Productivity Commission Inquiry into Mental Health
Relationships Australia South Australia Submission | April 2019

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EXECUTIVE SUMMARY

Relationships Australia South Australia (RASA) welcomes the opportunity to provide input to the Productivity Commission's inquiry into mental health. We recognise the importance of greater community understanding about the effect of mental health on people's ability to participate and prosper in the community, and the effects it has more generally on our economy and productivity.

RASA is an independent, not-for-profit community organisation with nearly 70 years' experience improving the wellbeing of over 27,000 clients, including vulnerable and disadvantaged children, youth, adults and families, each year. RASA services operate within a public health framework that recognises the significance of the social determinants of health and the importance of strong social and family connections.

The mental health system is currently characterised by disjointed service provision and service gaps due to compartmentalisation of the service system in relation to comorbidities commonly associated with mental ill health. We have included five case studies to illustrate the lack of service integration we experience when attempting to work with the broader system. In our opinion, service fragmentation is a major concern because it amplifies the burden of mental illness for the individuals involved and ultimately for the broader community.

From our relationship service perspective, people experiencing family breakdown often have a constellation of problems including family violence, problem gambling, and risky alcohol or other drug use that have negative and often long-term harmful impacts on mental health, family wellbeing and economic participation. While we recognise a biomedical approach is necessary for many aspects of the treatment of mental illness, we believe a population health approach is also vital to ensure there is an appropriate response to comorbidities especially relationship and social stressors.

Failure to work with the relational contributions to and consequences of mental ill health is a common feature of the current fragmented system. We believe there is a need for stronger understanding and promotion of the bi-directional nature of family wellbeing and individual mental health. There is ample evidence that family dysfunction significantly diminishes individual mental health, often producing mental illness. Equally, an individual's mental illness tends to harm family functioning and diminishes social connections.

Children are particularly vulnerable to cumulative harm in families with multiple and complex problems in which the unremitting daily impact of numerous adverse circumstances and events profoundly and exponentially harm their wellbeing. Without support, children from these situations are acutely at risk of serious mental illness.

Research and our practice experience demonstrate that there are high rates of comorbidity unique to Aboriginal and Torres Strait Islander and culturally and linguistically diverse families that are amplified by multiple experiences of stigma and discrimination within the service system and the broader community.

Overall, in our experience, the needs of individuals living with mental ill health are often 'shoe horned' into a service system that is silo-bound, crisis oriented and often chaotic due to the fragmented and disjointed responses offered. This service chaos imposes an array of burdens on unwell individuals and their families requiring them to navigate a complex service maze. While risk is often managed case by case through partnerships and professional relationships between

individuals across different service providers, fragmentation imposes heavy burdens on individual clients as well as their workers.

We believe that there are a number of features of an efficient, integrated and holistic model of mental health support services. These include triage and stepped care at point of entry; joined up services provided early as well as beyond crises; clearly defined and agreed pathways through the system; collaborative approaches between family relationships services and mental health treatment services to manage the complex interplay between interpersonal relationships and mental health; collaborative care that optimises the role played by all providers, and; duration and intensity of support that is based on routine assessment and review, rather than arbitrary caps on service offerings.

At RASA, we have an evidence-based universal risk screening tool and framework, the Detection Of Overall Risk Screen (DOORS) that ensures all clients are systematically asked about the constellation of risks that impact their wellbeing. DOORS screening is an important engagement process at RASA that maps with the client their concerns, strengths and vulnerabilities. This enables us to develop relevant and well-sequenced intra- and inter-agency service responses, which are especially important in complex situations. DOORS also supports us to work collaboratively with other services and supports workers to share responsibility for managing complex case decision-making and acute situations.

Coherent service responses require agreed holistic screening protocols, validated assessments, evidence based interventions, and robust outcome measures, at all levels of service delivery, across organisations, sectors and jurisdictions. We believe there is an urgent need for a service framework that effectively and efficiently structures, guides and monitors the delivery of quality mental health care, at both individual and population levels.

While we recognise the government has gone some way to describe how they will coordinate and integrate services across sectors, governance processes to enable system transformation require greater clarity, especially in relation to the bridge between individual and population health outcomes. Joint planning, integrated communication technology, comprehensive change management, incentives, measurement, professional development, service user engagement, and innovation are required to enable the available services to be more effective. In our experience, key systems, processes, and behaviours necessary to facilitate coordinated care and an integrated system require robust leadership and a strong commitment to overcome roadblocks created by service silos.

Governance underpinned by accountability systems, measurement frameworks and a commitment to collective impact is required. Producing relevant data analysis based on meaningful outcomes and monitoring arrangements cannot be created at the service level alone. Instead, government must lead a whole of system development. Such a development would provide the basis for program level measurement that could replace service activity compliance. This would ensure services are focussed on effectively tracking and measuring client benefit rather than service outputs.

Client outcomes monitoring that aligns with population health measurements is an essential component of the necessary service system transformation. To achieve this, a culture change across the system, among professional groups and within service organisations is required.

Without committed leadership and effective governance systems that embrace the role of holistic services and multi-agency responses, there will be no system transformation. It will take courageous

leadership to establish, problem solve, monitor and evaluate transformation of the mental health and associated systems.

Building collective accountability involving all stakeholders (including clients) relies on a holistic and coherent system that detects and responds to the social determinants of health as well as treatment of acute episodes of illness. It is critical that family relationship services are recognised as an integral component of the mental health system.

INTRODUCTION

RASA welcomes the announcement of the Productivity Commission's inquiry into mental health and appreciates the opportunity to comment. We recognise the importance of greater understanding about the effect of mental health on people's ability to participate in and prosper in the community, and the effects it has more generally on our economy and productivity.

RASA is an independent, not-for-profit community organisation with nearly 70 years' experience improving the wellbeing of vulnerable and disadvantaged children, youth, adults and families. We provide a broad range of supports to over 27,000 clients per year. RASA services operate within a public health framework that recognises the significance of the social determinants of health, especially the importance of strong social and family connections.

Our Strategic Plan 2016-2021 articulates the organisational values of respect, diversity, belonging and learning, with Strategic Goal 1 'Improve individual, family and community wellbeing' delineating target actions to build and strengthen healthy relationships. We believe that positive social connections and nurturing families are the hub of wellbeing. The sense of belonging and family caring are important sources of wellbeing and mental health for individuals throughout their lives. How families function, including how family members communicate, relate, and maintain relationships, and how they make decisions and solve problems, can either undermine mental health or serve as a protective resource.

We believe a stronger understanding within the mental health system about the bi-directional relationship between family wellbeing and individual mental health is required. In our experience, family dysfunction significantly diminishes individual mental health, often contributing to mental illness. Equally, an individual's mental illness significantly affects the successful functioning of the family and tends to diminish social connections.

When a young person or child is affected by mental illness, parents undertake the role of carer. Caring responsibilities for adults living with a mental illness tend to fall to spouses, siblings, teenage children, or ageing parents, and to adult children for the elderly. Families react and cope in different ways and at different stages of the mental health problem. While some family members can pull together, without support others lose their collective strength. Ironically, the chronic stress that carers experience, along with the practical demands of caring, tend to create mental health problems that ultimately harm day-to-day living, health, careers, and financial security of multiple members of the family.

When family caring responsibilities break down, individuals with mental illness become reliant on the social support systems and are often acutely at risk of homelessness. The social and emotional costs of the breakdown of family support systems are high and ultimately result in high financial costs to the community through attempting to provide care and support for individuals with mental health concerns.

A core aspect of family and relationship services at RASA is addressing the modifiable risk factors, and strengthening protective factors associated with family wellbeing. We specialise in helping families to manage life changes and challenges so that they can have resilient relationships, look after their children, and be productive and contributing members of the community. We also provide therapeutic support services to enhance the wellbeing of children and young people who are at risk of an emerging mental health issue.

In all of our work, we use a restorative practice approach, bringing together individuals, families, social networks, and professional networks, through informal and formal processes, to proactively build relationships that resolve or prevent conflict and wrongdoing. The fundamental premise of restorative practice is that people are happier, more cooperative and productive, and more likely to make positive changes when services and authorities do things *with* them, rather than *to* them or *for* them. This aligns with the principles of the Ottawa Charter for Health Promotion and continues to be a core aspect of RASA's theory of change.

Through the Australian Institute of Social Relations, our Registered Training Organisation, we have since 2005 provided an internationally recognised Mental Health First Aid training course to a wide range of professional groups, providing them with a basic understanding of, and response strategies for, mental health problems affecting Australians today. In 2006 we also developed square (Suicide Questions Answers and Resources), an education resource for GPs and other community health professionals. These materials, located at www.square.org.au continue to be used across Australia.

Our submission draws heavily on this substantial body of knowledge and experience arising from our service provision, and is significantly enhanced by the valuable insights provided by our client groups into the effects of mental health. This places us in a strong and informed position to provide input to the inquiry.

RASA's WORK WITH MENTAL ILL-HEALTH

RASA services primarily operate at the prevention and early intervention stages of the continuum of care, however, our holistic detection of risks means we are aware that we are often working with clients and their families who are living with significant and sometimes acute mental illness. We are one of many community sector service organisations providing important support to individuals, families and communities dealing with distress, psycho-social challenges and trauma that can lead to, or have resulted in, mental ill-health or diagnosed mental illness.

The existing mental health system, oriented as it is towards tertiary care, provides essential treatment for those diagnosed with a mental illness. The family relationships services sector provides a continuum of support to individuals and families from first point of contact at a moment in time where our responses are able to significantly mitigate or alter their trajectory into mental ill health or need for tertiary care. Family relationships services regularly identify factors that affect the mental health of individuals, families and communities and assist people to address relationship related difficulties.

We have conducted an audit of over 3,200 client files from 2013-2018, and found that a significant proportion of clients reported mental health concerns, along with violence and harm to children. The table below provides a summary of client self-reported mental health concerns at intake.

DOORS (Detection Of Overall Risk) item	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 concern
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 concern
If yes, do you feel that way lately?	9.5%	599	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)
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)

Relational co-morbidities, such as family violence, neglect of children and family breakdown are often neglected within the mental health system. We have provided five case studies within this submission that describe how our services respond to and work alongside mental ill health.

THE LINK BETWEEN FAMILY BREAKDOWN AND MENTAL HEALTH CONCERNS

It is well established that there is a bi-directional relationship between mental health and family breakdown (McIntosh & Ralfs 2012; Gibb, Fergusson, & Horwood, 2011; Mooney, Oliver, & Smith, 2009). The concept of family breakdown is broader than separation and divorce. It may be a process that can be gradual or abrupt or occur well in advance of actual separation. The pathways that couples take are diverse: they may have trial separations, or trial reconciliations before or after separation, and reconciliation may "work" for a time or permanently (Qu, Weston, Carson, & Kaspiew, n.d.).

Adults

We note the inquiry's focus on people with a mild or moderate mental illness, and suggest that family relationship services have a vital role to play in the prevention of, and avoidance of relapse and recovery from mental illness. Failure to support family and social networks inevitably amplifies mental health concerns.

Statistics commissioned from the Australian Bureau of Statistics for the Detection of Overall Risk Screen (DOORS) (McIntosh & Ralfs, 2012a, 2012b) indicates divorced/separated individuals are more likely to have an anxiety disorder than married and never married individuals. They are also more likely to have an affective (i.e. emotional or mood) disorder than married and never married individuals. Prior research also confirms a significant association between separation or divorce and increased rates of depression, high/very high levels of psychological distress, and total number of mental health problems (Gibb, Fergusson, & Howard, 2011; Kessing, Agerbo, & Mortensen, 2003). With respect to gender differences, research suggests that psychological distress more often precedes divorce amongst women, but lasts longer following divorce amongst men (Gahler, 2006).

We also note the inquiry's focus on suicide prevention, and suggest that the correlation between family breakdown and suicide ideation demonstrates that post separation services have a strong role to play in suicide prevention strategies. Research suggests that depression increases by three times the probability of experiencing all levels of suicidal ideation and also attempted suicide (De Leo, Cerin, Spathonis, & Burgis, 2005). There is also a higher rate of serious suicidal ideation in men during separation than women (28.3% compared with 15.5% respectively) (Kolves, Ide, & De Leo, 2010), and with young adult men aged 15-24 years at highest risk (Wyder, Ward, & De Leo, 2009). Recent separation is an important factor in predicting suicide (Kolves, Sisask, Anion, Samm, & Varnik, 2006), particularly for men (Cantor & Slater, 1995). Moreover, statistics commissioned from the Australian Bureau of Statistics for the DOORS reveal rates of suicide amongst divorced and separated adults are increasing, particularly among women. Notably, research also suggests that separation is an independent risk factor for suicide worldwide, operating separately from a range of demographic and socioeconomic factors, including race, employment status, income, education, migration, religion, and alcohol consumption (Ide, Wyder, Kolves, & De Leo, 2010; McAllister, 1995, as cited in Andrews, 2012).

CASE EXAMPLE #1 – Family and Relationship Service

The client was a 51-year-old man who had recently separated from his partner after a 22-year marriage. The couple had two children, 10 and 14 years of age. The client had depression and anxiety, which he had managed by isolating himself, spending most of his time alone on his computer after work, and becoming increasingly disengaged from his partner and children. The client's experiences of anxiety also led him to be very rigid and become easily frustrated in his family relationships.

The client was grieving over the loss of his relationship. He also talked about not knowing how to spend time and interact with his children. At the time, he was seeing them on weekends and one day during the week. The client stated that before the separation he mostly interacted with his children with his partner during 'family activities', and did not really know how to relate to them by himself. He was also struggling to know how to communicate with his former partner, particularly around building an effective parenting alliance post separation. The client's former partner said she was frustrated that every conversation around a plan for the children turned into a conversation

about her returning. She reported feeling that the client kept making the plans complicated, to give him reason to talk to her.

The client had also recently lost his job working as a technician, and was deeply worried whether, at his age, he could ever find further work.

The client came to RASA's Family and Relationship Services. He disclosed concerns about his mental health during initial screening. In discussion with the counsellor the client acknowledged that current stressors, including his separation, parenting concerns, and redundancy, had heightened his depression and anxiety, but also that his mental health had been a long term concern. The client also revealed feeling that his mental health was a sign of weakness that he did not want his family to know about, so he never spoke to his partner about it or sought outside help.

As part of ensuring the client had appropriate supports that were tailored and sequenced to be effective, the counsellor also referred him to the local mental health network for a more complete mental health assessment. Conversations between RASA and other engaged services enabled a coordinated collective response to the client's interwoven issues. The counsellor provided individual counselling to the client, including coaching around child centered fathering approaches. The client also saw a GP who prescribed a short course of anti-depressant medication and remained in contact with him for the duration of the treatment.

After a period of time, the client was able to process and accept the grief and loss he was going through. With the depression and anxiety not being so present in his life he was able to implement some of the coaching around child centered fathering approaches he learnt in counselling, and slowly the relationship with his children developed. He also became more able to negotiate with his former partner around a parenting alliance without feeling the need to convince her to return.

Young people

We note the inquiry's intention to focus on young people, and suggest that young people living with family breakdown are at high risk of developing significant mental health problems. Youth mental illness is also a stressor for families, often contributing to family breakdown and thereby amplifying the harm to the mental health of multiple individuals. Services that support family wellbeing are therefore significant and cost-effective opportunities to interrupt mental health problems.

Family breakdown has the biggest adverse impact on children's mental health. About 50,000 to 60,000 children in Australia each year experience their parents separating. Around one in five Australian children (about one million) will experience parental separation before the age of 18 (Australian Bureau of Statistics, 2018). Acrimonious separations with ongoing levels of poorly resolved or uncontained conflict between parents constitute about one third of separations and are associated with negative parenting practices (Gold et al., 2011). This has been linked to an array of mental health and adjustment problems in children, including poor peer interaction, conduct problems, poor physical health, depression and anxiety, low self-esteem, eating disorders, substance misuse and poor attachment. If left untreated, mental health problems have a 50% chance of persisting throughout childhood and into adolescence (Hiscock et al., 2012).

Evidence also indicates that family breakdown is likely to be transmitted inter-generationally (Amato & DeBoer, 2001; Amato & Keith, 1991; Amato & Patterson, 2017; Mueller & Pope 1977; Teachman, 2002) to the extent that the children of divorced parents are estimated to be twice as likely as children of non-divorced parents, to experience divorce themselves (Amato & DeBoer, 2001). Considering that the longer a society waits to intervene, the more costly it is to remediate the

disadvantage (Heckman, 2008), we believe that early intervention initiatives that focus on parenting practices can prove a crucial and cost‑effective way to manage the burden of mental health problems in children and adults.

CASE EXAMPLE #2 – Youth Service

The client was 16 years of age, identified as transgender, and had a diagnosis of borderline personality disorder and autism spectrum disorder (ASD). The client lived with their mother, and the relationship between them was volatile, or particularly difficult, because of the fluid nature of the client's gender identification and the extreme emotions associated with their borderline personality disorder. For multiple and extended periods of time the client had either moved out or been kicked out of the house and had ended up either couch surfing or living on the street. The client had also disengaged from school roughly 2 years ago.

The client came to RASA's Schools, Community, Innovations, and Learning Service (SCILS). The assigned Case Manager helped the client to engage with other RASA services to assist with a range of programs. The Case Manager also connected with external support services, setting up mental health services liaison, independent Centrelink income, and housing; negotiating with the client's school and the Department of Child Protection, and; completing a NDIS application. The Case Manager also worked hard to maintain a connection with the client's mother, keeping her involved in the client's life and decisions.

The liaison with support services has been difficult because of the client's age. The client was initially too young for housing support, but too old for priority assistance from the Department of Child Protection. Prior to being diagnosed with ASD, the client was ineligible for NDIS support. Also, accommodation supports fell apart multiple times, with services expelling the client for behavioural outbursts.

The client has, to date, achieved improved academic, living skills, and wellbeing, including a positive relationship with their mother.

Aboriginal and Torres Strait Islander families

We note the inquiry's intention to focus on disadvantaged groups, and suggest that greatest consideration should be given to Aboriginal and Torres Strait Islander peoples who are experiencing family breakdown. Aboriginal and Torres Strait Islander peoples recognise the importance of connection to land, culture, spirituality, ancestry, family and community, how these connections have been shaped across generations, and the processes by which they affect wellbeing.

We know that they have experienced trauma as a result of colonisation, including the associated violence and loss of culture and land, as well as subsequent policies such as the forced removal of children. In many Indigenous families and communities, this trauma continues to be passed from generation to generation with devastating effects.

The high rates of poor physical health, mental health problems, addiction, incarceration, family violence, self-harm and suicide in Indigenous communities are directly linked to experiences of trauma. These issues are both results of historical trauma and causes of new instances of trauma, which together can lead to a vicious cycle in Indigenous communities (Atkinson, Nelson, & Atkinson, 2010). They have been high on the list of priorities of successive mental health prevention strategies at national and state/territory levels for decades, with little positive effect.

We note that healing of historic and multigenerational trauma is a necessary precursor to, and an enabler of, health and wellbeing.

Culturally and linguistically diverse families

In noting the inquiry's intention to focus on disadvantaged groups, we also suggest that priority consideration should be given to culturally and linguistically diverse (CALD) families who are experiencing family breakdown.

With Australia's increasing cultural diversity, understanding family and mental health within a multicultural context also requires understanding the differences that arise through cultural and linguistic diversity. The emotional impact of migration, particularly forced migration and refugee experiences, combined with the impact of adjustment to Australian society, leads to family breakdown and family violence for many CALD families.

Comorbidity

Family breakdown and mental health problems rarely exist in isolation. People may have a number of issues that may be contributing to their family breakdown and mental health problems, or they may be the product of their family breakdown and mental health problems.

CASE EXAMPLE #3 – Elm Place Service

Originally referred to RASA's Elm Place service at 23 years of age, the client was a 30 year old women who had a history of sexual abuse and trauma. She lived with her partner and two young children, the eldest of whom was diagnosed with Level 3 Autism and Avoidant/Restrictive Food Intake Disorder. The client disengaged with the service for a period of time, then she re-engaged last year after a psychotic episode, which was triggered by a constellation of issues related to her relationship, complicated grief and loss, and physical health issues. She lacked finances to maintain ongoing psychiatry and therapy appointments, and had exhausted her Mental Health Care Plan allowance.

The Elm Place Case Manager liaised with Western Intermediate Care Centre and Mental Health Triage to link the client to community mental health services, and advocated for the client to have an ongoing therapist. The worker also found affordable temporary accommodation for the client during her recovery, in order to reduce the strain on the relationship with her partner, and to avoid exposing her children to her night terrors or episodes of psychosis. The worker also linked the client to RASA's Family and Relationship Services for relationship counselling, and advocated for the Adelaide City Council to waive parking fines.

Family Violence

RASA has evidence from numerous evaluations demonstrating that over 60% of our overall service delivery involves family violence issues.

Family violence victims live with a pervasive sense of fear and mistrust which manifests in a broad range of symptoms. They often develop long-term mental health problems, with some research demonstrating clear causal links between the experience of family violence and the development of mental health problems in victims. These impacts extend to depression, dysthymia, post-traumatic stress disorder, bipolar disorder, personality disorder, psychoses, phobias, anxiety, eating disorders, drug and alcohol issues, suicidal tendencies, and suicide attempts and completions, with the incidence, severity and co-morbidity of these conditions correlating with the type, extent and duration of the violence. (Campbell & Soeken, 1999; Cole, Logan, & Shannon, 2005; Bennice, Resick,

Mechanic, & Astin, 2003; Black et al., 2011; Dutton et al., 2006; Golding, 1999; Holden et al., 2013; McFarlane et al., 2005; Mechanic, Weaver, & Resick, 2008; Quinlivan & Evans, 2001; Rees et al., 2011; Robertiello, 2007; Seedat, Stein, & Forde, 2005; Temple et al., 2007; VicHealth, 2004; Vogel & Marshall, 2001; Wingwood, DiClemente, & Raj, 2000). Notably, mental health conditions are the largest contributor to the burden of disease due to physical/sexual intimate partner violence, with anxiety disorders making up the greatest proportion (35%), followed by depressive disorders (32%) (Ayre, Lum On, Webster, Gourley, & Moon, 2016).

Family violence is overwhelmingly gendered. Multiple research studies demonstrate that women are at least three times more likely than men to experience violence from an intimate partner (Australian Bureau of Statistics, 2016) with one in four Australian women experiencing intimate partner violence (Australian Bureau of Statistics, 2012). 54% of women who have experienced violence by a *current* partner, and 61% who have experienced violence by a *former* partner had children in their care at the time of the violence (Australian Bureau of Statistics, 2012). Furthermore, about one woman a week, one child every two weeks, and one man a month are killed as a result of violence from a current or previous partner (Australian Institute of Criminology, 2017). In addition**,** family violence is the leading contributor to preventable cause of death and illness for women aged 18 to 44.

While research on family violence has thoroughly addressed its negative consequences, we believe that this line of inquiry obscures how women transform their struggles with such adversity and, consequently, a more complete picture of recovery is often missed (Cobb, Tedeschi, Calhoun, & Cann, 2006; Humphreys, 2003). In other words, a list of symptoms or problems tells us little about the tremendous strengths and resources women draw on to recover from family violence. It also does not allow the woman's capacity to respond to the power and control she has been subjected to be illuminated and highlighted in order for her to reflect on the strength and capacity she drew on to get through.

The post traumatic growth phenomenon, defined as the experience of positive change that occurs by virtue of the struggle with highly stressful and challenging life circumstances, including family violence (Calhoun & Tedeschi, 1998) underscores the importance of service responses that strengthen women's recovery to contain the devastating impact of family violence (Anderson, Renner, & Danis, 2012; Kunst, Winkel, & Bogaerts, 2010). Taken together, this suggests that services and practitioners need to have a perspective that encompasses the positive as well as the negative aspects of functioning following traumatic experiences of family violence – specifically, the way in which these influence one another - enabling us to have a more complete and holistic understanding of how to support recovery.

Young people
Our work with families impacted by family violence confirms that children and young people experience significant harm, regardless of whether they have been directly assaulted or witnessed the violence.

Children's emotional and physical safety are profoundly compromised in an environment where they are aware that their mother is in danger. As well as physical impacts of violence, children and young people are likely to experience high levels of terror and anxiety about their own and/or their mother's safety and feel shame and guilt regarding their family situation. Many children internalise guilt for 'somehow not protecting their mother'. This is particularly evident in our work with boys and young men. 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 (Bancroft & Silverman, 2004; Fantuzzo & Linquist, 1989; Fantuzzo & Mohr, 1999; Graham-Bermann & Edleson, 2001; Sachmann, 2001; Wolak & Finkelhor, 1998).

Among children who have lived with significant levels of family violence, researchers frequently note there is a cluster of behavioural, cognitive, and emotional symptoms, including: aggression, conduct disorders, delinquency, truancy, school failure, depression, anxiety, and low self-esteem (Kelly & 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 & McIntosh, 2011), and; insecure and disorganised attachments generate a host of follow-on deficits in early childhood development, and 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, & Maraganore, 1999; Sroufe, 2005). Co-parenting conflict is a significant predictor of ongoing distress for adolescents and adolescent antisocial behavior (McIntosh, 2003).

When family violence and conflict co-occurs with other risks (namely, poor mental health of parents, poverty, parental substance abuse, unemployment, or low education), greater developmental impact is evident (Crockenberg & Langrosk, 2001; Dixon, Charles, & Craddock, 1998). Children of parents with untreated or poorly contained mental illness have a high risk of physical neglect. In such situations, children might assume the role of a carer for their ill parent, resulting in significant levels of emotional stress (Huntsman, 2008).

It is also important to understand other impacts on children, which are often overlooked. These include having to change schools (and experiences of being ostracised and bullied), loss of friendship networks, loss of favourite toys and books, loss of sporting teams, loss of pets, and general feelings of being 'different' from others.

Aboriginal and Torres Strait Islander families
Research has shown that family violence occurs at higher rates for Aboriginal and Torres Strait Islander Australians than for non-Indigenous Australians, and needs to be understood as a cause and effect of social disadvantage and intergenerational trauma (Australian Bureau of Statistics, 2016).

Rates of family violence-related victimisation for Aboriginal women may be as high as 40 times the rate for non-Aboriginal women. Indigenous children are seven times more likely to be the subject of substantiated child abuse or neglect as non-Indigenous children (Australian Institute of Health and Welfare, 2017). Two in five Indigenous victims are killed by a current or previous partner, which is twice the rate of non-Indigenous homicide victims (Australian Institute of Criminology, 2017).

For Aboriginal and Torres Strait Islander women, the intersection of gender and racial inequality underpins the conditions for high rates of violence. The loss of community connection and family resulting from family violence is compounded for Aboriginal women and children, as this represents not only a violation of the individual, but also of cultural identity.

Culturally and linguistically diverse families
While there is limited information and no uncontested national data available on the prevalence of family violence in women from CALD backgrounds, women may lack access to culturally appropriate services, leading to lower rates of reporting. Cultural values can increase the complexities normally involved in family violence, and immigration may cause social and cultural dislocation, intensifying the violence. (Parliament of South Australia, 2015).

Problem Gambling

Gambling problems affect family functioning as well as individual wellbeing. Families affected by problem gambling are often characterised by high levels of anger, conflict, lies, and deception; low levels of clear and effective communication, commitment, support, and participation in social activities; and even confusion over family roles and responsibilities (Ciarrocchi & Hohmann, 1989; Ciarrocchi & Reinert, 1993; Dowling, Smith, & Thomas, 2009; Hodgins, Shead, & Makarchuk, 2007). These characteristics and negative feelings often lead to the breakdown of relationships, with research suggesting that problem gamblers are six times more likely to be divorced or separated (Thomas & Jackson, 2008).

Approximately 75% of Australian adults gamble in any year, and approximately 300,000 Australians have a gambling problem (Thomas & Jackson, 2008). These numbers do not reflect the partners, children, other family members, friends, employers, etc. who are affected by each individual's problem gambling. Gambling problems have a cascade of consequences that are wide ranging and complex, and comorbidity is an expectation rather than an exception.

There is a strong link between problem gambling and mental health problems. Australian estimates suggest that 60%-80% of problem gamblers experience depression, anxiety disorders, and are five times more likely to commit suicide than non-problem gamblers (Abdollahnejad, Delfabbro, & Denson, 2013; Delfabbro & King, 2011). At RASA, the majority of Gambling Help Service (GHS) clients have considerably poor wellbeing, with analysis of client data indicating they have 'very high'(37.5%), 'high' (27.5%) or 'moderate' (20.6%) levels of psychological distress (according to the Kessler Psychological Distress Scale (K10)). Furthermore, 39.3% of gamblers report that things in their life have felt so bad that they thought about killing themselves, compared to 25.7% of non-gamblers.

Research also suggests that problem gambling is associated with a greater likelihood of both perpetrating and experiencing intimate partner violence, and that violence extends to other family members (Suomi et al., 2018). At RASA, family violence is detected in 46.2% of GHS clients. Also, 36.3% of gamblers are parents, and 41.8% report that it they are sometimes or often harsher towards their child(ren) than they meant to be.

Australian estimates also suggest that 15%-20% of problem gamblers experience drug/alcohol dependence, which serves to increase the risk of mental health problems and suicide (Abdollahnejad, Delfabbro, & Denson, 2013; Delfabbro & King, 2011). At RASA, 37.2% of gamblers report having drunk alcohol and/or used drugs more than they meant to. Also, 56.5% of problem gamblers with a risky alcohol and other drug (AOD) use report that things in their life have felt so bad that they thought about killing themselves, compared to 30.8% of problem gamblers with no risky AOD use. Furthermore, risky AOD use in parents as problem gamblers results in diminished caregiver sensitivity.

CASE EXAMPLE #4 – Gambling Help Service

The client was a 45-year-old Aboriginal woman. She grew up in a violent environment and was eventually placed in foster care. She left home at 13, and had eight children with several partners. One child was a result of rape, one died at 2 years of age. She gambled to find "time out" from her challenging life, and in the hope of winning money to alleviate her financial pressures, which included responsibility for her grandchildren as well as own children. She had significant debts. The client had been variously diagnosed with depression, bipolar disorder, and borderline personality disorder. She had repeated suicidal ideation and made a number of suicide attempts. She lived in a

rural town and was 'well known' by the mental health services. She had often received 'jaded' responses from services, including comments such as "She can go to the hospital if she is suicidal. We know her. There is nothing we can do".

The client came to RASA's Gambling Help Services because other agencies had refused service, telling her that she was too demanding. Our counsellor responded to the client's history of trauma using mindfulness and psychosomatic therapy, as well using holistic case management.

The case management work included referral to RASA's Financial Counselling Service, and referrals to external agencies including Housing SA, Personal Helpers and Mentors service, and Partners in Recovery. While the counsellor had pre-existing relationships with some of these agencies in the course of working in the region, others were created specifically for the purpose of linking the client to the services necessary to assist with her complex needs. Through case conferences - at times with the client being present and at times, if they preferred, in her absence - services were able to negotiate realistic service options that were sustainable. Ongoing contact to track progress and assess outcomes facilitated the service coherence and helped to maintain client engagement.

Through collaborative efforts, the client remained focused on supporting her children, and being a reliable grandmother to her grandchildren. Her gambling has ebbed and flowed throughout this time. While it is still on occasion needed as her "time out" strategy, it is no longer causing major harm in her life.

The client is now also part of our gambling help peer support activities and services.

Alcohol and Other Drug Use

Statistics commissioned from the Australian Bureau of Statistics for the DOORS reveal that divorced or separated females with dependent children are twice as likely as married/defacto females 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).

Alcohol and drug-related mental health issues are prevalent within Aboriginal communities, and alcohol abuse is strongly associated with Aboriginal family violence.

The cost of relationship breakdown, family violence, problem gambling, and AOD use

We know that family breakdown in all its forms costs the Australian economy more than $14 billion a year, with each Australian taxpayer paying about $1,100 a year to support families in crisis (Wilson & Cornish, 2014). The cost of violence against women and their children in Australia is estimated at $22 billion, and may add an additional $4 billion accounting for women underrepresented in this calculation (e.g. Aboriginal and Torres Strait Islander women) (KPMG, 2016). The social cost of problem gambling is at least $4.7 billion a year (Productivity Commission, 2010). A conservative estimate of the social costs of alcohol and other drug use in Australia is $14.35 billion, with the highest cost associated with productivity losses (42.1%), traffic accidents (25.5%) and cost to the criminal justice system (20.6%) (Manning, Smith, & Mazerolle, 2013).

Given that the issues affecting families are fundamental to the kind of societies in which we live, the delivery of family relationship services makes economic sense. Research on the economic benefits of family and relationship services has provided insight into the value of 'positive family functioning'. A

cost-benefit analysis conducted in 2010 to establish the returns to government and society for investments made in supporting family functioning revealed that there are health, productivity, and social outcomes associated with family functioning. Furthermore, the total potential net present value of benefits from intervening early (in other words, the gains in terms of positive family functioning) were in the order of $5.4 billion per annum (Department of Families, Housing, Community Services and Indigenous Affairs, 2010).

HOLISTIC DETECTION AND RESPONSE

Understanding risk

We know that comorbidity is associated with worse outcomes, more complex clinical management, and increased costs (Kessler, 1995; Valderas, Starfield, Sibbald, Salisbury, & Roland, 2009). This is probably partly because people with comorbid issues are more difficult to treat, and partly because these issues are not detected (Hall, Lynskey, & Teesson, 2001). Failure to identify and respond effectively to complex issues is the hallmark of a fragmented mental health system. Responding to single issues without attending to comorbidities is a frustrating and usually ineffective process for clients and their families as well as the professionals involved.

Family breakdown brings many risks to families (McIntosh & Ralfs, 2012a, 2012b). Families who seek support present with greater risks compared to families not using services (Ballard, Holtzworth-Munroe, Applegate, & Beck, 2011). However, clients using such services may not tell practitioners about the risks unless they are asked, and service providers often fail to detect risks unless they use validated tools (DeMaio, Kaspiew, Smart, Dunstan, & Moore, 2015) in a systematic and standardised manner.

If issues are improperly identified, interventions can be targeted at the wrong factors. At best, such interventions may be ineffective and a waste of scarce resources; at worst they may exacerbate other issues.

Screening for risks

Screening is a vital part of preventive medicine. Identifying individuals early enough to provide treatment and avoid or reduce symptoms or other consequences, is proving to be more cost effective (Aronsson, Carlsson, Levin, Hager, & Hultcrantz, 2017; Baggaley et al., 2017; Black et al., 2014; Lansdorp-Vogelaar, Knudsen, & Brenner, 2011), and ultimately improves health outcomes of populations (Blanks, Wallis, & Moss, 1998; van Velzen at al., 2016).

Screening tools are increasingly developed and used in community settings to quickly assess the health and social needs of people – or identify multiple domains of risk - and match them with the most appropriate support/interventions that are available (Andermann, 2018; Billioux, Verlander, Anthony, & Alley, 2017; Browne-Yung, Freeman, Battersby, McEvoy, & Baum, 2018; OrgCode Consulting Inc, 2015). However, there is a lack of coherence or standardisation of screening protocols across service systems. Screening is often ad hoc and there tends to be significant ideological and practice differences between services and among practitioners that results in a disjointed and patchy screening landscape.

We believe that taking responsibility for systematically identifying the constellation of clients' concerns through universal screening at the point of entry is a prerequisite of integrated and holistic service provision. Evidence suggests that, in the absence of universal screening, even the most experienced clinicians miss at-risk clients, and the risk identification process can be improved by

using robust and reliable assessment tools. At RASA, we have a universal risk screening process that ensures all clients are systematically asked about the constellation of risks that impact their emotional and physical safety, including screening for physical safety and developmental risks for infants and children in the care of the client.

The Family DOORS

What is it?

In collaboration with Professor Jennifer McIntosh (Deakin University), RASA has been involved in the development of and have implemented the Detection of Overall Risk Screen (DOORS) (McIntosh & Ralfs, 2012a,2012b). The Federal Attorney-General's Department originally funded the Family Law DOORS (FL-DOORS) in 2011, for use across the family law system. Since that time, it has been become the Family DOORS and is used by a majority of the Relationships Australia organisations, as well as by other relationship service providers, including Anglicare Northern Territory, Anglicare Sydney, and some law firms. The DOORS has also been piloted internationally, including in Norway, Sweden, Singapore and the USA.

The DOORS is a three-part framework that assists professionals to detect and respond to wellbeing and safety risks related to family breakdown. Within the DOORS framework, risk is broadly defined as physical or psychological harm to self and/or other family members and, in the case of children, developmental harm. Risk is built through overlapping and mutually reinforcing factors, including individual characteristics, situational variables, and historic factors that combine to increase the likelihood of adverse safety and wellbeing outcomes. As used in the DOORS, risk is an outcome of a constellation of long-term and short-term factors that act together, can change over time, and vary from family to family. Screening and assessment are terms used for the connected and overlapping phases of a risk evaluation process.

There are a number of noteworthy findings from recent research on the DOORS (McIntosh, Wells, & Lee, 2016; McIntosh, Wells, Lee, & Tan, 2018). Firstly, the DOORS has 11 meaningful risk domains, showing good overall internal reliability. Clients' self-report of safety concerns 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 separation. For example, when one parent in a dispute reported feeling unsafe, the other parent was highly likely to report unsafe behaviour. This was important, 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 K10 (Kessler et al., 2002) (i.e. in other words, the DOORS could reliably indicate mental health risks using fewer questions).

How does it work?

DOOR 1 (McIntosh, 2011a) is a standardised self-report questionnaire completed by individual family members. It covers various domains of risk, including victimisation, perpetration, mental health concerns, family functioning, child wellbeing, parenting capacity, financial distress, housing, problem gambling, and substance abuse. DOOR 2 (McIntosh, 2011b) takes responses to DOOR 1 and identifies areas of risk endorsed by family members that need to explore more deeply in order to

find out if something is happening or is likely to happen in the future. It is crucial for us to make sure that family members provide responses to all domains that we ask them about in DOOR 1, as failure to do so could potentially conceal vital information related to their wellbeing and in turn our service response.

Raising wellbeing concerns with families requires sensitivity and care. As red flags can sometimes be taken out of context to either over or under identify risky situations, prompts provided by DOOR 2 help practitioners to establish an effective follow-up conversation and navigate questions about the broader context of their lives. For instance, for a family member who indicates in DOOR 1 that they are feeling 'hopeless/powerless', we encourage practitioners to clarify the intensity of these feelings by asking "How manageable are these feelings now?" and "Are you getting enough support with this?"

Crucially, only when an individual screens positive at DOOR 2 for a risk do we then conduct a detailed risk assessment, often using a validated risk assessment process (from DOOR 3). This approach underpins our universal screening approach because it means we comprehensively review the constellation of risks associated with family services but do not waste time or resources on needless risk assessments. It also means our DOORS screening is suitable for use with every profile of help seeker - across the continuum of concerns (i.e. from those at lower risk (often referred to as the 'worried well') to acute risks) and across the continuum of care settings (i.e. primary, secondary, and tertiary care).

While risk assessment cannot predict all events, structured and validated risk assessments enable the implementation of informed, tailored, and proactive risk management strategies. The DOORS is designed to help practitioners to enlist clients in risk screening, thereby building relevant and realistic strategies for managing risks.

Creating a tailored response

Our holistic and universal approach ensures our services have a detailed understanding of the notoriously interlocking problems, or risks, that families face. This is an important element of our case formulation, which importantly engages families in a partnership to manage risks. It also enables us to develop relevant and well-sequenced intra- and inter-agency service responses. These arrangements are particularly important in complex cases where many services are involved, especially when the timing and choice of different services is complicated. Trying to tackle all the problems facing a vulnerable family simultaneously can be overwhelming and confusing. Parents are unlikely to be able to focus on their relationships if their survival and safety needs are not being met first. Therefore, families with complex problems may not have the capacity to engage in specific interventions if they are, for example, still being exposed to family violence, unable to meet their children's basic needs for stable housing, food and clothing, or cannot pay the rent.

Fragmented service systems

The last thing individuals and families dealing with mental health concerns need from services is chaos between services that result in disjointed and even contradictory service interventions. We are particularly concerned that vulnerable children and infants often get lost – or are concealed – in service fragmentation that ultimately increases the likelihood of intergenerational mental ill-health. A key aim of reform must be to build sector coherence and multi-agency service coordination.

Families often have multiple and complex problems that cannot be solved by one service alone (Bromfield, Lamont, Parker, & Horsfall, 2010; Penner, 1995, as cited in Foster-Fishman, Salem, Allen,

& Fahrbach, 2001; Tuma, 1989, as cited in Foster-Fishman et al., 2001). For instance, one family may require assistance with money to live on, somewhere safe to live, access to health care, and information and advice about parenting. In our experience, however, families' needs are often 'shoe horned' into service silo-bound, fragmented practices which pose an array of burdens on them as they must navigate complex mazes - from professional disciplines and their hierarchies, geographical divisions, bureaucratic areas of 'subject matter' responsibility, and disparate funding sources. Lack of integration is often experienced by families as gaps in service (e.g. between early intervention and prevention services and secondary/tertiary services). Clients get pushed between services (e.g. to waiting lists) and they fall through the cracks of the system because the connections between services are either absent or problematic, or needed services are missing all together (Gillespie & Murty, 1994; Bunger, 2010). While risk is often managed informally through having relationships between service providers, fragmentation also imposes heavy burdens on them. In our experience, many community services are well-networked and linked at the local level, but referral pathways are less robust between health and community service sectors.

CASE EXAMPLE #5 – Elm Place Service

The client was a 43-year-old male who was in state care during his teenage years, and had a mother who was a Forgotten Australian. He had a diagnosis of schizophrenia but was unable to take the most suitable medication due to significant side effects. While the client had an injectable treatment regimen to help him manage, he was often unwell, and this significantly affected his daily life.

While the client was supported by Skylight Mental Health, he came to Elm Place for counselling and social groups. He was unable to maintain regular appointments due to his mental health. During those that he could attend, the worker has helped the client to navigate his problematic family relationships, social skills and drug and alcohol issues. The worker also referred the client to RASA's Gambling Help Service and Financial Counselling Service.

The worker also previously attempted to connect the client with other mental health services with minimal success. The worker tried to refer the client to a specialist therapist, that is, one for those impacted by hearing voices, but the client refused all offers as he believed the voices were real and questions why he would need to work on managing them. The client also refused to work with a psychologist and reported feeling triggered to attend their office. The worker has found that other mental health services seem to only become involved at times of crisis, or when his mother becomes insistent on action.

More recently, NDIS have become the case managers for the client, but the high turnover of staff meant that he did not have a regular contact person, and consequently did not feel supported. The client's mother had asked NDIS repeatedly to contact the RASA worker to discuss the client's needs, and despite the worker attending a case conference, there was little follow up on NDIS's part. Again, the client did not receive any attention until he was in crisis.

Building collaborative arrangements

Notably, when examining the literature, it is clear that multidisciplinary and collaborative approaches to care enable services to offer clients the most appropriate response for their problems because they are based on a broad range of expert knowledge from the start, and all aspects that influence service options are considered. Moreover, they have proven to be a cost-effective option that is positively evaluated by users, carers and referrers in a variety of areas (Capomolla et al., 2002; Carling, Fung, Killion, Terrin, & Barza, 2003; Fader, Wise, Normolle, & Johnson, 1998; Gade et al., 2008; Timpka, Leijon, Karlsson, Svensson, & Bjurulf, 1997) including mental health (Burns,

Beadsmoore, Bhat, Oliver, & Mathers, 1993; Burns, Raftery, Beadsmoore, McGuigan, & Dickson, 1993; Knapp et al., 1994; Wolfs, Dirksen, Kessels, Severens, & Verhey, 2009). We have experience in the continuum of collaborative arrangements, including cooperation, coordination, collaboration, and service integration (Selden, Sowa, & Sandfort, 2006). The variety of ways in which we have worked with other services within and external to RASA include information exchange and service promotion, partnership opportunities, joint group facilitation, cross referrals, assistance to vulnerable groups, co-work with mutual clients, interagency meetings, networking, and forums. We credit these arrangements with enabling families to more easily access support from multiple service providers, and in a seamless way, rather than having to navigate a complex service system.

Developing better service coherence that enable individuals living with mental health concerns and their families to receive relevant and integrated support requires significant sector reconfiguration. When families are at risk, the last thing they need from services is more chaos. Vulnerable families too often get lost in the ideological and practice differences between services. There is an urgent need for the successful implementation of common frameworks, shared protocols and practical tools, which build a more unified system and prevent disorganised service responses.

Integrating services

Valuing relational models

In working towards integrated mental health services, it is important to steer away from biomedical models. Their emphasis can privilege medication (and other responses provided by medical practitioners) as the primary treatment modality at the expense of other treatment models (such as community-based and peer worker mental health services), and limit capacity to provide a holistic and tailored response. A more responsive service culture should support relational models, where symptoms are understood and more effectively addressed in the context of relational factors (for example, family breakdown, family violence, early childhood relational trauma). A major impediment to increased recognition of relational processes is in the DSM definition of mental disorder, which focuses on the patient as an individual and not the relational dynamics that may contribute to mental ill-health or which may be the result of untreated or under-treated mental ill-health.

Recognising the importance of family relationship services

It is critical to recognise that family relationship services are an integral component of a holistic service response. Family services play a pivotal role across the continuum of care, including in the preventative, treatment aftercare and recovery/rehabilitation phases of responses.

Evidence increasingly demonstrates the efficacy of specific couple and family therapy and partner-assisted approaches for treatment of mental illness. Family-based therapies are as effective as individual CBT and psychodynamic therapy in treating depression. 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 is showing promising results with depressed and suicidal adolescents. Thus, mental health service funding should also be extended to support family members to aid the recovery of those who are suffering and also to access support if and when their own mental health has been impacted.

With easily accessible and up to date information about complementary services, GPs offer a large footprint of frontline services, which can be a first point of entry into holistic supports. However, RASA has observed that such details in directories (e.g. Health Direct) are hindered by medicalised assumptions and rules, making it difficult for community service providers to satisfy eligibility criteria

for the database (e.g. a Medicare provider number, and registration of individual practitioners, rather than services).

Intervening early

The tension between prevention/early intervention and crisis services could be eased by providing a greater emphasis on the provision of services to children and young people at risk of developing mental ill-health as a result of family breakdown. This would create opportunities to break cycles of disadvantage and dysfunction. Providers also need more support to build relationships with communities so that people come to trust the service enough to feel safe in engaging and seeking help.

Family Wellbeing Hubs - Features of an efficient, integrated and holistic model

We strongly support the Family Wellbeing Hubs concept in providing a holistic and integrated service response. In order to nurture integration, hubs should be designed around the needs and circumstances of the communities they serve, with the input of consumers and carers crucial to this. They should 'front-load' costs, directing resources towards prevention, early intervention, and capacity building activities. As families have different journeys through the care system, hubs should also offer support that is proportionate to their needs and resources. It is also important to foster an organisational culture that enables a no wrong door approach.

Hubs may take a range of forms, for instance, a physical presence where services are co-located in a building and/or within or adjacent to relevant places such as schools or community centres. Hubs could also, or alternatively, have a virtual presence where services could be provided online.

Regardless, five key components of hubs include a no wrong door approach; ease of access; universal screening; assistance across the continuum of care, from information provision to intensive case management; and, seamless collaboration and integration between services responding to families.

Integrated family systems approaches can be a better fit for engaging with kinship and community groups, as opposed to individualistic, potentially shameful approaches. However, given historic trauma and layers of mistrust arising from interventions by governments and service providers, clients who identify as Aboriginal and Torres Strait Islander must be offered a soft entry point into services, and services need to be supported to invest in the long-term development of relationships with Aboriginal and Torres Strait Islander individuals and communities. The layer of mistrust attached to mainstream non-Indigenous services adds to barriers to engagement (e.g. poverty, lack of transport, systems abuse). It is vital that ongoing work must respond to high levels of disconnection. Also, Aboriginal and non-Aboriginal organisations must be culturally competent as not all Indigenous clients want to use an Aboriginal-controlled service.

Navigating the system

Rather than a high level of duplication, RASA has found that there is a lack of coordination which makes the mental health service system difficult to navigate. We suggest that all participants (users and service providers) have access to comprehensive and contemporary information. A publicly available, dynamically updated national map of the entire system (including current funders, service providers, community supports and peer workers) would be a useful guide, particularly for participants outside the mainstream health arena.

GOVERNING COLLABORATIVE ARRANGEMENTS

The importance of integrated governance

Establishing integrated governance strategies across mental health, child protection, drug and alcohol services, family law and family relationship services is a big task, which requires strong leadership to enable effective cooperation. Without this, our most vulnerable individuals and families continue to struggle in a fragmented service system that inevitably leads to agencies operating primarily at crisis response thresholds. This ultimately ensures prevention, early detection and intervention opportunities are missed, which in turn drives up costs across the service system and compromises individual and population health outcomes.

We know that an effective framework to create, support, and maintain the delivery of quality mental health care is critical in a complex service system in order to have an impact on mental health at both individual and population levels. This requires shared understanding and coherent service system responses (screening, assessment, intervention and outcome measures) at all levels of service delivery across organisations, sectors and jurisdictions.

While we recognise the government has gone some way to describe how they will coordinate and integrate services across sectors, the governance model to enable system transformation requires greater clarity in relation to individual and population health outcomes. We believe that an integrated governance model requires strong leadership informed by a sound understanding and application of individual (program level) and population level health outcomes. Integration at service and governance levels enables more comprehensive tracking of outcomes at both individual and population levels in the context of the wider social determinants of health and mental health. This provides clear opportunities for prevention, detection and early intervention responses to the service system. The following outlines what we believe are key systems, processes, and behaviours necessary in such a model to facilitate coordinated care and an integrated system.

In our experience, integrated governance often breaks down at a whole-of-system level because of confusion and a lack of shared understanding of population health outcomes and program outcomes within service systems. A shared understanding of the elements that comprise an integrated governance and service system is necessary.

Elements necessary for integrated governance

Joint planning

We see joint planning as a key element in developing an integrated continuum of care across the service system, supported by a range of coordinated interventions. We have found that undertaking a joint strategic needs assessment provides a starting point and common aim. The challenge is to build capacity whilst respecting the role and reach of existing service infrastructure. Formal arrangements between us and other organisations have allowed us to move beyond informal partnerships to a serious commitment to integrated care, and management of deliverables, risk, and process through collaborative business approaches. Integrated organisational governance initiatives such as having board members on each other's boards has facilitated greater appreciation of the shared vision and values of organisations and the service system as a whole, and this has, in turn, resulted in building trust and collaborative decision-making. Having a guide for collective decision-making has further assisted our work with other organisations as it has enabled us to share interests as well as concerns in an open and transparent way. Multi-level partnerships (e.g. between

managers and practitioners, between primary and secondary care) that promote coordination across settings are also important.

Integrated communication technology

We know that integrated information communication technology (ICT) is a key element and significant enabler in integrating care across the continuum. We recognise that the journey through the service system requires technical and physical infrastructure to deliver the expanded scope of practice. We believe that having an integrated ICT system has the potential to enable acute, primary, and community service providers to access more accurate and detailed clinical information to identify families at risk and inform clinical decision-making. It is essential for service coordination across the continuum of care, and could assist interagency communication across organisational boundaries, and provide evidence of outcomes. It also has the ability to integrate clinical and financial information across services, which is important for monitoring cost effectiveness.

Change management

In our experience, having an effective change management strategy is the foundation that underpins integration work. Change takes time, should be managed locally, and requires committed resources for the development of processes and strategies that support implementation to be sustainable. With strong and committed executive and clinical leadership, it is possible to sustain partnerships, and to deliver innovation and improvements in care. Key individuals instrumental in providing support to integration initiatives have to step outside traditionally established boundaries and commit to making a change and supporting others in creating it. Integrated governance is guided by a strong jointly agreed vision to align efforts and conflicting aspirations of different parts of the service system, shared and clear purpose and goals, and a frequent revisiting of the mandate to keep a focus on the system. Change management is also provided through organisational support with demonstration of commitment to integrate which in turn enables practitioners and managers to develop the ability to make change happen.

Incentives

We know that incentives to participate are an important facilitator of collaborative initiatives. Stakeholders must see some gain for their participation, either for themselves, their organisation, or the larger cause. In our experience, incentives to participate increase when stakeholders can see a direct relationship between their participation and tangible outcomes and, conversely, decrease when stakeholders feel their role is advisory or ceremonial. Important to this are monitoring and evaluation processes that ensure stakeholders receive regular and relevant information regarding the impact of their efforts.

Measurement

Success of integrated systems depends on a strategic focus on quality improvement by systematically examining data at different levels and mapping clinical processes to identify and address gaps, and to test improvement. Using data this way creates a learning tool to drive change and supports quality with an emphasis on system performance and accountability. *For example,* improvement in the quality of patient care was reported in the case of a multidisciplinary medical team who incorporated a quality assurance program. The multidisciplinary team was able to resolve issues across the continuum and not simply moving them downstream.

Professional development

In our experience, practitioners are more likely to engage in collaborative practice if they understand the advantages of the collaborative initiative and are confident in their knowledge about how to

contribute. Coordinated cross-sector training programs can create a common language between services and improve workers' understanding of other services, strengthen professional relationships, and increase confidence to refer.

Service user engagement

We believe there is a need for client and community engagement in developing an integrated service system. Integrated mental health systems should be easy for people to navigate. Research supports the importance of involving the communities served as well as encouraging them to participate. We support the Commission's approach to including input from individuals at various levels, including individual experiences of services, and as part of community forums and public meetings.

Innovation

We believe that there is a need to support innovation in achieving change. For us, co-located facilities provide one-stop-shopping and coordinated services built around the needs of residents in particular areas. At the same time, they provide the physical proximity that affords us opportunities for face-to-face interaction and relationship building over time with other services. For co-location to be successful, adequate office space and resources must be available and there needs to be the capacity for co-locating staff to participate in team case discussions, contribute to shared care plans and to retain professional supervision and connection to their core discipline.

MONITORING AND REPORTING OF OUTCOMES IN COLLABORATIVE ARRANGEMENTS

Accountability and governance

Accountability is an essential governance tool. Defining accountability is crucial for the successful implementation of coherent, integrated, and coordinated system responses (across screening, assessment, and intervention stages) at all levels of service delivery across organisations, sectors, and jurisdictions. Collective impact literature emphasises an outcomes focus, in terms of collecting data and measuring results consistently to ensure efforts remain aligned and participants hold each other accountable.

Given the constellation of factors associated with mental health concerns, a focus on population outcomes and service outcomes needs to be clarified and successfully implemented. The poor link between service KPIs within funding contracts and meaningful population outcomes needs to be resolved to ensure service delivery contributes to population wellbeing.

Overall, a cultural change across the sector is required that grows an appreciation for the valuable contribution outcomes monitoring and relevant data can make to service delivery. Well-targeted and coordinated service delivery relies on accurate data about the efficacy of service provision. Service contract KPIs that focus only on service activity and outputs do little to strengthen a focus on meaningful outcomes. Such KPIs also have the tendency to reinforce the idea that monitoring is about compliance rather than service quality. Ensuring outcomes monitoring has a direct relationship to client benefit is an important change management strategy.

Results Based Accountability

Mark Friedman's Results Based Accountability (RBA) provides a simple framework against which to track and improve outcomes (Friedman, 2009). RBA provides a common language and shared data

that links population and individual level outcomes. In this way, stakeholders have access to a feedback loop of agreed service outcome data to monitor collaboration efforts and enhanced results. Beyond this, the RBA approach can demonstrate how client results delivered by organisations through their programs and services, contribute to the mental health, or wellbeing, of a whole population. Notably, RBA has been used in the radical transformation of children's services in Leeds (United Kingdom) to improve the safety and wellbeing of children and young people (Mason, Ferguson, Morris, Monton, & Sen, 2017).

Building Blocks of RBA

Results

Results are conditions of wellbeing for children, adults and families who live in a geographic area. These population level results should be written and communicated in plain language to encourage broad understanding and engagement across stakeholders. Examples of how results can be worded are: Mental Health and Wellbeing, Positive Workforce Participation, Social and Community Engagement. The community shares accountability for achieving population results.

Indicators

Indicators answer the question of what the conditions would look like if we could see them. There are a variety of different indicators that could represent a result (e.g. suicide rates, absenteeism, disability-adjusted life year measures, self-reported measures). Some things to consider when choosing an indicator are communication power (i.e. does the indicator communicate to a broad audience?), proxy power (e.g. can this indicator stand as representative for the plain language statement of quality of life?), and data power (e.g. can you receive quality data on this indicator in a timely way?).

Strategy

Strategies bridge the gap between population level accountability and performance level accountability. Strategies are a coherent and systematic collection of actions that could reasonably be expected to have an impact on population level outcomes. A robust understanding of what works is vital, and is supported by a utility focused evidence-base.

Performance Measures

Performance measures examine how well a program, service or agency is performing. Performance measures answer three key questions, *how much are we doing*, *how well are we doing it*, and *is anyone better off?* Performance measures are designed to answer questions about clients, customers or people who interact with that particular program or service. A particular service or agency is accountable for how they perform.

Linking performance and population outcomes

The outcomes that a service or agency works towards for their clients (performance) is a contribution towards the quality of life of the community (population). For example, a performance measure for a program designed to help organisations improve workplace conditions for people living with a mental illness could be 'Reduced Absenteeism'. This would be a performance measure to answer the question, *is anyone better off?* Importantly, this performance measure for the program is also an indicator of the population result (e.g. Positive Workforce Participation). This orients the work of different organisations/actors, in different sectors and contexts, with different clients, towards achieving shared population level results.

The relationship between mental health and economic participation

Develop a population health outcomes framework

We believe that the Commission should present a population health outcomes framework that provides a unifying vision of the conditions of well-being that would enhance mental health for all Australians. Initially, this would involve identifying cross-sectional population level results, choosing indicators for these results with good communication, proxy and data power, collaborating with partners and interrogating the evidence-base for strategies that best achieve the population results. Engagement with the community around aligning performance measures with evidence-based strategies and population results will take time and requires an adaptive and iterative approach.

Governments should develop service contracts that support organisations to develop performance outcomes that align with and contribute to the monitoring of population outcomes.

Support organisations to develop a performance outcomes framework

Organisations need support to integrate the use of RBA into their internal operations and ensure they use a performance outcomes framework for their programs that is aligned with the population health outcomes framework. We believe an evaluative approach, which clearly defines program logic works alongside RBA, assists organisations develop a clear data/evidence backbone that is focused on the impact of the support they provide rather than compliance. Such an approach enables organisations to monitor and evaluate their performance and see how they contribute towards impact at the population level. The routine and robust collection of program and service data in turn builds an evidence-base that enables informed understanding of what works for whom and when. Linking data collection at these different levels in order to comprehensively report individual and population health outcomes across the system is a key governance and leadership responsibility.

Ensure organisations use standard measurement tools

Standardised tools can provide ways to measure both performance and population results with a RBA approach. The Productivity Commission's issues paper mentioned the National Outcomes and Casemix Collection (NOCC), which is a collection of recommended tools for clinicians to deliver as part of routine outcome measurement. Although this is a useful first step, more work needs to be done in enabling organisations, including organisations outside of a medical setting, to routinely collect, store, understand and use these tools. It is only if these tools are used appropriately that they provide benefit for clients, families and the community. In addition to client benefit, the tools provide the dual purpose of allowing organisations to report on whether *anyone is better off* (performance) and these tools can also be used at a population level to track progress towards results (population). For instance, we can identify that individuals are more or less psychologically distressed compared to the general population. Examples of such tools include the Kessler Psychological Distress Scale (K10), Strengths and Difficulties Questionnaire (SDQ), Work and Social Adjustment Scale (WSAS), and the DOORS, and the Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPSAT).

There remains work to be done on connecting the outcomes measurement of organisations in line with the RBA approach. Standardised data measurement tools used across organisations (and services within them) guide and streamline efforts towards achieving wellbeing in the population. These are agreed instruments that enable data concerning clients, and/or programs to be collected unambiguously, that is, in a robust, agreed, and accessible way, by a range of professionals in a number of different organisations. This enables them to tailor the service provided as well as

evaluate/provide information about the service effectiveness. Notably, validated measures have a relationship to population outcomes because they allow us to identify the state of wellbeing compared to broader population samples.

Report against the outcomes framework

The population outcomes framework should remain stable to enable the consistent monitoring of wellbeing. It is important to decide how often reporting against the populations outcomes framework will occur, and reporting should include assessment of progress towards identified outcomes. The direction of change is the key variable to be monitored. As new data becomes available it should be included on a dedicated website, designed specifically to report progress on population outcomes. This should be coordinated with reports from individual organisations with their own aligning performance outcomes frameworks. If individual initiatives appear to be working well based on short-term measures, but the population outcomes do not improve over time, or only for certain groups, this should raise questions for organisations. These questions might include whether interventions are reaching the right people, whether there are gaps in what is being delivered, or the reasons why change is not being sustained.

Sustain the work

Application of RBA with full implementation and collective impact sustained over time requires a long-term commitment to training, technical assistance, coaching and skilled facilitation, along with project management support. Organisations should be supported to begin with a cadre of highly skilled trainers and facilitators to pursue a comprehensive, top-down, bottom-up approach to population-wide implementation of RBA, equipping everyone to understand and practice the core concepts. Once RBA is fully adopted, there should be options for sustaining the work over time. Any method chosen needs to incorporate the complex and dynamic nature of the work required to transform outcomes that affect children, families, and communities. The best option should include ongoing work with a 'backbone support organisation' in order to make certain that the organisation maintains its focus on data-driven decision-making and shared accountability for collective impact.

CONCLUSION

Our submission highlights the importance of mental health in supporting individual and family wellbeing, economic participation, enhancing productivity and economic growth and contends that this fundamentally requires a population health approach that recognises the broader social determinants of health and in particular mental health. It is our experience that mental health is promoted and mental ill health avoided or mitigated by an effective and integrated service system. We have described a number of features that would characterise this system. Key in this are service responses that achieve individual service level outcomes and contribute to promoting overall population mental health outcomes. We believe that our experience in delivering services based on holistic detection of the constellation of mental health risks combined with tailored service responses for individuals, families and communities, contributes to the promotion of population mental health outcomes.

While our services are generally understood to offer prevention and early intervention support within the continuum of care, our holistic detection of risks means we are aware that we are often working with clients and their families who are living with acute mental illness.

We have also described the need for a robust population health framework that exhibits strong integration vertically and horizontally across the continuum of care. Vertical integration, that is,

from individual level health outcomes (service or program level) to systemic inter-sectoral and cross-jurisdictional outcomes at a population level, promotes clear accountability through strong leadership and governance and an evidence base drawn from agreed program and population data. Horizontal integration within the framework we propose is essential for good collaborative practice and required shared use of agreed tools and strategies to intervene early and work collectively to provide 'wrap around' support for individuals, families and communities.

We believe these elements will substantially assist to improve population mental health outcomes that realise economic and social participation and productivity benefits over the long term.

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