' can be counterproductive especially if women relapse and as it then becomes an impediment to further treatment attempts. The solution is policies that prioritise the elimination of the stigma and marginalisation associated with substance use. Women want to be 'normal', to have their children grow up in safe and productive environments (Champine et al., 2018; Kruk & Sandberg, 2013).

Women: Parent-Child Model Benefits

Lyons-Ruth et al. (2006) emphasises that women who survived trauma, either in childhood or adulthood must be provided opportunities to be 'heard' in ways that validated their experiences to ensure progression to recovery. Recovery occurs when treatment processes address the causes of underlying dissociative behaviours rather than silencing and shutting

out traumatised women by focusing on her parenting skills alone. Validation of their own trauma allows mothers to 'hear' their children and enter a "collaborative dialogue" that effectively prevents her from causing trauma to her children. This treatment emphasis causes a mother's reflective functioning to improve engagement and greater communication with her children (Rostad & Whitaker, 2016).

Substance-using women commonly feel stigmatised and marginalised by socially constructed concepts of motherhood as their substance use and criminality are potent social indicators they have failed as mothers. The concerns of courts and child protection services for the safety of her children and their substance using mother's identity, are both anchored in 'good mother' 'bad mother' discourses. However, these discourses do not account for the harmful implications of political, structural and socio-economic disadvantages and traumatising childhood experiences endured by substance-using women (Kilty & Dej, 2012).

Best and Lubman (2012) assert that for recovery from SUDs to begin, participants require "a safe place free from threat, freedom from acute physical and psychiatric distress, … freedom to make choices and a clear sense of self determination …" (p. 595). Women are motivated to enter rehabs when the experience includes participating in treatment with women and helping them in their recovery, also, the great majority of women wanted rurally based facilities to experience quiet and nature. Significantly, women emphasised the need for rehabs to be in areas where the distractions of suburbia or inner-city life were easily avoided (Kruk & Sandberg, 2013).

Children: Parent-Child Model Benefits

Children living with parents who have a substance use disorder often have poorer developmental outcomes, are more likely to be neglected or otherwise abused, and more

likely to experience social disadvantage (Dawe et al.2008). Capacity for parenting is often extremely limited and intervention via Child Safety Services can result in the child being placed in foster care while the parent seeks help or continues to struggle with addiction. In addition to substance use rehabilitation and mental health therapeutic intervention, the Grace Homestead program provides mothers with parenting training to assist them to develop skills to become effective parents.

Where a need has been identified, Grace Homestead offers therapeutic intervention to children, however, frequently the provision of a safe, caring, and consistent environment is enough to reverse the detrimental effects of living with a parent who has a substance use and mental health disorder.

Treatment Outcomes: Parent-Child Model Benefits

Sustained recovery for parenting women is achievable and evidence based. Research demonstrates that trauma-informed empowerment models are particularly appropriate for women as they usually have higher levels of trauma-related stress, depression, anxiety and more severe mental illness than men due to violence and childhood sexual abuse (Fallot & Harris, 2002; Nelson-Zlupko et al., 1995; Rhodes et al., 2018).

72% of Grace Homestead's residents have remained substance free and continue to parent their children up to 2 years post graduation.

4. Bidirectional nature of DFV & SUDs

Both AOD and Domestic and Family Violence (DFV) research demonstrates that more frequent DFV victimisations are correlated to a greater probability of substance use for women and a constellation of child maltreatment, socio-economic disadvantage, social isolation and mental health and psychological problems (Nicholas et al., 2012). Substance

use disorders are complex and frequently intergenerational partly because they are socially learned but also evidence demonstrates a well-established correlation between sexual and emotional victimisation, emotional exploitation and trauma-related mental health disorders experienced by substance-using women (Bailey et al., 2020; Prendergast et al., 2011; Worley et al., 2005). Substance use is not correlated to gender; however, women often begin to experiment with substances attempting to self-medicate the effects of childhood adversity and when coerced to or to gain the approval of current sexual partners (Werner et al., 2007; Worley et al., 2005).

Female victim/survivors of DFV are more likely to report high rates of anxiety, PTSD, depression, suicide attempts as well as problematic substance use (Bailey, Trevillion, & Gilchrist, 2020; Levendosky, Lannert & Yalch, 2012), the DFV sector does not accept a causal link between AOD use and DFV. However, White et al., (2013) found that "AOD use itself … is a form of intimidation or threat" (Part A: p. 2) and concluded that a bi-directional rather than co-occurring relationship exists. Research demonstrates that treatment designed to treat substance use and mental health issues without addressing DFV related trauma is unlikely to be successful, promote sustainable substance recovery and prevent DFV revictimisation (Dawe, Fry & Hartnett, 2008; Lipsky et al., 2010). Consequently, practitioners are recommended to integrate rather than silo AOD use and DFV treatment (Bailey, Trevillion, & Gilchrist, 2020; White et al., 2013).

Women with dependent children are the societal group most at-risk for DFV as a traumatic event affecting a mother and her children's physical, psychological and emotional health. Children who witness DFV in the home are more likely to use substances in later life and experience social disadvantage (Dawe, Fry & Hartnett, 2008), develop schemas that result in an interrupted formation of interpersonal relationships and, to experience anger, fear of

others, insecurity, developing an indiscriminate attachment to others, and an inability to trust their perceptions about others (Whiting et al., 2009). White et al., (2013) found that most women in AOD treatment reported recent DFV but also, that for every adult seeking treatment at least one child has been negatively impacted by their parents' AOD use. Their research confirmed that as a complex and inextricable relationship between substance use and DFV exists, a holistic AOD treatment that addresses the complex issues for women and child victim/survivors is essential to achieve sustainable recovery and necessary family protective factors. White et al. (2013) also recommends that treatment addresses associated mental health, poverty and housing challenges which are the known bidirectional social determinants associated with SUDs and DFV.

5. Grace Homestead Supporters

- Child Safety Officers and Team Leaders with the Department of Children, Youth Justice and Multicultural Affairs.
- Jim McDonald MP
- Jennifer Howard MP
- Ros Bates MP
- Amanda Camm MP
- Rob Molhoek MP
- Senator Amanda Stoker
- Scott Buchholz MP
- Lord Mayor Theresa Harding
- Lord Mayor Tanya Milligan
- Lady Mayoress Schrinner
- QNADA

6. Case Study

"Marie, 35, experienced significant trauma throughout her childhood and adult years and coping with this abuse contributed to her using methamphetamine for 18 years.

She had lost custody of her two older children as a result of her substance use, and now ten years later had another two very young children in her care. Continuing to deteriorate, Marie elected to enter the Grace Homestead program with her two small children.

From week 4 onwards, Marie consistently reported a reduction in her level of cravings from 9 out of 10 to zero out of 10. Her ratings on measures of anxiety, depression and stress also reduced from "severe" to "normal" over the course of her treatment.

Marie learned how to reconnect with her children, enrolled in and completed a course of study and entered the workforce in her chosen field. She continues to live a substance-free life, lives independently, continues to care for her two children and has regular contact with her adult children."

7. Future & Expansion

Grace Homestead's three year plan includes expansion of our service to include 10 families each year in the Lockyer region. This plan requires the purchase of acreage and construction of small houses, similar to those seen in many retirement villages, as well as buildings necessary for administration, therapies and staff training.

Further, the Grace Homestead Executive is ready to respond to interest expressed by other parties who hope the parent-child model will be replicated in the Logan, Sunshine Coast and in North Queensland regions. This plan requires the purchase of suitable housing in each region as well as clinicians and support staff able to implement the trauma-informed treatment model developed by Grace Homestead.

8. Current & Potential Partnerships

Grace Homestead has entered into partnership with the Churches of Christ and plans to form partnerships with both Mission Australia and Uniting Care.

9. Summary

Research conclusively shows that SUDs are neither self-inflicted nor self-induced; rather they are caused by complex psychological, developmental, genetic and socio-economic factors that are consequential to and/or exacerbated by adversity. Any of these factors on their own are enough for individual and family trauma however, when children endure more than one, the deleterious outcomes to mental health, education, satisfactory employment and criminality are lifelong and intergenerational. Therefore, evidence-based treatment approaches that recognise the presence of comorbidity and provide holistic programs that address mental health issues and SUDs consequential to trauma, are required. The research shows that what is missing are health-care policies that offer a coordinated mental health and SUD treatment provision that acknowledges what science has established are the causal pathways to dependency. Also, that an emphasis on human rights-based approaches to trauma ensures effective treatment provision that leads to sustainable recovery and new life trajectories for individuals and their families and therefore, the best possible standard of health, well-being and transformational change.

Successful AOD treatment and government policy is understanding the complex forces that drive substance-use and the implementation of treatment strategies that assist women overcome their lived experience. Extensive evidence demonstrates that governments and rehabilitation centres are that "unless and until the link between coping strategies and risk taking behaviour is appreciated, neither public health campaigns nor treatment programs are likely to be effective" (Kezelman et al., 2015, p. 46).

Grace Homestead's parent-child residential AOD rehabilitation model is a proven concept. The parent-child model satisfies human rights requirements, trauma-informed practice principles, sustainable recoveries, parent-child reunification and utilitarian economic criteria.

Submission authored by

Zoe Knorre (Founder & CEO)

Christine Eckert (Director Research & Development)

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Appendix A - Cost Savings of the Parent-Child Model

The Australian National Institute of Criminology report completed in 2011 stated the costs for treating a person without children in residential rehabilitation to be $215 a day or $16,110 a treatment episode [$78,475 per year per person] – this amount is also claimed to bring cost benefits seven times greater than the outlay (Smith, 2018). Other research highlights that strengthening family bonds increased resilience in terms of substance avoidance and resulted in a reduction in financial outlay from Government departments for rehabilitation (Heerde, 2018). The NSW 2016-17 government allocated $8 million over 4 years for drug and alcohol residential rehabilitation for parents with dependent children (Williams, 2017). In comparison, the Queensland Government within the 2018-19 budget, there was no funding allocated for support services for women needing residential rehabilitation with their children (Queensland Government, 2018-19).

The benefits of SUD treatment centres for parenting women is that they provide a vehicle for Child Protection systems policies and practices to preserve and reunify families safely. Provision of both health care and family reunification options that preserve the integrity of the family meets fundamenta/ human rights obligations and economic and social benefits. For example, substance-using mothers who were not reunified with their children are twice as likely to have a subsequent birth and, three times more likely to have a substance-use exposed birth compared to, 78.1% of mothers who completed substance-use treatment with their children having no other children after graduation with only 12.3% giving birth to a child exposed to substances (Grant & Graham, 2015).

Grace Homestead can rehabilitate one family (a mother with 2 children) for $170,000. The savings for the government for Health, AOD, and child protection for this one family are estimated to be up to $1,500,000 per year (savings calculated at $500,000 per child in the

child protection system, $500,000 for AOD, health and mental health treatment, and $500,000 financial losses resulting from being unemployed, and involvement in the criminal justice system).

Savings Department of Health

According to Kezelman et al., (2015) "the Commonwealth Government's last issued inter-generational report (Swan, 2012) showed that the major future stress on government expenditures is in health outlays. As a percentage of GDP, health expenditure is forecast to rise from 3.9% in this current year to 7.1% in 2049-50 – an almost doubling in proportional expenditure" (p. 44).

Savings Department Children, Youth Justice and Multicultural Affairs

An estimated 55% of Australian children have experienced physical abuse and are also exposed to domestic violence, while an estimated 40% experienced sexual abuse and are also exposed to domestic violence (Bedi & Goddard 2007). Early life trauma affects the developing brain; changing it from a `learning' brain to a `survival' brain. This shift has many negative impacts both on daily functioning and the developmental trajectory as a whole. Also, the effects of trauma on children do not end when they reach adulthood. The economic consequences of trauma are well documented however, commonly they are not accounted for in policy decision-making. Strong evidence exists for the presence of intergenerational trauma in parents with complex mental health problems and substance-use disorders. Further, regardless of the cause, trauma has a significant detrimental impact for children via the disruption of secure attachment with their adult caregivers but also a range of other impairments, disorders risk factors (Kezelman et al., 2015).

For example: -

- **educational impairments** - over a working life of 40 years, costs the equivalent to around $600,000 in today's dollars (Kezelman et al., 2015),
- **work impairments** - the inability to work at full capacity and/or due to trauma a person who can only maintain part time employment, adjusting for an average 30% tax rate, the full-time worker will earn around $1 million more than the part-time earner. Diminished earning capacity also has a significant budgetary implication for government revenue i.e. a loss of $500,000 in this example (Kezelman et al., 2015),
- **suicide & attempted suicide** - an increased rate of both suicide and attempted suicide are associated with childhood trauma, particularly child sexual abuse with significantly higher rates of suicide and accidental fatal overdose in those who experience childhood sexual assault. Also, research in the United States identified that adults who have experienced four or more adverse childhood experiences are 12 times more likely to have attempted suicide than those who have not experienced any forms of childhood trauma or abuse. The estimate for deaths in 2011 was 2,614. This level has been stable for over a decade,
    - **suicide** - a total revenue loss of $28 million with an estimate of a revenue decline of $11,386 per suicide.
    - **attempted suicide** - the average medical costs per suicide attempt in Australia is $4,900.00 (Kezelman et al., 2015),
- **anxiety & depression** - an American study identified that adults who had been abused as children were two and a half times more likely to have major depression and six times more likely to have Post Traumatic Stress Disorder compared to adults who had not been abused. These risks were compounded when adults had

experienced parental divorce as well as child abuse. An estimate of the annual cost to the budget of mental illness/the individual affected is $7,686 per person per year (Kezelman et al., 2015),

- **dissociative disorders** - are strongly associated with a history of childhood abuse and trauma. During times of high stress a child may 'slip into dissociative states to remove themselves from the situation'. 22 It has been found that a high proportion of adults diagnosed with Borderline Personality Disorder (81%) or Dissociative Identity Disorder (90%) were sexually, and/or physically abused as children (Kezelman et al., 2015),
- **Risk Factors in Adults** - linked to childhood trauma are obesity, smoking, lack of exercise, poor diet and excess alcohol and illicit substance consumption. Further, the Royal Commission identified that while most adults could identify their health risks, many did not understand or had a limited understanding of the links between childhood trauma and their health risks.
    - **obesity** - the cost of obesity is around $6,000 per obese person per year (Kezelman et al., 2015),
    - **alcohol** - the per-person, per-year cost to the Government budget of alcohol abuse is calculated at $4,983 (Kezelman et al., 2015),

Savings Department of Justice and Attorney General Office for Women & Violence Prevention

- **relationship impairments** - the costs associated with relationship breakdown are significant for both family members and governments. For example, recent research estimates the total annual cost of divorce to society at $14 billion per year. Costs include the incremental welfare payments of single parent families, along with legal

and child administration services. Pegasus estimates that each divorce each year costs the federal government around $14,000 (Kezelman et al., 2015),

- DFV homicides -in 2005, there were 500 homicides recorded in Australia with an estimated per-incident cost of $1.9 million (Kezelman et al., 2015). The rate of DFV related homicides is around 1 person per week, therefore a cost of approximately $98,800,000 per year,
- Cost of DFV federally is $22 billion per year

Prioritising a rights-based trauma-informed AOD treatment that supports the integrity of the family is the best interests of children is not only

Appendix B - Budget & Costings

Grace Homestead charges a service fee to residents, calculated at 80% of Centrelink benefits paid. This revenue, however, does not cover the costs of running a residential recovery centre of this type, and Grace Homestead has relied on the generosity of volunteers for over 3.5 years to run the centre 24 hours a day 7 days a week. Grace Homestead is incredibly grateful to our cohort of volunteers. However, in order to become sustainable and ensure service continuity, Grace Homestead requires ongoing and adequate funding.

Given the success of the parent-child treatment model, Grace Homestead is seeking funding for current expenditure and replacing volunteers with paid staff. Further, as our data demonstrates that we only meet 15% of the need it is essential we expand our overall treatment capacity. Therefore, Grace Homestead intends to expand its current operation to treat 10 families per year and also replicate the model to meet the need in the Logan, Sunshine Coast and North Queensland regions. This requires additional clinical, administration and support staff to ensure the current and future centres operate with

sustainable staff levels and professional treatment provision for more than 20 mother's and families a year.

10 Family Acreage Centre Lockyer Valley

Expenses	Family Costs per Year	Centre Costs per Year	Costs per 3 year cycle
Administration	$15,283.26	$152.832.60	$458,497.80
Operations	$4,300.00	$43,000.00	$129,000.00
Wages	$155,641.02	$1,556,410.15	$4,669,230.45
Sub Total	**$175,224.28**	**$1,752,242.75**	**$5,256,728.25**
Food	$7,800.00	$78,000.00	$234,000.00
Dietician, Gym Membership,	$1,550.00	$15,500.00	$46,500.00
Sub Total	**$9,350.00**	**$93,500.00**	**$280,500.00**
Total	**$184,574.28**	**$1,845,742.75**	**$5,537,228.25**
Revenue			
Service Fee (minus)	-$20,800.00	-$208,000.00	**-$624,000.00**
Grand Total	**$163,774.28**	**$1,845,742.75**	**$4,913,228.25**

Logan, Sunshine Coast & Far North Queensland Centres

Three new family centres with the capacity to treat three mothers and their families per year per region.

Expenses	Cost per family/year	Cost per Centre/year	Cost per 3 year cycle
Administration	$20,031.70	$60,095.10	$180,285.30
Operations	$10,933.33	$32,800.00	$98,400.00
Wages	$210,019.98	$630,059.94	$1,890,179.82
Sub Total	**$240,985.01**	**$722,955.04**	**$2,168,865.12**
Food	$7,800.00	$23,400.00	$210,600.00
Dietician, Gym membership	$1,550.00	$9,000.00	$81,000.00
Sub Total	**$9,350.00**	**$79,200**	**$291,600.00**
Total	**$250,335.01**	**$802,155.04**	**$2,460,465.12**
Revenue (minus)			
Service Fee	$20,800.00	$62,400.00	$187,200.00
Grand Total	**$229,535.01**	**$739,755.04**	**$2,273,265.12**