Relationships Australia

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ACT Office for Mental Health and Wellbeing – development of priority areas

Relationships Australia Canberra and Region and Relationships Australia (National Office) welcome the work of the Office for Mental Health and Wellbeing to enhance the mental health and wellbeing of all members of the community. We thank your Office for this opportunity to contribute to the development and articulation of priority areas for mental health and wellbeing. This submission is a joint submission from Relationships Australia Canberra and Region and Relationships Australia (National Office).

The work of Relationships Australia

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

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

Relationships Australia has provided family relationships services for more than 70 years. Relationships Australia State and Territory organisations, along with our consortium partners, operate around one third of the 66 Family Relationship Centres (FRCs) across the country. In addition, Relationships Australia Queensland operates the national Family Relationships Advice Line and the Telephone Dispute Resolution Service.

Relationships Australia is committed to:

- Collaboration. We work collectively with local and peak body organisations to deliver a spectrum of prevention, early and tertiary intervention programs with elders, men,

women, young people and children. We recognise that often a complex suite of supports (for example, drug and alcohol services, family support programs, mental health services, gambling services, and public housing) is needed by people affected by family violence and other complexities in relationships.

- Enriching family relationships, including providing support to parents, and encouraging good and respectful communication.
- Ensuring that social and financial disadvantage is not a barrier to accessing services.
- Contributing its practice evidence and skills to research projects, to the development of public policy and to the provision of effective supports to families.
- Working in rural and remote areas, recognising that there are fewer resources available to people in these areas, and that they live with pressures, complexities and uncertainties not experienced by those living in cities and regional centres.

We believe that:

- people affected by poor mental health and their families are vulnerable and in need of support if they are to lead safe and fulfilled lives
- there is a bi-directional relationship between poor family relationships and mental ill health. Mental health can be challenged during periods of family conflict, especially during separation, post-separation, and negotiating and managing co-parenting and contact arrangements for children. In turn, mental ill-health can lead to conflicted family relationships and relationship breakdown
- supporting healthy and respectful relationships between people affected by mental ill-health and their families can reduce burdens on healthcare services (including repeat visits)
- the community sector plays a vital role in prevention and early intervention work in the area of mental health. We believe that while there is clearly a place for medical models of mental health intervention and treatment, there is also real and unmet need for community models of mental health. General counselling and community mental health models should sit alongside, and collaborate with, medical models and provide early intervention pathways and choice for clients seeking to access mental health services
- collaboration within and across the non-government and government health and community services sectors is essential for delivering a spectrum of prevention, early intervention and tertiary intervention programs with men, women, young people and children. Many people experiencing mental health problems are also dealing with insecure housing, employment, gambling, drug and alcohol problems, family violence, relationships and financial issues
- long-term, ongoing financial and practical assistance needs to be available for those experiencing chronic mental illness; this includes support for their family members

- governments and service providers need to consult across sectors and work with consumer, advocacy and self-help groups to provide a broad range of effective mental health services.

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

Relationships Australia supports people affected by poor mental health through the services, advocacy and research that contributes to evidence-based practice. Our services engage with people across the full continuum of mental health, and with members of their families, to support (and, where necessary, re-establish) healthy connections between them. This occurs in the course of our ordinary work in universal family support services, as well as through a range of specific mental health programs. We also work around the country in suicide prevention, often in collaboration with other service providers, peak bodies, governments and alliances. Funded services delivered by Relationships Australia organisations that target poor mental health have included Access to Allied Psychological Services, headspace, Partners in Recovery, COPE Mental Health, Mental Health First Aid, Family Mental Health Support Services, the Coronial Counselling Service in the ACT,[1] and the Tasmanian Suicide Prevention Community Network.

Relationships Australia also provides counselling, co-ordination and advocacy services for people affected by mental ill health through a range of family relationships and related specialist programs including:

- family and relationships services funded by the Commonwealth Attorney-General's Department and the Department of Social Services
- services to support people affected by the Royal Commission into Institutional Responses to Child Sexual Abuse
- services for Forgotten Australians
- Past Adoption Support and Find and Connect services
- LGBTIQ support services
- Rural Primary Health Services
- Multicultural services
- Victims of Crime Counselling and Support services.

We engage in child-inclusive practice and trauma-informed practice.

[1] The Coronial Counselling Service operated by Relationships Australia Canberra and Region is unique to the ACT. It is funded by the ACT Health Directorate under the Managing Risk of Suicide: A Prevention Strategy for the ACT and the ACT Mental Health Services Plan. It provides intensive therapeutic counselling to ACT residents who are affected through coronial processes.

Accordingly, the information in this submission reflects our involvement with, and support of, clients who have lived experiences of poor mental health, and other complex co-morbidities, such as substance abuse, problem gambling, and violent behaviour. This submission draws upon:

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

This submission also draws substantially from the submission that Relationships Australia member organisations made to the development of the Fifth National Mental Health Plan in 2016. The priority areas identified in that submission remain significant concerns.

Priority areas identified by the Office

Relationships Australia notes that the Office's early engagement has identified the following mental health and wellbeing priority areas:

- increased focus on prevention and early support. This includes:
    - fostering positive mental health and wellbeing across the community
    - improving general health and wellbeing
    - supporting healthy and respectful connections within families, through family and individual counselling and other support services
    - reducing the demand on health services
- improved holistic outcomes for people with mental illness through a renewed focus on the social determinants of health, including enhanced access to suitable accommodation, education, employment and meaningful activity and increased social connections
- coordinated services that do not require the individual to navigate
- improved coordinated holistic approaches for vulnerable cohorts
- reduced suicide attempts and suicide deaths, through better integration of suicide prevention services
- ongoing appropriated and considered consumer and carer engagement and participation
- increased capacity to grow, develop and sustain an effective mental health workforce, including peer workers
- further targeted research and evaluation.

Relationships Australia Canberra and Region and Relationships Australia (National Office) support these priority areas, and offer further observations and suggestions in relation to:

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

Integration of planning and service delivery

Relationships Australia supports integrated service systems. Silo-bound practices impose an overwhelming array of burdens on vulnerable clients, who must navigate complex mazes of service pathways are separated by, for example:

- the various professional disciplines and their hierarchies
- (sometimes arbitrarily drawn) geographical divisions
- bureaucratic areas of 'subject matter' responsibility, and
- reliance upon disparate funding sources.[2]

Over-reliance on biomedical models

We are of the view that merely changing structures within and between organisations will not result in increased collaboration without cultural change; forced collaborations, in our experience, do not effectively overcome siloed professional cultures and come with significant administrative costs to service providers. For example, our experience nationally is that Primary Health Networks (PHNs) have been generally ineffective in connecting and collaborating with the Family Relationships Services and Family Law Services. This is partly because LHNs and PHNs continue to focus on medical models, with limited engagement and lower value accorded to community services. This could reflect similar stovepipes in government with funding for LHNs and PHNs deriving from Commonwealth and state/territory departments of health, rather than social or community services.

The risk is that service delivery models will limit capacity to respond from a tailored holistic approach and will identify, assess and respond to mental health issues within a narrow and medicalised lens. The emphasis on medicalised models can privilege medication (and other interventions provided exclusively or predominantly by medical practitioners) as the primary treatment modality, at the expense of other treatment models.

The value of relational models in a more responsive service culture

Mental health frameworks are frequently bereft of insights into the pivotal role family relationship services can play in the preventative, treatment after care and recovery phases of responses to mental ill-health. Yet it is important for family relationship services to be recognised as integral components of a holistic service response because:

1. mental disorders affect individuals and family/relatives, and may be both a cause and a consequence of family/relationship difficulties
2. although most common mental disorders are amenable to treatment, the majority go undiagnosed and untreated

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

3. many disorders are chronic or recurrent and often call for long-term management, far beyond acute care
4. much of the care provided for people with mental disorders is informal care provided by family members; if these relationships are severed, there is an increased reliance on general health and mental health services, and
5. 'vulnerable' family groups in family relationships services often have a greater risk of mental health problems than average (Elly Robinson, Bryan Rodgers and Peter Butterworth, FRSA conference, Sydney, November 2009).

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

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

One day, through contacts with the Iranian community, our service became aware that Soraya was missing from work and had been seen jumping in front of cars. It later emerged that this was the expression of significant distress over her relationship with Farbod. Despite their separation, Soraya had found it hard to separate from him and they had pursued a twelve month secret affair. Members of Soraya's family felt that Farbod made her dependent upon him, which made it hard for her to end their relationship, despite their legal separation. When Farbod then became involved with another woman, Soraya had become progressively distressed. Members of the school community, Children's Contact Services and members of the Iranian community had noticed her increasing emotional stress. Police were contacted and Soraya was hospitalised for 5 weeks.

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

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

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

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

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

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

Accordingly, it is imperative that mental health services must be strongly connected with systems and services traversing child protection, housing, criminal justice, drug and alcohol misuse, problem gambling, and family violence/family law services. This is particularly important when responding to case complexity and social disadvantage, such as for clients who live in regional and remote areas, who are Aboriginal and Torres Strait Islander people, and traumatised clients such humanitarian refugees and forgotten Australians.

We therefore respectfully suggest that the Office for Mental Health and Wellbeing should prioritise the development of tangible strategies (and measurable outcomes) for integrating policy and planning. In Western Australia, for example, our services report that the most visible element of integrated planning and collaboration appears to be the consultation processes underway at a regional level, with the PHNs encouraging people to come forward with all their good ideas. These ideas are considered by staff and progressed if supported. This encourages a highly politicised environment for consultation events, with proposals championed by the more dominant participants (and predominantly medical service providers) appearing to get the most attention.

Instead, it may be more helpful if consultation processes were better informed of developments at higher levels; ie what are the broader systemic priorities? This might bring a clearer focus to the deliberations and encourage participants to focus more on the big picture and how they might contribute to integrated solutions.

The relationship between planning and commissioning processes can also be problematic. In a competitive funding environment there needs to be adequate attention given to separating out planning processes and commissioning processes to ensure probity. Safeguards need to be put in place to ensure consultation processes are focussed on clear outcomes and rigorous consideration of the evidence base.

Providing services that build strong connections to family and community support, skills in problem solving and conflict resolution (all protective factors associated with long-term recovery) are key strengths of our current service offerings.

Gaps in service; no wrong door

At the service delivery level, lack of integration is most commonly experienced as gaps in service; for example, between early intervention and prevention services and secondary or tertiary services. Sometimes, this can lead to attempts to push clients between services if their needs cannot be met (waiting lists, narrow referral criteria, etc.). In most cases, this risk is managed informally by having good relationships between service personnel. At other times, these gaps are places people in need can fall through.

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

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

While the efforts are welcomed within the 'stepped care model' of the PHN funding and service development, to date this has tended to fall at the 'ends' of the service continuum, leaving a gap in services for people who fall within a 'missing middle'.

At the primary preventative level, there is substantial growth in targeted low intensity interventions. This includes awareness raising educational websites, referral and resources sites, online treatment programs, support apps to augment face to face services and, at the top end, an emphasis on acute crisis mental health responses and hospital services.

The 'missing middle' and relationship services as a pathway to better mental health and well-being

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

In these circumstances, multiple family members may be at risk, as mental illness often ripples through families and can affect the safety and support needs of all family members. Service models need promote the disclosure of any serious risk (including mental health, child protection and family violence) for each family member. Service providers should position themselves in relation to the whole family, and take responsibility for safety planning for the entire family and for each individual.

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

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

- Carr (2009) provides evidence that family-based therapies are as effective as individual cognitive-behavioural therapy and psychodynamic therapy in the specific treatment of major adolescent depression.
- Dwyer and Miller (2006) argued that while fewer and fewer services are mandated to work with young people and families together, family work is essential to assisting recovery from trauma.

- Attachment-Based Family Therapy (ABFT) is showing promising results with depressed and suicidal adolescents (Diamond, 2014; Diamond, Diamond & Levy, 2014; Kissil, 2011; Shpigel, Diamond & Diamond, 2012). ABFT aims to promote age-appropriate reconnection and attachment between young people and their parents during this time of crisis. This model of care and treatment looks at identifying attachment issues, working with the family to understand the presenting symptoms within this context and then engaging with the family to repair attachment and reconnect with each other. The ABFT approach is in keeping with the experience that the extreme distress and emotional dysregulation seen in child and adolescent mental health emergencies is most often a reaction to relational issues, and on a background of complex intergenerational factors. Rarely does the distress represent the manifestation of a serious mental illness such as psychosis or a major mood disorder (Bikerton, 2014).

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

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

For instance, in a baby's first year, 67% of new parents have a significant drop in relationship satisfaction, significant increases in relationship hostility, and deterioration in intimacy. This is associated with 50 to 80% of new mothers having progressive postpartum depression.

Systemic understanding has the potential to counterbalance the tendency toward too ready a reliance on bio-psychiatry and pharmacology. In turn, keeping close to psychiatry and to its problems can be useful to systemic therapists, by involving them in social and epistemological queries that are otherwise extraneous to professionals mainly devoted to private practice.

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

Suicide prevention

Relationships Australia Canberra and Region and Relationships Australia (National Office) support a framework that unambiguously establishes a public health response. Detection and treatment of mental illness is only one facet of a holistic public health approach to suicide prevention, noting that the most effective national suicide prevention strategies have a range of elements, as shown in the framework recommended by the World Health Organisation.

It would be useful to strongly articulate strategies that include collaboration by all stakeholders who can affect the rate of suicide, and that support models which encourage care outside of the medical system. Strategies that assist caregivers and other related community services to provide follow-up care should also be considered.

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

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

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

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

A number of our clients are distressed on a daily basis, and there is a need for a system that provides continuity of care for those at risk of suicide and protocols for sharing information to reduce risk for these clients.

Aboriginal and Torres Strait Islander mental health and suicide prevention

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

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

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

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

Physical health of people living with mental health issues

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

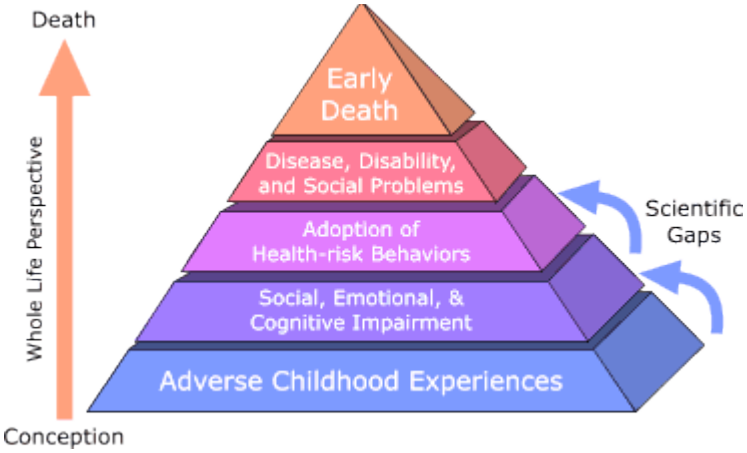
When reflecting on the possible causes of mental illness, such as depression and anxiety, it is essential to broaden considerations to also include lifestyle factors such as diets high in

processed foods, lack of physical activity, social isolation resulting from affluence, and altered brain activity from information overload.

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

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

- adverse childhood experiences[3] are vastly more common than recognised or acknowledged
- a powerful relationship between our emotional experiences as children and our mental and physical health as adults, and
- adverse childhood experiences are the major causes of adult mortality with the conversion of traumatic experiences during childhood into organic diseases later in life.



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

The Office could also develop frameworks for engaging marginalised people who may have poor physical and mental health, such as those affected by homelessness.

Stigma and discrimination reduction

Relationships Australia services are experienced in supporting individuals and families with a range of complex and difficult social issues, including mental ill-health, that result in discrimination and stigmatisation. This experience could inform an approach for mental health discrimination and stigmatisation reduction, potentially through regular and carefully targeted

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

public campaigns, possibly involving high profile public figures. The Office, operating within the context of a jurisdiction with specific human rights legislation (the *Human Rights Act 2004*), is well placed to collaborate with the ACT Human Rights Commission to develop and spearhead such campaigns.

Topics could include raising awareness of particular mental health issues or directly targeting stigma. Strengthening community understanding helps build people's capacity to identify and better understand the early signs of mental distress; however, improvements in community understanding and mental health literacy are not necessarily associated with a reduction in discriminatory behaviour and stigmatising attitudes.

The understanding and conduct of health professionals is particularly important as the lived experience of people with mental illness is directly affected by the skill, attitudes and behaviours of staff. The Office could take a valuable role here, too, in collaborating with the ACT Health Directorate and relevant professional associations, to develop tailored education and training modules.

Law enforcement officers, too, and prison service officers, are frequently called on to engage with people suffering from acute mental illness. The Office could collaborate with law enforcement agencies in the ACT to develop tailored modules to ensure that encounters between these professionals and those affected by mental ill-health are not tainted by stigma and discrimination, but informed by knowledge and understanding.

Evidence suggests that longer-term anti-discrimination and anti-stigma initiatives have more success in reducing the experience of discrimination by people living with a mental health difficulty than short-term initiatives. Relationships Australia has made progress in embedding racial anti-discrimination initiatives in the workplace.

For example, Relationships Australia South Australia has delivered Mental Health First Aid since 2007. This is a program that facilitates the learning of staff and volunteers within community services, so that there is a stronger capacity for early intervention in the development of mental health disorders and increased knowledge to promote emotional development in the wider community context. This program has proven effectiveness in improving mental health literacy and decreasing stigmatisation. In 2010, Relationships Australia adopted the Cultural Fitness Package, an ongoing training program developed by our Indigenous network. The program unpacks cultural norms and exposes privileges assumed by majority populations and the consequent impacts of inequity on Aboriginal and Torres Strait persons and people from other marginalised groups. In 2013, Relationships Australia also joined forces with the Human Rights Commission and many of Australia's leading businesses, sporting bodies and NGOs to support the 'Racism. It stops with me' campaign. Work is currently underway, within our federation, to refine and strengthen our cultural fitness at a national level.

Many of our services routinely screen for mental health issues using standardised and validated assessment tools. A common feature of our client-focused services is that they employ a 'no wrong door' approach. This means that the responsibility of providing care to address the whole range of a person's needs, either directly or by referral, falls on the care provider/service where the person first presents. Holistic services can only be provided effectively if clients

undergo universal screening at the point of entry (noting that the universality of screening itself diminishes potential stigma). Evidence suggests that, in the absence of universal screening, even the most experienced clinicians miss 'at risk' clients and the risk identification process can be improved by using robust and reliable assessment tools.

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

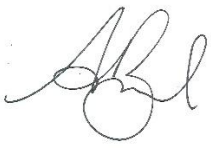
Diagnostic and statistical manual of mental Disorders (DSM) diagnostic categories are often the organising principles identifying the targets for funded research on potential treatment for mental illness. Relationships Australia is concerned about the tendency to pathologise symptoms that would be better understood in the context of relational factors (such as childhood behaviour problems). There is also concern expressed about potential misdiagnosis, the role of subjective judgements, pressure to provide a diagnosis for funding purposes, and the potential to over or under diagnose.

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

Concluding remarks

Should you require any clarification of any aspect of this submission, or would like more information on the services that Relationships Australia provides, please contact either of the signatories to this letter.

Yours sincerely,



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