

Strengthening prevention and early intervention services for families into the future

Prepared by Deakin University and Family & Relationship Services Australia (FRSA)

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RECOMMENDED CITATION:

Toumbourou, J., Hartman, D., Field, K., Jeffery, R., Brady, J., Heaton, A., Ghayour-Minaie, M., & Heerde, J. (2017). Strengthening prevention and early intervention services for families into the future. Deakin University and FRSA.

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It is with great pleasure that FRSA releases this research report, *Strengthening prevention and early intervention services for families into the future.*

This report is invaluable to the family and relationship services sector in guiding the way toward us taking a more coordinated, sector-wide approach to meeting the needs of our clients.

A great and relatively untapped opportunity exists in the sector to have a far more integral role in identifying risk factors in the lives of the children, families and communities with whom we work, enabling us to contribute to a more holistic service delivery response.

The development of this report has been a highly iterative process. In 2014, FRSA invited support from our membership through a Strategic Projects Fund to initiate and develop a new body of work with a prevention and early intervention focus. The successful tender applicant was internationally renowned Public Health and Prevention Science expert Professor John Toumbourou at Deakin University.

As the lead author, Professor Toumbourou has applied a Public Health lens in proposing the contents of this report and its recommendations for sector-wide and inter-sector discussion. It has been a great honour for the FRSA Board and particularly the FRSA Research Advisory Committee to work closely with Professor Toumbourou and to co-author the report with him to capture the specific progress and nuances of the family and relationship services sector.

FRSA is looking forward to progressing the discussion of the recommended strategies within the report with our sector, other sectors and government in 2017 and beyond. Through these discussions we aim to identify and develop the most efficient and effective approaches for our sector to achieve the best possible outcomes now and into the future for the children, families and communities we serve.

Yours sincerely



Michael Austin
FRSA Board Chair

Foreword	1
Executive Summary	3
Background	5
Challenges in health and social problems over the coming decade	6
Eight priority health and social problems for prevention and early intervention programmes	6
Prevention and early intervention frameworks	7
Family and relationship-based prevention and early intervention programmes can address many risk processes that lead to health and social problems, while also building supportive relationships	8
Family and relationship services may increase protective factors for children and families at high risk of health and social problems	12
Risk and protective factors are indicators of preventable processes that cause health and social problems	13
The need for advances in intake screening and assessment methods	15
Economic benefits of investing in family and relationship-based prevention and early intervention programmes or approaches to service delivery	16
Strengths within Australian family and relationship services that support an expanded role in prevention and early intervention	18
Challenges to family and relationship services taking a prevention and early intervention approach	21
Discussion and recommendations	23
References	29
Appendix: Expert advice on trend projections for health and social problems	32

EXECUTIVE SUMMARY

Many of the health and social problems Australia currently faces are preventable. This report aims to initiate a discussion as to how a coordinated strategy to increase family-based prevention and early intervention services could be utilised in Australia to prevent priority health and social problems. The report was completed by consulting expert opinions and drawing upon key policy documents, prior reviews and published sources. Eight priority health and social problems were identified based on evidence that they have a preventable component through the delivery of family and relationship services:

- ▶ substance abuse (costing at least \$55 billion [B] annually in Australia)
- ▶ antisocial behaviour (including violence and crime, costing \$36 B annually, with family violence contributing between \$22 and 26 B in 2015–16) (Department of Social Services [DSS], 2016)
- ▶ obesity (\$21 B)
- ▶ mental illness (\$8.5 B in 2014–15; up \$911 million from 2010–11) (Australian Institute of Health and Welfare [AIHW], 2017)
- ▶ developmental injury (e.g., foetal alcohol problems, child neglect and abuse leading to preventable disability)
- ▶ chronic illness (including preventable Type 2 diabetes, cancer, cardiovascular disease, asthma, allergies)

- ▶ school failure (including leaving school and not participating in further education) and
- ▶ social exclusion (lack of meaningful and constructive social and economic participation).

Many of these problems arise from common modifiable risk factors in families and child development. The family and relationship service sector is able to address many of these risk factors and to integrate prevention and early intervention responses across the health, community and education service sectors. Relevant strengths of the family and relationship service sector include: well-developed expertise and resources for working with a range of families; national coverage and extensive community links; developing expertise in the delivery and evaluation of evidence-based family programmes and evidence-informed practices; a national service footprint; engagement with families across key transitions in the family life course; non-stigmatised services relative to tertiary services (such as child protection, corrections and mental health).

Prevention and early intervention approaches are cost effective and many programmes have a demonstrable return on investment. This report identified the current funding arrangements for the family and relationship services sector to be a barrier—limiting the sector's capacity to work more extensively within universal prevention and early intervention approaches.

The existing policy investment is slanted to working with disadvantaged populations and with families that are already experiencing problems.



The existing policies do not seek to involve the family and relationship sector in prevention and early intervention across the whole population (universally). But there is great potential for cost effectiveness and efficiency as the government seeks to invest in prevention and early intervention across a range of health risks, consistent with the objectives of national initiatives for women, children and families. Such initiatives include the National Framework for Protecting Australia's Children 2009–2020 (DSS, 2009); the National Plan to Reduce Violence against Women and their Children 2010–2022 (DSS, 2010); the National Homelessness Strategy (Department of Family and Community Services, 2000); the National Suicide Prevention Strategy (Department of Health, 2015); and other frameworks, strategies and plans.

We argue that a more holistic and coordinated public health approach is needed, offering both universal and targeted programmes and services. Currently, tertiary services such as mental health, child protection, substance abuse and corrections operate within separate funding silos, while the family and relationship service sector offers programmes and supports families in both universal and targeted services addressing major health and social problems.

This report argues for the development and trial of a common approach to client screening at the point of service intake to enable assessment and intervention to be directed at preventable processes that contribute to the development of major health

and social problems. A common approach to client intake screening and assessment in the sector would enhance service system coordination and referral, enabling families to be more easily directed to the right type and amount of service in a timely manner at the specific transition point when they require support. A change in funding arrangements for the family and relationship service sector has the capacity to reduce the existing siloing of services to tertiary clients and to offer universal prevention services to any family experiencing difficult life events.

Many health and social problems have common foundations in experiences across the family life course. Hence, harnessing the family and relationship sector's existing capacity within a public health approach to increase the delivery of prevention and early intervention services makes sense as a strategy for coordinating with other professionals and organisations addressing Australia's priority health and social problems. Based on the above synthesis, four recommendations were outlined, to:

- 1.** develop a national action plan to increase family and relationship-based prevention and early intervention services;
- 2.** develop a common intake screening and assessment framework and tools;
- 3.** trial this framework and tools; and
- 4.** obtain capacity building funding.

Background

Although it is widely accepted that prevention saves money and is better than cure, government and non-government service investment continues to go mainly to treatment and crisis management (e.g. Jorm, 2014). Given many preventable problems share common risk factors in families and relationships, it is important to identify how the family and relationship service sector can contribute within a public health approach to prevention and early intervention services in Australia.

The objective of this report, commissioned by Family and Relationship Services Australia (FRSA), was to begin a national conversation as to how investing in coordinated strategies to increase family-based prevention and early intervention services can be utilised in Australia to better address priority health and social problems. In particular, this report seeks to:

- ▶ suggest ways that funders and the family and relationship sector can capitalise on the existing national services' footprint and prevention and early intervention expertise or skills to reduce health and social problems and poor outcomes for children
- ▶ identify ways to maximise the public health potential of the sector to achieve prevention and early intervention outcomes
- ▶ outline practical ways to increase integration with health, education and community service systems.

The authors of this report, led by Professor Toumbourou at the Deakin University Centre for Social and Early Emotional Development (SEED), began by consulting key Australian policy documents and expert opinions. Major trends in health and social problems in Australia were documented together with the potential for family and relationship services to contribute to solutions.

This report synthesised knowledge of preventable risk factors, with common underlying causes over the family life course within families and relationships that contribute to major health and social problems, including comorbidity of problems. Evidence was also summarised regarding the effectiveness, including the cost-effectiveness, of family-based prevention and early intervention services that can reduce priority health and social problems. The existing strengths and challenges for the family and relationship service sector to play an increased role in prevention and early intervention at major life transition points were examined.

Based on this synthesis, recommendations were developed for coordinating strategies to increase family and relationship-based prevention and early intervention services in Australia.

Challenges in health and social problems over the coming decade

This report sought to forecast important future trends that are likely to require appropriate responses from family and relationship services. Key policy documents were analysed (Fox et al., 2015; Organisation for Economic Co-operation and Development [OECD], 2016; United Nations, 2008; 2015). The OECD (2016, p. 13) *Future of families* report outlines a number of trends that forecast future problems that the family and relationship sector must respond to:

- ▶ *More single-parent, cohabiting couples and reconstituted families living with a high risk of poverty*, requiring the family and relationship sector to work closely with social and economic policy experts, and to implement strategies that prevent relationship breakdown, while strengthening resiliency
- ▶ *Rising single-adult households coupled with growing numbers of elderly people*, suggesting that the significant proportion of elderly people among society's poor will persist in coming years, requiring the sector to implement programmes that increase bridging social capital.
- ▶ *An increase in childless-couple households, divorce rates, remarriages and step-families*, which may weaken family ties and undermine capacity for informal family care, requiring the sector to implement programmes that increase social trust and cohesion.
- ▶ *Growing numbers of single-adult households*, putting increased pressure on housing. An increase in the share of households in which women are in some form of employment that is likely to increase the need for more formal childcare, requiring the sector to coordinate with others to monitor trends with the objective of preventing and reducing health and social problems.

Experts in social and family services were consulted and asked for their advice regarding trend projections that have relevance to family and relationship services in Australia (see Appendix 1). Current trends were understood as part of a further decade of challenging social transitions toward greater individual freedom in line with the United Nations Human Development Program's Sustainable Development Goals (2008; 2015).

The need was identified for structural social determinants to be minimised and for individuals

and families to be supported through these structural changes, while maintaining optimal conditions for social trust and cohesion. Increasing family-based prevention and early intervention is considered a critical investment in supporting Australia through these transitions.

Eight priority health and social problems for prevention and early intervention programmes

This report sought to identify the major health and social problems that can be prevented over the family life course. Emphasis was placed on areas that contribute to high levels of social and economic burden in Australia for current and future populations. Australian government policies recognise the following eight major problems that have high health and social costs:

- ▶ substance abuse (alcohol misuse, tobacco use, substance use disorders)
- ▶ antisocial behaviour (including family violence and other crime)
- ▶ mental illness (preventable distress due to depression, anxiety, suicidal behaviour and less common mental disorders)
- ▶ obesity (identified as amongst the top prevention priorities by the Australian National Preventative Health Agency, 2011)
- ▶ developmental injury (leading to preventable disability)
- ▶ chronic illness (including preventable Type 2 diabetes, cancer, cardiovascular disease, asthma, allergies) (Vos et al., 2010)
- ▶ school failure (including leaving school and not participating in further education)
- ▶ social exclusion (lack of meaningful and constructive social and economic participation) (AIHW, 2014a).

As detailed in later sections, many of these problems share common risk factors and can be alleviated through increasing protective factors within families and relationships. The above health and social problems are estimated to have sizable cost impacts for Australians. Alcohol, tobacco and illicit drug use were estimated to cost Australia \$55.2 billion per year in 2004–05 (Collins & Lapsley, 2008). The costs of antisocial behaviour and crime were estimated at \$36 billion annually in 2009 (Australian Institute of Criminology, 2015), with family violence estimated at between 22 and 26 billion in 2015–16 (DSS, 2016).

The cost of mental illness was estimated at \$8.5 billion in 2014–15, which is up \$911 million from 2010–11 (AIHW, 2017) and the impact of overweight and obesity was costed at \$21 billion in 2005 (Colagiuri et al., 2010).

A public health approach to prevention and early intervention is required if priority health and social problems are to be prevented and effectively treated. Increasingly, multi-disciplinary and multi-sector public health partnerships are recommended to address these complex health and social problems (Hayes, Mann, Morgan, Kelly & Weightman, 2012). Evidence supports the need to invest in responses to reduce the disparity in health associated with socioeconomic disadvantage (Marmot, 2010). This report identifies that family and relationship services can play an expanded role in supporting the development of children and adults within key family and relationship transitions, within an integrated effort with other sectors.

Prevention and early intervention frameworks

Prevention refers to strategies or programmes that avert or delay the onset or severity of health, mental health, or social problems. Figure 1 reveals

that prevention responses can be classified as: universal, where they apply to an entire population; selective, where they target groups with elevated risk; and indicated, where they target individuals already showing signs or symptoms of problems.

A PUBLIC HEALTH APPROACH

refers to a coordinated service system response to move whole populations toward healthy norms and lower risk factors while offering targeted responses to those at higher risk (Hayes et al., 2012).

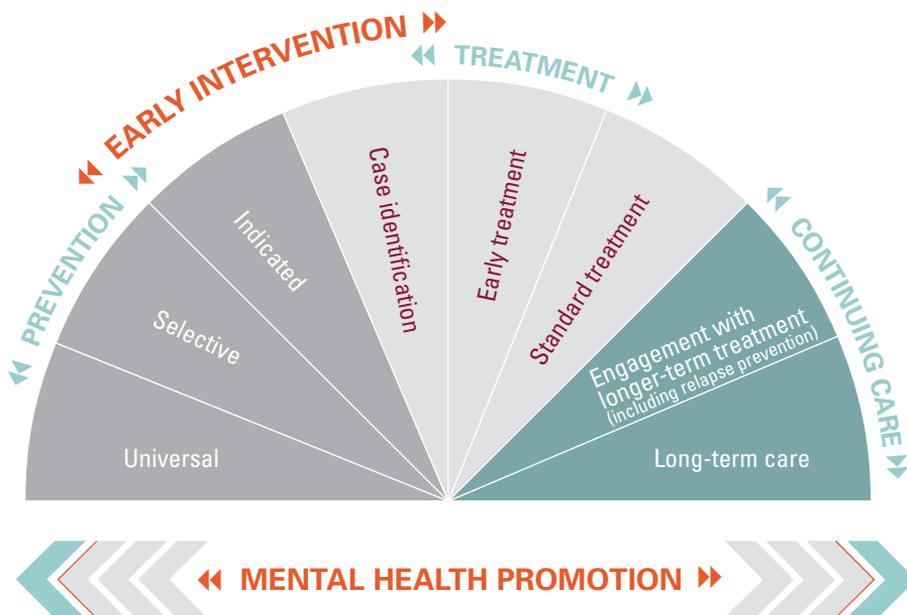


Figure 1. Definition of prevention from spectrum of intervention model.

(National Research Council and Institute of Medicine, 2009)

Early intervention has some overlap with indicated prevention, but may also encompass earlier treatment based on screening and assessment to identify people at an early stage of health and mental health disorders. Services can take a prevention and early intervention approach early in life as well as early in the situation occurring at specific moments in the family life course. For example, relationship and pregnancy health education needs to occur early before teenagers start developing romantic or sexual relationships and before co-habiting, and parenting education needs to occur before people become parents. Knowledge of how to prevent health and social problems is based on developmental sciences that identify: which problems contribute the most to social and economic burden within defined populations; indicators of healthy human development pathways; and risk and protective factors that predict health and social problems and shape evidence-informed solutions. The concepts used in the current report address the progression from risk factor to health and social problems within specified populations (National Research Council and Institute of Medicine, 2009). These concepts have influenced Australian approaches such as the 2000 National Action Plan for Promotion, Prevention and Early Intervention for Mental Health (Commonwealth Department of Health and Aged Care, 2000).

Prevention responses are also conceptualised in the health sector based on their integration of: primary prevention (targeting the whole population); secondary prevention (targeting those sub-populations at greater risk of health problems); and tertiary prevention (treating those diagnosed with health problems). On this conceptualisation, primary prevention has similarities to universal prevention, whereas secondary prevention covers aspects of selective and indicative prevention. Tertiary prevention (treatment) is not categorised as prevention within the National Research Council and Institute of Medicine (2009) framework.

Universal programmes work with everyone to promote family and child wellbeing and build the known strengths of well-functioning families (Arney & Scott, 2013; DeFrain & Asay, 2007). For example, the whole population needs accurate information on health behaviour relating to nutrition, physical activity, and alcohol, tobacco and other drug use. Everyone can benefit from knowledge of good relationship skills and how to care for children. We argue in this report that family and relationship services should have an expanded role in universal services, within a coordinated public health strategy aimed at preventing and reducing priority health and social problems.

Family and relationship-based prevention and early intervention programmes can address many risk processes that lead to health and social problems, while also building supportive relationships

The family is the most important part of a child's social environment during the early years. Family and relationship interventions during these years can make important contributions to preventing health and social problems later in life. Providing interventions during the early years can prevent problems later in life by reducing important risk processes (described in later sections) related to physical development, the impacts of toxic stress and trauma and pathways to behavioural problems. Supporting the enhancement and development of protective factors to mitigate against risks are also crucial at key transition points in the family life course, such as adolescence, forming, breaking up and re-forming relationships and having children. Increasing social support for those at high risk can reduce health and social problems into old age. As the family and relationship sector has a strong track record delivering programmes to improve parenting skills and warm, safe, respectful and healthy relationships amongst high-risk groups, the sector has a significant potential to contribute to public health across the family life course.

Family and relationship services already contribute significantly to preventing the high priority health and social problems described in this report. However, there is great potential for the sector to contribute further through a systematically planned public health approach coordinated with other sectors. Such an approach would achieve this by providing universal and targeted programmes to reduce risk factors and increase protective factors (as defined below).

RISK FACTORS

are indicators of underlying 'risk processes' that explain the development of health and social problems. Many risk processes can be reduced by evidence-based family and relationship services.

Risk factors are defined at one level as independent predictors of health and social problems. Risk factors are indicators of underlying 'risk processes' that explain the development of health and social problems. Protective factors refer to things such as skills and relationships that reduce the likelihood of health and social problems amongst individuals and groups that have high levels of risk factors (Loxley et al., 2004; National Crime Prevention, 1999).

This and the next section provide examples of the following risk process theories and protective factors, drawing upon information from prior review papers (Centre on the Developing Child, 2010; Foley et al., 2000; Fox et al., 2015; Loxley et al., 2004; National Crime Prevention, 1999; Stone, Becker, Huber & Catalano, 2012; Toumbourou, Olsson, Rowland, Renati & Hallam, 2014a) and from current Australian promising practices in services funded by DSS and state governments (Australian Institute of Family Studies, 2016; Higgins & Katz 2008; Robinson, Scott, Meredith, Nair & Higgins, 2012).

The following theories are discussed:

Risk process theories

- ▶ physical development risk processes
- ▶ toxic stress and trauma risk processes
- ▶ behavioural risk theories
- ▶ social development theories
- ▶ unsafe community environments
- ▶ adult stressful and traumatic life events
- ▶ risk aggregation theories.

Protective factor theories

- ▶ social attachments and support
- ▶ social-emotional competencies.

Physical development risk processes occur when exposure to unhealthy and inadequate nutrition, poisonous chemicals and substances are destructive to healthy physical, neurological and immune development. As the early years set the foundations for healthy physical development, unhealthy nutrition and chemical exposure in the early years can embed problems in the developmental sequence and result in more severe disability and poor outcomes later in life (e.g. Shonkoff, Boyce & McEwen, 2009). Risk and protective factors need to be evaluated not simply in terms of their strength at different ages but also in terms of how common they are across the population.

Some risk factors, such as child and adolescent substance use, are common causes of physical changes such as tolerance to alcohol that increase the likelihood of adult substance abuse and related outcomes (e.g. McCambridge, McAlaney & Rowe, 2011). Family services are in a strong position to identify these issues at an early stage by identifying early risk factors. More clearly identifying problems and risk factors at different ages would enable universal and targeted service delivery to be better coordinated between sectors.

A number of cost-effective (Lee, 2016) family and relationship programmes have been shown to reduce substance use problems (e.g., Family-based tobacco and substance use prevention; Communities That Care; Community mobilisation). Programmes of this type would ideally be delivered in Australia through service partnerships with family-based relationship counselling and parenting support and psycho-education programmes.

Toxic stress and trauma risk processes can impair physical development early in the family life course where children and young people have intense negative experiences (such as child maltreatment, peer bullying and family violence) that are maintained over time. Stress and conflict can also undermine health and wellbeing through key later life transition events such as family breakdown and relationship disputes. The extended arousal of the nervous system and the release of stress hormones such as cortisol can incur damage at all life stages but can result in permanent damage to the development of the childhood brain, and stress and immunity systems (Middlebrooks & Audage, 2008), with damage extending to altered genetic structures. Toxic stress is a risk factor for all of the health and social problems described in this report affecting cognitive and physical disability (poor educational outcomes), mental health problems (substance abuse and antisocial behaviour), and physical health problems due to greater infections (resulting in chronic health problems). Toxic stress risk processes have more severe effects in the early years when the brain and biological systems are rapidly developing and hence are more vulnerable to being permanently damaged (Centre on the Developing Child, 2010). Because the development of biological stress response systems is influenced by early experience, early exposure to toxic stress can 'biologically embed' lifetime vulnerabilities in immune and stress response systems that increase health and social problems later in life (Shonkoff et al., 2009).

Family and relationship-based prevention programmes have been shown to reduce these risk factors. For example, the Nurse Family Partnership Behavioural Parent Training programmes (listed in Lee, 2016) and Parent Child Interaction Therapy (listed in Table 2) target services to families where children may be vulnerable to experiencing toxic stress. As is indicated in the sections that follow (see Table 3) programmes of this type would ideally be delivered in Australia through family and relationship services working in partnership with maternal and child health services. Relevant family and relationship services may include: family-based/relationship counselling; parenting support and psycho-education (using home visits and Children's Contact Services); alternative dispute resolution; and assertive engagement/social connection activities (including playgroups, supported playgroups, and Communities for Children). Harnessing and expanding the sector's existing knowledge and capacity to deliver universal and early intervention programmes and practices would ensure a greater reduction in risk factors.

Behavioural risk theories refer to the tendency for the early introduction of behaviours to shape the later sequence of behavioural development. The developmental sequence is related to physical processes whereby neurological changes explain skills that form into habits that are then established in social identification and lifestyles. For example, lack of physical activity in childhood and adolescence results in behavioural habits that predict inactive adult lifestyles (Mathews, Moodie, Simmons & Swinburne, 2010). Many behavioural lifestyle risk process theories trace the first experiences of food and substance use back to the pre-birth environment where mother's behaviours can influence the development of the foetus shaping the child's behavioural preferences (Centre on the Developing Child, 2010).

Social development theories: Catalano and Hawkins (1996) emphasise social relationships as key influences on behavioural development. According to these theories, children and adolescents tend to adopt the behaviours, beliefs and values of people with whom they develop strong emotional bonds. Emotional bonds are in-turn developed by having opportunities and social skills to interact in ways that lead to positive recognition and rewards (Catalano & Hawkins, 1996).

Behavioural and social development risk process theories underlie many of the therapeutic practices in the cost-effective programmes listed in later sections. These programmes assist parents to develop clear family standards and to use cognitive

behavioural techniques to reduce child behaviour problems that can lead to problems such as crime and violence, mental illness, and obesity in later life (e.g. Strengthening Families; Parent Child Interaction Therapy; Behavioural Parent Training (Lee, 2016); Triple P Positive Parenting Programme; Families and Schools Together—Table 2). As is indicated in Table 3 below, programmes of this type might be delivered in family and relationship services that include: family-based/relationship counselling; parenting support and psycho-education (ranging from one-off seminars, group work, home visits, Children's Contact Services); alternative dispute resolution; and assertive engagement/social connection activities (including supported playgroups and Communities For Children coalitions).

Unsafe community environments: People who do not have a high number of childhood risk factors can be put at risk later in life by unsafe environments in childhood, adolescence and early adulthood. Even healthy children and adults can be put at risk by dangerous conditions: Think of a snowstorm blizzard. If exposure to environmental hazards continues for long enough and the individual has little protection, health and survival are placed at risk. Where individuals have low protective factors (analogous to providing shelter in stormy weather: such as assistance from social supports) in communities with easily accessed hazards (e.g., physical environments that pose risks for injury and violence, internet pornography, online access to substances), the likelihood of an individual succumbing to unhealthy outcomes increases.

The snowstorm risk process occurs in communities that have high levels of environmental hazards such as injury risks, community disorganisation, and marketing by vested interests for substances, and unhealthy foods. From this perspective, solutions lie in making communities safer for healthy human development (Toumbourou et al., 2014a).

Family and relationship services can play an important role in encouraging social environments that safely meet human development needs. A number of the cost-effective universal prevention programmes encourage families and communities to adopt healthy norms and safe environments across the whole population (e.g. Family-based tobacco and substance use prevention; Communities That Care; Community mobilisation [Lee, 2016]; Families and Schools Together [Table 2]). As is indicated in Table 3 below, programmes of this type might be delivered in community partnerships with family and relationship services, working in partnerships with local government, community health and education services.

Adult stressful and traumatic life events are identified as risk factors for a range of health, mental health and social adjustment problems amongst adults. Stressful events are the product of an interaction between individual vulnerability and adversity within the environment: for instance physical illness, family or social conflict or isolation, work-related stress, financial strain. Stressful life events are more common in key family life course transition points such as couples transitioning into parenthood or during family breakdown. Vulnerability to these events is often increased during life-transitions such as financial and other pressures associated with pregnancy and birth and relationship loss. These life events vary in their impact, duration and predictability, and in the level of control an individual has upon them. Where coping and support are inadequate to the challenge, an adverse impact on health and social adjustment may occur (Schwarzer & Schulz, 2003).

A number of the family and relationship services listed in Lee (2016) and Tables 2 and 3 are targeted to assist individuals and families through stressful life events. Nurse Family Partnership, Strengthening Families (Lee, 2016) is targeted at families facing economic stress. Many parent training programmes (e.g. Triple P Positive Parenting Programme and Parent Child Interaction Therapy, The Incredible Years [Lee, 2016]) target families experiencing stressful parenting problems. New and innovative services such as trauma-based counselling services are targeted to assist the management of grief and loss.

Risk aggregation theories: Risk factors operate in complex ways and have interactive and reciprocal effects that have a cumulative (or clustering) impact over the family life course. The more risk factors that are present and the longer they persist over time, the greater their subsequent developmental impact (e.g. Farrington, 2003; Toumbourou & Catalano, 2005; Vassallo et al., 2002). There is no single risk factor that fully explains developmental outcomes. Rather, outcomes have complex causes involving influences and interactions between multiple risk and protective processes. Offering universal and targeted family programmes, such as parent education and family support, at a 'dose' or amount appropriate to the issues families present with, can reduce early risk factors leading to lower cumulative risk across the family life course.

The cumulative effect of early risk factors can be described using the analogy of a snowball (Toumbourou & Catalano, 2005; Toumbourou et al., 2014a). According to this view, snowball risk trajectory processes start early in life. Due to the

sequencing of the risk processes described below, adversity in the early years can lead to subsequent risk factors that tend to 'adhere' and accumulate as a consequence of the experience of earlier problems (e.g. antisocial behaviour and substance misuse leading to school failure and mental health problems). The process of accumulating risk factors at later life stages is analogous to a snowball gathering size as it rolls down a mountain.

Social and economic mobility patterns in our society have increased socioeconomic differentials and led to a situation whereby children experiencing snowball risk trajectories tend to be disproportionately clustered within disadvantaged geographic communities and schools (Toumbourou et al., 2007). Using this analogy, one important solution is to invest within targeted disadvantaged areas to prevent the potential for an avalanching snowball by building protective solutions and reducing early life risk factors. In communities such as this, a public health approach utilising coordinated targeted and universal programmes and practices by a range of service providers focusing on a specific issue could have a significant benefit in reducing the risks of subsequent health and social problems. An example of such a place-based approach is the Communities for Children (C4C) programme. Many C4C sites have currently adopted collective impact approaches that have demonstrated success in addressing specific social problems in the USA and in locations in Australia (Bumbarger & Campbell, 2012; Homel, Freiberg & Branch 2015). In Australia, the approach has been used to address identified social issues such as youth crime and school readiness in specific locations and with specific populations within those locations (The Smith Family, 2016).

There are a wide range of evidence-informed programmes and practices that could assist families and children to further reduce risk factors that adversely impact the eight health and social problems identified in this paper. Specific evidence-based programmes are useful in addressing particular health and social problems. Many of the programmes listed in Table 2 and in other sections of this report are deliberately designed to assist families and children living in communities where there are high numbers of children experiencing snowball risk trajectories. They are offered as examples of evidence-based programmes that the sector could consider in a public health approach including universal and targeted services. The programmes could supplement and be included in a coordinated approach utilising a range of evidence-informed programmes and practices.



PROTECTIVE FACTORS

such as skills and relationships are deliberately enhanced by family and relationship services to reduce the likelihood of health and social problems amongst those with high levels of risk factors and those experiencing difficulty at a particular point of transition through the family life course transition.

Family and relationship services may increase protective factors for children and families at high risk of health and social problems

In some cases where it has not been possible to reduce exposure to risk factors it remains possible to prevent later health and social problems by increasing protective factors that reduce and ameliorate the effect of risk factors. Protective factors that can be increased by family and relationship services include: social support and bonding; health promotion; and social-emotional competencies. Innovative family-centred evidence-informed programmes and practices have been and could continue to be developed and evaluated to ensure they achieve beneficial outcomes. There is great potential for further collaboration within and across sectors for these programmes and practices to be implemented and evaluated by organisations or coalitions of organisations. The selection of these programmes and practices are best determined by local evidence and designed and implemented to be appropriate to a particular location, context or identified group (e.g., www.episcenter.psu.edu/). There are examples of programmes that enhance protective factors

within coordinated cross-sectoral prevention and early intervention strategies in both the USA (Bumbarger & Campbell, 2012) and Australia (Homel et al., 2007).

Social attachments and support have been described as important protective factors for ensuring mental health, wellbeing and quality of life. Social support is commonly cited as a buffering mechanism against the experience of stressful and adverse life events. Social support is often provided within social networks (Heerde, Toumbourou, Hemphill & Olsson, 2015) to provide mutual assistance and support to manage and reduce the impact of stressful events; social support lending itself to the further potential role of family and relationship services intervening early at the onset of problems. Social support and social bonding have been associated with reduced anxiety (e.g. Lewinsohn, Gotlib, Lewinsohn, Seeley & Allen, 1998), depressive symptoms (e.g. Stice, Ragan & Randall, 2004), suicidal ideation (Sheeber, Hops, Alpert, Davis & Andrew, 1997) and substance use (e.g. Wills & Vaughan, 1989). Many cost-effective family and relationship services have an explicit role in building social support to assist individuals and families through vulnerable life transitions. Family and relationship services play a vital role in reducing health and social problems by: assisting family members to understand and better develop social supports required for health and wellbeing; and building social network for people that are vulnerable by virtue of problems such as an absence of parent role models.

Social-emotional competencies are ‘teachable’ skills that operate as protective factors that reduce the likelihood of a range of health and social problems. Family and relationship services, through parenting interventions, have a role in better preparing adults in their transition to parenthood and care-giving to develop social and emotional competencies for children under their care. These approaches are already incorporated into a wide variety of family and relationship programmes and promising practices. Social competency training may be included in parent and relationship training programmes in areas such as the development of family rituals that increase opportunities for communication. Emotional competency training used in family and relationship programmes include strategies to tackle stress, address trauma, and manage emotions such as anger and grief. Innovative research is currently being undertaken with great public health potential for support and education of parents. For example, the Fathers and Families research team at the University of Newcastle are developing digital communication strategies to educate new fathers and mothers and

track moods immediately after the birth of a child (Fletcher et al., 2016). Assessment methods of this type may offer the possibility of identifying parents that need early assistance to avoid mental health and other problems.

Risk and protective factors are indicators of preventable processes that cause health and social problems

Tables 1a and 1b below demonstrate how a range of risk and protective factors act as common influences for the high priority health and social problems described in this report. Table 1a synthesises information on risk factors that can be found in a number of literature reviews (e.g. Fox et al., 2015; Toumbourou et al., 2014a). The following

section reviews research that demonstrates the influence of the risk factors on the health and social problems listed in Table 1a.

(1) The first line of Table 1a indicates that the risk factor 'Child neglect/abuse; family and relationship conflict and violence' influences the development of all of the priority health and social problems. As described in earlier sections, this effect is explained by the influence of toxic stress and trauma risk processes whereby stress-induced damage to the development of the childhood brain and immunity systems lead to increased risk for all of the listed priority health and social problems (Centre on the Developing Child, 2010; Middlebrooks & Audage, 2008; Shonkoff et al., 2009). Child and adolescent exposure to family violence can also model to the child or adolescent and lead them to engage in violence later in life, as explained in behavioural risk and social development theories (Costa et al., 2015).

Table 1a: Risk factors for priority health and social problems

Risk factors	Alcohol, tobacco and other drug abuse	Crime, antisocial behaviour and violence	Common mental health problems such as depression & suicide	Obesity, chronic disease & injury
Family				
▶ Child neglect/abuse; family and relationship conflict and violence (1)	✓	✓	✓	✓
▶ Family and relationship attitudes and behaviours favourable to the problem (2)	✓	✓	✓	✓
▶ Poor family management (3)	✓	✓	✓	✓
Community				
▶ Socioeconomic disadvantage and community disorganisation and mobility	✓	✓	✓	✓
▶ Marketing and sales of unhealthy products (fast food, guns, access to suicide means)	✓	✓	✓	✓
▶ Laws & norms favourable to problem	✓	✓	✓	✓
Education				
▶ Low participation, attendance and achievement	✓	✓	✓	✓
▶ Bullying and exclusions	✓	✓	✓	✓
Peer/Individual				
▶ Early age initiation of problems	✓	✓	✓	✓
▶ Constitutional factors (impulsiveness, genetic vulnerability)	✓	✓	✓	✓
▶ Favourable attitudes, low appraisal of risks, perceived prevalence of problems	✓	✓	✓	✓

(2) The influence of the risk factor ‘family and relationship attitudes and behaviours favourable to the problem’ is explained by behavioural and social development risk process theories. These risk processes have been consistently observed as influences on the development of: alcohol and other drug use; crime and antisocial behaviour (Hawkins et al., 2008), which includes family violence; and obesity (Mathews et al., 2010). Parental mental health problems are well-known predictors of child mental health problems, explained in part by child adoption of ineffective family stress-coping practices (Letcher, Smart, Sanson & Toumbourou, 2009; Ryan, Jorm, Toumbourou & Lubman, 2015).

(3) ‘Poor family management’ refers to problems in the core parenting skills of: setting rules; monitoring child behaviour; rewarding positive behaviour; and providing moderate consequences for misbehaviour (Toumbourou, 2016). Poor family management contributes to increased likelihood of all of the priority health and social problems through social development and physical development risk processes. Where families fail to set healthy rules and standards, the likelihood increases of early exposure to alcohol (e.g. McCambridge et al., 2011), tobacco and other drug use (Shonkoff et al., 2009; Toumbourou et al., 2014a), leading

to vulnerability in the child brain and body that increase the likelihood in adulthood of alcohol and drug use disorders and related problems of antisocial/violent behaviour (including family violence) and mental and physical health problems.

Table 1b below summarises the influence of key protective factors on priority health and social problems. The sections that follow discuss the role of family protective factors.

(4) The experience of ‘warm attachment’ and the availability of ‘positive role models’ act as protective factors reducing the likelihood of all of the priority health and social problems. These effects are explained by social development and social attachment and support theories. Secure early attachments have been shown to predict positive social relationships and reduced crime and antisocial behaviour in later life (Shonkoff et al., 2009). Social support and social bonding have been associated with reduced: alcohol and other drug use (e.g. Wills & Vaughan, 1989); conduct problems; mental health problems (e.g. Lewinsohn et al., 1998; Stice et al., 2004); eating disorders; and intentional injury (Sheeber et al., 1997).

Table 1b: Protective factors for priority health and social problems

Protective factors	Alcohol, tobacco and other drug abuse	Crime, antisocial behaviour and violence	Common mental health problems such as depression & suicide	Obesity, chronic disease & injury
Family				
▶ Warm attachment, positive role models (4)	✓	✓	✓	✓
Community				
▶ Safe, stimulating and healthy environments.	✓	✓	✓	✓
▶ Opportunities, connections, positive role models	✓	✓	✓	✓
Education				
▶ Social connections, positive role models	✓	✓	✓	✓
Peer/Individual				
▶ Social connections and positive role models	✓	✓	✓	✓
▶ Religiosity and civic engagement	✓	✓	✓	✓
▶ Social and emotional skills	✓	✓	✓	✓

Family members can also protect healthy development by providing positive role models for social-emotional competencies that have been shown to reduce the likelihood of: alcohol and other drug use; crime and antisocial behaviour; and mental and physical health problems (Hawkins et al., 2012; National Research Council and Institute of Medicine, 2009).

The need for advances in intake screening and assessment methods

The sections that follow discuss how the information summarised in the above tables can be more systematically used to guide family and relationship services. When a family or family member contacts a service within the family and relationship sector, they are asked a number of questions to ascertain how the service can meet their needs. The process used by services to ask questions and to ascertain client needs is referred to here as 'intake screening'. Currently, family and relationship services use a variety of intake screening processes to determine the scope, nature and urgency of client issues. Valid screening measures are available and are used in some health services to target early intervention programs for alcohol and drug use (e.g. Tanner-Smith & Lipsey, 2015). This includes tools that have been developed specifically for the delivery of family law services, such as DOORS (McIntosh, 2011a & 2011b). Improving intake screening in the family and relationship service sector would require a review of existing practices and the identification of valid frameworks and tools for identifying a more comprehensive range of priority health and social problems and the modifiable risk and protective factors listed above.

INTAKE SCREENING

refers here to the process services use from first contact with the family to identify the type and intensity of interventions required.

If the family and relationship sector is to deliver a wider range of prevention and early intervention services, it is important to use valid criteria to assess the services that are best matched to needs within their locality. Information from intake screening provides one important basis for deciding what prevention and early intervention services may be required. However, some risk and protective factors may also be assessed by examining community and education data. To improve decisions in the allocation of evidence-based programmes and evidence-informed practices, services require better methods for assessing what services and interventions are needed within their locality. One example of this is the assessment and safety planning where family violence is present.

ASSESSMENT

refers here to the appraisal of a range of risk and protective factors at the individual, family and community level, in order to inform prevention and early intervention service allocation.

There is variation currently in how the sector decides on service allocations. drummond street services in Victoria utilises information collected at intake to assess family risk factors and this information is used to refer appropriate clients to family mental health support (drummond street services and Stepfamilies Australia, 2016). Parent Child Interaction Therapy (see Table 2) provides one-to-one parent coaching in family contexts where children have been assessed at high risk due to indicators such as alerts from protective services or child welfare. By intervening at times of vulnerable transitions, family-based early intervention and prevention programmes can reduce snowball risk trajectories (Catalano et al., 2012). As is indicated in Table 3 below, programmes of this type would ideally be delivered in Australia through family-based services working in partnership with: maternal and child health; General Practitioners; schools; child protection; substance abuse; mental health; aged care services; and justice and correction.

A valid and comprehensive assessment framework and tools for measuring priority health and social problems and their risk and protective factors is currently used in Australia for community planning for child and adolescent services (e.g. Arthur, Hawkins, Pollard, Catalano & Baglioni, 2002; Hemphill et al., 2009). A version of this instrument has been designed for adults (Tombourou et al., 2014b).

Economic benefits of investing in family and relationship-based prevention and early intervention programmes or approaches to service delivery

There is now growing evidence internationally to support the economic benefit of investing in prevention and early intervention programmes and approaches in existing services in the family and relationship sector to address risk and protective factors and, in turn, reduce the eight priority health and social problems identified in this report. The sections that follow summarise systematic work to evaluate the economic benefits in areas related to prevention and early intervention. We initially summarise Australian economic analyses and this is followed by evidence gathered overseas.

Pezullo et al. (2010) modelled Australian longitudinal data to evaluate the economic benefit of three very different Australian interventions that sought to achieve positive family functioning. This analysis showed the total benefit to cost ratio of the Communities for Children programme (described later in this report) was \$4.77 returned for every \$1 spent. The analysis showed a benefit of \$13.83 was returned for every \$1 spent on the Triple P programme. The Reconnect programme targeting family relationship support to youth aged 12–18 at risk of homelessness (see Table 3: www.dss.gov.au/families-and-children/programmes-services/reconnect) was identified to return \$1.81 for every \$1 spent on the programme. The analysis of these programmes illustrates that broad-based whole of community approaches, targeted services focusing on a particular problem and specific groups and evidence-based parenting programmes can each have cost benefits.

However, due to little funding and hence limited focus on prevention and early intervention programmes in Australia, there have been relatively few economic analyses of programmes. In the Australian context, despite knowledge of risk and protective factors sitting largely within the family setting, there has been little investment in preventative efforts within this sector. Accordingly,

we were only able to identify relatively few Australian economic analyses of family-based prevention and early intervention strategies. A previous report completed for Family and Relationship Services Australia (FRSA) (Allen, 2013) briefly overviewed a range of Australian analyses that reported economic benefits from family-based early intervention and prevention services. The economic benefits through early interventions in childhood and adolescence were estimated to be in the order of \$5.4 B per annum in 2010.

On the other hand, due to the large prevention investments initiated from the 1970s in the US, much of what is known of the efficacy and cost-effectiveness of family and relationship-based prevention and early intervention has originated from there. The leading international agency for estimating the economic returns from prevention is the Washington State Institute for Public Policy (WSIPP: www.wsipp.wa.gov/BenefitCost). In what follows, information from WSIPP analysis completed by Lee (2016) is summarised to describe how family and relationship programmes can cost-effectively improve risk and protective factors to prevent the priority health and social problems listed in the earlier sections of this report.

The available information illustrates that family and relationship programmes can offer both economic and social value within a coordinated public health approach that includes family services. Prevention science is an international undertaking and Australian researchers and program developers have made important contributions to programme evaluations. As a result, a number of the programmes identified by the WSIPP as cost-effective are also included in the Australian Institute of Family Studies Expert Panel listing of evidence-based programmes (<https://apps.aifs.gov.au/cfca/guidebook/programs>). Of the 32 programmes listed by the Expert Panel as evidence-based in 2016, six were also listed on the WSIPP website: Triple P; Families and Schools Together; Incredible Years; Parent-Child Interaction Therapy (PCIT); Parents as Teachers; and Second Step. The information in Table 2 focuses on the economic evidence for these six family and relationship-based programmes, demonstrating their good prevention returns based on rigorous economic investment analyses. Table 2 lists details in \$USD for the total benefits and costs of programmes and their benefit to cost ratios. Of the six programmes evaluated by WSIPP that overlap with the Australian Institute of Family Studies recommendations, five were identified to produce positive economic returns, ranging from \$1.07 (Families and Schools Together) to \$12.99 (Parent Child Interaction Therapy for families in the child welfare system) for every \$1 invested.

Table 2. Cost benefit information on family and relationship programmes relevant to major areas of early intervention and prevention

TARGET PROBLEM/ Programme (Life Transition/Population)	Benefits	Costs	Benefits minus costs	Benefit to cost ratio
Antisocial behaviour, crime/alcohol and drugs/mental health				
Triple P Positive Parenting Programme: System. (Pre- to Primary school).	\$1,120	-\$150	\$970	\$7.48
Families and Schools Together. (Primary to Secondary school).	\$1,982	-\$1,854	\$128	\$1.07
Incredible Years: Parent Training. (Primary to Secondary school).	\$2,153	-\$1,305	\$847	\$1.65
Parent Child Interaction Therapy for families in the child welfare system. (Pre- to Primary school/Disadvantage).	\$21,089	-\$1,623	\$19,466	\$12.99
Education				
Parents as Teachers. (Primary to Secondary school).	\$8,843	-\$2,688	\$6,156	\$3.29
Parents as tutors with teacher oversight. (Primary to Secondary school).	\$3,962	-\$809	\$3,154	\$4.90
Second Step. (Primary to Secondary school).	\$114	-\$119	-\$5	\$0.96

Source: Lee, 2016 (www.wsipp.wa.gov/BenefitCost)
 Note: Dollars are \$USD

A brief outline is provided below of some examples of the risk and protective processes that each of the above cost-effective family and relationship programmes address in order to prevent priority health and social problems. Family and relationship interventions are characterised by stages that are common to all therapies and include: recruitment; engagement; alliance building; assessment; goal setting; therapeutic change; and maintenance (Toumbourou, 2016). The same recruitment, engagement and alliance building skills could be utilised in a preventative framework, including health promotion and education strategies aimed at increasing the protective factors through more universal evidence-informed practices.

In order to address snowball risk processes, family and relationship services in Australia have developed expertise in recruitment, engagement and alliance building with vulnerable and socioeconomically disadvantaged families. Programmes that offer a clearly specified therapeutic process model to complete assessment and goal setting to achieve therapeutic change and maintenance when working with vulnerable families experiencing parent-child relationship problems often seek to reduce risk factors such as 'child neglect/abuse, family and relationship conflict and violence'. Intervention strategies reduce snowball risk processes by

intervening at an early stage to therapeutically enhance parent-child interaction using behavioural, cognitive-behavioural, attachment and family system therapies (Toumbourou, 2016) to address behavioural, social development and social attachment and support processes. Programmes that seek to reduce the above risk factors may also aim to improve 'family management' using cognitive-behavioural and other intervention strategies to address behavioural risk processes.

Programmes such as Families and Schools Together have a focus on recruitment, engagement and alliance building in the school setting to also address 'family and relationship attitudes and behaviours favourable to the problem'. In addition to using the therapeutic strategies listed above, programs of this type also use social ecological intervention strategies (Toumbourou, 2016) to target behavioural and social development risk processes to encourage family support for education. Programmes such as Parents as Teachers and Families and Schools Together also seek to enhance protective factors of 'warm attachments and positive role models' using interventions to address social development and social attachment and support processes to improve educational outcomes.

In highlighting the small number of Australian programmes that have been economically evaluated, it is important to recognise that the majority of Australian family and relationship programmes may be cost-effective, but have not had the evaluation resources to demonstrate this. The initial step for programmes that have not completed outcome evaluations is to document their programme logic in manuals to demonstrate how their intervention process models address risk and protective processes. DSS, through the AIFS expert panel, supported a range of programmes to document their programme logic models in 2015–2016. Once programme logic models have been documented it is feasible for programmes that have not completed outcome evaluations to demonstrate their efficacy by using valid measures to demonstrate that their programmes are achieving measurable improvements in targeted risk and protective processes. Also, not only do entire evidence-based programmes need to be documented and evaluated, but so too aspects of family and relationship services' approaches to meeting the needs of children and families, including intake screening and assessment frameworks and tools used that can identify the onset of problems, and the ensuing steps taken by services. The majority of family and relationship services have intake screening and assessment/intervention matching processes and tools. These could be enhanced to screen across the common health and social issues impacting on families in order to determine universal prevention service priorities and to identify vulnerable families early and prioritise service levels for the most 'at risk' families.

As described here, comprehensive assessment would identify modifiable risk and protective factors that are a priority within the locality a service operates within, while also assisting to allocate the dose and intensity of evidence-based interventions to meet each family's needs. Hence, comprehensive assessment would assist the sector to take a universal and targeted approach. This is a critical step for social service systems to ensure they are improving the profile of risk and protective factors, while also matching the needs of the family to the appropriate evidence-based programme. The availability of an integrated intake screening and comprehensive assessment framework and tools would assist therapeutic efficacy by providing a framework for monitoring service systems. This would harness the public health potential of the family and relationship sector to make an increased contribution to the delivery of universal and targeted prevention and early intervention services.

Table 3 describes how the settings for prevention and early intervention integrate with key transition points across the life cycle. Table 3 also describes family and relationship services that may respond to early intervention and prevention opportunities at each transition point. To more fully achieve the potential of the family and relationship sector to engage with families at early and key times of relationship transition will require a valid assessment framework and tools that more comprehensively monitor indicators of risk and protective factors for priority health and social problems. This information can be combined with rigorous criteria for screening clients to ensure they receive the type and amount of service required to meet their needs. To achieve this will require some reorientation of the service system to integrate with universal services that engage with families at key life transitions (i.e. maternal and child health, schools, general practice) and tertiary services that work with clients after health and social problems have emerged.

Strengths within Australian family and relationship services that support an expanded role in prevention and early intervention

The family and relationship services sector in Australia has a number of areas of strength that are compatible with an expanded role in prevention and early intervention. Key strengths include:

- ▶ well-developed expertise and resources, including existing intake screening and assessment tools that can be expanded into additional domains to achieve recruitment, engagement, alliance building and sustained therapeutic change working with a range of families, in contexts that include socioeconomic disadvantage, Cultural and Linguistic Diversity, Indigeneity and people who identify as Lesbian, Gay, Bisexual, Transgender, Intersex or Questioning (LGBTIQ);
- ▶ a national footprint of services and extensive community links;
- ▶ a developing expertise and system support in the delivery and evaluation of evidence-informed and evidence-based family and relationship programmes and practices;
- ▶ service delivery across multiple family life course transitions, including: relationship formation; transition to parenthood; parenting children and teens; and post-separation and family re-formation. Services offered

Table 3: Potential points for family-based prevention and early intervention service delivery across different family life stages

Family life stage	Risk and protective processes addressed	Relevant service settings and systems
Infancy and early childhood, early adult family transition/ pregnancy	Reducing: toxic stress and trauma risk processes, snowball risk trajectories (encouraging maternal mental health, reducing family violence); and physical development risk processes (encouraging breastfeeding, smoking cessation, reducing maternal alcohol use).	Family and other services in partnership. May include: family-based/relationship counselling; parenting support and psycho-education (using home visits); alternative dispute resolution; and assertive engagement/social connection activities; placed-based family and community programmes (including supported playgroups, and Communities for Children activities).
Primary and secondary school years	Reducing behavioural and physical risk processes and unsafe community environments. Increasing stress management and social support to parents.	Service partnerships with schools may include: family-based/relationship counselling; parenting support and psycho-education; and social connection activities. Services models include: Parent Training, Strengthening Families; Families and Schools Together; Resilient Families.
Early adult family transition	Reducing snowball risk trajectories, physical and behavioural risk processes and unsafe community environments. Enhancing stress management and social support. Encouraging civic engagement and social trust.	Service partners may include: family-based/relationship counselling; parenting support and psycho-education; alternative dispute resolution; and assertive engagement/social connection activities.
Late adult family transition	Enhancing stress management and social support in contexts such as relationship breakdown and grief and loss. Reducing behavioural and physical risk processes and unsafe community environments.	Service partnerships may include: family-based/relationship counselling; social support and psycho-education; and social connection activities.

across the family life course can include the following types: universal and targeted initiatives for developing healthy, respectful relationships in schools and youth; family and relationship services; financial literacy services; interventions promoting parenting confidence and competence; playgroups, nutrition and exercise programmes; parenting advice services; family dispute resolution; and support for high-conflict post-separation families;

- ▶ family and relationship services have a great public health potential in that families engage with the sector right across the risk continuum. Families view the sector as non-stigmatised and this offers potential to provide both universal prevention and targeted early intervention programmes. It also offers the potential to identify families requiring further referral to and engagement with various tertiary service providers, such as family violence, mental health (including alcohol and other drugs AOD) and homeless services; and

- ▶ the significant investment DSS has made and continues to make in the provision of evidence-informed and evidence-based services, outcome measurement and reporting mechanisms (e.g. the Expert Panel and Data Exchange). The sector has also invested heavily, in partnership with government, in responding to the new reporting requirements in efforts to build a stronger evidence base regarding achieved outcomes.

The sector has well-developed expertise and resources for working with a range of families such that many of the cost-effective programmes listed in Table 2 and in Lee (2016) were originated by Australian developers. The existing service agencies that make up the family and relationship sector come from across Australia. These services have extensive community links. Larger organisations have the capacity to develop practice systems that integrate and underpin all service delivery for example, the Benevolent Society Resilience Practice Framework (Antcliff, Daniel, Burgess & Sale., 2011).

Smaller organisations may operate in specific locations with specific groups and have strong community knowledge informing screening and referral processes.

The inclusion of some additional evidence-based programmes specifically targeting family behaviours in relation to the priority health and social problems listed in this report can make a significant contribution, as family and relationship services are often in a good position to both assess and intervene early in emerging health issues. One example is the inclusion of evidence-based nutrition programmes in some Communities for Children activities in specific sites (e.g. The Smith Family, 2016). The family and relationship service sector has well-developed relationships with agencies such as DSS that are developing policies to promote evidenced-based investment and outcome measurement to advance early intervention and prevention capacity. There are many examples within the sector where agencies are systematically combining universal and targeted approaches to increase involvement in prevention and early intervention.

There is strong policy and funding support from federal, state and territory governments in Australia such that most strategic initiatives in the sector are government-funded through DSS working with state departments, or by similar state government initiatives. This situation is similar to that in the health sector and supports the view that government could take a lead role in developing and implementing an action plan to encourage the family and relationship sector to coordinate with other sectors using a public health framework. The section that follows describes strategic efforts that have been implemented by the federal government and other organisations to encourage the adoption of evidence-based services within the family and relationship sector in Australia.

The DSS Families and Communities Programme aims to enhance family and community functioning by supporting families, improving child wellbeing and increasing the participation of vulnerable people within the community. Within this programme, Families and children activity seeks to support families by improving child and young people's wellbeing, increasing economic engagement and developing cohesive communities. The support is provided through the integrated provision of a suite of family services (e.g. family law services [including relationship centres and children's services, family and relationship services, Communities for Children], children and parenting

services [intensive family support services, child support advocacy], youth services and adult specialist services).

The broad range of programmes and services with promising and innovative practices provided by the family sector are funded through the DSS Families and Communities Programme. The department has invested significant funds and effort into devising data gathering, reporting and outcomes evaluation measures for these activities.

DSS Families and Children Performance Framework (2014) has been devised with the aim of improving child, individual, family and community wellbeing, increasing economic engagement and developing cohesive community structures. Measurement and achievement of these aims occurs through the examination of long-term population level indicators, such as: reduction in rates of child abuse; improved school attendance; learning outcomes measured via the Australian Early Development Census (AEDC) and the National Assessment Programme Literacy and Numeracy (NAPLAN) scores; increased rates of employment and return to work; and increased community capacity. These outcomes are sought through the use of evidence-based practices, prevention and early intervention strategies, service integration and collaborations, and improved access to services for vulnerable and/or disadvantaged individuals and families.

Communities for Children is a place-based families and communities programme designed to address the Australian Government's commitment to delivering strong outcomes for Australian families through a focus on prevention and early intervention strategies. The programme is designed to ensure resources are invested strategically over time and supported by evidence-based practices in disadvantaged communities. Whole community approaches support and enhance early childhood development and wellbeing from birth to 12 years. The DSS data exchange (DEX: <https://dex.dss.gov.au/>) provides an electronic platform for data collection and family assessment (SCORE) that could be further expanded to enable a comprehensive public health assessment system.

The above examples demonstrate that DSS is already supporting organisations in the sector to adopt a public health approach to the implementation of universal and targeted programmes. We argue that there is scope to expand these activities to coordinate with other sectors to more comprehensively address Australia's priority health and social problems.

The Australian Institute of Family Studies

Expert Panel. The Expert Panel project was established in 2014 and brought together research, practice and evaluation experts from a range of backgrounds. The Expert Panel was designed to be accessible to DSS-funded services as a resource to support Family and Children (FaC) service providers with programme planning and evaluation advice. The Expert Panel have provided guidelines and an industry listing of evidence-based programmes that the panel recommends based on evaluation evidence and assessed suitability for use in the FaC sector (<https://apps.aifs.gov.au/cfca/guidebook/programs>). The Expert Panel has great potential to undertake and oversee a more systematic public health approach by the family sector and its contribution to prevention and early intervention strategies addressing the major health and social issues facing families.

Challenges to family and relationship services taking a prevention and early intervention approach

The sections above make clear that the family and relationship service sector offers considerable potential to play an expanded role in prevention and early intervention. In what follows we describe some of the challenges the sector currently faces in seeking to contribute to prevention and early intervention.

- ▶ *Workforce capacity challenges:* Cortis, Chan and Hilferty (2009) overviewed workforce challenges within the sector. Their report noted that workforce issues were inadequately quantified but included: low remuneration; difficulties recruiting and retaining qualified practitioners; and poorly defined career paths, with problems more pronounced in rural and regional areas. Often, rural and socioeconomically disadvantaged areas are not as well serviced as urban and wealthier areas and also find it hard to attract, retain, reward and offer continuing professional development to highly qualified staff. These problems are exacerbated in places where there are high levels of socioeconomic disadvantage, service gaps and ineffective school management and teaching practices (Hemphill & Smith, 2010).
- ▶ *Service system challenges:* Family and relationship services face the problem that state-funded services are fragmented and poorly coordinated with federally-funded services, and are poorly matched to the family life cycle at a community level (Fox et

al., 2015). As one example, typically child and maternal health services (e.g., infant welfare services) have assessment contact with more than 80% of families within a given locality. However, mechanisms and systems are not established to transfer and communicate assessment information (Schmied et al., 2015). Hence, families in need are unlikely to benefit from ongoing contact with the same professionals they initially engage with for health assessments, and services are not forewarned when families make predictable future life cycle transitions.

- ▶ *Service funding silos:* Although it is possible for communities to operate highly-integrated service systems, currently Australian services tend to operate within distinct funding silos. As one example, Hamilton (2015) observed that alcohol and drug treatment services in Australia tend not to establish whether their clients are parents to avoid the potential for conflicts that may arise due to mandatory reporting and child protection interventions. This is an important gap in service integration given that at least 10 per cent of children in Australia 'live in households where there is parental alcohol abuse or dependence and/or substance dependence' (Dawe, Frye, Best, Moss & Atkinson, 2006, p. vii).
- ▶ *Uncoordinated data collection:* Given that many priority health and social problems can be prevented by modifying common risk and protective factors, service coordination could be greatly improved by using common risk screening and assessment systems to measure the prevalence of problems and their common risk and protective factors. The use of sector-wide assessment systems would encourage improved screening and referral protocols, further clarifying service coordination. Currently, the role of family and relationship services in prevention and early intervention is hampered in Australia by important gaps in data systems (Schmied et al., 2015). Schmied et al. (2015) surveyed 161 professionals across Australia regarding the organisation of child and family health services. Participants noted a lack of coordinated data systems limiting the potential for planning and evaluation. An integrated cross-sectoral public health approach to families with good intake data gathering and sharing mechanisms could overcome this problem. Data gathered through common frameworks and tools could be integrated into existing databases such as DEX.

- ▶ *Demands for tertiary services that are each separately funded:* Family and relationship services may find it difficult to prioritise prevention and early intervention services, given that severe family problems represent an increasing area of demand for family-based services in Australia (Fox et al., 2015). For one example, the number of children in state care and families involved with child protection services doubled in Australia over the decade to 2012–13 (AIHW, 2014a; AIHW, 2014b). However, local integration strategies to share research and practice information and advocate for the needs of families in this situation are emerging (Cocks, 2014).

If family and relationship services are to play a more prominent role in prevention and early intervention services, service users will need to be better informed of the benefits they offer at the point of service intake. Common intake screening and assessment techniques would enable service users to receive more accurate advice as to what type and how much service would be optimal. It is important that screening and assessment systems are appropriate to the family context. For one example, Ryan et al., (2015) found in a systematic review that family factors associated with accessing services for a young person with mental health needs included: parental burden, parent problem perception, parent perception of need, parent mental health, single-parent household, and change in family structure.

In 2015, ARACY (Fox et al., 2015) conducted a review of research and practice relevant to prevention and early intervention in order to synthesise the factors that promote positive child development and to identify effective prevention and early intervention programmes. This review noted the characteristics of an effective system which included: being responsive and considerate of cultures; structures and processes that produce service responses tailored to the needs and circumstances of families and communities; systems underpinned by robust accountability and governance mechanisms that enable adaptation and problem-solving; and an explicit focus on delivering interventions that are grounded in evidence (Fox et al., 2015).

Investigations for this report identified that the sector is increasingly funded to address family crisis problems and that this has shaped the culture of the family and relationship service sector.

A different mix of funding must be strategically provided if the sector's capacity is realised to work in a coordinated public health approach to deliver universal and targeted programmes with other professionals and organisations addressing Australia's priority health and social problems.

DISCUSSION AND RECOMMENDATIONS

The findings of this report indicate that while there is much potential for the family sector to contribute to a public health approach incorporating universal and targeted prevention and early intervention strategies to address major health and social problems, this potential is currently not fully realised. Considerable effort and funds have been expended in the sector in moves toward implementing evidence-based programmes, promising practices and to evaluate the impact of these activities. There are currently many examples of universal and targeted approaches within services, within the sector and within cross-sectoral coalitions formed around addressing specific community concerns.

However, the move towards a fully realised public health approach would be a significant innovation in the sector, requiring further investment in planning and sector capacity building. It would require a much more systematic, integrated and coordinated approach to include the family sector in a public health approach designed as a concerted system-wide effort to reduce the priority health and social problems in Australia. To realise the public health potential of the sector, the development of a national action plan is required, detailing how the family and relationship sector can contribute to the prevention and early intervention of priority health and social problems (e.g. Commonwealth Department of Health and Aged Care, 2000).

Such a plan would address the workforce, fragmentation and coordination challenges in the sector (including funding silo challenges) and better align services to the family life cycle at a community level. A useful initial step in such a systematic approach to prevention and early intervention would be the development of a framework and tools for a common intake measure providing valid indicators of health and social problems and the modifiable risk and protective factors that influence their development. This data gathering and assessment of the risk and protective factors impacting on clients would not only ensure that at the service level the needs of individuals and families are addressed (intensity of dose and wraparound of interventions) but would also drive family and relationship services to coordinate with other organisations in coalitions with community, health and education services. It would support a public health approach to universal and targeted programmes by assisting services to better direct clients to appropriate and timely services early in the family life course or early in the development of a problem (drummond street services and Stepfamilies Australia, 2016).

This report outlines demonstrable economic returns of family-based and relationship services and good evidence for their potential to prevent and reduce high-priority health and social problems. Important components of antisocial behaviour (including family violence), substance abuse, mental health

problems and education failure can all be prevented through family and relationship-based interventions. Relevant programmes can either be run with public subsidy or, in some cases, at an immediate profit (based on consumer ability to pay). The economic evidence summarised in this report reveals a number of Australian programmes are estimated to achieve longer-term returns above \$3 in prevention savings for every \$1 invested. Evidence-based programmes that apply both universal prevention strategies (targeting the whole community) as well as programmes deliberately targeting disadvantaged (vulnerable) populations are available to the sector. Although initially costly to run, a number of services specifically targeting the needs of disadvantaged populations have prevention returns above \$7 for every \$1 spent. By investing wisely in disadvantaged populations, this report makes clear that it is possible to reduce risk processes and strengthen protective factors that can lead to long-term consequences in multiple health and social problems that currently impose large burdens.

An action plan could identify the ways these evidence-based programmes could be selected and implemented by local family and relationship services to contribute solutions to the specific health and social problems that are elevated in each location. An action plan would identify key areas for further investment in family-based, evidence-informed programmes addressing health and social issues. This would build on the existing investment by DSS Families and Children in capacity building of the sector, including the work of the DSS Families and Children Expert Panel.

Service models, programmes, strategies and promising practices considered relevant to prevention investment were organised in this report according to the major transition points in the family life course that they target (e.g. pregnancy, the school years, family transitions: please see Table 3). The opportunities for services to respond were examined in the context of limitations posed by: community service fragmentation; systems not designed to coordinate services across different life stages; and demands for tertiary service crisis and emergency responses. Family-based interventions were examined based on categories that are familiar to Australian service providers, including: family-based/relationship counselling; parenting support and psycho-education (ranging from one-off seminars, group work, home visits, Children's Contact Services); alternative dispute resolution; and assertive engagement/social connection activities (including playgroups,

supported playgroups, Communities for Children activities). Specific needs and roles for universal and targeted programmes within these service types could be identified in an action plan.

This report identified a range of strengths and system enablers within the family and relationship services sector that provide opportunities for scaling-up prevention and early intervention services in Australia that would form the basis for further action. An action plan would address important challenges that define the context for efforts to enhance the role of family and relationship services in early intervention and prevention in Australia. Based on the above synthesis, the following recommendations were developed to increase family-based prevention and early intervention services in Australia.

RECOMMENDATION 1

Develop an action plan to coordinate expansion of the family and relationship sector work in prevention and early intervention.

It is recommended that DSS, in partnership with FRSA and other government and non-government stakeholders, develop an action plan for a coordinated approach within the family and relationship services sector, as well as to work in partnerships with other sectors to reduce the eight high-priority health and social problems detailed in this report. An action plan would integrate evidence in policy, service design and delivery and encourage a mixture of universal and targeted service delivery. Similar action plans have been developed in Australia with relevance to: violence prevention (National Council to Reduce Violence against Women and their Children, 2009); crime prevention (National Crime Prevention, 1999); and mental health promotion (Commonwealth Department of Health and Aged Care, 2000). A part of the plan could be to increase awareness across sectors of public health and common risk and protective factors, and the need to invest in effective, coordinated and holistic prevention and early intervention approaches.

This report shows strong evidence that costly high-priority health and social problems in Australia can be prevented through coordinated investment in family and relationship-based prevention and early intervention services. This report also shows that the Australian family and relationship services sector has many strengths that could be further developed to ensure an effective role in family-based prevention and early intervention.

This report identified the current funding arrangements for family and relationship services to be an important factor that limits the sector's capacity to work within universal prevention and early intervention approaches (AIHW, 2014a; Fox et al., 2015). The existing policy investment is far more slanted to disadvantaged populations, single issues and crisis responses.

As outlined in the present report, there are many examples of place-based programmes that are working collaboratively with other sectors in efforts to improve child outcomes. Government is currently seeking to invest in prevention and early intervention through its national initiatives, such as the National Framework for Protecting Australia's Children

2009–2020 (DSS, 2009) and the National Plan to Reduce Violence against Women and their Children 2010–2022 (DSS, 2010).

This report recognises that investment and co-ordination of integrated, evidence-based interventions, delivered through the existing national footprint of families and community services, has great potential to be both cost effective and efficient. A national action plan to expand the family and relationship services sector work in prevention and early intervention could inform changes in funding arrangements that could increase the family and relationship service sector capacity to improve integration across service systems that are currently highly siloed. Currently, tertiary services such as mental health, child protection, substance abuse and corrections typically operate within separate funding silos. We argue that many of these priority health and social problems have common foundations in the development of children, families and relationships. Hence, a coordinated action plan to increase the delivery of prevention and early intervention services within a public health approach would be of strategic value in addressing Australia's priority health and social problems.

There is an opportunity for a broad, whole-of-government actuarial investment approach using the family and relationship sector to trial joined-up government funding (under DSS leadership) in a sector that has a national platform for delivery to further achieve prevention and early intervention outcomes. A national action plan would draw together work relevant to prevention for a range of issues that have their origins largely in families and relationships, including: alcohol and drugs; crime and family violence; mental health; health; school failure; and child abuse and neglect. Prevention funding from these initiatives could be drawn together in an integrated prevention and early intervention trial to reduce common risk and protective factors supported by evidence-based interventions. Work of this type could be embedded within a national effort to develop common intake screening and assessment tools that would coordinate outcome measurement frameworks and evaluation systems over time. The recommendations below are actions that can be adopted in implementing Recommendation 1.



RECOMMENDATION 2

Develop a comprehensive framework and tools for family intake screening and assessment across the eight priority health and social problems and their risk and protective factors.

It is recommended that the existing accountability and governance mechanisms provided through the DSS Families and Children Performance Framework be further developed by designing and piloting a comprehensive intake screening and assessment framework and tools that includes valid measures of the eight priority health and social problems identified in this report and their modifiable risk and protective factors. This recommendation could be optimally achieved by DSS funding.

Most family and relationship service organisations have intake processes that could be broadened. A common intake screening and assessment framework and tools would seek to demonstrate that services are identifying families at risk of developing, or that have early signs and symptoms for, key health and social problems across the family life course. An agreed screening and assessment framework would enable practices that do not currently have enough evidence to be included on evidence-based service lists such as Table 3 (e.g. playgroups) to also participate in outcome evaluations to examine impacts on priority health and social problems and associated risk and protective factors.

A common intake screening and assessment framework and tools relevant to the prevention of high-priority health and social problems would prove valuable for monitoring prevalence when clients first contact services, would assist service evaluation, and could also be used in client screening and assessment.

Efforts to design a common intake screening and assessment framework and tools should be developed by: auditing currently used tools; modifying current instruments aligned with the DSS Families and Children Performance Framework; and by seeking to demonstrate that services are addressing prevention targets in key life transitions. The DSS Families and Children Performance Framework currently lists examples of performance indicators that include: children meeting their developmental milestones; reduction in adult problems of mental health; and violence. The DSS Families and Children Performance Framework service quality outcomes of 'increased

service integration and collaboration' are likely to be facilitated by the family and relationship sector more explicitly measuring indicators related to: alcohol and drug use; overweight and obesity; physical health problems; and participation in education.

In emphasising the existing evidence-based programmes in Table 2, it is important not to undermine innovation in promising services such as playgroups (Commerford & Robinson, 2016). Although there has not been time to complete long-term randomised trials of innovative programmes of this type, theoretical family drivers of healthy child development suggest that attachment and play are important contributors for healthy brain development and creativity in children (Commerford & Robinson, 2016). An agreed assessment framework, when combined with client follow-up, would enable innovative programmes such as playgroups to participate in service evaluation by demonstrating impacts on significant risk and protective factors.

Engagement remains a critical focus for family and relationship services in Australia and with increasing demands for family crisis responses (AIHW, 2014a; AIHW, 2014b; Fox et al., 2015), many family-based and relationship services are left with limited resources to deliver the strategic therapeutic interventions required for effective early intervention and prevention. Improving the assessment of client needs at service intake provides a potential means of matching available funding and service quantities to provide a rational basis for fitting the amount of service required to the level of client needs.

In pursuing Recommendation 2, efforts should be made to assess service contributions to increasing social trust and cohesion across the whole population and in vulnerable populations (Clancy et al., 2016). Recommendation 4 discusses in more detail the potential to offer services in coordination with volunteers that encourage social trust and community cohesion.

RECOMMENDATION 3

Trial the common intake screening and assessment framework and tools developed under Recommendation 2 to better target family-based services.

Once agreed protocols for an intake screening and assessment framework and tools are developed (Recommendation 2) it is important to trial them to evaluate their potential to encourage targeted and integrated prevention and early intervention at both the individual service and at a whole-of-community level. Trials of this type would have a two-fold focus. Firstly, trialling common intake and assessment systems within specific services offers the potential to evaluate their capacity to improve intervention choices for families, by flagging preventative and early intervention options. Secondly, trialling common intake and assessment systems offers the potential to evaluate their contribution to better integrating community service efforts to reduce the overall priority health and social problems within a specific community.

At the service level, common intake and assessment systems offer family and relationship services increased capacity to uniformly identify risk and protective factors for each family at the point of intake. This will improve the identification of families in greatest need (through more fine-grained assessment of risk processes), increasing the ability to match clients to evidence-based interventions that address the breadth of their needs, including the need for supportive referral to other community supports. Through service level data, DSS via DEX would garner significant consistent population service user and intervention data and have the capacity to consistently measure client level outcomes in addressing risk and protective processes. In this way, progress could be monitored towards reducing the significant priority health and social problems impacting Australian families.

At a community level, a trial of common intake and assessment systems would enhance the capacity of family and relationship service sector agencies to provide the back bone support to coordinate collective impact efforts (Clancy et al., 2016) to lead service system improvements in advancing prevention and early intervention services across diverse agencies. A collective impact approach guided by common assessment would mobilise the efforts of diverse agencies towards establishing a community profile of risk and protective factors that would then integrate the collective efforts of a diverse range of services within a specific community.

We recommend that collective impact partnerships complete community needs assessments similar to those used in the Communities That Care process (Hawkins et al., 2008) to agree on priority health and social problems and risk and protective factors to be addressed in a specified community. The community profile would then drive the selection of interventions and community service collective efforts to reduce the identified health and social problems for that particular community.

The delivery of evidence-based universal and targeted early intervention services would then be increased by the partners within a planned strategy to prevent the priority health and social problems.

It is important to make the point that the common intake and assessment framework outlined in this report would not simply focus on identifying late-stage problems such as alcohol disorders and criminal violence. While not ignoring these issues, prevention theories call for additional assessment of indicators of the risk process that lead to these problems in areas such as early age alcohol use and exposure to family conflict. Screening and assessment systems are currently used to determine service levels in some Australian family programmes and these systems have been demonstrated as an effective strategy for localities to use to reduce problems such as child injury. It has also been found that health and other services are able to use alcohol screener questions at intake to target effective brief behaviour change interventions to reduce pathways to alcohol problems for adolescents and young adults (Tanner-Smith & Lipsey, 2015).

Following a trial in selected sites, successful intake screening and assessment frameworks and tools could be applied more widely as an aid to coordinating appropriate service system responses: intake into an existing internal programme; referral to an external service; and support coordinated collective community strategies to address specific prevention targets (e.g. agency-specific and/or community-based: tobacco, alcohol and other drug use prevention; family violence prevention; healthy eating and physical activity promotion). A service and community level trial would provide an appropriate evaluation design for assessing population-wide health and social benefits of the common intake screening and assessment framework.



RECOMMENDATION 4

Provide capacity building funding for the implementation and evaluation of family-based prevention and early intervention programmes within agencies and community partnerships.

It is recommended that funding and support be allocated for organisational capacity building to select, develop, deliver and evaluate evidence-based prevention and early intervention programmes. Support and evaluation funding should also be provided for collaborative research projects to undertake prevention and early intervention programmes across agency partnerships and to evaluate the effectiveness of programmes and collectively delivered strategies.

In pursuing Recommendation 4, FRSA are encouraged to work with member agencies and relevant institutions to develop a community-based model for enhancing the workforce conditions and training and professional development for family-based service staff and volunteers. Many family-based service staff operate on short-term and part-time contracts that have limited opportunities for professional advancement and development (Cortis et al., 2009). This context makes it difficult for staff to stay up-to-date with developments in evidence and practice or to continue the long-term client relationships required for prevention.

Capacity building may involve agencies and staff receiving support to develop skills and expertise in existing evidence-based prevention and early intervention programs. Alternatively, capacity building may involve the development of research partnerships to assist agencies and staff to develop skills and resources to evaluate program models.

Many family-based services work in close alignment with health services, schools and the broader community that bring opportunities to coordinate with staff from other sectors and volunteers. Volunteer training offers the potential to coordinate inter-agency relationships while encouraging social capital, community cohesion and trust (Clancy et al., 2016). In pursuing Recommendation 2, efforts should be made to assess service contributions to increasing social trust and cohesion across the whole population and in vulnerable populations. By

training volunteers to implement evidence-based relationship services, a locality partnership could plan targets such as increases in social support (e.g. Clancy et al., 2016).

Implementing the four recommendations will see the family and relationship sector better placed to take a coordinated and holistic public health approach to implementing prevention and early intervention service delivery. The recommendations and their rationale backgrounded throughout this report provide the opportunity for our sector to engage in robust discussion with one another, across sectors and with government toward taking the most efficient and effective approaches to ensuring long-term and far-reaching developmental and wellbeing outcomes for Australian children, families and communities into the future.

References

- Allen, K. (2013). *Value for everyone: Understanding the social and economic benefits of family support services*. Canberra, ACT: Family Relationship Services Australia.
- Antcliff, G., Daniel, B., Burgess, C., & Sale, A. (2011). *Resilience Practice Framework*. New South Wales: Benevolent Society.
- Arney, F., & Scott, D. (Eds.). (2013). *Working with Vulnerable Families: A partnership approach* (2nd edition). Cambridge, UK: Cambridge University Press.
- Arthur, M. W., Hawkins, J. D., Pollard, J. A., Catalano, R. F., & Baglioni, A. J. Jr. (2002). Measuring risk and protective factors for substance use, delinquency, and other adolescent problem behaviors: The Communities That Care Youth Survey. *Evaluation Review*, 26, 575–601.
- Australian Institute of Criminology (AIC). (2015). *Costs of crime*. Retrieved from www.aic.gov.au/crime_community/communitycrime/costs.html.
- Australian Institute of Family Studies. (2016). *Communities for children facilitating partners evidence-based programme profiles*. Canberra, ACT: AIHW. Retrieved from <https://apps.aifs.gov.au/cfca/guidebook/programs>.
- Australian Institute of Health and Welfare (AIHW). (2014a). *Mapping of children and youth indicator reporting frameworks*. CWS 48. Canberra, ACT: AIHW.
- Australian Institute of Health and Welfare (AIHW). (2014b). *Child protection Australia 2012–13*. Child welfare series 58. Cat. no. CWS 49. Canberra, ACT: AIHW.
- Australian Institute of Health and Welfare (AIHW). (2017). *Expenditure on mental health services*. Canberra, ACT: AIHW. Retrieved from <https://mhsa.aihw.gov.au/resources/expenditure/>.
- Australian National Preventative Health Agency. (2011). *Strategic Plan 2011–2015*. Canberra, ACT: Australian Government.
- Bumbarger, B. K., & Campbell, E. M. (2012). A State Agency–University partnership for translational research and the dissemination of evidence-based prevention and intervention. *Administration. Administrative Policy and Mental Health*, 39, 268–277. doi: 10.1007/s10488-011-0372-x
- Catalano, R. F., Fagan, A. A., Gavin, L. E., Greenberg, M. T., Irwin, C. E. Jr., Ross, D. A., & Shek, D. T. (2012). Worldwide application of prevention science in adolescent health. *Lancet*, 379, 1653–1664.
- Catalano, R. F., & Hawkins, J. D. (1996). The social development model: A theory of antisocial behaviour. In J. D. Hawkins (Ed.), *Delinquency and crime: Current theories* (pp. 149–197). New York, NY: Cambridge University Press.
- Center on the Developing Child. (2010). *The foundations of lifelong health Are built in early childhood*. Center on the Developing Child, Harvard University. Retrieved from www.developingchild.harvard.edu.
- Clancy, E., Marshall, B., Toumbourou, J. W., Devenish, B., Day, A., Satyen, L., Leung, R., & Bauld, C. (2016). *Aligning effort integration and coordination—Preventing and responding to violence and promoting social inclusion and community connection: A research project for the Eastern Metropolitan Social Issues Council*. Geelong, Vic.: Deakin University.
- Cocks, J. (2014). *Building better relationships: Outcomes of the Family Inclusion Practice Forum*. Family Inclusion Strategy Hunter. Retrieved from www.lwb.org.au/assets/Uploads/Building-Better-Relationships-2014.pdf.
- Colagiuri, S., Lee, C., Colagiuri, R., Magliano, D., Shaw, J., Zimmet, P., & Caterson, I. (2010). The cost of overweight and obesity in Australia. *The Medical Journal of Australia*, 192(5), 260–264. Retrieved from www.mja.com.au/journal/2010/192/5/cost-overweight-and-obesity-australia.
- Collins, D., & Lapsley, H. (2008). *The costs of tobacco, alcohol and illicit drug abuse to Australian society in 2004/05*. Commonwealth of Australia. Retrieved from: [www.health.gov.au/internet/drugstrategy/publishing.nsf/content/34F55AF632F67B70CA2573F60005D42B/\\$File/mono64.pdf](http://www.health.gov.au/internet/drugstrategy/publishing.nsf/content/34F55AF632F67B70CA2573F60005D42B/$File/mono64.pdf).
- Commerford, J., & Robinson, E. (2016). *Supported playgroups for parents and children: The evidence for their benefits (CFCA Paper No. 40)*. Melbourne, Vic.: Child Family Community Australia information exchange, Australian Institute of Family Studies. Retrieved from <https://aifs.gov.au/cfca/publications/supported-playgroups-parents-and-children>.
- Commonwealth Department of Health and Aged Care. (2000). *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health*. Canberra, ACT: Commonwealth Department of Health and Aged Care.
- Cortis, N., Chan, S., & Hilferty, F. (2009). Workforce issues across the family relationship services sector: Models, responses and strategies. *Australian Family Relationships Clearinghouse, Issues No. 5*. Melbourne, Vic.: Australian Institute of Family Studies. Retrieved from <https://aifs.gov.au/cfca/publications/workforce-issues-across-family-relationship-services-sec>.
- Costa, B. M., Kaestle, C. E., Walker, A., Curtis, A., Day, A., Toumbourou, J. W., & Miller, P. (2015). Longitudinal predictors of domestic violence perpetration and victimization: A systematic review. *Aggression and violent behavior*, 24, 261–272.
- Dawe, S., Frye, S., Best, D., Moss, D., & Atkinson, J. (2006). *Drug use in the family: impacts and implications for children*. Canberra, ACT: Australian National Council on Drugs.
- DeFrain, J., & Asay, S. M. (2007). Epilogue: A strengths-based conceptual framework for understanding families world-wide. *Marriage & Family Review*, 41(3–4), 447–466.
- Department of Family and Community Services. (2000). *National Homelessness Strategy: A discussion paper*. Retrieved from http://homelesshub.ca/sites/default/files/national_homelessness_strategy.pdf.
- Department of Health. (2015). *National suicide prevention strategy*. Retrieved from www.health.gov.au/internet/main/publishing.nsf/content/mental-nsp.
- Department of Social Services (DSS). (2009). *Protecting Children is Everyone's Business: National Framework for Protecting Australia's Children 2009–2020*. An initiative of the Council of Australian Governments. Canberra, ACT: Commonwealth of Australia. Retrieved from www.dss.gov.au/sites/default/files/documents/child_protection_framework.pdf.
- Department of Social Services (DSS). (2010). *National Plan to Reduce Violence against Women and their Children 2010–2022*. An initiative of the Council of Australian Governments. Canberra: Commonwealth of Australia. Retrieved from www.dss.gov.au/sites/default/files/documents/08_2014/national_plan1.pdf.

- Department of Social Services (DSS). (2014). *Families and Children Performance Framework*. Canberra, ACT: Department of Social Services. Retrieved from www.dss.gov.au/our-responsibilities/families-and-children/programs-services/family-support-program/families-and-children-performance-framework.
- Department of Social Service (DSS). (2016). *National plan to reduce violence against women and their children: Third Action Plan 2016–19*. Canberra, ACT: Commonwealth of Australia. Retrieved from www.dss.gov.au/sites/default/files/documents/10_2016/third_action_plan.pdf.
- drummond street services and Stepfamilies Australia. (2016). *Service intake assessment protocol*. Carlton, Vic.: drummond street services and Stepfamilies Australia.
- Farrington, D. P. (2003). Developmental and life-course criminology: Key theoretical and empirical issues—the 2002 Sutherland Award Address. *Criminology*, 41(2), 221–225.
- Fletcher, R., May, C., Wroe, J., Hall, P., Cooke, D., ... Rawlinson C. (2016). Development of a set of mobile phone text messages designed for new fathers, *Journal of Reproductive and Infant Psychology*, 34(5), 525–534 doi: 10.1080/02646838.2016.1214250
- Foley, D., Goldfeld, S., McLoughlin, J., Nagorcka, J., Oberklaid, F., & Wake, M. (2000). *A review of the early childhood literature*. Prepared for the Department of Family and Community Services by the Centre for Community Child Health.
- Fox, S., Southwell, A., Stafford, N., Goodhue, R., Jackson, D., & Smith, C. (2015). *Better systems, better chances: A review of research and practice for prevention and early intervention*. Canberra, ACT: Australian Research Alliance for Children and Youth (ARACY).
- Hamilton, M. (2015). Reflecting on the interface between alcohol and other drug use, parenting and the outcomes for children in the modern state. *Drug and Alcohol Review*, 34, 1–3. doi: 10.1111/dar.12245
- Hawkins, J. D., Brown, E. C., Oesterle, S., Arthur, M. W., Abbott, R. D., & Catalano, R. F. (2008). Early effects of Communities That Care on targeted risks and initiation of delinquent behavior and substance use. *Journal of Adolescent Health*, 43(1), 15–22.
- Hawkins, M. T., Villagonzalo, K., Sanson, A. V., Toumbourou, J. W., Letcher, P., & Olsson, C. (2012). Associations between positive development in late adolescence and social, health, and behavioral outcomes in young adulthood. *Journal of Adult Development*, 19(2), 88–99.
- Hayes, S. L., Mann, M. K., Morgan, F. M., Kelly, M. J., & Weightman, A. L. (2012). *Collaboration between local health and local government agencies for health improvement*. Cochrane Database of Systematic Reviews 2012, Issue 10. Art. No.: CD007825. doi: 10.1002/14651858.CD007825.pub6
- Heerde, J. A., Toumbourou, J. W., Hemphill, S. A., & Olsson, C. A. (2015). Longitudinal prediction of mid-adolescent psychosocial outcomes from early adolescent family help-seeking and family support. *Journal of Research on Adolescence*, 25(2), 310–327.
- Hemphill, S. A. & Smith, R. (2010). *Preventing youth violence: What does and doesn't work and why? An overview of the evidence on approaches and programs*. Canberra, ACT: Report prepared for the Australian Research Alliance for Children and Youth.
- Hemphill, S. A., Smith, R., Toumbourou, J. W., Herrenkohl, T. I., Catalano, R. F., McMorris, B. J. & Romaniuk, H. (2009). Modifiable determinants of youth violence in Australia and the United States: A longitudinal study. *Australia and New Zealand Journal of Criminology*, 42(3), 289–309.
- Higgins, D. & Katz, I. (2008). Enhancing service systems for protecting children: Promoting child well-being and child protection reform in Australia. *Family Matters*, 80, 43–50.
- Homel, R., Freiberg, K., & Branch, S. (2007). *Pathways to a better quality of life for children and families through smarter social systems*. The Brisbane Line, May, online journal of The Brisbane Institute. Retrieved from www.brisinst.org.au/resources/homel_ross_freiberg_kate_branch_sara_pathways.html.
- Homel, R., Freiberg, K., & Branch, K. (2015). Creating capacity to take developmental crime prevention to scale: A community based approach within a national framework. *Australian and New Zealand Journal of Criminology*, 48(3), 367–385.
- Jorm, T. (2014). Why hasn't the mental health of Australians improved? The need for a national prevention strategy. *Australian & New Zealand Journal of Psychiatry*, 48(9) 795–801. doi: 10.1177/0004867414546387
- Lee, S. (2016). *Benefit–Cost Results 2016*. Olympia, Washington State: Washington State Institute for Public Policy. Retrieved from www.wsipp.wa.gov/BenefitCost.
- Letcher, P., Smart, D., Sanson A.V., & Toumbourou, J. W. (2009). Psychosocial precursors and correlates of differing internalizing trajectories from 3 to 15 years. *Social Development*, 18(3), 618–646.
- Lewinsohn, P. M., Gotlib, I. H., Lewinsohn, P. M., Seeley, J. R., & Allen, N. B. (1998). Gender differences in anxiety disorders and anxiety symptoms in adolescents. *Journal of Abnormal Psychology*, 107(1), 109–117.
- Loxley, W., Toumbourou, J. W., Stockwell, T., Haines, B., Scott, K., Godfrey, C., Waters, E., Patton, G., Fordham, R., Gray, D., Marshall, J., Ryder, D., Siggers, S., Sanci, L., & Williams, J. (2004). *The prevention of substance use, risk and harm in Australia: A review of the evidence*. Canberra, ACT: Population Health Division, Australian Government Department of Health and Ageing. Retrieved from www.health.gov.au/internet/main/publishing.nsf/Content/health-pubhlth-publicat-document-mono_prevention-cnt.htm.
- Marmot, M. (2010). Fair society, healthy lives [Internet]. Strategic review of health inequalities in England post-2010. *The Marmot Review*. Retrieved from www.local.gov.uk/health/-/journal_content/56/10180/3510094/ARTICLE.
- Mathews, L. B., Moodie, M. M., Simmons, A. N., & Swinburn, B. A. (2010). *The process evaluation of It's Your Move!, an Australian adolescent community-based obesity prevention project*. BMC Public Health. doi:10.1186/1471-2458-10-448.
- McCambridge, J., McAlaney, J., & Rowe, R. (2011). Adult consequences of late adolescent alcohol consumption: A systematic review of cohort studies. *PLoS Medicine*, 8(2), e1000413.
- McIntosh, J. (2011a). DOOR 1: Parent self-report form. In: McIntosh, J. E., & Rafis, C. (2012). *The Family Law DOORS Handbook*. Canberra, ACT: Australian Government Attorney-General's Department.

- McIntosh, J. (2011b). DOOR 2: Practitioner Aide Memoire. In: McIntosh, J. E., & Ralfs, C. (2012). *The Family Law DOORS Handbook*. Canberra, ACT: Australian Government Attorney-General's Department.
- Middlebrooks, J. S., & Audage, N. C. (2008). *The effects of childhood stress on health across the lifespan*. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Retrieved from http://health-equity.pitt.edu/932/1/Childhood_Stress.pdf
- National Council to Reduce Violence against Women and their Children. (2009). *The cost of violence against women and their children*. Canberra, ACT: Report prepared by KPMG for Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA). Retrieved from www.dss.gov.au/sites/default/files/documents/05_2012/vawc_economic_report.pdf.
- National Crime Prevention. (1999). *Pathways to prevention: Developmental and early intervention approaches to crime in Australia*. Canberra, ACT: Commonwealth Attorney Generals Department. Retrieved from www.crimeprevention.gov.au/agd/www/Ncphome.nsf/Page/B78FEDFB9A1D980ACA256B14001A096E?OpenDocument.
- National Research Council and Institute of Medicine. (2009). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities*. Washington, DC: The National Academies Press. doi:10.17226/12480
- Organisation for Economic Co-operation and Development (OECD). (2016). *The future of families to 2030*. Location: OECD. Retrieved from www.oecd.org/futures/49093502.pdf.
- Pezzullo, L., Taylor, P., Mitchell, S., Pejovski, L., Le, K., & Bilgrami, A. (2010). *Positive family functioning*. Final report by Access Economics Pty Limited for Department of Families, Housing, Community Services and Indigenous Affairs.
- Robinson, E., Scott, D., Meredith, V., Nair, L. & Higgins, D. (2012). *Good and innovative practice in service delivery to vulnerable and disadvantaged families and children* (CFCA Paper No. 9). Melbourne, Vic.: Australian Institute of Family Studies.
- Ryan, S. M., Jorm, A. F., Toumbourou, J. W. and Lubman, D. I. (2015). Parent and family factors associated with service use by young people with mental health problems: a systematic review. *Early Intervention in Psychiatry*, 9, 433–446. doi: 10.1111/eip.12211
- Schmied, V., Homer, C., Fowler, C., Psaila, K., Barclay, L., Wilson, I., ... Kruske, S. (2015). Implementing a national approach to universal child and family health services in Australia: professionals' views of the challenges and opportunities. *Health & Social Care in the Community*, 23, 159–170. doi: 10.1111/hsc.12129
- Schwarzer, R., & Schulz, U. (2003). *Stressful life events. Handbook of psychology*. Wiley Online Library.
- Sheeber, L., Hops, H., Alpert, A., Davis, B., & Andrews, J. (1997). Family support and conflict: Prospective relations to adolescent depression. *Journal of Abnormal Child Psychology*, 25(4), 333–344.
- Shonkoff, J. P., Boyce, W. T., & McEwen, B. S. (2009). Neuroscience, molecular biology, and the childhood roots of health disparities: Building a new framework for health promotion and disease prevention. *JAMA*, 301(21), 2252–2259.
- Stice, E., Ragan, J., & Randall, P. (2004). Prospective relations between social support and depression: Differential direction of effects for parent and peer support? *Journal of Abnormal Psychology*, 113(1), 155–159.
- Stone, A. L., Becker, L. G., Huber, A. M., & Catalano, R. F. (2012). Review of risk and protective factors of substance use and problem use in emerging adulthood. *Addictive Behaviors*, 37(7), 747–75.
- Tanner-Smith, E. E., & Lipsey, M. W. (2015). Brief alcohol interventions for adolescents and young adults: A systematic review and meta-analysis. *Journal of Substance Abuse Treatment*, 51, 1–18.
- The Smith Family. (2016). *C4C Facilitating Partner Community Programs Fact Sheet*. Raymond Terrace, NSW: The Smith Family.
- Toumbourou, J. W. (2016). *Modifiable processes targeted in evidence-based parent, family and relationship interventions*. Prevention Science Consulting Group, Centre for Social and Early Emotional Development (SEED), School of Psychology, Deakin University and drummond street services for the Commonwealth Department of Social Security Expert Panel.
- Toumbourou, J. W., & Catalano, R. F. (2005). *Predicting developmentally harmful substance use*. In T. Stockwell, P. Gruenewald, J. W. Toumbourou, W. Loxley (Eds.), *Preventing harmful substance use: The evidence base for policy and practice* (pp. 53–66). London, UK: Wiley.
- Toumbourou, J. W., Evans-Whipp, T. J., Smith, R., Hemphill, S., Herrenkohl, T., & Catalano, R. F. (2014b). Adolescent predictors and environmental correlates of young adult alcohol use problems. *Addiction*, 109(3), 417–424.
- Toumbourou, J. W., Hemphill, S. A., Tresidder, J., Humphreys, C., Edwards, J., & Murray, D. (2007). Mental health promotion and socio-economic disadvantage: Lessons from substance abuse, violence and crime prevention and child health. *Australian Journal of Health Promotion*, 18(3), 184–190.
- Toumbourou, J. W., Olsson, C., Rowland, B., Renati, S., & Hallam, B. (2014a). Health psychology intervention in key social environments to promote adolescent health. *Australian Psychologist*, 49, 66–74.
- United Nations. (2008). *Millennium Development Goals*. New York, NY: United Nations.
- United Nations. (2015). *Sustainable Development Goals*. New York, NY: United Nations.
- Vassallo, S., Smart, D., Sanson, A., Dussuyer, I., McKendry, B., Toumbourou, J., Prior, M., & Oberklaid, F. (2002). *Patterns and precursors of adolescent antisocial behaviour (The first report)*. Melbourne, Vic.: Crime Prevention Victoria and Australian Institute of Family Studies.
- Vos, T., Carter, R., Barendregt, J., Mihalopoulos, C., Veerman, J. L., Magnus, A., Cobiac, L., Bertram, M. Y., Wallace, A. L., & ACE-Prevention Team. (2010). *Assessing cost-effectiveness in prevention (ACE-Prevention): Final report*. University of Queensland, Brisbane and Deakin University, Melbourne.
- Wills, T. A., & Vaughan, R. (1989). Social support and substance use in early adolescence. *Journal of Behavioral Medicine*, 12(4), 321–339.

Appendix: Expert advice on trend projections for health and social problems

Expert advice on projected trends for health and social problems that have relevance to family and relationship services in Australia was obtained from three sources. Firstly, a search was completed for key documents. Secondly, expert views were obtained from the research advisory group members of Family & Relationship Services Australia at a meeting on 11 April 2016. Those in attendance were: Dr Deborah Hartman (Assistant Director, Family Action Centre, the University of Newcastle), Dr Ricki Jeffery (Director, Centacare Central Queensland), Karen Field (CEO, drummond street services). Jackie Brady (Executive Director, FRSA) and Dr Adam Heaton (Senior Policy Officer, FRSA).

Thirdly, six experts were contacted and invited to comment from the following institutions: Adolescent Health Research, Murdoch Children's Research Institute; Australian Research Alliance for Children and Youth (ARACY); Centre for Social and Early Emotional Development, Deakin University; Family Research Centre, University of Queensland; Population Health Hunter New England Health; Save the Children; and Parenting Research Centre. The above expert panel were asked:

- ▶ What are the major health and social trends Australian family services should prepare for?
- ▶ Are you aware of forecast reports we should be examining?







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