Protecting Victoria's Vulnerable Children Inquiry Submission

This Submission was Prepared By

Karen Field

Chief Executive Officer

drummond street services

Issue:

To inquire into, and develop recommendations to reduce the incidence and negative impact of. child neglect and abuse in Victoria.

This submission will address the following **terms of reference**:

1. The factors that increase the risk of abuse and neglect occurring, and effective preventive strategies.

1.1 Given the different forms which child abuse and neglect may take, and the very broad range of risk factors involved (for example, parental substance misuse, domestic violence, socio-economic stress, inadequate housing, availability of pornography, parental history of child maltreatment, poor parent-child attachment, social isolation etc):

- 1.1.1 What are the key preventive strategies for reducing risk factors at a whole of community or population level?
- 1.1.2 What strategies should be given priority in relation to immediate, medium and longer term priorities?
- 1.1.3 What are the most cost-effective strategies for reducing the incidence of child abuse in our community?
- 1.1.4 Do the current strategies need to be modified to accommodate the needs of Victoria's Aboriginal communities, diverse cultural groups, and children and families at risk in urban and regional contexts?
- 1.1.5 Some in the sector have argued for the introduction of a 'Public Health Model' in relation to child protection. What might be the benefits of introducing such a model in Victoria? What are the main characteristics of such a model?

2. Strategies to enhance early identification of, and intervention targeted at, children and families at risk including the role of adult, universal and primary services. This should include consideration of ways to strengthen the capability of those organisations involved.

2.1 What is the appropriate role of adult, primary and universal services in responding to the needs of children and families at risk of child abuse and neglect? Please provide comment in relation to any of the services listed below or any additional services that you regard as relevant to this Term of Reference.

- 2.1.1 Universal and primary children's services such as general medical practitioners, antenatal services, maternal and child health services, local playgroups, early childhood education and care services, primary schools, secondary schools, and telephone and internet based services for children and young people seeking information and support.
- 2.1.2 Targeted child and/or family services such as enhanced maternal and child health services, children's disability services, specialist medical services, child and adolescent mental health services, family support services, family relationship counselling services and Aboriginal managed health and social services.
- 2.1.3 Specialist adult focused services in the field of drug and alcohol treatment, domestic violence, mental health, disability, homelessness, financial counselling, problem gambling, correctional services, refugee resettlement and migrant services.

2.2 How might the capacity of such services and the capability of organisations providing those services be enhanced to fulfill this role?

2.3 What strategies should be given priority in relation to immediate, medium and longer term priorities?

2.4 What are the most cost-effective strategies to enhance early identification of, and intervention targeted at, children and families at risk?

Submission Key Messages:

This submission draws on the experience of our agency in working with families at an early stage to address vulnerability and reduce risk in a range of areas including family violence, mental health, drug and alcohol, gambling and Key learnings from program research undertaken in the past five years are as follows:

1. The family is the key site of intervention for child protection. Vulnerable children are a product of vulnerable families, and multiple interventions may be required which support the whole of family as well as individual members. We must stop thinking and acting in silos if we want to impact on the health and wellbeing of children and the families they come from.

2. Through the process of mapping a family developmental pathway (including its different permutations – such as gay and lesbian families, stepfamilies, child free/less families) – we can predict likely pathways towards health and wellbeing, and towards increased risk factors. This includes the pathway to family violence, mental illness, alcohol and other drug use and problematic gambling. These research findings show that there are common risk and protective (resilience) factors across multiple health risk domains. Interventions which prevent or ameliorate risks and building protective factors at the individual, family and community level can prevent and reduce the impact of health risks and increase family wellbeing and resilience across the life course.

3. Engaging families in prevention and early intervention programs is vital and cost effective. A focus on family wellbeing, family relationships and functioning and parenting in our programs and service is successfully engaging families at every level of need and at different times throughout the family life course.

4. As an agency, we have contributed to the knowledge and evidence base by using a developmental approach to families, with interventions at an early stage to promote family wellbeing as well as respond to risks and the specific needs of individual members. This approach prevents future problems and supports vulnerable families before issues become severe. A public health approach has been vital in developing our understanding along with programs which are targeted and responsive to whole populations.

5. Health and wellbeing risks impact on families causing health risks for carers and their children. In addition, family interventions can diminish these risks for carers and children and support the recovery and quality of life for consumers. Even in the alcohol and drug field, evidence suggests that a focus on parenting and family wellbeing results in a reduction of drug use in users.

6. Key family transitions are times where families are amenable to seeking knowledge and support. At these times families can be engaged to build protective factors and manage adversity and vulnerability (thereby building resilience). These cumulative protective factors can be drawn on at the next family transition stage or where the family is faced with an adverse life event or vulnerable situation. Family life course transitions such as: transitioning to parenthood, parenting challenging adolescents, post separation and forming stepfamilies are transitions when families seek services and tend to be more open to intervention.

7. An effective mechanism for screening is a Whole of Family Assessment: qualified, experienced staff screen for a range of health and wellbeing risk across the whole family and then wrap programs around the family rather than fitting people to

programs. This approach requires greater resourcing and a range of referral pathways to tertiary services.

8. No one sector or discipline can provide a public health response to child abuse and neglect. In fact we would argue that Child Protection is seen by the community as the tertiary end service and therefore has limited capacity to engage vulnerable families at an early stage. Rather, we must examine – where do these families go for services and at what times, and develop the capacity of those services to respond and to provide evidenced-based programs. The training of GPs and other allied health workers in mental health screening is an example of this kind of approach.

9. To do this work within our agency has required additional resources, borrowing knowledge across a range of disciplines, engaging in workforce training and development including up-skilling our employees to screen for mental health risk factors, building organisational capacity and change management, forming partnerships with a broad range of sectors and services from universal to tertiary services, and drawing on academic research expertise. It has also required the organisation to examine its role as a non-government agency within a geographical space, responding to existing and future local needs. It has required us to understand and plan for the community in which our services reside and understand the diversity within that community. Research projects incorporating program development, service trials and evaluation funds have had to be sourced in order to undertake this work.

10. More funding is required to grow the evidence base in relation to interventions to promote family wellbeing, health promotion targeting the family setting, and family violence prevention programs.

1. Background

For over 124 years ***drummond street services*** (known previously as the Citizens Welfare Service of Victoria, and Drummond Street Relationship Centre) has developed and delivered a whole range of programs and services in response to social issues. For well over 100 years, this role has meant drummond street services has contributed to the frameworks and practices of the welfare sector, as well as the disciplines that engage in developing the provision of these services, such as family support services and in its early days, services for vulnerable children. During the past five years, drummond street has undertaken strategic efforts to establish a **public health approach across its family service program**. This work has led to use of a broader concept of **"family wellbeing"** rather than a single risk focus (such as mental illness, or child abuse and neglect). Research is now showing that families tend to present with multiple health and wellbeing risks, and the relationship between specific health risks is a complex one. We also know that the impact of the risks on individual family members tends to lead to poorer health and wellbeing outcomes for other family members. There is also a growing body of research showing that if we are positively able to impact on family functioning we improve the outcomes for all its individual members. By actively and continually asking the question "what works", we have been able to direct the development of service delivery, including establishing innovative and responsive programs, on practice-based evidence. By actively and continually engaging in academic research and evaluation, we have built up a knowledge and evidence base in relation to family health and family based interventions. Three key areas of family wellbeing risks were explored through program development and research grants to impact on high rates of family violence, mental illness and childhood obesity. Whilst focusing on specific issues, research findings demonstrated common pathways leading to health and wellbeing risks in families, along with key family life course (developmental) transition points for prevention and early interventions across a range of health risk domains. Arising from this evidence, it is also promising to note that positive client outcomes in these areas may well reduce the risk for other wellbeing issues and/or increase the coping capacity of the family (which involves a combination of cumulative protective factors and resilience) - outcomes that potentially impact on parents, children and young people in the future.

2. The Context of Family Service Delivery

To fully understand the policy and service system implications of these findings - in particular with regards to the health and wellbeing and vulnerability of children - it is useful to understand the context in which this agency is funded and therefore the perception the local community and our clients have of our services and our position within the service system.

Today drummond street services is a generalist not-for-profit agency located in Carlton servicing six local government areas in inner metropolitan Melbourne. Its primary funding comes from the Commonwealth Department of Families, Housing, Community Services and Indigenous Affairs – Family Support Program and Community Based Mental Health Program. Programs and Services which are funded via the Family Relationship Service program include Relationship and Family Counselling (1400 clients per annum) and Family Relationship Education and Skills Training (900 participants in community education seminars and groups per annum). The Commonwealth Mental Health funding allowed drummond street to establish in Victoria the first Family Mental Health Support

Service (there are seven nationally across each state and territory) which provides a whole of family public health approach to mental health promotion, prevention and early interventions for mental illness, and supporting families impacted by mental illness. Five years ago drummond street1 embarked on a process of embedding a public health framework into the agency to guide the development, delivery and evaluation of its entire suite of Family (Wellbeing) Service programs. The public health model conceptualises programs and services across the spectrum of interventions, from promotion, prevention, early intervention, treatment, and recovery. This strategy was based on the following aims, principles, and rationales:

1. To **capitalise on the potential of the 'Family' as a setting for promoting** and building physical, mental and emotional, social, economic and cultural wellbeing (for both adults and children).[2]
2. That **increasing family functioning and enhancing family relationships and parent child relationships impact on a range of wellbeing risks** such as mental illness, family violence, alcohol and other drug use, gambling.
3. To **capitalise on the large and growing family relationship service sector** as a sector enabling access to large numbers of families[3]. This included families across the family life course such as: individuals seeking relationships, newly formed couples, couples becoming parents, child/less/free couples, sole parents, separated couples, reforming families such as stepfamilies and blended families, grandparents as carers and so on.
4. The **willingness of some community members (men) to seek family relationship counselling and family relationship education and skills training more readily** than other specialist services, such as family violence programs and mental health services.[4] Since the federal government expansion of this program a number of studies have shown that not only does this sector have a national broad reach into all families across economic, social and cultural divides, but also that increasingly families are identifying this as a **non-stigmatised sector** where they would go to seek help for problems within the family. Client data shows that clients accessing our services are seeking skills, knowledge and support through a specific family transition or are struggling with one or more issues which are impacting on family relationship and functioning (including parenting) such as mental illness, gambling, problematic alcohol and other drug use, but have never sought assistance with a service-provider before.
5. The **capacity for family relationship services to screen and assess the needs of all family members** as well as the presenting client(s), in order to identify issues early and intervene in the full range of issues that may develop in adults, young people and children.[5]
6. To **develop partnerships** with other complimentary universal service providers to provide integrated services, assertively engage families in promotion and prevention interventions and identify early vulnerable families requiring more intensive family services such as parenting support or family counselling programs. Such complimentary services include GPs, local hospitals with

[1] Drummond street is provider of child and family relationship counselling, groups for parents, children and young people, and education and training services for professionals and those working with families across a range of sectors. The Centre is located in Carlton, Victoria. View their website at: http://www.ds.org.au

[2] Promotion, Prevention and Early Intervention for Mental Health, A Monograph (2000), National Mental Health Strategy. and A Plan for Action 2005–2007: Promoting Mental Health and Wellbeing Vichealth: www.vichealth.vic.gov.au

[3] The Australian Government's increased investment in the Family Relationship Sector, via reforms to the Family Law system, and emphasis on prevention and early intervention programs to strengthen family relationships. www.fahcsia/families.

[4] drummond street Client Information System data regarding mental health issues in particular. Also for example, men with violence issues more readily seek relationship counselling than men's behaviour change groups, Partnerships Against Domestic Violence (PADV) (2003) Commonwealth of Australia

[5] DRUMMOND STREET Client Information System data

maternity units, Maternal and Child Health Centres, Childcare Centres and primary and secondary schools.

As you will see, drummond street sits outside of the state-funded child protection, tertiary mental health and family violence sectors in a funding sense. However, our work often intersects with these sectors in a number of ways, shares client groups or has a common goal but possibly a different approach. Whilst the connection to tertiary-end service is obvious to us as an agency, a shift in language and broader focus on family wellbeing as well as risk may well resonate with families who are vulnerable and fearful of these systems or hold negative views about them.

1. **Specialist Parenting expertise including vulnerable parents:** drummond street has a range of parenting programs which are based on developmental needs of children and young people, and embed health and mental health promotion, prevention messages and skills, and parenting skills and strategies to all parents. From these programs we receive self-referrals or identify particularly vulnerable parents and take referrals from Child First and Child Protection, Maternal and Child Health, GP's and other agencies of vulnerable parents with infants and toddlers for our "one to one" Hands on Parenting Education Program (including young men in juvenile justice centres and young parents who have grown up in care) and our Parenting Support Sessions and Family Therapy for older children and young people.
2. **Link between enhanced family relationships and functioning and multiple health and wellbeing risks:** Our Family Clinical programs provide therapeutic support and counselling in relation to issues impacting on family relationships, functioning, cohesion and parenting, and reduce conflict. When vulnerable families present with complex issues we are able to make warm referrals to tertiary end services where required and engage in case management and conjoint case work with other services such as Child First, Child Protection, the Family Court, and Family Violence Services. In addition, we are able to provide family level interventions which both prevent further risks for carers and children and at the same time support life-long recovery for consumers.
3. **Targeted Interventions for vulnerable and marginalised populations**: drummond street has developed specific programs and practice and engages with specific at risk and vulnerable populations such as our African Family Support program and our GLBTI (Queer) community programs for the Gay, Lesbian, Bisexual, Transgender and Intersex community and their families. Not only do these programs have significant self-referrals from these communities but also referrals based on other agencies knowledge of this expertise such as local schools, child care, GPs and other services. One example is specialist unfunded programs that drummond street has needed to develop in response to the Police-referred family violence cases involving Queer couples and families where it was not appropriate for them to attend mainstream Tertiary Family Violence Services.
4. **Research trials to build the evidence base:** drummond street has been involved in a number of key research trials through its Deakin University Health Psychology research partnership of family level interventions which harness parenting interventions to address risk issues either in parents or their children. This includes:
    - Deakin Family Options: which targets young people (with mental health risk or illness and/or alcohol and other drug use) and their families and recruits

them in for assessment and randomised allocation to one of three interventions: 1) the BEST PLUS family group intervention; 2) the CBT individual young person intervention; 3) both interventions provided. This partnership is funded by beyondblue and a National Research Council Industry Grant

- Backyard Blitz: this program sought to harness the parenting role towards increasing the physical activity levels, improving nutrition, and strengthening relationships of fathers and their children. The program was particularly aimed at those men who were separated, divorced or not working, who often only had weekend access to their children. These men felt they had some issues around their own levels of optimism and ability to provide positive family experiences and or cope with the demands of parenting. Specific client outcomes for this program are presented later in this submission.

3. A Public Health Approach to Family Wellbeing as a means to better outcomes for its individual members including children

A useful model for guiding an expansion of family interventions and family-centred community interventions in the Australian context is Mrazek and Haggerty's Mental Health Intervention Spectrum, spanning prevention, early intervention, treatment and continuing care. In relation to families, the spectrum can be applied both to the individual needs of family members (in relation to individual wellbeing including the children), and to a family group as an entity (family wellbeing). The framework has relevance for both individual developmental pathways and the Family Life Course, and demonstrates the importance of having a full range of interventions. It has also pushed the organisation particularly in the areas of health promotion and interventions to increase wellbeing at each level of intervention. A comprehensive public health system will offer:

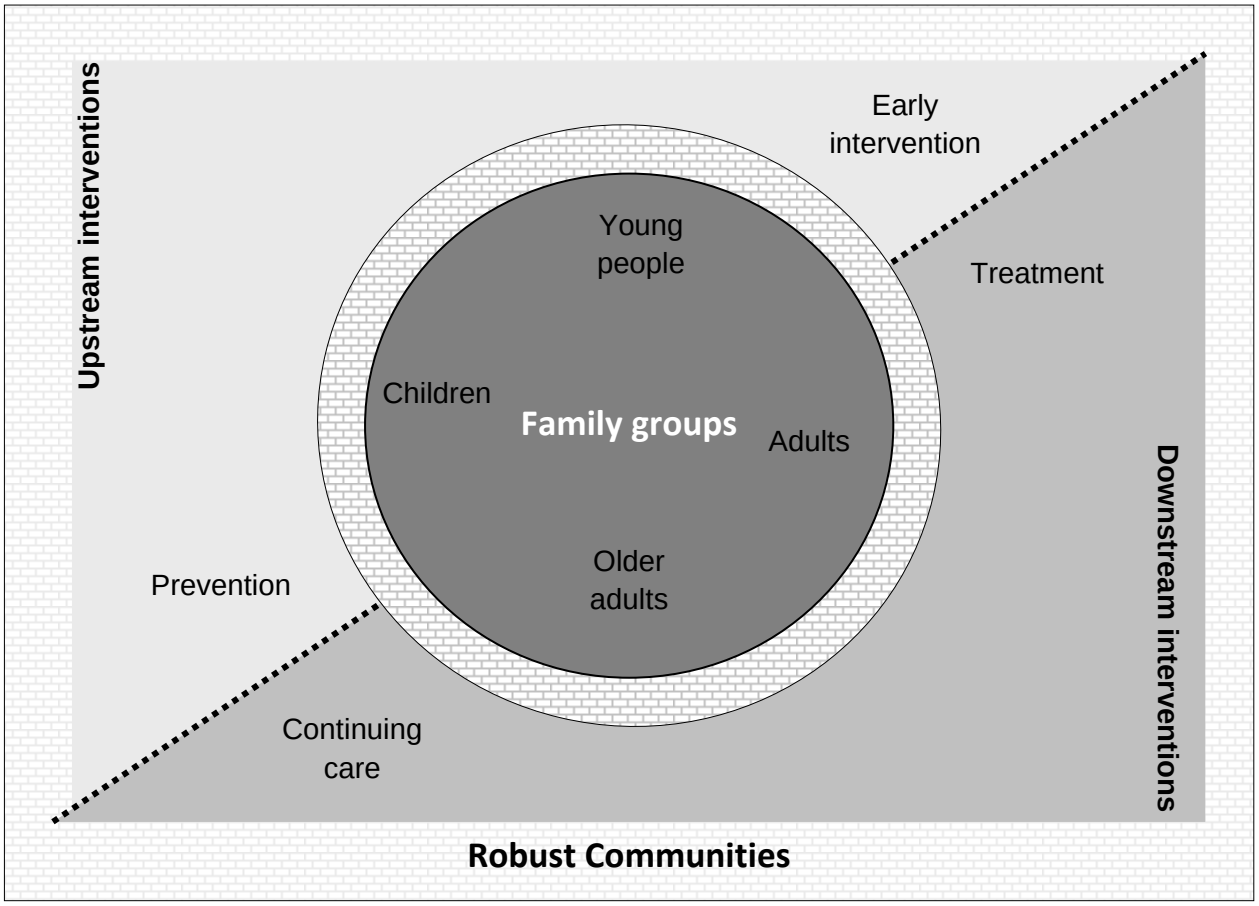
- Promotion - Interventions which maximise health and wellbeing by addressing the underlying influences of health in environments and everyday life for the whole population. They are universally applicable to all individuals, families and community.
- Preventive strategies for whole populations (e.g. new families and children); Early interventions for at risk sub-populations (e.g. struggling families and young people);
- Treatment interventions for unwell or dysfunctional sub-populations (e.g. violent families or adults with identified health issues); and
- Continuing care strategies for sub-populations living with a vulnerability or disorder (e.g. single-parent families, or older adults living with illness).

Health promotion activities are useful across the spectrum but are so often left out of intentional programming and practice along with funding. Within public health, interventions are described as either 'upstream' (preventative measures), or 'downstream' (rescue measures). A robust public health system will support both upstream and downstream interventions.

At some stage, all families will need the support of their community. Families will benefit most from communities that offer the full range of health interventions: Upstream - communities can build prevention and early intervention strategies into the fabric of informal social relationships by offering a range of accessible health-promoting activities; Downstream - communities can offer families services, structures and institutions to treat and care for families who struggle.

The following Figure highlights the central role families fulfil in supporting the health and wellbeing of individual members. Family groups provide a central hub for the efficient transmission of health promotion information, resources and actions. Targeting family groups as a primary setting for health promotion activities across the spectrum of public health will concurrently build the robustness of families and communities.

Figure: Families as a primary setting for health promotion across the life span



As service providers and practitioners, we recognise the need for: a range of interventions to meet the diverse needs of families across the various stages of the family life course; greater emphasis on supporting families earlier in their family life cycle in order to prevent issues such as family breakdown; and the provision of support for those transitioning to parenthood. To optimise the effectiveness of our programs and services in meeting these needs, drummond street has used the Spectrum of Interventions model (Mrazek & Haggarty, 1994) to:

- plan, develop and map its programs and services in relation to strengthening family wellbeing (promotion and prevention);
- identify and address risks early when present (early intervention);
- provide evidenced-based treatment when required (treatment); and
- support families to recover and move on (recovery).

Examples of how our programs and services, and their level of intensity, are mapped onto the spectrum of interventions are given below in Table 1.

Table 1. drummond street programs/services mapped across the spectrum of interventions

Intervention Level	**Risk / need**	**Program/Practice Service response**
Health Promotion	Family Wellbeing and Mental health	Fact sheets Get involved in your local community neighbourhood Harnessing social connection through peer support and mentoring across all group programs. Mental Health Promotion Fact Sheets – • Exercising your mental health, • Work-life balance, • Raising mentally healthy kids
	Parenting, physical activity and healthy nutrition	Backyard Blitz for Dads and their Children
Prevention Whole of population or for groups identified to be at risk, including strengthening coping across the spectrum of interventions	Family Violence	Seminars and Groups including: • Maintaining your relationship for couples transitioning to parenthood (in antenatal classes) • You and Your new Baby
	Mental Health	Seminars and Groups including: • Stress-management • Assertiveness for women • Mindfulness meditation • Alcohol use by parents

Low intensity	Physical health	Seminars and groups including: • Physical activity and healthy nutrition program for dads and their kids (Backyard Blitz) • Oral health prevention for African refugee families
	Strengthening families and building communities, and family and social capital	Community gatherings • Welcome to the community picnics for newly arrived African families • Rainbow family picnic (for Gay & Lesbian parents and families) • National Gay Dads Forum Social marketing campaigns e.g. It takes a village to raise a queer (mentoring program) Community Seminars: • Supporting staff with family issues in the workplace • Raising happy healthy kids • Strengthening our relationship Fact sheets • Get involved in your local community neighbourhood
Early Intervention Low-medium level risk and intensity of program response	Early identification of risk issues present, including targeting key family transitions	Seminars and Groups: • Relationships under stress • Antenatal classes (incorporating changes to the couple relationship with birth of new baby) and Enjoying Your New Baby group • Parenting primary schoolers • Parenting adolescents Just Families Program, targeting parents with their first child under 12 months, to strengthen couple relationships and prevent family violence Family Intake Program screening and pathways to early intervention services, including • Counselling • Parenting support services • Groups
Treatment – Tertiary Services Medium to High	Significant Relationship and Parenting Issues present including: • Family Separation	• Pathways to specialist treatment services via Family Intake Program and other programs, including to mental health, alcohol and other drug, health, crisis services etc.

level of risk and intensity of program response	• Reforming families Includes health risk issues such as mental illness impacting on other family members, and presence of adverse life events	• Individual/couple relationship counselling and family therapy • Family dispute resolution and decision-making, • Family case work Specialist parenting support Seminars and Groups: • Parenting adolescents with complex issues present • Parenting with depression • Supporting your partner with depression
Continuing Care – Maintenance Medium level of risk and intensity of program response	Recovery from presence of health risk issues including mental illness, family violence, alcohol and other drug use, relationship/family breakdown, re-partnering/step-families	Referral to other recovery services, including family/carer services, as well as to address other impacts including employment Individual/couple/family counselling Community Seminars and Groups: • Grandparents as carers support group • Taking a break recreation program for young carers

4. Why Families as settings for action? What has informed our thinking – new knowledge.

In 1999 the Commonwealth Attorney General's Department released a report entitled "Pathways to Prevention" Developmental and Early Intervention approaches to Crime in Australia. This report provided a useful attempt at understanding the pathway to antisocial behaviour throughout the life course and made particular reference to also thinking in terms of the family life course as offering key transition points for early intervention. These concepts are foundational to a public health approach when thinking of wellbeing risks for families, parents and children.

All humans go through particular developmental stages and experience significant age-related transition points. These transition points are understood as part of normal human development. In similar ways, families experience a common set of transition points as they develop, along what is called the Family Life Course. Family groups adjust to changes occurring for individuals, as well as changes happening for the family as a whole, in order to continue on.

All families are different, but all families are vulnerable to getting 'stuck' at points of transition. Known transition points provide an ideal opportunity for families and communities to undertake preventive action or intervene early, in order to maintain the health of family members and move into the 'next stage' smoothly (cumulative protective factors and resilience). A healthy community will have mechanisms in place to support families through each stage of transition. It is vital that both individual family members and family groups are assisted to find a new stability after times of change.

4.1 Family Life Course

The 'normal' developmental stages of a family group have been identified, from childhood through to older adulthood. For each different type of family group, there may well be additional predictable transition points. For example gay or lesbian couples may have to cope with extra legal and social challenges if they decide to have children. The following Table outlines common transition points experienced by families, from childhood through to older adulthood.

Table 2. Family Life Course Stories

Birth to age 2: A baby learns about his/her primary carers, and their ability to meet his/her needs. The child develops a view of the world as a safe place or otherwise and attachment is critical to for cognitive development. In addition to family supports, a community that supports young families has an impact on children at this early stage of development.
Age 5-6: Children begin school and the success or otherwise of this transition (to their first major institution outside family) can set the scene for the child's whole school experience. Children who are encouraged by parents and teachers during this stage can develop skills that will help them to adjust to many other institutions during the course of their life. In these new settings, children will learn to manage new social expectations and adapt to new behavioural norms.
Age 10-12: The move from primary school to secondary school is another major milestone. If students can recognise and embrace the different demands of this somewhat less nurturing setting, they will manage well and may become successful life-long learners. Transition into secondary school requires young people learning when to conform and when to assert themselves. For those who fall behind academically, experience ongoing bullying, or fail to understand the different rules and structures, a struggle begins that may result in lowered self esteem, a dislike of education, and in some cases, early school-leaving, which can limit future economic opportunities.
Transition from adolescence to adulthood: This stage is often heralded by a fight for autonomy, thus some conflict with family or caregivers. Young people at this stage of life are trying on many different masks to see 'what fits'. Adolescents work to find out what kind of person they are, who they want to be, and if will they be accepted. For those with like-minded friends and supportive families, this stage can be a time of great fun and gradual freedom. For young people who are isolated from the mainstream (usually because they are different in some way) this transition can be a time of emotional pain.
Late adolescence: Sometimes stretching into their 20's, young people generally attempt to establish themselves as an entity outside the family. Older adolescents negotiate education, training, employment, unemployment, social and sexual relationships, and begin to envisage the future.
Couples: Young people tend to form into couples, and may try living together; some consider marriage or long-term commitment. Others see their peers coupling, but either choose to remain single, or do so through lack of opportunity. For young people who remain single, this time can be stressful. Families and communities may exert expectations, resulting in feelings of pressure about partnering. In some cases, an alternative plan or a reformed identity may need to be established.

Parenthood: Couples may plan to become parents, and either achieve this, or enter a world of pregnancy attempts, which may include assisted fertility technology. Fertility difficulties place extra strain on relationships. Some couples choose not to have children, a choice which may then set them apart from the dominant culture to some extent (although this is changing). If a couple experiences pregnancy and has their first child, life may change completely. Early parenthood is a time of increased stress, and is the most common time for family violence to emerge. Many adults find they are facing parenthood alone, and thus make a transition to single-parenting, meaning a significant increase in pressure and workload. The majority of families make it through their child's first year in tact.

Young children: Adults with young children experience ups and downs – particularly if toddlers go through a stage sometimes called 'the terrible twos'. This stage is often one of stretched patience and question marks – am I a good enough parent?

Teenagers: As children grow, the time of greatest transition for most families are the teenage years. Many families find the increased pressure of relating with adolescents demanding. Teenagers push the boundaries and fight for autonomy. For some adults, now in their 30s or 40s, this time is often coupled with a parallel experience of needing to start caring for parents or elderly relatives. These caring roles are still predominantly picked up by women, who then experience the stressful task of caring for and visiting their own parents, whilst managing their relationship and the behaviours of their teenage children. For some, this can be an overwhelming time.

Empty nests: As children turn to adults and (hopefully) leave the family home, many parents enter a time of relative peace. For some, this stage include separation and/or divorce (in our culture, separation is often left until children have left home). If this occurs, another major life transition is experienced, bringing with it issues of success and failure, family and community judgement, financial strain, and legal issues. Grief and loss are often overlooked, but are present in all separations (even those that may come as a relief).

Child-free: If people remain healthy, they often enjoy a high level of contentment during this stage of their life - especially if involved in community life and/or if they have satisfying work or leisure activities.

Retirement: For those who have worked and who do not have to negotiate ill health, retirement is the next common transition point. Depending on how people view their job (i.e. either just a way to earn money, or as an integral part of their identity) people will either celebrate or mourn the end of their working life. They then face life as an older person.

Old age: For many, the cycle of life begins again. Older adults tend to engage in supporting the next generation. If they have grandchildren, they may take a key role in supporting their children with the changes and challenges that parenting brings. Grandparents often take a keen role in enculturating their grandchildren - including sharing family history and traditions, giving children a sense of their heritage. Older adults who do not take on a grand parenting role often find volunteer work in the community, or take on carer roles for older friends, sick friends, and/or children. Social networks may keep older adults busy - a sense of being needed and productive seems to be the important element in enjoying this last stage of life.

The Family Life Course is just one way of representing common experiences for families. Different life cycles have been identified for diverse family groups. For example, Howden (2008) identified unique stages of transition for stepfamilies, including: Honeymoon / fantasy stage, Confusion stage, Chaos stage, Flexibility stage, and Stability stage. Issues of grief and loss, combined with a mix of optimism and adaptation take place for all stepfamilies. Stepfamily members need to navigate these changes both individually, and as an 'expanded' family group, towards a new kind of stability. With an understanding of expected transition points, extended families and communities are able to prepare for, and support, stepfamily members through these known transition points.

4.2 Socio-ecological approaches to family

A number of theorists, governments and peak bodies have adopted an ecological approach to families (Australian Department of Family and Community Services, 2000; Scott, 2001; Families Commission, 2009; Lippman, 2004).

Bronfenbrenner (1979) described the ecological model of individual development as occurring within concentric circles of environmental influence (like a Russian doll), which include the family, the school, peers, neighbourhood, community and Nation.

Coatsworth's social ecological model of human development includes the significant influence of parents, including parents' job context and parent support networks (called Exosystems –a social system surrounding the Microsystems) (Lippman, 2004). Ecological approaches to family and notions of socio-ecological health prepare us to examine families in terms of their relational systems, and their interactions with broader social networks and environments.

4.3 Family social capital

Measuring family wellbeing has both challenged and perplexed many social scientists. In recent times, the concept of social capital has provided researchers with new parameters for examining family wellbeing. According to Winter (2000), family life is a bedrock of social capital (p.2). Social capital is about the value of social networks, bonding similar people and bridging between diverse people, with norms of reciprocity (SCR, 2010).

Family social capital (FSC) examines the collective wellbeing of individual members, and is that part of family wellbeing which is the wellbeing of the entity itself (over and above the wellbeing of individual family members) (Fletcher, 2007). Family social capital (FSC) can be described therefore, as the sum of family functions/practices and family strengths, including: communication, togetherness, sharing activities, affection, support, acceptance, commitment, resilience, flexibility and adaptability.

Dorothy Scott's work (Scott, 2001; Scott, 2005) provides a strong argument for the need to revitalise communities at the micro, neighbourhood and 'familiars' level. For Scott, the relationship between FSC and community social capital appears to be interconnected and cyclical in nature. For example, the greater the support networks around families, the stronger family capital grows, resulting in greater participation and resource-sharing with extended families, neighbours, familiars and community members. This, in turn, strengthens social capital - which again strengthens family resources and sense of wellbeing.

Clearly, families have a vital role to play in minimising the health risks, and maximising the protective barriers for family members and family groups. Yet these definitions, frameworks, concepts, models and spectrums lead us nowhere, unless they are translated into action.

4.4 Promoting Family Wellbeing and Health Promotion within the Family Setting

From a strong research evidence base relating to the social determinants of health, the Victorian Health Promotion Foundation (VicHealth) developed a strategy for promoting the health (including mental health) of Victorians. VicHealth (2005, p.13) identified the following social and economic prerequisites for health and wellbeing: Social inclusion (supportive relationships, involvement in community and group activities, civic engagement); Freedom from discrimination and violence (valuing of diversity, physical security, self determination and control over one's life; and Access to economic resources (work, education, housing, and money). In 2005, these prerequisites became themes for action with a specific focus vulnerable population groups.

Strategic planning processes undertaken by VicHealth (2005) lead to the identification of a number of key "settings for action". Key settings reflected 'hotbeds' of social capital in the Victorian community including: Housing, Transport, Community services, Corporate, Education, Public, Workplace, Arts, Sport and recreation, Local government, Health, Justice, and Academic.

Recognition of the central role families play in resource sharing (including time, income, human capital, psychological capital and social capital), leads families to be considered a natural 'hub' for health promotion aims. It's possible, that within some families, all of VicHealth's identified target groups may meet under the one roof. These realities mean that families are an ideal setting for health promotion. Bonds based on shared goals and aspirations, trust, reciprocity and mutual obligation mean families provide an efficient transmission point for passing on health promotion information (including education and role-modeling) to influence members' health-related behaviours. Health promotion within families is likely to prove an effective method for achieving family wellbeing. Families deserve recognition for the primary role they already play in promoting the health of individuals and communities –they are a key 'setting for action', potentially under-utilised.

These frameworks provide us with new understandings, strategies and models in the aim of promoting health, wellbeing, economic sustainability and a robust community life.

4.5 Putting it all together

Although limited, preliminary research already supports the development of family social capital (including family wellbeing and resilience) via the following means:

- Doing things together, spending time, building the mutual stock of goodwill
- Establishing norms of trust, mutual obligation, cooperation, shared identity and reciprocity
- Modelling for children the benefits of social engagement
- Bringing imagination and energy together to achieve mutual goals
- Sharing resources, helping
- Building links with informal and formal community networks

- Strengthening established networks and growing new social networks, encouraging active participation in the life of local communities.

Family-centred practice is important; yet the intentional act of establishing family groups as 'primary settings for health promotion' recognizes the key resource families offer in the realm of public health.

Despite these tentative findings, development and research work in this area in Australia, seems to be piecemeal and not well funded. drummond street has embedded these elements of family wellbeing across our suite of programs, and is attempting to develop new innovative approaches to work at the neighbourhood micro/ community level. Our activities are linked to healthy outcomes for the family, its individual members and the community. Our programs have two key aims:

- Harnessing the protective capacity of families for promoting health, wellbeing, identity, resources and mastery, and the transmission of these from one generation to the next. Assisting people to invest in the wellbeing of their family as an entity.

- Establishing nurturing neighbourhoods (micro-community building). These interventions seek to build social connection street by street (within a housing estate), between adults and young people, and within emerging communities (African Australian communities) or excluded communities and groups (the Queer community and young parents).

The aim is to build a sense of belonging and safety within your local context and to develop natural helping networks around families and generate social capital at the neighbourhood level. This provides a two way interaction between two levels of social capital – at the family and community levels - with benefits for both.

5. Research Examples:

The following provides a brief summary of three research projects within drummond street incorporating program and practice development, trial and evaluation. We believe the learnings from these programs provide working examples of the benefits and positive outcomes for a public health approach to family wellbeing, the capacity to develop evidenced based prevention and early interventions to address specific wellbeing issues at key times in the family life course.

5.1 Backyard Blitz – Health Promotion within a Family Setting

Backyard Blitz was a 7 week health promotion program funded by the Department of Health and Ageing. The broad aim of the government funding was to tackle the increasing rates of obesity in children and many of the funded programs nationally primarily focused on school and community based interventions. drummond street's successful submission sought to harness the parenting role towards increasing the physical activity levels, improving nutrition, and strengthening relationships of fathers and their children. The program was particularly aimed at those men who were separated, divorced or not working, men who thus felt they had some issues around their own levels of optimism and ability to provide positive family experiences.

Struggling separated dads were mixed in with other dads who felt they were ‘doing well’, who acted as

informal mentors around managing children’s behaviour, trying new things and connecting with others. The program content was developed to help whole families: improve their eating habits; reduce obesity; and address chronic disease, while building family wellbeing and positive relationships. These aims were achieved through appealing to men (traditionally difficult to engage) via their role as ‘dads’. For the sake of their children, we found that men will attend a series of whole day activities. Themes of ‘backyard adventures’ and ‘positive parenting’ worked well, whereas they would not necessarily have attended a program aimed at weight loss, fitness or nutrition or a specific program targeted at separated dads.

Each program consisted of seven sessions run over a fourteen week period. The programbegan with an information night for fathers, which pointed out the value of involved active fathers and emphasised the many positive outcomes for children, outlined healthy eating, provided suggestions for engaging others (eg: adult friends or other families) in outdoor activities and finished with practical information about the program, what to bring/wear etc. The group then met up on five Sunday mornings to take part in a full day program emphasising having fun and playing together as a family on each occasion. These activity days ran every second Sunday rather than consecutively in order to include separated fathers, who accounted for 51% of the fathers participating. Two or three Mentor Fathers were chosen from previous intakes and other programs we run. These fathers were experienced in dealing with children but don’t necessarily fit the mould of the “young fit Dad” which we wanted to avoid. These mentors were trained by drummond street staff and understood that their role was to lead by example and encourage positive behaviours rather than overtly tell participants what to do. This more natural subtle approach was very effective with overweight men particularly, who often resist being guided by others they don’t identify with.

At the end of the program a Celebration Night was held where mothers, grandparents, family and friends etc. attend. The main focus was on the projected photographs from the activities, set to music, showing humorous scenes from all the activities. This casts the fathers as the heroes and shows them performing strenuous feats including jumping from high ropes, paddling rafts with eight passengers and helping their children reach the top of the rockclimbing course. drummond street has an ongoing commitment to quality research, therefore the past three Backyard Blitz programs have been independently evaluated by Dr Anita Pryor under the supervision of Deakin University, in association with the Centre for Family Research and Evaluation. The full evaluation report shows findings such as:

After participation:

- All fathers agreed that teaching their kids about physical activity and good eating was a major part of their role as a Dad
- The amount of meals Dads and their children prepared together increased and they felt closer
- Dads were more likely to use outdoor spaces and initiate active outings such as bushwalking

- Dads identified the enjoyment of good healthy food as one of the most useful aspects of the program
- Dads felt better connected to other Dads and the community as a whole

Despite the successful client outcomes for this program for both fathers and children, and the broader implications of effective health promotion interventions targeting the family setting, it is disappointing that we have not been able to secure ongoing funding for this program.

5.2 Family Violence Prevention and Early Intervention:

The William Buckland Foundation Just Families Project – building the evidence base of interventions that reduce the prevalence rates of family violence – what works

Despite the increasing prevalence of and knowledge base regarding the effects of family violence on female victims, children and perpetrators, research shows a lack of successful interventions. Existing interventions and the family violence service system tends to be tertiary in nature, intervening when violence is already serious and entrenched, with relatively poor outcomes for victims (women and children) and relatively ineffective interventions for perpetrators. On average, it can take up to 6 years for a woman to leave a violent relationship (UK – Home Office Report,

2003) and family violence is the leading cause of death and disability in women 15-44 years in Victoria (VicHealth, 2006).

The growing concern regarding prevalence and the enormous social and economic costs associated with family violence is shared by our agency and was the driver for the development of this project. The link between family violence and its impact on children is now well understood. The aim was the development and evaluation of prevention and early interventions in order to prevent higher numbers of family violence cases rather than a focus on attempting to ameliorate the trauma of living with violence for years and a primary focus on Men's Behaviour Change Groups and recovery programs for women and child victims - "after the horse has bolted".

The Just Families Project was particularly interested in the area of interventions which seek to prevent the onset of family violence or seek to intervene early where indicators of family violence risk are present. The evidence shows that pregnancy6 and when parenting commences (the first 12 months of a child's life) are times of particular risk in terms of family life course transitions, for the onset of the first physical violence episode. In addition, we also know that there are a range of indicators which, if present, increase the likelihood of family violence occurring.

The project aimed to prevent and intervene early to prevent the onset of family violence by:

[6] [6] Please note case where onset occurred during pregnancy were eliminated from the study because of the indication of pyscho-pathology in the perpetrator and the need for tertiary and legal reponses.

- developing a set of at risk or early intervention indicators for family violence
- providing strategies for identifying families for prevention and early identification
- providing family-based interventions addressing risk and protective factors for family violence
- intervening at a key family transition point known to be associated with increased risk of onset of family violence.

Key components of the project:

1. Developing indicators that were able to identify couples transitioning to parenthood (CTTP) who may be vulnerable to family violence. We have been able to develop screening tools and processes appropriate for early intervention into family violence as differentiated from those important for identification of cases where family violence has already occurred and where the level of risk and tertiary intervention required needs to be ascertained.
2. Establishing a partnership with agencies that provide universal services to CTTP such as Ante/Prenatal Course providers and Maternal and Child Health Care providers (who engage with all families) in order to identify families at risk (using the developed screening tools) and create a pathway to early intervention. Early intervention includes Parenting and Relationship counselling with a skilled Family Relationship Counsellor.
3. Develop and provide innovative evidenced based family services including prevention interventions to all couples transitioning to parenthood (psycho-educational sessions on impact of baby on the couple relationship etc.) and early intervention for those couples identified as “at risk of” family violence which included Family Counselling with a skilled parenting and relationship counsellor. This includes the development of good practice principles.

The Results

Results after three years are showing some clear evidenced based approaches for the prevention and early intervention of onset of family violence for couples transitioning to parenthood. For clients attending early intervention relationship counselling a comparison of pre and post - test measures indicated:

- significant improvements in family functioning (specifically, conflict and cohesion) and couple relationship functioning,
- significant improvements in parenting skills and confidence
- significant improvements in mental health symptoms as a result of involvement in early intervention couple counselling. Of importance, mental health symptoms were found to be at a clinical level (meet criteria for diagnosis) prior to

counselling, and reduced to a population level after counselling (six sessions). This includes building coping skills and minimising stress.

A second wave data analysis is about to occur and will also measure parent child attachment for both parents.

Anecdotally, follow up data is showing that these client outcomes are sustained over the 12 month period and may well develop the patterns for sustaining over the family life course. It supports the efficacy of providing interventions early on in a couple relationship and early parenthood because it is a period of time when couples are amenable to seeking help (this is supported by Geoff Olds research in the United Kingdom) and creates the attitudes, skills and behaviours for the life of the family.

Achievements and leanings include:

- Built into a universal service, the capacity to screen for and early intervene in risk factors for family violence, at the family level

- Developed the capacity to identify and screen for risk factors earlier on the pathway to family violence, to inform the development of prevention and early interventions, and differentiate between the need for an early intervention versus tertiary level family violence intervention

- Developed prevention and early interventions which not only address risk factors but have a dual focus on protective factors for couples transition to parenthood, to strengthen couples and families at this key transition stage

- Developed interventions for prevention targeting a particularly vulnerable family transition point at high risk for onset/first episode of family violence

- Partnership with MCHS to ensure a whole-of-population approach

The results of this project provide evidence of a suite of programs which have significantly reduced the risk factors and onset of family violence first episodes during the most vulnerable period of a family's life course. A myriad of research exists which clearly indicates the most common time for the onset of the first family violence being the period when couples are transitioning to parenthood and the first 12 months of a baby's life.i7 It is promising therefore, that the program has the potential of thereby reducing the overall prevalence rates of family violence throughout the family life course rather than just at this transition point. In addition, given the protective capacity of the family and its role in transmitting values and behaviours from one generation to another, it could be argued that this may have a positive impact on diminishing community attitudes which are supportive of family violence.

[7] [7] Please note case where onset occurred during pregnancy were eliminated from the study because of the indication of pyscho-pathology in the perpetrator and the need for tertiary and legal responses.

5.3 Integration of Public Health approach to Mental Health and Illness within a Family Relationship program

Four years ago when drummond street services was selected as Victoria's Family Mental Health Support Service Demonstration Project funded by the Commonwealth Department of Families, Housing, Community Services and Indigenous Affairs – Mental Health Branch. From the outset we embarked on a process of embedding a public health framework for mental health and illness into the agency to guide the development, delivery and evaluation of its entire suite of family service programs. Rather than instituting a separate, stand-alone mental health program we integrated mental health services into our existing services, and developed our capacity to promote mental health, detect mental health risks, and respond quickly and effectively by providing appropriate counselling, programs and links with other agencies. In particular we strengthened our intake process to identify a range of mental illness risk factors for all family members, enabling interventions to take place at an early stage. In this way we have brought a mental health 'lens' to everything we do while at the same time reducing the stigma associated with mental illness in the community and towards the mental health treatment system.

We took this approach for the following reasons:

- Existing evidence was showing a strong correlation between family functioning and mental health as well as the impact of mental illness of family relationships and functioning;

- We recognised the potential of the "family" as a setting for building physical, mental and emotional, social, economic and cultural wellbeing (for both adults and children), and the fact that people were more likely to access family relationship services rather than specific mental health services;

- We saw the capacity for family relationship services (as an increasingly universal service) to screen and assess across a range of health issues and for all family members and to embed mental health promotion and prevention interventions within our family community education and groups; and

- We anticipated that the large and growing family relationship service sector would enable access for large numbers of families.

We would argue that the client outcomes and key learnings from the program have been very positive and have implications for mental health promotion, the prevention of mental illness, supporting treatment and recovery, and understanding and minimising the impact of mental illness on families.

Learnings include:

- There is a strong correlation between family functioning and mental health. Where interventions were able to increase family function and cohesion, and

decrease couple conflict we see a reduction in mental illness symptoms from diagnostic levels to below diagnostic levels;

- It is possible to integrate mental health promotion and prevention messages and interventions within community family education and seminars especially those targeting parents; and

- Through incorporating health wellbeing risk screening including mental health and illness within our Family Intake and Assessment program we have been able to access an alarming number of individuals who have high levels of mental health symptoms and /or risks and have never attended a service before. This was also the case for other health and wellbeing risks including family violence, problematic alcohol and other drug use, and problematic gambling. In addition, high levels of co-occuring health risks were present in a significant number of families.

- We would strongly argue that one of the significant impacts for a family with a family member with mental illness relates to family relationships and functioning. A family service agency outside of mental health treatment can demonstrate interventions that mitigate against these impacts to improve the mental health and wellbeing of other family members (carers, children for example) as well as assist in the recovery of consumers.

- An evaluation of client outcomes performed by Deakin University based on pre- and post- surveys by clients in our counselling program found:

    - a significant decrease in family conflict;

    - a significant decrease in social dysfunction symptoms;

    - a significant decrease in overall health symptoms;

    - a significant decrease in anxiety and insomnia; and

    - a significant decrease in depressive symptoms

- Of particular note was the number of clients who initially reported mental health symptoms to an extent likely to lead to a diagnosis of mental illness, and who subsequently reported a reduction in those symptoms to levels below the clinical diagnosis level.

- The evaluation also found that key program outcomes were achieved, and outputs well exceeded requirements with 573 clients attending for counselling and 960 attending seminars and groups over a 32 month period, demonstrating the relevance, cost effectiveness and appeal of the program.

- There is great potential for this program to be implemented within the Department of FaHCSIA - Family Support Program and therefore provide a national universal population health approach to mental health and illness. Given

the size and breadth of the FRSP sector, as well as state funded family services, this provides an enormous public health potential to screen for and ameliorate mental health risks early as well as provide critical health education to prevent mental health problems and build resilience for individuals and their families.

6. The building picture for family wellbeing and the implications for policy and practice

As set out above, drummond street is breaking new ground in terms of understanding and responding to family wellbeing. Our approach and framework for our work with families has crystalised to include the following findings that are directly relevant to this inquiry:

1. The family is the key site of intervention for child protection. Vulnerable children are a product of vulnerable families, and multiple interventions may be required which support the whole of family as well as individual members. We must stop thinking and acting in silos if we want to impact on the health and wellbeing of children and the families they come from.

2. Through the process of mapping a family developmental pathway (including its different permutations – such as gay and lesbian families, stepfamilies, child free/less families) – we can predict likely pathways towards health and wellbeing, and towards increased risk factors. This includes the pathway to family violence, mental illness, alcohol and other drug use and problematic gambling. These research findings show that there are common risk and protective (resilience) factors across multiple health risk domains. Interventions which prevent or ameliorate risks and building protective factors at the individual, family and community level can prevent and reduce the impact of health risks and increase family wellbeing and resilience across the life course.

3. Engaging families in prevention and early intervention programs is vital and cost effective. A focus on family wellbeing, family relationships and functioning and parenting in our programs and service is successfully engaging families at every level of need and at different times throughout the family life course.

4. As an agency, we have contributed to the knowledge and evidence base by using a developmental approach to families, with interventions at an early stage to promote family wellbeing as well as respond to risks and the specific needs of individual members. This approach prevents future problems and supports vulnerable families before issues become severe. A public health approach has been vital in developing our understanding along with programs which are targeted and responsive to whole populations.

5. Health and wellbeing risks impact on families causing health risks for carers and their children. In addition, family interventions can diminish these risks for carers and children and support the recovery and quality of life for consumers. Even in the alcohol and drug field, evidence suggests that a focus on parenting and family wellbeing results in a reduction of drug use in users.

6. Key family transitions are times where families are amenable to seeking knowledge and support. At these times families can be engaged to build protective factors and manage adversity and vulnerability (thereby building resilience). These cumulative protective factors can be drawn on at the next family transition stage or where the family is faced with an adverse life event or vulnerable situation. Family life course transitions such as: transitioning to

parenthood, parenting challenging adolescents, post separation and forming stepfamilies are transitions when families seek services and tend to be more open to intervention.

7. An effective mechanism for screening is a Whole of Family Assessment: qualified, experienced staff screen for a range of health and wellbeing risk across the whole family and then wrap programs around the family rather than fitting people to programs. This approach requires greater resourcing and a range of referral pathways to tertiary services.

8. No one sector or discipline can provide a public health response to child abuse and neglect. In fact we would argue that Child Protection is seen by the community as the tertiary end service and therefore has limited capacity to engage vulnerable families at an early stage. Rather, we must examine – where do these families go for services and at what times, and develop the capacity of those services to respond and to provide evidenced-based programs. The training of GPs and other allied health workers in mental health screening is an example of this kind of approach.

9. To do this work within our agency has required additional resources, borrowing knowledge across a range of disciplines, engaging in workforce training and development including up-skilling our employees to screen for mental health risk factors, building organisational capacity and change management, forming partnerships with a broad range of sectors and services from universal to tertiary services, and drawing on academic research expertise. It has also required the organisation to examine its role as a non-government agency within a geographical space, responding to existing and future local needs. It has required us to understand and plan for the community in which our services reside and understand the diversity within that community. Research projects incorporating program development, service trials and evaluation funds have had to be sourced in order to undertake this work.

10. More funding is required to grow the evidence base in relation to interventions to promote family wellbeing, health promotion targeting the family setting, and family violence prevention programs.

We welcome further engagement on this issue and thank the inquiry for the opportunity to present a submission.

drummond Street
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