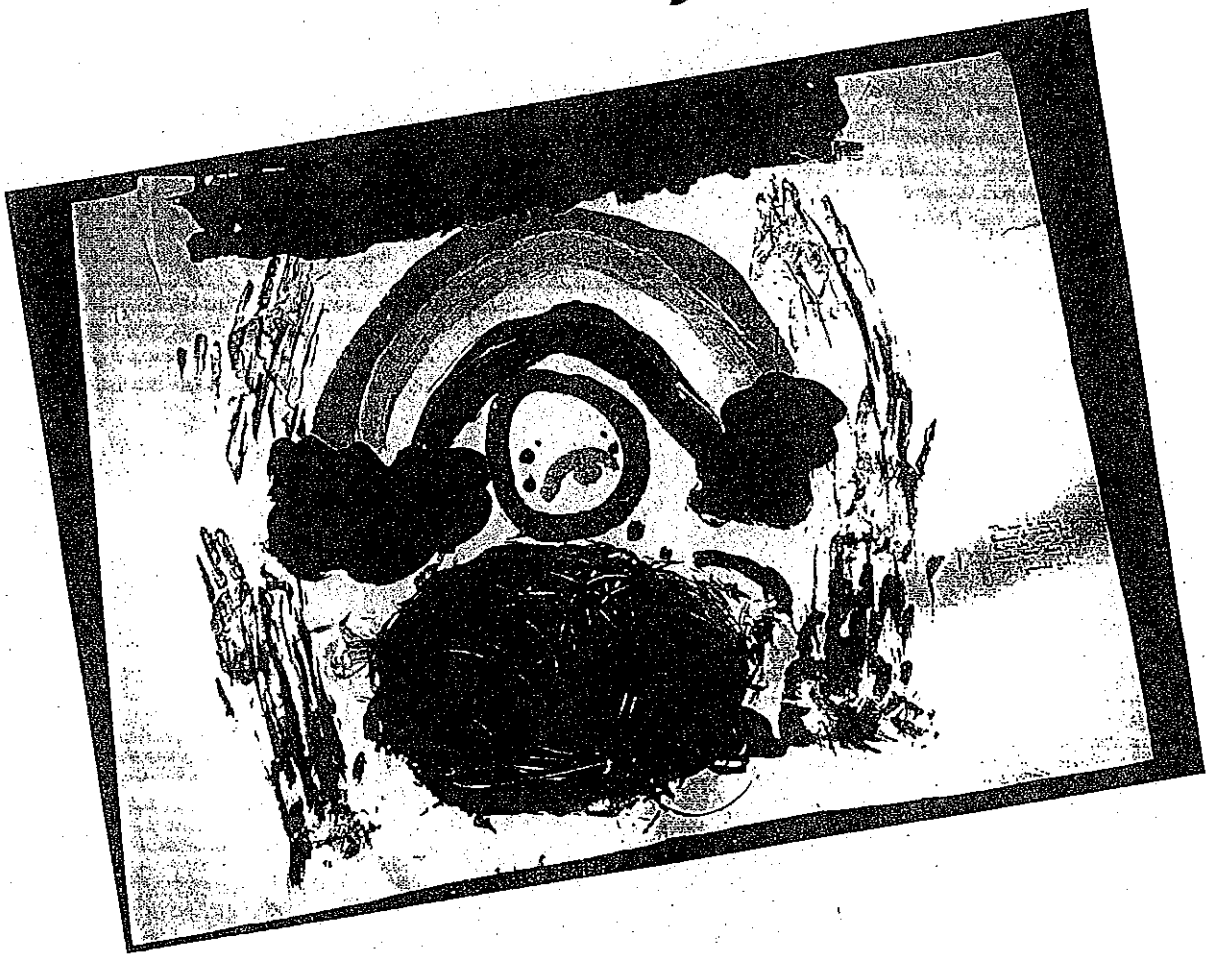
'Can we stay here?'



A study of the impact of family homelessness on children's health and well-being

Front Cover:

Report title *'Can we stay here?'* is a quote made by one of the children after moving into Hanover's supported accommodation. This was that family's third move in the preceding six weeks.

The picture was drawn by seven year-old Belinda while she was in Hanover's short-term housing program. Belinda says this about her picture:

'The sun is crying because it wants to come out but the clouds are there.'

'Can we stay here?'

A study of the impact of family homelessness on children's health and well-being

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This study was made possible through
a grant by The Financial Markets Foundation for Children.
Hanover gratefully acknowledges their interest in,
and support of this issue.

Hanover

Royal Children's Hospital

'Can we stay here?'

A study of the impact of family homelessness
on children's health and well-being

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PO Box 1016, South Melbourne, Vic 3205
Telephone: 03 9699 6388

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About Hanover

Hanover is an independent welfare agency, incorporated as a non-profit company. The organisation is totally independent, having no structural links with governments, institutions or religious bodies. It is managed by a Board of Directors who are elected by its members.

Hanover began in 1964, bringing together the work with Melbourne's homeless that had been carried out for almost a century by several charitable organisations, missions and churches. Hanover takes its name from its first location, Hanover Street, Fitzroy.

Hanover's mission is to empower homeless people to enable them to take greater control over their lives and to stimulate and encourage change in Australian society to benefit them. It achieves this by delivering services, conducting research, and through advocacy.

Hanover believes homelessness is being deprived of the normal supports of home - people who care and for whom one can feel responsible, private living space, security of self and belongings, a base from which to work, a secure environment for the development of self-confidence and personal competencies. It is not merely a lack of shelter.

Hanover's services assist over 400 people daily, involving the provision of meals, accommodation, financial and material aid, counselling, budgeting, medical assistance, work skills training, employment placement, and recreational opportunities.

About the Centre for Community Child Health and Ambulatory Paediatrics

The Centre is a unit of Melbourne University based at the Royal Children's Hospital.

The Centre's mission is to provide for and promote the optimal health of children who use the hospital's ambulatory services as well as children in the wider community.

The Centre is committed to the notion that health care for the young is a continuum - from the child with the minor illness who is cared for at home through to those requiring inpatient care; that hospitals and academic institutions have a responsibility beyond treating sick children; and that there should be integration and continuity between preventive and curative health care and between hospitals and community-based services.

The Centre's aim is to act as a bridge between hospital and community-based services by:

- making hospital-based services more responsive to the needs of consumers and community-based health professionals, whilst also
- working with community agencies to promote high quality services that are informed by research and are supported by good data collection and ongoing evaluation.

The Centre's goals are:

- to provide outstanding clinical services to children and their families who attend the Centre, and support such services in the community.
- to develop and provide a range of appropriate health education resources for parents, children and families.
- to develop, distribute and manage ongoing educational programs in child health for professionals involved with children.
- to foster and enhance hospital/community liaison and extend co-operative programs to the community.
- to develop and maintain multi-disciplinary training programs in child health for professionals.
- to undertake multi-disciplinary research to inform the Centre's efforts in clinical services, teaching, and advocacy.
- to advocate changes and influence public policy as it relates to children and families.

Acknowledgements

This study was conducted to raise awareness of the impact of family homelessness on the health and development of children and to encourage policy initiatives that place greater emphasis on children's needs.

The authors gratefully acknowledge the contribution of the parents and their children, who not only participated in the study but talked about, what were often, sensitive issues.

Many thanks also to Rosemarie De Haas, who conducted most of the interviews, to Melinda Barker for the follow-up interviews, and to Lesley McLaverty for her efficient typing and lay-out of the study.

Daryl Efron, Research Fellow, Centre for Community Child Health and Ambulatory Paediatrics
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Melbourne

June 1996

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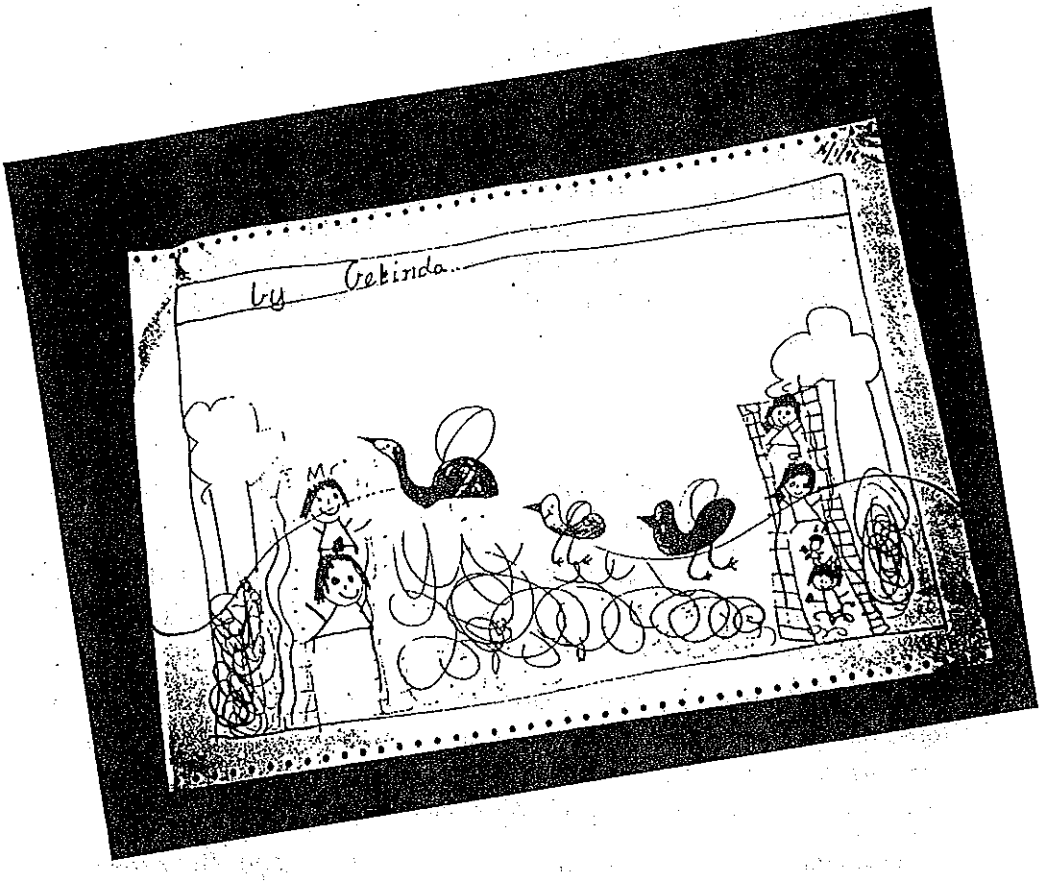


This picture was also drawn by Belinda. It shows an outing to the park with the children's support worker. Happily the sun has found a way to shine.

Summary of Findings, Issues and Policy Challenges

This study presents the findings and implications of research conducted jointly by Hanover and the Royal Children's Hospital into the health status of children in homeless families.

In the 18 months between July 1994 and December 1995, Hanover was contacted by 2,613 families in housing crisis. Of these, 1,400 with over 2,000 accompanying children, were either literally without shelter or without appropriate safe accommodation. Hanover was able to accommodate 234 or 17% of these families. The following findings are based on a sample of 51 children, chosen at random from 31 of the families.

Findings

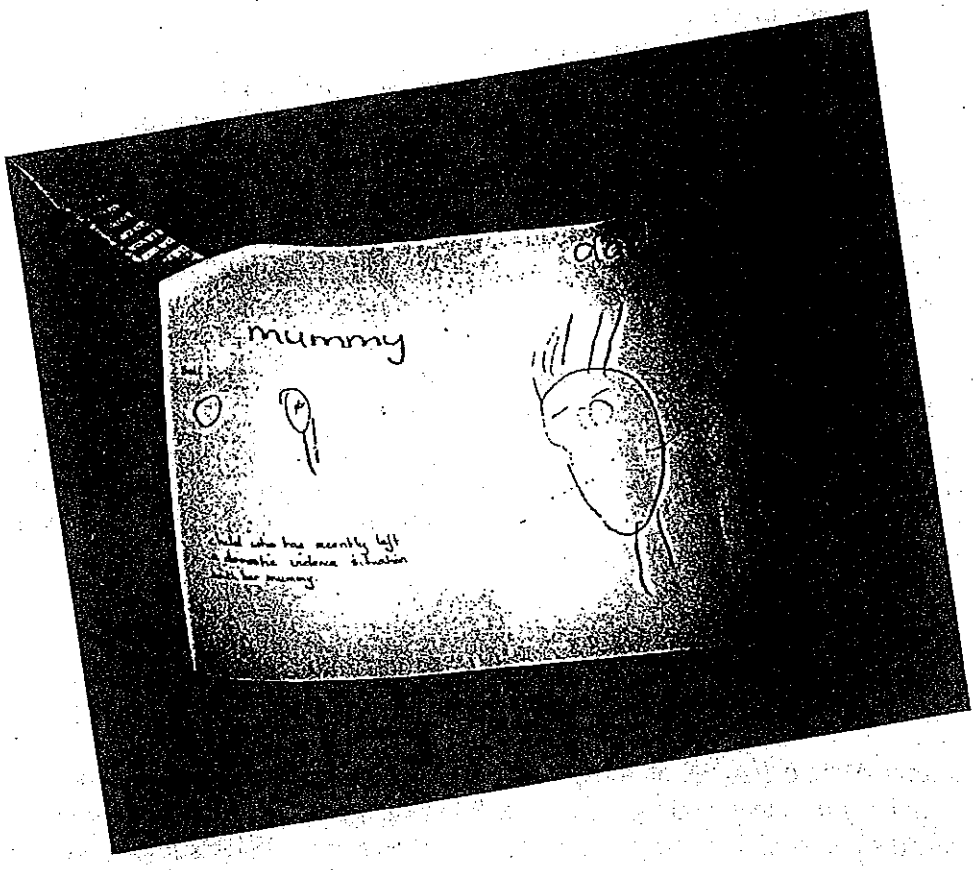
- Children in homeless families are clearly affected psychologically by the crisis of 'houselessness' and the complex issues that have led up to it
- Over one-third of children in the study had significant behavioural disturbance, as rated by their parent(s). There was a relationship between the number of home moves and the degree of behavioural disturbance.
- On arrival at Hanover accommodation, the children had extremely limited social interactions. The follow-up study suggested that after six months housing stability, children were successful in increasing social interaction opportunities. However, their academic and activities scores were still of concern.
- These children are at major risk of educational disadvantage. The frequent changes in school documented in this study compounds other environmental and behavioural impediments to learning.
- Mothers in the study had high rates of psychological symptoms, particularly anxiety and depression. Some improvement was noted in the follow-up study. However, it would also be important to consider the high incidence of family violence and sexual abuse in the families accommodated by Hanover.
- The physical health of these children appears to be less compromised than that of children in homeless families in North America and Europe. This may be due to better nutritional status, Australia's less severe climate and more extensive income and health 'safety nets'. Despite this, children had higher than average frequencies of asthma, ear infections, skin problems and developmental delays. Incomplete immunisation schedules were also higher than state averages.
- Medical assistance tends to be sought on an acute needs basis, rather than through health maintenance and prevention. Families perceive transport and treatment costs as barriers to accessing the health care system.

Issues

- The research study has highlighted the need for services, working with children in families who experience homelessness, to include health, in its broadest sense, as part of the casework intervention.
- Children's opportunities and development are being put at significant risk due to a cycle of transience and housing crises of families.
- Families seeking assistance from homeless persons services often have complex needs, are socially isolated and highly transient in their lifestyle. It is critical that the level of support is timely and effective to meet the needs of the children as well as the parents. Such agencies are invariably the only services with an opportunity to identify problems and provide appropriate intervention.
- Many families are having to endure a number of short-term moves in expensive or unsuitable accommodation due to the lack of either temporary or permanent housing.
- Financial assistance is a critical tool to assist children to regain a sense of purpose and belonging through having adequate clothing, play materials and educational necessities.
- The physical health of children in homeless families in Victoria is relatively well looked after. Families, even in crisis, appear able to access health services. This reflects the benefits of Australia's universal health and welfare system.

Policy Challenges

- Policy makers must give higher priority to reducing unemployment and to increasing the supply of affordable housing in order to lower the prevalence of family homelessness and its consequences for accompanying children.
- The poverty associated with long-term unemployment renders many families vulnerable to homelessness. The provision of education and training to the most disadvantaged in the labour market is essential to provide these families with the opportunity to escape the cycle of poverty.
- For families in housing crisis, it is essential that suitable temporary accommodation, such as emergency and supported housing, is available to meet presenting needs. Reductions in the number of housing moves is critical to lessening the adverse impact on accompanying children's health and development.
- Family violence is one of the major causes of homelessness. The challenge for governments is to strengthen the available range of education, preventative and crisis response programs.
- Access to early intervention and support services for families and children has been restricted due to funding cuts and policy shifts over recent years. This trend leads to further disadvantage for those children, whom this study has found to already be at serious disadvantage. The government's commitment to the provision of a broad range of community supports for families and their children needs to be strengthened.
- The Supported Accommodation and Assistance Program (Victoria) has been developing guidelines for workers assisting children and integrated case management policies. However, policy will remain as rhetoric unless resources are given a high priority so that service providers are able to meet children's complex and urgent needs. To assist in service delivery, the authors have developed a practical assessment tool and information guide for use by service providers.



This picture was drawn by a four year-old girl living in a situation of family violence. Note how 'Emma' herself has no features and how large Daddy is in comparison to Mummy.

1. Introduction

The composition of the homeless population in Australia is changing. Whereas once consisting of older single males, today an increasing proportion of the people who experience homelessness are families with children. Families account for over a quarter of the clients accommodated on any night under the Supported Accommodation Assistance Program (Commonwealth Department of Housing and Regional Development 1994). In Victoria, 31% of clients in the period July 1994 - June 1995 were accompanied by children, that is, 4,839 parents accompanied by 10,914 children were accommodated or supported by SAAP services. (Victorian SAAP Client Data Collection 1995).

The Supported Accommodation Assistance Program (SAAP 3) is expected to place increased emphasis on service delivery to meet the specific needs of children in families experiencing housing crisis. About one third of all residents in SAAP funded supported housing programs are children and adolescents. The National Evaluation of SAAP recommended priority be given to strategies that would address the needs of accompanying children and stated that,

> "It is imperative that SAAP services focus upon the special needs of this group as one means of breaking the cycle of homelessness and general deprivation." (Lindsay, 1993, p.41)

Hanover Welfare Services, an independent welfare agency, has been providing services to homeless people in Melbourne for over 30 years. Hanover seeks to empower homeless people to take greater control over their lives. In 1989, Hanover established a specialist family service in recognition of the emerging needs of homeless families. In the 18 months between July 1994 and December 1995, Hanover was contacted by 2,613 families. Of these, 1,400 families with over 2,000 accompanying children were literally without shelter or appropriate safe accommodation. Hanover was able to accommodate 234 or 17% of these families. (This is due to the limited resources available.)

In 1991, Hanover commissioned the Australian Institute of Family Studies to undertake research into homelessness amongst families. *Where Now?* (McCaughey, 1992) acknowledged the health difficulties experienced by many of the children in homeless families, however, investigation of the issue was outside the scope of that study.

Studies in North America have suggested that children in homeless families experience a range of health problems, with significantly higher prevalence than poor children living in stable homes.

Preliminary investigations indicated a lack of quantitative data on the health status of these children, and of their utilisation of health services, in Australia. It was important to gain objective benchmark information on the key health issues and needs of a sample of homeless children in Australia, in order to develop effective service provision and to maximise long-term outcomes.

The research study aimed to collect this information, and to assess the need for supported accommodation and associated agencies to recognise and work to achieve change in the health and well-being of these children over time. In this context health is considered in terms of physical, mental and social well-being rather than merely the absence of disease or infirmity. (World Health Organisation 1973)

The specific aims were:

- To determine if the health status of children in homeless families differs from that of children in the general population.
- To assess attitudes towards, and utilisation of, health services
- To measure any changes in the health status and well-being of children during their stay in supported accommodation.
- To develop a tool for use by welfare agencies to assess the health and well-being of children, with a view to supporting parents to seek health care for their children.

The research project was jointly auspiced by Hanover Welfare Services and the Centre for Community Child Health and Ambulatory Paediatrics at the Royal Children's Hospital, Melbourne.

The research focuses specifically on the health needs of a sample of children accompanying their parents into Hanover's supported accommodation services. This report draws together the research findings with Hanover's service provision data and experience.

2. Background

2.1 Government's Response to the Needs of Children in SAAP Services

The numbers of children as a proportion of all Victorian SAAP service users has been steadily increasing since 1990. In Victoria alone, between July 1994 and June 1995, 10,914 children accompanied their parents who were accommodated and/or supported by SAAP services. (Victorian SAAP Client Data Collection (1995), Health and Community Services Annual Report, p.8)

Periodic reviews since 1988 have reiterated the importance of developing strategies which address the particular needs of children in families. In 1988, the national review of SAAP 'Homes Away from Home, (Chesterman 1988), recommended that children be taken into account in the allocation of resources, while in 1993, the National Evaluation of SAAP 'Moving Forward' (Lindsay 1993), recommended that strategies to address the needs of accompanying children should be given priority in each state plan. There has been gradual recognition that children have needs in their own right, requiring a specific focus as part of casework support.

In Victoria, new guidelines are being introduced by Victorian SAAP for working with children in SAAP services (Working with Children in SAAP Services - Framework and Guidelines, Jan. 1996 - Draft). These guidelines help to reinforce the need for the program to be responsive to the needs of children.

2.2 Hanover's Services for Families in Housing Crisis

Hanover has operated a supported accommodation service for families since 1987. The original service, Family Care, was the first service to be initiated as part of the redevelopment of Gordon House, Hanover's 285 bed night shelter, which was finally closed in June 1994. Hanover now has a fully integrated supported accommodation service for families, known as Hanover Family Service, which includes:

- two very short-term crisis units
- eight short-term units
- twenty-one medium-term units.

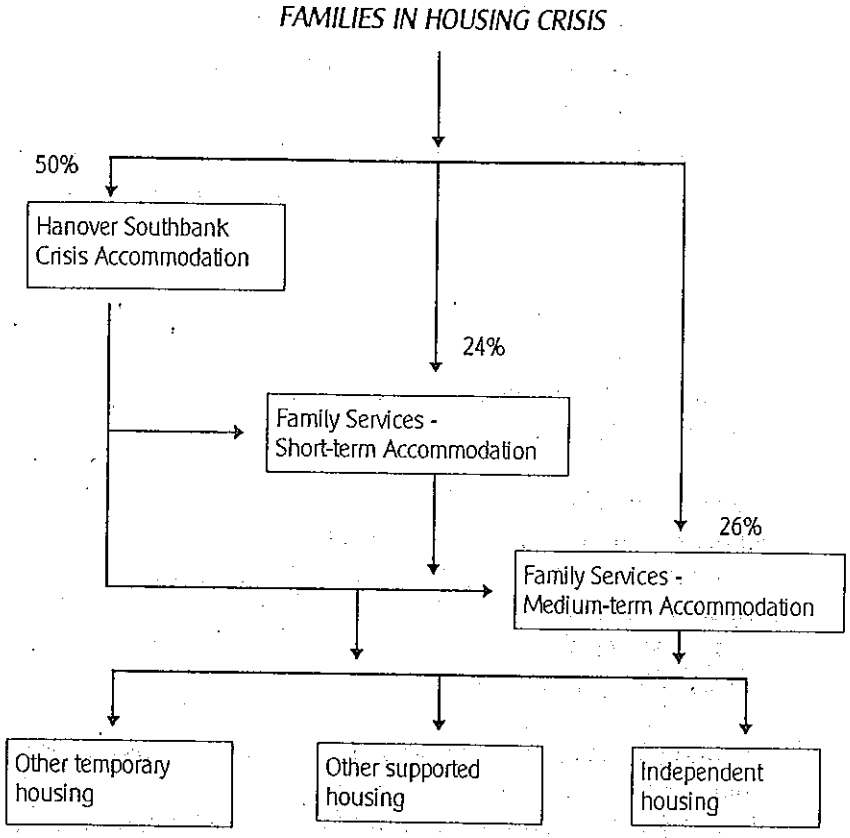
Hanover Southern with outlets in Moorabbin and Dandenong, also provides services to families in housing crisis. Services offered include:

- medium term units
- crisis and referral assistance.

A total of 43 families can be supported and accommodated through Hanover at any one time.

Figure 1 shows the different transitional pathways through the service programs.

Figure 1 - Hanover Family Services - Service User Flow Chart



Note: Percentages refer to families staying in each accommodation type over the 18 month period (July 94 - Dec 95)

2.3 Hanover's Response to Accompanying Children

In 1993, Hanover adopted a child protection policy that would ensure that a child's right to protection was given primary consideration in any casework decision where there was a conflict of interests between the parent(s) needs and the child(ren)s needs. Hanover also sought innovative ways to enhance their capacity to respond to accompanying children's needs in the design and delivery of their services.

The short-term accommodation centre in South Melbourne has a children's room which is registered as a Class 2 child care centre. In 1994, Hanover was the first non refuge in Victoria to receive recurrent funding for a full time child support worker. The position commenced at the start of 1995 and has greatly enhanced Hanover's capacity to understand and provide effective responses to the needs of accompanying children.

The position objectives are:

- to enhance the service's capacity to respond to the needs of children
- to contribute to a broader understanding of the impact of homelessness on children
- to provide expertise to the service team on the developmental needs of children
- to develop and implement models of service delivery that will enhance and/or support a parent's ability to recognise and respond appropriately to their children's needs.

2.4 Children's Support Work

The objectives of the various services offered by the children's support worker are shown in Appendix 1.

An average of 62 children per month have direct contact with the children's support worker. This is through a range of play activities provided in the child's home or in the children's room. On average, eight families a month have sessions which involve the parent(s) and child(ren). School liaison and support activities have facilitated the local school's understanding and support of children in homeless families.

A 'how to use a playgroup' playgroup was designed to assist parents in medium-term accommodation, to experience the benefits of a playgroup in a safe and supported environment. After a few months, most parents have made a successful transition to their local community playgroup.

Future plans include reinforcing linkages with family and children's services in the Western suburbs, in order to advocate for support groups for older children and their parents to address issues of loss and grief resulting from homelessness, family violence or family breakdown.

The development of the above resources has greatly enhanced Hanover's ability to provide responsive support to families and their children in housing crisis. The next section provides a contextual profile of families accommodated over the past 18 months.

3. Profile of Accommodated Families (July 1994 - December 1995)

3.1 Profile of the Families

A total of 234 families, comprising 433 children and 348 adults, have used Hanover's supported accommodation services in the 18 month period. The profile of these families differs from both Victorian SAAP data and Hanover's crisis assistance database. Two-parent families account for 41% of accommodated families, compared to 12% (SAAP data) and 29% (Hanover's crisis database). SAAP data includes the high numbers of homeless sole-parents accommodated in refuges, while Hanover's crisis database reflects the numbers of sole-parents struggling to survive in private rental who have contacted Hanover for financial support.

Table 3.1 Selected Homeless Family Data Comparison Between SAAP and Hanover Data

Data Source	Vic [1] SAAP Clients (N=4,586)	Hanover [2] Crisis/Assistance Clients (N=2,613)	Hanover [3] Accommodated Clients (N=234)
Collection period	July 94-June 95	July 94-Dec 95	July 94-Dec 95
Type of families (%):			
Single-parent families	88	71	55
Two-parent families	12	29	41
Other	0	0	4
Total	100%	100%	100%

Sources:
[1] Victorian SAAP Client Data Collection, Annual Report (1995)
[2] Hanover Crisis Assistance Client Database
[3] Hanover Family Services Client Database

Age of Adults

Just under a quarter of adults were aged 18-25. The majority (68%) were between 26 and 40 years old.

Number of children

Fifty-nine per cent of families had two or more children.

Income

All families relied on pensions or benefits when they entered Hanover's services.

Table 3.2 Main Income Type of Families, %

Sole Parent Benefit	46
Newstart/Jobsearch	32
Disability Support Pension	12
Sickness Allowance	10
Total (n = 234)	100

Specific Issues

Family Violence - Ongoing family violence was an issue in 40% of the two-parent families. Among sole-parents, 30% had recently left violent relationships.

Sexual Abuse - Just under 30% of mothers reported having been sexually abused either as children or as adults, while 9% of fathers also reported having been victims of sexual abuse.

Alcohol or Drug addiction/usage - 26% of adults were using or struggling to overcome an addiction to alcohol or illicit drugs.

Mental Health- 14% of all adults had a diagnosed psychiatric illness.

Physical Health - 22% of adults had significant ill health requiring medication or hospitalisation.

Sally's Case Study (next page) shows the devastating impact these issues can have on children's development

While Hanover has focussed its attention in its assessment processes on the highest need families, it should not be assumed that all families in housing crisis have this level of need.

Sally and family

Sally and her two daughters, aged five and seven, came into Hanover's medium-term supported housing program directly from a residential drug rehabilitation centre. Prior to their time in rehab, the family had a history of evictions from both public housing and private rental. Sally's youngest daughter had been sexually abused and both children had witnessed domestic violence.

Sally had a very sad history of abuse in her own life. She was a victim of incest and had left home at 14 years of age. She had been raped several times during the next nine years and had had a number of relationships with violent and abusive men.

When Sally came to Hanover, she said that she was 'clean' and that she was determined to get her children counselling because of all the 'shit' they had been through. She did not want counselling for herself.

Over the next few months, support staff became aware that Sally was still using and dealing drugs from the house. The children's school attendance was spasmodic and the house was becoming smelly and chaotic. Strangers were often found sleeping in the house when support staff visited. No rent was paid.

Health and Community Services Child Protection unit were called in to assess Sally's ability to parent and protect her children. For a few months some stability was achieved as Sally attempted to keep her children in her care. However, her own needs and drug use predominated, resulting in the children eventually being removed.

Sally is currently serving a prison sentence for drug dealing and fraud. Her children are living with their maternal grandmother.

The consequences of Sally's own abuse as a child and as a young woman have had a devastating impact on both her own and her children's lives.

3.2. Profile of the Children

While 433 children accompanied their parent(s) into Hanover's services, 15% of the families had other children who were either permanently or temporarily in alternative care.

There were no significant differences in the numbers of boys and girls in any of the age groups.

The numbers of children in the various age groups (shown in Table 3.3) are similar to those of the Victorian SAAP data collection (however, note the different categories for age between data sets).

Table 3.3 Age of Children in Families
Comparison Between SAAP and Hanover Data

Data Source	Vic [1] SAAP Clients (N=4,586)		Hanover [2] Crisis/Assistance Clients (N=2,613)		Hanover [3] Accommodated Clients (N=234)	
Collection period	July 94-June 95		July 94-Dec 95		July 94-Dec 95	
	%			%		%
Age of children:						
0-4 years	48		(0-4)	54	(0-4)	45
5-9	29		(5-11)	27	(5-11)	29
10-14	16		(12-15)	12	(12-15)	22
15+	7		(16+)	7	(16+)	4
Total	100%			100%		100%
No of Children	10,914			3,883		433

Sources: [1] Victorian SAAP Client Data Collection, Annual Report (1995)
[2] Hanover Crisis Assistance Client Database
[3] Hanover Family Services Client Database

School Attendance

Only three of the 17 children aged over 15 were still attending school. Fifteen per cent of school-aged children had prolonged or continuous absences from school prior to, and /or during their stay with Hanover. Trying to assist children back into the school system became part of the casework goals.

Mobility

More than 60% of the children had moved with their parent(s) more than three times in the preceding 12 months. Older children were more likely than younger children to arrive with very few personal possessions.

Changes in Family Composition

Over 90% of the families had experienced a change in the composition of their family. On average, there were three changes per family. Usually, this involved an adult partner leaving or coming into the family household. Families report that these changes were often accompanied by adverse behavioural changes in their children, such as the child becoming shy or introverted, quarrelsome with adults, upset and distressed or being difficult to manage.

Child Protection

Concerns for children's ongoing safety in the family were noted for 19% of all families accommodated. Health and Community services were already involved, or became involved with 16% of all families.

Just under 12% of children were reported by their parents as having been sexually abused at some point in their lives.

However, the majority of parents demonstrated that, despite the difficulties, they were very committed to their children and able to respond to their needs.

3.2 Length of Stay and Exit Points

Hanover provides three levels of supported accommodation, each with a different focus and objective (see Appendix 2). The services provide a range of supports that are designed to assist families to access and maintain appropriate safe secure housing independent of Hanover.

Table 3.4 Length of Stay by Number of Families in Each Accommodation Type.

Type of Service	No. of Families	Average Length of Stay
Crisis	118	7 days
Short-term	55	9 weeks
Medium-term	61	7.5 months

The length of stay in the medium-term program has been steadily increasing over the last few years. In 1990, the average was four months and, by 1993 it was six months. The service has found that achieving long-term outcomes which adequately address the additional underlying issues requires a more substantial period of stability and support. Over 50% of the families currently using this service have been in the program for more than 12 months.

It is also becoming more difficult for families to access suitable housing once their support goals have been achieved. Public housing priority panels appear reluctant to consider that a family who has spent some time in supported housing is 'homeless'. The number of private rental vacancies at affordable rents has also been declining.

Achieving satisfactory exit points for families in transitional housing remains one of the major stumbling blocks for service users in achieving their objectives. Public housing is often the preferred and only affordable option if families are to achieve any respite from the cycle of poverty. Private rental is the next most likely exit point

A comparison of the exit points for the different services are presented in Table 3.5. The differing percentages highlight the different service objectives.

Table 3.5 Immediate Exit Points by Type of Accommodation, %

Accommodation at Exit	Crisis	Short-term	Medium-term
Public housing	3	39	27
Private rental	7	17	33
Unknown	12	11	17
Caravans/Boarding/Hotel	33	7	11
Family of origin	11	1	3
Interstate	7	4	3
Hanover short-term housing	17	N/A	N/A
Hanover medium-term housing	4	17	N/A
Other emergency housing	4	None	None
Other supported housing	2	4	None
Refuge	2	1	4
Total per cent	100	100	100
Total families	118	55	61

Crisis

Only 6% of these families were able to access non-Hanover emergency or supported housing. This left 33% of families in housing crisis with no options other than poor quality or high cost temporary shelter. Some of these families are eventually successful in accessing either Hanover or other agencies emergency or supported housing.

Short-term

Fifty-six per cent of families were able to go directly from this program to independent long term housing. A further 21% moved into medium-term transitional supported housing.

Medium-term

Sixty per cent of families achieved positive long-term housing outcomes. As described in Appendix 2, the objectives of the medium-term program include working on a number of underlying issues and complexities that prevent either access to, and/or the ability to maintain, their hold on long-term housing options.

Support goals include practical goals such as:

- saving for furniture
- getting a tenancy reference
- paying off debts to Department of Planning and Development
- finding work or undergoing training for employment

and personal goals such as:

- personal counselling
- resolving family disputes
- attending to children's health, educational or emotional needs
- gaining a sense of security and belonging to a community
- detoxing from substances of dependence.

In most cases, families who have achieved positive housing outcomes have also made significant progress in these other areas.

Across all three programs, the relatively high proportion of families, for whom the next housing outcome is unknown, partly reflects the assessment and intake procedures used by Hanover to target those families who have a history of transience and complex needs. For many of these families, the time has not been right to make changes in their lives. However, some of these families have returned to the service to try again, as exemplified by the experience of Frank and his son, Jamie (next page).

Frank and Jamie

Frank is a single father who has raised his 11 year-old son Jamie for the last nine years since the death of Jamie's mother. Frank and Jamie have been in and out of Hanover's services several times over the last three years.

Having spent most of his childhood in orphanages, Frank had very little experience to draw on in providing a sense of home and family for himself and Jamie. After Jamie's mother died, Frank began drinking heavily.

The family moved every few months, sometimes every few weeks. Their housing included temporary shelter in new relationships, caravans, emergency houses, hotels and squats.

Jamie was eight when Frank first contacted Hanover. After a brief period in short-term housing, Frank was assisted to gain priority public housing and some furniture. However, Frank's difficulties were greater than a lack of housing, and his drinking continued. Within six months the family had been evicted by the Department of Planning and Development for rent arrears.

The next time Frank contacted Hanover, he and Jamie were accommodated in the medium-term supported housing program. By this time, Jamie had already attended at least 20 different primary schools, generally for very short periods of time. Despite all they had endured, the bond between father and son was strong. They both expressed fear that the 'welfare' would separate them. With the assistance of their support worker, Frank and Jamie began to work on a plan for future stability. Frank, however, remained mistrustful and after a couple of months the family disappeared along with some of Hanover's furniture.

Nine months later, Frank contacted Hanover again. The support staff spoke to him openly and honestly about their concerns for Jamie. This coincided with Frank explaining that Jamie himself was putting pressure on his dad to give them a 'normal' home. As soon as a vacancy occurred, the family moved back into the medium-term supported housing program.

This time, Frank has made some changes in his life, including having his money handled by Hanover's Pensioners' Trust. He is determined to stay in the program until the end of the year when Jamie will finish primary school. Jamie says he feels safe with Hanover. He is a fun-loving, well balanced boy despite the transient and at times risky life he has spent with his father. Frank's desire to do the 'right' thing by his son has provided the catalyst for change that may enable Jamie and his dad to develop a sense of home and family together.

4. Research into Health Status of Children in Homeless Families

This chapter documents the research project conducted in conjunction with the Royal Children's Hospital in 1994 and 1995.

4.1 Background

As stated in the Introduction, the composition of our homeless population is changing. Once consisting mainly of single adult males, since the late 1980s an increasing proportion of the homeless are families with children. In Victoria, nearly 11,000 children accompanied families accommodated and supported by SAAP services in the period July 1994 - June 1995.

While still a far cry from the situations in the USA and the UK in terms of prevalence and duration of homelessness, available evidence indicates that family homelessness is a growing problem in Australia which cannot be ignored.

The pathways to the crisis of homelessness for the families are many and varied, but often include one or a combination of the following: poverty, unavailability of affordable housing, job loss, domestic violence, family breakdown, eviction (for various reasons), substance abuse and poor health. (See for example, McCaughey 1992, Alperstein 1993, Thorman 1988.) Along with poverty, homelessness is becoming an inter-generational problem. Ellen Bassuk makes the point that '..."houselessness" is only one aspect of homelessness' (Bassuk 1991). Homeless families are often extremely mobile and have limited personal or community support networks, and as such are a particularly vulnerable group with multiple disadvantages.

4.2 Literature review

The adverse effects of homelessness on health have been well documented in adults. Similarly, the health needs of homeless youth (ie young people outside families) have been systematically investigated, and specific recommendations have been tabled with a view to providing appropriate services for this important group (NHMRC 1992).

More recently, adverse health effects have been recognised in children living in homeless families (Alperstein and Arnstein 1988, Lowry 1990, Redlener 1994). Studies from North America, and to a lesser extent the UK, indicate that this population of children experiences a range of problems with significantly higher prevalence than poor children living in stable homes. These include acute and chronic medical problems, emotional and behavioural problems, developmental delays and learning difficulties. A common scenario for these children is to begin life as a low birth-weight baby and then to be subjected to the influences of maternal depression, poor nutrition, overcrowding, increased risk of injuries (particularly burns and scalds), high mobility, inadequate access to health services and delayed or missed immunisation (Lissauer et al 1993, Acker et al 1987).

Nutrition

While chronic malnutrition is a common problem in poor populations, it is often compounded in the homeless by lack of adequate basic facilities for food storage and cooking. Obesity has been documented as the commonest nutritional problem in repeated samples of homeless children (Miller 1988, Wood et al 1990). There is also some evidence that homeless children (particularly those from larger families and with single mothers) are at greater risk of stunted growth than domiciled poor children (Fierman et al 1991).

Acute and chronic medical problems

Health problems commonly reported in children from homeless families include ear infections, respiratory and gastrointestinal infections, asthma, dental problems, recurrent abdominal pain, iron deficiency, lead toxicity, obesity, and mental health problems (Miller 1988, Parker et al 1991). Redlener reports similar types of problems from the New York (Homeless) Children's Health Project, noting that 'the problems one might intuitively expect are indeed repeatedly encountered' (Redlener 1994).

Emotional and behavioural problems

Several authors have reported that homeless children experience more developmental, emotional and behaviour problems than housed poor children (Bassuk et al 1986, Zima et al 1994), although a Minneapolis study of poor children found that parental distress and recent life events were more important predictors of behaviour problems than housing status (Masten et al 1993). Rates of child abuse and neglect have also been reported to be higher than those for children of similar socioeconomic status living at home (Alperstein et al 1988). Developmental delay (particularly language) has been documented to be common in these children (Zima et al 1994). It has also been observed that some homeless preschool children have not learnt to play (Hamley et al 1993).

Inadequate access to health services

Health care for the homeless tends to be crisis-oriented. Homeless families are less likely to report a regular provider for preventive/well child or sick care, and depend more on hospital emergency departments and outpatient clinics (Miller 1988, Wood and Valder 1991). Homeless children are more likely to be admitted to hospital with mild illnesses than similarly socioeconomically deprived but permanently housed children (Orenstein et al 1992). However, deficient preventive and primary care leads to delayed presentation of common problems, resulting in higher rates of complications and chronicity and, as has been demonstrated in adults, mortality (Redlener 1994). They may also be more likely to die from overwhelming infection (Lissauer 1993).

Educational disadvantage/learning difficulties

A number of factors conspire to disadvantage these children's academic progress. (Thorman 1988, Wood et al 1990, Jenkins 1993). Frequent changes of school, high rates of absenteeism and lack of a quiet space for homework, combined with high rates of emotional disturbance, poor nutrition, iron deficiency and stress all contribute to the great risk of learning difficulties.

A recent report by the Smith Family confirmed the seriously high rate of functional illiteracy amongst socio-economically disadvantaged Australian high school students (3-6 times the general school population rates), with family mobility a particular risk-factor (Orr 1994). Lack of literacy has been shown to be a significant factor in the perpetuation of the inter-generational poverty cycle.

Parents

Parents of children in homeless families have high rates of depression, substance abuse, physical abuse and chronic health problems. (Bassuk 1991, Lissauer et al 1993, Parker et al 1991). The complex factors culminating in the homeless state (economic and educational disadvantage, dysfunctional family of origin, domestic violence etc) may erode the capacity to provide effective parenting (Hausman 1993).

Most of this data comes from overseas work. The populations of homeless families surveyed in overseas studies often differ demographically from Australia's, in that they are predominantly from minority backgrounds with more extreme poverty, and are usually housed in sheltered rather than supported accommodation. Shelters are crowded, heating and air-conditioning are often inadequate and conditions are usually quite unsafe for children.

There is at present a lack of equivalent data on Australian children in homeless families. As the problem of family homelessness is a growing one in our community, it is important to gather local data on the key health issues and needs of these homeless children, as well as to determine whether supported accommodation and associated 'empowering' services are having an impact on these issues over time.

In this study we set out to determine the 'health' (in its broadest sense) status of children in homeless families, the prevalence and degree of psychological stress in their parents, and to assess utilisation of health services by homeless families. We also wanted to measure change in the children's health status over their time in supported accommodation.

Based on intuition as well as overseas data, we hypothesised that children in homeless families in Melbourne would have high rates of adjustment difficulties, which would manifest as behavioural and emotional disturbance, with associated developmental and learning problems. We predicted that their physical health might also be poorer than the general population, though perhaps not to the extent reported in children in homeless families overseas. We expected parents in supported accommodation to be experiencing great stress and anxiety, both as a result of the trauma leading up to the housing crisis as well as their current circumstances and uncertain futures.

Our ultimate aim is to develop an assessment tool for use by welfare agencies to assess children's health and well-being when they enter the service. This will be a targeted screening instrument, informed by the findings of the current research project. The purpose will be to identify active problems, as well as markers of particularly high risk for such problems within this population (eg high mobility, single-parent families, parental anxiety or depression etc). Appropriate lines of referral for formal evaluation of such children will be established.

4.3 Methodology

Sample

All families entering supported accommodation with *Hanover Welfare Services* between May 1994 and June 1995 were invited by their case workers (verbally and in writing) a week after crisis support began to participate in the study. They were told: "We are interested in a range of factors that may influence your child's health. We hope that the information we collect will help us to understand the special needs of children in homeless families".

Participation was voluntary and subject to the provision of informed consent. It was made clear to families that the provision of services by Hanover was in no way related to their decision regarding involvement in the study. Case worker access to the research files was dependent upon permission from the client, which was granted in every case. A maximum of two children per family were surveyed, so as to minimise inconvenience to families.

Design

Initial interview

Data was collected by a research assistant with a special education background and experience in working with disadvantaged families. Interviews took approximately 1.5 hours. Where literacy was a problem, the questions were read aloud.

The following questionnaires were completed by parents under the supervision of the research assistant:

(a) **Child Health Questionnaire** (CHQ: Eisen et al 1980). This is a standardised 48 item child health screening instrument designed to identify children with chronic illnesses. The CHQ was derived from the Rand Corporation Medical History Survey, developed initially for the National Health Insurance Studies in the USA in the 1970's. Chronic illness was defined for this instrument as that causing recurring or persisting symptoms for at least three months in a year, and/or requiring hospitalisation for one month or more in a year.

The CHQ has been shown to be a highly sensitive screening instrument with sound psychometric properties (high inter-rater and test-retest reliabilities and validity). The CHQ has been validated in Australia against hospital medical records with extremely high agreement. Australian normative data are available for comparison (see results).

(b) **Child Behaviour Checklist** (CBCL: Achenbach 1991). 103 - 126 item (depending on age) standardised rating scale of children's behaviour problems. Each symptom is rated on a 3-point scale (0 = *not true, 1 = somewhat or sometimes true, 2 = very true or often true*). The items are designed to be rated by parents, or parent surrogates, who can directly observe children's behaviour in various contexts. The CBCL was completed by parents of children over two years of age. The Youth Self-Report (Achenbach 1991) behaviour questionnaire (similar design) was completed by children/young people over 11 years.

The CBCL is well known and empirically based (ie derived from assessment data on actual samples of children). It has high test-retest and inter-rater reliabilities, as well as soundly-demonstrated validity. Studies from Melbourne (Bond et al 1994) and Adelaide (Sawyer et al 1991) support the use of American normative data for the CBCL in studies of Australian children and adolescents.

Scores were derived by means of the publisher's computerised scoring program, which converts raw scores into *T* scores. *T* scores are statistical measures which allow estimation of the degree of deviance of the study sample compared with the normative data for age and sex. Scores are computed for three <u>global</u> dimensions - *Internalising* (withdrawn, anxious/depressed, somatic complaints), *Externalising* (aggressive, delinquent behaviours) and *Total Problems*. Scores for the global scales are classified as being in the 'clinical' range when the *T* score is ≥60. This range correlates well with the likelihood of the presence of a significant problem. That is, children with scores in these ranges should be referred for a comprehensive evaluation.

It is important to note that the CBCL was designed to provide standardised *descriptions* of behaviour rather than diagnostic inferences. High scores on CBCL problem scales do not automatically equate with any particular diagnosis or disorder. Instead, CBCL profiles are integrated with other types/sources of data by professionals in the course of a comprehensive diagnostic evaluation.

In addition, for children over five, three domains of <u>competence</u> (social, activities and academic) are scored from the CBCL data. The <u>social</u> domain questions include: *Please list the number of/frequency of contact with friends; how well does your child get along with siblings, other kids.* The <u>activities</u> questions include, *number of clubs/organisations your child belongs to, favourite hobbies, , sports, games etc.* The <u>academic</u> score is derived from the parents ratings of the child's performance in various school subjects, and whether he/she has repeated a grade or is in a special class.

(c) **General Health Questionnaire** (GHQ: Goldberg 1971). A 28-item questionnaire to screen for psychiatric disorders in community settings, was administered to both parents individually. Each item consists of a question asking whether the respondent has recently experienced a particular symptom on a four-point scale ranging from "not at all" to "much more than usual".

The GHQ is a well-validated and widely used questionnaire which addresses symptoms of anxiety/insomnia, social dysfunction, depression and somatic complaints. Australian normative data are again available for comparison (see results).

The GHQ is not a diagnostic tool, rather an instrument which attempts to differentiate the psychologically 'well' from the psychologically 'sick'. Although, the problem of where normality ends and clinically significant disturbance begins for an *individual* remains unresolved, it is possible to compare the amount of psychiatric disturbance in two *populations* by a comparison of mean scores, and also to follow the changes in psychiatric disturbance that occur with time by testing a given population on different occasions.

(d) **Purpose-designed questionnaire** . This questionnaire was devised in order to elicit information not obtained specifically by any of the other questionnaires used, and where no standardised instrument could be found for this purpose in the literature. Questionnaire design was in accordance with standard methods in social science research, with care taken to avoid potential biases (eg social desirability response set). There were five components:

- *Demographic data.* Family composition, ages, first language, education, income source, housing history, reason currently homeless, social networks.
- *Child health* (areas not covered in CHQ). Gestation, birth weight, age-specific symptoms (eg. infants - colic, sleep problems; children - activity, appetite; adolescents - risk-taking behaviours), learning difficulties, changes of school.
- *Health maintenance.* Immunisation, dental care, nutrition.
- *Utilisation of health services.* Well-child care, illness care, barriers to access.
- *Parent health.* Global ratings for each parent on linear analogue scale.

This questionnaire is reproduced in Appendix 3.

A pilot survey of three families was conducted initially to test the proposed method and acceptability of the questionnaires to participants. As no significant alterations were made to the structure of the interview or to the purpose-designed questionnaire, these data were included in the set for analysis.

Follow-up interview

Participating families were invited to take part in a follow-up survey six months after the initial interview. A $40 token of appreciation was offered. The purpose was to determine changes coincident with the period of supported accommodation. The GHQ and CBCL were administered.

4.4 Results

The demographic characteristics of the sample are summarised in Table 4.1

Table 4.1 Demographic data

	n (%)	
Families surveyed	31	
two-parent	14 (45)	
single parent	17 (55)	
Parents' education	Mothers	Fathers
≤ year 8	4 (14)	1 (9)
year 9-10	14 (48)	4 (36)
year 11-12	9 (31)	5 (46)
tertiary	2 (7)	1 (9)
Parents' age		
< 20 yrs	0	0
20-29 yrs	14 (48)	6 (50)
30-39 yrs	12 (41)	5 (42)
40-49 yrs	3 (10)	1 (8)
Number of times family moved in past 12 months		
1	4 (12.9)	
2 or 3	13 (41.9)	
≥ 4	14 (45.2)	
Reasons for current housing crisis		
inability to find or maintain affordable housing	17 (55)	
no money	11 (35)	
relationship breakdown	8 (26)	
family violence	7 (23)	
eviction	6 (19)	
Number of children surveyed by age		
<2 yrs	8 (16)	
2-4.9 yrs	16 (31)	
5-11.9 yrs	21 (41)	
≥12 yrs	6 (12)	

A total of 31 families were surveyed, including 51 children. Four families declined to participate.

Parents

Parents surveyed consisted of 29 mothers and 12 fathers. There were no teenage parents.

Although mothers reported an average of 2.8 children, only 2.3 were currently living in the family. Fathers reported having an average of just 1.9 children.

Two sets of parents were Aboriginal, and six mothers and one father were born outside Australia. Two mothers spoke a language other than English as their first language.

No parents reported being currently employed, either part-time or full-time, at the time of the survey. The commonest source of income for mothers was the sole parent pension, and for fathers Newstart or Jobsearch. Several parents were receiving the Disability Support Pension.

Accommodation immediately prior to the housing crisis included private rental (26%), emergency shelters (19%), or with friends (10%). The remainder had a variety of housing arrangements, including private hotels, rooming houses, caravans, drug rehabilitation facilities and staying with relatives. Eighteen (58%) families had stayed in emergency or welfare housing before. Five (16%) families had stayed in emergency housing two or three times in the preceding 12 months. For many families there were multiple contributing causes of their current housing crisis.

Children

Children surveyed consisted of 30 boys and 21 girls. The ages of the children ranged from three weeks to 16 years, with a mean (SD) age of 6.4 (4.7) years (boys 6.2 [5], girls 6.6 [4.3]).

Child physical health

Mean birth weight (BW) of the children was 3080g This compares with a mean Victorian BW of 3370g (Consultative Council on Obstetric and Paediatric Mortality and Morbidity [CCOPMM] 1993). Thirteen (26%) children were born prematurely (cf 5.9% of Victorian births in 1993: CCOPMM 1993),

Immunisation delays were reported frequently in children under five. The percentages fully immunised by vaccine type were triple antigen 57% (85%), polio 70% (69%), measles-mumps-rubella 70% (85%) (Victorian 0-6 years immunisation rates in parentheses, Victorian Department of Health and Community Services 1994). Fifty-two per cent of children under five had delayed Haemophilus influenzae type B (causes meningitis, epiglottitis) immunisation schedules. Very few delays were reported in children beyond age five, suggesting either catching up or recall bias. The commonest reason given for delays was 'moved and haven't linked with Maternal and Child Health Centre'.

Three (6%) of these children had swallowed a poisonous substance, and five (10%) had suffered a burn or scald. These rates appear high. (Unfortunately, there is no community-based data on childhood injuries available for comparison; only for injury-related hospital admissions).

On the CHQ, parents reported whether their child did or did not have certain chronic health problems. A number of conditions appeared to be more prevalent in this group of children than the rates reported in a large Australian community-based normative population (Australian Temperament Project Cohort surveyed with CHQ in 1990, age 7 yrs - F. Jarman, personal communication. Cohort characteristics described in Oberklaid et al 1986). These included asthma (32%), recurrent ear infections ≥6/year (6%), vision problems (18%), intellectual disability/developmental delay (12%), eczema (14%) and other skin problems (16%) This data is presented in Table 4.2.

Table 4.2 Child Health Questionnaire -

Percentage of Children With Chronic Illnesses
("Symptoms for ≥ 3 Months, and/or Requiring Hospitalisation
for ≥ 1 Month Over the Past Year")

Condition	Homeless (n = 51)	Normative (n = 1590)	Condition	Homeless (n = 51)	Normative (n = 1590)
Ear infections (≥ 6)	6	1.7	Migraine/recurrent headache (≥12)	10	5.6
Recurrent colds/sore throats (≥	6	5.7	Anaemia	4	0.4
Asthma/wheezing (≥1)	32	22.7	Epilepsy	4	0.4
Other breathing/lung problem	8	2.8	Intellectual disability/developmental delay	12	1.8
Hay fever	14	14.6	Orthopaedic deformity	4	1.0
Hearing problems	6	7.4	Genetic/metabolic disease	4	0.4
Vision problems	18	9.5	Eczema/dermatitis	14	9.7
Urinary tract infections (≥ 1)	8	4.3	Other skin problems	16	5.6
Other kidney problem	4	1.6	Digestive/bowel problem	6	4.0

Child behaviour

The CBCL data can be examined in a number of ways. When we analysed the mean global problem scale scores (Total Problems, Internalising and Externalising) by sex and age category, we found that our sample of homeless children scored one half to one standard deviation higher (ie. more problems) than the normative sample. That is, on average these children are rated by their parents to have significantly more behavioural problems than the general population of children.

Of perhaps more practical importance, however, is that a substantial proportion of individual children in this group scored in the so-called 'clinical' range on the global internalising and externalising scores on the CBCL, indicating significant behavioural dysfunction. ***More than one-third of all children had total behaviour problems scores in the clinical range*** (Table 4.3).

In this sample, girls were more commonly behaviourally symptomatic than boys on parent report. More than half of the teenagers rated themselves as having Total Problems scores in the clinical range.

Children in families which had moved two or more times in the preceding twelve months had higher total CBCL scores than those few who had only moved once. However, there was no further increase in score with mobility beyond two moves per year.

Table 4.3 Percentages of Children with Child Behaviour Checklist Global Scores in the Clinical Range (*T* score ≥ 60)

	Age 2-3		Age 4-18			Youth Self-Report	
	Homeless (n = 16)	Normative (n = 321)	Homeless-baseline (n = 27)	Homeless-follow-up (n=11)	Normative (n = 2110)	Homeless (n = 6)	Normative (n = 1054)
Total score	50	9	41	45	18	67	19
Internalising score	37	9	41	55	18	50	18
Externalising score	62	11	44	36	17	67	16

Note: As the 'children in homeless families' sample size is small, percentages should be interpreted with a degree of caution

Competence

The CBCL for 6-18 year olds also gives information on Competence (social, academic and activities). Fifty per cent of this group (10 of 20) had total competence scores in the clinical range (Table 4.4). The scale in which most difficulties were found was the social domain.

Table 4.4 Percentages of Children Aged 6-18 With Child Behaviour Checklist Competence Scores in the Clinical Range (*T* score ≤ 34)

	Homeless at baseline (n = 20)	Homeless at 6 month follow-up (n = 7)	Normative (n = 3716)
Activities	10	14	4
Social	55	0	5
School	10	14	4
Total competence	50	14	16

School

More than half of the school-aged children (n=28) had been to five or more different schools. All but three had changed schools at least once. The parents of six school children felt their child was under-achieving relative to his/her ability.

Parent mental health

Mothers (n=29) scored higher (ie. more symptomatic) than a large community-based normative sample (Australian Temperament Project Cohort Mothers of cohort children surveyed with GHQ in 1989 - F. Jarman, personal communication) on mean scores on all variables on the GHQ (Table 4.5). Differences were most marked for 'Anxiety-Insomnia', and 'Severe Depression', as well as Total Score. No such differences were found for fathers (n=12).

As with the children's CBCL scores, mothers' GHQ scores increased with mobility up to two moves in the preceding twelve months, with no further increase beyond two moves per year.

Table 4.5 General Health Questionnaire scores for homeless parents - means (SD for reference population)

Variable	Study mothers -baseline (n = 29)	Study mothers - follow-up (n = 12)	Reference population mothers (n = 260)	Study fathers (n = 12)	Reference population fathers (n = 225)
Somatic Symptoms	6.90	6.25	4.40 (3.2)	4.08	4.12 (3.0)
Anxiety/Insomnia	7.64	7.68	4.29 (3.6)	4.17	3.88 (3.2)
Social Dysfunction	7.57	5.50	6.48 (2.3)	6.83	6.51 (2.1)
Severe Depression	3.89	2.77	0.90 (2.6)	0.83	0.66 (1.8)
Total Score	25.89	22.00	16.07 (9.0)	15.91	15.16 (7.4)

Parent 'health'

Parents were asked to rate their own health on a Likert scale of 1 (terrible) to 5 (excellent). Only seven of 29 mothers and one of 12 fathers rated themselves a 1 or 2 (ie. most considered their own health to be average or better). There was a significant inverse correlation between mothers' global rating of their own 'health' and their 'Social Dysfunction', 'Severe Depression' and Total GHQ scores. That is, mothers with more psychiatric symptoms considered their own 'health' to be worse.

Access to health care

Eighty per cent of families reported using a general practitioner or community health centre for check-ups or minor health problems. One third did not use the same service each time. For illness care ('when your child is sick'), half went to the GP and half to a hospital emergency department; one quarter varied their choice of provider in this situation.

One-quarter of children had been seen in a hospital emergency department at least once in the previous six months, and a similar proportion had had a non-emergency out-patient visit in that time. Twelve children (24%) had been admitted to hospital one or more times over the preceding two years. This appears to be a relatively high admission rate, when compared to approximately 1% of Victorian children admitted for the ten commonest paediatric Australian National Diagnosis-Related Groups (Victorian Department of Health and Community Services 1994).

The commonest reported barriers to access were the cost of treatment (33%) and transport difficulties (23%). Other issues were time waiting for the doctor, not knowing where to go, and waiting for an appointment. The most important restrictive costs were for transport and medication.

Follow-up

Twelve families took part in the longitudinal part of the study, completing the GHQ and CBCL six months after the initial interviews. The proportion of children reported to have significant behavioural problems on the CBCL was similar to baseline (Table 4.2). Fewer children appeared to be displaying social competence problems (Table 4.4). Mothers (n=12) scored slightly lower (less symptomatic) on 'social dysfunction', 'severe depression', and total score compared to baseline score on the GHQ, though still well above reference population scores (Table 4.5).

4.5 Discussion

This study came into being because staff at Hanover noticed that over recent years an increasing proportion of their client base have been families with children, and that little was empirically known about the characteristics and specific needs of this group of children. It was considered important to measure the impact of their socioeconomic disadvantage on a range of parameters of child and parent well-being.

Comparison of family status of the sample with the profiles in Table 3.1 shows that the sample was representative of Hanover's accommodated client population. However, single-parent families were under-represented compared to SAAP and Hanover's crisis assistance populations.

The child behaviour data for this group are of great concern, with over one-third having total behaviour scores in the 'clinical' range. There were roughly equal proportions of internalising (anxious/depressed/withdrawn) and externalising (aggressive/acting-out) problems. Our data were skewed somewhat by four children with developmental delay/intellectual disability who had CBCLs completed - three of these children had total, internalising and externalising scores in the clinical range. A larger sample would be required to confirm the adverse effects of homelessness on Australian children's behaviour profiles. Nonetheless, the evidence is strong that children in homeless families exhibit a range of difficult behaviours to an extent that is maladaptive. These behaviour styles, if persistent, will compromise these children's personal development and interpersonal relationships, further limiting their capacity to experience happiness and achieve success.

These children also appeared to have very limited social interactions. As expected, this was an extremely mobile sample, so it was not surprising to learn that the children had reduced opportunities to participate in regular sporting or other activities, nor that they find it difficult to maintain close friendships. For some children their 'difficult' personalities (excessively boisterous or introverted) might be contributing to their social isolation.

The high frequency of changes of school in this sample was alarming. When combined with the other educational risk factors outlined in the literature review, the chances of these children receiving adequate education or achieving their potential are clearly greatly diminished, which puts them at considerable disadvantage in an increasingly qualification-dependent labour market.

The high prevalance of psychological symptoms reported by mothers on the GHQ (particularly depression and anxiety/insomnia), though not surprising, was the other major finding of this survey. This may impact on their ability to respond appropriately to the children's needs. Interestingly the 'fathers' who participated in this study, though small in number, appeared to be protected from any adverse psychological outcomes. Although the information was not specifically elicited, it may be that the nominated 'father' (defined for the purpose of the study as the male adult in the current household, if present) had only been in the home for a relatively brief period of time and therefore had not been exposed to the same traumas as the mothers.

Although several chronic physical conditions had high prevalence on the CHQ, this group of children did not appear to suffer physical health problems to the same extent as has been reported in children in homeless families in North America or Europe. Reasons for this might include better baseline nutritional status (ie prior to housing crisis), a more extensive health-care 'safety-net', and a less severe climate.

Some of the conditions present in high frequency were predictable and mirrored overseas studies (eg. recurrent ear infections, asthma, developmental delay). The high prevalence of vision problems however, is more difficult to explain and may be an anomaly related to limited sample size.

Immunisation delays were higher in this group of children compared to state averages. Besides increasing the individual's risk of vaccine-preventable infectious diseases such as whooping cough and measles, the risk of community epidemics is increased as the so-called 'herd immunity' is lowered.

Access to regular health care was restricted for these families. They appeared to rely to a large extent on public hospital facilities for their children's medical needs and, as previous investigators have found (Wood, Valdez 1991, Orenstein et al 1992), well-child health surveillance is a luxury to which these families cannot afford to allocate the time, money or energy. Their involvement with health professionals tends to happen on an acute needs basis, with health maintenance and disease/injury prevention given lower priority.

When they do desire the assistance of health professionals, there are a number of factors which these families see as barriers which make access difficult within the structure of the current health care system. The most important of these are treatment costs and problems with transport.

The six-month follow-up component of this study found that mothers appeared to have fewer symptoms of 'social dysfunction', 'severe depression' and total psychological symptoms compared to the initial survey. On the other hand, children surveyed after six months in supported accommodation showed little change in their behavioural symptomatology. This suggests that current services, with an adult focus, seem to benefit the mothers in homeless families, but may not be adequately addressing the needs of the children.

This study had a number of limitations. Firstly the number of families surveyed was relatively small. Collaboration between agencies would be required to conduct a study with a larger sample size, which would enable greater confidence in making inferences based on the findings to homeless families in general.

There was potentially some selection bias, as four families declined the invitation to participate. However it is unlikely that these families would have had fewer problems than the participating group, so their exclusion probably did not artificially strengthen the findings. The lack of data from these families may in fact have diminished the power of the results (for example, because fear of child protection issues may have prevented these families from participating).

In order to ascertain which particular child or family problems are related to homelessness specifically, rather than poverty and low socio-economic status, a control group of comparably poor but housed children would need to be studied and the findings compared (cohort study design). This is clearly a complicated and difficult research undertaking, however, attempts have been made to recruit such a control group in other countries and it would be a worthy endeavour to pursue here, given adequate resources.

The validity of the CHQ used on disadvantaged groups is unknown, and it would be interesting to compare reported health status with more objective measures (eg. medical records, immunisation records, assessment of vision, physical examination) to support the questionnaire data. In general, such records were not available in this group of mobile families, and we elected not to subject the children to physical examination in the interests of protecting their privacy.

As this study was a cross-sectional survey, it was not possible to examine for specific cause and effect associations, and these can only be postulated. For example, the relationship between parental stress and child behavioural disturbance is complex to tease out, and inferences may be drawn in either direction. Parental perceptions of their children's behaviour (as well as the children's behaviour measured by more objective methods) are related to the parents' own levels of stress, and difficult children cause parents to feel more strained and less confident. A prospective longitudinal study would be required to examine this relationship more systematically.

The families in this study had been homeless for brief periods only (at least on this occasion), and so no comment could be made about the effects of chronic homelessness on the parameters studied.

Despite attempts to minimise the likelihood of socially desirable responses to questions, there were some areas where we wondered whether we were hearing the whole truth. For example, most of these children seemed to have perfectly nutritious diets! More careful questionnaire design or the use of structured interviews might have reduced this problem.

It is noteworthy that despite their extraordinarily difficult circumstances, many of these families seem to cope surprisingly well. Whilst this study has focussed on risk factors for children's health, an important subject for future research would be to try to identify traits which confer resilience, protecting children from adverse outcomes despite their environmental deprivation.

Collaboration between health and welfare agencies is often necessary in conducting quality community child health research. The sharing of complementary skills and knowledge from different disciplines is particularly valuable in this type of work, and this research represents an example of such a venture.

4.6 Conclusion

Homelessness is a marker of multiple disadvantage, and children living in homeless families are clearly a particularly at-risk group. Although the number of families surveyed in this study was too small to make meaningful statistical analysis or to be able to generalise with any certainty to the broader population of homeless families, these findings are disturbing and support concerns regarding the emotional and physical health status of these children.

The roots of family homelessness are complex and need to be examined on a societal level. However, at the same time the reality of this growing problem, and the associated child and family outcomes discussed in this paper, must be seen as a challenge to policy-makers to fund programs for the homeless aimed specifically at families with children. There is also a need for further research involving multiple community agencies in order to gather more comprehensive data on the particular problems and needs of these people.

The implications of these findings for service providers include the obvious need for a more appropriate model of service delivery for families with children. Service providers should develop programs and train staff so that they are better skilled to serve the specific needs of the children. As a first step in this process, an assessment tool and information brochure has been developed.

Jenny and family

Jenny fled her family home with her three children aged 12, 10 and 8, following many years of violence and abuse from her husband. The trigger for her to leave came when her husband began to abuse her eight year-old daughter. Jenny told staff that she could put up with being hit, but that she would not tolerate him hitting her children. As Jenny was unable to access a refuge, she came to Hanover and was accommodated in a flat in the short-term support housing program.

All the family members were clearly traumatised by this sudden disruption to their lives. Ten year-old Keith was very angry with Jenny for leaving his dad and making him lose all his friends. He didn't seem aware of the violence his mother experienced. Jenny informed staff that it generally occurred at night when the children were asleep. However, Richard, the 12 year-old, had seen and heard a lot of the violence. He told staff that he had been frightened and ashamed that he had not protected his mother or his sister. He said he wanted to kill his father.

Julie, the eight year-old, was very sad. She thought it was all her fault. If she had not been naughty, daddy wouldn't have hit her and they would all be at home.

Over the next few weeks the support staff, together with a domestic violence outreach worker, helped Jenny to start the process of resolving all the issues that now confronted her. At times, Jenny felt that she was being torn in half by the conflicting pressures put on her by the children.

Jenny successfully gained priority public housing and developed links with community and legal support services in the new suburb. Fortunately, Jenny's husband abided by the terms of the intervention order and he has begun access visits with the children. This has helped the two youngest to settle. He intends fighting Jenny for custody and the children's sense of dislocation and confusion is by no means resolved.

Jenny is finding life a struggle, both emotionally and financially, but has found the strength she needs to cope with these struggles through the positive changes she is experiencing through no longer living in fear of being hit.

5. The Issues

Hanover has traditionally concentrated its casework services on outcomes for adults. Critical issues impacting on the children have been addressed, but there has been no systematic attention paid to the children's overall health and development. The research study has highlighted the need for services working with children in homeless families to include health, in its broadest sense, as part of the casework intervention.

Many of the children accompanying their parents into Hanover's family services have been subjected to witnessing or experiencing family violence, have parents with substance addictions and/or poor physical and mental health. This is often in addition to the loss of home and possessions. Due to the social isolation of many of these families, the support staff and health and education professionals are in the best position to assist parents to recognise and respond to the symptoms of their child(ren)'s distress.

Having expertise within the service has greatly enhanced the service's capacity to understand and respond to the emotional, social, recreational and educational needs of accompanying children. Services without access to such expertise are severely disadvantaged in their task of providing appropriate support and intervention.

Access to immediate independent, permanent or supported temporary accommodation is a critical component in the process of recovery for a family in housing crisis. Many families are having to endure a number of short-term moves in expensive or unsuitable accommodation due to the lack of either temporary or permanent housing.

The research has shown that children in transient families are more likely to have reduced opportunities to fully participate in, and benefit from, educational and recreational activities, and that these deficits are already having a negative impact on the children's development.

Financial assistance is a critical tool to assist children to regain a sense of purpose and belonging through having adequate clothing, play materials and educational necessities. Financial assistance is also critical if the children's social, activity and academic disadvantages are to be addressed.

The American experience suggested that children in homeless families suffer significant physical and mental health disadvantages. This study indicates that the physical health of children in homeless families in Victoria is relatively well looked after. Families, even in crisis, appear able to access health services. This reflects the benefits of Australia's universal health and welfare system which has made basic health services available to all.

Children in homeless families have significant levels of problematic behaviour that over time could compromise their personal development and growth. Knowledge of the complex underlying issues confronting the parents indicates that exposure to violence, abuse and poverty may contribute more to these findings than the housing crisis itself. Preventative support programs for families are essential tools in addressing these issues.

George, Belinda and family

George, Belinda and their three children came to Hanover after being evicted from private rental. The family had never used welfare services before and knew very little about the range of services to assist families in crisis. Prior to being made redundant, George and Belinda had worked in the same factory and were on good incomes. They had provided well for their family and had lived in the same house for almost six years. Their lives were changed dramatically when they were both laid off when the factory downsized its operations.

Initially, they retained some optimism about finding other jobs and they managed their rent and other expenses by dipping into their redundancy pay and savings. A few weeks later, they were hit by another devastating crisis when their seven year-old was hospitalised for almost two months. By the time she recovered the family had no savings left and had begun to sell their household goods to survive.

With no immediate family to assist them and no jobs becoming available, the family's downhill slide continued until they were evicted from their home because of rent arrears.

When they contacted Hanover, George and Belinda were very distressed and felt that they had failed their children. They had even sold the children's bikes and toys in order to survive. As it would take some time for the family to recover emotionally and financially, they were accommodated in the medium-term supported housing program. A donation to Hanover enabled support staff to assist Belinda and George to replace some of the children's toys and purchase school uniforms for their new school.

The secure and comfortable home, together with support and information about community resources, assisted the family to begin the painful process of regaining their esteem and sense of control over their lives. The family developed a savings plan that successfully enabled them to acquire furniture and get back on their feet again. George and Belinda eventually regained work. The family is now back in private rental, although they have chosen to live in a less expensive house just in case they become unemployed again.

6. Policy Challenges

Structural Issues

The roots of family homelessness are complex and need to be examined on a societal level. Poverty, unemployment, and the inadequate supply of affordable and secure housing, together with family violence, have all been associated with Hanover's experience of family homelessness. Policy-makers must give a higher priority to reducing unemployment and to increasing the supply of affordable housing in order to lower the prevalence of family homelessness. The consequences for the next generation of failure to intervene now are evident in this report.

Education and Training

The poverty associated with long-term unemployment renders many families vulnerable to homelessness. Many of us have experienced hard times, but have either known or expected that things will improve in the future. For many of these families, the present is the future. Year after year, they will juggle the money, make ends almost meet, buy second-hand goods, live with second-hand inefficient and often dangerous furniture and equipment, say no to their children, dress unfashionably, have to ask for grants, money or goods and go without. They are also likely to see their children enter the same cycle of disadvantage.

The provision of education and training to the most disadvantaged in the labour market is essential in providing these families with the opportunity to escape the cycle of poverty. Too many families have no parent in employment.

Housing

The difficulty most often reported by Hanover clients and staff is that of securing long-term suitable housing: affordable housing of a decent quality in a location that will ensure it provides a basis for families to satisfy their other needs. For the most disadvantaged families assisted by Hanover, the affordability and security of tenure provided by decent government-funded housing is an essential ingredient in tackling their homelessness.

An increased commitment by our governments to public and community housing is urgently required if the most disadvantaged families experiencing homelessness are to build a secure future for their children.

Family Violence

Family violence is one of the major causes of homelessness and is reflected in the over-representation of one-parent families amongst homeless families. Hanover's data has demonstrated the large extent to which violence contributes to the homelessness of women and their children.

More rigorous enforcement of legal options for removing the violent person from the family home, and the provision of adequate and prompt responses to breaches of intervention and restraining orders, would assist in preventing women and their children becoming homeless. The challenge for governments is to strengthen the available range of education, preventative and crisis response programs.

Family Support Services

Services delivering early intervention and support for families and their children are essential. Families struggling with poverty, complex relationships, poor parenting skills, social isolation, educational disadvantage, violence and abuse, require a range of supports that are accessible and affordable. These include services such as maternal and child health centres, kindergartens, play-groups, respite foster care, financial counsellors, family counsellors, sexual abuse counsellors, parenting programs, domestic violence outreach and support groups, family support programs, child-care programs and school support programs. Access to early intervention and support services has been restricted, due to funding cuts and policy shifts over recent years. This trend leads to further disadvantage for the children, whom this study has found to already be at significant disadvantage.

Children's Support Services

Services designed to support children to cope and deal with the many disruptions and traumas they are experiencing, are currently under-resourced. In particular, psychological counselling for children is difficult to access if the child has no diagnosed mental health disorder. School support services and special needs resources are important components for redressing the educational disadvantages, which transient families experience.

The governments' commitment to the provision of a broad range of community supports for families and their children needs to be strengthened.

Informed Intervention with Accompanying Children

The implications of these findings for service providers include the need to develop more appropriate interventions and models of service delivery to assist workers to understand and respond to the needs of children. SAAP has been developing guidelines and integrated case management policies. However, policy will remain as rhetoric unless resources are given a high priority so that service providers are able to meet the children's complex and urgent need for intervention. To assist in service delivery, the authors have developed a practical assessment tool and information guide for use by service providers. (see next page)

Description of Assessment Tool and Information Brochure

Whilst experienced workers do have keen observational skills and are often able to 'sense' a health problem that needs addressing at some stage, we would argue that these skills are neither intuitive nor reliable. The health (in its broadest sense) issues for children in homeless families are often seen as a lower priority in the overall scheme of the family's needs, and as such may well be overlooked or not properly addressed. We believe that the routine application of a formal assessment tool (as part of the assessment process of the family) would greatly enhance the ability to identify children's specific health needs and safeguard against their neglect.

In the light of the findings of this study, a package has been developed for use by staff of agencies working with families and their children. There will be two parts:

(a) An information brochure for workers, highlighting the important issues for children in homeless families. This information reflects the findings of the research project, with the aim of alerting staff to the specific health and emotional needs of the children they are working with. It includes practical information on ways of accessing the health care system in Melbourne on behalf of their clients, to ensure that problems are properly assessed and managed (eg. addresses, phone numbers).

(b) A targeted screening instrument, informed by the findings of the research project. This aims to be a compact, easy to administer tool which will enable early identification of the most important issues affecting the health and well-being of this at-risk population of children.

The above initiatives should be viewed as a practical step in raising the issues of children's health and well-being within the SAAP service network and developing improved linkages between SAAP workers and health services.

Appendix 1

Hanover Family Services - Child Support Program Objectives

Goal: To integrate the particular needs of individual children into the overall Family case-plan and objectives.

Children's Room Activities

- For Crisis/Emergency Families:

  Child Care during Parent Interview (Southbank/ Housing Options/SAAP/Support)

  Objectives:

  - to enable parents to discuss sensitive matters without children present
  - to provide children with some safe, supported time-out from the crisis

- For Emergency/SAAP Families:

  (a) Child Care during Support Interviews

  Objectives:

  - to enable parents to discuss sensitive matters without children present
  - to provide children with safe, supported time-out from the crisis
  - to develop working relationship with child/children
  - to assess child developmental levels and offer appropriate play experiences and challenges

  (b) Single Family Session

  Objectives:

  - to develop working relationship with parent/s and child/children
  - to identify strengths and needs of parent/s
  - to support parent strengths, boost parent self esteem, offer parenting support through information and modelling
  - to assess child developmental levels and offer appropriate play experiences and challenges
  - to assess the emotional and relationship status of child and parent/s and to provide support/development opportunities as necessary
  - to provide enjoyable experiences for children and adults

- One to One - Child and Children's Support Worker

  Objectives:

  - to assess child developmental levels and offer appropriate play experiences and challenges
  - to develop safe relationship/space for children who may wish/need to disclose information
  - to provide respite time for parent/s to attend appointments, shopping, etc. where access to local care is difficult (vacancies/cost)

- Small Group Session

  (a) Pre-school Children

  Objectives:

  - to provide children with safe supported time
  - to strengthen working relationships with the children
  - to provide opportunities for children to play with others
  - to provide enjoyable play experiences

- to provide respite time for parent/s to attend appointments, shopping, etc. where access to local care is difficult (vacancies/cost)

(b) School Age Children

Objectives:

- to offer enjoyable, age appropriate activities and experiences for children who have difficulty accessing local 'out of school programs' (logistics/cost/vacancies)
- to develop safe relationships/space for children who may wish/need to disclose information

- **Playgroup (Parent/s and children together)**

Objectives:

- to provide opportunities for children to play with others
- to assist parent/s to overcome reservations or fears about interacting with other parent/s
- to provide supported opportunities for parent/s to talk to each other and to Children's Workers
- to introduce parent/s to Playgroup concept so that families may be encouraged to access local groups

Home Visits for SAAP Families

Objectives -

- to intervene in families where dysfunctional parent/child boundaries restrict opportunities for productive support work
- to provide opportunities to observe child alone or parent/child interaction
- to assess and respond to specific parenting/child/family needs

School Support

As most primary age children in Emergency Accommodation will attend the local primary school, there will be frequent short-term admissions.

Objectives:

- to offer educational support under direction of classroom teachers in one to one or small group programs
- to maintain access to support material for older children
- to facilitate the school's understanding of the needs of children in homeless families

Advocacy

Objectives:

- to support parents in accessing appropriate services for their children
- to ensure children's protective needs are addressed
- to ensure that children's needs are considered in the service's overall casework strategies and service development

Appendix 2

Objectives of the 3 levels of Hanover Family Services Supported Accommodation programs

Crisis Accommodation

The primary objective is to provide immediate access to shelter for families who have no income and no other appropriate shelter for the night

To facilitate this objective, accommodated families are assisted to locate alternative shelter as soon as possible. Usually this means as soon as the family can locate more suitable emergency, temporary or supported housing and have sufficient income to access it.

The crisis units operate quite differently from Hanover Family Service's other short and medium term transitional supported housing programs, which provide fully independent temporary accommodation with support workers to assist families to access and, where necessary, to maintain tenancy of longer term housing options.

Short term Supported Housing Program

- To provide short term, good quality, secure, affordable and fully independent accommodation to families in a housing related crisis.
- To assist families to secure permanent or long term accommodation.
- To assist those families who have additional problems which contribute to or compound their housing crisis, to identify and overcome those problems in order to secure and maintain long term housing.
- To provide practical and psychological support to all family members during the period of crisis.

Medium Term Supported Housing Program

- To provide supported housing to families while assisting them to re-establish their capacity to live independently of Hanover
- To assist families to resolve difficulties they have identified as impacting on their housing crisis.
- To assist families to access and maintain long term secure and affordable housing

Appendix 3

Children in Homeless Families Study

Purpose-designed Questionnaire

A. Child Health
(areas not covered in CHQ)

B. Health Maintenance

C. Utilisation of Health Services

D. Parent Health

Date of Interview:.....

Interviewer's Initials:.....

Children surveyed: (Note: If two children being surveyed, older child will be 'Child 1': Younger child 'Child 2')

	Initials	DOB	Age (yrs; mths)	Sex
Child 1				
Child 2				

A. CHILD HEALTH

All ages

	Child 1 pounds	ounces	Child 2 pounds	ounces
- Birth weight				
- Premature (<37/40)	Yes 1		1	
	No 2		2	

Go to section corresponding to child's age:

Less than 12 months

- *My baby has had:*

	None	*Mild*	*Mod.*	*Severe*	*Cannot say*
Colic	1	2	3	4	5
Sleep problems	1	2	3	4	5
Excessive crying	1	2	3	4	5

- *Compared to other babies, I think my baby is:*

Much easier than average	Easier than average	Average	More difficult than average	Much more difficult
1	2	3	4	5

- *How do you feel about the way your child is developing?*
(eg. rolling over, sitting up, walking, talking, etc.)

Very satisfied	1
Quite satisfied	2
Neither satisfied nor worried	3
Quite worried	4
Very worried	5

1 - 12 years

- *How do you feel about this child's EATING habits*

	Child 1	Child 2
Very satisfied	1	1
Quite satisfied	2	2
Neither satisfied nor worried	3	3
Quite worried	4	4
Very worried	5	5

- *How do you feel about this child's SLEEPING habits?*

	Child 1	Child 2
Very satisfied	1	1
Quite satisfied	2	2
Neither satisfied nor worried	3	3
Quite worried	4	4
Very worried	5	5

1 - 12 years (cont'd)

- *Compared to other children, I think my child is:*

	Child 1	Child 2
Much more active than average	1	1
More active than average	2	2
About normally active	3	3
Less active than average	4	4
Much less active than average	5	5

12 or older (substitute son/daughter for child)

- Health compromising behaviours

  - *As far as you know, does your child:*

	Child 1		Child 2	
	Yes	No	Yes	No
Smoke (>2/d)	1	2	1	2
Drink alcohol regularly	1	2	1	2
Binge drink	1	2	1	2
Keep a strict diet	1	2	1	2
Binge eat	1	2	1	2
Smoke marijuana (> monthly)	1	2	1	2
Use other drugs	1	2	1	2
Specify:				

- Exercise

  - *Does your child do vigorous or structured exercise on two or more days per week?*

	Child 1	Child 2
Yes	1	1
No	2	2

- Injuries

  - *Over the past year, has your child been injured in:*

	Child 1	Child 2
Sports	1	1
Car/bike accident	2	2
A fight	3	3
At work	4	4
Other	5	5
No injury	6	6

- Runaway

  - *Has your child run away from home in past 12 months?*

	Child 1	Child 2
Yes	1	1
No	2	2

All Ages

- Placement:

	Child 1	Child 2
Child care	1	1
Pre-school	2	2
School	3	3
Other	4	4
None	5	5

- *If age >5 and not attending school, reason:*

	Child 1	Child 2
Too young	1	1
Moving too much ∴ not enrolled	2	2
Refuses	3	3
Has lef school	4	4
Other	5	5

- *Please rate your child's <u>ability</u> to learn things on this scale.*
  (1 = well below average, 5 = well above average)

Child 1	1	2	3	4	5	Don't know 6
Child 2	1	2	3	4	5	Don't know 6

- *Please rate your child's <u>achievement</u> on this scale*

Child 1	1	2	3	4	5	Don't know 6
Child 2	1	2	3	4	5	Don't know 6

If achievement is below ability:

- *Why do you think your child is now achieving to the level of his/her ability?*

Child 1:

Child 2:

- *How many different schools has your child been to?*

	Child 1	Child 2
Current grade		
Maximum no. years at one school		

B. HEALTH MAINTENANCE

(i) Immunisation (refer to Child Health Record)

Current = 1; Delayed - intend to catch up = 2;
Delayed - not intending to catch up = 3; Don't know = 4

	Child 1	Child 2
Triple Ag	.....	.....
OPV	.....	.....
MMR	.....	.....
HIB	.....	.....
Hep. B	.....	.....

- *If any delayed, reason:*

	Child 1	Child 2
Moved and haven't linked with M&CHC	1	1
Haven't gotten around to it	2	2
Forgot	3	3
Didn't know	4	4
Don't believe in it	5	5
Other	6 Specify:	6 Specify:

(ii) Dental Care (>5 yrs)

- *No. visits in previous year*

	Child 1	Child 2
For problem	.....	.....
For check-up	.....	.....

- *If no visits - reasons:*

	Child 1	Child 2
Moved and haven't found new dentist	1	1
Haven't gotten around to it	2	2
Can't afford	3	3
Didn't think children needed to see dentist	4	4
I don't believe it's important for children to visit dentist	5	5
Other	6 Specify:	6 Specify:

- *Dental problem*

	Child 1	Child 2
Cavities	1	1
Crooked teeth	2	2
Pain	3	3
Infection	4	4
Trauma to teeth	5	5
Other	6 Specify:	6 Specify:

(iii) Nutrition

- *Please indicate how often your child eats each of the following foods (on average):*

Daily = 1; 2-3 times/wk = 2; Wkly = 3; Less than weekly = 4; Never = 5

	Child 1	Child 2
Red meat	.....	.....
Other meat (eg. chicken, fish)	.....	.....
Fresh fruit	.....	.....
Vegetables	.....	.....
Cereals	.....	.....
Take-away foods	.....	.....

- *Do you think your child eats too much of certain foods?*

	Child 1	Child 2
Yes	1	1
No	2	2

- *If yes, which?*

Child 1.....

Child 2.....

- *Is there anything you would like to do, if you could, to improve your child's diet?*

Child 1.....

Child 2.....

C. UTILISATION OF HEALTH SERVICES

- *Who is your child's regular health care provider?*

Child 1.....

Child 2.....

(i) Preventive/well-child care
(eg. for check-ups or minor things)

	Child 1	Child 2
None	1	1
M&CHN	2	2
CHC	3	3
GP	4	4
Pharmacist	5	5
Hospital	6	6
Other	7 Specify:	7 Specify:

- *Do you use the same service each time?*

	Child 1	Child 2
Yes	1	1
No	2	2

(ii) Illness care (when your child is sick)

	Child 1	Child 2
None	1	1
M&CHN	2	2
CHC	3	3
GP	4	4
Pharmacist	5	5
Hospital Emergency Dept	6	6
Specialist - Community	7	7
- Hospital O/P	8	8
Locum	9	9
Other	10 Specify:	10 Specify:

- *Do you use the same service each time?*

	Child 1	Child 2
Yes	1	1
No	2	2

- Barriers to access to health care

- *Which of the following have made it difficult for you to obtain health care for your child?* (eg. times when it's not essential but you would quite like your child to be seen).

	Can circle › 1
Transport difficulty	1
Cost of treatment	2
Not knowing where to go	3
Making an appointment	4
Waiting to receive appointment	5
Waiting until appointment	6
Time wiating for doctor (in waiting area)	7
No Medicare card	8
Unable to take time off work	9

- *If <u>cost</u> is a problem, which of the following costs are important?*

Transport	1
Dr's bills	2
Medication	3
Time lost at work	4
Other	5 Specify:

- Utilisation of hospital services

- *No emergency dept. visits/child in past 6 months*

	Child 1	Child 2
None	1	1
1 or 2	2	2
3-5	3	3
>5	4	4

- *No. non-emergency O/P vists/child past 6 months*

	Child 1	Child 2
None	1	1
1 or 2	2	2
>2	3	3

- *Hospital admissions in past 2 years*

	Child 1	Child 2
None	1	1
1	2	2
2	3	3
3	4	4
>4	5	5

- Child Safety

- *Have you ever had to take your child to a doctor or hospital because he/she:*

(I) *Accidently swallowed some medicine, pills or poison?*

	Child 1	Child 2
Yes	1	1
No	2	2

(ii) *Suffered a burn or scald?*

	Child 1	Child 2
Yes	1	1
No	2	2

- *When travelling in a car, does your child use a child's booster seat or harness, ordinary seat belt, or no restraint? If not, why not?*

	Child 1	Child 2
Booster seat/harness	1	1
Ordinary seat belt	2	2
No restraint	3	3
Cannot say	4	4

- Health Insurance

- *Do you currently have private health insurance?*

Yes	1
No	2

- *If no, did you ever?*

Yes	1
No	2

- *If yes, reason for discontinuation:*

Cost	1
Didn/t get around to renewing and membership lapsed	2
Moved and didn't receive renewal notice	3
Decided it wasn't worth it anymore	4
Other	5

D. PARENT HEALTH (Each parent)

- *Please rate your own health on the following scale:*

Mother

Terrible 1 2 3 4 5 Excellent

Father

Terrible 1 2 3 4 5 Excellent

Go to GHQ. (Separate questionnaire for each parent)

- *Did any of the qeustions in this or the previous questionnaires make you feel uncomfortable, or were there questions you wish we had not asked?*

Mother

Father

- *Would you be interested in the results of this study?*

Yes 1
No 2

- *We will be following this questionnaire with a briefer version in 6 months time, to see if things have changed at all. Would you be willing to participate in this follow-up part of the study?*

Yes 1
No 2

E. DEMOGRAPHIC DATA

Family: No. adults 1 2

If 2:
Are the 2 adults in the family the parents of this child? Yes/No
If no, *Which is the biological parent?*

Mother 1
Father 2

No. of children: 1 1 3 4 >5
1 2 3 4 5

Parents:

		Mother	Father
Age:	<20	1	1
	20-29	2	2
	30-39	3	3
	>40	4	4

Aboriginal/Torres Straight Island Yes 1
No 2

		Mother	Father
Country of birth			
First language			
Number of biological children to this parent			
Education	>Yr.8	1	1
	Yr. 9-10	2	2
	Yr. 11-12	3	3
	Tertiary	4	4
Income Type			
	F/T work	1	1
	P/T work	2	2
	Casual work	3	3
	SPP	4	4
	Newstart	5	5
	Jobsearch	6	6
	Sickness Benefit	7	7
	DSP	8	8
	Other	9	9
	None	10	10

Housing History

- *Most recent* (immed. prior to crisis or supported accommodation)

Own home/buying	1	
Parental home	2	
Private rental	3	
Public housing	4	
With friends	5	
Emergency shelter	6	
Sleeping out/squat	7	
Other	8	Please specify:

- *No. moves in past 12 months:*

1	2 or 3	4 or 5	>6
1	2	3	4

- *Longest stay past 2 years:*

>18/12	12-17/12	6-11/12	3-5/12	<3/12
1	2	3	4	5

- *Have you stayed in emergency or welfare housing before?*

Yes	1
No	2

- *If yes, No. times stayed in emergency housing in past 12 months?*

0 times	1 time	2 times	3 times	>4 times
1	2	3	4	5

- *Reason for coming to Hanover* (may respond to >1 option)
(Housing crisis)

No money	1	
Relationship breakdown	2	
Housing issue (inability to find or maintain affordable housing)	3	
Eviction	4	
Unemployment	5	
Poor health	6	
Family violence	7	
Other	8	Please specify:

Social Networks

- *When you have a <u>problem</u>, do you have someone to turn to for assistance/support?*

Yes	1
No	2

- *If yes, is that person:* (may circle >1)

Immediate family	1	
Relative	2	
Friend	3	
Neighbour	4	
Professional (eg social worker, etc)	5	Please specify:
Other	6	

- *Do any of the following people provide you with <u>friendship/moral support</u>?*
(May circle >1)

Relatives		
Friend(s)	2	
Neighbours	3	
Professional	4	Please specify:
Other	5	
None	6	

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