

**A STUDY OF CRISIS INTERVENTION  
AND PLANNED FAMILY SUPPORT WITH  
VULNERABLE FAMILIES**



A National Homelessness Research Project

Karen Healy, December 2011

MICAH PROJECTS INC



Breaking Social Isolation  
Building Community



Australian Government

Department of Families, Housing,  
Community Services and Indigenous Affairs

# **A study of crisis intervention and planned family support with vulnerable families**

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Professor Karen Healy, University of Queensland, December 2011

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## 14.0 Executive summary

In this project we aimed to compare vulnerable families' experiences of, and outcomes associated with, two models of service delivery: crisis intervention and outreach planned family support services. Crisis intervention models are widely used in homelessness services, including some Micah Project services, to intervene in service user lives at a point of housing crisis and to develop a short-term, goal orientated response to housing and other needs (Healy, 2005). By contrast, the outreach planned family support approach is a service model that enables the support worker to work simultaneously on a range of family goals, some of which may not be directly related to housing crises.

In this study, we sought to understand:

- How, if at all, do the demographic characteristics, housing, income and employment experiences of the families using the two types of services differ?
- What goals do families in both sample groups hold for themselves in relation to housing, employment and various dimensions of quality of life, such as health and well-being, family and friendship relationships?
- What differences, if any, are observed in the reported service provision outcomes achieved by these families over a twelve month period?

The study was conducted over a 14 month period from October 2010 to November 2011. We collected three forms of data. These were:

- survey interviews with two groups of families, those who received crisis intervention services and those who received planned family support services. These families were recruited from three non-government service agencies: Micah Projects, Brisbane Youth Service, and Domestic Violence Resource Centre
- these families were interviewed three times over 14 months. The interviews focused on gathering data about the families' housing circumstances, employment, relationships, community connection, education and training and use of services such as early childhood, health and community services;
- focus groups with service providers from crisis intervention and planned family support services. The focus groups involved analysis of data collected in the interviews and on examining practitioners' views of similarities and differences in best practice with vulnerable families accessing crisis intervention and planned family support services; and
- case record reviews. At the outset of the project, we examined the case records at Micah Projects of the families participating in the project who were also clients of Micah Projects' services. Our focus was on analysis of the types of services provided and the time allocated to each type of service provision.

## **Characteristics of the family participants**

Initially, 43 families receiving crisis intervention services and 45 families receiving family support services were interviewed in phase one of data collection in October 2010-January 2011. In the initial phase, substantial differences in the two groups were noted. These differences included that compared to families receiving planned family support services, those receiving crisis intervention services were: older; had larger families; more likely to be homeless; and less likely to use early childhood services and less likely to have their school aged children currently enrolled in school. There was also a higher representation of Aboriginal and Torres Strait Islander people in the crisis intervention group. The differences between these two samples complicate any attempt to compare the outcomes of two models of service provision. In essence, families who use the two services are different and these differences, not only the models of service intervention, are likely to shape the outcomes achieved. It must be noted that some families may have received extensive periods of support prior to the first phase of interviews and this could impact on some of the differences between samples. In addition, the eligibility criteria of services may have accounted for some of the differences in family characteristics. For example, two out of three of the planned family support services were targeted at young families under 25.

In the second and third phases of the research project there was a high drop-out rate of participants from the crisis intervention sample. Indeed, the sample almost halved from 43 in phase one to 25 in phase 2 and then 22 in phase 3. Moreover, the respondents who dropped out were more likely to have larger families and to be in unstable housing when they were first surveyed than those who remained in the sample. The fact that respondents who left the study changed the characteristics of the crisis intervention sample limits our capacity to make any generalisations to the broader sample.

In summary, our examination of the demographic characteristics and living circumstances of both samples revealed:

- Most participants in the crisis intervention sample lacked access to affordable and adequate housing with the majority having moved home at least once in the previous six months. Almost a quarter of the original sample were in highly unstable forms of housing such as motels, 'couch surfing', and boarding with family or friends.
- Most participants in the planned family support sample had access to subsidised forms of housing particularly public housing and community housing.
- In both groups, only one quarter of respondents had completed secondary school to year 12.
- In both groups there was a high reliance on government benefits as the primary source of income.

- Participants in the planned family support group were much more likely than those in the crisis intervention sample to have enrolled their children under 6 years in early childhood services and continued involvement with planned family support services was associated with increased levels of enrolment in early childhood services. Indeed, by the final data collection phase, 27 of the children aged 5 years and under in the planned family support sample (representing 79.4% of that sample) were reported to be enrolled, by contrast only 3 of the 16 children in the crisis intervention sample (representing 18.8% of the sample) were reported to be enrolled.
- In the main, the majority of children and young people of school age in both samples were enrolled in school. However, in both groups, a substantial proportion (around 20%) had missed a day of school in the previous week. In the first round of data collection, we noted high levels of non-enrolment amongst school aged children and young people in the crisis intervention sample. This seemed to be related to the timing of data collection which occurred over the November-February period when one school year was ending and another beginning. Our study suggests that it is at the beginning and end of the school year that children and young people whose families are in unstable circumstances are most likely to miss out on educational opportunities.

### **Service provision types**

An examination of the types of services received by the families in both samples revealed:

- Participants in both samples had substantial and similar involvement with Centrelink services, mental health services and police services.
- Participants in the crisis intervention sample were more likely than those in the planned family support sample to report using alcohol and drug treatment programs, emergency relief, domestic violence and employment services.
- Participants in the planned family support sample were more likely than those using crisis intervention services to make use of family support services and medical services.
- Of the families using Micah Projects services, families involved with crisis intervention services were less likely than those receiving family support services to maintain involvement with these services. Our case record review of families using Micah Projects' services showed that two-thirds of those using crisis intervention services had not had contact with Micah Projects in the previous month. Where contact had occurred it was focused on housing issues.

- With only one exception, all families using planned family support services offered by Micah Projects had maintained contact with that service. The case record review revealed that a broad range of issues were addressed within the planned family support model including emotional/ personal support, child and family concerns, housing, employment and training issues.

### **Impact of the floods**

In January 2011 many parts of Southern Queensland were inundated by floods. In the second phase of data collection we asked participants if they had been affected by the floods and, if so, how had the floods impacted on the respondent and their family. Participants in the crisis intervention group were more likely than those in the planned family support group to report that they had been affected by the floods and that the impact had been severe and ongoing.

### **Outcomes reported by respondents**

Over the course of the project we noted improvements in the stability of the housing circumstances of respondents in the crisis intervention sample. In phase one of the study, 14 respondents indicated that their families were living in highly unstable forms of housing such as motel, crisis accommodation, and rent-free at family/ friends homes, by phase three only 3 respondents reported this was the case. However, it may be that this difference in housing circumstance may be associated with the high drop-out rate of families in the crisis intervention group.

On average, respondents in the planned family support sample reported that over the 14 month period they had experienced substantial improvements in their family relationships and their mental health. They attributed these improvements to improved communication skills and to better access to mental health services. Respondents in both groups who were in an intimate relationship reported substantial improvements in those relationships and this was attributed to reduced stress, such as housing stress, and also to improved communication. A minority of respondents in both samples reported improvement in their employment circumstances over the 14 months in which the study was conducted.

## 1.0 Introduction

In this study, we aim to compare families' and service providers' experiences and perceptions of two types of services: crisis intervention and family support services. Our objective is to build knowledge about the characteristics of these two groups of families, their pathways through service provision and the outcomes of service provision to these two groups. Overall, we seek to understand what works for improving outcomes for these vulnerable families. We envisage that the project will contribute to an evidence base for improving service provision to vulnerable children, young people and their parents.

### Study aims

Initially, our study had aimed to compare two models of service intervention, crisis intervention and outreach planned family support. It soon became apparent that this comparison was limited because, for various reasons, the groups using these services appeared to differ significantly. As these differences became increasingly apparent, we changed our study aims to examine the differences between the groups using these services as well as their experiences and outcomes in services received. In this study, we have sought to understand:

- How, if at all, do the demographic characteristics, housing, income and employment experiences of the two groups vary?
- What goals do families in both sample groups hold for themselves in relation to housing, employment and various dimensions of quality of life, such as health and well-being, family and friendship relationships and community connection?
- What differences, if any, are observed in the reported service provision outcomes achieved by these families over a twelve month period?

We have adopted a longitudinal approach in which we have interviewed vulnerable families over a 14 month period from October 2010 to November 2011. This longitudinal approach is important because, while the factors contributing to housing crises in the lives of vulnerable families are well understood, little is known about the impact of different models of service provision on key outcomes in the medium or long term for vulnerable families. In addition, we also undertook a review of case records of direct service work undertaken at Micah Projects with the families who participated in the study and we conducted three focus groups to gain workers' reflections on the nature of service provision to these two groups of service users.

The research project is intended to shed light on the nature and impact of two different models of service provision (crisis intervention and planned family support) on a range of housing and other outcomes for vulnerable families. The term "crisis intervention" is used to refer to a short-term, goal orientated approach to respond to housing or other immediate needs of families (Healy, 2005). The planned family support approach is a service model which provides structured support to families to support positive housing outcomes while also, simultaneously, addressing a range of other family goals that may (or may not) be directly related to improving housing stability.

## 2.0 Literature Review

### Extent of family homelessness

Increasingly, the Australian and International community is recognising the growing incidence of family homelessness. Over the past few decades the numbers of families experiencing homelessness has been growing, and is challenging traditional responses to homelessness which have focused on the needs of single adults (Commonwealth of Australia 2008, p.2; Building Changes 2011, p.5). Data from the Australian Institute of Health and Welfare (AIHW) reveals that in 2010-2011, 230,500 people accessed government-funded specialist homelessness services. Of these, 88,000 were children accompanying clients (AIHW 2011a, p.4). This has increased from just a few years ago, with data from 2008-2009 showing a total of 204,900 people accessing services, of whom 79,100 were accompanying children (AIHW 2010, p.9). This situation is particularly pressing for Indigenous families. Figures from Queensland show that just over 34% of accompanying children were Indigenous, well over-represented relative to their population size (AIHW 2011b, pp.1-5).

### System issues

Family homelessness presents a significant challenge to the homelessness service sector. In 2010-11, 640 families with 869 children who were homeless or at risk of homelessness accessed Micah Projects for support. This includes 244 children under 4 years. These high numbers are supported by national data. In 2009-10 the AIHW reported 1 in every 60 Australian children aged 0–17 years (84,100) and 1 in 38 young children aged 0–4 years (37,100) accompanied a client to a specialist homelessness service (AIHW 2011c, p.v). Evidence suggests that our current service system is ill-equipped to respond to family homelessness. Data from the AIHW reports that family groups with children had the highest rates of turn-away from homelessness services, representing 82% of couples with children and 67% of individuals with children (Mission Australia 2011, p.2). Lack of accommodation was the reason given for turn-away for 95% of cases for couples with children, and 91% of cases for individuals with children, in comparison to 81% for individuals without children and 64% for couples without children (AIHW 2011d, p.5). This data “indicates that individuals who present without children are more likely to obtain accommodation than those who present in family groups” (AIHW 2011d, p.5).

Black and Gronda (2011) cite international evidence that a key structural factor behind the experience of family homelessness is the lack of accessibility and availability of affordable housing. Furthermore, the homelessness service sector is not set up to cater adequately for the growing number of families. While families are able to access cross-target or generalist agencies, family specific services represented only 8.6% of funded agencies in Australia in 2008-09 (Black & Gronda 2011, p.35). Accommodation provided by crisis services is also frequently inadequate and unsuitable for families. Accommodation generally lacks cooking facilities; is overcrowded; highly unaffordable (particularly motel and rooming house

accommodation); short term; and unsafe for children (particularly in shared accommodation such as rooming houses) (Black & Gronda 2011, p.35).

Where services are provided to vulnerable families there exist a number of barriers to families accessing those services. The Centre for Community Child Health, located at the Royal Children's Hospital Melbourne, identifies a number of service level or structural barriers to families accessing support:

- lack of publicity about services
- cost of services
- limited availability
- failure to provide services that meet parents' felt needs
- inability of services to respond promptly to requests for help
- rigid eligibility criteria
- inaccessible locations
- lack of public transport
- limited hours of operation
- inflexible appointment systems
- lack of affordable childcare
- poor coordination between services
- the absence of an outreach capacity (Centre for Community Child Health 2010, p.2).

Overall, the current support system for vulnerable families can be confusing, complex and inadequately tailored to their needs and circumstances (Mission Australia 2011, p.4).

### **Factors related to the experience of homelessness**

Families experience homelessness for a range of different reasons, including both structural and personal. Families experiencing homelessness, or who are at risk of homelessness, often face a number of other challenges in their lives. These challenges are linked with the experience of homelessness in complex ways.

A key issue is domestic and family violence. Women with children presenting at specialist homelessness services in 2010-2011 gave interpersonal relationship issues as their main reason for seeking assistance, representing 61% of all support periods. Domestic and family violence in particular represented 45% of all support periods (AIHW 2011a, p.14). Domestic and family violence is the single largest driver of homelessness among women in Australia, and significantly impacts upon the lives of children within these families (Commonwealth of Australia 2008).

Families experiencing homelessness are also frequently struggling with a range of complex issues, including mental health problems, poor physical health, parental substance abuse, educational disruption, behavioural issues, and experience of intergenerational disadvantage (Mission Australia 2011, p.2).

Substance use is a problematic issue for vulnerable families. A longitudinal study undertaken by Hanover Welfare Services in Victoria of outcomes for families receiving housing support reported that one in four families identified substance abuse as a reason for their housing crisis (Hanover Welfare Services 2004, p.22). International research reveals that families where parents are engaging in problematic substance use are highly represented among families experiencing homelessness, and furthermore are at the highest risk for repeated episodes of homelessness (Tull 2004, p.1).

Mental health concerns are also a significant burden for vulnerable families. A 1996 assessment of mothers residing in Los Angeles homeless shelters found 72% reported high levels of current psychological distress or symptoms of lifetime major mental illness or substance abuse. Their children were also more likely to symptoms of emotional or behavioural disorders (Zima, Wells, Benjamin, Duan 1996, pp.336-337). Significantly, research demonstrates the extent to which homelessness is a cause of mental illness, due to the lack of appropriate and affordable accommodation, rather than traditional understandings of homelessness resulting from mental health problems (Norris, Thompson, Eardley, & Hoffmann 2005, p.11).

The traumatic impact of homelessness itself also cannot be neglected. For a family entering homelessness, grief and loss issues for both parents and children have a significant impact, as families lose their home, familiar environments, routines and relationships (Tischler, Edwards, Vostanis 2009, p.42). Following entry into homelessness, families' journeys within the homelessness service system are often protracted and characterised by extreme uncertainty and a profound lack of security and safety (Mission Australia 2011). Given this continued unstable and stressful environment, the provision of safe and long-term housing is crucial for the experience of trauma to be addressed adequately (Reynolds 2009).

## **Child wellbeing**

Homelessness and unstable housing can have a profound effect on children's physical and mental wellbeing and development. Children from these vulnerable families experience mental health disorders, difficulty with attachment, poor physical health, developmental delays, social exclusion, poor educational performance and attainment, and generally elevated feelings of stress and insecurity (Gibson & Johnstone 2009).

Keys (2009) outlines four categories of the effects of homelessness on children. These are health and wellbeing; family relationships; community connectedness; and, education.

*Health and Wellbeing:* Children who experience homelessness have lower levels of general physical health, with studies noting in particular poor dental health, asthma, skin problems, vision problems, and recurrent headaches. Nutrition is significant, with data from the United States revealing one in five do not receive enough to eat. Mental health is also severely impacted, with numerous studies revealing higher rates

of mental illness and elevated stress and anxiety, including higher rates of mental distress when compared to similarly poor yet housed children. Developmental progress and cognitive capacity can be impaired due to chronic stress and inadequate access to needed resources (Keys 2009, p.13).

*Family Relationships:* Parent-child relationships can be severely compromised by housing instability and homelessness. Attachment can be effected, and parents can feel unable to fulfil their parental role. Where parents are experiencing other issues such as mental illness, children can be forced to assume responsibility for caring for their parents, inverting the parent-child relationship (Keys 2009, p.14; Mission Australia 2011, p.3).

*Community Connectedness:* To participate in society and develop meaningful and enriching relationships, parents and children need stability and continued connections to places, people and institutions such as schools. Homelessness and insecure housing can prevent these valuable links from being made, leading to poor outcomes for the whole family (Keys 2009, p.15).

*Education:* Children's connections to education and their access to the resources needed to perform in school are impacted on by homelessness. An Australian study found that 15% of children had prolonged or continuous absences from school prior to, and/or during their stay in emergency accommodation and 60% had moved more than three times in the 12 months preceding the study, increasing their risk of educational disadvantage (Key 2009, p.16).

## **Child protection**

The links between homelessness and child protection are under-researched in Australia. However a 2006 review that drew on a number of studies estimated the rate of child protection involvement with families experiencing homelessness at around 20% - 50%. (Noble Carr 2006, p.45). Research from the United States also sheds light on this connection. A 2004 study from the US estimates that 24-26% of children who are homeless have spent time in foster care, a rate that is more than 34 times the national average. Similarly, studies have argued that as many as 30% of US children in foster care were removed from their families due to lack of housing (Corporation for Supportive Housing [CSH] 2011, p.4). Furthermore, there is evidence of a bi-directional relationship between homelessness and child protection involvement. Rates of childhood foster care involvement among adults experiencing homelessness have been estimated at between 10 to 38%. Mirroring these figures is the greater extent to which families experiencing homelessness enter the child protection system, with a 2002 U.S. study finding that homelessness was more strongly associated with removal of children than other factors such as substance misuse or mental illness. Homelessness is also arguably one of the greatest barriers to reunification, with one study suggesting 30% of children in US foster care would be reunified with their parents if housing was obtained (CSH 2011, p.5). Overall, the links between child protection services and homelessness is strong.

## **Responses to family homelessness**

Overall, as the numbers of families entering homelessness rise, national and international systems have struggled to respond to the distinct needs of this group. Traditional homelessness responses have focused on single adults, primarily males, and have been orientated towards reactive and temporary solutions enacted only after a person has fallen into homelessness (Building Changes 2011, p.5; Thomas 2007, pp.23-24).

This section will explore the two main service responses examined in this research project; namely that of crisis intervention and family support. This research report understands crisis intervention to be services that intervene in service user lives at a point of housing crisis and develop a short-term, goal orientated response to housing and other needs. In contrast, family support is understood to be a service model that enables the support worker to work simultaneously on a range of family goals, some of which may not be directly related to the housing crisis. More information is provided in the Methodology section. The following details national and international research around these two models of intervention.

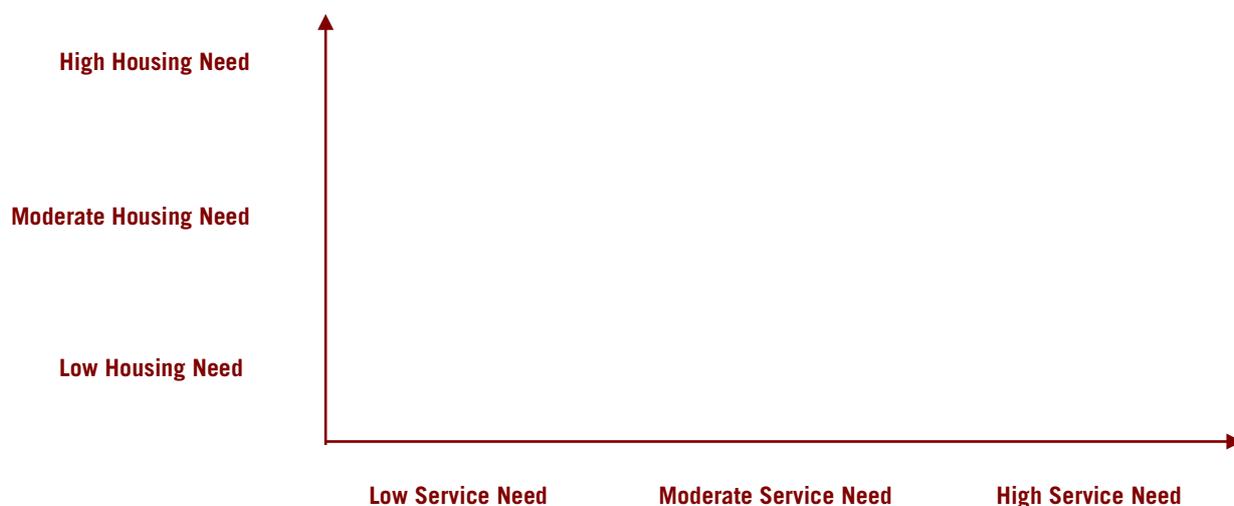
### **Crisis intervention**

Two crisis service models are early intervention and rapid re-housing models. The greatest utility of crisis intervention services is arguably obtained when they are used to prevent families from entering homelessness; as first response services that can link a family with more long-term supports, or when a family's needs are not complex or multiple, and stability can be achieved through a once-off service (Building Changes 2011, pp.31-36). Early intervention services aim to intervene before a family loses their home. This intervention can take a number of forms, but in terms of crisis intervention it often involves short-term interventions such as financial assistance; assistance in locating and moving to more affordable accommodation; or short-term advocacy with housing providers. It is often most effective when used with families who are in generally sustainable housing who have experienced a threat to their housing security, for example through illness, loss of work, or expense such as a large electricity bill (Kahn 2011).

Rapid re-housing is an intervention that focuses on providing swift exits out of homelessness. Prolonged time spent within the homelessness service system results in stress and trauma for families. By re-housing these families as swiftly as possible families are spared these consequences. Rapid re-housing aims to quickly re-establish a family within affordable housing as soon as possible after they lose their accommodation. Rapid re-housing by itself is arguably most effective with families who, prior to the recent housing crisis, were living relatively independently. Families with more complex issues impacting on their lives may require more long-term supports (Kahn 2011; Bill and Melinda Gates Foundation 2011).

Building Changes, a United States non-profit heavily involved in addressing family homelessness, advocates a flexible response to families needs based on the following two-axis framework:

**Figure 1:**



(Building Changes 2011, p.30).

Families may appear anywhere on this two-axis framework. A family, for example, may have low housing needs (e.g. a recent eviction notice for rent arrears); yet moderate service needs (e.g. the parent may have mental and physical health concerns). Based on this framework, services need to be tailored to the needs of families. Some families may only require the once-off response provided by a crisis intervention service (Building Changes 2011, pp.24-30). In addition, where a crisis intervention service assesses the needs of a family to be beyond their current capacity, referrals can be made for the family to a wider range of supports.

However, criticism has been made of crisis intervention services where linkages are not made to additional supports that may be required by the family. It is the recognition of these underlying issues within family's lives, which may not have directly contributed to the current housing crisis, which has led to the push for family support services within the homelessness sector (Building Changes 2011, p.5).

### **Family support**

The advantage of family support services is their ability to address these underlying issues. However, there are very limited family specific services within the specialist homelessness service sector, as of 2010 representing only 8.6% of Supported Accommodation Assistance Program (SAAP) funded agencies (Black & Gronda 2011, p.35). There are also significant gaps in research and literature around models of case management for families experiencing homelessness (Black & Gronda 2011, p.13). Nonetheless, there are a number of family support models that have demonstrated efficacy.

The HOME Advice program funds one community organisation and a Centrelink social worker in each state to provide information and support to families at risk of homelessness. Five components make up the program model, including early intervention; an holistic approach to interventions; strengths-based, family-centred practice; flexible brokerage and partnerships (MacKenzie, Desmond & Steen 2007, p.18). A 2007 evaluation of the program found that 86% of families either maintained their housing or improved their housing situation during their support period. Follow-up surveys conducted 6-12 months after exit found that 72% of families did not experience subsequent homelessness (MacKenzie *et al*, pp.46-47).

Another model was the Micah Projects Homeless to Home program, funded in 2006-07 as a family support demonstration project under the National Homelessness Strategy. The service provided support and advocacy to families who were homeless or at high risk of homelessness, with an emphasis on flexible, practical support and strong connections with housing providers. There were a number of positive outcomes for the 46 families who received support during the 12 month evaluation period. Overall, families increased their housing stability, with thirteen families maintaining their accommodation and seven families who were homeless at the point of referral to the project assisted to locate and sustain stable housing in public or private rental markets. Families also identified that the project had enabled them to better access and use a range of health, welfare and education systems (Healy & Gal 2007, pp.31-35).

Evidence has also come from the United States around the efficacy of combining housing and family support programs. A key example of supportive housing for families is the Sound Families initiative. This initiative provided funding to increase the numbers of supportive housing units available for families within Washington State. The funding was provided by the Bill and Melinda Gates Foundation. Along with housing, families were provided with intensive case management. Specialised services such as drug and alcohol treatment were accessed through referral. Many of the units were provided as transitional housing with a maximum stay of 2 years; however at exit families received support to obtain permanent housing (Northwest Institute for Children and Families 2007, p.1). A 2007 evaluation of the program found a number of positive outcomes for families. Eighty-nine per cent (89%) of those families who successfully completed the transitional housing program obtained permanent, stable housing at exit. Levels of employment of primary caregivers and school stability of children also improved (Northwest Institute for Children and Families 2007, pp.2-9).

A best practice family support model around homelessness that has emerged in recent years is that of permanent supportive housing under a Housing First framework. There are a number of permanent supportive housing organisations providing this service, particularly in the United States where the Housing First framework was first developed. Each organisation may provide this service in different ways, yet generally permanent supportive housing incorporates the following characteristics:

- Tenants pay no more than 30% of household income towards rent and utilities
- No limits on length of tenancy
- No obligations on part of tenants to participate in support services. Only required to keep to the provisions of a standard lease agreement
- All members of the family have facilitated access to flexible and comprehensive support services specifically tailored to their needs
- Property management strategies include approaches to addressing concerns resulting from issues such as substance use and mental health crises, with the focus on maintaining the tenancy (Corporation for Supportive Housing 2011, pp.10-11).

While permanent supportive housing is a relatively new approach for families, research is demonstrating its efficacy with vulnerable families. A 2006 analysis of outcomes for two permanent supportive housing projects in California, where support services were voluntary, had retention rates of 94% and 95% after one year. No families were evicted during this time (Bassuk, Huntington, Amey and Lampereur 2006, pp.19-20).

Permanent supportive housing has also demonstrated efficacy in addressing high rates of child protection involvement among families experiencing homelessness. The Keeping Families Together pilot provided permanent supportive housing to 29 families with child protection involvement who had experienced homelessness for at least one year (Swann-Jackson, Tapper & Fields 2010, pp.1-4). There were substantial outcomes for children, with all 6 of the children who had been placed in out of home care prior to the pilot reunified, and just over 60% of current child protection cases closed. Housing stability was also improved for these families, with 26 of the 29 families remaining in the supportive housing, compared to a comparison group who largely remained within the shelter system (Swann-Jackson *et al*, 2010, pp.29-36).

Overall there are a number of new approaches within the field of family support that provide quality outcomes for vulnerable families. Nonetheless, the question of how best to mobilise resources to address homelessness is complex. It is anticipated that the results of this current study will serve to shed light on one aspect of this question. In particular the study will illuminate the characteristics of families who access crisis intervention and family support services share in common and how they differ, as well as differences in their pathways into and through service provision and finally how the outcomes experienced by these families is common and different over time.

## 3.0 Methodology

In this section, we outline the two models of service delivery compared in this study and the methods used to investigate vulnerable families' experiences and pathways through two models of intervention. We begin with a description of the two models before discussing the methods we used to collect and analyse the data.

### The models of intervention

Overall, in this project we aimed to compare two models of service delivery: crisis intervention and family support services. Crisis intervention models are widely used in homelessness services, including some Micah Project services, to intervene in service user lives at a point of housing crisis and to develop a short-term, goal orientated response to housing and other needs (Healy, 2005).

The planned family support approach is a service model initiated and utilised by the Micah Projects workers in their ongoing work with vulnerable families. In contrast to the crisis intervention model, the planned family support approach enables the worker to work simultaneously on a range of family goals, some of which may not be directly related to housing crises.

While researchers have shown aspects of crisis intervention and family support models to be successful in achieving positive outcomes with service users (see Chamberlain and MacKenzie, 2008) our project will be the first to compare the impact of these models on the lives of vulnerable families. Comparison of these two service types can help to develop best practice with these families.

Crisis intervention models are widely used in homelessness services to intervene in service user lives at a point of housing crisis and to develop a short-term, goal orientated response to housing and other needs (Healy, 2005). Two crisis intervention services were involved in this research – Micah Projects Assessment and Referral Team and Brisbane Youth Service Berwick Street. Both services are centre-based programs with support workers providing crisis interventions to people who phone or present in-person at the service. Interventions are generally 1-5 hours in duration, and families generally need to re-present for follow-up assistance. The primary presenting need for families at these agencies is housing. Most families are currently homeless or at imminent risk of homelessness. Support workers at Micah Projects and Brisbane Youth Service assess immediate needs and provide information, referrals, advocacy and practical assistance to meet these needs. The most common interventions for families include:

- assistance to access Emergency Relief and other forms of financial assistance;
- referrals to Specialist Homelessness Services for crisis accommodation;
- sourcing and brokering motel accommodation;
- advocacy with landlords to maintain tenancy;
- active referrals to address acute healthcare needs, including psychiatric health;

- advocacy with Centrelink and other government agencies to access entitlements;
- provision of transport to safe accommodation;
- active referrals to domestic violence services;
- assistance to complete housing applications for long-term social housing;
- information about sustainable housing options;
- assessment of children's immediate needs, including identifying signs of abuse and neglect.

While crisis services work with people in a planned manner, their interventions are brief in nature, and they do not develop a case plan to respond to the broader needs of the family in the longer-term. The goals for crisis interventions with families are:

- Families access or maintain safe, affordable and appropriate housing
- All family members have access to shelter, clothing, food and water
- All family members are safe from domestic and family violence
- Families are linked with other specialist or mainstream services that can meet their longer-term needs.

In contrast, the planned family support approach is a service model that enables the support worker to work simultaneously on a range of family goals, some of which may not be directly related to housing crises. The family support services involved in this research are Micah Projects Family Support and Advocacy Team, Brisbane Youth Service Young Families team and the Brisbane Domestic Violence Advocacy Service. These services work with families both in their service centres and provide outreach to families in their home and community. Workers are proactive and flexible in their efforts to engage families. Family support workers undertake an assessment of the needs of both parents and children, and develop support plans with the family to work towards addressing these needs. Activities undertaken include:

- Support to access and maintain appropriate housing, including liaison and advocacy with housing providers;
- Advocacy with agencies to access entitlements;
- Support with parenting such as communicating effectively with children, establishing routines, and managing behaviour;
- Referrals and support with addressing health needs, including mental illness and substance use;
- Supporting women living with domestic violence, including developing safety plans, applying for Domestic Violence protection orders, and linking with legal aid and specialist counselling services;
- Ensuring children are enrolled and engaged in school or childcare;
- Assisting parents to engage with education, training and employment;
- Communication, liaison and advocacy with Child Safety Services to support case conferencing, case planning and reunification plans;
- Referrals to specialist children's services such as paediatric assessments and specialist allied health services, children's counselling and education support.

The goals for planned family support include:

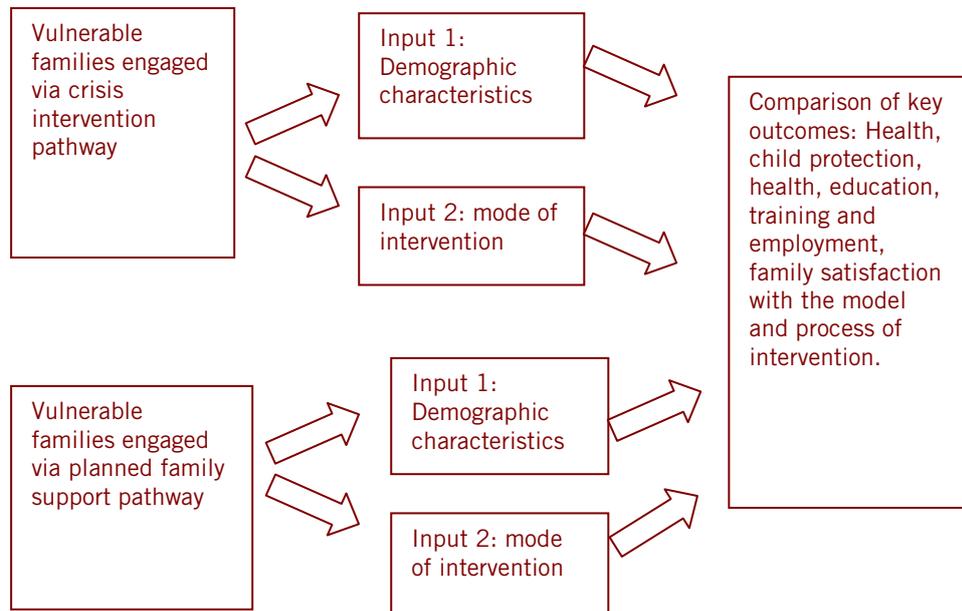
- Obtaining and maintaining safe, affordable long-term housing;
- Improving family functioning and decreasing stressors;
- Decreasing neglect, abuse and violence for adults and children;
- Improving the health and wellbeing of family members;
- Reducing the impacts of mental illness and substance use on individuals and their family members;
- Engaging children with school, early childhood or childcare programs.

Overall, the planned family support model addresses a larger range of non-housing issues than the crisis intervention approach.

### The research model

In this research project we sought to explore families' experiences and perceptions of pathways through crisis intervention and family support service delivery. We sought to compare the characteristics of families involved in each program type, their experiences of service provision and health and welfare outcomes reported by them over a fourteen month period.

**Figure 2: Key variables and relationships between them to be tested in the analysis**



Our research objective was to understand similarities and contrasts in how the different modes of intervention (crisis intervention and planned family support) impact on key outcomes for vulnerable families. Through our research design, we sought to recognize the different pathways through which homeless families accessed intervention and differences in the characteristics of families in each sample.

## Types of data collection

Three types of data were collected. This included, firstly, interviews with families who received either crisis intervention or family support services. These families were interviewed on three occasions over a 14 month period, to allow us to track their experiences during and, in some cases, post service intervention. The second type of data collection involved focus groups with service providers involved in crisis intervention or family support work. The third type of data collection involved a review of case records in relation to the families who were clients of Micah Projects. The purpose of the case review was to analyse the types of services received by these families over a one month period. The following table outlines the types of data collection and the time periods in which the data was collected.

Data was collected over three waves.

**Table 1: Phases of data collection**

	Phase 1	Phase 2	Phase 3
Interviews with families involved with planned support and crisis intervention	October 2010 – January 2011. 88 families participated in this phase of data collection.	May-July 2011. 68 families participated in this phase of data collection.	October- November, 2011. 61 families participated in this phase of data collection.
Focus groups with practitioners	This group was focused on workers' experiences of the needs and capacities of service users in both populations (15 participants). Completed December 2011	In this group we sought participants' views on findings from the first survey analysis (16 participants). Completed April 2011.	This group focused on practice insights in working with the two populations (14 participants). Completed July 2011
Case record reviews	The review identified the main fields of practice and time allocated to these different fields with families involved in the study who were also Micah Projects' clients over the last month. Completed in February 2011 (total of 57 case reviews, 32 family support and 25 crisis intervention)		

## Data analysis

The data types were analysed separately. We applied descriptive statistical analysis to the quantitative data from the interviews with parents and the case record reviews. We used a thematic analytic approach to analyse the qualitative data from the interviews with parents, the focus groups with practitioners and the case record reviews. We used constant comparison techniques to compare the themes within each data set and to compare emerging themes across each data set particularly in relation to the commonalities and differences in the impact of the two service models – crisis intervention and family support - on key health and welfare outcomes.

## Interviews with families: features of the sample

The study involved three sets of interviews over a 15 month period with families receiving crisis intervention services and those receiving family support services. The first interview was conducted with at least one adult member of the family participating in the study. Subsequent interviews were conducted with the original family member. The interview was based on a structured questionnaire and involved the collection of a range of baseline data about the family: demographic data; family structure including information about children not resident with the family; housing circumstances; and children's participation in child-care, pre-school, and education.

The total number of families who participated in the project varied over time. Table 2 outlines the number and average age of participants.

**Table 2: Number and average age of participants**

	CI (number)	CI (average age)	FS (number)	FS (average age)
Phase 1	43	31.4 years	45	25.8 years
Phase 2	25	34.3 years	43	27.5 years
Phase 3	22	34.8 years	39	27.6 years

In phase one, 88 families participated, with 43 being from the crisis intervention group and 45 from the family support group. In phases two and three the number of participants dropped markedly, with 68 families participating in phase two and 61 families participating in phase three. The majority of the drop-out was from the crisis intervention group, which almost halved between phases one and two. It is likely that the families in the crisis intervention sample who continued in the study were in more stable personal circumstances than those in the original sample. The possibility that the families who continued in the study were different in some way from the original sample needs to be taken into account when interpreting the trends observed in other parts of the data.

A key difference in the responses between the two service types was that the vast majority of respondents in the crisis intervention sample reported that they were not in receipt of services from the three referral agencies by the third wave of data collection. Indeed nineteen of the twenty-two respondents reported that they were not currently in receipt of crisis intervention or family support services from any of the three referral agencies. By contrast, sixteen of the thirty-nine respondents in the family support group reported that they were still receiving family support services from one of the three referral agencies in phase three of the research project.

The age range of the respondents who were drawn from the crisis intervention stream was from 17 to 50 years with an average age of 31.4 years, while the age range of those from the family support stream was 16 to 54 years with an average of 25.8 years. Further, in later phases the average age in both sample groups increased quite markedly, with the average age of crisis intervention respondents increasing by more than three years and the family support group by just under two years. In phase one, the difference in the average ages between both groups was 5.6 years while in phase two it was a difference of 6.8 years and in phase three this difference was 7.2 years. The average older age of crisis intervention group suggests perhaps a more entrenched pattern of homelessness, there was also a great of variation within the age range of both groups. It is also likely to be attributable to the referral agencies for the research project. Many participants from the family support group were drawn from Micah Projects Young Mothers for Young Women, and from the Brisbane Youth Service's Centre for Young Families. This services work with young people under the age of 25

Nineteen (19) of the respondents from the crisis intervention group (44% of this sample) identified as Aboriginal and/ or Torres Strait Islander, while ten (10) of the respondents from the family support stream (15.5% of this sample) identified as Aboriginal and/ or Torres Strait Islander. As we did not collect data on cultural identity in later rounds, we do not know if these patterns of difference in the representation of Aboriginal and Torres Strait Islander families were maintained into later phases of the study. English was the first language of 82 of the 88 respondents. For the remaining six respondents the first languages were identified as: Portuguese, Dutch, Pippijara (an Indigenous language), Arabic, Farsi (Persian), and Samoan. Of these respondents, four were from the crisis intervention group and two were from the family support group.

The majority of families were referred through Micah Projects, with 67 referred from this agency, 15 referred from the Brisbane Youth Service, and 6 from the Domestic Violence Resource Centre. The majority of respondents were females, with 80 of the 88 respondents being females. The gender of the respondents appeared unrelated to service type, with 5 males being drawn from crisis intervention services and 3 from family support services. There were slightly more females drawn from family support referral pathways (42 of the respondents) compared to 38 of those drawn from crisis intervention.

We asked respondents about their families. There was substantial variation in family size, particularly in the first phase of data collection.

**Table 3: Number of children per household by research phase and sample type**

	<b>CI (phase 1)</b>	<b>FS (phase 1)</b>	<b>CI (phase 2)</b>	<b>FS (phase 2)</b>	<b>CI (phase 3)</b>	<b>FS (phase 3)</b>
Number of children young people resident with respondent	87	69	43	73	20	41
Average number of children per household	2.02	1.53	1.72	1.70	0.9	1.05

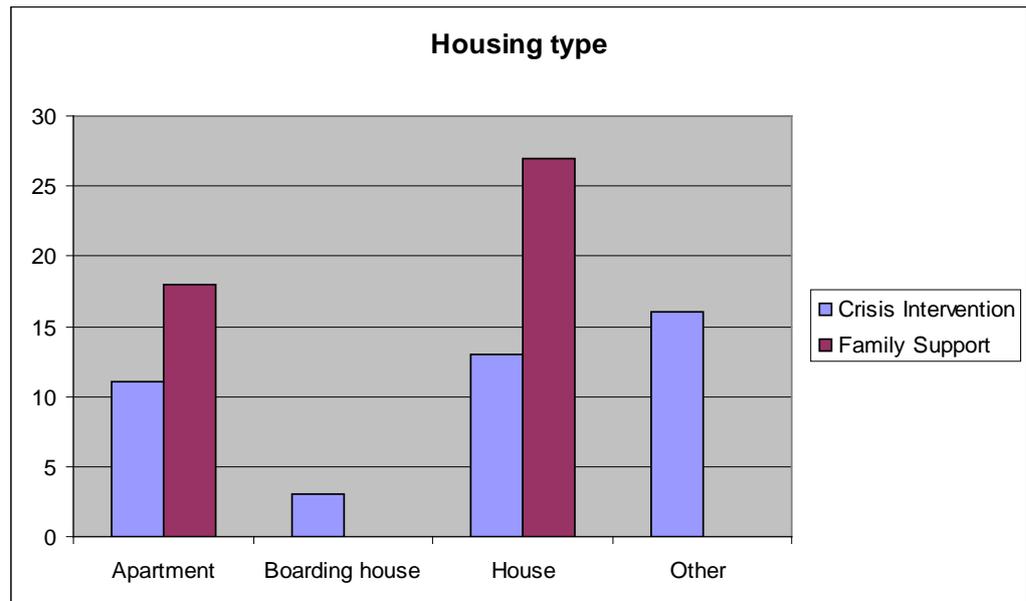
In phase one, respondents in the crisis intervention group reported between 1-6 children living with them, while in the planned family support group, families reported between 1-3 children living with them. Overall, we see an increasing convergence in number of children per household over the three periods of the research data collection. This suggests that the families who remained in the sample differed from those who dropped out. It is apparent that families who remained in the sample had fewer children per household than those who left the sample. A substantial proportion of respondents also reported that they had children not resident with them. Indeed, in the first phase of data collection, 19 of the 43 respondents in the crisis intervention sample reported that they had children not living with them while 17 of the 45 respondents in the family support sample also reported that they had children who were not resident with them.

## 4.0 Housing and Accommodation

### Types of housing

The housing circumstances of respondents were markedly different between the two sample groups. Those in the crisis intervention group were more likely to be in unstable, unaffordable and inadequate housing than those in the family support group. The first table shows main housing types by sample group.

**Figure 3: Housing type for crisis intervention and family support groups**



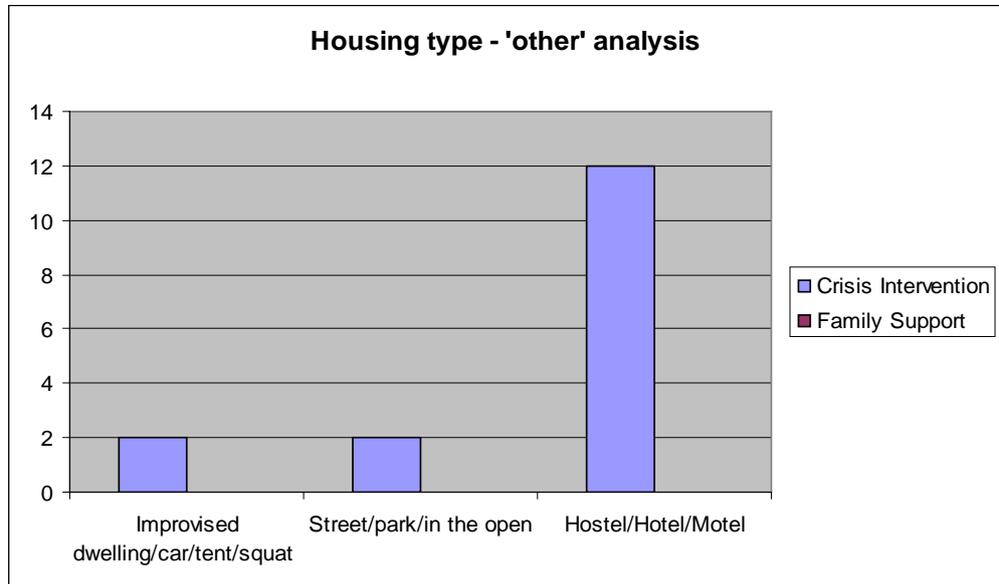
All respondents in the family support samples were housed in apartments or houses. Respondents in the crisis intervention group were less likely to be accommodated in these housing forms and more likely to be housed in less stable forms of accommodation. Indeed, the crisis intervention group constituted the entire population of respondents in boarding houses and 'other' forms of accommodation.

Respondents who fell into the 'other' category were arguably the most vulnerable, and on further analysis can be grouped into 3 main types:

- Improvised dwelling/car/tent/squat
- street/park/in the open
- hostel/hotel/motel.

Figure 4 shows the number of respondents residing each of these types of accommodation.

**Figure 4: “Other” housing types by crisis intervention and family support groups**

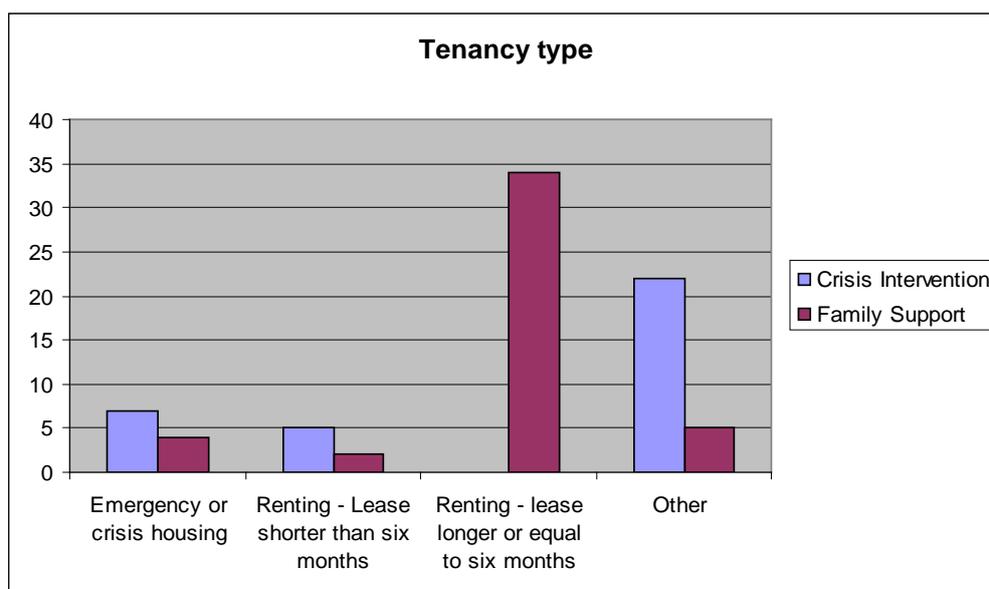


As Figure 4 shows, all of the respondents living in the category of “other” housing, which were less stable forms of housing, were in the crisis intervention sample. The three types were: hostel/ hotel or motel forms of accommodation, which 12 respondents reported living in; 2 reported living in improvised dwellings (such as cars); and, the other 2 reported living on the street or out in the open. This difference in housing types between the two samples was less marked in the later data collection phases of the study. In the second and third phases of the study only three respondents, all in the crisis intervention group, reported that they lived in an accommodation type other than a house or flat.

## Tenancy type

In addition to some differences in types of accommodation, families in the crisis intervention group were also more vulnerable in their tenancy arrangements than were those in the family support group. Figure 5 shows types of tenancy by sample group type.

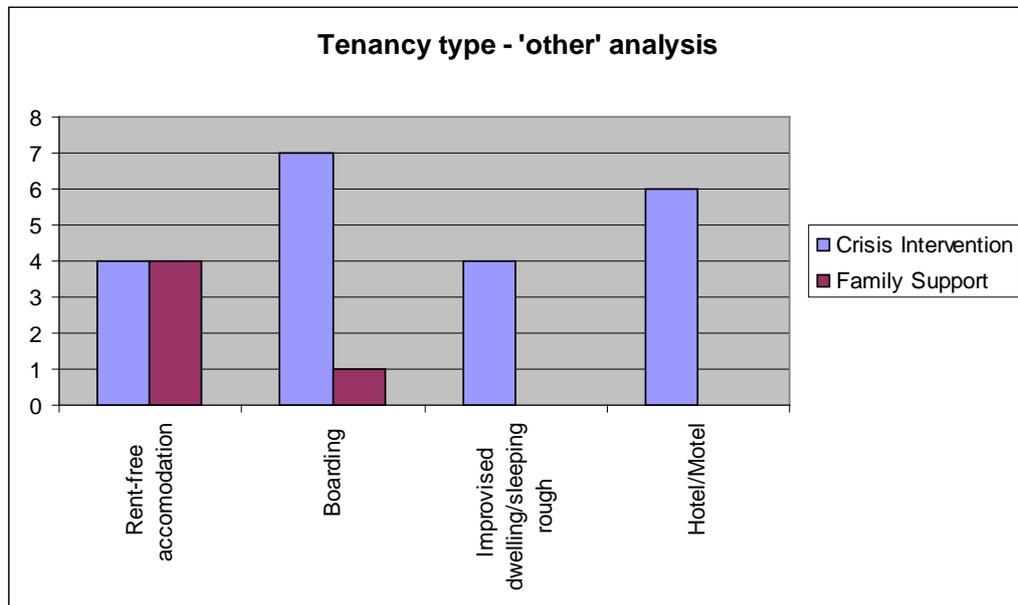
**Figure 5: Tenancy type comparison of crisis intervention and family support groups (phase 1)**



As Figure 5 demonstrates the majority of those in the family support sample group reported that they were in rental accommodation with a lease of at least six months duration, while no respondents in the crisis intervention group reported this to be the case. Respondents in the crisis intervention group were slightly over-represented compared to those in the family support group among those in emergency housing and housing with short term leases.

In the “other” accommodation group, the crisis intervention group were substantially over-represented compared to the family support group. Of the crisis intervention group, 22 fell into the ‘other’ category, as opposed to 5 families in the family support group. This is represented in Figure 5.

**Figure 6: Tenancy type, analysis of “other” forms of tenancy by crisis intervention and family support categories**



Further analysis of the ‘other’ category reveals these are the most vulnerable families. These tenancy arrangements can be grouped into 4 main types:

- Rent-free accommodation (couch surfing, staying with friends and/or family)
- Boarding (predominantly with friends and/or family)
- Improvised dwelling/sleeping rough
- Hotel/motel

Tenure in Department of Communities (Housing and Homelessness Services) properties (public housing), and in housing provided by community organisations (community housing), was almost exclusively held by families in the family support group. This is a particularly important difference as these forms of housing are intended to deliver more stable, secure and affordable housing than is typically found on the private rental market (as illustrated in Figure 7). Data from the practitioner focus group’s suggested that a key reason for the crisis intervention group’s reliance on less stable forms of housing was that they were excluded from more stable forms such as being listed on the TICA database due to rental arrears or damage to property and limited ability to manage a tenancy financially or personally.

**Figure 7: Residence in community or public housing by sample type**

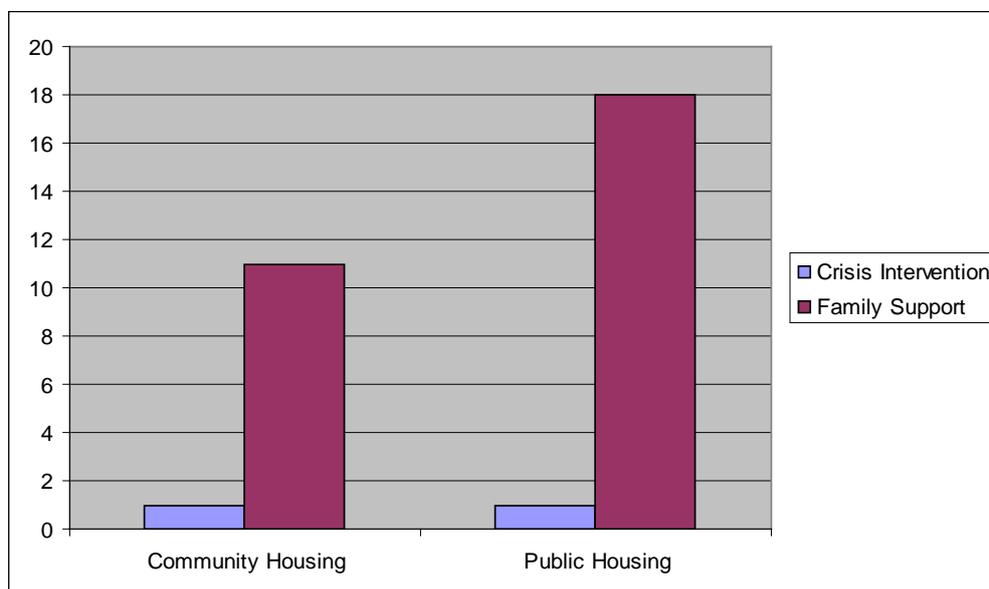


Figure 7 shows that those in the family support sample were much more likely to reside in subsidised housing (community or public housing) than was the case for the crisis intervention group. Data from the practitioner focus group suggests there are several reasons why those in the crisis intervention group were under-represented in these housing types with a major reason being ineligibility due to previous breaches of housing regulations and rent arrears. A key theme in the focus group reflections by workers concerned the importance of assisting people at risk of homelessness to develop knowledge and skills for sustaining housing.

We turn now to the housing circumstances of participants reported in later rounds of data collection.

**Table 4: Accommodation circumstances rounds 2 and 3**

	Crisis Intervention Phase 2	Family support Phase 2	Crisis Intervention Phase 3	Family Support Phase 3
House/flat	23	43	20	39
Caravan	0	0	1	0
Boarding/ rooming house	0	0	1	0
Other	1	0	0	0

In later phases of data collection, we see an increased similarity in accommodation types between the two sample groups with the majority in phases two and three stating that they reside in houses or flats. The only exceptions to this was in the crisis intervention sample where there were three examples of alternative forms of accommodation, these were: caravan, boarding house and one respondent who reported they were currently living at a residential service associated with drug and alcohol rehabilitation.

It is likely that this increased similarity between the two groups can be primarily accounted for by the high drop out rate among the crisis intervention group in the second and third phases of the study. It is likely that the families who continued in the study, in both sample groups, were in more stable personal circumstances than those in the original sample. The possibility that the families who continued in the study were different in some way from the original sample needs to be taken into account when interpreting the trends observed in other parts of the data.

While in later phases of the research, we noted a convergence in the accommodation types reported by both groups of respondents, data collection in these later phases continued to demonstrate differences in the tenure type for both groups. These differences are outlined in the following table.

**Table 5: Tenure type compared by sample**

	<b>Crisis Intervention Phase 2</b>	<b>Family support Phase 2</b>	<b>Crisis Intervention Phase 3</b>	<b>Family Support Phase 3</b>
Public housing	4	21	7	20
Private rental	8	6	6	2
Community housing rental	6	8	2	6
Specialist (crisis) housing accommodation	2	4	1	2
Boarding	2	3	4	3
Purchasing own home	0	0	0	0
Rent free	1	1	2	2
Hotel/ motel	1	0	0	0
Other	1 (unspecified)	0	0	0

As Table 5 shows, in phases two and three the family support group continued to report living in public housing as their primary type of accommodation. By contrast, those in the crisis intervention group reported being in a range of housing types. These included private rental, community housing and crisis accommodation.

We also considered the mobility of families by asking them whether they and their family had moved home in the last six months.

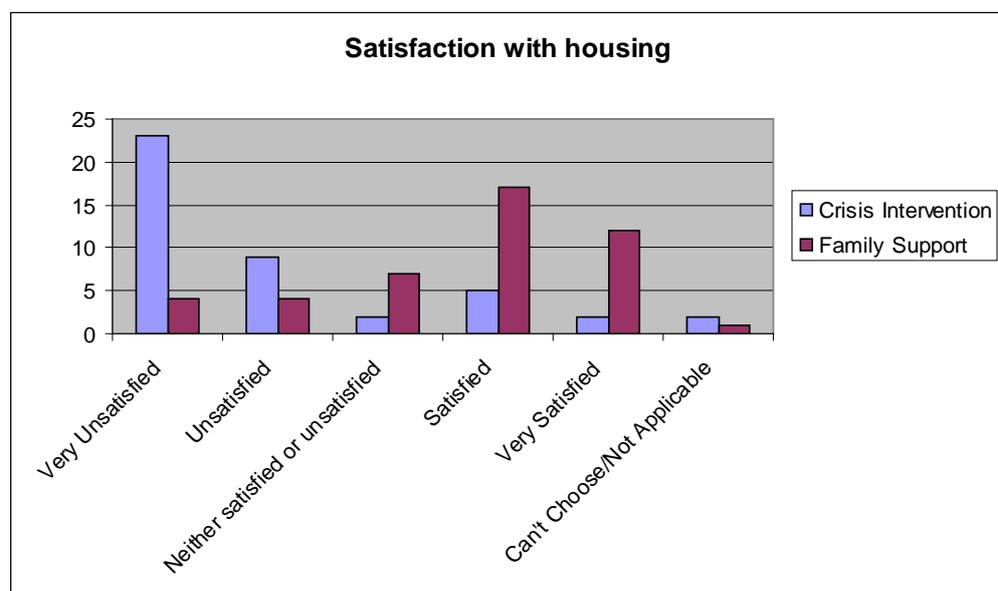
**Table 6: Have you and your family moved home in the last six months?**

	CI Round 2	FS Round 2	CI Round 3	FS Round 3
Yes	18	14	10	16
No	7	29	12	23

The data in Table 6 shows that participants in the crisis intervention group were much more likely to have moved house the past six months. In phase two, 6 of the 18 who had moved in the last six months had moved at least twice, with one family reporting that they have moved 3-4 times in this period. In phase three, 10 families reported moving at least once and 6 of these families reported moving more than twice, with one family claiming to have moved “more than 50 times”.

Respondents in the family support sample were less likely to report that they had moved. In phase two, seven of the 14 families who had moved had moved more than once and four of these families reported moving three times. In phase three only 4 families in this sample had moved more than once, though one family reported moving 4 times in this period. Respondents were also asked to indicate their satisfaction with their current housing. While members from each group are represented in each satisfaction score, overall those in the family support group were more likely to be satisfied with their housing. Their responses are summarised in Figure 8.

**Figure 8: How satisfied are you with your housing by sample type**



The data presented in Figure 8 shows substantial differences in the reported satisfaction with housing between the two groups. Respondents in the crisis intervention group were substantially more likely to report that they were very dissatisfied with their housing than those in the family support group. By contrast, those in the family support group were substantially more likely to report being satisfied or very satisfied with their housing.

Respondents were also asked to provide an explanation for why they chose a particular satisfaction rating. The responses given to this question highlighted the differences in housing experience for the two samples. In analysing this question, the data was broken down into positive and negative statements about their housing, made by those in the crisis intervention sample as compared to those in the family support sample. Themes were generated from the data and used to compare and contrast the housing experience for the crisis intervention sample and the family support sample.

### **Negative statements about housing**

For families in the crisis intervention group a key theme concerned the lack of affordable housing. This was evidenced by statements such as *"I'm paying \$460 a week at the Yumba Hostel - we don't get fairly treated at the hostel. Takes up all my income. I'm only left with \$10"* (crisis intervention respondent) and *"Well - \$90 a night 7 nights a week - what do you have left for food?"* (crisis intervention respondent). The theme of affordability was mentioned only once within the family support sample. This could be due to those within the family support sample having received more intensive service assistance to obtain suitable and sustainable accommodation.

Another major theme for participants within the crisis intervention group was that of homelessness. These families reported that they did not have any housing of any kind, with statements such as *"Because we have nowhere and it's not nice to live on the streets with kids"* (crisis intervention respondent) and *"Because we're homeless"* (crisis intervention respondent). This theme was not evident in the family support sample. This supports the finding that families within the family support sample report far greater levels of security in housing.

There were also two minor themes generated by the crisis intervention sample that were not shared by the family support sample. The first of these was poor quality of housing, evidenced by statements such as *"The standard of the house wasn't that good to start with - been there for 2 years - for first 10 weeks in winter we had no hot water - There was a lot of termite damage"* (crisis intervention respondent). Again, this may be attributable to the more intensive support received by the family support sample in obtaining suitable accommodation. The second theme was that of violence, as evidenced by statements such as *"We've been running from (child's) dad because of domestic violence"* (crisis intervention respondent). It is interesting that no families from the family support sample noted violence as an issue, as it is clear from the practitioner focus groups held that violence is an issue for this sample also.

Despite these differences there were a number of commonalities between themes for the two samples. A major theme shared by both the crisis intervention sample and the family support sample is that their housing did not meet their needs. This was for a number of reasons, such as maintenance requirements that were outside their capacity, *"I don't like my yard, it's too big (trouble mowing)"* (family support respondent); overcrowding *"It's a bit crowded, there is always lots of mess cos there is so many people"* (family support respondent) and distance from services *"The area's just crap. No close transport, no close shops and I'm on a bloody hill"* (family support respondent). The main way in which housing did not meet families' needs however was in its unsuitability for children. Families from both sample groups made statements to this effect, such as *"Just the area, I don't like the area for my son... you're on the main road, the noise...it's just far from everything"* and *"We're near the main road... kids can get out easily... I had to tie a children's gate onto the gate so they couldn't get under it and get out"* (family support respondent).

Another shared theme between the crisis intervention sample and the family support sample is around the lack of stability of housing. These families were either facing eviction, or were in short-term accommodation, and this theme is evidenced by statements such as *"I only have three months left there"* (family support respondent) and *"I love it there but I have to move because the real estate agent said there were too many people in the house"* (crisis intervention respondent).

### **Positive statements about housing**

A shared theme between both samples was an expressed relief at having found accommodation. Participants articulated this theme through statements such as *"Comparatively - after couch surfing etc - it's fantastic"* (family support respondent). Four out of the seven crisis intervention families expressed satisfaction with their housing and noted relief at no longer being homeless, as opposed to only five out of the 29 family support families.

Another shared theme between both groups was the feeling that their current housing met their needs, mirroring the previous finding that dissatisfaction with housing was linked to the housing not meeting the needs of the families. A wide range of needs was identified as having been met by the housing, from support with basic living needs *"your meals are all cooked for you"* (crisis intervention respondent) ; access to needed services *"cos I'm close to the shopping centre, and that's where my doctor is"*(family support respondent) ; greater independence *"Very relaxed, more freedom than other accommodation (respondent) previously been in"* (family support respondent); and security *"It's a quieter area and I feel safe"* (family support respondent). Again, in a reflection of the previous section, children's needs were identified, with responses such as *"a least I've got a place and it's good for the kids"* (family support respondent); and *children having more ability to settle in and live independently* (family support respondent). One respondent expressed that her housing allowed her to address other issues *"this house that I've got keeps me off the streets, away from drugs, I don't sniff no more"* (crisis intervention respondent). In a

possible reflection of the increased scrutiny by child safety services experienced by homeless families, one respondent stated *“as long as my son's out of family services eyes I'm more than happy”* (crisis intervention respondent).

A key difference between the two groups was that only respondents in the family support group linked access to public housing as a reason for satisfaction with housing. Public housing was not mentioned by the crisis intervention group, which is understandable given only one member of this group identified within the survey that they were residing in public housing. While most statements simply noted attainment of public housing to be a positive thing without further detail given, on two occasions it was linked to security and affordability *“it's pretty secure - we're in a Department of Housing house. We can't get thrown out and they can't hike the rent”* (family support respondent) and safety *“where I'm living is safe and secure”* (family support respondent).

### **Goals for change in housing circumstances**

We asked participants about what changes, if any, they would like to see in their housing circumstances over the next twelve months. One common theme between the two groups was the importance of stable, adequate and affordable housing. Yet, while both groups believed stable housing to be desirable, there were differences in what stability of housing meant for each sample.

For family support participants stability often referred to the continuation of their current arrangements. For example, participants from the family support group stated *“We don't want to move, I have really nice neighbours, we have a nice backyard.”* And another stated: *“Just stay in this area, but in a house, we've got everything here and people are friendly.”*

By contrast, those in the crisis intervention group were more likely to aspire to achieving stability. For example, participants in the crisis intervention sample stated:

- *“Stability, that's what it all comes down to”* (crisis intervention respondent);
- *“A three bedroom house in Brisbane, that would be great. Somewhere stable, somewhere to call home, with a place for the kids to play in.”* (crisis intervention respondent);
- *“I want a stable home. I landed up in TICA (Tenancy data base) because I help people when they are down on their luck and they trash my place. That's been my big downfall”* (crisis intervention respondent).

Another difference was that respondents in the crisis intervention group frequently raised the issue of safety in their housing, while this issue was raised by only one respondent in the family support sample. Some examples of aspirations to safety found among the respondents in the crisis intervention group include:

- *“I hope to go into a three bedroom home with proper safety/ security”* (crisis intervention respondent);

- *“Just a house to ourselves. Two bedrooms and safe” (crisis intervention respondent).*

A further difference was that several respondents in the family support group aspired to purchasing their home, whereas this was uncommon in the crisis intervention group. For example, one respondent in the family support group stated:

- *“I’m still in the process of getting us back on track. Five to ten years I’d like to look at getting my own house” (family support).*

## 5.0 Income, education, and employment

### Income

In phase one, we asked participants the nature of their source of income. The following table outlines their responses.

**Table 7: Income sources by sample type phase one**

	Crisis Intervention	Family Support
Government benefit	43	42
Employment	0	3

We can see that government benefits were identified as the only source of income for respondents in the crisis intervention group and as the primary source of income for the family support group. In the family support sample, a further three (3) respondents identified employment as a primary income source.

In data collection phases 2 and 3 we asked participants if their income had changed since the previous interview. The following table outlines their response to this question.

**Table 8: Reported changes in income by sample type in phases two and three.**

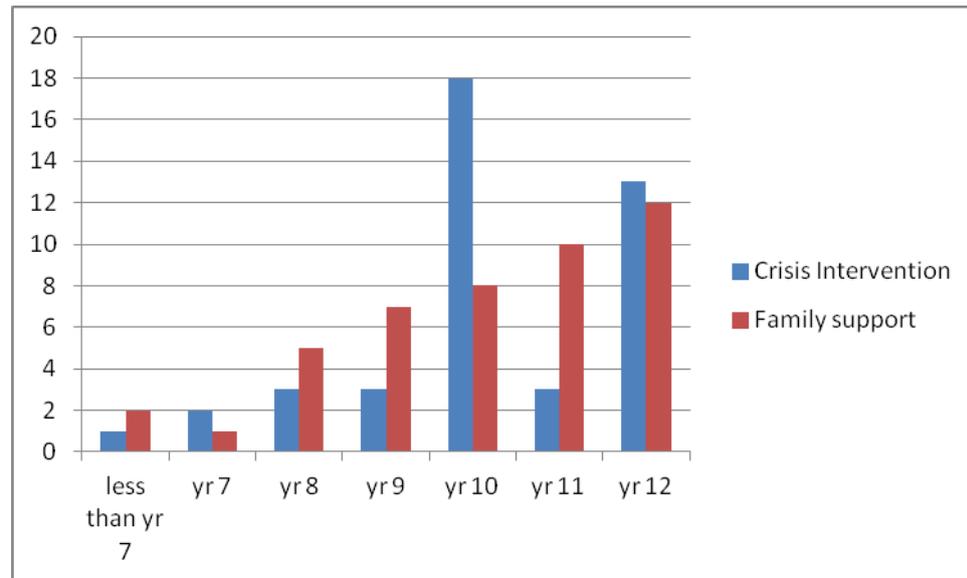
	CI (Phase 2)	FS (Phase 2)	CI (Phase 3)	FS (Phase 3)
Yes (change of income)	11	16	9	12
No (no change in income)	14	27	13	27

As Table 8 indicates, a substantial proportion of both samples indicated that their income had changed over the previous four-six months. The primary reason respondents' income changed was due to a change in Centrelink benefits. Changes in benefits occurred for a variety of reasons, such as gaining a partner (who was also receiving benefits) or having a child. A second reason was change in employment circumstances. A small number of respondents in each phase and in both sample groups reported that either they or their partner had gained employment, this was a total of 9 respondents in the crisis intervention sample (over two phases) and 7 respondents in the family support (over two phases). Over the two phases, 3 respondents in the crisis intervention sample and 2 in the family support sample reported losing their jobs. In a small number of cases, participants' income sources changed as a result of changing family maintenance arrangements. In one case, in the family support sample, a change in income was due to the fact that the parents' had three children removed from their care.

## Education and training profile

The education and training profile of the respondents indicated relatively low levels of educational completion and participation in post school education. Table 1 presents data on levels of school completion comparing responses from the two sample groups.

**Figure 9: Reported School completion levels by intervention stream.**



The crisis intervention group reported markedly lower levels of year 12 completion than the family support group, with 18 of the 43 respondents in the crisis intervention group having left school at year 10. In the family support group by contrast, almost half had completed years 11 or 12. However, it was surprising to find that the majority of respondents also reported completing post-school qualifications, with 22 of the crisis intervention group (51.2%) and 25 (55.5%) of the family support group reporting completion of post-school qualifications. However, in some cases these qualifications were completion of short courses, such as a certificate in the responsible service of alcohol. In the family support sample, 12 (or 26%) respondents had completed a VET qualification of at least Certificate III or higher, whereas only two (4.7%) of the respondents in the crisis intervention group had completed VET qualifications at this level. Further, only two respondents in the crisis intervention group and one in the family support group reported completing bachelor level qualifications.

In the practitioner focus group, we explored the reasons for the low school and post-school completion rates in both groups. Practitioners identified that both groups experienced some common barriers to school participation including: social disadvantage particularly intergenerational patterns of school non-engagement, housing instability, poverty, abuse and lack of role models for school completion

within the family. Essentially, workers in both groups reflected that education had been a low priority in the families of origin of the participants compared to other considerations, such as finding accommodation and managing extremely challenging circumstances.

### **Employment circumstances**

Only a minority of participants in both samples reported that they were currently employed. The following table outlines the total number of participants who reported they were currently in employment in each sample and phase of the research.

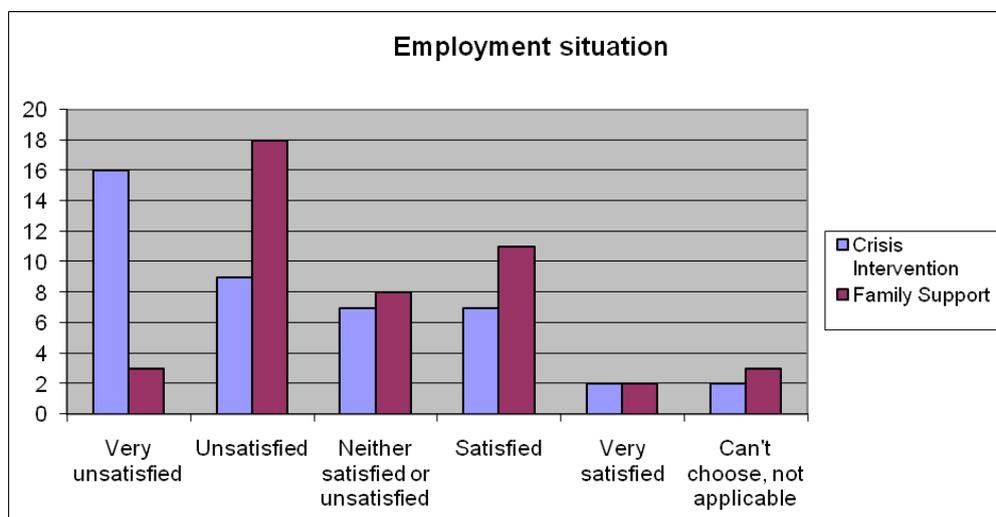
**Table 9: Have you had employment in the past 6 months by sample type**

	<b>Phases 1</b>	<b>Phases 2</b>	<b>Phase 3</b>
CI	1 (out of 43)	4 (out of 25)	5 (out of 22)
FS	3 (out of 42)	9 (out of 43)	6 (out of 39)

The nature of the work undertaken by respondents was, in most instances, unskilled or semi-skilled employment such as cleaning and retail work. One respondent was undertaking an apprenticeship in mechanical work and four (two from each sample group) reported working in community services support roles such as women’s shelters and disability support groups.

Of the crisis intervention group, twenty-one (21) respondents (which is 48.8% of that sample), indicated that they had not had paid employment in the last two years or longer; indeed, 5 of this group indicated they had never been in paid employment. In the family support group, 32 respondents (71.1%) of the sample indicated they had not been in paid employment in the past two years or longer, with 2 of these indicating they had never held a paid position. The majority of those who had been in paid employment had been in “low skill” and casual jobs, particularly in retail and cleaning.

**Figure 10: Reported satisfaction with employment status by sample type**



In both samples there was a high level of dissatisfaction with employment circumstances, though this was much more marked for the crisis intervention sample than the family support sample. On a scale of 1-5 with 1 being highly dissatisfied with employment and 5 being very satisfied, the crisis intervention sample had an average score of 2.4 while the family support sample recorded an average score of 3.0. We see also that the families in the crisis intervention sample were very strongly represented among those who were very highly dissatisfied with their employment circumstances.

Crisis intervention participants were far more likely to report feeling very unsatisfied (1 on a 5 point scale) with their employment situation; however the family support sample was far more likely to report feeling unsatisfied (2 on a 5 point scale) with their employment situation. The family support sample was slightly more likely than those in the crisis intervention sample to report feeling satisfied with their employment situation.

#### **Participants who ranked their satisfaction with their employment situation as 'unsatisfied' or 'very unsatisfied'**

The main reason for both samples expressing dissatisfaction was the fact that they were not working, reflecting the low levels of employment noted earlier in this report. Reasons given for wanting to work included the need for a higher income; learning new skills; keeping out of trouble; enjoying work; and an increased ability to provide for family.

A key difference between the two samples is the crisis intervention sample reported a greater number of barriers to finding employment. Barriers cited included poor

health; inability to work due to childcare responsibilities; lack of qualifications or experience; lack of transport; and lack of housing.

### **Participants who ranked their satisfaction with their employment situation as 'neither satisfied or unsatisfied'**

Both samples tended to report that they would like to be working but that there was a barrier that prevented them from doing so. This is illustrated by comments such as *"I do want to get a part (time) job but my current situation is kinda get in the way of that, and I would need to put (child) in child care which I can't afford"* (family support) and *"can't do anything about the situation at the moment"* (crisis intervention).

### **Participants who ranked their satisfaction with their employment situation as 'very satisfied or satisfied'**

A shared theme across both samples was satisfaction with not having paid employment as it allowed them to care for children, illustrated by statements such as *"Mine is very satisfied because I love being a mum"* (family support) and *"when this fella (son) was born, I stopped working"* (crisis intervention).

A difference between the two samples is three participants from the family support sample noted satisfaction due to either their own employment or their partners. No respondent in the crisis intervention sample reported satisfaction with their employment situation was due to being employed.

### **What participants would like to see change over the coming year regarding their employment situation?**

There was little variation in the responses given by the two samples. The strongest theme was the desire to work. The second strongest theme was a desire for the participant's partner to work. Another common theme was the desire to continue studying or begin studying. Both samples identified barriers to finding employment, with the crisis intervention sample slightly more likely to note barriers. The barriers largely revolved around family and childcare responsibilities, evidenced by statements such as *"the reason I haven't got a job over the last six months is because I've been focused on getting my kids back and staying clean"* (family support respondent) and *"not at the moment due to the fact that my partner is a first time mum and needs my support"* (crisis intervention respondent).

## **Practitioners' views**

In the practitioner focus groups, we also explored the reasons for low workforce participation. The practitioners' responses reflected many shared themes in the reasons for low workforce participation across the two sample groups. These shared themes included low levels of formal qualifications or recognised skill sets; limited literacy; health and welfare issues, such as mental health issues, domestic violence and drug and alcohol issues. It was also noted in both groups that matters of appearance and hygiene, particularly in relation to poor dental health, limited the capacity of service users in both groups to gain employment.

Another common theme was the impact of government policy in creating disincentives for vulnerable families to access employment opportunities. These disincentives include that the work available to them is often low paid and can be undignified. It also may involve receiving a lower total income after other factors, such as loss of welfare benefits and subsidies are taken into account.

Another issue that was raised in both groups was the time involved in negotiating various systems as a barrier to workforce participation. As one family support worker put it:

*“Once there’s any kind of involvement with the courts, any kind of contact with Child Safety [child protection bureaucracy], there’s this flow on effect that just keeps people really busy...People who have child safety, Centrelink, parole and methadone programs...they can’t fit work into that” (Family Support Practitioner).*

In essence involvement in various health and welfare services imposed a substantial time cost on participants.

Participants from the crisis intervention group appeared to be subject to more substantial levels of disadvantage that affected their ability to participate in the workforce. While housing instability was identified as a common barrier to employment among both groups, it appeared to be a more persistent problem for those in the crisis intervention group. The crisis intervention group identified that prior criminal histories were a common barrier to achieving employment among the participants. Another barrier was difficulty in “altering behaviour between boarding house lifestyle (which is untrusting and rough) and job interview behaviour; these are ‘two different worlds’” (Crisis Intervention Practitioner). A further problem identified only by the crisis intervention group was lack of identification papers as a barrier to employment.

## 6.0 Participation in Early Childhood Services and School Education

We turn now to participation in child care, pre-school and school education. Engagement with child-care and pre-school education can be important for achieving school preparedness among children. Patterns of school engagement are linked to levels of school achievement which, in turn, can be important for addressing intergenerational disadvantage.

### Children 0-5 years

In this section we consider the total number of children 0-5 years in the sample and examine patterns of enrolment in both samples. In Table 10 we outline the total number of children aged 0-5 in the sample in each round.

**Table 10: Total number of children by sample type and research phase**

Child's Age	Phase 1		Phase 2		Phase 3	
	CI	FS	CI	FS	CI	FS
>1	10	11	6	1	3	4
1	4	9	3	5	2	4
2	10	16	5	6	2	9
3	5	6	4	5	4	9
4	5	3	1	3	4	6
5	3	1	3	5	1	2
Total	37	46	22	52	16	34

The number of young children in the family support group is substantially larger than the crisis intervention group. In essence, participants in the family support sample are at an earlier phase of their family's life cycle than the crisis intervention group.

We turn now to the data on enrolment in child-care, kindergarten or pre-school for children 0-5 years.

**Table 11: Crisis intervention sample enrolment data for children in child-care, kindergarten or school**

Child's Age	Phase 1		Phase 2		Phase 3	
	Number	Enrolled	Number	Enrolled	Number	Enrolled
>1	10	0	6	0	3	0
1	4	0	3	1	2	0
2	10	1	5	3	2	0
3	5	0	4	1	4	1
4	5	2	1	1	4	1
5	3	0	3	3	1	1

Families involved with crisis intervention services reported very limited involvement with child-care, kindergarten or school. This pattern of enrolment did vary markedly over the three phases of the study. In phase one, respondents reported that three children five years and under (representing 8.1 % of the sample) were enrolled in child-care, kindergarten or school, this proportion grew in phase two to 9 enrolments (representing just over 40% of the sample). In phase three, the number fell to just three enrolments in this group (representing 18.75% of the sample).

We turn now to examine the enrolment data for young children in the family support sample.

**Table 12: Family support sample enrolment data for young children in child-care, kindergarten or school**

Child's Age	Round 1		Round 2		Round 3	
	Number	Enrolled	Number	Enrolled	Number	Enrolled
>1	11	2	11	1	4	0
1	9	4	8	5	4	4
2	16	11	12	6	9	9
3	6	5	11	5	9	8
4	3	2	5	3	6	4
5	1	1	5	5	2	2

Respondents from the family support group were more likely than those in the crisis intervention group to report having enrolled their children in child-care, kindergarten or school. In phase one, respondents in this group reported that 25 of the 46 children 5 years and under in this sample (54.3%) were enrolled in child-care, kindergarten or school. In phase two, it was reported that 25 of the children in this sample aged 5 years and under were enrolled (representing 48% of the sample) while in round 3, 27 of the children aged 5 years and under (representing 79.4% of the sample) were reported to be enrolled.

In summary, young children in the family support sample were significantly more likely than those in the crisis intervention to be enrolled in child care, kindergarten or pre-school. Moreover, we see that over time the level of enrolment increased markedly so that by phase three almost 80% of these children were enrolled, which contrasts with less than 20% enrolled in the crisis intervention sample. This pattern suggests that planned family support interventions are associated with higher rates of participation in child-care, kindergarten and pre-school. This patterns augers well for ensuring school readiness of young children as involvement in early education and childcare programs is associated with higher levels of school readiness and success in schooling (Ramey & Ramey 2004). This is particularly relevant as success in schooling is important to addressing intergenerational disadvantage (High 2008, p.1108).

In both groups, respondents identified some common challenges to enrolling children in child-care or pre-school. A key barrier for both groups was the cost of child-care. However, in the family support group, two respondents identified that they had access to subsidies through the Commonwealth government employment support program and this had made child-care affordable for them. For the crisis intervention group, transient lifestyles contributed to difficulties in enrolling in child-care and school. Several families discussed planning to enrol children in child-care and pre-school in the future when the family's accommodation circumstances were more settled.

We explored the differences between the two groups in the practitioner focus group. The crisis intervention workers identified that the transient lifestyle of their client group was a barrier to children's participation in child-care. By contrast, family support workers identified that access to resources, such as brokerage money, allowed them to facilitate families' access to child-care and pre-school. For example, one worker stated:

*"If you've got brokerage you can pay off old debts etc. For example, family support workers can pay off debts that clients have accrued at child-care centres allowing those families to re-enrol at those centres" (Family Support Practitioner).*

Another family support worker identified that *"You've got to have housing to start the child care process"*. Fewer of the families in the crisis intervention sample had access to stable and suitable housing and this too was a barrier to their children's participation in child-care and pre-school.

## School enrolment and participation

We turn now to school participation among children in the crisis intervention and family support categories. The following table shows the number of children of school age (6-17 years) in the crisis intervention sample. The first number in each column is the number of children enrolled while the number in parenthesis is the total number of children in that age category in the sample.

**Table 13: School enrolment as a proportion of children/ young people in each age group in crisis intervention sample.**

Age of Child	Crisis Intervention		
	Phase 1	Phase 2	Phase 3
6	5 (7)	4 (4)	1 (1)
7	3 (4)	3 (3)	2 (2)
8	3 (7)	1 (1)	2 (2)
9	2 (8)	1 (1)	0 (0)
10	4 (5)	5 (5)	2 (2)
11	2(3)	1 (1)	5 (5)
12	4 (4)	2 (2)	1 (1)
13	1(2)	1 (1)	0 (0)
14	2(3)	2 (2)	0 (0)
15	0(3)	1 (1)	1* (1) enrolled at 'other' an educational facility
16	0(2)	3 (3)	0 (1)
17	0(2)	1 (1)	0 (0)

In the crisis intervention sample we see that that in the first phase of data collection, many of the school aged children in this sample were not enrolled in school. Indeed, 24 of the 50 school aged children in this sample (or 48%) were not enrolled at the time of the interviews. However, we see that in phases two that all school aged children are enrolled and similarly in phase three, there is only one school aged child not enrolled (that is one 16 year old child).

The qualitative data indicated that low enrolment rate was linked to the timing of data collection in phase one. We undertook interviews at the end of the school year of 2010 and the beginning of the new school year 2011. For families in the crisis intervention category, the relative instability of their housing circumstance may contribute to lower enrolments particularly at the end of the school year and in

difficulties in enrolling early in the school year. In phase one, respondents in the crisis intervention sample explained the non-enrolment of their school aged children in the following ways:

*"No school at the moment - we've only been here for two weeks (from Sydney), so no point in putting them in now." (Parent of four children aged 8-13 years)*

*"Lots of worries because being in a hostel you don't where you're going to be. We face a lot of judgment when kids forget to bring something [to school] but we try our hardest." (Parent with six children, aged 10 months to eight years).*

We can see in these excerpts that instability or low quality of accommodation arrangements is experienced as a barrier to school participation by respondents in the crisis intervention group.

### **Enrolment patterns among family support sample**

In Table 14 we outline the data on school enrolment for children and young people aged 6-17 years in the family support sample. The first number in each column is the number of children enrolled while the number in parenthesis is the total number of children in the sample.

**Table 14: School enrolment as a proportion of children/ young people in each age group in family support sample.**

	Family support			
Age of child	Round 1		Round 2	Round 3
6	4(4)		0 (0)	2 (2)
7	2 (2)		3 (3)	2 (2)
8	2(2)		2 (2)	1 (1)
9	1(1)		2 (2)	1 (1)
10	4(4)		2 (2)	1 (1)
11	0(0)		2 (2)	3 (3)
12	2(2)		0 (0)	0 (0)
13	3(3)		3 (3)	2 (2)
14	3(3)		3 (4)	2 (2)
15	1(1)		1 (1)	2* (3) one is enrolled in 'other' educational facility
16	0(0)		1 (1)	1 (1) enrolled in 'other' educational facility
17	1(1)		1* (1) *enrolled in 'other' educational facilities	0 (1)

In most age categories, all school age children in the families of those receiving family support services are enrolled in school. The only exceptions here were one 14 year old and two young people (15 and 16 years old) who had enrolled in a college based school program. In phase three one 17 year was reported as not enrolled in school.

### Patterns of school attendance

We now turn to consider the proportion of school age children who are enrolled who were reported to have missed at least one day of school in the previous week. In analysing school attendance, we have excluded those families who were interviewed during school holidays or in weeks with public holidays. This has meant that a total of one family (with one five year old child) from the crisis intervention sample and 4 families with a total of 6 children from the family support group were excluded from this category. In each of the data columns, the first number is the number of children who were reported to have missed a day of school, the number in the first parenthesis is the total number of children in that age bracket and the second parenthesis presents information about the number of days of school absence for children in each age category.

**Table 15: Number of children crisis intervention group who missed at least one day of school last week compared to total number enrolled in each age category.**

	CI		
Age of Child	Phase 1	Phase 2	Phase 3
6	0(5)	2(3), [1 missed 1 day and 1 missed 2 days]	0 (1)
7	0(1)	0(3)	0 (2)
8	1(3)	1(1), [1 missed 1 day]	1 (2), [1 missed 5 days]
9	0(1)	0(1)	0
10	0(4)	0 (5)	0
11	1(1)	0(1)	1 (5) [1 missed 5 days]
12	0(4)	0(2)	0 (1)
13	0(1)	0(1)	0 (0)
14	1(1)	1(2), [1 missed 3 days]	0 (0)
15	1(3)	0(1)	0 (1)
16	0(1)	1(3) [1 missed 5 days]	0 (0)
17	1(2)	0(1)	0 (0)

In phase 1, we collected data only about whether enrolled children had missed at least a day of school in the previous week. In later phases we asked how many days had been missed. In the crisis intervention sample we see in phase one that five (5) of the 27 children (18.2%) had missed at least a day of school. In phase two, we see that 5 of the 23 (21.8%) school aged children had missed a day of school and had missed anything in the range of one to five days of school. In phase three, we see that two of the twelve children (16%) had missed school and in both cases, they had missed an entire week of school in the last week.

We turn now to the data on school attendance and absences among children and young people in the family support sample. In each of the data columns, the first number is the number of children who were reported to have missed a day of school, the number in the first parenthesis is the total number of children in that age bracket and the second parenthesis presents information about the number of days of school absence for children in each age category.

**Table 16: Number of children in family support group who missed a day of school last week compared to total number enrolled in each age category**

Age of child	Phase 1	Phase 2	Phase 3
6	0(2)	0 (0)	0 (2)
7	0(0)	0 (3)	0 (2)
8	0(2)	0 (2)	0 (1)
9	0(0)	1 (2) [one missed 2 days]	0 (1)
10	4(4)	2 (2) [both missed 1 day]	0 (1)
11	0(0)	0 (2)	0 (3)
12	0(2)	0 (0)	0 (0)
13	1(3)	0 (2)	1 (2) [one missed 1 day]
14	2(3)	0 (2)	2(2) [one missed 2 days One missed 5 days]
15	1(1)	0 (1)	2(2) [both missed 1 day]
16	0(0)	0 (1)	1 (1) [one missed 2 days]
17	1(1)	0 (0)	0 (0)

In the family support group we see that in phase one 9 of the 18 children enrolled in school (50%) were reported to have missed school in the last week. In phase two, we see that 2 of the 18 children and young people enrolled in school have missed a day of school (11%) and in phase three, we see that six (6) of the 17 children (35%) had

missed at least a day of school and the amount missed ranged between one and five days.

In both samples, the majority of children did not miss school in the last week except in the first phase. In that phase, half of the children and young people in the family support group had missed at least a day of school in the previous week, although it should also be noted that a larger proportion of children in the family support group were enrolled than was the case for the crisis intervention group. Given that in the other phases, the majority of children did attend school without absence, we do not suggest there is a substantial difference in school absences between the two samples.

For both groups, key reasons for absence related to financial and transport difficulties.

Both the respondents and the practitioners identified that lack of money for lunch or bus fares were reasons for children in both groups missing school. In both groups, a small number of respondents identified learning difficulties as presenting challenges for the family. Two members of the crisis intervention group and one of the respondents in the family support group also raised issues about the hidden costs of school attendance, as illustrated in the excerpts below:

*“I always make it. Financially it can be difficult - in terms of stuff they need to have - school is not cheap: books, excursions, swimming lessons. I pay things off in instalments. The school is supportive” (crisis intervention respondent).*

*“Being able to pay the school fees, text books. The original problem was my ex-partner not paying the child support so I couldn't get the girls to school, plus the older son was incarcerated which affected the girls” (family support respondent).*

In both groups, families experienced substantial financial disadvantage and the hidden costs of school participation could serve as a barrier to regular school attendance.

Three families in the crisis intervention group reported violence to be an issue, in two cases this was specifically domestic violence. As the mother in this family stated:

*“I have to keep everything a secret. I have to state on the enrolment form that none of my ex-partners can come to the school” (crisis intervention respondent)*

In addition to issues of domestic violence, one participant identified that their family had been a victim of crime and fear of further attacks was a barrier to school attendance.

Participants in the crisis intervention sample identified housing instability as a barrier to regular school attendance. When asked what barriers, if any, their children faced in regularly attending school, two respondents stated:

*"Accommodation - because last couple of months I've been moving around because I haven't been able to get decent long-term accommodation - makes it hard to get him to school" (crisis intervention respondent).*

*"Lot of worries because being in a hostel you don't know where you're going to be. We face a lot of judgement when kids forget to bring something, but we are trying our hardest" (crisis intervention respondent).*

We can see in the second example that the respondent stated their housing instability contributed to stigma for her children. Two participants in the crisis intervention sample raised concerns that school attendance also risked exposing the family to more surveillance by government agencies, particularly child welfare services. As these respondents stated:

*"Because I'm an Indigenous woman there's that constant stereotyping...the Principal actually called in family services...I said 'No, this is ridiculous'" (respondent, Crisis Intervention).*

*"Worries I have is people getting worried about a little scratch...you know, 'should we ring family service'...so I'll be prepared for it, I'll be prepared for it heaps." (crisis intervention respondent).*

While this concern about welfare surveillance was raised by only two participants in the crisis intervention sample, it was not raised by any participants in the family support group.

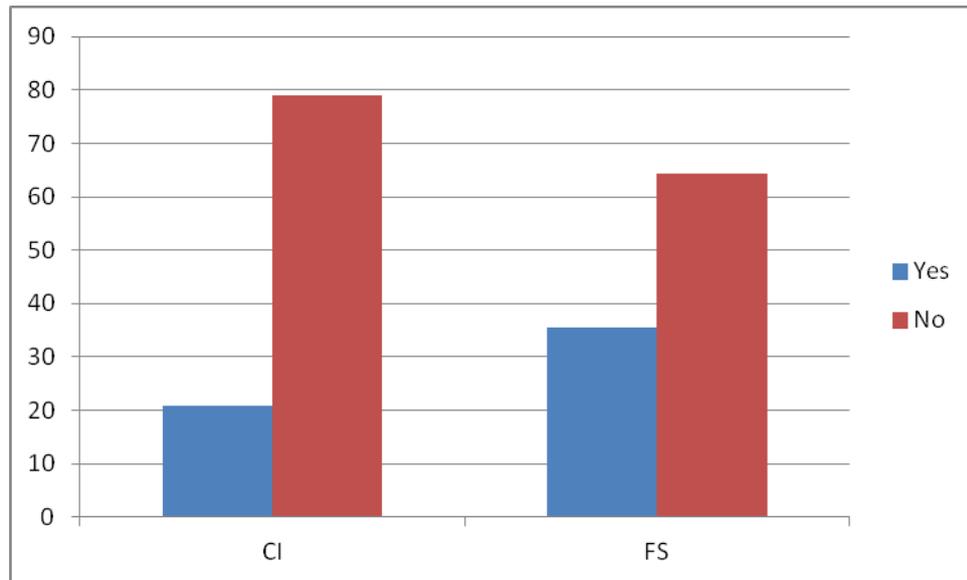
### **Summary: Patterns of child-care, pre-school and school attendance**

Overall, we see that participants in the crisis intervention group were less likely than the family support group to enrol their children in child-care or pre-school. We also see that there were lower levels of enrolment of children in the crisis intervention group in the first phase of data collection. This lower level of enrolment appeared to be due to the timing of the data collection phase around the long holiday break at the end of the school year. The fact that this pattern of non-enrolment was not found later in the sample may be due to the high drop out rate of crisis intervention families and the possibility that families less likely to enrol their children did not participate in the later phases of the study. Another possibility is that families in the crisis intervention sample struggle to maintain enrolment around long school breaks because of uncertainty about long term accommodation arrangements.

## Children's access to specialist medical or allied health services

We asked participants whether their children received specialist medical or allied health services, such as speech therapy and psychology. The following table shows the percentage of respondents in each category who indicated that their children received these services.

**Figure 11: Do your children receive allied health services?**

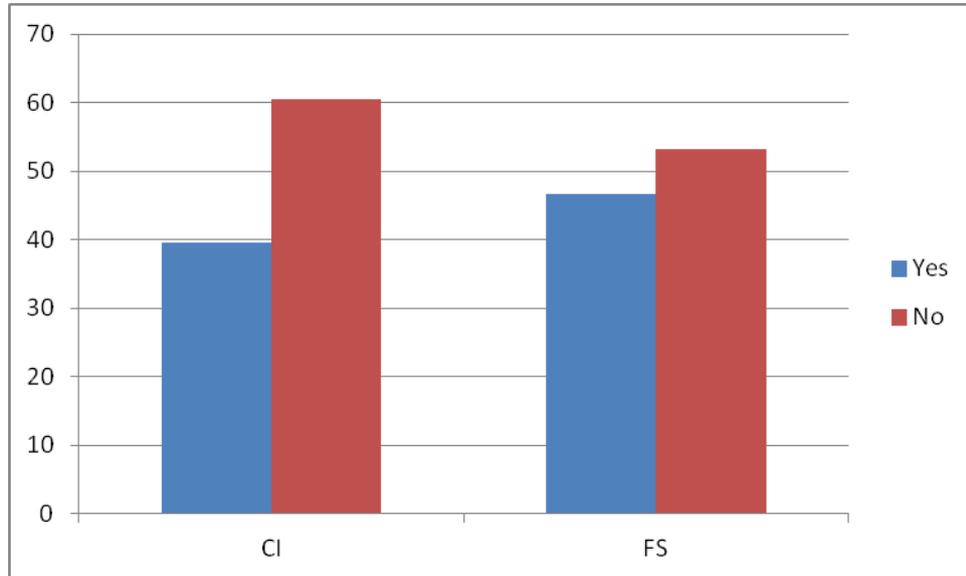


Nine of the 43 (20.9%) of crisis intervention respondents answered yes to this question. The range of services these respondents reported that their children received included speech therapy, occupational therapy and psychological support. Four of the respondents referred to paediatric or midwifery services as services to which their children had access.

By contrast, 16 of the 45 (35.6%) of respondents in the family support group indicated that their children had access to specialist medical or allied health services. Four of these responses related to children accessing counselling or psychological services and another five were for allied health services (physio, speech and occupational therapies). The remaining seven examples involved children's access to child health services and paediatric services.

We also asked about respondents' perceptions of unmet needs for specialist medical and allied health services. We asked the respondents whether they believed that their children needed specialist medical or allied health services but lacked access to them. In Figure 12 we outline their response to this question.

**Figure 12: Do you believe your children need allied health services but lack access to them?**



In both samples, a large group of respondents reported that their children lacked access to specialist medical or allied health services they needed. Twenty-one (21) of the 45 respondents (46.7%) in the family support group identified that their children lacked access to services they needed. Seventeen (17) of the 43 respondents (39.5%) in the crisis intervention group indicated that they believed their children lacked access to specialist medical and allied health services. In both groups, respondents discussed the need for better access to dental services. For example, when asked what services the children need, one respondent in the family support group stated that:

*"Dental - because to go private it's so expensive. Children have work they need done on their teeth that we cannot afford. And, it's almost impossible to get an appointment at the dental hospital" (family support respondent).*

In both groups, respondents identified that children needed better access to allied health therapies, particularly speech therapy and there was strong demand for programs to assist children with learning difficulties.

In the crisis intervention group, respondents discussed the need for services to help their children deal with trauma and exposure to violence. For example, one respondent in the crisis intervention sample stated that:

*"[need help] with [daughter]. She's so beautiful, but that sniffing has killed her brain cells. She's going through a lot of grief and hurt over what her family has been through. She was close to her sister who died two years ago due to a terminal illness." (crisis intervention respondent).*

Another respondent stated:

*“I think my son needs counselling due to living situation we live in. The person I share with becomes violent towards me and he has hit my son once. I’m having a lot of drama with my son’s behaviour and I’m sure it’s a backlash to our living situation.” (crisis intervention respondent).*

Although some in the family support group also discussed the need for counselling services, it was generally to deal with past events rather than current experiences.

## 7.0. Reported use of a range of health and community services

We asked participants to identify whether they had used any of a range of health and community services over the last 12 months. The services we considered are listed below and include child safety, mental health, general health, and Centrelink and employment assistance services. The following table outlines participant responses in relation to the type of services they had used and the number who had used them.

**Table 17: Reported use of health and welfare services by sample type and data collection phase**

	CI Phase 1	FS Phase 1	CI Phase 2	FS Phase 2	CI Phase 3	FS Phase 3
Child Safety Services	15	8	5	3	6	9
Mental Health Services	12	10	6	8	1	12
Drug Treatment Services	9	5	3	3	2	3
Alcohol Treatment Services	7	1	2	1	1	3
Family support services	15	36	8	17	7	19
Emergency relief	31	12	14	6	11	19
Domestic violence	15	7	2	3	2	4
Centrelink services	25	24	5	3	22	39
Employment services	22	12	6	10	8	13
Medical services	NA	0	22	35	19	31
Police services	NA	0	7	6	9	14

Table 17 shows that in the first phase the service use patterns among respondents in the two samples differed in certain ways. In phase one within the crisis intervention group, there was greater use of child safety services, alcohol treatment services, and domestic violence and employment services. The crisis intervention group also made less use of family support services than those in the family support sample. Interestingly, respondents in the family support reported making much greater use of mental health and this difference becomes more substantial over the course of the data collection.

We note substantial variation in the use of Centrelink services over the different phases of data collection. The qualitative data does not indicate why comparatively so few respondents reported on their use of Centrelink services in phase two, but we can see that in phase one, over half of the participants in both samples report using these services and by phase three the majority of service users in both samples report using these services. It is likely that this is due to a change in the way Centrelink services were described to families by the interviewer in phase one and two (as only services other than payments) and round three (any contact with Centrelink including relating to payments)

In later phases of data collection we also asked about use of medical and police services. We sought this information in later round because in phase one, participants had spontaneously remarked on their use of these services. The data indicates that a substantial minority of respondents in both samples used these services.

We note that the service use patterns of the samples converge in several ways by the third phase of data collection. These include similar levels of child protection intervention, emergency relief, domestic violence, employment and medical services.

## **Service inputs**

Participants were asked about services they found most helpful to themselves and their family, and about services they had found least helpful to themselves and their family. Overall, participants identified a wide range of organisations providing a wide range of services as both helpful and unhelpful. In this section, we examine the themes in their responses.

## **Services participants found most helpful**

Participants were asked which services they found most helpful for themselves and their families. In this section, all participants noted a wide range of services. In the crisis intervention sample, 47 participants specified non-government services. Eight (8) participants noted government services. In the family support sample 65 participants noted non-government services, 9 noted government services. In both samples, there were many instances where participants did not specify which service type they were referring to when discussing what they found helpful or unhelpful about services.

Participants were also asked to explain why they found these services helpful. The answers provided relate to a wide range of different organisations, providing a wide range of different services. However, from these answers a few general themes were identified. Overall there were a number of differences between the answers provided by the crisis intervention sample and the family support sample. Four key themes were present in the answers provided by the crisis intervention sample. The first was the attitude of staff, or the relationship developed between themselves and the service provider. This included statements such as *“They’ve never gave up, they*

*never will*” (crisis intervention sample) and *“make you feel welcome and not look at you like you’re off the street”* (crisis intervention sample). The second theme was assistance with accommodation. The third was assistance with material aid, for example food vouchers. The final theme was assistance with information, advice and referral.

A key difference between the two samples was that the family support sample noted at a far higher rate the attitude and relationship developed between themselves and the service provider. For the family support sample also this theme appeared to be closely tied to a long-term relationship with the service provider, and the provision of a comprehensive service response. This was evidenced by statements such as *“helped me with housing, with moving, with connecting with different services...just lots of support and practical things...and being a friendly shoulder to cry on or listen to”* (respondent, family support), *“They have helped me through so much, they’ve been there when I needed a shoulder to cry on”* (respondent, family support) and *“They have been like a family to me”* (respondent, family support).

Overall however a key shared theme between the two groups was appreciation of services that provided them with practical assistance in the context of a supportive relationship. This supports findings that the most effective change for service users occurs through the provision of comprehensive, practical support by workers with whom the service user has a persistent, reliable, intimate and respectful relationship (Gronda 2009, pp.9-11).

### **Services respondents found least helpful**

Participants were asked which services they found least helpful for themselves and their families. In this section, all participants noted a wide range of services. In the crisis intervention sample, 17 participants noted non-government services. Eighteen participants noted government services. This is a rough calculation as occasionally, due to the way participants answered the question, it was difficult to ascertain the exact service they were referring to.

In the family support sample 12 participants noted non-government services, 17 noted government services. Again, this is a rough calculation as occasionally, due to the way participants answered the question, it was difficult to ascertain the exact service they were referring to.

Participants were also asked to explain why they found these services unhelpful. Again, the answers provided relate to a wide range of different organisations, providing a wide range of different services. However, from these answers a few general themes were identified. Both samples identified 3 main themes around services they found unhelpful to themselves and their families. The first was that the service did not or was not able to provide them with the support they needed. The second was that the staff at the service did not treat them in a respectful or caring manner. This was evidenced through statements such as *“It’s kind of like ‘I’ll listen to your story, but once you walk out that door you don’t exist to me any more”* (family

support sample), *“they worry about their own life, their own problems, they don’t worry about us...they gossip amongst each other”* (crisis intervention sample) and *“I think they’re racist, they don’t have the cultural awareness, they don’t try and understand our people and our cultural needs”* (crisis intervention sample). The third theme was that the processes the service used were poor and the communication to the service user was problematic, for example *“You never get told the same story twice, you have to tell the same story a thousand and ten times and you get a different answer each time”* (crisis intervention sample), and *“my case worker (Child Safety Services) was useless as anything. She never called when she said she would and she never visited when she said she would”* (family support sample).

## 8.0. Practitioners' perspectives on working with vulnerable families

We examined the focus of the work via a case record review and also through three focus groups with practitioners. We undertook a review of the case-records at Micah Projects regarding main fields of practice undertaken with participants who were Micah Projects clients. Twenty four participants in the crisis intervention group and thirty two in the family support group were Micah Projects clients. Table 18 indicates the nature of work undertaken with clients in both sample groups in the previous month.

**Table 18: Nature of work undertaken in the previous month with Micah Projects service users who were participants in the research project**

	CI	FS
No Contact	16	1
Housing issues	8	9
Child and family issues	0	5
Financial Assistance	0	3
Domestic Violence	0	3
Support (emotional and practical support)	0	6
Training, employment and education	0	5

The case record review showed that workers tended to provide a narrower range of services to clients in the crisis intervention sample than those in the family support sample; this, of course, is consistent with the distinct features of the models of intervention. Another difference in the nature of service provision was that the majority of the crisis intervention group had no service contact in the previous month and where contact did occur it was in relation to housing. In most cases, this was about support to find crisis accommodation. This focus is reflective of the greater housing instability in this group. Although family support workers were also focused on housing issues the nature of this work tended to be on supporting service users to maintain their tenancy.

Consistent with the planned family support approach, case record data showed that family support workers engaged in a more varied range of service provision activities. Service provision included providing service users with support with parenting issues, gaining access to child care and managing child protection concerns. Intervention to address domestic violence was also noted as an area of service provision. The provision of emotional and practical support was noted as the primary area of work in six cases and provision of assistance in relation to training, employment and education was also reported in five cases.

Thirty two respondents were receiving family support services from Micah Projects. The following table outlines the nature of the work undertaken with these families and the time allocated to it, as reflected in the case records.

**Table 19: Time allocated to categories of family support work for participants in research project.**

Housing	Child and family	Domestic and Family Violence	Financial	Support	Employ. Training and admin	Admin
55.9	45.4	48.6	22	43	36.8	0.5

Based on the overall hours, we then calculated the average time per client load in the past month on specific field of service delivery.

**Table 20: Average time allocation to categories of family support work for participants in research project.**

Housing	Child and family	Domestic and Family Violence	Financial	General Support	Employ. Training and admin	Admin
1.75	1.42	1.52	0.7	1.3	1.15	0.02

We see that even within the planned family support group, housing issues absorbed the greatest amount of worker time, although child and family support and domestic and family violence issues required similar time allocations.

In focus groups, respondents from both family support and crisis intervention teams were asked to rank order areas of priority in their work. The workers could also add priorities. The list of practice areas provided to the group was: housing, child protection, domestic violence, health, education and training, and employment.

Housing issues were identified as the primary priority for both the crisis intervention and family support teams. Lack of access to affordable and adequate housing was seen as a major barrier to achieving other outcomes such as education, employment and training. It was observed by the crisis intervention workers that the Global Financial Crisis had brought a different kind of family to crisis intervention services. The Participate in Prosperity workers were the only group of respondents who did not identify housing as the top priority of their practice. Instead, members of this team identified education, training and employment issues as their top priority. This focus reflects the fact that service users in this program were referred from other services in the agency which also continued to work with the families to address needs such as housing and other forms of support.

Family support workers were more likely to report focusing on parenting and children's needs as a high priority in their work. Indeed, across all family support teams, workers identified this as their second highest priority (after housing). This work area was not identified on the original ranking list but was instead added to the list by all of the family support workers; this suggests the high priority of this work area to this group of practitioners.

Helping families to escape domestic violence was an important theme in both groups. Data from the service user interviews suggested that family support workers were also very involved in helping families to address the aftermath of violence. While, undoubtedly, social isolation and financial hardship affected both groups, only the crisis intervention workers mentioned this as a high priority in their work. Notably these work areas were not identified on the original ranking list but were added by the crisis intervention workers, presumably reflecting the high priority of this work field. Even so, the issue of isolation was clearly a concern for both groups as indicated in the qualitative data. For example, one of the family support workers commented: *"my caseload includes very few families who have friends"*.

Despite the differences in the issues being responded to by the family support and crisis intervention groups, some common themes emerged in the practice approaches of both groups. These included the importance of building relationships with families and the importance of persistence as families are likely to be resistant or reluctant to engage at first. A second theme was the importance of addressing urgent practical needs first, such as housing and food. A third theme was the value of a planned and structured approach that enables the family to move towards long term goals and involving families in the assessment and intervention process. As one crisis intervention worker stated:

*"We keep them [the family] up to date. So not leaving the room and making phone calls. We keep them involved. They see that we are engaged. They see we have gone through a list and we have tried. They see the options that are available. That works for lots of people."*

A final common theme was the importance of the worker engaging in a consistent but flexible way with families. This involved following through on any undertakings with the client and also being able to adapt to the families' circumstances. As one family support worker described it, her role involved: *"Joint visits with the other teams the family is involved with. Being flexible in your role as well, so doing things that may not be exactly in your job description"*.

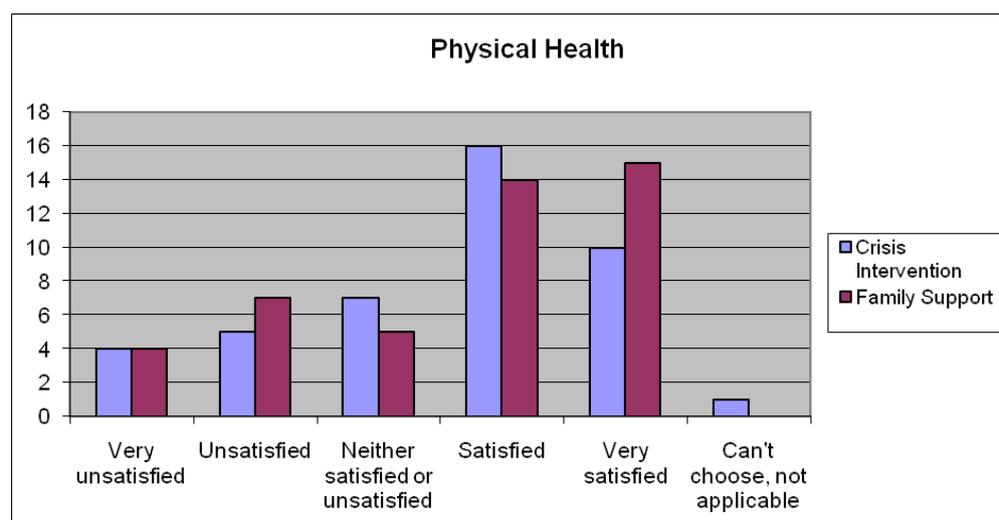
## 9.0 Goals and quality of life questions

We asked respondents a series of questions about their quality of life. In the first round we collected base line data on levels of satisfaction in relation to matters such as the physical and mental health of the family, social relationships, involvement in community activity, employment and their current relationship. We also asked them to detail their goals over the coming year in relation to these areas. In later phases, we asked them to comment on whether each of these dimensions of their life had changed over the past six months, particularly whether it had got better or worse.

### Physical health

We asked participants to rate, on a five point scale, their satisfaction with their own physical health and that of their family. Figure 13 outlines the range of responses to this question by sample group.

**Figure 13: How satisfied are you with you and your family's physical health?**



A wide range of responses were recorded in both groups and the average score for both samples was 3.6 out of 5. The distribution of responses was varied with participants in the family support group significantly more likely to report being very satisfied with their family's physical health than those in the crisis intervention group.

Overall there was not a great difference in the ratings given by the crisis intervention sample as opposed to the family support sample. Participants were also asked to explain the reasons for these rankings.

### **Participants who ranked their satisfaction with their and their family's health as 'unsatisfied' or 'very unsatisfied'**

There were a few common reasons given by families in the crisis intervention sample and the family support sample for their ranking as unsatisfied with their own and their family's health. Behavioural reasons, for example smoking, drinking and exercising were noted by both groups, illustrated by statements such as *"I didn't think I had a problem with alcohol, but I do, my liver is packing it in. I probably have a six pack or more a day"* (crisis intervention respondent). Instances of poor quality health care provided by health services was noted by one participant in each sample, with one participant stating the *"(hospital) midwives didn't do the stitches right after the baby so (I) was in a lot of discomfort"* (family support respondent). A final common theme was medical conditions, for example *"I gotta wait for an operation to get my gall bladder out, my kidneys are stuffed and I've got to have a heart operation"* (family support respondent).

A key difference between the samples was around mental health, with three participants from the crisis intervention sample noting mental health problems. This was not raised by the family support sample. Statements included *"It's (mental health problems) affecting my partner which then affects the children which then affects me"* (crisis intervention respondent). The family support sample also raised concerns resulting from the operation of government departments and services, including the health system and welfare system, with statements such as *"because dental health (care) is hard to get a hold of"* (family support respondent), and *"my partner's borderline disabled but not considered disabled enough for a disability support pension. They disregard his medical condition"* (family support respondent). These issues were not raised by the crisis intervention sample. One participant from the family support directly linked her physical health concerns with her current housing and family circumstances, stating *"I think it's cos of my current situation, it brings me down. I eat a lot, I use to be really fit and healthy, I use to walk everywhere, I've put on a lot of weight since I've been in the refuge"* (family support respondent). This link was not made explicit by other participants.

### **Participants who ranked their satisfaction with their and their family's health as 'neither satisfied or unsatisfied'.**

There was little difference in the kind of responses given by participants who ranked their satisfaction with their own and their family's health as 'neither satisfied or unsatisfied' compared to those who ranked their health as 'unsatisfied or very unsatisfied'. Again, a common theme between the samples was behavioural reasons, such as *"alcohol brings out all the sickness"* (crisis intervention respondent). The crisis intervention sample again identified mental health concerns as impacting on their physical health, with statements such as *"the emotional stuff takes its toll, I feel sick"* (crisis intervention respondent). This was not noted in the family support sample. One crisis intervention participant noted a concern resulting from the operation of the health system, with the statement *(the Indigenous medical centre can take forever. Some day they'll turn up on time and other days have to wait. Other day the baby had an ear infection and they didn't turn up as expected and we had to*

*find another doctor*" (crisis intervention respondent). Specific medical conditions noted included weight problems, blood pressure, premature birth and pregnancy.

### **Participants who ranked their satisfaction with their and their family's health as 'satisfied or very satisfied'**

Two main reasons were raised by both samples. The first was the absence of health problems, evidenced by statements such as *"there's nothing wrong with us"* (family support respondent) and *"we're not sick or anything"* (crisis intervention respondent). The second shared theme was behavioural reasons, or actions taken to promote health, evidenced by statements such as *"I used to be very bad, I used to drink, I used to sniff...I don't even crave it no more"* (crisis intervention respondent), and *"we eat healthy, once a week we have takeaway but six days a week we make meals"* (family support respondent).

A key difference between the samples was the participants in the family support sample noted regular visits to health care services as a strategy to maintain their health. This was illustrated by statements such as *"been able to get to the doctors and look after him properly"* (family support respondent). Interestingly this was not mentioned by crisis intervention participants, and may reflect the greater level of support provided to the family support participants to access health care services.

### **Participants' aspirations for their physical health**

We asked participants to identify what they would like to change about their and their family's physical health. There were common themes in both samples. Most notably, a substantial proportion of respondents in both samples (about 12 overall) stated that they did not have any aspirations with regard to changing their physical health. Furthermore, in both groups, many respondents discussed aspirations related to improving their general physical health, by, for example, giving up smoking, losing weight and undertaking exercise.

*"I'd like to get a bit fitter and work off my baby belly that I haven't lost yet"* (respondent, family support sample).

*"I guess my weight - to feel more energetic. And, I'd like to quit smoking - which I did for two months weeks ago but failed. That's definitely something I want to look at - especially for the kids and the passive smoking."* (crisis intervention sample respondent).

This concern with achieving improvements in one's general health was found in both samples. Both groups also referred to ongoing substantial health problems including: heart complaints, arthritis, gall stones.

The one area in which the groups varied was the greater impact of crowded and unsuitable living conditions as an impediment to physical health. The crisis intervention group were more likely to raise issues concerning the unsuitability of their current living environments for achieving optimal health.

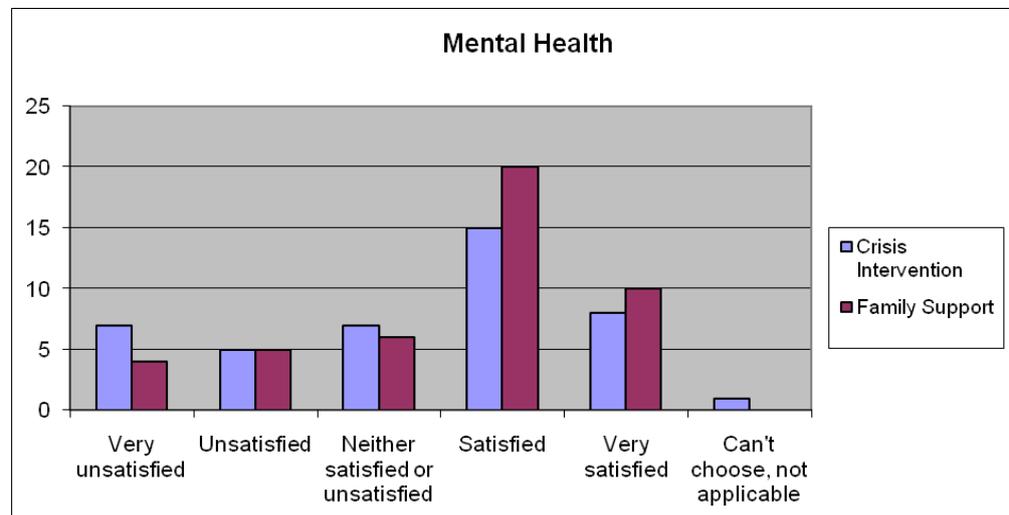
*"Just being out on our own, our own little family, that would be a lot healthier; especially now with the eldest going to school, I'd like to be able to sit him down in a quiet room" (crisis intervention respondent).*

As this response suggests, overcrowded living arrangements contributed to health problems for some families.

## Mental Health

Respondents were asked to rate their satisfaction with their own and their family's mental health. The range of responses in both groups is outlined in Figure 14.

**Figure 14: Respondents' satisfaction with their and their families' mental health by sample type.**



The average score for the crisis intervention group was 3.35, which was lower than the family support group which recorded an average of 3.6. We see also that the crisis intervention group had a slightly greater representation among those who were very unsatisfied with their mental health. Participants were also asked to explain the reasons for these rankings and we turn now to an analysis of their responses.

### Participants who ranked their satisfaction with their and their families' mental health as 'unsatisfied' or 'very unsatisfied'

There were two reasons for this ranking that were shared by the family support sample and the crisis intervention sample. The first was specific mental health conditions, or symptoms of distress. Specific conditions mentioned were depression and bi-polar disorder. Statements around symptoms included *"I struggle, most days I hate my head"* (family support respondent), and *"I get mood swings which affects my partner and daughter"* (crisis intervention respondent). The second shared theme was around stressful circumstances in family's lives, illustrated by statements such as

*“Because with (child), he’s seen a lot of violence, his father would be drunk and he’d be on the street. He has dealt with a lot of negativity. (other child) is not too bad, (but) he’s dealing with a lot of issues too with his father. I’m concerned about (third child), and all the stress, losing the house (in a fire)”* (crisis intervention Respondent). However, a key difference is that six participants from the crisis intervention sample mentioned stressful circumstances, compared to only three from the family support sample. This may reflect the greater insecurity and instability experienced by the crisis intervention families generally.

A second difference between the two samples in relation to this question is that two participants from the crisis intervention sample mentioned substance use impacting on their and their family’s mental health. One participant stated that her daughter was sniffing, but that she had had difficulty accessing services to help her daughter (crisis intervention respondent). The other participant stated that *“it’s really isolated where they are (eldest daughter, cousins and brothers). There’s nothing to do but listen to the birds plus drink or sniff”* (crisis intervention Respondent). A participant from the family support sample also expressed a desire for greater social understanding about mental health and more peer mental health services, along with making medication easier to access (family support respondent).

#### **Participants who ranked their satisfaction with their and their family’s mental health as ‘neither satisfied or unsatisfied’**

There was little difference in the kind of responses given by participants who ranked their satisfaction with their own and their family’s mental health as ‘neither satisfied or unsatisfied’ compared to those who ranked their health as ‘unsatisfied or very unsatisfied’.

The two shared themes of specific mental health conditions or symptoms of distress; and stressful circumstances in family’s lives were evident in this question also. However, again the crisis intervention sample noted stressful circumstances more frequently than the family support sample, with statements such as *“it’s more the emotional upsets that we all had throughout the year that has led to our moods...domestic violence by the kid’s father caused the upset”* (Crisis Intervention Respondent) and *“it’s the stress on top of everything (stress from fearing homelessness)”* (Crisis Intervention Respondent).

#### **Participants who ranked their satisfaction with their and their family’s mental health as ‘satisfied or very satisfied’**

The most common reasons for satisfaction given by both samples was the absence of mental illness, evidenced by statements such as *“because we don’t have mental health (issues)”* (Crisis Intervention Respondent). However, a number of the statements made by the crisis intervention sample along these lines appeared to demonstrate an element of denial of mental health concerns, or a lack of knowledge about mental health. For example, one participant stated *“I just have a little bit of post-natal depression...I just have melt-downs sometimes”* (crisis intervention). It is possible this is a response to the stigma associated with mental illness and psychological distress within society. The fact that it was the crisis intervention

sample that appeared to most demonstrate this may be due to a relative lack of support around mental health concerns, compared to the family support sample. This assistance may have aided the family support participants to acknowledge the impacts of homelessness on mental health. Similarly, the family support sample may have felt more comfortable speaking to the researchers about mental health concerns due to experience talking about these issues with their support workers.

Another shared theme was around receiving support to address mental health concerns. Four participants from the family support sample and three from the crisis intervention sample noted receiving assistance with mental health concerns, for example *“I put my hand out and got myself some help...I’m on the right medication now”* (family support respondent). One participant from the family support sample noted that this assistance came from their support agency.

A final shared theme was around changing circumstances allowing for an improvement in mental health, illustrated by statements such as *“been settled after moving into this house and both kids have got into their course which means we both get to have a break”* (family support respondent), and *“like I said, the reason why I took them (children) out, their mothers a drug addict, suicidal, tried to commit suicide in front of them...now they’re as happy as can be (since children moved into fathers care)”* (crisis intervention respondent). There was no great difference between the two samples in this respect.

### **What participants would like to see change over the coming year regarding their and their family’s mental health**

There was a considerable difference in the way the family support and crisis intervention samples answered this question. A strong theme within the crisis intervention sample was a desire for changes around housing and income issues, illustrated by comments such as *“stability to fix up our worries...stability and housing”* (Crisis Intervention Respondent), and *“I’m hoping I’ll have a stable home where me and my kids can finally be happy”* (Crisis Intervention Respondent). These issues were only briefly mentioned in the family support sample by one participant, who stated *“stop stressing, I stress about running out of things like nappies, milk formula, I stress about the money and where you’re going to get it from”* (Family Support Respondent). Again, this may reflect greater instability experienced by the crisis intervention sample.

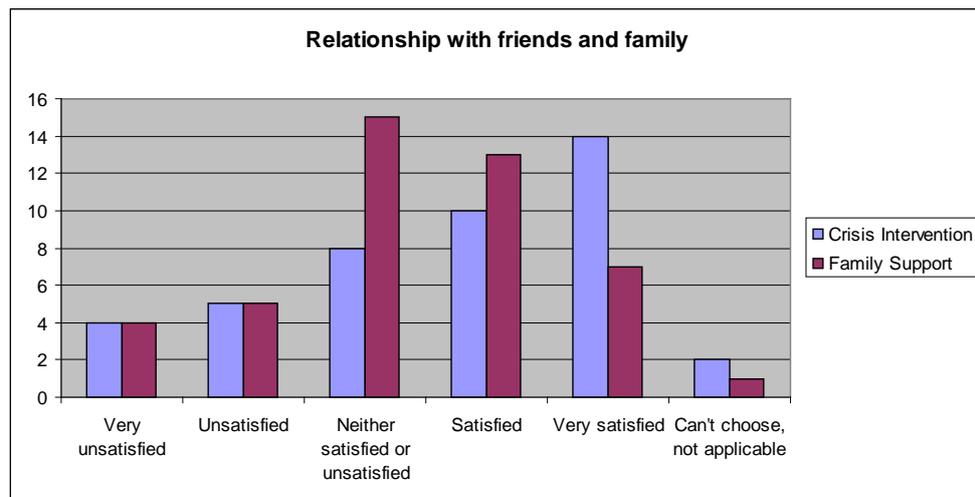
The family support sample in contrast spoke far more frequently about addressing mental health concerns and psychological distress, with statements such as *“to feel better about myself, to be a confident, strong person”* (Family Support Respondent). Twenty-five (25) family support participants spoke of this desire, compared to 11 crisis intervention participants. The family support sample also noted engagement with mental health services, or a desire to be engaged with mental health services, at a far higher rate than the crisis intervention sample. This was illustrated by statements such as *“I’m just going to keep seeing this psychologist, and yeah just see where it goes from there”* (Family Support Respondent) and *“get (child) into counselling and get a mental health check up”* (Family Support Respondent). This

may be due to greater assistance from support workers to access mental health services, and/or their greater stability has given them the time and resources to begin to address mental health concerns.

### Family and Friendship Relationships

Respondents were asked to rate, on a five point scale, their satisfaction with their family and friendship relationships.

**Figure 15: Satisfaction with friendship and family relationships by sample type.**



Notably on this dimension of quality of life, the crisis intervention group reported higher levels of satisfaction than the family support group. The average score for the crisis intervention group was 3.7 while the family support group was 3.4. It is noted that more family support participants ranked their family and friendship relationships as 'neither satisfied or unsatisfied' and 'satisfied'; whereas more crisis intervention participants ranked their family and friendship relationships as very satisfied.

#### Participants who ranked their satisfaction with their family and friendship relationships as 'unsatisfied' or 'very unsatisfied'

The major theme in both crisis intervention and family support responses to family and friendship relationships is one of disconnection from family; and a lack of connection with others. Other themes relating to family relationships included issues with the partner's family (in-laws), mental health issues and physical distance from family. Other themes relating to friendship relationships include having family members as friends, and changes in circumstances that affected relationships with friends. Family support responses identified a lack of family support as a common reason for negative family and friendship relationships and to a lesser extent distance from ones family and friends was also identified as a reason for unsatisfied family and friendship relationships.

Crisis intervention and family support responses showed that low satisfaction with family and friendship relationships occurred when there was disconnection from family and friends, for example *"None of my family want to know me and some of them I don't want to know them."* (crisis intervention respondent). Crisis intervention responses attached mental health issues as well as problems with a partner's family (in-laws) as the reason for their disconnection from their family, illustrated by statements such as *"His mum don't like me. My parents hate him, his parents hate me. Situation like this makes it hard to fix our relationship."* (crisis intervention respondent). To a lesser extent crisis intervention responses identified distance from family as a reason for a low relationship with family, for example *'My two sons Mum married someone when I was away at work.'* (crisis intervention respondent). Family support responses attributed a lack of family support as the reason for their disconnection from family, for example *"It's not my friends, it's me and my family doesn't give me support...things could have been a lot different if I had of had support."* (family support respondent). Distance played a lesser role in participants feeling disconnected from their family.

Crisis intervention participants identified a lack of connection to people and changed life circumstances as the reason why they were not satisfied with their friendship relationships. Both crisis intervention and family support participants acknowledged experiencing social isolation from people or not being able to form social networks, for example, *"What friends??? When I had a nice house, I had lots and lots of friends but they weren't real...Men don't have the same networks as women."* (crisis intervention respondent). A change in life circumstance was also identified by crisis intervention participants as a reason for unsatisfied friendship relationships, for example *"They can't handle that I have a baby now...it's no more partying"* (crisis intervention respondent). Two respondents identified that their family were their friends, but saw this as a negative, for example *"None of my family want to know me and some of them I don't want to know them. My sister-in-law is the only friend I got."* (crisis intervention respondent). Family support responses to friendship relationship identified a lack of connection to people and the negative influence of friends, for example *"My friends are bad friends so I don't really hang around them, they cause trouble."* (family support respondent). Concerns surrounding social isolation may be linked to limited social networks and participation in social activities, illustrated by statements such as *'I don't have a lot of friends...I feel sorry for them cos I'm always saying shit is happening. I used to be really social but when you've been shit on, I just withdraw...I don't want to know anyone"* (Family Support Respondent).

There are a lot of similarities in the responses given by crisis intervention and family support participants. The only major difference was that crisis intervention responses attributed the disconnection with family to an event, such as abuse, mental health issues or disputes with partner's family (in-laws). These problems may be more apparent in the crisis intervention responses, because the conflicts experienced between family and participants may be a contributing reason for their contact with a crisis service on the day of interview.

### **Participants who ranked their satisfaction as ‘neither unsatisfied or satisfied’**

Again, there was a strong theme of disconnection for both samples. Participants felt disconnected from their family and experienced difficulty increasing or maintaining their social networks.

### **Participants who ranked their satisfaction as ‘satisfied’ or ‘very satisfied’**

Overall, both samples made general statements about positive relationships, but did not provide high levels of detail. An interesting theme for both samples was satisfaction due to withdrawing from contact with friends or family who they had had negative relationships with, evidenced by statements such as *“cause I’m pretty good without my friends, they dragged me down”*, (Family Support Respondent), and *“I stay away from family, all they want is money money money, they always broke”* (Crisis Intervention Respondent). Participants from both samples also indicated that their satisfaction was due to reconnection with family, with one participant from the family support sample reconnecting with her younger sister after 13 years with no contact; and a crisis intervention participant reconnecting with her brother. A difference between the samples was that more family support participants noted changes that they had made which had led to more positive relationships, for example *“Now that I’ve left my ex-husband, I can get out and see friends... (I was not able to do that before”* (Family Support Respondent), and *“cause I’m pretty good without my friends because they dragged me down – getting into trouble – in and out of court. When I was on the street I was drinking everyday, chroming, stuff like that. I’m pretty glad they’re out of my life”* (Family Support Respondent). Another difference is that the crisis intervention sample were more likely to indicate that their friends or family were providing them with support, for example *“I love my friends...they support me through everything”* (Crisis Intervention Respondent). This may be due to the fact that these participants were interviewed when they were seeking assistance from a crisis service, and thus their experience of receiving support from friends and family due to a crisis situation was more recent.

### **Participants’ views on what they would like to see change over the coming year regarding their family and friendship relationships**

Overall respondents in both samples made statements around reconnecting or strengthening relationships with family. This was a strong theme for both samples, evidenced by statements such as *“I’d like a better relationship with my father and my older sister”* (Crisis Intervention Respondent). However, there were a number of interesting differences between how the two samples answered this section. Eight participants from the family support sample stated that they would like to increase the number of friends they had. Only one participant from the crisis intervention sample made a statement like this. This is interesting given that in the earlier section, a strong theme for both samples was a lack of social connection. It may be that the greater stability experienced by the family meant that they could begin to consider expanding their social networks. This is supported by statements made by five crisis intervention participants that housing is needed for them to be able to improve their family and friendship relationships, for example *“I would like our relationship with my wife’s brother to be better but the problem is housing. Once we*

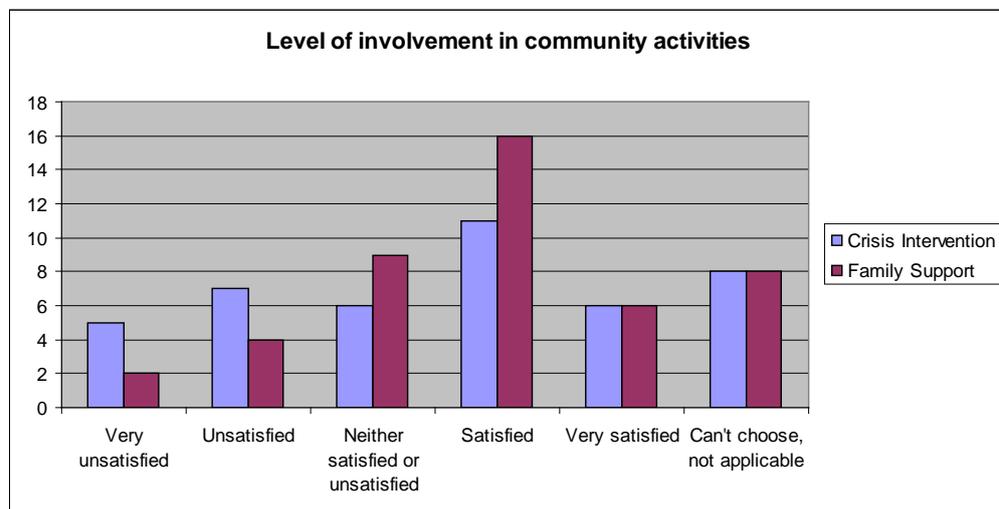
*get our place it will improve” participant and family are currently living with extended family (Crisis Intervention Respondent), and “I’d like to have a house so they can visit me for once” (Crisis Intervention Respondent). No participants from the family support sample echoed this theme.*

Additionally, 20 crisis intervention participants stated that they did not want anything to change, compared to only seven family support participants. However, both samples reported similar levels of satisfaction and dissatisfaction with family and friendship relationships. This arguably supports the idea that it is the greater stability experienced by the family support sample that has allowed them to consider improvements to their family and friendship relationships. Interestingly, two of the statements from the crisis intervention sample indicating they did not want changes suggested resignation rather than satisfaction, for example *“I can’t change anything with my family, and with friends... I don’t want to change anything”* (crisis intervention), and *“I haven’t got the foggiest idea”* (crisis intervention).

### **Involvement in community activities**

Participants were asked to rate on a five point scale their satisfaction with their level of involvement in community activities, such as participation in sports; volunteering; participation in their child’s school or other community networks. The range of responses is indicated in Figure 16 below.

**Figure 16: Reported satisfaction with involvement in community activities by sample type**



Overall, participants from the family support sample were more likely than those in the crisis intervention sample to report that they were satisfied with their level of involvement in community activities.

### **Participants who ranked their satisfaction with their level of involvement in community activities as 'unsatisfied' or 'very unsatisfied'**

Participants from the crisis intervention sample reported their level of satisfaction as 'unsatisfied' or 'very unsatisfied' twice as often as the family support sample. Overall, the responses from both samples indicated that the reason they were unsatisfied was because they were not involved, with statements such as *"Because I don't do any of that"* (father of 4 children, aged 3 months- 14 years, crisis intervention). Both groups also noted specific circumstances that were preventing them from becoming involved. The crisis intervention sample cited the following circumstances: pregnancy; lack of housing; being in a crisis situation; feeling "too paranoid to walk the streets"; children not currently enrolled in school, preventing mother from volunteering at children's school; lack of trust in others; supporting a sister with a disability; and a knee injury which prevents involvement. The circumstances noted by the family support sample included "too much happening' at the time; lack of transport; not liking being around too many people; and health issues that prevented involvement.

### **Participants who ranked their satisfaction with their level of involvement in community activities as 'neither satisfied or unsatisfied'**

There was little difference in the kind of responses given by participants who ranked their satisfaction with their level of involvement in community activities as 'neither satisfied or unsatisfied' compared to those who ranked their health as 'unsatisfied or very unsatisfied'. A difference is participants noted they were not concerned about their lack of involvement, with statements such as *"I'm not really involved in any of those things, and not really looking to be"* (family support).

### **Participants who ranked their satisfaction with their level of involvement in community activities as 'satisfied or very satisfied'**

A key difference between the two samples is the family support sample noted involvement in activities run by support organisations, including the agency providing them with family support. Eight participants from the family support sample made statement such as *"I love getting in and doing stuff, volunteering. If (support agency) asks me to do stuff I will. I love keeping busy, it makes me feel good. I've performed, written song for (support agency), got involved in the drug and alcohol summit at Parliament. And I'll help clean up around here (support agency)"* (family support). Only one participant from the crisis intervention sample noted this type of involvement. This may indicate that the support agencies are viewed by these participants as part of their community, and that involvement in these agencies is providing these participants with a sense of community connection. The greater access of family support participants to activities run by support agencies may be a factor behind the greater levels of satisfaction reported by the family support sample in their level of involvement in community activities. Interestingly however, the family support sample was more likely to report that they were not involved with community activities, and did not wish to be, evidenced by statements such as *"I don't volunteer for anything...I play with my kids and that is about enough activity for me"* (family support).

Overall, where specific activities were noted, they largely revolved around the participants children. This was the same for both samples. Activities noted were their children’s participation in sporting groups, and the participant’s involvement in their children’s school. Few activities that were not related to children were identified. This may reflect a general lack of time and resources by both samples for activities purely for their own enjoyment.

**Participants’ views on what they would like to see change over the coming year regarding their involvement in community activities**

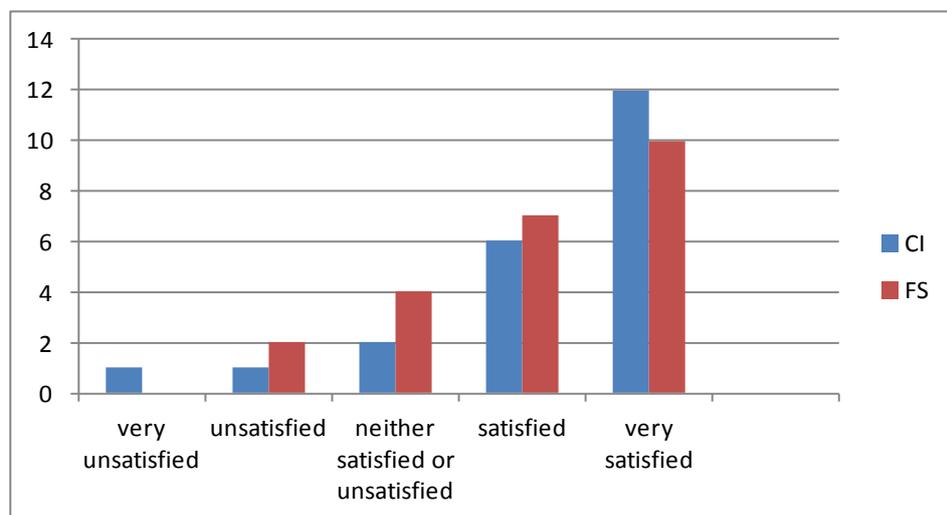
All respondents who reported on their aspirations for change in community involvement indicated they would like to become more involved in community activities. This is likely to reflect the low level of participation noted earlier. Again, overall the activities participants said they would like to be more involved were for their children, evidenced by statements such as *“I’d like to get (child) into soccer or something to keep his mid active and his energy levels up”* (respondent, family support sample) and *“help more at (child’s) daycare”* (respondent, crisis intervention sample). However, the family support sample mentioned this at a greater rate than the crisis intervention. This may reflect the higher levels of enrolment in school and childcare among the children within the family support sample; the greater assistance from support workers to parents to get their children involved in extra-curricular activities; and/or the greater stability of the family support sample.

Activities that participants would like to get involved in that did not relate to their children were predominantly volunteering and sports or fitness activities. There were no noticeable differences between the samples in this respect.

**Satisfaction with current relationship**

We asked participants who were currently in a relationship to rate, on a five point scale, their level of satisfaction with the relationship. The range of responses is outlined in Figure 17.

**Figure 17: Reported satisfaction with relationship by sample type**



We can see that respondents in both crisis intervention and the family support samples report high levels of satisfaction with their relationship status. The average score for the crisis intervention sample was 4.3 while for the family support sample it was 4.17. We can see that both samples report a high level of satisfaction with their relationship. Of course, the distribution of the responses may reflect an attractiveness bias in so far as respondents may be reluctant to acknowledge dissatisfaction with their relationship.

#### **Participants who ranked their satisfaction with their partner relationship as 'unsatisfied' or 'very unsatisfied'**

Only four participants reported being 'unsatisfied' or 'very unsatisfied' with their current relationship. Of the crisis intervention sample the reasons given were largely to do with current circumstances, with statements such as *"the current situation is making it harder for us... we gotta get to know each others thought patterns, what ticks each other off so we can work on it...we're sitting in a negative place, so of course we're going to be negative"* (crisis intervention), and *"yeah it's good, but sometimes she is very angry because she has high depression because we have problems with housing...we fight"* (crisis intervention).

In the family support sample, one participant reported the reason for her dissatisfaction was *"because he (partner) unexpectedly went to jail and now I'm lucky to see him once a week"* (Family Support Respondent). Another participant reported relationship difficulties, stating *"cause we've always had a very complicated, on a off, bitchy sort of relationship. We break up a couple of times a year, it's pretty dodgy. We have lots of little fights non-stop. It's been like that pretty well all our relationship"* (Family Support Respondent).

#### **Participants who ranked their satisfaction with their partner relationship as 'neither unsatisfied or satisfied'**

Again the reasons given did not vary greatly from participants who ranked their satisfaction as 'unsatisfied' or 'very unsatisfied'. One participant from the crisis intervention sample noted relationship difficulties arising from having to live with family due to lack of housing, *"we're arguing a lot because of the family. It was good when it was just us three"* (Crisis Intervention Respondent). Another crisis intervention participant stated that her partner's use of alcohol was creating difficulties. One participant from the family support sample reported that things had gotten better recently *"he's been kinda good and we've been laughing a lot together...been a while since we've laughed together"* (Family Support Respondent). The other three family support participants noted relationship difficulties, with statements such as *"we have too much problems, me and him and our relationship"* (Family Support Respondent) and *"cause previously we have been on the rock and currently the situation is that we are together but not together. It's enabled us to have more freedom"* (Family Support Respondent).

### **Participants who ranked their satisfaction with their partner relationship as 'satisfied' or 'very satisfied'**

There was little difference between the crisis intervention sample and the family support sample in responses given for satisfaction with their relationship. Many participants made general statements of satisfaction, such as *"because we're happy"* (Family Support Respondent) and *"we're happy together"* (Crisis Intervention Respondent). Both samples noted specific qualities of their partner that led to this satisfaction, such as *"he's really good cos he'll do anything for me, he'll go without so that I got what I need, it's not everyday you find a guy who will take your three kids in"* (Family Support Respondent) Both samples also noted specific strategies they used to maintain their relationship, largely around communication, such as *"cause we, even through our stresses and dramas, we can always manage to stay together and talk through it in the best way possible"* (Crisis Intervention Respondent), and *"we don't really argue we just talk about it"* (Family Support Respondent).

### **What participants would like to see change over the coming year regarding their relationship with their partner**

Most participants from both samples stated that they would like their relationship to improve over the coming year. A key difference between the two samples is that the crisis intervention sample noted income and housing as being necessary to allow improvements in their relationship. This was evidenced by statements such as *"I just hope we can get our own place so we can be really a family"* (Crisis Intervention Respondent), and *"be settled and be employed...and stay in one spot, no moving around"* (Crisis Intervention Respondent). Two of the crisis intervention participants also spoke of reuniting with children, for example *"to be a happy family, and hopefully get his (partner's) daughter back"* (crisis intervention). No participants from the family support sample spoke of the need to reunite with children and this may reflect the earlier phase of the family life cycle in which most of the family support sample respondents were located.

## 10.0. Respondents' experiences of change over the course of intervention

In later phases of data collection, we asked participants to comment on whether they had experienced change in this range of quality of life indicators. We asked participants to rate on a three point scale whether each of the indicators had got worse (1), stayed the same (2) or improved (3) since the last interview, which was 3-6 months previously. The average responses for both sample groups over two phases of data collection (phases two and three) is outlined in Figure 21.

**Table 21: Changes in quality of life indicators in the past six months, phases 2 & 3.**

Reported Changes	CIR2	FSR2	CIRS	FSR3
Physical Health	2.16	2.37	2.37	2.1
Mental Health	2.28	2.42	2.18	2.33
Involvement with community activities	2.16	2.21	2.05	2.41
Employment situation	2.12	2.19	2.14	2.41
Family relationships	NA	NA	2.09	2.74
Friendships	NA	NA	2.64	2.49
Relationship with partner	2.58	2.25	2.44	2.53

In this table we see that overall most of the results are around the midpoint on the three point scale. This means that most participants indicated that the various indicators remained about the same. There are several areas nonetheless in which participants indicate substantial positive changes over time. It appeared that families who engaged in planned family support began intervention in a stronger position on these quality of life indicators and that the intervention was associated with continued improvements in these domains. The key outcomes identified by respondents in both samples included that:

- Many of those involved with planned family support services reported substantial improvements in family relationships. In phase three of data collection 43.6% (17) of respondents in the planned family support sample reported that their family relationships had improved over the previous six months. The key reasons included that improved communication with family members and changes in self had led to better relationships with family members. For example, one respondent from the family intervention sample stated: *"Because I've gotten better, which makes it easier to communicate with my family members"*.

A further 25.6% (10) reported the relationships had stayed the same, with only 4 (10%) reporting a deterioration. By contrast, in the crisis intervention, the vast majority of respondents, 16 (73%) indicated that their family relationships had not changed over the previous six months.

- In phase two of data collection, the majority of respondents in the planned family support sample (22 respondents, or just over 51% of the sample) reported that their mental health had improved. A range of reasons were reported for this including improvements in housing situation, leaving an unsatisfactory relationship and gaining better medical or psychological support for a mental health condition.
- Over the course of the project we noted improvements in the stability of the housing circumstances of respondents in the crisis intervention sample. In phase one of the study, 14 respondents indicated that their families were living in highly unstable forms of housing such as motel, crisis accommodation, and rent-free at family/ friends homes, by phase three only 3 respondents reported this was the case. However, this difference in housing circumstance may be associated with the high drop-out rate of families in the crisis intervention group.
- In both samples, a minority of respondents reported that they were currently in a relationship, 17 in the family support sample and 9 in the crisis intervention sample. Both groups reported that their relationships had improved, though this was most marked for the family support sample. 9 of the 17 family support respondents stated their relationship had improved in the previous 6 months, while 3 of the 9 crisis intervention respondents reported the same. Some attributed this improvement to the development of their communication skills over the last six months, as one respondent in the family support sample stated: *"[we are] learning to speak to each other and coping strategies. We used to just yell and scream at each other but now we just walk away from each other."* It was not clear whether the coping strategies had been learnt through family support services, although improving family communication is often a focus of family support intervention. No-one in the family support group reported that their relationship had got worse, while one person in the crisis intervention group reported a deterioration and a further respondent in this sample stated they could not choose.
- In both sample groups, respondents reported substantial improvements in their relationships with friends. In the crisis intervention group, 10 (45%) of respondents stated that their relationships with friends had improved and the same number also indicated that these relationships had stayed the same. No-one in this sample indicated that there had been a deterioration, though two respondents stated they could not

choose a rating. In the family support sample, 16 respondents (41%) indicated that their friendship relationships had improved, 14 respondents (35.9%) indicated these relationships had stayed the same, while a further 5 (12.8%) of respondents stated the relationships had deteriorated and 4 (10.3%) stated they could not choose a rating. In the crisis intervention group some respondents commented that friends had helped them during the tough times they were experiencing, for example, one respondent stated: *“Because when you really hit the lowest point of your life [I’ve found that] my friends have been generous to me, now that we are in hard times.”* In the family support sample, respondents identified that changes in their own outlook such as being “happier” and “more open” had meant they attracted more friends and others identified the opportunity to meet with others in a similar situation, such as other pregnant and parenting young women as contributing to better friendships.

- 7 (18%) respondents in the family support sample, and 4 (18.2%) respondents in the crisis intervention sample, stated that there had been improvement to their employment circumstances. Some attributed the improvements to the support they received through their support service, for example, one respondent from the family support sample stated: *“I’ve got a resume now, Micah helped me write it. I’m more stable now so I can actually apply for work”*. While only one respondent in the family support sample stated that their employment had worsened, a further five respondents couldn’t choose a rating.

## 11.0 Impact of January 2011 floods

In January 2011, Brisbane was affected by severe flooding leading to evacuations of many areas of the city. Families participating in the study were asked whether they were affected by the floods. Table 22 outlines their responses.

**Table 22: Respondents' reports on whether they were affected by the January 2011 floods by sample type.**

	<b>Crisis intervention</b>	<b>Family Support</b>
Yes	16	16
No	9	27

Respondents from the crisis intervention group were more likely than the family support group to report being affected by the floods and to report the impact as being significant. Indeed, almost two thirds of the crisis intervention sample reported being affected by the floods while only one third of the family support sample reported this.

In both the crisis intervention and family support group, several respondents indicated that they were affected generally by the floods, for example losing power or belongings. In the family support group, respondents reported being affected in two ways. The first was the impact of the loss of electricity on their household, as reported by four respondents. The second impact was the inconvenience of being flooded and, in one case, having to move to another location for the duration of the floods. One respondent reported that they had lost outdoor furniture.

In the crisis intervention group, it appeared the precariousness of their circumstances contributed to the greater impact of the floods for them. Three respondents reported that they were homeless at the time of the floods and that this exacerbated the impact of the flooding. As one respondent in the crisis intervention group stated:

*"I was homeless at the time. I got caught in the floods, I had no access to anything, and I couldn't go anywhere." (crisis intervention respondent)*

Another respondent reported that:

*(participant) stayed with a friend (after losing housing prior to the floods) who lost power. Went to the RNA showgrounds. (crisis intervention respondent).*

Respondents without housing had little choice but to turn to emergency support services in the aftermath of the floods.

Another issue reported by respondents in the crisis intervention group was difficulties arising from the loss of household and personal items in the floods. One respondent stated that:

*“My laundry was flooded. I did not have a washing machine for a long time. I am still recovering.” (crisis intervention respondent).*

*“All my gear was stored in a garage, all the boxes got soaked. Many possessions were ruined...it was expensive.” (crisis intervention respondent).*

Given the low incomes and unstable life circumstances experienced by many in this group, it is difficult for them to replace belongings lost during the floods.

### **Impact on family relationships**

Respondents in the crisis intervention group were more likely than those in the family support group to report that family relationships were affected in the aftermath of the floods. Only one respondent in the family support group reported that family relationships were affected, stating that:

*“We stayed at parents for a couple of weeks. Everyone was at each other. Twelve people in one house, three rooms.” (family support respondent).*

By contrast, six of the respondents in the crisis intervention group reported that family relationships were strained during the floods. For example, one respondent who moved with her family to her mother’s house stated:

*“Yes, it strained my and my mother’s relationship to the extreme” (crisis intervention respondent).*

Another respondent reported that:

*“It was stressful. We blamed each other. I nearly lost him [partner]” (crisis intervention respondent).*

### **Impact on children’s participation in child-care, kindergarten or school**

Again, crisis intervention respondents were also more likely than family support respondents to indicate that their child’s child-care, kindergarten or schooling had been affected by the floods. Overall eight respondents in the crisis intervention group indicated the floods affected their children’s child-care, kindergarten or schooling, compared to only one respondent in the family support group.

Four respondents indicated that their children had missed child-care or school, in two cases because the facilities had been closed during the floods, and in the remaining two cases because the children were personally affected by the floods. Two respondents also reported that their children’s school equipment (books and/ or uniforms) were affected by the floods.

## **Impact on participation in employment or training**

Respondents in the family support group were slightly more likely to indicate that their (and their family's) access to employment and training had been affected. Five respondents in this group indicated that their access to employment and training had been affected whereas only two respondents in the crisis intervention group indicated that this was the case.

In the crisis intervention group, one respondent indicated that her partner has lost his employment as a result of the floods. As she stated:

*"[partner's name] lost his job because of it. Because he could not go. How are you supposed to go?" (crisis intervention respondent).*

In all other instances, the floods were reported to inhibit respondents from attending training or employment rather than leading to the loss of employment. The slightly lower proportion of respondents in the crisis intervention group reporting that their employment was affected perhaps reflects their overall lower level of engagement in work or training opportunities.

## **Other impacts of the floods**

When asked if the floods had affected their family in any other way, respondents from the crisis intervention group were again more likely than those from the family support group to indicate that it had. Eight respondents in the crisis intervention group indicated this to be the case, as did five respondents in the family support group and in most instances this appeared to be related to general inconvenience in their lives, such as losing belongings and having limited capacity to replace them. The financial stresses on some of the respondent families are evident in the following response from a respondent in the crisis intervention group who stated that, as a result of the floods, she was:

*Paying for storage, paying rent, paying petrol driving from Kippa-Ring to the city twice a day (to take son to school) also a lot of our stuff got wrecked in the floods. Also due to the floods, St.Vincent's did not have many goods left and it was extremely difficult to get an appointment. (crisis intervention respondent).*

When asked what types of help they had received following the floods, 12 of the crisis intervention participants indicated that they had received the Centrelink flood relief payment available to all citizens who met the Centrelink threshold for this payment. Only two of those in the family support group indicated they had received this payment, though as we did not specifically ask about the payment we cannot comment on whether they did in fact receive this payment that was widely available.

Only a small number of respondents in both groups reported receiving help from community services following the floods. Four respondents in the family support group and two in the crisis intervention group reported receiving help from support services. In the main the forms of support received were of a practical nature

including the provision of food, clothing and equipment for infants (such as, in one instance, a pram and a car seat).

## 12.0 Summary and Recommendations

Our study found that families involved in crisis intervention and planned family support services were vulnerable due to limited pathways out of poverty. Respondents in both sample groups experienced a range of health and well-being challenges such as drug and alcohol addiction, domestic violence and mental health concerns.

Yet, despite their similarities the two groups of respondents substantially differed from each other. The respondents in the crisis intervention group were older on average, had lower levels of school completion and had larger families than the family support group. A higher proportion of people from Aboriginal and Torres Strait Islander cultural groups were found in the crisis intervention group. Most respondents in the crisis intervention sample were excluded from affordable and secure housing and this lack of a secure home base negatively affected their capacity to access services, such as child-care and kindergarten services and schools, that could positively impact their own, and their children's, well-being. We found that the families involved in crisis intervention were older and at a later stage of their family life cycle than the family support sample. The magnitude of the housing crises facing these families was such that it was the primary focus of social service intervention and limited the capacity of workers to engage the family around other social concerns. Furthermore, when other crises struck, such as the Brisbane floods of 2011, families in the crisis intervention group were more likely than those receiving family support services to be badly affected because their pre-existing housing and social circumstances were so tenuous. In essence, these families have fewer of the financial and personal resources that enable resilience in the face of disasters, such as the Brisbane floods of 2011.

Although it appeared that the two samples became more similar over time as, for example, the average size of families in both samples became more alike, the differences among the two sample groups were substantial. It is not possible to disentangle the differences between the sample groups from the differences in observed outcomes. Moreover, the significant drop out among the crisis intervention sample further complicates analysis of outcomes achieved as a result of crisis intervention with this sample. It is complicated because it appears that those who did not participate in later phases of data collection may have differed from those who continued.

On average respondents from both sample groups identified improvements in friendship relationships and relationships with their partners. An improvement in friendships is important given the high levels of isolation commonly found among these families particularly at the outset of intervention. Planned family support interventions appeared to be associated with substantial improvements in two areas, these were: improvements in family relationships and increased use of early childhood services, such as child-care and kindergarten. As noted earlier, participants in the planned family support sample reported substantial improvements in family relationships which, in the qualitative data, was associated with improved communication skills. It was evident also that these respondents made increased use

of early childhood services over the 14 month period of data collection. At the outset of data collection, 54% of respondents in this group reported that their children, under 6 years, were enrolled in child-care or early childhood education services and by the final phase of data collection 14 months later, this had increased to almost 80% of respondents. This is an important outcome for ensuring school readiness of children from disadvantaged backgrounds.

## **Recommendations**

### **1. Preventing and addressing housing exclusion.**

Lack of access to stable, affordable and secure housing was a major barrier for families to access services and to achieve improvements in their health and welfare. For example, the lower level of young children's participation in child-care and kindergarten found among the crisis intervention group was linked to poor housing stability as these families did not stay in an area long enough to access child-care services. Families in the crisis intervention group were much more likely than those in the family support sample to lack access to stable, affordable and secure housing.

Strategies for preventing housing exclusion include: providing intensive support and advocacy for families at risk of losing access to housing. This support could include assisting families to develop budgeting skills and to ensure that rental and other financial commitments are met. Intensive advocacy could be targeted at preventing removal of families from housing, particularly subsidised housing. There are already some good models for prevention services available (HomeStay and HOMEAdvice being two), however these have limitations in terms of their budget for financial assistance, their capacity to take on new families, eligibility restrictions relating to the location of the family or the service, and the length of time they are able to support families for.

Strategies for addressing housing exclusion include the provision of brokerage money to enable families to pay off debts to housing providers. However, brokerage is especially important before a family becomes homeless and while the challenges they face can be managed through casework processes. Another strategy is to ensure that workers monitor the level of housing debt being accrued by tenants and take active steps to prevent the accumulation of unmanageable levels of debt. A further option is for families to have access to "debt forgiveness" or debt reduction to allow families to avoid a cycle of crippling debts that can prevent them regaining access to housing.

### **2. Housing as a first response**

Given the transience of homeless families and difficulty engaging families over a longer period of time through the crisis model, the provision of stable housing as a first step should be prioritised. *Housing First* approaches emphasise that a homeless individual or family's primary need is to obtain stable housing, and that other issues that may affect the household should be addressed once housing is obtained. Crisis services should focus on quickly supporting families to obtain housing before they are

entrenched in transience and homelessness. The provision of affordable, long-term housing for families should be a focus for policymakers.

### **3. Connecting housing and support - Supportive Housing for families**

Connecting housing with family support is important for vulnerable families considering the benefits families experienced from a family support model, and the noted difficulties faced by families with housing instability. *Supportive Housing* is the intentional connection of permanent housing and support services people need to break the cycle of homelessness. Supportive Housing is being implemented in cities across Australia, with a focus on chronically homeless individuals. However, internationally there is increasing evidence that this approach is successful in ending homelessness for families. In addition, permanent supportive housing has also demonstrated efficacy in addressing high rates of child protection involvement among families experiencing homelessness. Some of this evidence is included in the literature review for this report.

Policymakers could consider aligning resources from housing, family support, child protection, early childhood and education to create Supportive Housing with the range of services parents and children need to end their homelessness and improve their quality of life.

### **4. Creating incentives for participation in employment and training**

Respondents and practitioners reported on several barriers and disincentives to participation in the training and employment opportunities. One of the greatest disincentives was loss of access to welfare benefits, such as health care and child care benefits, and exposure to high taxation levels upon entering the workforce which could mean that the household budget was negatively affected by workforce participation.

Strategies for addressing employment and training include ensuring that families have access to the full range of government workforce participation programs. For example, the JET scheme should be extended to include two partner families. The income support agency, Centrelink, could improve its support for vulnerable people re-entering the workforce by assessing income levels on an annual rather than a weekly or fortnightly basis. Currently, the assessment focused on short-term changes in income disadvantages people who take up casual work offers.

Creating pathways for participants to gain access to education and training opportunities is also important to encouraging workforce participation. Low levels of literacy and school completion meant that many respondents were ineligible for work with reasonable remuneration levels commensurate with their age and life phase. Another concern was health issues, including dental issues, which affected participants' appearance and capacity to engage in the paid workforce. Ensuring that homeless and vulnerable families receive access to health services, including dental

health, is also important for creating pathways out of unemployment into work that is dignified, meaningful and appropriately remunerated.

### **5. Promoting opportunities for child-care and early childhood development**

Participants in the planned family support group made much more extensive use of early childhood services such as child-care and kindergarten services than respondents in the crisis intervention. Given the tenuous housing circumstances and the multiple challenges facing families in the crisis intervention sample, it is unlikely that parents and carers will be able to provide children in these families with stimulating early childhood learning experiences. Hence, these children are vulnerable to poor preparation for school and to difficulties in school participation.

The priority given to “children at risk” in child care services was seen as a positive by workers involved with this project. However, it was also noted that the tendency of disadvantaged families to be concentrated in the same location means that additional allocation of such places needs to be considered in areas of high need. Further it was noted that the “Special Child Care Benefit”, covering the full cost of child care, was an excellence resource. It was noted however this was difficult to access because of the complexity of the application process and the demands placed on families to demonstrate financial need or risk of abuse and neglect.

Workers participating in the project noted that a small number of intensive child care services exist in disadvantaged areas. It would be helpful to see the further extension of these intensive services into other geographical areas of high need. Funding infrastructure to facilitate transportation for children living in crisis accommodation to attend child care services would also be helpful for improving uptake of these services by vulnerable families.

Greater availability of occasional or crisis child-care opportunities would also provide homeless families somewhere safe for their children to receive care while they address housing needs. Importantly, access to child-care in a crisis should not be limited to those receiving child safety services.

### **6. Maintaining school enrolment and participation**

We noted that for the most part, the majority of children and young people in both sample groups were enrolled in school and attended regularly. Nonetheless, a substantial minority in both groups (around 20%) missed at least a day of school in the week prior to the interview. Lack of access to practical resources such as transport, food for lunch, and money for textbooks and uniforms were all identified as factors limiting school attendance and/ or participation among both groups. A key difference between the two groups was the apparent much lower level of school enrolment at the end and beginning of the school year reported for children/ young people in the crisis intervention sample. The lower rate of enrolment at this time was linked to high rates of mobility among the group. Parents in this sample group expressed a view that there was little to be gained educationally for children/ young

people if their enrolment in a school was likely to be short-term, as might be the case with a change of school at the end of the year.

Strategies for improving school participation include ensuring that there is a positive relationship between schools and vulnerable families. Family support workers can assist by helping the family to talk with the school about the challenges they are facing. Families also require help with addressing the practical support they need to participate fully in their school environment. These practical supports include access to transport, food for lunches, and access to textbooks, uniforms and travel cards. The collaboration of education departments, both in the government and non-government sector, is needed to address the practical needs of homeless families. Options could include the development of a flexible fund within State Government Education Departments for homeless families. Another option would be to co-locate special education services with homeless services so that children and young people may gain support in undertaking educational activities at the end or beginning of the school year when it appears they are most vulnerable to missing out on these learning opportunities.

### **7. Promoting transition from crisis intervention to planned family support**

Our research data suggested that families using crisis intervention services and those using family support services experienced some similar challenges, though the challenges facing participants in the crisis intervention sample appeared to be more entrenched. Many of these families were subject to housing exclusion and were highly mobile and this mobility was reflected in the high drop out rate from the sample. Nonetheless, approximately half of the sample continued to participate in the project over the 14 month period. Few of these families availed themselves of planned family support services during this period even though it would appear they could have benefited from the broader range of intervention strategies provided by this model.

Given the value of planned family support for improving family relationships and access to a range of services, we recommend that strategies are put in place for encouraging families utilising crisis intervention services to make the transition to planned family support services. Families who have achieved some level of housing stability or ongoing contact with a crisis intervention service would seem particularly suited to making this transition. Workers participating in the project observed that more resources needed to be allocated to family support services if the demand for these services was to be met. Another challenge is that access to family support services is often tied to other service systems, for example, families are referred via child protection services or housing services. Once these child protection or housing issues are addressed, many families are then unable to access family support services via an alternative pathway.

## 8. Building resilience

Our research indicates that families who are experiencing high levels of mobility and stress are ill-prepared to manage the impact of crises such as the floods of January 2011. It appeared that the families with the fewest resources reported the greatest negative impact of the floods both at the time of the event and in the longer term. These families had already stretched their often meagre social and practical resources to the limit and became entirely reliant on emergency support services as a result of the floods. Crisis intervention and planned family support services have an important role to play in building the resilience of vulnerable families so that they are more able to cope with unexpected events. These services can help families achieve resilience through advocacy and support activities that enable families to access and maintain affordable and adequate housing, and through linking families to the range of services and supports that will facilitate their well-being and participation in their community. Furthermore, these services have a vital role to play in getting families “back on their feet” following disasters. Our study indicates that the timely provision of practical support with housing, food, and access to household goods, such as whitegoods, was vital to enabling vulnerable families to move out of emergency support services and back into the community. Family support workers also reported that they played an important role in reducing families’ anxiety about the natural disaster by providing families with information (such as emergency numbers) and resources (such as food) they needed in the event that they were required to evacuate.

## 9. Providing services that service users’ value

Families in both samples reported a range of experiences with service providers. Service users reported valuing services that provide practical resources, particularly access to housing, and timely information. In both samples, participants discussed the importance of a constructive relationship between themselves and service providers. Consistent with previous research, service users valued workers who were warm, persistent and flexible in their approach (Sheldon and Macdonald, 2009).

## Conclusion

The families who participated in this study experience a range of vulnerabilities. Our intention in this study was, initially, to compare two forms of intervention: crisis intervention and planned family support. However, it soon became evident that substantial differences existed between the two groups using these services. For example, while both families experienced vulnerability to homelessness, those using crisis intervention services appeared to experience more entrenched housing exclusion than those in the family support group. The magnitude of the differences between the two groups who use these services necessarily raises questions about whether any full comparison between the service types is possible.

Nonetheless, we can conclude that the respondents in both groups, who maintained involvement in the study over its duration, did show improvements in some key dimensions of well-being. Involvement in crisis intervention services was associated

with reported improvements in social and personal relationships. Participants in planned family support services demonstrated increased use of early childhood services and perceived that their family, friendship and personal relationships had substantially improved. Further research could investigate whether these impacts are sustained over the longer term.

## 13.0. References

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