

A family support service for homeless children and parents: users' perspectives and characteristics

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Abstract

The objective of the present study was to establish the psychosocial characteristics and perspectives of 49 consecutive homeless families who received input from a new designated family support worker (FSW) post at a large statutory hostel for homeless parents and children. The FSW provided: assessment of social, educational and health needs; support and parent training; and liaison with and referral to specialist services. Measures included quantitative questionnaires (i.e. the Hospital Anxiety and Depression Scale, the Parenting Daily Hassles Scale, the Eyberg Child Behaviour Inventory, and the Health of the Nation Outcome Scales for Children and Adolescents), and a qualitative (semistructured) interview on service experiences and satisfaction. The psychosocial measures indicated high rates of parenting difficulties, mental health and related needs among children and their parents. Parenting difficulties were associated with child behaviour problems. Parents expressed satisfaction with the service whilst they were residents at the hostel, but they were often not clear about the objectives of agencies and interventions. Family support interventions have a key role in service provision for homeless and other vulnerable families by providing direct parenting interventions and ensuring that specialist agencies are appropriately involved. Family support worker involvement needs to continue when families are re-housed in the community.

Keywords: children, domestic violence, families, family support service, homeless, mental health

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Introduction

Homeless children and their parents have complex and interrelated health, social and educational needs (Connelly & Crown 1994). Children's difficulties include behavioural and emotional problems, developmental delays, general health problems and injuries, learning disabilities, and abuse (Brooks *et al.* 1998, Webb *et al.* 2001). Homeless parents are at high risk of presenting with depression and substance misuse, and to have suffered domestic violence (Bassuk *et al.* 1996, Walters & East 2001). The mobility of homeless families, usually as a direct result of violence or family breakdown, leads to

poor access of services through the usual referral routes, such as general practices and schools (Lissauer *et al.* 1993, Power *et al.* 1995). Although there is strong research evidence from these UK and North American studies on homeless families' multiple and unmet needs, there is very limited knowledge of effective interventions and service models.

An outreach mental health service model was established following an earlier epidemiological study with 114 homeless families with 249 children who had been admitted to statutory hostels in Birmingham, UK. The main reasons for becoming homeless were domestic violence (56%) or violence from neighbours (29%; Vostanis

et al. 1997). Homeless mothers reported high rates of abuse (45%) and mental health disorders (50%). Homeless children were at high risk of having histories of abuse, living in care, being on the at-risk protection register, having delayed communication and suffering from significant mental health problems (30%). Despite this high level of mental health needs, only 3% of the children and less than 10% of the mothers had been seen by a mental health worker during the preceding year, and contact with other services had been fragmented (Cumella *et al.* 1998). At one-year follow-up, mental health problems among children and mothers, lack of social integration, and children's delayed communication persisted (Vostanis *et al.* 1998). One-third of families had moved house at least once more during this year. Their contact with child or adult mental health services remained very low (5% for children and 12% for mothers).

The findings also led to: the development of a local interagency Homelessness Forum; the dissemination of recommendations to housing and health providers, as well as policy-makers (Vostanis & Cumella 1999); and also the establishment of a designated child mental health nursing post to provide an outreach mental health service to hostels for homeless families (Tischler *et al.* 2000). When this service was compared with a control group of children in hostels without access to similar help, the parenting and behavioural interventions provided by the community psychiatric nurse were associated with significant improvement in behavioural problems at 6-month follow-up, and were positively perceived by parents and housing staff (Tischler *et al.* 2002). However, parents identified a number of needs such as benefits, housing assistance and child protection, which did not fall within the direct remit of a specialist mental health professional.

For this reason, an alternative family support service model was developed in another UK city, Leicester, in partnership between the housing department and the health authority, initially through a 3-year, jointly funded family support worker (FSW) post. The broad objectives of the service were to provide assessment and identification of health and social care needs, liaison with specialist services, and parent training and support (Vostanis 2002). The aim of the present study was to establish: (1) the characteristics of homeless families referred to this service during its first phase; and (2) the users' perspectives and experiences of the service whilst residents at the hostel.

Subjects and methods

Setting and subjects

The service was established at the main local authority hostel for homeless families in Leicester, which accom-

modates approximately 20 families at any one time. The FSW has nursery nursing training, and past experience in parenting and child protection work through social services family centres. She coordinates services before and after re-housing, conducts individual and group parenting skills training (an adapted version of the Webster-Stratton parent training programme; Webster-Stratton & Hammond 1997), and supports the hostel staff. Her role is to: identify a broad range of needs (e.g. child protection, possible mental health problems, substance misuse, or school problems); provide different levels of support to the majority of families; organise activities at the hostel for toddlers, older children and parents; ensure children's school placement and attendance; and maximize the involvement of specialist (e.g. social services, health visitor, child or adult mental health service, educational welfare, or Sure Start) or non-statutory agencies (e.g. domestic violence or resettlement services). Local professionals attend a weekly multi-agency meeting, where information is corroborated and agency roles are established within the overall care plan, which is coordinated by the FSW (this should be distinguished from the statutory child protection role additionally held by social workers, where appropriate). The service is monitored by a multi-agency policy forum, with senior managers or practitioners from the above agencies. The FSW is based at the hostel. She is placed and line-managed within the housing department, and receives additional supervision on parenting work and mental health issues by a specialist mental health professional. Families were recruited from consecutive referrals to the FSW over a period of one year (between April 2001 and April 2002). The main carer, usually the mother, was interviewed at variable points in their stay, as soon as possible following contact with the FSW.

Measures

The families were assessed utilising quantitative and qualitative measures. The quantitative measures were used to establish parenting difficulties, and mental health problems among parents and children. Measures were completed by the mother or main carer. Children's measures referred to one child only, i.e. the child about whom the carer expressed concerns to the FSW.

Quantitative measures

The Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith 1983) is a standardised for validity and reliability, and widely used measure of anxiety and depression in adults. Each of the 14 items (seven for anxiety and seven for depression) is rated between zero

and three, depending on the severity of the symptom (range = 0–21 for each subscale). A cut-off total score of 11 or more indicates likely psychiatric morbidity, while a score of seven or more on either subscale indicates the likelihood of anxiety or depressive disorder.

The Parenting Daily Hassles Scale (PDHS; Crnic & Greenberg 1990) assesses the impact and frequency of 20 experiences that can be perceived as a 'hassle' by parents. The carer rates each item for frequency and intensity. The total frequency (range = 0–80) and intensity scores (range = 0–100) are obtained, with scores for challenging behaviour (range = 0–35) and parenting tasks (range = 0–40) being further derived from the intensity scale.

The Eyberg Child Behaviour Inventory (ECBI; Eyberg & Ross 1978) is a standardised measure of child behavioural (oppositional) problems. The items refer to 36 common childhood problem behaviours. Each item is rated: (1) as present or absent, the sum of which consists of the problem number score (range = 0–36); and (2) on its frequency (Likert scale = 1–7), the sum of which consists the problem intensity score (range = 36–252). Cut-off scores of 11 on the problem number score and 127 on the problem intensity score have been found to indicate behaviours that might require assessment and treatment (Eyberg & Robinson 1983).

The Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA; Gowers *et al.* 1999a) include 13 clinical/psychosocial scales (Section A: disruptive/aggressive behaviour, overactivity and attentional difficulty, non-accidental self-injury, alcohol or substance/solvent misuse, scholastic or language skills, physical illness/disability problems, hallucinations and delusions, non-organic somatic symptoms, emotional and related symptoms, peer relationships, self-care and relationships, and poor school attendance), and two items on information about services (lack of knowledge-nature of difficulties and lack of information on services/management). Each item is rated on a five-point severity scale between (0) 'no problem', (1) 'minor problem requiring no action', (2) 'mild problem but definitely present', (3) 'moderately severe problem' and (4) 'severe to very severe problem', with a detailed glossary for each point on the scale and item, standardised in clinical populations (Gowers *et al.* 1999b). All cases were independently rated by a researcher (V.T.), who had previously completed the video and manualised training for the HoNOSCA.

Qualitative measure

The clients were interviewed by an independent researcher (V.T.) within one month of admission to the hostel using a semistructured interview to explore their

Box 1 Semistructured interview guide

- 1 How did you become homeless?
- 2 How did you come to live here?
- 3 Do you have any family or friends in Leicester?
- 4 What is the hostel environment like?
- 5 What is it like to live in the hostel?
- 6 How long have you been in the hostel?
- 7 Have you any concerns about your children?
- 8 Do you need any help whilst at the hostel?
- 9 Have you had any help at the hostel?
- 10 What did you expect of the service?*
- 11 What happened when you saw the family support worker?
- 12 How many times have you seen her?
- 13 What difference has it made (if any)?
- 14 Is there any help you would really like now?
- 15 Have you seen any of the following in the past month: general practitioner, community psychiatric nurse, social services, midwife, health visitor, other nurse hospital service or solicitor?

* For those who only used the Family Support Service.

experiences and opinions of the hostel and family support intervention provided. This allowed the development of the emerging themes for further analysis (the interview guide is presented in Box 1). The interview was developed from themes that emerged from previous studies with homeless families on their perceptions of health and social care services (Cumella *et al.* 1998, Tischler *et al.* 2002). The initial part of the interview ascertained the reason for the admission to the hostel and any local support networks available. The clients' opinions of the hostel environment and experiences of living there were then sought, together with any concerns about their children's well-being (physical and emotional). The clients' expectations of the intervention were explored after discussing previous help received and the help they felt they required. Their experiences of the intervention and the difference it made were documented. The help the clients require in future was also explored (Box 1).

All interviews were conducted at the hostel. Parents provided informed consent to take part in the study. They were assured of confidentiality and that taking part in the research would have no impact on their housing application or the services they received. The study was granted approval by the local health research ethics committee.

Data analysis

The frequencies of categorical data are presented. Established cut-off scores were used to provide rates of problems likely to require specialist assessment and treatment. The relationship between parenting problems,

maternal psychopathology and child behaviour was investigated by Spearman correlation since the continuous scores were not normally distributed. The associations between parenting factors, maternal psychopathology and child behaviour were explored by linear regression analyses, with all variables entered together in each model. The ECBI and PDHS depression scores alternated as the dependent variable, with HADS scores as the covariate (independent variable). The findings of the regression analyses are presented as suggestive because of the moderate sample size. The SPSS Version 11.0 computer program was used in the analysis.

Qualitative data analysis was based on a thematic content coding (Flick 2002) with similar and identical responses to each question grouped into categories. This involved detailed consideration of the responses to each question, but also to the responses to other questions, to prevent repetition. Multiple responses to the same question were counted in different categories, but not more than once in the same category. This enabled the development of concepts relevant to the hostel residents. The relative strengths of each response could then be quantified. Examples in the participants' own words were used to illustrate their responses.

Results

Out of the 55 eligible families, 49 participated and six did not. No specific reasons were given for not participating, which would indicate that these families may have differed from the remaining sample. The majority of families consisted of mother and children ($n = 33$, 67%), with the remainder being couples with children ($n = 14$, 29%), and father and children ($n = 2$, or 4%). Families had a mean number of three children (range = 1–7). The ethnic status of the main carer was: White British ($n = 30$, 61%), Asian ($n = 7$, 14%), White Irish ($n = 5$, 10%), Black African ($n = 4$, 8%) and Middle Eastern ($n = 1$, 2%), while ethnicity was not recorded in two cases. The carers' mean age was 32.3 years [range = 19–46 years; 95% confidence interval (CI) = 30.4–34.3] and the children's mean age was 7.6 years (range = 2–17

years; 95% CI = 6.5–8.7); the latter only refers to children seen by the FSW, for which reason no infants were included. There were 15 girls (31%) and 34 boys (69%).

Quantitative data

These are presented in terms of frequencies of the main scales used, followed by the investigation of their potential relationship.

When a total HADS cut-off score of 11 was used, 38 carers (78%) were within the clinical range (total HADS mean score = 19.8, SD = 9.7, range = 2–40; 95% CI = 17.0–22.9). When a cut-off score of seven for each subscale was considered, 36 carers (74%) scored within the clinical anxiety range, and 33 (67.3%) within the depression scale. The HADS depression scores were significantly correlated with all PDHS subscales scores, but there was no significant correlation between HADS anxiety and PDHS scores (Spearman correlation; Table 1).

On the ECBI, 19 children (39%) scored within the clinical range of the intensity scale (mean = 98.7, SD = 42.9, range = 45–207; 95% CI = 85.5–111.8), and 10 (20%) within the clinical range of the problems scale (mean = 9.2, SD = 10.1, range = 0–36; 95% CI = 6.1–12.3). The ECBI intensity scores were significantly correlated with maternal HADS depression scores ($\rho = 0.30$, $P = 0.043$), but not with HADS anxiety scores ($\rho = 0.17$, $P = 0.26$), and with all PDHS scores: PDHS frequency scores ($\rho = 0.63$, $P < 0.001$); PDHS intensity scores ($\rho = 0.66$, $P < 0.001$); PDHS challenging behaviour ($\rho = 0.61$, $P < 0.001$); and PDHS parenting tasks ($\rho = 0.63$, $P < 0.001$).

The frequencies of children's HoNOSCA items and scores are presented in Table 3. Since 12 cases were missing, valid percentages are presented for 37 children. When scores of (3) 'moderate' and (4) 'severe' were grouped together as potentially requiring assessment and treatment, the most frequently reported difficulties were: aggressive and disruptive behaviour ($n = 8$, 21%); overactivity and attention deficit ($n = 9$, 24%); scholastic or language skills problems ($n = 9$, 24%); emotional problems ($n = 8$, 21%); peer relationships ($n = 9$, 24%);

Parent Daily Hassles Scale	Hospital Anxiety and Depression Scale			
	Anxiety		Depression	
	Rho	P-value	Rho	P-value
Frequency	0.19	0.20	0.36	0.012
Intensity	0.13	0.37	0.39	0.006
Challenging behaviour	0.20	0.17	0.37	0.010
Parenting tasks	0.11	0.46	0.33	0.024

Table 1 Spearman correlation between Parent Daily Hassles Scale and Hospital Anxiety and Depression Scale scores ($n = 49$)

Table 2 Scores and frequencies on the Health of the Nation Outcome Scales for Children and Adolescents ($n = 37$)

Variable	Severity				
	None (0)	Slight (1)	Mild (2)	Moderate (3)	Severe (4)
Aggressive, antisocial and disruptive behaviour	15 (41%)	9 (24%)	5 (14%)	6 (16%)	2 (5%)
Overactivity and attention deficit	9 (24%)	14 (38%)	5 (14%)	5 (14%)	4 (10%)
Non-accidental self-injury	32 (86%)	3 (8%)	1 (3%)	1 (3%)	0
Alcohol, solvent and substance misuse	32 (86%)	2 (5%)	1 (3%)	2 (5%)	0
Scholastic or language skills problems	15 (41%)	6 (16%)	7 (19%)	6 (16%)	3 (8%)
Physical illness or disability	27 (72%)	4 (11%)	5 (14%)	1 (3%)	0
Hallucinations, delusions and abnormal perceptions	33 (92%)	3 (8%)	0	0	0
Non-organic somatic symptoms	21 (57%)	3 (8%)	8 (21%)	4 (11%)	1 (3%)
Emotional and related symptoms	13 (35%)	7 (19%)	9 (25%)	6 (16%)	2 (5%)
Peer relationships	14 (38%)	8 (22%)	6 (16%)	5 (14%)	4 (11%)
Self-care and independence	24 (68%)	6 (16%)	3 (8%)	2 (5%)	1 (3%)
School non-attendance	24 (65%)	3 (8%)	5 (14%)	3 (8%)	2 (5%)
Problems with family life and relationships	17 (46%)	6 (16%)	7 (19%)	4 (11%)	3 (8%)
Carer's knowledge and understanding of the young person's difficulties	23 (62%)	4 (11%)	7 (19%)	2 (5%)	1 (3%)
Carer's lack of information about services and handling child's difficulties	21 (57%)	2 (5%)	8 (21%)	5 (14%)	1 (3%)

Table 3 Predictors of child behavioural problems (dependent variable: Eyberg Child Behaviour Inventory intensity score): (PDHS) Parent Daily Hassles Scale; and (HADS) Hospital Anxiety and Depression Scale*

Predictors	Coefficient B	Ninety-five per cent confidence interval		Level of statistical significance (P-value)
		Lower	Upper	
Parenting frequency problems (PDHS frequency score)	0.36	-1.87	2.59	0.75
Parenting intensity problems (PDHS intensity score)	1.38	-5.06	2.31	0.45
Parenting problems in dealing with behaviour (PDHS challenging behaviour score)	3.62	-1.75	8.98	0.18
Parenting tasks problems (PDHS tasks score)	3.25	-0.78	7.28	0.11
Maternal depression (HADS depression score)	0.33	-2.37	2.33	0.98
Maternal anxiety (HADS anxiety score)	0.23	-2.53	2.98	0.87

* $R^2 = 0.48$.

school non-attendance ($n = 5$, 13%); family life problems ($n = 7$, 19%); and lack of information about appropriate services ($n = 6$, 17%) (Table 2).

The FSW addressed a number of family factors that are often interlinked in her intervention. For this reason, the present authors explored the potential associations between parenting skills, parental depression and child behavioural problems in two linear regression analyses. Initially, they wanted to explore which factors predicted child behavioural problems. The ECBI intensity scores were entered as the dependent variable, with PDHS and HADS scales scores as covariates (Table 3). None of these variables were significantly associated with ECBI intensity scores. When the variables were reversed, i.e. PDHS scores being the dependent variable, with HADS and ECBI scores as the covariates, parental tasks problems were predicted by the intensity of child behaviour and maternal depression (Table 4).

Qualitative data

The qualitative data is presented below, using headings to describe each theme. The themes are illustrated using examples where appropriate.

Reasons for being homeless and service contacts

Half of the families ($n = 24$, 49%) had been homeless in the past. Their reasons for becoming homeless were: domestic violence ($n = 6$, 12%); relationship breakdown ($n = 15$, 31%) – on further questioning most of these mothers were also found to be victims of domestic violence; neighbour harassment ($n = 13$, 27%); eviction ($n = 7$, 14%); refugee status ($n = 3$, 6%); overcrowding ($n = 3$, 6%); natural disaster ($n = 1$, 2%); and release from prison ($n = 1$, 2%).

The families had been in contact with the following services/agencies during the month prior to the interview:

Table 4 Predictors of parenting tasks problems (dependent variable: Parent Daily Hassles Scale tasks score): (ECBI): Eyberg Child Behaviour Inventory; and (HADS) Hospital Anxiety and Depression Scale*

Predictors	Coefficient B	Ninety-five per cent confidence interval		Level of statistical significance (P-value)
		Lower	Upper	
Child behaviour intensity (ECBI intensity score)	0.22	0.051	0.38	0.012
Child behaviour frequency problems (ECBI problems score)	0.20	0.48	0.88	0.56
Maternal depression (HADS depression score)	0.96	0.09	1.82	0.031
Maternal anxiety (HADS anxiety score)	0.44	1.43	0.56	0.38

* $R^2 = 0.49$.

social services ($n = 11$, 22%); general practitioner ($n = 25$, 51%); health visitor ($n = 12$, 24%); community psychiatric nurse (adult service) ($n = 7$, 14%); other nurse ($n = 1$, 2%); midwife ($n = 4$, 8%); hospital service ($n = 12$, 25%); and solicitor ($n = 16$, 33%). Out of the 49 families, 40 (82%) had friends or neighbours in the locality of the hostel.

Experience of living in the hostel

The comments regarding the hostel covered a wide range of issues related to both the physical environment and the context of their circumstances. The majority of general comments were positive; however, some residents were unhappy with different aspects of the accommodation:

[The hostel] is not as bad as its reputation.

[It] depends what you make of it.

[It's] like a prison, hell.

The locality of the hostel was not perceived as beneficial because of its distance from the city centre, family or schools, and also, because of incidents of racism in the area. The accommodation itself received hardly any praise with the complaints covering the facilities available, security, lack of privacy and hygiene levels. All statements regarding sharing facilities were of a negative nature; for example, 'dirty, disgusting, fleas', 'no lock on door, poor security' and 'not enough laundry facilities'.

Housing staff were mainly seen as helpful and friendly, although some residents felt that the staff did not respect their privacy; for example, 'friendly staff, supportive' and 'treated like kids, staff barge in'.

There was a mixed picture with respect to the other residents. There were many examples of supportive relationships, but also of intimidation and even attacks by other residents; for example, 'made a lot of friends with other residents, like big community' and 'people abusive, stole food'.

Concerns regarding children's mental health and related needs

The majority of concerns were that the children's behaviour had deteriorated whilst being resident at the hostel. Parents also described children's distress or boredom as significant issues. A few commented on mental health or educational problems. Twelve parents reported no difficulties.

When asked what type of help the resident needed, there were multiple responses. The greatest subgroup was the need for practical help, mainly with re-housing and benefits, but there were virtually the same number of comments regarding child-care issues, housing, and counselling or mental health input:

Dr X [was] involved, dealing with flashbacks.

Expectations of the family support worker intervention

The expectations of the intervention were variable, and there were fewer responses to this question. Residents wanted information on services, help with schooling or letters of support for re-housing. Some residents wanted someone to talk to, while others were unsure of what was being offered. Six residents stated they did not want help. The assessment interviews with the FSW appeared to cover a wide range of issues. The residents felt that the support and counselling provided was an important part of the intervention. The majority of comments regarding the FSW were positive:

[H]elped with emotional problem, helped to get on feet, counselling.

Her advice on practical issues, parenting, and schooling, were also positively received:

[She] showed how to make bottles.

[She showed] how to discipline children.

Referrals were made to other agencies, and contact was enabled with community psychiatric nurses from the adult service, social workers, health visitors and general

practitioners. The majority of the residents felt that the FSW had made a positive difference, with a small number unsure, or reporting no change; for example, 'good difference, did not know where I was' and 'kept me going'.

Discussion

This designated FSW post was set up to address a number of objectives, i.e. to provide access and support to families during periods of crisis, improve the detection of social and health care needs, deliver individual and group parent training, and ensure access to specialist services whilst at the hostel and after re-housing. The post was broadly based on previous family support service models (Chaffin *et al.* 2001, Sanders *et al.* 2002), but adapted to the requirements of this vulnerable and highly mobile client group. Therefore, although there are similarities with interagency community services for children at high risk of behavioural and emotional problems (Barlow 1999, Window *et al.* 2004), the findings also need to be considered in the context of their differences, particularly the families' mobility and short stay in homeless accommodation.

The clients' characteristics appeared to be broadly similar to previous studies, with the principal cause of homelessness reported as domestic violence, and a range of health and social care needs (Bassuk *et al.* 1996, Webb *et al.* 2001). However, there were additional causes among families living in this large hostel, which made it even more difficult to provide appropriate interventions (e.g. the co-residence of victims of violence, and abusive residents or drug users). Clients seen by the FSW had a range of problems in parenting, maternal and child mental health, which are appropriate to be filtered by the FSW, with the less complex cases potentially benefiting from direct support and intervention, and the more severe ones (e.g. child protection or psychiatric disorders) being referred on to specialist services via a weekly multidisciplinary meeting. Of these factors, parenting difficulties were found to independently predict both maternal depression and child behavioural problems, which is consistent with previous research (Gopfert *et al.* 1996). Therefore, parenting interventions should be an essential component of FSW duties.

Although there was significant variation between their perceptions of the service, certain themes were evident. The living environment evoked a great deal of criticism and a negative reaction. Since the present study took place, there have been improvements in this area. On the whole, housing staff were positively perceived. Some clients expressed negative views concerning all aspects of their experience of the hostel, which may be

a reflection of their mental health or of their previous life experience, i.e. their perceptions of the environment and circumstances were closely linked with their adverse life events. Overall, parents had few or no expectations of the service, which may indicate the need for information not only at the time of admission, which occurs during emotional turmoil and a number of conflicting priorities for the families, but also throughout their residence. A FSW is well placed to undertake this role, which incorporates casework and care coordination.

The intervention dealt with a wide variety of problems, but it appeared that support was one of the major benefits to a group of people who often felt isolated and lonely. The majority stated that they benefited from this service. However, the FSW was only one of several agencies involved in their care (e.g. health, housing, education, social and legal services), often in an unclear or overlapping way. Since there were particularly high levels of contact with primary health care professionals, social workers and solicitors, it would be useful to increase multidisciplinary working and sharing information about clients in order to improve service provision. However, the sensitive nature of this group requires careful consideration of the balance between confidentiality and safety for vulnerable clients (e.g. when to instigate child protection procedures whilst attempting to engage the parents in therapeutic work). The FSW can provide a focal point in initiating appropriate and cost-effective specialist service involvement, and to act as advocate, if appropriate (e.g. parents and children may be apprehensive in meeting a psychiatrist). Parents clearly stated that practical help is at least as important to them as counselling and emotional support, and this should not be underestimated in designing similar services. For example, accessing non-statutory resources or specialist housing advice would be particularly valuable and engaging.

A number of difficulties may have affected clients' perceptions in this study. Being a new post, there was only one worker available, which limited her input to the client group. The families' characteristics indicate that, although this was a single post, the service and the findings could be generalized to other local authority and non-statutory hostels. There were also a number of limitations to the present study. Not all questions were answered in the semistructured interview, which may have biased the final analysis. However, the qualitative design of this study still enabled the identification of important themes. Furthermore, the authors did not describe or evaluate the specific components of the FSW's interventions, the therapeutic process and whether these were maintained after the families had been rehoused in the community. A larger sample size might have enabled such analysis. However, it was important

to establish a baseline of family needs and experiences of the initial service. This may also explain why clients were often unclear about the objectives of the intervention and the role of the FSW. Future evaluation should include children's views. In addition, the resource constraints (one FSW post) meant that she could not continue her involvement after re-housing, when families are most vulnerable and at risk of becoming homeless again (Walters & East 2001, Tischler & Gregory 2002). Since the completion of the present study, the housing department has identified funds to expand this post to a family support work team, consisting of five FSWs, who are now undertaking resettlement work in the community. This should be subject to further evaluation.

There are a number of implications for policy makers and providers across health and social care. The multiple and complex needs of families and children on the margins of existing community networks cannot be met by a single agency, nor by expansion of specialist services, without taking into consideration the characteristics of this population group. Recent policies in the UK such as the Green Paper *Every Child Matters* (Department of Education and Skills 2003) and the National Service Framework (Department of Health 2003) set the context for joint commissioning and service partnership through new organizational structures (i.e. children's trusts). The establishment of a central government directorate to oversee the provision of services for homeless people and the requirement that each local authority develops an interagency homelessness strategy are positive steps in addressing health and social care needs.

However, policies are not easily translated into implementation without clear objectives, local partnerships, commissioning and performance monitoring. For example, agreeing that all homeless children should be in education is not sufficient to free school places in the proximity of a hostel or after families have been rehoused. Access to mental health services, particularly for children, will not improve if services only follow 'stability' referral pathways through general practitioners. Similarly, primary care trusts facing a number of commissioning priorities will not automatically commission health services for homeless families without evidence of effective models and integration with the existing health agencies. Housing departments and associations are facing increasing demands for lower housing stock. The findings from the present study support the emergence of services tailored to the needs of a particular group (in this case, the FSW post), whilst maximizing access to existing community services (e.g. schools, health visiting or social work). Housing departments are ideally placed to lead and facilitate this process since this is the first agency in contact with families when they are most vulnerable.

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