ANGLICARE AUSTRALIA

The State of the Family Report 2000

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CONTENTS

EXECUTIVE SUMMARY

The State of the Family Report draws on the experience of Anglicare agencies around Australia, identifying issues affecting families and those providing services to families in need, as well as highlighting stories of family struggles. This initial report focuses on three broad areas of Anglicare's work; supporting families in their caring role; helping families in conflict; and assisting families who are struggling just to make ends meet.

Anglicare agencies support families in their caring role through the provision of foster care, family support services, aged care and disability services. For agencies involved in foster care, a major challenge is providing appropriate care for children with extremely disruptive behaviours. State and Territory governments have closed, or are in the process of closing, their large residential facilities which in the past cared for children with significant physical and emotional problems. The lack of recognition of the cost of providing high quality care to such children means that there is now inadequate provision of alternative forms of care.

Traditionally family support programs focused on families in crisis, but are now becoming more preventive in nature with the provision of broad-based parenting education and community development type programs. In addition, services are becoming more integrated as agencies seek to address the whole range of client needs. A major challenge facing agencies providing family support services is developing appropriate programs for groups currently under-represented in client profiles such as fathers and Indigenous Australians.

Home-based aged care aims to reduce inappropriate admission to residential facilities. Socially isolated and financially disadvantaged Australians are particularly at risk of inappropriate admission to residential facilities. However, even where people have a history of long-term transience, alcohol abuse or a mental illness, the provision of appropriate support means that such people are able to maintain independent housing.

The major focus of disability support programs is supporting families who are the main providers of care for people with a disability. Giving families a break is an important

element in enabling them to continue caring for a family member with a disability. However, there is significant unmet need within the community for disability respite care, particularly for those families caring for children with moderate or severe disabilities as well as extremely challenging behaviours and high support needs.

Two of the ways in which Anglicare agencies support families in conflict is through domestic violence and youth and family mediation programs. In both areas client needs are complex and best addressed through a range of integrated services. Much of the work done in this area is preventive and long-term as it involves helping individuals change violent and abusive patterns of behaviour. However, if such programs are to be successful, funding needs to reflect the long-term nature of service provision.

The chapter, 'The Economic State of Families', explores what it is like to live on a low income in Australia today. In looking at services provided for sole parents, those who are homeless (or at risk of homelessness), gambling services and financial counselling, it is clear that social and economic disadvantage are inter-related. For example, those on low incomes are unable to access a full range of education and health services. Limited access to transport is part of this picture of cumulative disadvantage. Housing is another important element, with the cost of housing pushing many people into poverty or intermittent financial crises.

Disadvantage in Australia is becoming increasingly localized. The clustering of families who live in poverty in particular geographic areas increases the probability of poverty being passed on from one generation to the next. Children raised in such areas are likely to have a sub-standard education compared to most other Australian children and may have no role models in their locality of adults who are successful in the labour market. The likelihood of inherited poverty is one of the most disturbing features of families in poverty in Australia today.

Six themes emerge from the material in the body of the report all of which have implications for the funding and delivery of services. These are:

- the complex, interdependent nature of client needs;
- the difficulties of accessing services in rural and remote areas;

- the importance of peer support and a sense of connection to family, or group of friends;
- the importance of developing social networks;
- the importance of trust between the client and those providing the service; and
- the need for adequate funding of preventive programs.

Complex, interdependent client needs demands an integrated service delivery model where client need is assessed in broad terms (that is, not just in terms of the problem they present with) and clients are able to access a range of services within the one agency. Many Anglicare agencies already provide integrated services, or are moving towards this model of service delivery. Small agencies which may not be able to offer a range of services need to develop good information and referral networks so that clients can be referred to appropriate services. In this environment, co-operation and collaboration between agencies (which has been damaged by the introduction of competitive tendering) is essential.

An integrated model of service delivery has significant implications for the funding of services. Governments fund specific services which are designed to deal with a specific "problem". Integrated service delivery requires flexibility in funding and contract specifications so that agencies are able to provide an individualized package of services, the cost of which may vary from client to client.

The second theme to emerge from the material in this report is the difficulties experienced by those living in rural and remote areas in accessing services. Agencies operating in rural areas may not be able to provide a full range of specialist services, necessitating travel to regional centres. Those living on a low income may not be able to afford to run their own car, and with limited public transport, it becomes expensive, in terms of time as well as money, to access specialized services outside the local area. Clients may need to access specialized support services (such as gambling services) on a regular basis over a considerable period of time, thereby adding to the costs involved. The fact that many rural and remote areas are characterized by relative economic and social disadvantage, means that difficulty in accessing services occurs in areas where need is greatest.

Not only does it cost more to access services in rural and remote areas, it costs more to provide services. Agencies which provide out-reach and home-based services in rural and remote areas often have to travel a long way to bring the service to the client. Co-ordination, administration costs and training costs are higher. If the economic and social disadvantage experienced by those living in many rural and remote areas is not to worsen, funding agencies need to recognize the greater cost involved in providing services in these areas.

The importance of peer support, the importance of building social networks and the importance of trust between client and service provider, all point to the ways in which welfare agencies generate social capital. Young people at risk of homelessness, individuals trying to change violent behaviour patterns, and parents struggling to relate to their adolescent children, all find it beneficial to meet and talk with others in the same situation.

But what happens when programs (such as parenting programs) are completed? The program is finished, but the need for some form of on-going support remains. Programs which utilize peer support or aim to develop social networks need to build self-sufficiency into program design so that the peer support groups and social networks can continue after the formal program ceases.

Much of the work carried out by Anglicare agencies is preventive. Preventive programs are, by their very nature, focused on a wider proportion of the population than programs designed to assist those in crisis. In other words, preventive programs are broad-based and must be funded as such. There is evidence of significant unmet community demand for preventive programs, particularly disability respite care and parenting support. If access to such programs is severely restricted because of funding constraints, the programs will have little impact in terms of ameliorating future crises. Similarly, the potential benefits of preventive, early intervention strategies (such as Program for Parents) will never be fully realized if successful pilot programs are not made available to the wider community.

1. FAMILIES AS CARERS

Caring is seen as the natural function of families. Caring for children, caring for ageing parents or a spouse or caring for family members who have a disability. Anglicare, and Anglicare affiliated agencies, support families in their caring role through the provision of foster care, family support, home-based aged care and disability services.

Anglicare programs provide support for vulnerable family members and for those who care for them. Providing support for carers can be in the form of respite care, so that carers can have "time out" from their caring responsibilities, or by providing practical advice and sympathetic understanding so that the carer feels they are no longer struggling alone.

> Just knowing that with the lift of the phone, day or night, the load is shared and that even something that seems silly or trivial but is bothering us is treated seriously and respectfully is a great comfort and support to my husband and myself (Foster parents with Anglicare Central
> Queensland Shared Care Program).

> Being on the Anglicare program has brought a sense of security for us both. Problems which I sometimes feel are large are easily solved by talking with the co-ordinator and I no longer feel I have to muddle through and cope by myself. Feeling that you have to cope alone is quite debilitating - being on the Anglicare program means we are no longer alone (Daughter of an Anglicare SA aged care client).

A large proportion of Anglicare's work in this area is, therefore, preventive; it is aimed at preventing family breakdown or inappropriate admission to residential facilities.

Anglicare agencies also work with families in crisis and there is an on-going tension between the need to provide immediate support to such families and the high level of unmet need within the community for preventive programs.

Foster care

There are times when parents are unable to care for their children as they struggle to cope with the pressures in their lives. In Australia, State and Territory governments are responsible for the care of such children. Placement of children in alternate care can be voluntary, but most placements are made as a result of a care and protection order or a juvenile justice order (AIH&W,1999:288). The majority of alternate care (or out-of-home) services are provided by non-government organizations.

At 30 June 1998, 14,470 children were in out-of-home care throughout Australia; that is, 3.1 children out of every thousand aged 0-17 years (AIH&W,1999:288 and 290). Of those 14,470 children, 56% were being cared for in foster homes (or some other form of community care) and 31% were living with relatives, with only 10% living in residential facilities (AIH&W,1999:289). The small numbers of children living in residential facilities is indicative of a growing trend away from residential care to foster care, particularly since 1993 (Barber,1999:21). Most States and Territories have closed, or are in the process of closing, their residential facilities and rates of care in residential facilities vary from 5% of children in Queensland and South Australia, to 21% of children in the Northern Territory (AIH&W,1999:289).

Similar variation exists within home-based care, with only 8% of children in SA living with relatives and 86% in foster care, to 45% of children in NSW living with relatives and 43% in foster care (AIH&W,1999:289). At 30 June 1998, the majority of children in out-of-home care were primary school age or young teenagers (28% were aged 5-9 years and 32% were aged 10-14 years). 20% of children were older adolescents (15-17 years) and 21% were aged under 5 (AIH&W,1999:288). Generally, children in residential facilities tend to be older than children in home-based care. For example, in NSW, 86% of children in residential facilities were aged over 10 years, as at 30 June 1998 (AIH&W,1999:288).

In the past, children with more significant physical and emotional problems were cared for in residential facilities (Barber,1999:9). As residential facilities close, such children are now being placed in foster care. Studies such as Wise (1999) and Batt (1998) indicate that children in foster care today experience higher rates of acute and chronic mental illness, developmental delays and learning difficulties than in the past. Barber (1999:10) points to the steady increase in special needs loadings[1] in South Australia since 1997 as evidence of this trend.

Agencies which facilitate home-based care agree that foster families are increasingly being asked to care for children who are suffering from an increasing array of

emotional and behavioural problems (Hamill,2000). However, those involved with foster care also see the difference such care can make when children start learning to manage difficult behaviours and make significant improvements in their emotional, physical and academic development; a major goal of foster care services being to try and reverse the effects of past abuse and neglect and help promote normal development (Hamill,2000).

Box 1: Foster care[2]

About 6 weeks ago a 13 year old girl came to live with us. A tough little nut with purple hair and multiple body piercing. She proclaimed, "I smoke, but only drink on special occasions. I don't care about my family and they don't care about me. I just want to be left alone"…On Saturday our lass was sick so didn't feel like shopping and spent the day lying around. She watched everyone else swim on Sunday, as she was still not well. "A boring weekend", I thought. After lunch I sat down to do some craft and the kids joined me at the table. Our lass made 2 stuffed toys and was so proud. I then went out to get a couple of hours gardening in before dark and was joined 5 minutes later by her again as she set about helping me to dig, weed, haul dirt and plant. After about an hour she stood up and said to me, "this has been the best weekend ever". Anyone who has ever fostered a child or young person will know how
that felt to me.

Services offered by Anglicare agencies such as Anglicare NSW Child and Family Services include short-term and crisis foster care, weekend respite care, permanent/long-term foster care and residential care. Anglicare NSW Child and Family Services also operates a Children's Counselling Service for children in the alternate care system, and an "after care" service to young adults (18-21 years) who have been through Anglicare's programs and are now living in the community.

An important component of Anglicare's work is preventive; that is, providing respite care and support to families so that they are able to continue caring for their children. Anglicare Victoria offers Regular Respite at eight sites across Melbourne and Gippsland. Regular Respite provides respite care one weekend a month for a period of

[1] Special needs loadings are paid to foster parents for expenses incurred in housing children with special needs such as a disability, a mental illness or severe emotional or behavioural disorders (Barber,1999:10).
[2] Case study supplied by Mandy Jones, Anglicare Shared Care Program, Anglicare Central Queensland.

six to twelve months. By giving parents a break, Regular Respite aims to prevent family breakdown. It also aims to empower the child through a specific learning program designed around the needs of the child. For example, one of Anglicare Victoria's Regular Respite clients is a single mother (Julie) and her three children; two girls aged 10 and 9 and a boy aged 4[3]. In the past, the children have experienced a number of short-term foster care placements with Julie unable to protect her children from physical and sexual abuse. In spite of Julie's inability to protect her children, foster care placements were always short-term because family bonds were strong, with Julie always willing (if not always able) to provide for her children. When the relevant State government department was investigating the sexual abuse of the younger daughter, their case worker decided that all three children needed to be educated on how to protect themselves if they were to be released back into the care of their mother. Julie wanted to be involved in the Regular Respite program and, at a series of meetings with the respite caregiver and the case worker, a Protective Behaviours program was designed for each of the children.

Input from the mother was vital in designing the children's learning program. Julie was able to talk about the needs of her children and discuss the sorts of activities that would interest them. The case worker used this information to put together a series of activities, which were then agreed to by Julie and the respite care giver. Regular Respite therefore depends on a model of service delivery which creates a partnership between the family, the respite care giver and the case worker, rather than the more traditional relationship of service provider and passive recipient.

Recognition of the individual nature of children's needs is also part of Anglicare NSW Child and Family Services which offer a range of different types of care programs. For example, Peter is 15 years old and has experienced a number of different programs over the course of his childhood (a short-term foster care placement, a long-term foster care placement for 10 years and a residential placement for 2 years). The importance of providing a range of options which children can access as their needs change is illustrated by the fact that throughout his life Peter has been able to maintain relationships with his carers, case worker and youth worker (Hamill,2000). The

[3] Case study material supplied by May Davey and Talya Samuell.

importance of difference is also acknowledged in the range of families who provide foster care for Anglicare NSW Child and Family Services. Foster families come from a range of social and economic backgrounds and include single people and couples as well as parents with children.

Support for those providing care improves the stability of foster care placement and is an integral part of all Anglicare foster care programs. Training is offered to foster families to assist them in building a relationship with children struggling to cope with the impact of past abuse or neglect. Staff maintain regular contact with foster families to help them remain optimistic and realistic about their foster child's growth and development.

> It is important to have a worker who can measure growth in increments and share these with the foster family (Hamill,2000).

Anglicare staff assist in liaison with government departments and with the child's natural family and facilitate interaction between carers facing similar challenges. Foster families are also supported in practical ways:

> Anglicare staff have been invaluable at times facilitating the collection of scripts and medication, as we live some distance from these services (foster family with Anglicare Central Queensland).

While agencies provide support to foster parents, it is not always possible to support the child's natural family. For example, in Queensland, this task is the responsibility of the Family Services Officer, but the pressure of child protection work means that children often return home to a family where there has been no substantial change to the circumstances which led to the child coming into care (TRACC,2000). For this reason, TRACC South Shared Family Care would like to be able to expand its services to provide a more holistic service encompassing support to both natural and foster families (TRACC,2000).

The strains placed on foster care by the closure of large residential facilities which provided care for those with significant physical and emotional problems has already been noted. In NSW, closure of State government residential facilities in the early 1990s, together with a lack of recognition of the cost of providing care to children with special needs, has meant that there is now inadequate provision of alternative forms of care.

> We have children waiting for foster families, interested volunteers in the community waiting to be assessed and trained as foster carers. However we have too few workers who care already working to capacity (Hamill,2000).

The situation is exacerbated when inadequate funding forces agencies to close their own residential facilities (see for example, Nevile,1999:33-34). Even when agencies continue to run residential programs, the cost of providing quality care to extremely needy children often forces them to reduce the number of children in their programs. For example, TRACC Residential was originally meant to provide medium-term therapeutic residential care for six children whose previous foster placements had broken down because of disruptive behaviours. However, TRACC found it was impossible to provide six children with the support they required, so the number of children had to be reduced to four (TRACC,2000). The need for more long-term care is further demonstrated by the fact that although TRACC Residential was designed to provide therapeutic residential care for between six to twelve months, two of the four children have been in the program for more than two years because the Queensland Department of Families, Youth and Community Care has been unable to find foster placements for these children (TRACC,2000).

Indigenous children are placed in out-of-home care at five times the rate of non-indigenous children. That is, at a rate of 14.2 children out of every 1,000 aged 0-17 years (AIH&W,1999:291). Rates across Australia vary from relatively low rates in the Northern Territory (3 children out of every 1,000) and Tasmania (4.6 children out of every 1,000) to relatively high rates in Victoria (30.7 children out of every 1,0000 and NSW (21.5 children out of every 1,000) (AIH&W,1999:291). Thus, Anglicare NSW Child and Family Services faces the challenge of attracting and recruiting more Aboriginal carers so that indigenous children are not placed in non-indigenous environments (Hamill,2000).

Family support

Foster care provides assistance for families in crisis, when parents are unable to care for their children (either temporarily or over a longer period of time). Family support services are designed to keep families from reaching that breaking point. Traditionally, family support services, such as counselling, the development of family and household management skills, and assistance with household budgeting were directed towards

families at risk (Allan & Potten,1998:2). For example, 'Operation Kinder Community' provides counselling and therapeutic services, crisis assistance, offender support and rehabilitation and youth programs to clients in the Ipswich/West Moreton region which is characterized by high levels of youth crime, a large concentration of public housing, high levels of unemployment and a population largely dependent on government benefits (Lister,2000).

More recently, governments have strengthened the preventive nature of family support services by specific family strengthening initiatives, such as the Positive Parenting Program[4], as well as funding a range of parenting education and community development type programs (Allan & Potten,1998:2). Funding for family support services comes from all levels of government (Commonwealth, State and Local), with delivery of services carried out by State and local governments and non-government organizations (AIH&W,1997:129).

Box 2: Family Support - support for parents

Parents often become stressed and confused about life changes that occur as their children go through adolescence. Other parents feel unable to cope with parenting due to stresses in their own lives, such as family violence, family breakdown, sole parenting, step-parenting, addictions, mental illness, isolation or a lack of role modelling from their own parents. Some parents see the child/adolescent as the problem and want someone to "fix the problem" (Vallis,2000).

For Anglicare Central Queensland (CQ), parenting programs are the major strategy in its preventive approach to intervention. Anglicare CQ Family and Adolescent Support Program offers a range of parenting programs which allows Anglicare to provide support that directly addresses individual needs. For example, Parenting Adolescents a Creative Experience (PACE) is designed specifically for parents of teenagers, while Planning Happy Family is designed for parents in general. Parents Matter Too (which encourages parents to first of all understand and develop themselves) is designed for

[4] The Positive Parenting Program is an early intervention program aimed at promoting positive, caring relationships between parents and children and assisting parents develop strategies to manage misbehaviour. Parents can participate on an individual basis or as part of a group. Anglicare Top End introduced a Positive Parenting Program for parents of children aged 0 - 12 years in 1999. Following the success of this initial program, further programs will be offered in Darwin and in remote communities in Katherine and Groote Eylandt.

vulnerable parents, including those who are very young, those who are isolated from support networks or geographically isolated, parents who are struggling with chronic ill-health, poverty, inadequate housing, or who have a disability or a child with a disability (Vallis,2000).

Step-families face particular problems. The need for programs, such as Anglicare CQ Living in a StepFamily, which specifically address the needs of step-families is clearly demonstrated in Murphy's (1998) study of step-families and poverty.

> Almost all of the couples commented on the lack of support and understanding that they received in their attempts to establish and maintain their new family. This ranged from general comments about "knowing what they had taken on", to specific issues dealing with hospitals and other health professionals, relationships with schools, legal issues (guardianship, inheritance, Wills and estate planning), establishing a working relationship with the children's other parent, and accessing support services for both the parents and the children (Murphy,1998:6).

The traditional focus of family support services to families at risk means that many participants in parenting programs are referred from the relevant State government department, where they may be required to take part in a parenting program as a condition of working towards family reunification. Other participants are referred from other community organizations, while others take the initiative of attending the program themselves.

Box 3: Family Support can make a difference

I remember when Jan first came to see me[5]*. I was a wreak. Through Jan's support I have learned to cope with almost anything. Having a family support worker was the best thing that ever happened to me. I needed someone to listen, give advice and to tell me I was doing a good job. I needed respect and I need a friend. Sometimes that is all some people need.*

Often when service users are referred to family support, they have little or no sense of what to expect[6]*. This was certainly the case for "Odette" who knew nothing about the agency or the program when she was referred by her doctor. [Odette] had significant emotional and physical health problems, was isolated from friends and family, unaware of local community services, experiencing relationship difficulties, and was struggling to care for adolescent children. After a long period of involvement with the family support program, [Odette] reported that the impact had been life changing. [Odette] now talks enthusiastically about how her confidence*

[5] Case study supplied by Carol Kelly, Family Support Program, Anglicare SA.
[6] Case study cited in Allan & Potten (1998:5).

and self-esteem have grown, how she has lost weight and made new friends. Her current goals centre on learning to read and write. She now embraces and enjoys life, whereas before she was severely depressed, even suicidal. [Odette] attributes this remarkable change in her quality of life to the worker assigned to her through Anglicare [Victoria's] Family Support Program.

One woman, the mother of five children, had a drinking problem before attending the Parents Matter Too program[7]*. On the last day participants were giving feedback. Her comment was, "before the course I used to drink on pension day. Now my friends are saying, 'what's wrong with you'? I tell them my kids are enough for me. When I*
wake up in the morning and they say they love me, that is enough.

International research has shown that protection of children at risk is best done by addressing family problems holistically (Tomison,1998:2). Strategies which ensure the safety and well-being of the children while recognizing the importance of the child and the family to each other and promoting a partnership between case workers and families are recommended as models of best practice (Tomison,1998:2). As is clearly evident from the case studies cited above, establishing a caring, supportive relationship is a vital part of Anglicare's family support programs. A study by Allan and Potten (1998) of what it is that clients value most about Anglicare Victoria's family support programs revealed that "the relationships and friendships, and, in particular, the way in which a service is provided, combined with practical assistance of various kinds, are the key factors for service users" (Allan & Potten,1998:5).

Those working in Anglicare SA Family Support Program believe the fact that family support work is done in the family's home (rather than an agency office) makes it easier to establish the sense of relationship which is crucial to program success (Kelly,2000). A sense of partnership is also developed because families are not regarded as passive recipients; they are expected to contribute just as much as the case worker by, first of all, accepting the service, then identifying goals, keeping appointments, practising strategies between home visits and reviewing achievements at the completion of the service (Kelly,2000). The introduction of client owned files has strengthened this feeling of partnership[8].

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[7] Case study supplied by Faye Vallis, Family and Adolescent Services Program, Anglicare CQ.
[8] Client owned files is a shift in the traditional use and manner of writing up case notes. Clients have access to, and ownership of, their own files which are kept at the client's home, unless (as in cases of

> The change to client owned files…has clearly demonstrated our "do with", not "do to", approach. Because the files record the work done on the day, what to practice or follow up during the week and what work will be done on the next visit, it has helped families to accept responsibility for choices they make in their parenting and has helped in developing their own sense of accountability (Kelly,2000).

The importance of offering a range of different programs catering to the specific needs of different types of families has already been noted. In 1999, Anglicare CQ therefore employed an Indigenous worker in order to offer parenting programs that are more culturally appropriate to Aboriginal, Torres Strait and South Sea Islander families (Vallis,2000). Conscious of the increasing number of referrals as a result of violent male adolescents, and the need to engage men in parenting, Anglicare SA has recently employed a male Family Support worker (with funding from the Commonwealth government). Anglicare SA hopes to establish groups that deal with issues of violence, parenting grief and loss for males and offer the same opportunities for building self-confidence, self-esteem and improved social skills as are currently available to female clients (Kelly,2000).

Family support programs are preventive programs. However, if preventive programs are to be successful, they have to be able to meet community need for that service. As indicated by the comments of step-families interviewed in Murphy's (1998) study, the need for family support programs currently outstrips supply. The experience of Anglicare CQ suggests that the different programs that they offer need to be offered more frequently throughout the year, at varying times of the day and in various locations (Vallis,2000).

Aged care

Care by family and friends remains the dominant form of care for the majority of frail and disabled older Australians. Over the last ten years the percentage of those with profound or severe core activity restrictions[9] living with relatives has risen slightly

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family violence) the client prefers to keep their files in the office, together with the case worker's copy.

[9] Core activities are defined as self-care (bathing or showering, dressing, eating, using the toilet and managing incontinence); mobility (moving around the home and away from the home); and communication (understanding and being understood by others). A person is considered to have a profound core activity restriction if they are unable to perform a core activity, or always need

from 63.8% in 1988 to 66.3% in 1998, while the percentage living in health establishments has fallen from 20.9% to 15.3%. Those caring for older people living at home provide assistance in the areas of self-care, mobility, communication, transport and paperwork, meal preparation, housework and property maintenance, often spending 40 or more hours each week providing such care (AIH&W,1999:174-175).

Anglicare SA is currently funded by the Commonwealth Department of Health and Aged Care to provide 175 Care Package Places to frail, elderly clients in metropolitan Adelaide. Care Package Places are individually designed home care and support services that give people the option of staying in their own home rather than entering low-level residential care. The fact that the percentage of frail, elderly Australians living in health establishments has fallen over the last 10 years indicates that home-based care is meeting its objective of reducing the rate of admissions to residential care.

Box 4: Caring for an elderly parent at home[10]

At the beginning of 1998 Mum was very sick and spent two months in hospital. Four times the Doctors told us she wouldn't make it (but she did!) The stress of those two months is still with me and I don't think I will ever forget it. When Mum finally came home, she was so weak she couldn't feed herself, or hold a glass to have a drink. She could barely walk, could not lift her legs to get into bed and could not attend to her toilet. For the first two weeks I was getting up every two hours through the night to turn her over in bed as she didn't have the strength to do this herself.

Being on the Anglicare program has meant a whole new life for both Mum and me. Having a shower every day is extremely important for Mum. This is the way she was brought up and she looks forward to her shower, even when she may be feeling a little off colour. Having the lovely, caring ladies who shower Mum come in so bright and cheery every morning has also done wonders for Mum. No matter how she's feeling of a morning when she first gets up, by the time she's had her shower and a good chat with the "girls" she's so cheerful and always says how much better she feels. I think
she looks forward to the chat as much as the shower.

assistance to perform a core activity. A person with a severe core activity restriction sometimes needs assistance to perform a core activity (AIH&W,1999:217).

[10] Material supplied by the daughter of an Anglicare client.

Caring for a family member places enormous demands on those providing care. Even with support from other family members, the primary care giver can feel overwhelmed by the demands placed on them.

> [T]here are times when I feel like I'm working 24 hours a day - work all day at the office, come home and work looking after Mum until she goes to bed at 9.30 (but this is only when I'm feeling a bit low) (daughter of an Anglicare SA client).

Thus, the Anglicare SA Northern Living At Home Program (which services the northern metropolitan area of Adelaide) and the Western Living At Home Program (which services the western region of Adelaide) have a strong focus on supporting carers, many of whom are themselves elderly people caring for their spouses. An important part of support for carers is providing respite care.

> The biggest impact on me is that I can't be spontaneous any more - can't meet a friend for a drink after work - stop off and do some shopping on the way home - go away for a weekend (daughter of an Anglicare SA client).

In April 1999, the Northern Living At Home Program received a grant from the Sylvia and Charles Viertel Charitable Foundation to enable clients to access short episodes of respite in either a residential care facility or in some other way in the community. For example, Irene[11] lives with her daughter, son-in-law and four grand-children. She is not well-off, living on a pension, often struggling to pay $4 a week 'club' money. Through the grant from the Charitable Foundation Anglicare SA was able to arrange for Irene to visit her sister in Queensland for two weeks whom she hadn't seen for many years. Irene was delighted to be able to visit her sister and her daughter was able to have a rest from her caring responsibilities.

Box 5: Supporting carers by giving them a break[12]

Jean and Robert are clients of the Anglicare SA Northern Living At Home Program. Jean has complex medical problems which result in her needing continuous oxygen. She can only walk 5 metres with the aid of a walking frame. Jean has had little contact with her family, but with Robert's assistance and support from the Northern Living At Home Program she is able to live in her own home. Jean and Robert are pensioners with no 'reserves'. Jean had spoken about a 'holiday' and giving Robert a rest so Anglicare SA booked her into a respite home on the beachfront of Adelaide. Coincidentally, Robert required surgery during this period, which didn't go as planned and he remained in intensive care for two weeks. Anglicare SA was able to

[11] Case study provided by Anglicare SA. Names have been changed to maintain confidentiality.
[12] Case Study provided by Anglicare SA.

find Jean alternative respite care for the four week period of his recuperation, which she would otherwise have been unable to afford - her only other option would have been to go into hospital.

It has long been recognized that access to care provided by family members reduces the chance of admission to residential care. But what of those who do not have access to family support? Has the increased availability of home-based care over the last 15 years made any difference to those living alone? The fact that the percentage of those with profound or severe core activity restrictions who live alone has risen slightly over the last ten years, from 12.6% in 1988 to 15.3% in 1998 (AIH&W,1999:171), suggests that it has. A study by Gibson and Liu (1999) of living arrangements at the time of admission to residential care supports this supposition. Gibson and Liu found that for the younger aged (those aged between 65 and 79) there was no clear relationship between living arrangements and rates of residence, which indicates that the expansion of home-based care has decreased the previous vulnerability of younger aged who live alone to admission to residential care (Gibson & Liu,1999:25).

Lack of family support causes greater problems if individuals are also financially disadvantaged. Socially isolated or financially disadvantaged clients with low-level care needs often transfer inappropriately to residential care, in spite of having needs that could be met in their own homes. Therefore, it is important that funding of home-based services recognize and reflect locational disadvantage. Some programs already do this. For example, Anglicare SA Inner City Aged Care Program[13] provides assistance to people who are aged, or prematurely aged due to their life-style, thereby preventing inappropriate admissions to low-level residential care. Clients of the Inner City program all have a history of long-term transience, living in insecure or sub-standard accommodation (rooming houses or private hotels). A history of alcohol abuse, gambling addiction or mental illness has led to a breakdown of family relationships and social isolation.

[13] The Inner City Aged Care Program is part of Anglicare SA Care Package Places. In November 1999 the Inner City program was allocated a further 20 Care Places by the Department of Health and Aged Care, bringing the number of older homeless people who can be assisted by the program at one time to 40. This increase in Care Places was recognition by the Department of the quality work being done by the program in South Australia.

Previously these clients sought assistance from centre-based services where interventions often failed because clients frequently changed their location or failed to turn up at the centre. The Anglicare SA Inner City program reverses earlier models of service delivery and takes the service to the client's home, whether that home is an independent unit, rooming house, private hotel, or, as is often the case at commencement of services, the night shelter. The success of the program also depends on the non-judgemental nature of service provision. For example, while care and concerns are communicated, especially during medical crises, the use of alcohol by clients is acknowledged as their choice (Anglicare SA,2000).

Trust develops between clients and those providing assistance when clients realize that continuation of the service is not conditional on a change of life-style. Trust between client and service provider facilitates interventions which ensure that basic shelter, nutrition and hygiene requirements are met and clients who were previously alone and homeless can achieve milestones (such as maintaining independent housing) that other people take for granted (Anglicare SA,2000).

Establishing a relationship of trust, rather than one of "the authorities" and "the recipient" is important in overcoming the reluctance of some older people to use services which are available because of strongly-held beliefs that individuals should "do for themselves", or where choosing not to utilize a service is the only way an individual can exercise independence or choice (Leveratt,1998).

The greater vulnerability of those socially isolated and financially disadvantaged to inappropriate admission to residential care has already been noted. For this reason, a major focus of an expansion of Anglicare SA Northern program (where 70% of clients are classified as financially disadvantaged and a high percentage are migrants and Aboriginal people) is the appointment of a Recreational Worker/Community Link position to enhance the breadth of services available to clients, link them into community activities and networks and re-connect clients with family and friends or members of their local community, if they so choose. In addition, Anglicare SA is developing an action research project designed to measure the impact of linking community support to socially isolated clients.

Country areas are often associated with high levels of social capital (see for example, Stewart-Weeks,1998:108-110). However, when younger members of rural communities move away from the area in search of work, family networks and support systems are disrupted, with the burden of caring for frail, older family members falling on the spouse or the few family members who still live locally (Foskey,1998:3). The majority of older residents in rural communities which are popular retirement destinations also lack extended family support. Once again, the major burden of care falls on the spouse (Foskey,1998:5). As retirees age and can no longer drive, the relative lack of public transport in such areas and the need to access higher level services in the nearest regional centre (as opposed to the local community) presents major problems for older Australians living in smaller regional communities (Foskey,1998:5). Similarly, the increasing reliance on communications technology to deliver services in rural areas can further disadvantage older Australians who do not have access to, or are unable to use, telephones because of hearing impairment or because of physical disabilities as a result of a stroke or arthritis (Foskey,1998:6).

Disability

In 1998, 4% of the population aged under 65 (655,000 people) reported a profound or severe core activity restriction which meant they needed full-time or part-time assistance with the activities of daily living (AIH&W,1999:216). Family and friends continue to be, and are increasingly called upon, to be the main providers of care for people with disabilities (AIH&W,1999:265). For example, between 1981 and 1993, the proportion of people aged 5-64 years with on-going support needs living at home rose by 43%, while those living in residential facilities fell by 29% (AIH&W,1999:252).

For people aged 0-64 years, physical disabilities are the most prevalent, affecting 10% of the population. Intellectual disabilities affect 1.6% of the population, sensory disabilities 1.2% and psychiatric disabilities 1.1% (AIH&W,1999:218). The impact of a disability on an individual's ability to look after themselves obviously depends on the main disabling condition. People with a stroke, nervous system or intellectual condition are the most likely to experience a profound or severe core activity

restriction, while those with diseases of the ear, the least likely (AIH&W,1999:218). Those with a physical disability are more likely to report difficulties in self-care and mobility, whereas communication is more likely to be a problem for those with diseases of the ear or an intellectual disability (AIH&W,1999:218).

Responsibility for formal support services is split between the Commonwealth and State and Territory governments. The Commonwealth government funds income support services for people with a disability and their carers, as well as employment services. State and Territory governments fund and provide accommodation and other support services, which are also provided by non-government organizations.

For non-government organizations such as Anglicare, the major focus of their disability support programs is supporting the families who are the main providers of care for people with disabilities. For example, the Anglicare CQ Biloela Support Service helps people with disabilities to live within their home communities by co-ordinating support options from other services (which need not have a disability focus). Clients range from 2-55 years and experience a range of disabilities, including intellectual, psychiatric, physical, sensory, and acquired brain injury. The diversity of client needs means that support is provided on an individual basis with clients (or their primary carers) encouraged to identify their own needs as they change over time (Anglicare CQ,2000).

Box 6: Caring for a child with a disability[14]

Caring for a child with a disability is a full-time job and places a great deal of stress on the entire family. Parents of a child with a disability do not get the same breaks from caring as other parents do. Their child does not get invited out to play, or visit and friends house, or stay over night. Siblings often miss out on activities such as sport or movies, because it is not possible to take the child with a disability to these venues. By offering respite care we are giving the family an opportunity to have a break or do things together that they might otherwise be unable to do.

Giving families a break is an important element in enabling them to continue caring for a family member with a disability. Anglicare NSW Host Family Respite program provides regular, planned respite care (for up to one weekend per month) for children

and adolescents up to the age of 18 years with moderate to severe disabilities. Anglicare provides training for volunteers so that they are able to provide care in their own homes or are able to look after the child and their siblings in the child's home. Recently, Anglicare NSW piloted two sibling support groups which are designed to provide opportunities for the siblings of children with a disability to meet other children in the same situation.

Box 7: Sibling support groups[15]

The children who attended the sibling support groups learnt that the feelings and thoughts they sometimes had towards their sibling with a disability are a normal part of life…The children learnt it was all right to talk about their thoughts and feelings with their parents…The children left the group with a more positive attitude toward
their sibling with a disability and their whole family.

Available data suggests that rates of disability and handicap among Aboriginal and Torres Strait Islander people may be twice as high as for the population as a whole (AIH&W,1999:223). Three years ago, Anglicare Top End established the East Arnhem Carer Respite Centre[16] at Nhulunbuy on the Gove Peninsula to provide respite care for East Arnhem land communities. Prior to the opening of the Respite Centre, there were no suitable respite facilities or disability support services in the East Arnhem region. Respite care has since been extended to include Ngukurr in the Katherine region. While the majority of respite care is provided through residential facilities, Anglicare Top End would prefer to provide respite care within the home community as regular weekly support is more appropriate, particularly for people with high support needs. At present, Anglicare Top End is able to provide community support for four people at Nhulunbuy, one at Ngukurr and two at Yirrkala. Respite care is also provided (for up to five hours per week) for people living on Groote Eylandt and Bickerton Island through a program jointly funded by the Commonwealth and Northern Territory governments. However, more carer support is needed, particularly for carers of those who have challenging behaviours.

[14] Material supplied by Anglicare NSW.
[15] Material supplied by Anglicare NSW.

Anglicare CQ also believes that available funding is not sufficient to meet community need for disability support services. Anglicare CQ Biloela Support Service operates over an area of 15,000 square kilometres, and in its experience, the co-ordination, establishment and operational costs of individualized packages are grossly underestimated.

> The logistics of arranging transport with only one vehicle in a rural area to service more than 20 clients is complex (Anglicare CQ,2000).

The strain on agency resources is exacerbated by Queensland funding allocation formulas. At present it is only possible to obtain funding for highest priority individuals.

> In short, the government's move to fund individually is great for those who get it. But there are large numbers of individuals whose needs are recognized as critical who receive no support, other than from already stressed family members. There has been little opportunity for growth of services to meet general demands in the community (Anglicare CQ,2000).

Unmet demand for disability support services is not a recent phenomenon. In 1997 the Australian Institute of Health and Welfare was commissioned by the Disability Services Subcommittee to examine the extent of unmet demand for Commonwealth/State Disability Agreement (CSDA) support services. The Institute made a conservative estimate that in 1996 there were 13,400 people whose need for accommodation, accommodation support or respite services was not being met (AIH&W,1999:288). While the Institute's report was taken up by State governments, with a number (including Queensland) providing additional funding to address unmet demand, this additional funding was generally spent on improving service quality and "has not been sufficient to address the unmet demand (Disability Administrators, 1999, *Supporting Australians with severe or profound disabilities*, Background paper for Commonwealth/State Ministers, p. 3 - cited in AIH&W,1999:228). It remains to be seen whether the additional $150 million CSDA funding promised by the Commonwealth government for the financial years 2000-2002 will be sufficient to address unmet need[17].

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[16] The Respite Centre was funded through the Commonwealth government's National Respite Carers Program.

[17] The Commonwealth funding is conditional upon State and Territory governments also contributing significant additional funding.

Another problem faced by agencies providing respite services is the increasing number of children being referred to the service with moderate or severe disabilities as well as extremely challenging behaviours and high support needs (Anglicare NSW,2000). Anglicare NSW Host Family Respite program has been operating for 19 years and, over that time, finding volunteers prepared to offer regular respite care, particularly for children with challenging behaviours and high support needs, has become increasingly difficult. Often one parent has to work on the weekend, or both parents spend almost the entire weekend taking their own children to sporting activities. Some families do volunteer, but usually withdraw from the program after a short period when they realize how difficult it is to provide quality respite care in the context of their busy life-styles (Anglicare NSW,2000). One solution may be to try and recruit volunteers for specific children. If the parents give permission, the agency could advertise in the child's local area, giving brief details of the child's behaviours and asking for volunteers who may be willing to receive training to care for that child. The training could be individually tailored around the specific needs of the child (Anglicare NSW,2000). Alternatively, families in the local area could be encouraged to sponsor an individual child so that occasional respite care from a paid carer could be provided.

2. FAMILIES FIGHTING

Anglicare agencies provide a range of services for individuals and families experiencing conflict, including preventive, early intervention programs and support for individuals and families in crisis. This initial State of the Family Report focuses on two specific areas; domestic violence and youth and family mediation. In both areas client needs are complex and best addressed through a range of integrated services. Much of the work done in this area is preventive and long-term as it involves helping individuals change violent and abusive patterns of behaviour. However, if such programs are to be successful, funding needs to reflect the long-term nature of service provision.

Domestic violence

Domestic violence affects a substantial proportion of women and children in Australia, particularly younger women aged 18-24 years (AIH&W,1999.295). For example, using data from the 1996 ABS Survey of Women's Safety, and defining violence on the basis of actions which would be considered offences under criminal law, the ABS estimated that 111,000 women (3% of all women aged over 18 years) who were married or in a de facto relationship had been subjected to physical or sexual violence by their current partner over the 12 months prior to the survey (AIH&W,1997:224). Of the 340,000 women who reported experiencing domestic violence at any time, 40% said that their children had witnessed the violence (AIH&W,1997:224). Domestic violence was cited as the reason for seeking assistance by two-thirds of women with children who sought assistance from Supported Accommodation Assistance Program agencies in 1997/98 (AIH&W,1999:319). The majority of single women over 25 also cited domestic violence as the reason for seeking assistance (AIH&W,1999:319).

Domestic violence is not confined to low income families, but the stress engendered by poverty can contribute to violence in the home (Anglicare Tasmania, n.d.:4; Anglicare Tasmania,2000:19). For example, in the rural area of South Burnett in Southern Queensland, which has a youth unemployment rate of 17%, as well as high incidents of stress-related illnesses, alcohol disorders and psychiatric disorders, Margaret Frawley (a community development worker and counsellor) notes how

> [a] constant stream of young males…filter through our doors, into the courts and vice versa. Likewise they also filter in and out of relationships. At any one time we would have five or six young (16-18 year old) de facto couples in some form of crisis. These relationships on average last one or two years and include the birth of at least one child. They are frequently marked by episodes of domestic violence and substance or alcohol abuse (Frawley,1998:3).

The South Burnett experience is echoed in research by Brown et al on the types of families who bring child abuse allegations to the Family Court. Brown (1998:3-5) found that parents who bring child abuse allegations to the Family Court are similar to the wider population in their region in terms of ethnicity, social class and general health, but have higher rates of unemployment, higher levels of criminal convictions, higher rates of substance abuse as well as higher rates of partner to partner violence.

The implications of these findings for service providers (and funders) is to recognize that the complex and inter-related nature of the issues surrounding domestic violence demands an integrated response where family violence services are part of a range of counselling, youth and family support services provided (wherever possible) within the one agency (Cavanagh,1998:3 & 7).

Behaviour change programs for men who have been violent often uncover experiences of violence and trauma where the men have been victims rather than perpetrators (Cavanagh,1998:8). For example, those facilitating anti-violence services in the Lismore area have foung that

> [i]n the group for Aboriginal men it has been important to allow plenty of time for telling life-stories. Aboriginal men commonly reveal a history involving terrible abuse. As the distress, hurt, anger and shame subside, Koori men readily absorb alternative suggestions to abusive communication (Anderson,1998:2).

The importance of peer support and the development of social support networks is a recurring theme in the experience of those working with men in anti-violence programs (see for example, Melvin,1998:5; Whitelaw,1998:4).

> We have noticed time and time again with fellows like this [who have a history of using violence against their partners…that once they hear someone else's story their identification with the other story cushions that blow. "I'm not alone, it's OK!" And they begin to normalise what they are wrestling with (Cooke,1998:4).

The creation of support networks is also an important part of preventive programs. For example, the pilot program Partnerships Against Violence Everywhere (PAVE) run by Anglicare Tasmania and Support, Help and Empowerment (S.H.E.) established ten community reference groups which are working towards raising local community

awareness of domestic violence issues and providing support to young people affected by violence (Anglicare Tasmania & S.H.E.,n.d.:5). Some of the schools who participated in the pilot are developing peer support systems based around the students who completed the program and existing support services in the school (Anglicare Tasmania & S.H.E.,n.d.:5).

While men who have participated in anti-violence programs are enthusiastic about the benefits, there is often a reluctance to seek help, to admit that they have "a problem".

Box 8: Men and violence: the challenge of seeking help[18]

John is a 36 year old factory worker, although he looks a lot older than his 36 years. He is six foot three and tattooed from neck to ankles. John never got beyond form three of high school. He is married and lives in a state housing commission area of Northern Melbourne with his wife and three children. He loves his kids and is devoted to them. He likes a few tinnies at the end of the day. He has been physically violent and verbally abusive since the birth of their first child.

John is in crisis. His relationship is in jeopardy as he has been given an ultimatum by his wife to do something about his violent behaviour.

John believes he should be able to solve his own problems. He has been trying to do that for some time and it hasn't worked. He is not sure this "counselling thing" is going to work either. He is suspicious of professionals, having had to deal with them and bureaucrats in other areas of his life. He is feeling ashamed and guilty about his behaviour. He expects to be punished, judged and rejected.

Because it is not easy for men to engage with traditional services, service providers need to be creative about how services are offered to men (Cavanagh,1998:9). Preventive programs for young people, such as PAVE, represent one (long-term) strategy for changing attitudes. For example, after participating in the domestic violence prevention workshops, young people were more likely to feel "a lot OK" about approaching people for help (Anglicare Tasmania & S.H.E. ,n.d. Part 2:26).

Domestic violence programs aim to establish new, non-abusive patterns of relating within the family so that violent behaviour does not pass to the next generation, as well as dealing with the impact of abuse on the partner and children (Melvin,1998:6).

"Deconstructing and reconstructing the male socialisation patterns which underpin power and control behaviour" takes time – at least eighteen months to two years (Melvin,1998:6). Twelve month funding cycles or continual funding through pilot programs, rather than recurrent funding, works against the continuity and stability of service delivery necessary for high quality outcomes in this complex and difficult area (Cavanagh,1998:9).

Youth and family mediation

Violent and abusive patterns of behaviour learnt within the family are often repeated in relationships outside the home. For example, young men and boys learn to relate to others with disrespect and take these attitudes with them into the school environment, forcing their peers or younger boys to perform acts against their will. The penalty for not conforming is on-going humiliation and abuse (De'Ambrosis,2000).

Programs which address issues of men and violence will help reduce the incidence of bullying in schools. Children and adolescents can also be taught how to settle fights and disputes without resorting to violence. For example, Anglicare Youth Services Glenroy runs peer mediation programs in high schools and primary schools in Melbourne's northern suburbs where children are trained to assist other children resolve disputes without conflict and without the intervention of teachers. Giving students the skills to resolve disputes involving name-calling, rumours and gossip, boyfriend/girlfriend disputes, property disputes, disputes over personal space or games areas, disputes involving personal appearance or sporting abilities empowers both mediators and disputants as students learn to take more responsibility for resolving their own problems, leaving teachers and school administrators with more time to deal with issues that require critical intervention such as physical or sexual assault, theft, or alcohol or drug issues (Anglicare Victoria,2000).

The role of mediators is to hear both sides of the dispute and encourage communication by helping those in conflict see the other side's point of view. Peer mediators also help those in conflict overcome the emotions that stand in the way of a resolution. Mediation

[18] Case study taken from Gee &Melvin (1998:2-3).

sessions carried out by students aim to produce an agreement containing the elements of the settlement (Anglicare Victoria,2000).

Anglicare Top End Resolve Family Conflict Resolution Service also uses mediation as part of a range of services aimed at preventing family breakdown and possible homelessness among young people. In 1999, an evaluation of Resolve's Adolescent Mediation/Family Therapy (AMFT) program highlighted the complex nature of issues facing adolescents in conflict with their family. The evaluation found family conflict occurring in the context of failure at school, depression, suicide ideation and attempts, sexual abuse, domestic violence and problems with step and blended families (Anglicare Top End,2000).

The findings of the AMFT evaluation on the inter-related nature of depression, suicide ideation and family conflict are echoed in the report, 'Mental Health - A report focusing on depression', released at the 1999 Health Minister's Conference. The report found that depression and anxiety symptoms occur in 4% - 6% of children and are likely to persist with age if not effectively treated; that 10% of young people have a depressive disorder; that almost 80% of people with depression also experience anxiety, a physical ailment and alcohol or other drug misuses; and that social disadvantage and family conflict are important risk factors for depression (Australian Health Ministers' Conference Media Release, August 1999). "Depression is not a fleeting sadness, but a pervasive and relentless sense of despair" (Australian Health Ministers' Conference Media Release, August 1999). As such it is hardly surprising that depression and suicidal thoughts are linked, with adolescents increasingly at risk. Longitudinal studies reveal that the emotional and behavioural problems of adolescents have increased over the past 10 years with more than 25% of young people experiencing depression before the age of 18 (Jenkin & McGlenniss,1999:40). In Australia, young women make more suicide attempts than young men, but young men are more successful. In 1998, 1,070 men aged 25-44 years (37 out of every 100,000) and 244 women (8.4 out of every 100,000) committed suicide (Gray,2000). While the suicide rate was highest among the 25-44 age group (for both men and women), 364 young men aged 15-24 (26.6 out of every 100,000) committed suicide in 1998 (Gray,2000), a figure which has more than trebled over the past 20 years (Jenkin & McGlenniss,1999:40).

Concern over the rising rates of depression and suicide among young people in Australia lead researchers to investigate why some children who experience deprivation and stressful family life do not develop depression and suicidal thoughts. After talking with young people, Fuller, McGraw and Goodyear found that, for young people, a sense of belonging is what makes a difference; that is, being connected to a family, an area, a friendship group or a school where you are known and can ask for assistance (Jenkin & McGlenniss,1999:41).

Program for Parents (PfP) is a broad-based, early intervention strategy based on the premise that enhancing parenting skills and emotional competencies and increasing connectedness in families will have an impact on reducing risk factors for youth suicide. The program was developed in collaboration with national directors of Anglicare and Centacare Australia, with funding provided by the Commonwealth Department of Health and Aged Care under its 'Supporting Families: National Parenting Initiative'. The program was implemented in 18 locations in all States and Territories from January 1998 to June 1999. Initially, Parenting Australia (a program of Jesuit Social Services) trained 230 staff from Anglicare, Centacare and other community agencies so that they could facilitate the PACE parenting education program. These group leaders then conducted the PACE program in a range of settings including schools, family support agencies, community venues and private homes in rural, metropolitan and regional areas (Jenkin & McGlenniss,1999:13).

An external evaluation of the project conducted by the Centre for Adolescent Health (Royal Children's Hospital/Melbourne University) found that PfP had a positive impact on a number of risk factors for youth suicide. That is, there were decreases in substance use, self-harm delinquency, parent adolescent detachment and adolescent depression (Jenkin & McGlennis,1999:9). Parents who participated in PACE groups reported a reduction in the number of conflicts with their adolescents and an increase in parenting confidence and satisfaction (Jenkin & McGlennis,1999:57).

Box 9: Program for Parents[19]

Sue and John live in Werribee and have three children, two attending primary school and a 14 year old son attending a local high school. Sue attended the group on her own and shared the information from the group with John and the children.

Sue said it was good to hear the perspectives of other parents, to realise that her son was not the only kid in Werribee that was hard to handle at times. The brainstorming session helped her to realise that there are options, that sometimes you just get a bit "stuck". She found that she was more patient and more confident in her parenting after attending the group. Sue now has other parents with whom she can discuss parenting issues.

Sue benefited from the opportunity to hear the ideas of other parents, and being able to recognize her skills and learn new ones.

In "control" schools where parents did not participate in a PACE parenting group, there was an overall tendency for youth suicide factors to increase, parents reported no reduction in parent/adolescent conflict and did not feel any more confident about their parenting abilities (Jenkin & McGlennis,1999:57).

St Saviour's Neighbourhood Centre in Goulburn, an Anglicare agency which participated in PfP, found that the program worked so well, they offered additional PACE programs in 1999 (Bollen,2000). St Saviour's conducted PACE programs in all local high schools, both State and Catholic, in Goulburn, Crookwell and Yass. St Saviour's found that utilizing schools provided excellent access points for parents. The experience of St Saviour's Neighbourhood Centre reflects the wider experience of participating agencies. The national evaluation confirmed the value of integrating PACE programs into the school environment. When PACE groups were held in schools, positive impacts were noted in families who did not attend a PACE program, which suggests that these parents had been influenced by PACE group parents (Jenkin & McGlenniss,1999:17).

Parents in the Goulburn area who participated in the PACE groups enjoyed the program's problem solving approach, its interactive style (parents were encouraged to share experiences) and the peer support offered by the program (Bollen,2000). The

[19] Case study supplied by Robyn McIvor, Lifeworks Relationship, Counselling and Education Services.

collaborative nature of the project also contributed to its success, with participating agencies utilizing local community links to establish the project (Bollen,2000), and generating enhanced community networks as a result of project activities (McIvor,2000).

Most community agencies do not receive funding for parenting groups. PfP has enabled selected agencies to provide a parenting program which has had a positive impact on drug use, self-harm, delinquency, adolescent depression and parent/adolescent attachment. PfP has also had a positive impact in local communities, building relationships between families, schools and service providers (Jenkin & McGlenniss,1999:31). Schools and local communities that participated in PfP want to extend the benefits of this program to other parents who face daunting parenting challenges, but without on-going funding to train new leaders, implement parenting groups and co-ordinate the program, very few parents will be able to take advantage of this successful early intervention strategy (McIvor,2000).

The need to engage fathers in parenting programs has already been noted. Fathers in a PACE parenting group for men in the Goulburn area felt more relaxed and able to talk about "big issues" (such as what was their role, especially in relation to adolescent daughters) towards the end of the program and expressed a need for on-going support (Jenkin & McGlenniss,1999:84). There is also a need for parenting programs among parents whose children are engaged in drug use and to develop a parenting program in collaboration with indigenous communities that meets the specific needs of Aboriginal families (Jenkin & McGinness,1999:33). If early intervention strategies are to maximize their cost-effectiveness, they need to be broad based and on-going and funded as such.

3. THE ECONOMIC STATE OF FAMILIES

This chapter explores what it is like to live on a low income in Australia today. In looking at services provided for sole parents, those who are homeless (or at risk of homelessness), gambling services and financial counselling, it is clear that social and economic disadvantage are inter-related. For example, those on low incomes are unable to access a full range of education and health services. Limited access to transport is part of this picture of cumulative disadvantage. Housing is another important element, with the cost of housing pushing many people into poverty or intermittent financial crises.

Poverty

In Australia, a person is considered to be living in poverty if their income is not sufficient to pay for basic necessities such as food and shelter (absolute poverty), or where their standard of living falls below some overall community standard (relative poverty). How that overall community standard is defined will affect the number of people who are classified as "living in poverty". For example, if the 'All Costs' Henderson Poverty Line (HPL) is used as a measure of relative poverty, in 1995/96, 3.4 million Australians were living in poverty. If the poverty line is set at 50% of the median equivalent income (MEI) for all income units[20], only 1.8 million people are considered to be living in poverty (ABS,1998:125). The characteristics of individuals or families (income unit) considered to be living in poverty can also vary depending on your measure of poverty. For example, while the majority of those living in poverty in 1995/96 were one person income units under both the HPL (61.1%) and the MEI (55.7%), elderly people living alone made up 18.7% of those living in poverty under the HPL, but only 5.7% using the MEI[21] (ABS,1998:126). The characteristics of those living in poverty is also dependent on the unit of analysis. For example, children aged 15-24 years who are living with their parents, but are not in full-time study, are classified as separate one person income units. Yet many of these "independent" one

[20] Income units are made up of one person, or a group of related people living in the same household. It is assumed that income is shared within the income unit. That is, it is assumed that income sharing takes place between married couples (registered or de facto) and between parent(s) and dependent children (ABS,1998:125).

[21] The divergence in poverty rates for the same group is party due to the effects of clustering of aged people's incomes and the close relationship that exists between government pension rates and the HPL (ABS,1998:127).

person income units have no income, which casts doubt on the assumption that these young people are financially independent of their parents. When the parental income is taken into account, the rate of young one-person income units living with their parents who are classified as living in poverty falls from 27% to 4% (ABS,1998:128). Poverty estimates are based on cash income. Even greater variation will occur if non-cash benefits, such as pensioner concessions or free child care by relatives, are taken into account (ABS,1998:128).

Against this background, what can be said about low income families; those in poverty or those most at risk of poverty[22]? Low income is commonly associated with unemployment and dependence on government pensions and benefits. In 1996/97, 65% of all families[23] with income levels which placed them in the lowest two quintiles (40%) of income distribution relied on government pensions and benefits as their principal source of income (ABS,1999:134). 30% of families in the lowest two quintiles were wage and salary earners, with the remaining 5% of families reliant on investments as their principal source of income (ABS,1999:134).

Box 10: The reality of living on a low income[24]

Families living on a pensions or benefits, or other very low incomes, have difficulty paying for the necessities of life - food, clothing, heating and housing. With most their income tied up in rent or regular payments to power utilities, the only part of the budget in which low income families can exercise any discretion is that part set aside for food.

> *I've had days when I've gone without food to feed the kids. I've done that a lot, you get used to it. It probably happens every couple of months - when the Hydro [electricity] bill comes in.*

> *I live on basics. If I want something I go without something else. My diet is cereal, sandwiches, cheese, eggs on toast, sausages, mash. It rare to go outside that. I spend $25 a week on food. Groceries are the only area where you can cut back.*

[22] In the subsequent discussion, "family" refers to family income units; that is, a group of related people living in the same household whose income is assumed to be shared.
[23] Excluding those with business interests.
[24] This material is taken from *Hearing the Voices: Life on a low income in Tasmania* (Anglicare Tasmania,2000:19-20).

I've gone without food for 3-4 days. I've gone without food for the kids sake. People say, "how do you do it"? You have to do it if you've got kids.

I can't afford basic food. I have a 16 year old boy who is always hungry. He eats a loaf of bread a day. One standard loaf of bread a day costs $1,000 per year out of an income of $12,000 a year.

I go without food. The kids have a hot meal every night but it might be spuds and a carrot. I have a hot tea on Sundays and Wednesdays: other than that I have a Weetbix here and a Weetbix there.

Because food is the only area of the budget in which low income families can exercise any discretion, emergency relief parcels become a vital part of regular income support. Thus, restrictions placed on the number of emergency relief parcels families are able to access an cause a sense of crisis.

I've gone to the Salvos and to Anglicare for Emergency Relief parcels, but I'm not allowed to have any more this year. You can only have four a year. I don't know what I'll do now.

Sole parent families are at greater risk of poverty than couple families. In 1999, the average weekly income for sole parent families was $463, just under half the average weekly income for couple families ($931) (ABS Media Release 91/99). While the average weekly income for sole parent families as a whole was $463, the average weekly income for the two-thirds of sole parent families reliant on government pensions and benefits was $317 (ABS Media Release 91/99).

Of the 1.8 million people living in poverty in 1995/96 (as measured by the MEI), 581,000 were children (ABS,1998:125). That is, in 1995/96, 12.2% of all children were living in poverty. Harding and Szukalska (1999) examined trends in child poverty from 1982 to 1995/96 and concluded that the substantial real increases in rent assistance and social security pension levels have caused dramatic reductions in the before-housing poverty rates of children living in sole parent families, in families dependent on government cash benefits and in families living in private rental accommodation (Harding & Szukalska,1999:29). This trend is reversed for adolescents aged 15-18 years who do not live with their parents and 15-18 year olds

who live with their parents but are not in full-time study. These groups are now more likely to be living in poverty than in 1982 (Harding & Szukalska,1999:29).

However, when housing costs are taken into account, the reduction in poverty is less dramatic, with poverty rates falling by only 1 or 2 percentage points, rather than the 5 or 6 percentage points of before-housing calculations (Harding & Szukalska,1999:30). The types of families living in poverty also change when after-housing poverty is examined, with "self-employed and social security dependent families moving out of poverty and the working poor moving in" because low income working families are more likely to be buying their own home and therefore facing relatively high mortgage repayments (Harding & Szukalska,1999:27).

There is debate within Australia over the question of intergenerational poverty; of the extent to which welfare dependency is handed down from parents to children. Preliminary research by Pech and McCoull (1998) which utilizes the *Negotiating the Life Course* survey found some evidence of correlations between educational attainment and the employment experiences of parents and their children (Pech & McCoull,1998:7). Qualitative analysis (such as that carried out by Anglicare Tasmania TasCOSS and The Poverty Coalition illustrates the type of disadvantage suffered by children in low income families in terms of educational opportunities. Children in low income families are unable to participate fully in the public education system, often missing out on electives, extension activities and excursions (Anglicare Tasmania,2000:18).

Box 11: Poverty: impact on children[25]

My son never goes anywhere or gets to do anything. There was a school excursion on and he really wanted to go. He said, "I'll cut the flowers form the garden and sell them to the neighbours". I said, "no". I didn't want the neighbours knowing we didn't have enough. He started crying and it just tore me apart, so I took the $20 I had in my purse and went to play the pokies. It was all the money we had left for the fortnight, but it was the only chance I had of getting the money for the school excursion.

[25] Case studies taken from Anglicare Tasmania (2000:17-18).

My daughter is very musical but we don't have any money for music lessons. There is no money for school trips or singing lessons. She'd love to be in the school choir, but if you are, you have to travel. We can't set aside the $1,000 - $2,000 they ask for. It makes me feel really guilty as a father. My daughter is very confident because we've worked hard to help her be like that. She could do those things. Having to say no is heartbreaking for her and for us.

Just as access to a full range of educational opportunities are denied to children living in low income families, access to health care is similarly restricted. Participants in the Tasmanian study, *Hearing the Voices*, reported that an inability to pay the gap fee for doctors and specialists was having a major impact on their health and well-being (Anglicare Tasmania,2000:23).

> Ninety-five per cent of specialists do not bulk bill. I have to pay the difference. How? (Anglicare Tasmania,2000:24)

> My four kids are all asthmatics. I couldn't always afford the medicines. The doctors go off at you because you've let it go on too long. They ask why you haven't given them the preventive medication, the nebuliser and the nebuliser medication. We couldn't do it, and then the doctors make you feel bad (Anglicare Tasmania,2000:23).

> I can't afford to go to the doctor and if I do go I can't afford the medicine. Both my daughter and I need to go, but we can't…I owe the Northern Suburbs Medical Centre $9 and I haven't got it. If you can't pay the bill the doctors charge an account fee and the bill increases (Anglicare Tasmania,2000:23)

Low income families cannot afford health insurance and are therefore affected by long waiting lists in public hospitals.

> Since I had my children I've needed to have an operation on my bladder. I wet myself. I've been waiting for two years now (Anglicare Tasmania,2000:24).

> I need a hernia operation and the waiting list is15 -18 months. It's starting to affect my health (Anglicare Tasmania,2000:24).

Access to dental services was an issue identified across Tasmania. Participants reported having to wait 2 - 3 years and of being refused service if they didn't have the $20 fee for service (Anglicare Tasmania,2000:25).

> I went to the dentist and he said the cost of fillings was not viable to spend on public patients, so he pulled out two of my teeth (Anglicare Tasmania,2000:25).

For low income families living in rural areas, the problem of making ends meet is exacerbated by higher food prices and transport costs (Anglicare Tasmania,2000:21). In rural areas (and on the fringes of metropolitan areas) public transport is limited, so low income families are reliant on their own car in order to access education, health services, community support services as well as cheaper retail outlets (Anglicare Tasmania,2000:21).

Box 12: Accessing services in rural areas[26]

I don't have any transport. I can't get to hospital for physiotherapy. I should have it twice a week. I only have enough money to get the taxi one way, but I don't have the strength to walk back. My leg has deteriorated something shocking. I've got to live with the pain. I try to keep myself motivated, but you have your off days.

I had to take my baby to see a paediatrician in Hobart. I had to stay two nights for the appointment. The trip cost me $300. I get $360 a fortnight on the pension.

I live in the country. Car repairs are expensive and I could not afford to get them done, so I couldn't get to school. My [Youth Allowance] was then cut off.

Recent research suggests that disadvantage in Australia is becoming increasingly localized. Gregory and Hunter's (1995) study of urban poverty in Australia revealed that within major cities, families where both partners worked are congregating in areas of high socio-economic status and families where neither parent works are congregating in areas of low socio-economic status. More recently, the State of the Regions Report, a study of employment in 55 regions across Australia, revealed that high unemployment is a feature of regions associated low value-added primary commodities, low skills and traditional manufacturing industries (Larcombe & Cole,1999:17). Thus, unemployment in industrial regions of Western Sydney and Northern Adelaide and non-metropolitan areas such as Wide Bay-Burnett in Queensland and Northern Tasmania, is up to five times higher than in the central areas of Sydney and Melbourne (Larcombe & Cole,1999:16).

Box 13: Life in South Burnett, a rural region in Southern Queensland[27]

[26] Case studies taken from Anglicare Tasmania (2000:22-23).

Kingaroy, three hours drive north-west of Brisbane, is the service centre for the South Burnett region. It is the location for such limited specialized medical, business and shopping facilities as can exist in a small rural area. Another hours drive north is Murgon and close to it is Cherbourg, an Aboriginal settlement. To the south-east of Kingaroy is Nanango. Further south-east again are Yarraman and Blackbutt/ Benarkin.

Traditional farming pursuits struggle on - peanuts, soy beans, corn, dairy cattle and pigs. Many farmers in the district are 50 - 60 years old. These men typically come from several generations of farming stock. They have tried everything. A barley crop in 1981 returned $139 per ton. Now $80 per ton is about average. In order to diversify, good farmers have replaced crops with flowers and now agriforestry (Paulownias and olive trees) and vineyards. They have grazed cattle, ostriches, deer and emus. They have watched middle men go bankrupt. Outlay has been expensive and returns have never eventuated. They have ploughed in the results of their efforts. Their children relocate to the cities in search of work or further education.

Their women are typically engaged in off-farm employment, either as teachers, nurses, secretaries or shop assistants. Their income holds the family together financially. The growing consciousness that women have their own needs, rights, potentials and search for measures of independence add to the confusion their men experience.

These men do not want to be the generation to say that they failed to keep the family or the farm. Neither are they educated for other work. Bus runs, handyman services and part-time labouring jobs sometimes supplement.

Others relocate to South Burnett. People's reasons for relocating vary. Some come as a result of changes in employment; some because public housing has been easier to obtain than in the cities; some because they are chasing the "great Australian dream" - the chance to own a bit of land, a home; to live with fewer restrictions and a little more privacy. Many buy cheap blocks on estate developments situated ten to seventy kilometres from the three main towns. We estimate there are over 3,000 such 'Blockies' (their name for themselves) living in the area around Nanango alone.

Small, self-sufficient ten to forty acre rural residential holdings are the ideal. The reality is more likely to be poor land, a caravan or a shed with a dirt floor and no power, or a partially completed owner-built home. A dam or rain water tank is often the only source of water. There have been twelve years of drought in some areas. Rural drought relief schemes have not always extended to the 'Blockies'. Loss and fear of aloneness stand in stark contrast to their hopes.

In South Burnett, shops are closing in smaller towns. People from outlying areas are being bused into town to the supermarket on Thursdays, the day social security payments arrive. Country pubs are being superseded by clubs, such as the RSL, with pokies, bistro food and night-time entertainment. Churches are being sold for use as

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[27] Case study is taken from the paper, 'Suicide and Depression in Males of Various Ages from a Rural Perspective' presented by Margaret Frawley, Centacare South Burnett, at the 1998 Forum on Men and Family Relationships.

restaurant cum wedding venues in tourist areas. Post offices, small schools and banks are being centralised. Avenues of communication traditionally used by rural males are no longer available - the publican, the bank manager, the postmaster, the local minister, even the butcher. The answering machine, the ATM, the post office box and the 1800 numbers sometimes seem poor substitutes for the personal touch.

So this is us. This is the face of South Burnett. We probably strike cords with many other rural communities. With the people who seek our help, we keep on walking; often with the heartache and the realisation of failure. The sad facts remain that too many men of all ages suffer from depression. Too many men of all ages die by suicide. Too many families in our rural communities are left with no answers, just bewilderment…and horror.

This picture of locational disadvantage is confirmed by Tony Vinson's (1999) study of social disadvantage in NSW and Victoria which provides detailed maps of the relative disadvantage of every postcode area in NSW and Victoria. The clustering of families who live in poverty in particular geographic areas increases the probability of poverty being passed on from one generation to the next. Children raised in such areas are likely to have a sub-standard education compared to most other Australian children and may have no role models in their locality of adults who are successful in the labour market. The likelihood of inherited poverty is one of the most disturbing features of families in poverty in Australia today.

Sole parents

A growing number of Australian families are sole parent families. Between 1986 and 1996, the number of sole parent families grew by almost 50% from 311,800 to 467,200 (ABS,1997:34). In 1998, almost one-fifth (19.5%) of all children aged under 15 years were living in sole parent families (ABS,1999:28). What hasn't changed is the relative proportions of lone-mother and lone-father families. In 1996, 87% of sole parents were women, 13% were men (ABS,1997:34). Lone mothers are more likely to be responsible for primary school age and adolescent children (ABS,1997:35).

However, contrary to the popular stereotype of single mothers, in 1996 only 12.3% of lone mothers were aged 15-24 years (ABS,1997:35). In fact, both lone mothers and lone fathers are getting older. Between 1986 and 1996, the percentage of lone mothers and lone fathers aged 15 to 24 years, 25 to 34 years and 35 to 44 years declined, whereas the percentage of lone mother aged 45 and over increased from 15.6% in 1986

to 18.9% in 1996 (ABS,1997:35). The percentage of lone fathers aged over 45 increased by a similar amount, from 32.5% in 1986 to 36.8% in 1996 (ABS,1997:35). Again, contrary to popular stereotype, the majority of sole parents do not remain dependent on the Sole Parent Pension for long periods of time. While the proportion of lone mothers receiving the Sole Parent Pension fluctuates between 84% and 90%, the majority move on and off the Sole Parent Pension depending on income and living arrangements (ABS,1997:38). For example, of the 342,000 parents receiving the Sole Parent Pension in June 1996, only 23% had been receiving the pension for five years or more (ABS,1997:38).

As discussed in the previous section, sole parent families are over-represented among low income families. Sole parent families are at greater risk of poverty than couple families because of the difficulty of undertaking paid employment while bringing up children alone.

Box 14: Barriers to paid work[28]

"Claire" is a sole parent with 3 primary school age children. She is in receipt of the sole parent pension and also works in a casual job for 18 to 25 hours per week. She is paying off a mortgage on her own. Her work involves night shifts and she says this takes a personal toll. "I'm now doing three shifts a week just to get ahead…But then it's just so hard on me personally." Claire says she is always stressed out and tired. Claire is angry that her sole parent pension is cut because of the amount of paid work she does, and she says this acts as a disincentive and means she can't 'get ahead'. She says, "for the hours I work, I only work for an extra $100, and that's annoying too…It is hard yakka, having to look after three kids during the day and then having to go to work at night time and not finishing until three in the morning and then waking up to them to school…It's damn hard." Claire says she would like to get back into the workforce but it is extremely difficult to work full-time without the family suffering.

Research conducted by Anglicare Werribee among women in receipt of the Sole Parent Pension highlights a number of impediments facing lone mothers who wished to supplement government payments by undertaking paid work. Lone mothers find it difficult to find paid work that allows them to meet family obligations. They are

[28] Case study taken from Anglicare Werribee study on 'The Financial Difficulties faced by Sole parent Women' (Anglicare Werribee,1999:35).

discouraged from engaging in paid work because the reduction in government payments, together with the cost of child care and transport to and from work, leves them "no better off" (Anglicare Werribee,1999:23).

> If I had to pay for child care, I'd be rooted. I may as well not go to work, that's basically it. If I had maintenance, yes (Anglicare Werribee,1999:23).

The financial stress experienced by lone mothers dependent on government payments can be exacerbated by the fact that the additional family payment is linked to child maintenance payments (Anglicare Werribee,1999:22). When child maintenance payments are irregular, lone mothers sometimes receive a lump sum covering money owed. When this happens, the amount of their additional family payment is reduced. Budgeting is extremely difficult when no advance notice is given of the reduction and when, after having the additional family payment reduced, the next maintenance payment does not arrive (Anglicare Werribee,1999:22).

The amount of money sole parents have to pay for housing is a significant determinant of whether or not they are in financial crisis. The Anglicare Werribee study found that there is an urgent need for more affordable and accessible housing for sole parent families (Anglicare Werribee,1999:18). In spite of the fact that the overwhelming majority of women who participated in the study were in the low income category, only two were in public housing (Anglicare Werribee,1999:18). For those in private rental, rent took up a significant proportion of their weekly income, a problem which was not alleviated by rent assistance.

> I was paying $694 monthly and that's the killer…finding $694 a month when you are on the pension and you've got a child and you've got to eat. It was either pay the rent, or do we starve? (Anglicare Werribee,1999:18).

Sole parents paying off a mortgage also struggle. The fact that sole parents paying off their mortgage do not receive any government assistance equivalent to rent assistance acts as a disincentive to home ownership (Anglicare Werribee,1999:18-19).

Box 15: Paying off your house on a sole parent pension[29]

"Betty" is a sole parent with two children aged 10 and 14 years. The sole parent pension is her only source of income. She is currently experiencing extreme

[29] Case study taken from Anglicare Werribee study on 'The Financial Difficulties faced by Sole Parent Women' (Anglicare Werribee,1999:36).

financial hardship and this is causing her great stress. She is struggling to meet her mortgage repayments and is "fighting the bank to keep my house". Her repayments are currently $188 per week and she says that after making her repayments, paying her house insurance and meeting utility bills, there is nothing left for food or little luxuries for the kids. Betty says her biggest complaint is that there is no form of assistance like rent assistance to help her hold onto her house…Betty says that because of the financial hardship she is experiencing, she is doing things out of desperation, including gambling. She says, "you get so desperate that you do things uncharacteristic of yourself…forced into food vouchers just to survive".

The financial hardship experienced by many sole parent families means that they are unable to participate in social rituals and interactive events.

> Last Saturday we were invited to go to a birthday party which included a barbecue. I said, "no, don't tell me, I have to buy meat, a steak, a salad. How much is it going to cost me?" So I add it all up and, on top of the present, do I get myself something to drink? No, I can't afford it. Now how do you explain to people that you can't afford to have a beer in your hands? I find that really embarrassing to be honest (Anglicare Werribee,1999:17).

Parents are unable to provide entertainment and outings for their children which leads to feelings of isolation and lack of respite or "time out". Social isolation is reinforced if the parent does not have access to a car (Anglicare Werribee,1999:17).

The majority of sole parents become sole parents as a result of a relationship breakdown. The transition from being in a relationship to being a sole parent is stressful and can be traumatic. Participants in the Anglicare Werribee study highlighted the importance of integrated service delivery where clients can receive support across a broad range of areas, such as legal, therapeutic and parenting assistance (Anglicare Werribee,1999:19). Participants in the study also noted the importance of family and friends in helping them cope with things "on their own" (Anglicare Werribee,1999:24-25).

Lone fathers face an even greater need for peer support and parenting assistance. While men will talk to their friends about the children's school or sporting activities, they often find it difficult to talk about more sensitive parenting issues such as a teenage daughter's need for privacy or her developing sexuality (Turner et al,1998:4). Lone fathers' lack of confidence in parenting may be reinforced by the general perception in the community that men are unable to care for their children without a woman in the

house (Mullin,1999). Support services are generally geared towards women and men may not feel comfortable attending such groups (Mullin1999; Turner et al,1998:4).

Box 16: Supporting lone fathers[30]

Mum decides to walk out and leaves the children with the father. Mum has no contact with the children once she left. Dad has to leave work, renegotiate the housing mortgage and other financial matters, including Social Security, and take on a role that he said was unfamiliar to him because he had been working full time since being with his partner. He has feelings of concern and anxiety - can he look after the children's needs; learn to shop and feed the children nourishing meals? Part of my role was to advise him on what to buy in the supermarket, that it was okay to use cheaper brand name foods and to set up a series of menus for evening meals.

I was only involved with the family for a short period of time. By giving Dad support and encouragement he was able to adjust to his new role quite easily.

While in-home support (such as that provided by Anglicare Werribee Family Services) can provide practical advice and support, agencies need to address the social isolation experienced by many lone fathers (Turner et al,1998). The lone mothers who participated in the Anglicare Werribee study highlighted the importance of informal support from family and friends. Lone fathers also need such support as well as the support, role models and solace which can come from other lone fathers. Agencies providing services to sole parents therefore face the challenge of assisting lone fathers to develop richer social networks as well as providing opportunities for lone fathers to get together.

In responding to the need for peer support and advice about relationship and parenting issues, Anglicare Tasmania has recently initiated a new program, Tools For Men[31], which takes a preventive approach by providing opportunities for men to take new initiatives that will enhance their relationships and reduce the possibility of relationship breakdown (Whittle,2000). The program arose, in part, out of the 1998 Men and Family Relationships Forum where counsellors noted the increasing numbers of men seeking assistance with relationship issues (Giblett,1998:1; De'Ambrosis & Gagan,1998:6). Tools for Men aims to work with men who are experiencing

[30] Case study taken from (Mullin,1999).

relationship or parenting difficulties, with men who are experiencing relationship breakdown and with particular groups in need, such as unemployed men, particularly those living in rural areas, men in prison and men who are socio-economically disadvantaged (Whittle,2000).

Homelessness

It is extremely difficult to make an accurate estimate of the extent of homelessness in Australia. Estimates vary depending on the definition of homelessness and the methods used to assess its extent. For example, a person is considered homeless if they are living on the street, or in crisis accommodation, or in temporary arrangements without security of tenure (for example, living with various friends and relatives, in squats or improvised dwellings, or in boarding houses) (AIH&W,1997:219). However, programs such as the Supported Accommodation Assistance Program (SAAP) extend the definition of homelessness to include those living in unstable family situations (for example, where there is domestic violence or child abuse) and those living on very low incomes and facing extraordinary expenses or personal crises (AIH&W,1997:219). The 1998-99 National Evaluation of SAAP estimated that between 50,000 and 100,000 people are affected by homelessness at any one time in Australia[32] (AIH&W,1999:299). Because the SAAP estimate is based on the number of people who access SAAP services, the actual number of people affected by homelessness is probably higher (AIH&W,1999:299).

The reasons why people experience homelessness are complex and inter-related. Unemployment, poverty, discrimination in obtaining housing or employment, being a political refugee, social dislocation resulting from divorce or family violence, all significantly increase the risk of homelessness (AIH&W,1999:295). Lack of affordable housing stock, difficulties experienced in home ownership and private rental, rural debt, multiple disability and mental health issues can also affect an individual's ability to access suitable housing (Popp,2000).

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[31] Tools For Men is funded by the Commonwealth government's Partnerships Against Violence program.

[32] This estimate was based on the numbers of people using SAAP services on a particular day, adjusted for the number of people who were turned away from SAAP agencies (AIH&W,1999:299).

Homelessness affects a wide range of different groups in the community. For example, Anglicare CQ Rural and Isolated Accommodation Service (RIAS) is used by a diverse range of people, including itinerant workers, families escaping domestic violence, young people leaving home, sole parents, low income families and families or individuals who have been evicted from private rental accommodation because of rental arrears (Popp,2000).

Indigenous Australians are particularly vulnerable to homelessness with difficulties in obtaining rental accommodation on a low income, discrimination and lack of housing stock compounding problems caused by the need to leave home to access services or fulfil cultural obligations (AIH&W,1999:296). For example, in 1997-98, 13% of SAAP support periods were for Indigenous Australians, when (at 30 June 1996) less than 2% of Australians aged over 15 identified themselves as Aboriginal or Torres Strait Islander (AIH&W,1999:316).

Episodes of homelessness also vary. For many people, homelessness is a temporary state. Others may experience extended periods of homelessness where they move between living on the street, being in support services or in someone else's house, or living in their own home. For others, particularly those with multiple problems such as mental illness or substance abuse, homelessness is a way of life (AIH&W,1999:296).

Because of the broad range of individuals and families affected by homelessness, as well as the varying nature of their experience, support needs vary. Thus, programs for homeless people encompass a range of support services, the majority of which are provided by non-government organizations. For example, Anglicare CQ RIAS provides crisis accommodation and personal and practical support by assisting tenants to work through issues (such as budgeting or life skills) that may be contributing to their difficulties in obtaining and maintaining accommodation, or assisting clients deal with issues (such as grief and loss, drug and alcohol dependency or mental health) that may be affecting their ability to function on a day-to-day basis (Popp,2000). RIAS also acts as an information and referral point, assisting people access other key services in the community (Popp,2000).

Anglicare SA Northern Family Accommodation program (a SAAP program in the northern suburbs of Adelaide) provides medium-term supported accommodation and outreach support for families in private rental, public housing or caravan parks. The program also provides crisis assessment and exploration of housing options for those in critical need without shelter.

The increasingly complex nature of client needs and increasing demand for services, particularly crisis accommodation, has meant that agencies such as Anglicare SA have had to re-evaluate traditional case-work service delivery models. Anglicare SA Northern Family Accommodation is currently developing a model of service delivery which focuses less on case work and more on developing mutual support networks and increasing the availability of housing related information through community education workshops (Connolly,2000). This approach draws on elements of existing service provision which are currently working well, in particular, the assessment and short-term intervention service. This service provides clients with a full range of housing options as well as information and referrals to other community services. Because this service focuses on linkages, it has become a critical access point in dealing with the full range of family concerns, not just housing (Connolly,2000).

Anglicare SA plans to strengthen its integrated approach to service delivery by introducing multi-skilled teams which bring together staff from different programs and disciplines (crisis accommodation, family preservation, gambling rehabilitation and financial counselling) to work as a co-ordinated team. This approach will eliminate the need to artificially refer families to other Anglicare SA programs and ensures support and intervention based on assessed needs, rather then on the initial problem which first brought the individual or family to the agency (Connolly,2000).

A focus on developing community networks also characterizes Anglicare CQ RIAS. Providing people with information and referral to other key services fosters self-determination and gives people the opportunity to make informed decisions about the most appropriate services for their needs while dealing with their housing problem (Popp,2000).

Networking with services outside the local area presents particular problems for Anglicare CQ staff who work in rural areas. For example, when trying to assist a family experiencing domestic violence, RIAS staff often need to contact other support services outside the local community to co-ordinate travel, specialized support services or accommodation. However, service providers based in metropolitan areas often fail to appreciate the difficulties associated with living in rural areas; difficulties caused by the need to travel long distances, limited bus and train services, the lack of anonymity for the family whilst in the home town which leaves them in danger of further harm, and limited access to emergency relief funds. Lack of understanding of these issues can delay assistance, leading to further stress for the family over their decision to leave town (Popp,2000).

Staff working in rural areas must be multi-skilled given the diverse range of clients (and client needs) and the limited number of specialized support services in rural areas. For example, if RIAS is providing supported accommodation for an individual or a family with mental health issues, the only access to specialized mental health services is via the telephone (Popp,2000). At the same time, upgrading and expanding skill levels by attending training courses can be expensive in terms of both time and money. Furthermore, because most rural services are provided by a single person, attending training courses means closing the office which makes the service less accessible to the local community (Popp,2000).

It was noted earlier how homelessness is closely associated with underlying structural factors such as poverty and unemployment. With declining youth wages (in real terms and as a proportion of adult earnings)[33] and rates of unemployment[34] which, even at the height of the current boom in economic activity, are around 20%, young people are at a greater risk of homelessness than in the past. For example, 89% of young people who sought assistance from Anglicare Top End Youth Housing Program[35] cited financial difficulty as one of the reasons for seeking assistance. 66% cited relationship or family

[33] See ABS (1997:122).
[34] For those aged 15 - 19.
[35] Anglicare Youth Housing Program provide medium-term accommodation, advocacy services, outreach support, community and education and emergency financial relief as well as information and assistance with referrals.

difficulties, indicating that family conflict is another important factor in youth homelessness. In the Northern Territory, the problem of youth homelessness is compounded by the lack of specialist residential facilities and youth incarceration rates (Anglicare Top End,2000).

Responding to the diverse needs of homeless young people in the Northern Territory, Anglicare Top End also provides a non-clinical health service for young people aged between 12 and 25 years in Darwin, Palmerston and rural areas. Health Connections for Youth offers intensive, long-term case management, short-term interventions and one-off assistance to homeless young people (or those at risk of being homeless) who have a range of health related needs including substance abuse, pregnancy and post-natal care, depression, self-harming behaviour and other mental health issues. These young people often lack the confidence, knowledge and skills to effectively access mainstream health care systems (Anglicare Top End,2000). For example, clients of Anglicare Family and Youth Program, Inala[36], describe clinical hospital and health care settings as intimidating; staff attitudes as judgmental, patronising and disapproving; and, as a consequence, feel powerless, under-confident, anxious and embarrassed (Anglicare Family and Youth Program, Inala,2000).

Developing community support networks is also an important part of youth programs. Arising out of the Prime Minister's Youth Homelessness Task Force, Anglicare Top End's 'Connect' program provides outreach and out-of-home support for homeless young people (or those at risk of homelessness) and their families in order to improve their level of engagement with their families, their schools or training institutions, their work places and the community. Engaging Indigenous young people and their families has been a priority for this project. In order to do this, the project has established productive referral links with Indigenous organizations and health services through networking, workshops and involvement in the project reference group (Anglicare Top End,2000).

Gambling

[36] Anglicare Family and Youth Program, Inala, provides support for young pregnant and parenting women who are also struggling with issues of unemployment, poverty, homelessness etc.

According to the recent Productivity Commission study on gambling, 330,000 Australians (almost 3% of the adult population) experience serious gambling problems (Hudson,1999). Problem gamblers often experience health problems caused by stress and anxiety, narrowing of social networks, financial distress, unemployment or homelessness (Kaldis,2000). When a family member has a serious gambling problem, the whole family, not just the individual, is affected. Bills are not paid, money which should be spent on food is spent on gambling, the gambler is physically and emotionally absent from the family and family relationships deteriorate.

Box 17: Excessive gambling affects the whole family[37]

"Helen" is separated with two children. Because of her gambling Helen didn't have enough money to keep and feed her children, so asked her husband to look after them, even though he lived a considerable distance away. But Helen didn't even have enough money left over after gambling to visit her children, which distressed her greatly.

With support from our gambling services, Helen stopped gambling and is now living with her daughter. Her son visits during the school holidays and Helen is able to support them financially. Helen has learnt money management skills and can plan and keep to a budget.

"Gina" lived with her two teenage sons in a caravan. As a result of her gambling she had very little money and was not able to meet her family's basic needs for food and clothing which caused considerable conflict within the family.

After some counselling sessions she stopped gambling. She said, "it is wonderful to have some money and see my boys eat as much as they want". Gina and her sons have since moved to a cabin, bought some furniture and have a telephone connected. The relationship with her sons has improved considerably.

"Kath" was a chronic poker machine player at a local hotel who, in the past, had tried to commit suicide because she was so worried about gambling debts. Kath's husband was expecting a tax refund of over $1,000 and intended to use the money to pay off some family debts. However Kath took the cheque to the hotel and persuaded them to cash it (even though it was in her husband's name) and then proceeded to spend the money on the gaming machines. When Kath's husband found out, he was desperate. Now there was not even enough money for basic necessities such as food and rent. The situation was made even more difficult by the fact that the couple had a son with an intellectual disability.

[37] Case studies supplied by Peter Didcott, Northern Rivers Gambling Service. Names have been changed to maintain confidentiality.

Kath's husband persuaded her to see our counsellors, who negotiated with the hotel to return part of the money. Kath has had a number of counselling sessions and is no longer gambling. In consequence, her relationship with her husband is more intimate
and she has gained considerably in self-confidence.

For individuals who have a serious gambling problem, gambling is a symptom of other underlying problems such as unemployment, poverty, bereavement and loss or isolation (Kaldis,2000). Gambling provides an "escape" from a situation which the individual feels unable to deal with.

> I hate myself every time I gamble and the alleviation of pain is too short, but I go to the Club or the TAB and block it out for a few hours…I don't care whether I win or lose, I just want to forget everything (Northern Rivers Gambling Service client).

As Kath's story illustrates, some problem gamblers are family carers, responsible for looking after a family member with a disability who desperately need a break from their caring responsibilities. Consequently, they seek solace and time out with poker machines (Didcott,2000). This is further evidence of the need in the community for more disability support services, particularly respite care.

Box 18: Gambling to escape[38]

"*Mary's" husband is mentally ill and very difficult to live with. To escape, Mary gambles, spending up to $1,000 a week on cards and poker machines. "If I don't gamble, I drink".*

"Lynette" had a small child and a husband whose employment took him away from home most of the time. In order to escape feelings of loneliness and boredom, Lynette has played the pokies almost every day for the past five years.

"Christine" is a single mother and plays the pokies almost every day. Christine manages not to take all her money from home, but will gamble what she does take with her. Christine's boyfriend drinks excessively and Christine used to drink heavily. Two months ago she stopped, but is not so sure about gambling. "It fills my life", she says, "and suppresses my emotions". Christine is overweight and her family continually criticize her, believing she could give up gambling if she wanted to. Christine feels trapped, but never having gone more than 30 kilometres from her home town, finds the idea of moving too frightening to contemplate.

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[38] Case studies supplied by Peter Didcott, Northern Rivers Gambling Service.

The amount of money spent by problem gamblers varies enormously. For example, problem gamblers interviewed by the Northern Rivers Gambling Service spent between $65 and $10,000 per week (Didcott,2000). However, all problem gamblers acknowledge that they "gamble until the money runs out" (Didcott,2000). Consequently, those with serious gambling problems usually do not seek help until they reach some sort of crisis. For example, for "Kath" it was spending her husband's tax refund; for "Helen", not being able to afford to visit her children; and for "Lynette" it was her husband saying he would throw her out of the home if she did not stop.

Agencies providing services for problem gamblers, such as BreakEven Anglicare SA and the Northern Rivers Gambling Service in NSW, experience a tension between supporting clients in crisis (through individual and family counselling and other crisis oriented work such as mutual aid and therapeutic group work) and community education and early intervention programs which aim to increase public awareness of problem gambling as a treatable disorder so that individuals seek help before they reach crisis point (Kaldis,2000; Didcott,2000). Both agencies report a particular need for community education programs that target specific groups that are currently under-represented in client profiles. Such groups include younger gamblers aged between 18 and 30 years, retirees, Aboriginal gamblers and their families and gamblers from non-English speaking backgrounds and their families.

For problem gamblers and their families who live in rural areas, access to services is a critical issue. For example, the NSW Northern Rivers Gambling Service finds it impossible to provide adequate services to an area of 10,000 square kilometres at four outreach locations as well as at their main centre with only 1.2 counsellor equivalents[39]. Lack of funding means that rural clients have to travel long distances to access available services, or may only be able to access infrequent services at outreach locations.

Box 19: Accessing services in rural areas[40]

[39] The Northern Rivers Gambling Service applied to their funding body (the NSW Casino Community Benefit Fund) for additional funding to employ more counsellors, but their request was refused (Didcott,2000).

[40] Case studies supplied by Peter Didcott, Northern Rivers Gambling Service.

"Jack" had been gambling for some years and had accumulated debts of over $40,000. His wife had left home because of those debts. To ease his situation, Jack applied for an early payout of his superannuation fund on hardship grounds. At the same time he started counselling sessions at one of our outreach locations and the financial counsellor helped him put arrangements in place to make it more difficult to access the money. Nevertheless, Jack gained access to his money and gambled it all in a short space of time, leaving him with nothing to pay his debts. The financial constraints on our service meant that we could only visit Jack's outreach location once every two weeks. If we could have seen him more often, we may have been able to prevent this outcome.

"Dave" lives in a rural location which is a three hour return drive from the counselling venue. After several visits, during which he cut down on his gambling considerably, Dave stopped coming as he found it too far and too expensive to travel that distance. The service has responded to Dave, and other clients living in the area, by opening an outreach service - albeit only once every two weeks - and Dave has resumed his counselling sessions. We know there are other people with a gambling problem who do not use our service because of access problems, but we are unable to
provide more outreach locations because of financial constraints.

Financial counselling

Financial counselling is an element of gambling services, but problem gamblers are not the only group in the community which need such services. Families or individuals may experience financial crisis as a result of unemployment or retrenchment, financial over-commitment, inadequate income or a failed business (Anglicare Tasmania,1998:12). Easy access to credit encourages financial over-commitment. Families on low incomes often become over-committed whilst paying off the family home because mortgage repayments absorb such a high proportion of their income that little or nothing is left to pay off other credit purchases such as a car (Joyce,2000).

The financial over-commitment of Australian families is reflected in the increasing number of consumer bankruptcies. For example, in the financial year ending 30 June 1997, 21,846 people were declared bankrupt, an increase of 26% over the previous financial year and three times as many as in the previous decade. 70% of those 21,846 bankruptcies were consumer bankrupts (Anglicare Tasmania,1998:12).

Low income earners with high financial commitments are vulnerable to a sudden change in circumstances or an unexpected, large expense. Inadequate incomes can also force

people into using credit (Anglicare Tasmania,1998:12). For example, a study (funded by the Tasmanian Department of Premier and Cabinet, the Hydro-Electric Corporation and Anglicare Tasmania) of Tasmanians in financial crisis found that a high proportion of rural clients of financial counselling services were either in part-time employment or receiving the Disability Support Pension (Anglicare Tasmania,1998: 67).

The vulnerability of people with special needs who are reliant on the Disability Pension and Carer's Payment is clearly demonstrated in the report "Hearing the Voices: Life on a Low Income in Tasmania 1999".

> I have two kids with disabilities. The pension nowhere near meets their needs. I spend $100 per fortnight just on nappies for the two children. The pension doesn't meet the needs of that child and it doesn't address the specific needs to provide for them (Anglicare Tasmania,2000:
> 24).

In rural areas, people living with a disability and their carers face additional costs as they have to travel further to access medical and other supports (Anglicare Tasmania, 1998:67).

Changes to the method of payment for the Youth Allowance has caused additional problems for some low income families. Parents who are eligible to receive the maximum rate of Family Allowance are paid $128.80 per fortnight while the child is aged 13-16 years. When the young person turns 16, the payment changes to the Youth Allowance. Unlike Family Allowance payments, the Youth Allowance payment of $146.40 per fortnight is made in the young person's name. Parents can chose to have the Youth Allowance paid into their bank account or into the young person's bank account. However, those working with low income families have found that it makes little difference which bank account the money is paid into - "the young people believe it is their's. Their peers at school tell them it is their's" (Joyce,2000). While some families are able to successfully negotiate with their teenagers to use the Youth Allowance as intended to help cover the costs of providing for the young person's needs, other families are less successful.

> Some young people will return a portion to their parents for board, many won't. Parents are put in the position of having to ask their children for money to help with bills. The loss of this income for the family has resulted in evictions, power disconnection and other financial crises. In my experience, the families most affected are sole parent families (Joyce,2000).

For some families living in Housing Commission homes, there is an increase in rental because of the assumption that the adolescent is paying board. Sometimes the only way such families can make ends meet is to ask the children to leave home (Anglicare Tasmania,2000:19).

> When my daughter turned 16 I lost $142 a fortnight. She got $145 a fortnight to live on. I couldn't take the lot - I got $70 a fortnight off her in board, but I still had to provide everything for her and my rent went up because I had someone paying board. I couldn't afford to keep her, so she left home (Anglicare Tasmania,2000:19).

> I had to make two of mine leave home because I can't afford them. They move around and get into debt because they can't afford to live on what they get. It's really hard, but in the end you have to put the smaller children first (Anglicare Tasmania,2000:19).

In order to avoid this situation, Anglicare WA believes the Youth Allowance payment should be made in the parent's name until the young person is 18, or living independently (Joyce,2000).

When individuals or families in financial crisis access financial counselling services the financial counsellor works with the client to evaluate their financial situation and work out possible solutions using their knowledge of consumer credit laws and hardship provisions. The financial counsellor can also help clients develop money management strategies to ameliorate current difficulties while still providing for normal household costs (Joyce,2000). Clients in the Tasmanian study emphasized the value of having a weekly budget to follow that was designed around their own particular circumstances (Anglicare Tasmania,1998:85). Clients also valued being part of the decision-making process; of working with the financial counsellor to develop solutions (Anglicare Tasmania,1998:85). For families facing financial crisis, the fact that financial counselling is offered free of charge is vital.

> When you can't pay the accountant, the solicitor and the financial advisor anymore, they just disappear (Anglicare Tasmania,1998:85).

Financial counsellors can also act on the client's behalf in negotiating with creditors.

> One client explained that when she approached a creditor to negotiate payments they had refused point blank, yet when the same payment package was negotiated by a counsellor, creditors accepted it (Anglicare Tasmania,1998:84-85).

Financial crises are often precipitated by a stressful event and in themselves cause high levels of stress in families.

Box 20: The reality of trying to cope with financial crises[41]

A sense of being overwhelmed by worry and of helplessness in the face of financial crises had a big impact on the participants, many of whom reported that they suffered from sleep disturbances and other effects of stress. The participants described a cycle of going without, of being shamed, of constant worry and of tensions in their relationships. "The pressure on your relationships is a terrible strain. We can't afford to go anywhere. We can't afford to get away from each other." A number of participants talked about struggling with suicidal thoughts. "I went to the doctor for depression tablets because I couldn't work because of my health. I had to force myself to walk past the chemist and not get the tablets because I knew I would take them all".

The fact that many families in financial crisis are also struggling with relationship problems points to the importance of early access to financial counselling as a preventive measure (Anglicare Tasmania,1998:44). The inter-related nature of the problems faced by families in financial crisis means that agencies that provide financial counselling services need to be able to assess client need for other types of counselling and be able to offer an integrated service, either within the one agency, or by referring the client to other specialized counselling services (Anglicare Tasmania, 1998:84). In such situations, funding has to be sufficiently flexible to allow agencies to offer individualized, integrated services.

[41] Case studies taken from the study "Hearing the Voices" (Anglicare Tasmania,2000:25).

4. CONCLUSION

Six themes emerge from the material in the body of the report all of which have implications for the funding and delivery of services. These are:

- the complex, interdependent nature of client needs;
- the difficulties of accessing services in rural and remote areas;
- the importance of peer support and a sense of connection to family, or group of friends;
- the importance of developing social networks;
- the importance of trust between the client and those providing the service; and
- the need for adequate funding of preventive programs.

The complex, interdependent nature of client needs is seen across the whole range of Anglicare's work; in foster care, family support and disability programs, in domestic violence and youth suicide programs and in programs for sole parents, those who are homeless, who have a serious gambling problem or are in financial crisis. Clients may seek help for a specific problem, but may also require support and assistance in other areas.

Complex, interdependent client needs demands an integrated service delivery model where client need is assessed in broad terms (that is, not just in terms of the problem they present with) and clients are able to access a range of services within the one agency. Many Anglicare agencies already provide integrated services, or are moving towards this model of service delivery. Small agencies which may not be able to offer a range of services need to develop good information and referral networks so that clients can be referred to appropriate services. In this environment, co-operation and collaboration between agencies (which has been damaged by the introduction of competitive tendering)[42] is essential.

An integrated model of service delivery has significant implications for the funding of services. Government fund specific services which are designed to deal with a specific "problem". Integrated service delivery requires flexibility in funding and

[42] For example, see Nevile (1999)

contract specifications so that agencies are able to provide an individualized package of services, the cost of which may vary from client to client.

The second theme to emerge from the material in this report is the difficulties experienced by those living in rural and remote areas in accessing services. Agencies operating in the rural areas may not be able to provide a full range of specialist services, necessitating travel to regional centres. Those living on a low income may not be able to afford to run their own car, and with limited public transport, it becomes expensive, in terms of time as well as money, to access specialized services outside the local area. Clients may need to access specialized support services (such as gambling services) on a regular basis over a considerable period of time, thereby adding to the costs involved. The fact that many rural and remote areas are characterized by relative economic and social disadvantage, means that difficulty in accessing services occurs in areas where need is greatest.

Not only does it cost more to access services in rural and remote areas, it costs more to provide services. Agencies which provide out-reach and home-based services in rural and remote areas often have to travel a long way to bring the service to the client. Co-ordination, administration costs and training costs are higher. If the economic and social disadvantage experienced by those living in many rural and remote areas is not to worsen, funding agencies need to recognize the greater cost involved in providing services in these areas.

The importance of peer support, the importance of building social networks and the importance of trust between client and service provider, all point to the ways in which welfare agencies generate social capital[43]. Young people at risk of homelessness, individuals trying to change violent behaviour patterns, and parents struggling to relate to their adolescent children, all find it beneficial to meet and talk with others in the same situation. They gain strength from the fact that they are not alone as well as ideas about what to do. When individuals participate in peer support groups they are no

[43] Social capital refers to the quality of relationships between individuals that affect their capacity to solve common problems. It is argued that where social capital is high, it is easier to achieve broad social goals because people and institutions are more willing to co-operate (Stewart-Weeks & Richardson,1998:2).

longer passive recipients, but equal partners in a process of change and learning and as such take responsibility for achieving desired outcomes.

But what happens when programs (such as parenting programs) are completed? The program is finished, but the need for some form of on-going support remains. Programs which utilize peer support or aim to develop social networks need to build self-sufficiency into program design so that the peer support groups and social networks can continue after the formal program ceases.

Much of the work carried out by Anglicare agencies is preventive. Preventive programs are, by their very nature, focused on a wider proportion of the population than programs designed to assist those in crisis. In other words, preventive programs are broad-based and must be funded as such. There is evidence of significant unmet community demand for preventive programs, particularly disability respite care and parenting support. If access to such programs is severely restricted because of funding constraints, the programs will have little impact in terms of ameliorating future crises. Similarly, the potential benefits of preventive, early intervention strategies (such as Program for Parents) will never be fully realized if successful pilot programs are not made available to the wider community.

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