Drummond Street Relationship Service

Frameworks for Practice and Promoting Family Wellbeing – A Whole of Agency Approach

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Why healthy relationships?

The health and wellbeing of individuals has long been found to be directly mitigated by the strength of their connections and relationships with other human beings. The links between social connection to individuals, peers, family and community is widely accepted by researchers, theorists and practitioners as a major determinant of health and wellbeing for our children, young people and adults, and throughout the lifespan. The strength of the relationships that characterise these connections are critical for health, defined in its broadest possible context to include physical, mental, social and cultural domains of health.

So what is social connection?

It is about having a sense of belonging, feeling supported by a social group such as family, peers and the community in which we live, and feeling safe and secure in your environment. Human relationships that encapsulate positive communication and mutual obligation make us feel loved, cared for, esteemed and valued which in turn has a powerful effect on health and our capacity to thrive. It provides us with the skills and knowledge in order to cope with negotiate life events and challenges as well achieve our potential.

Relationships and Wellbeing
Research tells us that if we are to successfully address the problems of individuals (such as mental illness, substance abuse, antisocial behaviour and domestic violence), it is paramount to strengthen families and improve outcomes for children (Hawkins, Catalano & Miller, 1992). Despite the central importance of family relationships to physical, mental and social health outcomes, the nature and state of family relationships, and the family relationship and services sector as such, has not previously emerged as a significant site for intervention to reduce risks and precursors for health and wellbeing risks.

Like many Family Relationships Service Program providers, DSRC is increasingly confronting the issue of complex issues, health problems and illness within the context of families who present at our service. From data collected at DSRC it is clear that many of these families present with known risk factors for multiple domains of risk behaviour and illness and the increasing complexity of relationship issues experienced by our family client group. We have further identified that many who attend our services have never sought assistance from other services within the community.

Research shows an increasing use of Family Relationship services by families to deal with a broad range of issues. As a sector, we have high rates of men accessing services regarding relationship issues and which serves as a pathway for them to receive further specialised assistance, for example regarding mental health, family violence, gambling, or alcohol and other drug use issues. The ready use of such non-stigmatised services and the breadth of new services initiated under the Family Law reforms encompass an enormous potential to provide a population health approach including prevention and early intervention services to families experiencing or at risk of a range of complex issues including mental illness. Other risk factors which may be identified and addressed early within this context include marital conflict, family breakdown, family violence, poor parenting, poor family connections and communication, which would reduce poor health and social outcomes such as mental illness as well as others including drug and alcohol abuse, gambling, early teen pregnancy and school leaving, homelessness, violence, antisocial behaviour, crime and suicide.

Much research has contributed to developing the understanding of the many individual [physical, intellectual, emotional, socio-emotional, relational], familial, social and community factors which impact upon life development and life trajectory [Fuller and McGraw 1996; Resnick et al., 1996]. These known factors exert either positive [protective] or negative [risk] influence. Robert Blum and Michael Resnik (1996) provide an evidence-based framework for the assessment of risk and protective factors across domains including individual and family, for a range of outcomes. A multi risk and protective factor approach for individuals and families placed within the Family Relationship and Services sector makes very good 'public health sense'.

Utilising a Public Health Model

The Australian National Mental Health Strategy uses the 'spectrum of intervention' model (Mrazek & Haggaerty,1994) within their public health approach to mental health. This model distinguishes between five primary types or a "spectrum of interventions": Promotion, Prevention, Early Intervention, Treatment and Continuing Care. The model recognises that efforts are required across the entire spectrum of interventions in order to maximise population health outcomes. The model further acknowledges that in reality, the boundaries between the various intervention types are blurred, and that services or programs may combine elements of each of the types of interventions.

Current Federal Government funding changes within the Family Relationship Services sector, including the introduction of the Family Relationship Centres, recognise the importance of a range of interventions across this spectrum, and place greater emphasis on promotion, prevention and early intervention in order to maintain positive and strong family relationships. There is recognition of the need for a range of interventions to meet the diverse needs of families, and across the various stages of relationship and family formation and development. There is greater emphasis on supporting families earlier in their family life cycle in order to prevent family breakdown. The spectrum of interventions is therefore, a useful framework from which to consider directions for DSRC programs and services. The full range of family relationship services

and programs are placed below under headings of: Prevention, Early Intervention, Treatment and Continuing Care.

DSRC Services and programs, or types of interventions, can be placed within the 'spectrum of intervention' public health framework. Interventions are further distinguished based on 'who' or 'what' in the family the intervention is targeting, for example, individual/couple, child/parent and family-group interventions.
Family Interventions may target (or focus on the needs of) different family members and different family issues. We distinguish between focussing: Individual/couple (couple issues); Child/Parent (parenting issues and the needs of children at different stages of couple relationship); Whole-of-Family (family dynamics).

Prevention
Refers to interventions that occur before the initial onset of significant difficulties, in order to prevent the development of difficulties. Within the mental health framework prevention uses interventions which are 'universal' (general public) and 'selective' (subgroup at significant risk), and there is *absence* of signs/symptoms of a problem at this stage.

Early Intervention
Refers to interventions targeting people displaying early signs and symptoms of a problem and those experiencing a first occurrence of the problem. This includes 'indicated' (minimal but detectable signs present), 'case identification' and 'early treatment'. Intervention occurs shortly after detection of a problem and aims to increase protective factors, coping strategies and reduce risk factors.

Tertiary Intervention or Treatment
Refers to standard treatment where the problem is already present and has been identified. Intervention involves the application of effective, evidence-based treatments, with the aim to provide the most effective treatment to achieve the best possible outcomes.

Continuing Care/Recovery

Refers to interventions for those whose difficulties are longer-term, or recurring. Aim is to provide optimal intervention, as well as to provide support and referral across a range of health areas, to prevent repeat of crises, and to promote optimal functioning and recovery.

Matching People to Programs and Service

DSRC primary aim in the delivery of programs and services is for the earliest identification and response to family need in order that the minimal intervention can shift the balance such that optimum development pathway unfolds and families are able manage their lives more successfully. Good program matching relies upon the early identification of known risk and protective factors, and the early recognition of known signs and symptoms of distress, problems and disorder, and a broad understanding of their impact on the family.

Interventions at every level focus upon the enhancement of these known protective factors and the avoidance and constraint of known risk factors for the individual, couple, family, community, and society. Furthering the number, strength and influence of protective factors positively influence developmental pathway even when risk factors cannot be eliminated. Additionally, DSRC requires sound linkages with broad range of service providers in the local community in order to ensure the needs of families can be met.

Risk and Protective Factors

Risk and Protective Factors reproduced from *A Monograph* [1] in Tables 1 and 2 below have added to the range identified by Fuller and McGraw (1996) and Blum and Resnick (1996), to represent a common set of risk and protective factors across multiple domains of mental health and behaviour risks, such as engaging in alcohol and other drug (AOD) misuse; violence; anti-social behaviour; crime and offending; and school refusal and pregnancy among youth.[2] These concepts can be useful tools for assessment purposes.

Table 1: **Protective factors** potentially influencing the development of mental health problems and mental disorders in individuals (particularly children and young people).

[1] Commonwealth Department of Health and Aged Care 2000, *Promotion, Prevention and Early Intervention for Mental Health – A Monograph,* Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra.

[2] Catalano Hawkins & Miller (1992)

Table 1. Protective Factors

Individual Factors	Family Factors	School Context	Life Events and Situations	Community and Cultural Factors
Easy temperament	Supportive caring parents	Sense of belonging	Involvement with significant other person (partner/mentor)	Sense of connectedness
Adequate nutrition	Family harmony	Positive school climate	Availability of opportunities at critical turning points or major life transitions	Attachment to and networks within the community
Attachment to the family	Secure and stable family	Prosocial peer group	Economic security	Participation in church or other community group
Above average intelligence	Small family size	Required responsibility and helpfulness	Good physical health	Strong cultural identity and ethnic pride
School achievement	More than two years between siblings	Opportunities for some success and recognition of achievement		Access to support services
Problem solving skills	Responsibility within the family (for child or adult)	School norms against violence		Community/cultural norms against violence
Internal locus of control	Supportive relationship with other adult (for a child or adult)			
Social competence	Strong family norms and morality			
Social skills				
Good coping style				
Optimism				
Moral beliefs				
Values				

Table 2: **Risk factors** potentially influencing the development of mental health problems and mental disorders in individuals (particularly children):

Individual Factors	Family/Social Factors	School Context	Life Events and Situations	Community and Cultural Factors
Prenatal brain damage	Having a teenage mother	Bullying	Physical, sexual and emotional abuse	Socioeconomic disadvantage
Prematurity	Having a single parent	Peer rejection	School transitions	Social or cultural discrimination
Birth injury	Absence of father in childhood	Poor attachment to school	Divorce and family break up	Isolation
Low birth weight/birth complications	Large family size	Inadequate behaviour management	Death of family member	Neighbourhood violence and crime
Physical and intellectual disability	Antisocial role models (in childhood)	Deviant peer group	Physical illness/impairment	Population density and housing conditions
Poor health in infancy	Family violence and disharmony	School failure	Unemployment, homelessness	Lack of support services including transport, shopping, recreational facilities
Insecure attachment in infant/child	Marital discord in parents		Incarceration	
Low intelligence	Poor supervision and monitoring of child		Poverty/economic insecurity	
Difficult temperament	Low parental involvement in child's activities		Job insecurity	
Chronic illness	Neglect in childhood		Unsatisfactory workplace relations	
Poor social skills	Long term parental unemployment		Workplace accident/injury	
Low self-esteem	Criminality in parent		Caring for someone with an illness/disability	
Alienation	Parental substance misuse		Living in nursing home or aged care hostel	
Impulsivity	Parental mental		War or natural	

	disorder		disasters	
Reliable emotional support	Harsh or inconsistent discipline style			
	Social isolation			
	Experiencing rejection			
	Lack of warmth and affection			
	Close bond with at least one person who has provided stable care/attention			
	Affectionate ties with alternative care givers (grandparents)			
	Involvement with siblings			
	Young females: Absence of over-protection			
	Emphasis on risk taking			
	Young men: Structure and rules in household			
	Encouragement for emotional expression			

DSRC Programs and Services utilise interventions involving a paradigm shift from a single focus on risk to building protective factors and resilience at the individual, family and community level.

1. Recognising the strengths and potential of the individuals, families and communities with which we work;
2. Decreasing or reducing modifiable risk factors;
3. Increasing and enhancing modifiable protective factors.

Strengthening families – and revitalising communities

All of us use the term 'family' to describe the people to whom we feel closely connected – but are we all operating from the same definition of family? Are we in fact referring to people who live in multiple households, across different generations, with or without biological connection, and does its membership change over time or even in different cultures and sub-cultures? Most would agree that the family is the bedrock of human existence but often that has been driven by the assumption that the family's primary function is to raise children. Perhaps even this assumption is time limited and therefore does not describe the function of familial relationships that increasingly exist today or over time (the continuing life course of families). Unless we define who it is we are talking about and understand it's complexity and commonalities we have little chance to harness the family's protective powers for the health and wellbeing of its individual members and increasingly the local community in which it lives, works and plays.

So how do we tell the story of families and how do we build family well-being?

Perhaps families are better described:

- ✓ by the ecological model with families at the centre of inter-related systems (the family as a network and process rather than a household)
- ✓ as interdependent units that share income generation and caring activities based on mutual obligation, reciprocity and trust
- ✓ as having collective goals and aspirations
- ✓ by the complexity of family life, and its members show us that there are intra-family differences in individual levels of wellbeing
- ✓ "the caring for" aspect of families (children, elderly parents, siblings, nieces or nephews, intimate friends, community members, kith and kin) has benefits for both individuals and across the family
- ✓ the composition and caring relationships which change over time (perhaps more individuals and childless couples will be caring for elderly parents than children, Family day care may become Life Activity Centres for older parents to attend while their children go off to work)

If we accept and understand this broader inclusive definition we must therefore also find ways of both enhancing the collective wellbeing of individual family members as well as the family as an entity itself. Measuring family wellbeing has been perplexing for many social scientists but in more recent times the concept of family social capital provides us with new concepts for family wellbeing (which some have measured) and ideas for interventions which will positively promote family wellbeing.

For the past three years as an agency we have been on a journey of reflecting on our purpose and approach to families seeking services. We have used the public health model to define our programs and service for all families along with specific family groups. Most fall within the prevention, early intervention, treatment and recovery spectrum of interventions for a range of issues impacting on families and their relationships. In the past 12 months we have also taken considerable steps to define and conceptualise interventions which promote strong and positive family connection

and the role of community in influencing this. Approaches that build social capital both at a family and micro-community level offer us two key areas of new program development and delivery which have an increasing evidence base and a are linked to healthy outcomes for the family, its individual members and the community. The two areas also represent a transaction between two levels of social capital which are interrelated even if we are not sure how:

1. How do we assist and support people as they invest in the wellbeing of their family as an entity. What are the things that families do to build family social capital and look after each other
2. Micro-level community building - interventions aimed at developing natural helping networks around families and generating social capital at the neighbourhood level

Although limited, research does indicate that a number of factors which appear to characterise the family's own investment in their family include:

- Activities and energy given collectively to achieve mutual goals
- Doing things together, spending time and building the stock of goodwill
- Establishing norms of trust, mutual obligation, co-operation, shared identity and reciprocity
- Links and investment in their local community and participation in community life. This includes the transactions between the whole family and their local community which can be transmitted over generations
- The resources they can muster and use including social networks

DSRC programs and activities therefore must seek to enhance and build family social capital but at the same time be mindful that this is a shared responsibility within families and not a gendered one. Too often research shows us that family members do not carry this role equally, women and mothers are more likely to carry the greatest role in building social capital (although their human and economic capital is not rewarded to the same extent as men) in their own families. Some studies even suggest that this gendered burden places too heavy a load for women and is linked to higher mental and physical health issues.

Dorothy Scott's work provides a strong argument for the need to revitalise communities at the micro or neighbourhood level. The relationship between family social capital and community social capital appears to be interconnected and cyclical in nature. The greater the resources and support networks around families the stronger the family wellbeing, the greater the family participation and contribution to community life even at the neighbourhood level, the greater the community social capital which in turn means the stronger the family wellbeing. US research shows a clear link between what they term civic engagement, for all family members, and family health and wellbeing. So what is civic engagement and how do we encourage families to engage in civic engagement activities?

Most of the studies focus in on community volunteerism, or involvement in sporting and recreational clubs. Our development work is focusing on two areas:

1. **Practical ways in which families can connect, lend support and be involved at the neighbourhood level.**

It can be as simple and informal as:
- family attending school working bees, encouraging children to donate their toys and books as they grow out of them
- helping a neighbourhood family who is under pressure
- buying a bunch of flowers for the elderly neighbour or helping them with shopping or gardening
- cooking a meal for a couple or person with a new baby or the family who has just moved in
- helping each other to paint or home working bees

Or it can be more formalised such as:
- getting involved in local environmental or social activism
- volunteering for Meals on Wheels, Auskick or similar
- attending community events
- attending neighbourhood playgroups
- joining committees for local festivals and arts events

2. **Supporting and enhancing communities of families through the delivery of our programs.**

Many of DSRC's programs incorporate opportunities to bring people and families together with similar issues, needs and experiences.
- Our Healthy Active Dad's program has created a community of dad's who have had fun with their kids "in their own backyard" incorporating physical activity, parenting and healthy nutrition
- Queernet brings young people with similar identities together for fun activities and social action
- at **the drum** our staff run community leadership training, healthy activities for men, women's sewing and hospitality groups which are developing social enterprises, homework clubs, soccer programs, and hip hop dance for children and young people
- We attend and support Queer community initiatives such as Rainbow Families, Pride and Midsummer's Festival and deliver Gay and Lesbian parenting groups
- Parenting for different age groups, grandparents raising grand children, partners of people with a mental illness

All of these activities involve the sharing of stories and ideas for helping each other, connection. In addition, a number of these programs and groups are now being led by people who have attended previously and want to pass on this support. Many of our services users are also investing in this agency and see it as a community asset that can be harnessed to support families and community groups. Many of these initiatives are exciting first attempts to develop programs and practice that promote family wellbeing and revitalise connection to communities.