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Mental Health Inquiry
Productivity Commission
By email: **mental.health@pc.gov.au**

Productivity Commission – The Social and Economic Benefits of Improving Mental Health – Response to Issues Paper

Relationships Australia welcomes the opportunity to participate in this vital inquiry.

1. The work of Relationships Australia

Relationships Australia is a federation of community-based, not-for-profit organisations with no religious affiliations. Our services are for all members of the community, regardless of religious belief, age, gender, sexual orientation, lifestyle choice, cultural background or economic circumstances.

Relationships Australia provides a range of relationships services to Australians, including counselling, dispute resolution, children's services, services for victims and perpetrators of family violence, and relationship and professional education. We aim to support all people in Australia to live with positive and respectful relationships.

Relationships Australia has provided family relationships services for more than 70 years. Relationships Australia State and Territory organisations, along with our consortium partners, operate around one third of the 65 Family Relationship Centres (FRCs) across the country. In addition, Relationships Australia Queensland operates the national Family Relationships Advice Line and the Telephone Dispute Resolution Service.

Relationships Australia is committed to:

- Working in rural and remote areas, recognising that there are fewer resources available to people in these areas, and that they live with pressures, complexities and uncertainties not experienced by those living in cities and regional centres.
- Collaboration. We work collectively with local and peak body organisations to deliver a spectrum of prevention, early and tertiary intervention programs with people at all points of the lifespan. We recognise that often a complex suite of supports (for example, mental health services, drug and alcohol services, family support programs, gambling services, and public housing) is needed by people affected by family violence and other complexities in relationships.

- Valuing and enriching healthy family relationships, including providing support to parents and carers, and encouraging good and respectful communication.
- Ensuring that social and financial disadvantage is not a barrier to accessing services.
- The provision of universal services, and of prevention/early intervention services to lessen the impact of significant mental health issues.
- Providing services that recognise, and leverage, relational service models to support healthy family relationships
- Contributing its practice evidence and skills to research projects, to the development of public policy and to the provision of effective supports to families.

Relationships Australia acknowledges that

> Consumers and carers are not *"merely repositories of need or recipients of services, but are the very resource that can turn public services around".* It is only then that we will achieve a truly transformative approach to reform….
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> Consumers and carers [must be] recognised and respected as being leaders and experts in their own right. [They] can, and do, provide long-term cost savings, greater outcomes …But [they] can only do so when we have equal weighting and authority as the other professionals.[1]

We recognise that the expertise and insights deriving only from lived experience should be at the heart of policy making and programme design and that governments and service providers need to genuinely, consistently and continuously engage with consumer, advocacy and self-help groups to provide a broad range of effective mental health services.[2]

We believe that:

- there is a bi-directional relationship between poor family relationships and mental ill health. Mental health can be challenged during periods of family conflict, especially during separation, post-separation, and negotiating and managing co-parenting and contact arrangements for children. In turn, mental ill-health can lead to conflicted family relationships and relationship breakdown.[3] Family members and carers occupy a dual role – as partners in the therapeutic reliance and as service clients in their own right. Further, where services do not respond to the needs of family members and carers, mental health outcomes will be limited (particularly in relation to collectivist rather than

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[1] National Mental Health Consumer and Carer Forum, *Soar beyond the Rhetorical: Nothing About Us, Without Us, is For Us*, 1 March 2019, located at https://nmhccf.org.au/publication/soar-beyond-rhetorical-nothing-about-us-without-us-us. (Emphasis in original)

[2] See Relationships Australia's *Mental Health Statement*, 2015, which is located at www.relationships.org.au/national/submissions-and-policy-statements/mental-health-statement/view.

[3] Cf Robinson E, Rodgers B and Butterworth P (2008), 'Family Relationships and mental illness: Impacts and service responses,' *Australian Family Relationships Clearinghouse*, no 4 (2008).

Western cohorts).[4] The holistic approach taken by Relationships Australia facilitates the exposure of mental health need and the identification of responsive pathways to therapeutic services.

- the community sector plays a vital role in prevention and early intervention work in the area of mental health. We believe that while there is clearly a place for medical models of mental health intervention and treatment, there is also real and unmet need for properly-resourced community models of mental health. In our experience, community mental health services are often better received by clients in regional and remote areas, as well as those from vulnerable or disadvantaged clients groups (eg those on low income). General counselling, community mental health models, peer workers and the engagement of family members and carers should sit alongside, and collaborate with, medical models and provide early intervention pathways and choice for clients seeking to access mental health services.

- long-term, ongoing financial and practical assistance needs to be available for those affected by chronic mental illness; this includes support for their family members

Relationships Australia also supports:

- a whole of nation, whole of government approach to mental health

- greater community understanding of, and efforts to, de-stigmatise mental illness through community education programs

- building literacy around mental health, which helps the community to better understand mental health problems and illness, and assists people to navigate the mental health and allied mental health systems to find appropriate services and support

- targeted, well-resourced services for identified at-risk groups, including:

    - Aboriginal and Torres Strait Islander people

    - culturally and linguistically diverse people[5]

    - lesbian, gay, bisexual, transgender and queer people

    - people born with intersex characteristics

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[4] Current service models often require clients to physically present to a service (or themselves have the emotional capacity and resources to make contact with a service over a telephone line or through a website). However, our experience with clients from collectivist cultures is that shame and stigma can be insuperable barriers, and it is through family members that the mental health need is exposed.

[5] Help-seeking can be hindered by limited availability of inclusive services to provide culturally sensitive interventions, services and interpreters (cf Sawrikar P and Katx I (2008), 'Enhancing family and relationship service accessibility and delivery to culturally and linguistically diverse families in Australia', Australian Family Relationships Clearing House, 2008(3).

- humanitarian entrants to Australia
- people concurrently experiencing mental health and substance misuse issues, as well as their family members and carers, with whom we work to develop their capacity to provide care, as well as to help them stay strong and resilient within their unique family role
- people who have experienced family and domestic violence, including children and young people who have experienced family and domestic violence, high conflict, other trauma (including child sexual abuse), and neglect, putting them at greater risk of both developing significant mental health issues *and* organic diseases later in life [6]
- older people, who are considered to be at risk (for example, this cohort is over-represented in suicides, and at greater risk of social isolation/loneliness stemming from circumstances such as loss of a partner and chronic health issues)
- people experiencing homelessness
- families in the peri-natal period
- people in prison, and
- children, including young carers, of parents with a mental illness.

- the efforts of Mental Health Australia, Beyondblue, headspace, Children of Parents with a Mental Illness (COPMI), National Mental Health Consumer and Carer Forum, and Child and Adolescent Mental Health Services (CAMHS), Suicide Prevention Australia and similar organisations.[7]

2. Relationships Australia and its work with people suffering mental ill-health

Relationships Australia became a national member of Mental Health Australia in 2014. We support people affected by poor mental health through the services, advocacy and research that contributes to evidence-based practice. Through our universal services, as well as our targeted services, we see a higher number of people with poor mental health than in the wider population. Indeed, recent studies have identified high rates of poor mental well-being in clients accessing family and relationship counselling and mediation services.[8]

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[6] Cf eg Felitti VJ, 'The Relationship of Adverse Childhood Experiences to Adult Health: Turning Gold into Lead', *Z psychosom Med Psychother* 2002, 48(4): 359-369.

[7] See Relationships Australia's *Mental Health Statement*, 2015, which is located at www.relationships.org.au/national/submissions-and-policy-statements/mental-health-statement/view.

[8] Cf eg Petch J, Murray J, Bickerdike A and Lewis, P (2014) 'Psychological Distress in Australian clients seeking family and relationship counselling and mediation services', *Australian Psychologist* 49: 28-36.

Our service offerings build strong connections to family and community support and skills in problem-solving and conflict resolution – each of which is a protective factor associated with improved mental well-being.

2012 Study

A nation-wide 2012 study, undertaken by Relationships Australia, was conducted in combination with the annual Family Support Program Performance Outcome Survey, a requirement of the Commonwealth funding body, [then] FaHCSIA. In meeting the rigorous research method standards set by Relationships Australia NSW's Ethics Committee, all clients received an information sheet about the study and signed a consent form before completing the survey.

The survey included standardised measures for current levels of adult psychological distress (Kessler Psychological Distress, Kessler & Mroczek, 1994), relationship distress (Couple Satisfaction Index, Funk & Rogge, 2007), and mediator impartiality (Mediator Impartiality Scale, Kelly & Gigy, 1988).

More than 4,500 clients presenting at a family and relationship service or family dispute resolution service during a one month period from April to May 2012 completed the survey after they had attended a session. Survey respondents included 58% of all clients attending a family and relationship counselling and education service and 54%of all clients attending a family dispute resolution mediation service at Relationships Australia in the study period. Just over 32% of survey respondents were first session attendees and 64% were attending their second or subsequent session. The average age of survey respondents was 40 years, with 58% female and 42% male clients. Almost 3% of respondents reported they were from an Aboriginal or Torres Strait Islander background, and 10% reported CALD backgrounds.

The table below shows the percentage of study participants reporting low, medium, high and very high levels of psychological distress across different service streams in the 2012 National Study. The 'very high distress' category is likely to indicate an anxiety and/or depressive disorder, and assessment and professional intervention are highly recommended for this group. A high proportion of clients accessing individual counselling (17.6%), individual education (15.6%) and couple counselling (13.7%) services reported very high psychological distress. Lower proportions of family dispute resolution mediation (9%) and couple education (5.7%) clients reported very high psychological distress. These rates are two to five times higher than those reported for the Australian population.

Levels of client psychological distress - Family and Relationship Services

	Low distress	Medium distress	High distress	Very high distress	Sample size
Couple counselling	27.5%	31.5%	27.3%	13.7%	1,504
Individual counselling	24.9%	31.2%	26.3%	17.6%	1,549
Couple education	37.1%	45.7%	11.4%	5.7%	35
Individual education	36.2%	26.2%	22.1%	15.6%	390
Family Dispute Resolution Mediation	45.0%	27.4%	18.6%	9.0%	634
TOTAL					**4112**

More recently, Relationships Australia South Australia conducted an audit of over 3,200 files from 2013-2018, and found that a significant proportion of clients reported mental health concerns, along with violence and harm to children.

Summary of audit findings

RASA, 2018

Detection Of Overall Risk 1 wording[9]	Clients saying 'Yes'	Sample size	Risk indicator
In the past 2 years, have you seen a doctor, psychologist or psychiatrist for a mental health problem or drug/alcohol problem?	33.9%	3232	Mental health problem
Have things in your life ever felt so bad that you have thought about hurting yourself, or even killing yourself?	18.8%	3189	Mental health
If yes, do you feel that way lately?	9.5%	599 (Yes only)	Suicide risk
In the past year, have you drunk alcohol and/or used drugs more than you meant to?	10.3%	3245	Alcohol or drug abuse
In the past year, have you felt you wanted or needed to cut down on your drinking and/or drug use?	9.4%	3177	Alcohol or drug abuse
Does your young child(ren) have any serious health or developmental problems?	10.5%	1452	Developmental risk (child <5 years)
In the past 6 months, has any professional (teacher, doctor, etc.) been concerned about how your young child(ren) was doing?	14.0%	1411	Developmental risk(child <5 years)
Does your child(ren) have any serious health or developmental problems?	20.6%	2107	Developmental risk(child >=5 years)

[9] DOORS 1 was developed by Professor J E McIntosh, 2011; see McIntosh and Ralfs, 2012 for the DOORS framework.

In the past 6 months, has any professional (teacher, doctor etc.) been concerned about how your child was doing?	33.7%	2028	Developmental risk (child >=5 years)
Have any child protection reports ever been made about your child(ren)?	13.1%	3095	Child abuse
As a result of the other parent's behaviour, have the police ever been called, a criminal charge been laid, or intervention/restraining order been made against him/her?	28.4%	3228	Family violence (victimisation)
Is there now an intervention/restraining order against other parent?	5.1%	3131	Family violence (victimisation)
As a result of your behaviour, have the police ever been called, a criminal charge been laid, or intervention/restraining order been made against you?	14.3%	3244	Family violence (perpetration)
Is there now an intervention/restraining order in place against you?	4.5%	3130	Family violence (perpetration)

The Australian Bureau of Statistics has been commissioned to gather mental health-related statistics, to support the ongoing use of FL-DOORS (Detection of Overall Risk Screening – see section 3.3.1). These indicate that:

- divorced/separated individuals are more likely to have an anxiety disorder than married and never married individuals.
- divorced/separated individuals are also more likely to have an affective (emotional or mood) disorder than married and never married individuals.
- divorced or separated females with dependent children are twice as likely as married/de facto families to have used an illicit drug in the last 12 months (17% compared to 8.4% respectively), despite similar proportions reporting a previous history of use (41.2% compared with 40.2% respectively). This is also true for men (22% compared with 12.7% for current use, and 44.2% versus 41.4% for past use respectively).

Our services engage with people across the full continuum of mental health, and with members of their families. This occurs in the course of our ordinary work in universal family support services, as well as through a range of specific mental health programs. We also work around the country in suicide prevention, often in collaboration with other service providers, peak bodies, governments and alliances. Relationships Australia organisations have, over many

years, delivered a diverse range of services targeting clients with poor mental health (including counselling, advocacy and co-ordination). These have included:

- Aboriginal Social and Emotional Wellbeing
- Access to Allied Psychological Services
- ACT Therapeutic Program for children and young people
- Better Access to Mental Health Care
- Carers Northern Territory
- Children's Therapeutic Team (Urban and Remote)
- COPE Mental Health and Wellbeing
- Family Mental Health Support Services (pre-2012)
- Gay Men's Health South Australia
- headspace
- Heal and Connect
- Healing Foundation
- Holding People Together (for children and young people)
- Partners in Recovery
- Mental Health First Aid
- MOSAIC Blood Borne Viruses Support Services South Australia
- Northern Territory Government Employee Assistance Counselling
- Northern Territory Police Fire and Emergency Psychological Services
- Northern Territory Stolen Generations Aboriginal Corporation
- Open Arms (formerly Veterans and Veterans Families Counselling Service)
- Past Adoption Support and Find and Connect services
- Problem Gambling Support and Prevention Services
- Rural Primary Health Services

- SCIL Living with Autism
- Strength to Strength (for children and young people)
- Tasmanian North West Suicide Prevention – trial site (which has a focus on older people)
- Tasmanian Suicide Prevention Community Network
- Unplanned Pregnancy Support
- Victims of Crime Counselling and Support
- family and relationships services funded by the Commonwealth Attorney-General's Department and the Department of Social Services
- services to support people affected by the Royal Commission into Institutional Responses to Child Sexual Abuse
- services to support people affected by the Royal Commission into the Detention and Protection of Children in the Northern Territory
- services for Forgotten Australians
- support services for people in the LGBTIQ communities
- multicultural services.

Relationships Australia's experience in delivering a range of support services targeted at individual and family wellbeing situates it to make an informed, evidence-based contribution to public policy development in the area of mental health, and to use its voice as an ally of the many Australians affected by mental health problems.

Accordingly, the information in this submission reflects our involvement with, and support for, clients who have lived experiences of poor mental health, and other complex co-morbidities, such as substance abuse, problem gambling, and violent behaviour. Relationships Australia also supports family members and carers to understand how to support, assist and (where necessary) challenge the care of their loved one). This submission draws upon:

- our experience in delivering programs in a range of communities, including
  - culturally and linguistically diverse communities
  - Aboriginal and Torres Strait Islander people, and
  - people who identify as part of LGBTIQ communities
- evidence-based programs and research, and
- our leadership and policy development experience.

This submission also draws substantially from the submission made by Relationships Australia member organisations to the development of the Fifth National Mental Health Plan in 2016.

Recently, Relationships Australia National Office and Relationships Australia Canberra and Region made a submission to the Office of Mental Health and Wellbeing of the Australian Capital Territory. The Office sought views on priority areas for attention in mental health services. It is apposite to set these out in this submission. The areas we identified as key priorities were:

- integration of services and the imperative for culture change to overcome silos and boundaries that inhibit clients from accessing services
- suicide prevention
- improving accessibility to culturally fit services for Aboriginal and Torres Strait Islander people
- understanding and responding appropriately to physical health needs of people affected by mental ill-health (ie overcoming a different kind of siloing)
- addressing stigma and discrimination that continues to the detriment of people with mental ill-health.

Each of these priorities will be expanded on in the course of this submission.

3. Fragmentation and integration

3.1 The burdens of fragmented service systems

Relationships Australia supports integrated service systems.

We observe that the fragmentation of services intended to support people affected by poor mental health corresponds closely to the fragmentation of the family law and family services systems, which comprises:

- Commonwealth Constitutional powers, and their relationships with State powers to legislate
- separation of powers within the Commonwealth Constitution, which has implications for what and how the Federal Government can fund programmes[10]
- bureaucratic structures at all tiers of government
- budgetary processes and structures – funding grants are often structured in alignment with bureaucratic divisions, so that one service provider can, in relation to even a single family, be administering funding for overlapping services from several different government departments, at different levels of government, which imposes substantial administrative burdens and costs
- competition between services, driven by questionable assumptions that competitive tendering is a necessary and sufficient pre-condition of innovation and efficiency;

[10] See *Williams v Commonwealth* (2012) 248 CLR 156, *Williams v Commonwealth (No. 2)* [2014] HCA 23 (the School Chaplains cases).

typically, however, grants of funding also call on services to act collaboratively – artificially creating a competitive dynamic that can undermine achievement of the policy objectives, and

- policy and programme responses corresponding to discrete segments of the lifecourse, rather than the lifespan, and supporting the well-being of families throughout lifespan (eg intergenerational conflict, elder abuse, peri-natal support needs, conflict among adult siblings)
- silos relating to professional disciplines, including:
    - social sciences
    - medical sciences
    - allied therapies
    - law, and
    - law enforcement services, and
- interacting/conflicting legal frameworks, including:
    - child protection and welfare
    - criminal law – family violence
    - criminal law – other
    - adult guardianship law
    - mental health, and
    - succession law.

Silo-bound, fragmented practices impose an overwhelming array of burdens on vulnerable clients, who must navigate complex mazes emanating from, for example:

- the various professional disciplines and their hierarchies
- geographical divisions
- bureaucratic areas of 'subject matter' responsibility, and
- reliance upon disparate funding sources.[11]

[11] Relationships Australia notes the 2015 and 2016 reports by the Family Law Council, a fundamental theme of which was the impact that this fragmentation has on families. Relationships Australia drew to the ALRC's attention the Council's findings about the impact of fragmentation on families affected by family violence. They may, for instance, potentially deal with: child protection services, police, domestic violence advocates, legal

Lack of integration is often experienced by clients as gaps in service; for example, between early intervention and prevention services and secondary or tertiary services. Sometimes, this leads to attempts to push clients between services if their needs cannot be met (waiting lists, narrow referral criteria, etc.). In many cases, this risk is managed informally by having good relationships between service personnel. At other times, however, these gaps are where vulnerable people fall through, and miss out on vital services.

Fragmentation also imposes on service providers heavy burdens of, for example:

- regulation and compliance activity
- performance reporting
- cumbersome communication channels and opaque referral pathways
- disjointed and process-laden attempts at 'co-ordination', and
- conflict between client need and program guidelines and scope (and lack of flexibility to work with program parameters to meet clients' evolving and emergent needs)[12]

We note, for example, that while many community services are well-networked and linked at the local level, referral pathways are less robust between the health and community service sectors. These stovepipes exist from the on-the-ground services and in the policy and program environment, from the funding bodies (Departments) up to Ministerial levels.

While the efforts are welcomed within the 'stepped care model' of the PHN funding and service development, to date this has tended to fall at the 'ends' of the service continuum, leaving a gap in services for people who fall within a 'missing middle'. At the primary preventative level, there is substantial growth in targeted low intensity interventions. This includes awareness raising educational websites, referral and resources sites, online treatment programs, support apps to augment face to face services and, at the top end, an emphasis on acute crisis mental health responses and hospital services.

In Western Australia, our services report that the most visible element of integrated planning and collaboration appears to be the consultation processes underway at a regional level, with the PHNs encouraging people to come forward with all their good ideas. These ideas are considered by staff and progressed if supported. This encourages, however, a highly hierarchical environment for consultation events, with proposals championed by the more dominant participants (and predominantly medical service providers) appearing to get the most attention. Instead, it may be more helpful if consultation processes were better informed of developments at higher levels; ie what are the broader systemic priorities? This might bring a clearer focus to the deliberations and encourage participants to focus more on the big picture and how they might contribute to integrated solutions.

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services, family court consultants, Independent Children's Lawyers, hospital and medical staff, child health services, counsellors, school teachers, day care staff, school and private psychologists, chaplains, Children's Contact Services, and Centrelink.

[12] For example, some of Relationships Australia member organisations administer more than 50 funding sources from which they are to provide services –often, to the same clients.

Ideally, an integrated system would mean there would be no wrong door for clients. Wherever they approach, they would be met by a consistent and appropriate level of support. Central to this ideal would be a consistent approach to case management. Individualised interagency care plans that go with the client would be very helpful. This would include clear protocols over who is responsible for what, procedures to negotiate gaps, and short, medium and long term strategies for supporting clients, particularly those with severe and complex mental health issues. The absence of such a consistent approach often leads to crisis situations and presentations to what is often the only available alternative – busy Emergency Departments, and treatment approaches not always well matched to client needs.

It is simplistic to focus on a general statement about the need for better community-based care services. This is certainly needed, but more pressing is the need for effective case management across the mental health system and the provision of consistent levels of support beyond what is now the mental health system.

3.2 Barriers to integration

3.2.1 Over-reliance on medicalised definitions and biomedical models

Merely changing structures and branding every few years, within and between organisations, will not result in increased collaboration, particularly without cultural change. Further, funder-driven collaborations, in our experience, do not effectively overcome siloed professional cultures and come with significant administrative/co-ordination costs to service providers. For example, our experience nationally is that PHNs are generally ineffective in connecting and collaborating with the Family Relationships Services and Family Law Services. This is partly because LHNs and PHNs continue to focus on medical models, with limited engagement and lower value accorded to community services. This could reflect similar stovepipes in government with funding for LHNs and PHNs deriving from Commonwealth and state/territory departments of health, rather than social or community services. Further, there do not appear to be mechanisms by which Commonwealth departments and agencies can effectively collaborate with each other (and/or a lack of a culture of collaboration among Commonwealth departments and agencies).

Further, high level government targets focus very heavily on medical interventions rather than community mental health (for example, the hospital-centric priorities in the 2012 National Partnership Agreement Supporting National Mental Health Reform). We agree with Mental Health Australia that existing mental health services are 'predominantly shaped around a biomedical model', and that this does not accommodate (or, in our view, appropriately value) community-based and peer worker mental health services.[13]

While many local community services networks are well connected, links between the medical and community services sectors are less robust. Services rely on local knowledge and there

[13] Mental Health Australia, *2019 Election Platform*, 3; the expected return on investment would be $1.30 for every $1.00 invested. The returns on investment in the Platform were modelled by KPMG, and are described in detail in *Investing to Save: The economic benefits for Australia of investment in mental health reform*: https://mhaustralia.org/sites/default/files/docs/investing_to_save_may_2018_-_kpmg_mental_health_australia.pdf

are few contemporary service maps that can be used to identify the services in the region. There is also a lower recognition by medical professionals, within and beyond government, of the key role and strengths of community services organisations, like Relationships Australia, and peer workers, in facilitating pathways for people with multiple needs, and providing ongoing support and follow-up. Relationships Australia supports the recommendation by Mental Health Australia that the paid peer workforce be expanded; we note MHA's expectation that this would provide a return on investment of $3.50 for every $1 invested.[14] The identified benefits of a peer workforce include:

- reduced social isolation
- increased service access
- improvements in social functioning
- enhanced empathy and acceptance
- reduced stigma, and
- increased feeling of hope.[15]

Finally, Relationships Australia is concerned that service delivery models with hard boundaries and inflexible program and/or eligibility guidelines limit capacity to respond from a tailored holistic approach and that such models identify, assess and respond to mental health issues through a narrow and medicalised lens. The emphasis on medicalised models can privilege medication (and other interventions provided exclusively or predominantly by medical practitioners) as the primary treatment modality, at the expense of other treatment models, including community support and peer workers.

Anonymised case example – a workforce culture that does not foster integration or collaboration

Soraya[16] first accessed Relationships Australia through one of its Children's Contact Services. These services support separated parents with contact and changeover arrangements. Soraya had sought a separation due to the abusive nature of her relationship with Farbod. The court ordered a shared parenting arrangement and so Soraya used the Children's Contact Service to manage contact and changeover of their children. The Children's Contact Service facilitated changeover strategies that were less anxiety- provoking for their child and the process appeared stable for almost 12 months.

One day, through contacts in the community, our service became aware that Soraya was missing from work and had been seen jumping in front of cars. It later emerged that this was the expression of significant distress over her relationship with Farbod. Despite their

[14] Mental Health Australia, *2019 Election Platform,* 4.

[15] Cf Repper J and Carter T A (2011), 'A review of the literature on peer support in mental health services', *Journal of Mental Health* 20(4): 392-411. See also Hosie A, Vogi G, Hoddinott J, Carden J and Comeau Y (2014), Crossroads: Rethinking the Australian Mental Health System, accessed 2 April 2019, https://apo.org.au/node/38336

[16] The names used in this case study are not the names of the individuals involved.

separation, Soraya had found it hard to separate from him and they had pursued a twelve month secret affair. Members of Soraya's family felt that Farbod made her dependent upon him, which made it hard for her to end their relationship, despite their legal separation. When Farbod then became involved with another woman, Soraya had become progressively distressed. Members of the school community, Children's Contact Services and members of the Iranian community had noticed her increasing emotional stress. Police were contacted and Soraya was hospitalised for five weeks.

After this time, her consulting doctor contacted our agency, suggesting that the suicide attempts were situational and a product of relationship issues rather than an organic or diagnosable mental illness. It was suggested that a return to work was in Soraya's best interests and that relationship counselling would support her in coming to terms with the end of her relationship with Farbod.

An experienced worker worked with Soraya to this end. Soraya still held strong hopes for a life with Farbod and was struggling to resolve feelings of humiliation and betrayal. With her Worker, she identified specific instances where she felt most vulnerable, such as during contact arrangements and when driving past her child's school during Farbod's time as carer. Her Worker engaged Soraya in developing a community safety plan to support Soraya to manage her vulnerability, and to serve as an indicator of suicide risk.

Soraya eventually broke this safety plan. One day, she left work in distress and drove away without informing anyone of her whereabouts or intentions. A previous suicide attempt is a strong indicator of risk, which in this case was compounded by Soraya's involvement in an abusive relationship, and the sense of loss over this relationship. Her Worker recognised these as risk factors and sought to take appropriate action.

She contacted a local Acute Crisis Intervention Service (ACIS) and the hospital at which Soraya was previously detained to alert them to these risk factors. Neither ACIS, nor the hospital, would take the information being offered. The hospital stated that should Soraya present to their service, they would assess her risk at that time. Despite having direct experience with her previous suicide attempt - and having themselves identified this as situational - the hospital refused to acknowledge this information as significant and deferred it instead to their clinical assessment processes. The Worker had identified suicide risk factors and developed a community safety plan. However, she was left with no avenues for appropriate action. She sought only to express the contextual risk factors that affected Soraya, so as to support the hospital in their assessment. However, the hospital was interested only in the information obtained through their assessment, which focused on her mental status and included none of the relevant and compounded risk factors. The hospital interpreted the Worker's contact as a request for referral and, in turn, this marked a sharp division between acute and community services, their perceived responsibilities and the limits of collaboration.

3.2.2 Over-reliance on modalities directed at individuals - the value of relational models to support a more responsive service culture

People affected by poor mental health need access to appropriate and timely medical support and therapeutic intervention. However, medicalised mental health frameworks rarely acknowledge, value or respond to the pivotal role family relationship services can play in the preventative, treatment aftercare and recovery/rehabilitation phases of responses to mental ill-health. Further, Diagnostic and Statistical Manual of mental Disorders (DSM) diagnostic categories are often the organising principles identifying the targets for funded research on potential treatment for mental illness. Relationships Australia is concerned about the tendency to pathologise symptoms that would be better understood, and more effectively addressed, in the context of relational factors (such as childhood behaviour problems). There is also concern about potential misdiagnoses, the role of subjective judgements, pressure to provide a diagnosis for funding purposes, and the potential to over or under diagnose.

General practitioners could be better positioned to provide pathways to the necessary supports with easily accessible and up to date information about complementary services. General practitioners offer a large footprint of frontline services which can be a first point of entry into an array of holistic supports and services. However, Relationships Australia has observed that provision of service details to common directories, such as Health Direct, is hindered by medicalised assumptions and rules. These make it difficult for community service providers to satisfy eligibility criteria for the database (eg a Medicare provider number, and registration of individual practitioners, rather than the services themselves).

It is critical that family relationship services are recognised as integral components of a holistic service response because:

- mental disorders have a significant – and potentially devastating - impact on individuals and family/relatives, and may be both a cause and a consequence of family/relationship difficulties
- although most common mental disorders are amenable to treatment, many go undiagnosed and untreated
- many disorders are chronic or recurrent and often call for long-term management, far beyond acute care
- much of the care provided for people with mental disorders is informal care provided by family members, and
- ‘vulnerable’ family groups in family relationships services often have a greater risk of mental health problems than average (Elly Robinson, Bryan Rodgers and Peter Butterworth, FRSA conference, Sydney, November 2009).

Mental illness in cohabitating couples co-occurs at a level far greater than expected by chance - if one partner has a mental illness, the other partner is more likely to as well. Relationship satisfaction is related to a person's own mental health as well as the mental health of their partner; between 21-24% of Australian children live in a household where at least one parent has a mental illness.

Over the past 40 years, extensive literature has documented intimate partner relationship distress as a primary reason for seeking mental health services, as well as an integral factor in the prognosis and treatment of a range of mental and physical health conditions. Relationship distress influences both parental adjustment and parenting behaviour toward children (Cummings & Davies, 2002; Erel & Burman, 1995; Krishnakumar & Buehler, 2000). Healthy families, or families characterised by low levels of stress and conflict, have been linked to resilience and mental health and adjustment in both children and adults. Unhealthy families, or families characterised by high levels of stress and conflict, have been linked to a wide range of parenting problems such as poor discipline (Gerard *et al* 2006), increased negativity (Belsky *et al* 1991), and decreased warmth (Davies *et al* 2004), as well as adjustment difficulties in children, including mental illness (eg Cummings *et al* 2000).

Effects of conflict and violence on children's mental health

Witnessing acute episodes of violence, living with chronic fear, being caught up in violent acts, or being cared for by a frightened parent all pose immediate and long-term developmental risks to children (cf Bancroft and Silvermann, 2004; Fantuzzo and Linquist, 1989; Fantuzzo and Mohr, 1999; Graham-Bermann and Edleson, 2001; Sachmann, 2001; Wolak and Finkelhor, 1998).

Children who have lived with significant levels of family violence are often noted by researchers to present with a cluster of particular symptoms which manifest at behavioural, cognitive, and emotional levels. These include:

- aggression, conduct disorders, delinquency, truancy, school failure, depression, anxiety, and low self-esteem (Kelly and Johnson, 2008)
- interpersonal problems marked by poor social skills, peer rejection, problems with authority figures and parents and an inability to empathise with others
- profound developmental sequelae follow for infants and school children (Siegel and McIntosh, 2011), and
- insecure and disorganised attachments generate a host of follow-on deficits in early childhood development; while recovery is possible with effective protection and treatment of both parent and child, the costs of early trauma remain high, especially when accompanied by other ongoing stressors (Ayoub, Deutsch, and Maraganore, 2005; Sroufe, 2005).

When family violence and conflict co-occurs with other risks (namely, mental health of parents, poverty, parental substance abuse, unemployment, or low education), greater developmental impact is evident (Crockenberg and Langrosk, 2001; Dixon, Charles and Craddock, 1998).

Children of parents with untreated or poorly contained mental illness also have a high risk of physical neglect, where their needs are not being met. In such situations, children might assume the role of a carer for their ill parent, resulting in significant levels of emotional stress (Huntsman, 2008).

> Co-parenting conflict is a significant predictor of ongoing distress for adolescents and adolescent antisocial behavior (McIntosh, 2003).

Mental health services should therefore be funded to extend to family members and communities affected by a person's mental ill-health. Evidence suggests that improved outcomes could be achieved with expanded services, such as couple and group interventions; however, there is at present a lack of understanding and awareness of these benefits. More broadly applied services would assist family members to aid with the recovery of the person and also allow for personal support where their own mental health has been negatively affected.

Providing services that build strong connections to family and community support, skills in problem solving and conflict resolution (all protective factors associated with long-term recovery) are key strengths of service offerings from Relationships Australia. Relational models of services delivery, employed by Relationships Australia, can also enhance the efficacy of prevention and early interventions services, with the potential of reducing the severity of mental illness and reduce multiple presentations not only to specialist mental health facilities, but also to generalist emergency departments.

Further, it would be most helpful if the Commission could adopt a broad perspective and understanding of mental ill-health, because the social determinants of mental health have a major impact on many aspects of the lives of those suffering from it as well as those of their families. These determinants include, but are not limited to, housing, employment, education, poverty, aged care, family support and access to other social services. Accordingly, it is imperative that mental health services are strongly connected with systems and services traversing child protection, welfare, housing, education, criminal justice, drug and alcohol misuse, problem gambling, and family violence/family law services. This is particularly important when responding to case complexity and social disadvantage, such as for clients who live in regional and remote areas, who are Aboriginal and Torres Strait Islander people, and traumatised clients such as humanitarian entrants to Australia and Forgotten Australians.

3.2.3 The Knowledge Labyrinth

Mental health service provision depends on states and territories and is coordinated from, and delivered by a multiplicity of government departments at different government levels, and service providers.

Relationships Australia respectfully suggests that an important, but fixable, barrier to integrated and collaborative service provision is simply that all participants (users and service providers) do not have ready access to comprehensive and contemporary information about who can give what help and where or by what channels.

A publicly available, dynamically updated national map of the entire mental health service system, including current funders, service providers, community supports and peer workers, would be a useful guide for navigation of the system, particularly for participants outside the mainstream health arena. Our member organisations report that, rather than a high level of duplication, there is a lack of coordination which contributes to the service system being difficult to navigate.

3.2.4 The tension between prevention/early intervention and crisis services

Much suffering caused by mental ill-health would be alleviated, and cost burdens over time lightened, through active, coordinated and comprehensive early intervention. Our members identify a lack of focus and funding for specific vulnerable groups including:

- young people
- older people
- people who are lonely or socially isolated
- people affected by homelessness
- members of the LGBTIQ communities, who may have faced conflicted family and other social relationships and diminished emotional and practical support, as well as negative experiences from actual or perceived institutional discrimination, and service providers who lack understanding of LGBTIQ issues
- culturally and linguistically diverse people, and
- Aboriginal and Torres Strait Islander people.

Attention also needs to be given to particular mental health issues which are more prevalent in specific vulnerable groups; for example, suicide prevention should be a major focus and priority for youth services, and for geographic areas affected by high levels of unemployment.

We support the proposal by Mental Health Australia to fund:

- preventive and early interventions targeted at children and young people showing first signs of mental health issues to build up protective factors like resilience and lower psychosocial risks,[17] and
- work to raise awareness and increase the use of e-mental health early intervention services, with an expected long term return on investment of $1.60 for every $1 invested (although not, we emphasise, at the expense of face-to-face services).[18]

Relationships Australia currently provides prevention and early intervention services such as:

- partnerships with grassroots organisations (eg cultural groups and other groups with a community development approach) to support their work, add service elements to complement theirs, and extend reach and access
- work with students, parents and teachers in a school/pre-school context eg parenting programs, healthy relationships programs, emotional intelligence programs

[17] Mental Health Australia, *2019 Election Platform*, 5. The expected returns on investment are: $1 for every $1 invested in the short term, and $7.90 for every $1 invested in the long term.

[18] Mental Health Australia, *2019 Election Platform*, 5.

- a parenting support group for refugees and other newly arrived migrants, in partnership with the Multicultural Council of the Northern Territory
- suicide prevention services such as through the Tasmanian Suicide Prevention Network
- counselling services to individual people, couples and families
- counselling services in Aboriginal organisations
- group programs in workplace contexts[19]
- elder relationships services, which can include (for example) family group counselling to support a family to identify, and plan responses to, issues emerging as family members age and needs change
- family law services which aim to reduce conflict in families
- family and domestic violence services that provide whole of family support (eg women's groups, men's behaviour change programmes, children's programmes).

Relationships Australia seeks to engage children and young people in the full spectrum of services (including tertiary services) to create opportunities to break cycles of disadvantage and dysfunction.

In our experience, barriers that inhibit the development and implementation of early intervention and prevention services include:

- insufficient funding for outreach to vulnerable communities
- numbers of clients who are high risk and must be prioritised
- the difficulty in identifying measurable and politically viable outcomes for services and in identifying modifiable drivers of differential impacts
- lack of support for providers to undertake preventative work the impact of which can be inherently difficult to quantify, despite its far-reaching impact
- lack of support for providers to undertake relationship building work over extended periods that can be a prerequisite to engaging fragile communities, particularly in cohorts with a history of trauma (for example, Aboriginal and Torres Strait Islander communities where trauma suffered from previous engagement with services can deter help-seeking). In working with these communities, for example, Relationships Australia staff undertake considerable community engagement work out of hours, attending local sports and arts events, shops or community activities. This kind of community participation allows space and time in which relationships can develop and, over time, clients may come to trust the service sufficiently to feel safe in engaging and seeking help
- short funding cycles (see also section 7.2 below)

[19] In this connection, Relationships Australia supports the proposals of Mental Health Australia to improve workplace mental health and wellbeing – *2019 Election Platform*, 6.

- prescriptive funding programs which restrict providers from proactively shifting effort and resources to early intervention and prevention, as needs emerge and evolve.

One example of an innovative early intervention program emerges from Relationships Australia Northern Territory:

> Two of our Indigenous workers ran a school holiday program that was developed locally. At the centre of the program were cultural activities which are an essential part of Indigenous healing. The program was run with no agenda, with the children being asked what they would like to do, and then the workers waited for them to show interest. This is a stark contrast to living in detention where children have no control over what they do. The workers told them what they themselves could do, for example they knew how to make nets and throw spears. Once the young people began to engage, there was *room for conversation and therapeutic intervention*. The cost of conducting the program was the cost of basic materials and the time of the workers, with the young people leaving with connection to country. These programs are designed by the people, for the people and were supported by counsellors from Darwin's Danila Dilba, one of the local Indigenous services. *These types of activities rarely fit within program guidelines or the criteria for evidence-based programs. These types of eco-therapy, including mindfulness, relaxation therapies and connection to country activities create an essential safe and calm space for victims of trauma*.

Relationships Australia acknowledges that funders and service providers alike are vulnerable to capture by the scale and exigency of need in more clinical therapeutic and other tertiary interventions and services. Within service providers, organisational mission and values ensure that disadvantaged clients receive a service, regardless of funding status. However, this can be mitigated by:

- longer term planning, beyond election and budget/forward estimates cycles, which explicitly takes into account the multi-generational impact (beneficial and adverse) that services (or absence of services) can have
- explicit focus on disrupting and ultimately breaking multi-generational cycles of poverty, disadvantage, dysfunction, and lack of social and economic capital
- public education to de-stigmatise and incentivise help-seeking at early stages
- clear line of sight between programmes and outcomes frameworks
- sufficient funding to enable service providers to cope with both crisis needs *and* early intervention supports
- development of reliable measures to calibrate the impact of early intervention and prevention measures (the lack of such measures can render less appealing the provision of funding for early intervention and prevention measures, because the effect of funding for short-term crises is be more easily measured).

3.3 Pathways to integration

3.3.1 Integrated services at the client level

The provision of ongoing services must be done in a way that ensures smooth connection and continuity between clients and services.[20] This should include an integrated system response that is easy to navigate and provides seamless transitions in line with an individual's journey (ie not pushing people from here to there). Key elements should include:

- warm, supported referrals
- flexible service delivery
- multi-layered options; for example, when working with Forgotten Australians and members of the Stolen Generation, therapeutic treatment or healing may need to occur over multiple domains, such as trauma from child sexual abuse, feelings of abandonment, loss and grief through separation from family, loss of culture, country and identity
- safe, welcoming and accessible physical locations (such as the 'Meeting Place' established by Relationships Australia Northern Territory, staffed by counsellors and Aboriginal and Torres Strait Islander Cultural Advisors, which was an outdoor refreshment area for people attending hearings of the Royal Commission into Institutional Responses to Child Sexual Abuse)
- mechanisms to accommodate intermittent, but long-term, needs for care, and
- transitional pathways for young clients as they 'age out' of services targeting children and young people, and into adult services.

The first step in delivering an integrated service is for the service at which the client first presents to take responsibility for identifying all of the client's needs. Thus, a common feature of our client-focused services is that they employ a 'no wrong door' approach. This means that the responsibility of providing care to address the whole range of a person's needs, either directly or by referral, falls on the care provider/service where the person first presents. Relationships Australia organisations employ various means to ensure that clients receive the services they require, particularly where there are mental health concerns. One of these is universal screening of clients at intake. At present, the intensity and depth of screening of clients for poor mental health varies across Relationships Australia organisations and programs, but the use of standardised and validated assessment tools is routine. Universal screening at the point of entry is a prerequisite of effective holistic service provision (noting that the universality of screening itself diminishes potential stigma). Evidence suggests that, in the absence of universal screening, even the most experienced clinicians miss 'at risk' clients and

[20] An example of where continuity was not achieved, ultimately preventing connection between services and those who needed them, is to be found in the mechanisms established after the National Forced Adoption Apology, through Access to Allied Psychological Services (ATAPS), rather than existing post-adoption services. ATAPS did not have a connection with the adoption community and had very few clients attending the program.

the risk identification process can be improved by using robust and reliable assessment tools.[21] To be worthwhile and effective, screening should offer a pathway to appropriate interventions.

Where it is a program requirement (eg of a gambling program), then universal screening is applied (for example, suicide ideation, Kessler10), but where services occur in a mainstream program (not specifically targeted at mental health), screening for mental health problems is less comprehensive. However, Relationships Australia has achieved good outcomes for our clients by using universal screening tools.

Universal Mental Health Screening Project – Relationships Australia South Australia

In 2013, Relationships Australia South Australia observed that nearly all children referred from our Family Relationship Centre to our Supporting Children After Separation Program (iKids) were at much higher risk of mental health problems than typical Australian children. This was based on parent/carer responses to a 'gold standard' mental health questionnaire (the SDQ) for their children upon entry into the Program.

In response, Relationships Australia South Australia initiated a Universal Mental Health Screening Project. Its purpose was to establish whether:

- this was true of all children whose parents/carers attended the FRC, and
- Relationships Australia South Australia had the organisational capacity to respond.

At intake to the FRC, parents/carers completed the DOORS universal screening questionnaires for their children and for themselves. A senior practitioner then reviewed screening and casefile information for those scoring above a no or low risk clinical cut-off to assess risk level and organisational response (if any).

Analysis of data from 238 families revealed that the scale of mental health problems in families was not larger than anticipated, with 68.8% of children or adults having no or low risk of mental health problems. Only 9.2% identified as high risk, half of whom accepted our offer of support, demonstrating that practitioners do not miss children's mental health problems when their parents/carers complete universal screening.

This project also demonstrated that Relationships Australia South Australia did have the internal capacity to respond to diverse mental health risks, with 13.8% of families already having supports in place. Furthermore, universal screening facilitated a more tailored response, where the remaining 8.3% of cases involved supporting the mediator to manage the mental health risks in the mediation because it was determined that the parental conflict was the key stressor.[22]

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[21] See Michael Kelly, Jamie Lee, Laurel Cuff, 'Over the Barriers, Onto the Benefits: How Practitioners Changed their Minds about Universal Risk Screening', Peer reviewed papers from the FRSA 2018 Conference: https://frsa.org.au/wp-content/uploads/2018/11/FRSA-conference-ejournal-2018.pdf, at p 52.

[22] From Lee, J (2014). *Screening for mental health risks during mediation in separated families*. Retrieved from: https://www.rasa.org.au/wp-content/uploads/2017/05/Screening-for-mental-health-Jamie-Lee-CFCA.pdf

Some features of an efficient, integrated and holistic model of mental health support services might include:

- triage and stepped care at point of entry
- services provided at the earliest opportunity, rather than in response to crises
- clearly defined and agreed pathways through the support system (including to system exit)
- collaborative approaches between specialist family relationships services and mental health treatment services, which could help to manage the complex interplay between interpersonal relationships and mental health
- implementation of collaborative care that optimises the role played by all providers (including peer workers, case managers, mental health nurses, GPs, psychologists, psychiatrists, housing workers, case managers, employment support workers and others)
- duration or intensity of care and support that is based on routine reassessment and review, rather than on arbitrary caps on service offerings.

Family Law Detection of Overall Risk Screen[23]

The Family Law Detection of Overall Risk Screen (FL-DOORS) is a three-part framework that assists separating parents and family law professionals to detect risk at client point of entry and provide pathways towards an effective, co-ordinated response. It is currently used by a majority of the Relationships Australia organisations, as well as by other service providers, including Anglicare Northern Territory and Anglicare Sydney. Several other Australian relationship services and law firms use DOORS, which has also been piloted internationally, including in Norway, Sweden, Singapore and the United States of America.

Its use has been the subject of several studies, key findings of which include:

McIntosh, J.E, et al (2016)[24]

- that clients' self-report of safety concerns on the FL-DOORS predicted at least one professional's decisions about risks in the case (e.g. a police officer drafting an intervention order, or a practitioner making a child protection notification), demonstrating good external criterion validity (i.e. self-report reflected objective markers of safety)
- there was more agreement than disagreement in parents' experiences of conflict and stress, as well as considerable accuracy in reporting the other parent's wellbeing after

[23] See McIntosh J (2011) DOOR 1: *Parent Self-Report Form*, in J McIntosh and C Ralfs (Eds), *The Family Law DOORS handbook*, 25-29; McIntosh J E and Ralfs, C (2012a), *The Family Law DOORS handbook*; McIntosh J E and Ralfs, C (2012b), *The FL-DOORS Detection of Overall Risk Screen Framework*; McIntosh J E and Ralfs, C (2012c), *The DOORS Detection of Overall Risk Screen Framework*.

[24] McIntosh J E, Well Y and Lee J,, 'Development and validation of the Family Law DOORS,' *Psychological Assessment,* 28(11), 1516-1522

separation. This was another important finding, given some practitioners see only one parent presenting for a service and may need to consider risk to the other parent and/or the children, in the absence of corroborating material

- the screening scales of infant, child and adult mental health risks, while very brief, had concurrent validity with much longer 'gold standard' measures, including the BITSEA (Briggs-Gowan, Carter, Irwin, Wachtel, & Cicchetti, 2004), SDQ (Goodman, 1997), and K-10 (Kessler et al., 2002) (i.e. in other words, the FL-DOORS could reliably indicate mental health risks using fewer questions)

Wells, Y et al (2018)[25]

- that the FL-DOORS had 11 meaningful risk domains, showing good overall internal reliability.
- that what clients said on FL-DOOR 1 (McIntosh, 2011) was strongly linked to many important case and safety decisions, showing good external criterion validity
- that participants broadly corroborated each other's story on FL-DOORS risk domains. For example, when one parent in a dispute reported feeling unsafe, the other parent was highly likely to report unsafe behaviour
- that other FL-DOORS risk domains were linked to adult mental health.

3.3.2 Physical health of people living with poor mental health – services integrating biomedical approaches to meet diverse client needs

Relationships Australia strongly supports strategies that aim to improve the physical health of people living with mental health issues, with the association between poor mental and physical health now well-documented. As for mental health, these strategies should include an examination of actions that address the social determinants of health and a broad range of physical health problems, including sexual health.

When reflecting on the possible causes of mental illness, such as depression and anxiety, it is essential to broaden considerations to also include lifestyle factors such as diets high in processed foods, lack of physical activity, social isolation resulting from affluence, and altered brain activity from information overload.

With a narrow focus on molecular biology, the biomedical model alone fails to capture these factors, and practitioners cannot give depressed patients the advice they need to address the complex causes of their problems.

[25] Wells, Y, Lee, J, Tan, E S, & McIntosh, J E. (2018). 'Re-examination of the Family Law Detection of Overall Risk Screen (FL-DOORS): Establishing fitness for purpose.' *Psychological Assessment*, 30(8), 1121-1126.

The ACE Study carried out in Kaiser Permanente's Department of Preventative Medicine demonstrated that:

- adverse childhood experiences[26] are vastly more common than recognised or acknowledged
- a powerful relationship between our emotional experiences as children and our mental and physical health as adults, and
- adverse childhood experiences are the major causes of adult mortality with the conversion of traumatic experiences during childhood into organic diseases later in life.

Felitti, VJ. The Relationship of Adverse Childhood Experiences to Adult Health: Turning gold into lead. Z psychsom Med Psychother 2002; 48(4): 359-369

The Productivity Commission could also recommend the development of frameworks for engaging marginalised people who may have poor physical and mental health, such as those affected by homelessness.

3.3.3 Confronting isolation, discrimination and stigma - social fragmentation through 'othering'

In seeking to address isolation, Relationships Australia is working with the Australian Coalition to End Loneliness and several academic institutions to raise awareness about the negative impact of loneliness and social isolation on mental and physical health. Recent estimates suggest that around one in four to one in six people report loneliness in any given year (Lim 2018; Mance 2018). Loneliness has been associated with poor mental health outcomes such as depression, low life satisfaction, low self-worth and poor subjective wellbeing, and suicide, with a risk of early death consistent with other known health risks such as lack of physical activity, obesity, substance abuse & violence, and smoking 15 cigarettes a day (Holt-Lunstad *et al* 2015; Masi *et al* 2011). A comprehensive community education campaign and

[26] Such as growing up in a household where someone was in prison; where the mother was treated violently; with an alcoholic or a drug user; where someone was chronically depressed, mentally ill, or suicidal; where at least one biological parent was lost during childhood (regardless of cause).

programmatic responses are needed to lift public awareness of the issue of loneliness to the same level as other major public health problems.[27]

Relationships Australia services are experienced in supporting individuals and families with a range of complex and difficult social issues, including mental ill-health, that result in isolation, discrimination and stigmatisation. Discrimination interferes with relationships and connections to family, friends, workplaces, community and culture. People experiencing mental ill-health often experience discrimination, yet prejudice and discrimination are known to interfere with recovery. The experience of stigma and discrimination also affects carers and support persons.

Family and relationship services are positioned as a general population service, and can therefore can address stigma directly. Mental health problems are very common and, as such, can be continually normalised across all populations and cultures. Family therapy has a long tradition of engaging diverse families and communities. Practitioners using family therapy approaches have the knowledge and skills to work with diversity, kinship groups and extend cultural fitness.

Regular and well-targeted public campaigns are needed, and there is potential for high profile public figures to be prominent and influential in these campaigns. Topics can include raising awareness of particular mental health issues or directly confronting stigma. Strengthening community understanding helps build people's capacity to identify and better understand the early signs of mental distress; however, we note that improvements in community understanding and mental health literacy are not necessarily associated with a reduction in discriminatory behaviour and stigmatising attitudes.[28] Other supports are also necessary to promote a society that includes and supports, rather than excludes or demeans. A key element of reducing institutional and individual discrimination is to strengthen community understanding.

In particular, Relationships Australia considers that the understanding and conduct of health professionals has critical significance, as the lived experience of people with mental illness is directly affected by the skill, attitudes and behaviours of staff. Further, evidence suggests that longer-term anti-discrimination and anti-stigma initiatives have more success in reducing the experience of discrimination by people living with a mental health difficulty than short-term initiatives. Relationships Australia has made progress with a range of campaigns.

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[27] Cf Holt-Lunstad, J., Smith, T.B., Baker, M., Harris, T., & Stephenson, D. (2015). Loneliness and Social Isolation as Risk Factors for Mortality: A Meta-Analytic Review, *Perspectives on Psychological Science*, 10(2), 227 –237; Lim, M. (2018). Is loneliness Australia's next public health epidemic? InPsych 2018; 40(4). Retrieved from https://www.psychology.org.au/for-members/publications/inpsych/2018/August-Issue-4/Is-loneliness-Australia-next-public-health-epide; Mance, P. (2018). Is Australia experiencing an epidemic of loneliness? Findings from 16 waves of the Household Income and Labour Dynamics of Australia Survey (working paper). Kingston, ACT: Relationships Australia. Retrieved from <http://www.relationships.org.au/what-we-do/research/is-australia-experiencing-an-epidemic-of-loneliness; Masi, C., M., Chen, H.-Y., Hawkley, L., C., & Cacioppo, J., T., (2011). Meta-Analysis of Interventions to Reduce Loneliness, *Pers Soc Psychol Rev*., 15(3).

[28] CF Reavley N J and Jorm A F (2011), 'Stigmatizing attitudes towards people with mental disorders: findings from an Australian National Survey of Mental Health Literacy and Stigma', *Aust NZ J Psychiatry* Dec 45 (12): 1086-93.

Mental Health First Aid training

For example, Relationships Australia South Australia has delivered Mental Health First Aid since 2007. This is a program that facilitates the learning of staff and volunteers within community services, so that there is a stronger capacity for early intervention in the development of mental health disorders and increased knowledge to promote emotional development in the wider community context. This program has proven effectiveness in improving mental health literacy and decreasing stigmatisation.[29]

Cultural Fitness Package

In 2010, Relationships Australia adopted the Cultural Fitness Package, an ongoing training program developed by the Relationships Australia Indigenous Network. The program unpacks cultural norms and exposes privileges assumed by majority populations and the consequent impacts of inequity on Aboriginal and Torres Strait persons and people from other marginalised groups.

Racism. It stops with me

In 2013, Relationships Australia also joined forces with the Human Rights Commission and many of Australia's leading businesses, sporting bodies and NGOs to support the 'Racism. It stops with me' campaign. Work is currently underway, within our federation, to refine and strengthen our cultural fitness at a national level.

Secular services that are not religiously affiliated, such as Relationships Australia, have the added accessibility of not holding religious beliefs in regard to sexual orientation or preferences. Accordingly, they are sought out by the LGBTIQ communities, who are at greater risk of suffering mental health issues, but who also may face discrimination, prejudice or lack of sensitivity to their needs and issues by mainstream health services.

3.3.4 Valuing relationship services as a pathway to better mental health and wellbeing

Outside the GP-referred, Medicare funded psychological treatment services, there is an apparent gap in services targeting interventions for a middle group whose mental health issues are not severe enough to warrant acute care and hospital services, but whose symptoms are nevertheless debilitating for them and the family members who support them. Family relationship services could play a significant role in assisting this group.

In these circumstances, multiple family members may be at risk, as mental illness often ripples through families and can affect the safety and support needs of all family members. Service models must promote the disclosure of any serious risk (including mental health, child protection and family violence) for each family member. Service providers should position

[29] Cf Jorm A, Kitchener B, MacTaggart, Lamb A, Brand S (2007), 'The evaluation of mental health first aid in a rural area: Determining its effectiveness in improving mental health literacy, attitudes and behaviour towards people with mental health problems', Sydney: New South Wales Department of Health.

themselves in relation to the whole family, and take responsibility for safety planning for the entire family and for each individual.

For young people, it is essential that mental health services operate with the understanding that both parents are key resources to a child in supporting their safety. Given that one in three families have experienced family breakdown in contexts where a parent may not live with the referred child, services need to seek to also understand the non-residential parent's capacity to be a resource to the child or young person, and the service must engage with and include them.

There is under-recognition of the value of couple and family therapies and partner-assisted approaches. Family systems research considers the demographics of marriage and family: the powerful effects of relationships and most aspects of human wellbeing; ways of understanding multi-generational transmission of risk; characteristics of relationships such as conflict, attachment, communication, gender roles and importantly family violence. As well, there is increasing research evidence as to the efficacy of specific couple and family therapy and partner-assisted approaches for treatment of mental illness presentations.

- Carr (2009) provides evidence that family-based therapies are as effective as individual cognitive-behavioural therapy and psychodynamic therapy in the specific treatment of major adolescent depression.
- Dwyer and Miller (2006) argued that while fewer and fewer services are mandated to work with young people and families together, family work is essential to assisting recovery from trauma.
- Attachment-Based Family Therapy (ABFT) is showing promising results with depressed and suicidal adolescents (Diamond, 2014; Diamond, Diamond & Levy, 2014; Kissil, 2011; Shpigel, Diamond & Diamond, 2012). ABFT aims to promote age-appropriate reconnection and attachment between young people and their parents during this time of crisis. This model of care and treatment looks at identifying attachment issues, working with the family to understand the presenting symptoms within this context and then engaging with the family to repair attachment and reconnect with each other. The ABFT approach is in keeping with the experience that the extreme distress and emotional dysregulation seen in child and adolescent mental health emergencies is most often a reaction to relational issues, and on a background of complex intergenerational factors. Rarely does the distress represent the manifestation of a serious mental illness such as psychosis or a major mood disorder (Bikerton, 2014).

A major impediment to an increased recognition of relational processes is found in the DSM definition of mental disorder, which focuses on the patient as an individual, paying little regard to relational dynamics that may contribute to mental ill-health or which may be the result of untreated or under-treated mental ill-health. That definition, utilised since DSM-III, states that '…each of the mental disorders is conceptualised as a clinically significant behavioural or psychological syndrome or pattern that occurs *in an individual'* [our emphasis]. However relational problems such as couple distress, child abuse, or couple violence number among the most distressing and salient of difficulties producing many negative effects, including missed work, lowered school performance, and individual difficulties (Heyman *et al*, 2006)

The connection between relationship distress and mental health problems (such as depression) is cyclical, with both negatively affecting each other. As the two are interlinked, practitioners working in mental health should assess for relationship difficulties and those working with couples should be assessed for individual mental health issues, such as is routinely done at Relationships Australia.

For professionals charged with delivering services to families, we acknowledge that the move from individual therapies to more family-based care is a difficult transition. For many, their training was almost exclusively in individual therapeutic models, and a majority of clinicians report receiving no training in family work in their professional training courses.

3.3.5 Integration at the service level

Relationships Australia has also engaged with several services and networks which encourage integration at the service level. For example, Indigenous Community Links, to support Aboriginal and Torres Strait Islander community members and their families by providing links and referrals to a range of mainstream and Indigenous services, such as welfare and social support, employment, family violence, health (including drug and alcohol services), legal, child care and housing. Services also encourage the development and fostering of relationships with other service providers by promoting access and pathways to their services, including through the provision of Internet access.

The Tasmanian Suicide Prevention Community Network (TSPCN) is an example of a network of community members, service providers, organisations and government representatives who are working together to reduce the rate and impact of suicide in Tasmania. The TSPCN is supported by a Suicide Prevention Facilitator and the LGBTI Project Officers. These positions have been funded by the Department of Health and Human Services (DHHS) and staff are located at Relationships Australia Tasmania, which is funded to auspice the TSPCN. Some activities of the TSPCN include:

- holding meetings around the State to discuss ideas, learn from each other, and share information on initiatives in regard to promoting mental health, reducing stigma around mental illness and suicide, suicide prevention, early intervention and post intervention
- belonging to working groups to progress ideas that the TSPCN identifies as important, and to help organise events and awards such as The Annual Suicide Prevention Forum and the LIFE Awards
- advising on the development of the TSPCN website
- developing resources to assist the community and service providers to refer people to the most appropriate service for their needs
- assisting to develop Community Action Plans, and
- communicating the discussions and recommendations of the TSPCN membership to the State Government through the Tasmanian Suicide Prevention Committee.

Relationships Australia also provides therapeutic services to headspace, or in the case of Relationships Australia WA, Relationships Australia Victoria, and Relationships Australia

Canberra and Region, overall management and co-ordination of a headspace centre. Other models which focus on integrated services delivered by Relationships Australia include Partners in Recovery (funded by DOHA) and Family Mental Health services (DSS).

3.3.6 Addressing physical barriers to integration – options for consideration

The Productivity Commission could consider a range of options to address physical barriers to integration. This might include physical co-location of workers from a range of related services.

Model 1 - the Family Wellbeing Hubs concept

Relationships Australia has strongly advocated for measures to address the severe fragmentation of services in the family law/family violence/child protection domains. Fragmentation across these domains is severe, and contributes to unsafe, unhealthy outcomes for children and their families. Fragmentation exacerbates risks around re-traumatisation, disrupts effective therapeutic responses to peoples' needs, and can enable the continuation of violence and abuse of vulnerable people. Relationships Australia Northern Territory staff observe that an increasing number of family dispute resolution clients presents each year with multiple complex issues. They are unable to access all the siloed services they require without the clinical assistance of a social worker. Family Dispute Resolution Practitioners do make referrals, but often clients need further help navigating the services. Such assistance is currently unfunded. Relationships Australian New South Wales has, in the course of consultations run by the Department of Social Services, suggested that the capacity of the service system to respond to client referrals is a more pressing issue than planning for holistic service delivery.

<u>Nurturing integration – some underlying principles</u>

To ameliorate this fragmentation – or at the very least, families' experiences of it - Relationships Australia proposed, in its submission responding to ALRC Issues Paper 48, and refined, in its submission responding to ALRC Discussion Paper 86,[30] an idea of multi-disciplinary Hubs. These would provide primary services in the forms of universal screening, education, information, advice and support. In addition, Relationships Australia argued that a holistic service approach should be designed according to principles including:

- holistic and integrated design from and around the needs of users, and not driven by existing legal, jurisprudential, administrative, funding or single-disciplinary structures, distinctions and hierarchies;
- 'front-loading' costs through prevention, early intervention, capacity-building within families, and follow up
- offering pathways and services proportionate to families' needs and resources (ie not a 'one size fits all' journey with the expectation that expensive tertiary services are always the 'gold standard')
- that there be no wrong door and one door only and, as an enabler of this principle, that service integration and collaboration happen at the organisational level, and

[30] See http://www.relationships.org.au/national/submissions-and-policy-statements/australian-law-reform-commission-review-of-the-family-law-system.

- that services be available on the basis of universal service and accessibility.[31]

Relationships Australia advocates moving towards service models which operate collaboratively across disciplines, and be integrated seamlessly and invisibly to the end users, who could be assisted by a continuum of intervention from referrals and the provision of information to navigation assistance to full case management, depending on their needs and capacities. For optimum effectiveness, Relationships Australia agrees with Mental Health Australia that user and carer co-design is integral. We agree with MHA's proposals to

> Permanently embed arrangements for ongoing and active co-design with consumers and carers in all areas of policy and oversight, development of models of care, service and program reform, and evaluation.[32]

Users of a genuinely co-designed system would be offered preventative, crisis and ongoing services, and providers would be expected to offer support and education to build users' capacities. In addition, users would be able to choose the medium by which they engage with services at different points of time: online, offline or a combination. We agree that

> Genuine engagement [in co-design] results in greater consumer and carer empowerment and, ultimately, higher return on government investment.[33]

<u>A pathway to integration - an opportunity for transformational consumer co-design</u>

Families Hubs would be a place for knowledge and skills acquisition (eg to build capacity), assessment feedback, skills training and coaching through peer workers, community supports and medical assistance. The services offered at and through particular Hubs should, to maximise the effectiveness of place-based services, reflect the needs of its community.

The 'hub concept' of service is flexible and deliberately non-prescriptive - hubs must take a range of forms to meet the needs, circumstances and exigencies of the communities which they serve. They could be housed in bricks and mortar premises; they may be online; they may exist by virtue of robust and effective cross-professional collaboration, or they may combine any or all of these. The essential parameters of the 'hub', physical or virtual, are:

1. one door only/no wrong door
2. ease of access, physically, online, or in combination
3. universal screening
4. a continuum of navigation assistance, from simply providing information, through navigation to intensive case management, and

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[31] Relationships Australia has previously observed that family law and family relationship services have long provided timely and effective help to clients with high rates of disadvantage within a universal framework.

[32] Mental Health Australia, *2019 Election Platform*, 6.

[33] Mental Health Australia, *2019 Election Platform*, 6; MHA acknowledges the National Consumer and Carer Forum, *Consumer and Carer Participation Policy: a framework for the mental health sector*, 2004. Relationships Australia understands that this Policy is currently under review: https://nmhccf.org.au/publication/consumer-and-carer-participation-policy

5. integration and collaboration between services dealing with the family in a way that is seamless for, and invisible to, the family.

The services offered at and through particular Hubs should reflect the needs of the people who live in the community. Potentially, they could include:

- universal risk screening, triage, warm referrals and safety planning
- mental health services (including mental health services for children)
- facilities for service users to access, in safety and privacy, online information and online services (including online services)
- children's advocacy centre (CAC) or Barnahus-type facilities for children who have been affected by violence or sexual abuse[34]
- case-management for families with co-occurring needs
- Aboriginal and Torres Strait Islander workers
- CALD workers
- social workers
- child development professionals
- psychologists
- financial counsellors[35]
- gambling counselling
- addiction counselling
- behavioural change programmes
- housing assistance
- an embedded Centrelink presence
- legal practitioners to provide early advice on co-occurring legal needs presented by users
- space for education programmes to be conducted.

Not necessarily bricks and mortar

Relationships Australia supports the notion of hubs as a family separation specific application of the concept of place-based services.

The physical Hubs could be totally or partially co-located with existing services, or be within or adjacent to places of social significance and ease of access, such as schools, community and health centres, family relationship centres, or shopping precincts. Like the Collingwood Neighbourhood Justice Centre (see Model 3 below),[36] physical Hubs could also offer space after hours for community activities, enhancing their utility and image as community resources.

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[34] For more information, go to: http://www.dcac.org/.

[35] In 2015, Women's Legal Service Victoria completed a pilot in which financial counsellors were involved in the support of family violence survivors, from the initial contact with the service. The pilot, described in the 'Stepping Stones' report, demonstrated that early access to financial counselling can markedly improve the speed and degree by which survivors can recover, financially and psychologically, following separation from abusers.

[36] Or, in the context of multicultural services, Access Gateway in Queensland: https://www.accesscommunity.org.au/the_gateway.

For some communities, a physical Hub may not be practical, resource-efficient or helpful to serve the community, and its purposes will be better achieved by virtual and online services, or other flexible means of collaboration. For example, in some smaller communities, people will often need a choice of services to offer appropriate assurance as to privacy and confidentiality.

Relationships Australia notes that recruitment of specialised professionals to live and work in particular areas can also pose significant challenges. Other models are also being explored in the family law/family violence domain,[37] and technology could support the establishment of Virtual Hubs.

Virtual Families Hubs could be based on the existing Family Relationships Advice Line service, operated by Relationships Australia Queensland and Culshaw Miller Lawyers. Current service offerings of the FRAL give clients access to well-designed, case managed approaches which use multi-disciplinary services to overcome barriers to service access, including conflicts of interest or lack of specialist professionals in a particular area to provide face-to-face services.

Existing use of a hub model in providing mental health services

Since January 2016, Relationships Australian Queensland has run the Logan and Southern Moreton Bay Islands Mental Health and Wellbeing Hub. It is funded by the Queensland Mental Health Commission until December 2019 as one of three *Regional mental health and wellbeing hubs*.[38] The Hub services aim to build resiliency and strength of those in the Logan and Southern Moreton Bay communities, and is now in its third year of operation.

The central tenet underpinning the service is that good mental health and wellbeing is the foundation of flourishing individuals, families, and communities, and a prerequisite of long-term social and economic prosperity. The Hub initiative uses existing evidence-based mental health and wellbeing frameworks, programs and tools such as the Wheel-of-Wellbeing (WoW). WoW, as developed and widely used across the United Kingdom by South London and Maudsley (SLAM) National Health Service, is informed by an extensive body of evidence that is translated into a practical and accessible framework and tools.

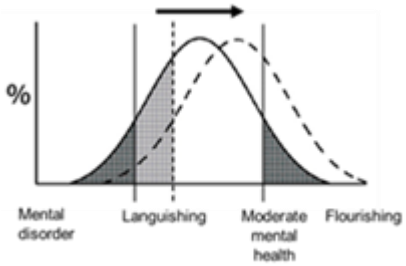
The model focuses on coordination of services across the catchment community. Evidence has demonstrated that an early intervention, community-based approach provides an opportunity to both improve the mental health and wellbeing of the population and reduce the incidence and impact of mental illness and suicide. As part of this initiative, Relationships Australian Queensland works with families and children through Kingston State School, in partnership with Kingston East Neighbourhood Group and the Benevolent Society, to promote 'wellbeing' skills in

[37] See, for example, the New South Wales trial in which family violence survivors will be housed in purpose-built units with access to on-site support where providers can come to them, as well as access to other social amenities: Anna Caldwell, 'Female domestic violence victims given two-bedroom units to live in, Daily Telegraph, 1 May 2018, quoting the New South Wales Minister for the Prevention of Domestic Violence, the Hon Pru Goward MP.

[38] In light of its successful delivery of the Hub initiative, Relationships Australia Queensland has been awarded the role of Statewide Wellbeing (WOW) Support Program to promote this wellbeing approach across the state, through multiple stakeholders, in a way that supports long-term, sustainable implementation.

vulnerable and at risk families. As stated, the wellbeing hub initiative is aimed at increasing the capacity of existing service providers in Logan to promote wellbeing skills in their clients.

Quote from a Wheel of Wellbeing workshop – “Achieving a small change in the average level of well-being across the population would produce a large decrease in the percentage with mental disorder, and also in the percentage who have sub-clinical disorder (languishing)”: Foresight Report (2008)



Model 2 – Family Advocacy and Support Services

The pilot of multi-disciplinary and co-located Family Advocacy and Support Services arose from the Third Action Plan under the *National Plan to Reduce Violence against Women and their Children 2010-202*2. The Services are intended for families experiencing family violence and the pilot sites are located in family law court registries. They:

- offer services on the basis of *universal* service and accessibility
- provide risk assessment
- prepare safety plans
- deliver holistic services to victims and perpetrators of family violence
- provide continuity of service between the State/Territory and Federal systems
- provide better support for peoples from Aboriginal and Torres Strait Islander communities and culturally and linguistically diverse communities.

The Federal Government funded the pilot with $18.5 million over three years (2016-2019). The FASS has been piloted in 23 service locations, comprising 16 family law courts (or local courts in the Northern Territory) and seven circuits. In each of the 16 permanent registries, the commissions established an integrated duty lawyer and family violence support service to help families navigate the family law courts where there are concerns of family violence. The roles of the duty lawyer and family violence support worker include:

- safety planning
- pre-court support
- legal advice
- trauma-informed social support and referral services
- providing information to escape the Knowledge Labyrinth of family law, domestic violence and child protection jurisdictions

- referring clients to specialist family violence, family support and other social services, as required.[39]

In its submission responding to ALRC DP86, Relationships Australia supports the expansion of FASS facilities to complement Families Hubs in communities.[40] Relationships Australia noted the observation, in the 2018 *Closing the Gap* report, that

> Early feedback from legal aid commissions is that the service is meeting a crucial need and that their lawyers' enhanced ability to intervene early and liaise with social workers is helping them to better identify clients' non-legal needs and support them to access other supports.

Relationships Australia New South Wales currently manages the men's FASS in Parramatta, which has achieved very positive outcomes for clients in the course of the FASS pilot. However, current funding arrangements limit the presence of FASS staff in the Court to just one day per week in Parramatta and half a day in Wollongong. This simply is not sufficient, and we would hope that a rollout of FASS facilities would be funded to provide a significantly increased service level. We acknowledge that, in his Budget speech for 2019-2020, the Treasurer has announced that a further $7.8 million over three years would be provided to employ dedicated men's social support workers. In our submission responding to ALRC DP86, Relationships Australia offered several examples of how this service model has benefited clients; in particular, how Relationships Australia New South Wales involvement in the FASS pilot has benefited clients. We further recommended that States and Territories collaborate with the Australian Government to include FASS facilities at state and territory courts that exercise family violence and/or child protection jurisdictions.

The Victorian Orange Door is a further example of an initiative that recognises the importance of multi-disciplinary and holistic services that are designed to be easy to access. Through Orange Door services, people can access a range of family violence and family services, in person or over the telephone. These services include, for example, specialist family violence workers, Aboriginal services and services for men who use violence. Through Orange Door, people can be connected with other relevant services.[41]

Model 3 - Collingwood Neighbourhood Justice Centre

An example of successful co-location is the Collingwood Neighbourhood Justice Centre, where workers employed by a range of services are embedded in a single location. The Collingwood NJC provides the widest range of service of any justice centre in Australia, and is based on the Red Hook approach from the United States of America.

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[39] See inside policy, *An Evaluation of the Family Advocacy and Support Services – Final Report*, 18 October 2018, 13.

[40] At the time of writing (March 2019), the ALRC's final report on its review of the family law system has not been published. Relationships Australia notes, however, that the ALRC received numerous submissions supporting the FASS model of services for families with complex needs.

[41] For more information, see https://orangedoor.vic.gov.au/

Available services include:

- mental health clinical support
- victims' support
- mediation
- specialised family violence services
- drug and alcohol treatment
- financial counselling
- housing support
- employment and training support
- Aboriginal and Torres Strait Islander support services, and
- refugee and migrant support.[42]

The Productivity Commission could also consider the Family Wellbeing Hubs concept, advocated by Relationships Australia in its submissions to the Australian Law Reform Commission and outlined in Model 1 above.[43]

Model 4 – Case navigators

A complementary model to assist users to access the services they need is a case navigation model, and has been effective in other health settings. One example is the Patient Navigator Service offered by the Peter MacCallum Cancer Centre:

> Your patient navigator is an important member of your care team. They work closely with you, your doctors, nurses, pharmacists and allied health professionals, like physiotherapists and social workers, to ensure you receive the right care in the right place at the right time. Your patient navigator is the first person you should contact if you have a question about appointments in Specialist Clinics or Allied Health. They are also the first person you should call to get help with clinical questions or if you are feeling unwell. The patient navigator is an administration role and so if your question is clinical in nature they will pass on a message to your care team to call you back….**Your patient navigator can help you by:**
>
> - Answering routine questions.
> - Helping you understand appointment instructions or change appointment times if possible.
> - Help you get in touch with your nurse consultant or another member of your care team if you have a clinical question or feel unwell.
> - Pass on your messages to your care team to ensure you get the help you need.[44]

[42] See https://www.neighbourhoodjustice.vic.gov.au

[43] See https://www.alrc.gov.au/inquiries/family-law-system

[44] See https://www.petermac.org/location/melbourne/your-patient-navigator [emphasis in original].

There are also online navigation approaches, such as the Counterpart Navigator App, supported by the Victorian Government:

> When you have questions about your cancer diagnosis, treatment or life after cancer, finding the right information online can be overwhelming. Counterpart Navigators are a stepping stone to reliable up-to-date information on topics you may want to know about. The Navigators included in the app are:
>
> - Breast cancer
> - Cervical cancer
> - Ovarian, fallopian tube & primary peritoneal cancers
> - Placental cancer
> - Uterine (including endometrial) cancer
> - Vaginal cancer
> - Vulval cancer
>
> Each Navigator is divided into separate sections to make it easy to find the information you want. The Navigators are reviewed by qualified Australian health professionals and women who have experienced breast or a gynaecological cancer.[45]

The concept of navigator services that attracted several submitters to the ALRC review of the family law system (eg the Centre for Innovative Justice).

Continuity in navigators, where practicable, would be optimal to support the development of trusting relationships with users who have ongoing and complex mental health needs.

4 Suicide prevention

> Unfortunately, suicide prevention is too often a low priority for governments and policy-makers. Suicide prevention needs to be prioritized on global public health and public policy agendas and awareness of suicide as a public health concern must be raised by using a multidimensional approach that recognizes social, psychological and cultural impacts (WHO, 2014). A national suicide prevention strategy is important because it indicates a government's clear commitment to prioritizing and tackling suicide, while providing leadership and guidance on the key evidence-based suicide prevention interventions (WHO, 2014).[46]

Relationships Australia supports a public health response to suicide prevention, noting the observation by the World Health Organization that:

[45] https://www.counterpart.org.au/information/navigators/

[46] Cited in *National Suicide Prevention Strategies – Progress, examples and indicators*, World Health Organization, 2018, https://www.who.int/mental_health/suicide-prevention/national_strategies_2019/en/, 1.

> A national suicide prevention strategy needs to be multisectoral, involving not only the health sector but also sectors such as education, labour, social welfare, agriculture, business, justice, law, defence, politics and the media….
>
> It is important to identify the key stakeholders in suicide prevention when developing a national strategy. Suicide prevention needs to involve different actors and disciplines working on suicide prevention – such as different ministries, health administrations, nongovernmental and nonprofit organizations, universities and civil society at different levels (national, regional, state or provincial, and community). Lead stakeholders are listed according to strategic actions for suicide prevention in WHO's Preventing suicide: a global imperative (WHO, 2014). Potential stakeholders at community level can be found in WHO's Preventing suicide: a community engagement toolkit (WHO, 2018b).[47]

Detection and treatment of mental illness is only one facet of a holistic public health approach to suicide prevention, noting that the most effective national suicide prevention strategies have a range of elements, as shown in the framework recommended by the World Health Organization. It would be useful to strongly articulate strategies that include collaboration by all stakeholders who can affect the rate of suicide, and that support models which encourage care outside of the medical system (for example, the Tasmanian Suicide Prevention Community Network). Strategies that assist caregivers and other related community services to provide follow-up care should also be considered.

The Blackdog Institute has referred to the importance of an integrated systemic approach to suicide prevention in its *Life Span* program. The core features include multi-sectorial involvement by all government, non-government, health, business, education, research and community agencies and organisations that operate within a localised area.

Relationships Australia also supports strategies that increase the accountability and reporting of health administrators, including the requirement for them to engage with the suicidal person and their support network, including family and non-family informal and formal caregivers. We would like to draw attention to the need for baseline data and a responsible entity that is adequately resourced to monitor and report on suicide nationally.

It would also be useful to consider storage and handling of information about client suicidality. The risk and associated stress of holding information from a client regarding suicidality, particularly in an environment where more appropriate support services are not readily available, causes much concern for our practitioners.

Suicide prevention strategies tend to focus on either the 'pointy end', where people are actively suicidal and at highest risk of completing a suicide attempt, or upstream with a preventative or early intervention focus, but support services at each intervening point of the continuum are less readily available.

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[47] Cited in *National Suicide Prevention Strategies – Progress, examples and indicators*, World Health Organization, 2018, https://www.who.int/mental_health/suicide-prevention/national_strategies_2019/en/, 5-6.

A number of our clients are distressed on a daily basis, and there is a need for a system that provides continuity of care for those at risk of suicide and protocols for sharing information to reduce risk for these clients (see, for example, the client whose situation was described in the case example provided in section 3.2.1)

Relationships Australia supports the recommendation of Mental Health Australia to provide community-based assertive outreach to people who have attempted suicide.[48]

5 Aboriginal and Torres Strait Islander mental health and suicide prevention

The issue of mental health and suicide prevention in Aboriginal and Torres Strait Islander communities receives, tragically, almost daily media coverage, and has been high on the list of priorities of successive suicide prevention strategies at national and state/territory levels for decades, to desperately little effect. We strongly believe that cultural fitness and well-developed cultural governance structures are foundational to addressing the epidemic rates of Aboriginal and Torres Strait Islander mental health and suicide prevention.

Relationships Australia notes that healing of historic and multigenerational trauma is a necessary precursor to, and enabler of, health and well-being. How can this be captured (and measured) as an outcome? It may be that experience in Canada and New Zealand offers some guidance as to how this might be done but, fundamentally, this must be led by Aboriginal and Torres Strait Islander people. Relationships Australia notes that, given historic trauma arising from interventions by governments and service providers, clients who identify as Aboriginal or Torres Strait Islander, in particular, must be offered a soft entry point to services, and services need to be supported to invest in long-term development of relationships with individuals and communities. As Relationships Australia has observed in other consultation processes,

> The layer of mistrust attached to mainstream non-Indigenous services *adds to* well-recognised barriers to participation such as poverty, lack of transport, systems abuse and disengagement experienced by many disadvantaged and vulnerable client groups. [emphasis added]

Relationships Australia notes the imperative for both Aboriginal organisations and non-Aboriginal organisations to be culturally competent. Not all Indigenous clients want to use an Aboriginal controlled service (for example, in communities where there may be conflicts of interest or kinship relationships that make it awkward).

It is essential that Aboriginal and Torres Strait Islander people are supported to choose their service providers. In our experience, integrated family systems approaches can be a better fit for servicing Aboriginal and Torres Strait islander people as they may be better positioned to engage with kinship and community groups as opposed to individualistic, potentially shame-inducing approaches. It is vital that ongoing work in this area take into account, and respond to, the high levels of disconnect between services and those most disengaged in the

[48] Mental Health Australia, *2019 Election Platform*, 2.

community. New strategies to bridge this gap and foster respectful and relevant engagement are urgently needed.

Relationships Australia Western Australia prioritises hiring and supporting Aboriginal and Torres Strait Islander staff and is currently working to build relationships with several Aboriginal Community Controlled Organisations. Relationships Australia Western Australia supports empowering and supporting ACCOs, including through transitioning funding in a way that will best tend to support success. Workforce planning and development, to staff ACCOs with appropriately qualified and skilled workers, is vital in this regard.

Relationships Australia notes that it can be difficult to find suitably qualified and skilled staff, particularly where the service requires professional, tertiary level qualifications, as is the case for many of the services provided by Relationships Australia. Many staff require support on their journey to obtain these qualifications, which is expensive for an organisation that needs to maintain mainstream service delivery targets, and requires a long-term commitment from both staff and the organisation.[49]

Relationships Australia Northern Territory, for example, hires and supports Aboriginal and Torres Strait Islander staff for both mainstream and Aboriginal Specific Positions. It has supported Aboriginal and Torres Strait Islander staff to undertake a range of relevant qualifications including:

- Diplomas in Counselling
- Certificates in Youth and Community Work
- Nationally Accredited Mediators courses, and
- Vocational Graduate diplomas in both Family Dispute Resolution and Relationship Counselling.

Most of the Relationships Australia organisations have accessed the Family Relationship Services Australia scholarships for Aboriginal and Torres Strait Islander and Culturally and Linguistically Diverse people, which are funded by the Attorney-General's Department.

Aboriginal and Torres Strait Islander clients need access to Aboriginal and Torres Strait Islander practitioners, and to male and female counsellors. In terms of outcome measurement, Relationships Australia suggests that 'client level reporting' is not apt for cohorts that, as a matter of culture, focus on community level outcomes. Community level metrics might include:

- fewer child removals

[49] In 2009, Relationships Australia Canberra and Region offered a Diploma of Counselling Course for Aboriginal and Torres Strait Islander people with seed funding from government (although it was largely self-funded over its years of operation). It is a mainstream qualification, but has tailored content that was developed in consultation with Aboriginal and Torres Strait Islander community stakeholders. It was positively evaluated by its 64 graduates. Unfortunately, we are not currently offering this qualification due to resource constraints. Some of our Indigenous staff are working towards counselling qualifications through our registered training organisation at Relationships Australia South Australia.

- improved school enrolment, attendance and retention
- reduced youth incarceration, and
- reduced family violence.

Funding bodies will need to accept that the outputs of programs [oriented to measurement of such outcomes] will be fewer, but that there is huge potential that the longer term outcomes will be better. We call these 'community-building' programs.[50]

Community-based services may also be better equipped to deal with the social determinants of mental health through interconnection with other services including, housing, employment, social inclusion, drug and alcohol, and family violence through integral service models that are 'complex case capable'. It is also vital to take into account the effects of intergenerational trauma when working with Aboriginal and Torres Strait Islander people and their communities. Given the prevalence of exposure to trauma and the chronic grief relating to the loss of lands, identity and culture, trauma-informed practices and understanding of the effects of institutionalisation are also imperative, as is recognition of traditional healing approaches. Western mental health services do not have a strong record of being able to readily reach and assist Aboriginal and Torres Strait Islander people.

It is evident that there is a practical inaccessibility of existing services, due to logistical issues of access (transport, making/keeping appointments etc), fear or resistance relating to previous negative experiences of services that prevent re-access, and the absence of assertive outreach to identify and support Aboriginals and Torres Strait Islander people who may be at risk of mental illness. These factors compound the current lack of service system capacity to design and deliver culturally relevant, holistic mental health services.

6 Mental wellness in the workplace

Relationships Australia recognises the need to respond to mental health needs of clients as a key part of delivering any support services, and provides a range of mental health training, employment assistance programme counselling and mediator services. For example, in Relationships Australia South Australia, 'COPE at work' (funded by the State government) delivers workforce training to mental health non-government organisations to increase mental health literacy and capacity to effectively respond to people affected by mental illness. The Mental Health First Aid (MHFA) training program facilitates the learning of staff and volunteers within community services so that there is a stronger capacity for early intervention in the development of mental health disorders and increased knowledge to promote emotional development in the wider community context. These programs give people skills and knowledge to provide a good first response to people disclosing suicidal ideation and / or experiencing episodes of ill mental health and provide pathways to support and professional assistance.

[50] At p 9.

7 Funding

7.1 Funding holistic, 'lifespan' outcomes while ensuring accountability

Funding mechanisms do not encourage service providers to focus on improving whole-of-life user and carer outcomes. Some of the main problems include:

- differences in the objectives and aims of program streams
- lack of discrete funding for evaluation and research
- short and/or non-ongoing funding cycles, and
- output driven performance indicators.

Relationships Australia acknowledges a tension between the need for the funding body to be assured that the contractual requirements of the funding agreement are met, and imposing on funded bodies unduly onerous reporting burdens - especially given the difficulty in defining and collecting outcome measures.

Outcomes must be relevant, achievable and measurable. The literature of collective impact supports the view that a strong outcomes focus provides a shared vision that can bind agents with different orientations and competing agenda, and thus support effective systems reform. It is optimal to engage communities, clients, individual practitioners, funders and researchers in developing outcomes, and we encourage governments to facilitate this engagement.

A robust outcomes framework must be trauma-informed, and sensitive to the impact of asymmetries of power and knowledge, and the enduring impact that abuse of power, as well as the social determinants of health, has had on marginalised families, including through intergenerational trauma. In summary, it is useful to start from the question: 'what has happened to them?', rather than 'what is wrong with them?'

An outcomes framework should also articulate an overall program logic to outline how different levels of outcomes fit together towards the overarching outcomes; the program logic should distinguish population goals (a government responsibility) from program goals (a service provider responsibility). Population goals should be developed with reference to research that indicates an association between improvements in 'social and economic capital' with good mental health – eg by reducing poverty, reducing the gap between rich and poor and building community connections.

Case management approaches are more likely to focus on improving outcomes for clients, but these types of services are resource intensive and expensive to fund. Relationships Australia is continuing to explore approaches which allow customers to self-service, such as on-line services, to improve and expand service reach in a cost effective way, while maintaining intensive face-to-face services for those clients requiring a higher level of care.

It is also important to note the existence of a very real Digital Divide, in which there are significant cohorts of Australians who do not have access to reliable, safe and private facilities by which to engage online.[51]

Programs where funding is linked to service integration appear to be most successful in providing integrated services to clients; however, there is little robust evaluative evidence as to whether these service models improve whole-of-life outcomes for consumers and carers.

Programs which have arbitrary caps on service provision also do not encourage holistic service provision which is focussed on achieving and maintaining long-term client outcomes. For example, invoice based systems (eg NDIS) do not encourage follow-up, referral and review of clients, and services funded under these types of models tend to provide specific service outputs in accordance with the invoicing system, not in response to user needs. These types of models do not encourage innovation, collaboration or networking outside the requirements for delivering the service output.

Priority could be given to clients who face significant financial barriers to service provision. Flexibility for service providers to direct funding to meet the specific needs of clients would also be beneficial in achieving improved client outcomes, and results should be measured with outcome-based, rather than output and compliance, reporting requirements. Users' needs can be complex, and are inherently dynamic, so funding arrangements must, to be effective, accommodate real time flexibility in service type and dosage. Accordingly, users might best be served by being able to access a mixture of universal, targeted and place-based services, preferably through a single portal – or at least through a 'no wrong door'/'one door only' route. It is unclear whether splitting funding based on a characterisation of specific needs (for example) will simplify accessibility, or support greater efficiency for funders or service providers. As noted previously, service fragmentation can stymie help-seeking by clients and hinder effective delivery of joined up services.

There also seems to be conflict between the approaches taken by the Commonwealth Government in different programs. For example, Government tenders for family and relationships services have sometimes permitted applications where up to 10% of funding was used for innovation, yet the NDIS service model and Stronger Relationships Trial were fee for service models.

7.2 Political and budget cycles – irreconcilable with effective services and capacity building?

Relationships Australia notes that the widely-shared predilection for establishing short-term pilot programs to meet contemporary exigencies, and then de-funding such services (whether evaluated as successful or not) militates against the establishment of trusting therapeutic relationships, employment and retention of skilled and experienced staff, and investment in vital infrastructure. Clients and community groups consistently express disappointment at the 'here today/gone tomorrow' approach which characterises short-term funding commitments.

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[51] See Roy Morgan et al, *Measuring Australia's Digital Divide*, 2018, https://digitalinclusionindex.org.au/wp-content/uploads/2018/08/Australian-digital-inclusion-index-2018.pdf

Relationships Australia has observed elsewhere that the constant rolling out of new, short-term programs imposes significant administrative burdens, potentially distracting time and energy, as well as money, from service provision. These cycles lead to worker and client fatigue, distrust, and little long term benefit to users.

Programs that are place-based, and intending to effect change at a cultural or intergenerational level, need stable funding over long periods of time; ideally, 20 years. A concerted emphasis on capacity building will eventually reduce the community need for targeted services, but such a shift might not be discernible for 7-10 years. This is very challenging from a budgetary / public accountability / political cycle standpoint, and requires commitment from leaders to communicate and persuade as to the benefits of such longer cycles as are needed to disrupt (and ultimately halt) cycles of entrenched disadvantage and dysfunction and reap the far-reaching and multidimensional socio-economic benefits of doing so.

The relationship between planning and commissioning processes can also be problematic. In a competitive funding environment, it is necessary to separate planning processes and commissioning processes to ensure probity. Safeguards are necessary to ensure that consultation processes focus on clear outcomes and that the evidence base is sound.

Concluding remarks

Thank you again for the opportunity to participate in your consultation. We look forward to considering the draft report that emerges from this stage of the process. Should you require any clarification of any aspect of this submission, or would like more information on the services that Relationships Australia provides, please contact me or Dr Susan Cochrane

Yours sincerely,

Mr Nick Tebbey
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