

Drummond Street Relationship Service

Family Mental Health Support Service – A Population Health Approach

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Drummond Street Relationship Centre (DSRC) employs a whole-of-family approach and adopts mental health promotion, prevention and early intervention frameworks in the development and delivery of the Family Mental Health Support Service. Like many Family Relationships Service Program providers, DSRC is increasingly confronting the issue of mental health problems and illness within the context of families who present at our service. There appears to be two specific family types who present with different issues and needs. The two groups are 1. Families with a member with a mental illness and; 2. Families who are “at risk” of developing mental health problems or illness.

1. Families with a member with a mental illness: The family member with the mental illness could be either an adult/parent or child/young person and therefore present different needs such as:

Table 1. Families with a member with a mental illness

Target Group	Issues
<ul style="list-style-type: none">• Adult with mental illness, Adult Partner/Carer• Parents with a child/young person with a mental illness• Child/Young person with parent with mental illness• Child or young person with a mental illness• Grandparents/ other extended family members with mental illness or supporting family with mental illness	<ul style="list-style-type: none">• Impact on intimate relationships and other family relationships/family system• Impact on capacity to parent• Impact on care and wellbeing of siblings, children and young people• Strategies for coping, finding support• Grief and loss, trauma• Need for self-care• Isolation• Stigma for individual and family• Need for specific information/advocacy in order to understand mental illness and access the mental health and broader service system• Safety of all family members

2. Families who are “at risk” of mental health problems/illness. There are risk and protective factors which increase and decreased likelihood of development of mental illness, across the individual, family, peer, school/work and community domains, throughout development. Family transition points and

adverse life events contribute to stress which increases the risk of development of mental illness. Prevention and Early Identification and Intervention with families at risk or showing early signs of mental illness may reduce onset and severity.

Table 2. Families who are "at risk" of mental health problems/illness

Target	Issues
<p>Family Transitions which include:</p> <ul style="list-style-type: none"> • Pregnancy and having a new baby • Parenting at different developmental stages including adolescence • Relationship conflict/separation/re-partnering • Parenting children/young people with disability/challenging behaviours • Children leaving home • Children partnering/Grandparenting • Retirement/ Aging/ Death of a partner 	<ul style="list-style-type: none"> • Relationship issues including managing conflict, communication, cohesion • Low confidence/skills re parenting (e.g. poor parenting role models) • Isolation and lack of connection/support • Grief and loss, trauma • Poor self-esteem, self-efficacy or sense of failure re: family role (e.g. as parent or partner) • Financial pressure • Relationship pressures • Need for self-care, support including respite • Increased need for coping skills, problem solving • Existing social and material supports and resources • Help-seeking behaviour and knowledge of supports • Young people who have high levels of mental health difficulties and who have low likelihood of accessing suitable help
<p>Adverse Life Events and Situations which includes:</p> <ul style="list-style-type: none"> • Severe/chronic illness or disability of family member • Accident or traumatic incident • Death/loss of family member/spouse • Relationship conflict/separation/divorce/re-partnering • Unemployment/unsatisfactory employment, poverty • Abuse or neglect (physical, emotional, sexual, including bullying) 	
<p>Specific Populations:</p> <ul style="list-style-type: none"> • Young People • Culturally and Linguistically Diverse Communities in particular those from a non-English speaking background and those arriving under the humanitarian and refugee entrants program • Indigenous Australians 	
	<p>And...</p> <ul style="list-style-type: none"> • Experience of racism and discrimination • Alienation/isolation from culture of origin/ethnic group • Experience of trauma and torture prior to settlement • Death of/forced separation from family members • Settlement issues including literacy

	<ul style="list-style-type: none">• Lack of understanding, connections and capacity to participate in mainstream culture, including employment• Intergenerational conflicts may be particularly marked
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Utilising a Public Health Model

The Australian National Mental Health Strategy uses the 'spectrum of intervention' model (Mrazek & Haggarty, 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.

DSRC's Family Mental Health Support Service 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 (individual or couple issues); Child/Parent (parenting issues and the needs of children at different stages of child development and/or family transition point); 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 and coping, 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 recur. The 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.

Health Promotion and Mental Health Promotion

Health promotion has its origins within the Ottawa Charter which was developed in 1996 (World Health Organisation, 1996). The key focus of health promotion is to enable people to increase control over, and to improve, their health: "To reach a state of complete physical, mental, spiritual and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change and cope with the environment"¹.

The Charter focuses on five action areas for public health and these have been incorporated within DSRC's program framework or within particular program strategic activities. Specifically they include:

1. Building healthy public policies
2. Creating supportive environments
3. Strengthening community action
4. Developing personal skills
5. Reorienting health services

The health promotion agenda provides a strong argument for the need for a model for health and mental health which focuses on reorienting services and the settings in which we live our daily lives, towards health and wellbeing rather than a single focus on illness.

In relation to mental health and the Family Mental Health Support Service, we have embedded the Victorian Health Promotion Foundation (1999)² prerequisites for mental health promotion within all our programs and services. VicHealth argues that the evidence base indicates that there are three essential prerequisites for health and well being of all members of society. These prerequisites are:

1. Social connectedness
 - A sense of belonging to a social network and community.
 - Live and work within a stable and supportive environment.
 - Participation in a variety of social and physical activities.
 - Have access to social networks and supportive relationships.
 - Have a valued social position, be it through work, family, friends, sporting clubs and community network;
2. Freedom from discrimination and violence
 - Ensuring physical security.
 - Feeling a sense of control of life.
 - Feeling of inclusion and supportiveness regardless of race, language, culture, sexuality or level of ability.
3. Economic participation
 - Access to work and meaningful activities.
 - Access to education.
 - The provision of adequate housing.
 - Access to financial resources;

¹ Ottawa Charter for Health Promotion, WHO, 1996.

² Victorian Health Promotion Foundation, Mental Health Promotion Plan, 1999

Health promotion interventions that focus on the achievement of these prerequisites for mental health are the key to addressing the family wellbeing and prevention of mental illness.

Matching People to Programs and Service

DSRC's 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 there is enhanced likelihood that an optimum development pathway may unfold, and that 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 influences developmental pathways 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*³ 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 associated with 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.⁴ 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).

³ 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.

⁴ Catalano Hawkins & Miller (1992)

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	

Reliable emotional support	disorder 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	disasters	
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DSRC Programs and Services utilises 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.