‘We can see future possibilities now’:

An evaluation of Bridging the Gap’s PLAN project

Prepared for Bridging the Gap

Prepared by the Centre for Social Impact

May 2023

Dr. Mariana Atkins, Emma Crane and Syarif Abdul-Wahed

CENTRE for SOCIAL IMPACT

THE UNIVERSITY OF WESTERN AUSTRALIA

Acknowledgement of Country

In the spirit of reconciliation, CSI UWA acknowledges that their operations are situated on Noongar land, and that the Noongar people remain the spiritual and cultural custodians of their land, and continue to practise their values, languages, beliefs and knowledge. We further acknowledge all Indigenous readers and their traditional unceded lands and we pay respects to their ancestors and Elders, past and present. In addition, we recognise and reflect upon the strength and resilience of Indigenous peoples in Australia with the longest surviving cultures on earth, including that their lands were the place of age-old ceremonies, of celebration, initiation and renewal, and that the Indigenous peoples have had and continue to have a unique role in the life of these lands.

Authors:

AUTHORS		
Dr. Mariana Atkins	Senior Research Fellow	Mariana.Atkins@uwa.edu.au
Emma Crane	Research Officer	Emma.Crane@uwa.edu.au
Syarif Abdul-Wahed	Research Assistant	Syarif.Abdul-Wahed@uwa.edu.au

Address for Correspondence
Dr. Mariana Atkins
Centre for Social Impact the University of Western Australia
Business School
The University of Western Australia
35 Stirling Hwy, Crawley, WA, 6009 Australia
Mariana.Atkins@uwa.edu.au

Suggested Citation

Atkins, M.T, Crane, E., & Abdul-Wahed, S., (2023). *'We can see future possibilities now': An evaluation of Bridging the Gap's PLAN project*: The University of Western Australia.
https://doi.org/10.25916/etkd-6n32

Centre for Social Impact

The Centre for Social Impact (CSI) is a national research and education centre dedicated to catalysing social change for a better world. CSI is built on the foundation of three of Australia's leading universities: UNSW Sydney, The University of Western Australia, and Swinburne University of Technology. Our **research** develops and brings together knowledge to understand current social challenges and opportunities; our postgraduate and undergraduate **education** develops social impact leaders; and we aim to **catalyse change** by drawing on these foundations and translating knowledge, creating leaders, developing usable resources, and reaching across traditional divides to facilitate collaborations.

Disclaimer

The opinions in this report reflect the views of the authors and do not necessarily reflect those of the Centre for Social Impact or Bridging the Gap.

Contents

List of figures

List of tables

ACRONYMS AND ABBREVIATIONS

BTG	Bridging the Gap
PLAN	Parents, Learning, Advancing, Nurturing project
CRFYP	Career Readiness for Young Parents project
CSI UWA	Centre for Social Impact, University of Western Australia
FDV	Family and domestic violence
AOD	Alcohol and other drugs
CALD	Culturally and linguistically diverse

TERMS USED IN THIS REPORT

Project terminology

Recruited: Participant is referred to the project.

Never engaged: Participant does not engage beyond the initial referral form.

Enrolled: Participant meets with mentors to complete initial assessment forms and creates Personal Life Plan (or meets with mentors but does not complete all initial assessment forms or Personal Life Plan).

Targeted support activities: Participant engages in intervention activities to achieve their personal outcome.

Case closure: Participant achieves their personal outcome (participant may still engage in project activities but no longer at a high-touch case management level).

Project completion: Participant achieves their personal outcome and exits the project.

Withdrew from project: Participant withdraws from the project after engaging in targeted support activities but without achieving their personal outcome.

Exited by project staff: Participant initially engaged but is not responding to contact (participant exited from the project by project staff).

Evaluation terminology

Evaluation: Systematic inquiry to inform decision-making and improve projects. Systematic implies that the evaluation asks critical questions, collects appropriate information, and analyses and interprets the information for a specific use and purpose.

Outcome evaluation: An outcome can be both the results/effects expected by implementing a program/ initiative/ strategy and the changes that occur in attitudes, values, behaviours or conditions. Changes can be immediate, intermediate or long-term.

Process evaluation: A process evaluation describes, documents and analyses the implementation activities of a project or intervention.

Qualitative data: Seeks to understand how the world is understood, interpreted and experienced by individuals, groups and organisations (usually through the eyes of people being studied and in natural settings). It unpacks the 'why', is often richly descriptive, flexible, relative and subjective. Qualitative data is usually text or narrative.

Quantitative data: Seeks to explain something by using numerical data: how many, much, often, change etc. It is highly structured and based on theory/evidence and is usually objective, but can also capture subjective responses (e.g., attitudes and feelings). It provides findings that can often be generalised and can greatly enhance understandings at a population level because it determines the breadth and scale of an issue.

Theory of change: A theory of change is a representation of how a project or initiative should work. It links inputs (the resources that go into a project), activities (what the project does), outputs (the number of people, places, supports, activities the project has produced), outcomes (what changes have occurred) and impact (long term change).

EXECUTIVE SUMMARY

Introduction

Vulnerability among parents is a common occurrence that can coincide with serious and sustained threats to personal and psychological safety. The coexistence of multiple indicators of vulnerability can create a complex picture and heightened risk of crisis and adversity. For many individuals, this can have profound consequences; for parents, these consequences can be passed on to children and outward into the community.

Bridging the Gap (BTG) identified a need for an effective, holistic support option for vulnerable parents in the Mandurah, Rockingham and Kwinana areas of the Peel region in Western Australia to address barriers to wellbeing, employment and financial and emotional stability. The Parents, Learning, Advancing, Nurturing (PLAN) project was created to fill this gap and offer high-touch case management with both practical and relational aspects of support that transcended traditional service boundaries. The project was funded by Lotterywest for a duration of 21 months, from October 2021 to June 2023.

The Centre for Social Impact (CSI) UWA was contracted to evaluate the project. This report presents evaluation findings based on the insights generated by the data, revealing the strong efficacy of the project in the outcomes it generated among participants as well as the strength of the suite of activities it offered.

Project aims and objectives

The PLAN project was open to vulnerable parents (between the ages of 18 and 64) experiencing one or more of the following: family and domestic violence, homelessness or housing instability, long-term (or recent) unemployment, mental health issues, or financial hardship. The project was delivered on a rolling start basis and the length of time in the project varied between participants due to the bespoke suite of support activities offered based on a participant's individual goals.

Vulnerable parents from targeted areas were recruited into the project to receive support for crisis prevention and early intervention through personalised and high-touch case management. Upon recruitment, their needs and the barriers they face were assessed as they worked with their mentor to develop their Personal Life Plan and begin working towards goals. Targeted support was offered to address a variety of needs through a bespoke suite of activities.

Evaluation purpose and scope

The evaluation sought to understand the effectiveness of the PLAN project to meet the needs of the participants to achieve outcomes in the three focus areas of **mindset and self-development, career development and life circumstances**, and examined whether this may be indicative of long-term social wellbeing and economic independence for the participants. A process evaluation was used to assess the efficacy of targeted support activities, and an outcomes evaluation explored the impact of the project on the participants. Evaluation questions were developed around the objectives and goals of the project, and this formed the basis of the measurement framework and subsequent data analysis. A range of quantitative and qualitative data sources were utilised, including administrative data, surveys and forms, semi-structured interviews and focus groups.

Reaching the right people

The PLAN project recruited 118 vulnerable parents in total at the time of data collection in January 2023. Almost three-quarters of these referred clients (84 people) enrolled in the project, and of these,

80% took part in targeted support activities. Thirty-seven per cent had achieved case closure (i.e. achieved their identified goals) and several participants were near case closure.

The majority of participants were enrolled in Mandurah/Pinjarra (64%; one outreach day per week was conducted in Pinjarra from April 2022 which provided one-on-one mentoring for 8 participants). Thirty-six per cent of participants were enrolled in Rockingham and Kwinana. Across all sites, 90% of enrolled participants were female and three-quarters were between the ages of 25 and 44. Most participants (73%) were born in Australia, and 12% identified as Aboriginal or Torres Strait Islander.

Individuals recruited to the PLAN project included both single and partnered parents; parents who were living in a refuge; parents who were immigrants; parents who were Aboriginal or Torres Strait Islander; parents receiving social support payments; and parents experiencing various and often co-occurring indicators of vulnerability such as homelessness/housing instability, FDV, mental health issues, un/underemployment, or financial issues. **Seventy-nine per cent of participants were unemployed when they commenced the PLAN project, 70% were single parents, and almost half were either homeless, experiencing housing instability, living in a refuge or at risk of homelessness.**

Ninety-three per cent of the 118 parents who were recruited to PLAN were referred by service providers such as a child health centre, FDV support service or other community services provider, and 7% self-referred. Thus, a strong network of service providers in the area was integral to the successful recruitment of vulnerable parents into the PLAN project.

Barriers to engagement

However, not all referred or enrolled clients remained in the project. Twenty-nine per cent of the 118 referred clients never engaged after referral, and of those who were referred and then enrolled, 22% withdrew or were exited by project staff (e.g. due to being uncontactable or moving away). Barriers to engagement included lack of transport, mental health issues, low confidence or motivation, childcare obligations, being overwhelmed, or not otherwise feeling able or ready to make changes. Some stakeholders indicated that there were vulnerable parents in the community who were therefore being 'missed', indicating the potential for the PLAN project to deepen its impact by reaching more individuals with the right capacity and resourcing.

Meeting participants' needs: critical success factors

Given the breadth of experiences and characteristics of parents in the PLAN project's target audience, participants often entered with high levels of unmet need. Data across multiple sources indicates that many needs were met for participants who engaged in the PLAN project, including needs which they were not necessarily cognisant of or ready to address at the time of starting the project. The translation from an individualised needs-assessment to action-oriented support and case management was perhaps the strongest aspect of the PLAN project in terms of producing outcomes. Many focus group participants agreed that the 'holistic' nature of the project was its strength, in the way that it provided wraparound support that was individualised and transcended traditional barriers.

> *"It was a non-judgmental place to sit and talk and get a result… To arrive fully broken and with nothing, and come out whole… It catered for MY needs, it wasn't a cookie cutter approach. It was versatile and there was always a fast result. You need fast results because you're so desperate" – Focus group member*

Data showed strong satisfaction of the project as a whole, and of individual supports and activities, among participants. **Ninety-seven per cent of participants who completed the satisfaction forms were satisfied with the service they had received in the project.** All respondents agreed that 'The service

listened to me and understood my needs', and 81% agreed and 19% tended to agree that 'I am better able to deal with issues that I sought help with'.

In particular, one-on-one mentoring was highly regarded among participants for the way it offered both relational and practical support, and an essential space for follow-through and clarity. Because of the individualised nature of the sessions, mentoring could be guided by a participant's goals and the insights of the mentor, including the mentors' expertise and lived experience. Building a sense of connection and safety with the mentor was an essential part of feeling supported to make change and achieve goals among project participants, and all Participant Exit Survey respondents agreed or strongly agreed their mentor provided a positive relationship experience based on respect and trust.

Sequential ordering of action steps helped to meet participants' needs effectively, and a brokerage fund enabled barriers to be overcome quickly. Participants often commented on the necessity of addressing urgent issues first, and the relief that was provided when these were taken care of: for instance, payment of household bills could prevent eviction, and obtaining a learner's permit offered steps to independence and freedom. Once urgent, immediate needs were taken care of, attention could be turned to longer-term goals. Group training provided practical training, skills and ways of thinking, as well as an opportunity for connection and peer support; this included through self-development, budgeting, cooking, and women's empowerment courses, as well as a training course for starting a profession as a disability support worker.

Mindset and self-development outcomes

The evidence indicating that PLAN participants had improved in the domain of mindset and self-development was significant. This happened through helping to alleviate symptoms and causes of mental health distress, building confidence and self-esteem, and achieving outcomes related to life circumstances; all of these things were closely connected and influenced each other. **Of the participants for whom mental health was identified as a priority area to address, 88% recorded a positive change in their mental health as a result of the PLAN project.**

Ninety-two per cent of question respondents in the Participant Exit Survey felt more satisfied about their physical and mental health after participating in the PLAN project, 93% agreed or strongly agreed that they were better able to access help with their physical and mental health when they need it, and 83% of question respondents had accessed support from mental health and/or medical services as a result of being in the PLAN project.

> *"It's transformative… The person I was when I came into the project is not the same as who I am now. I feel empowered – there's that inner conviction that I'm willing and determined to win the day" – Focus group member*

Ninety-six per cent of survey respondents agreed or strongly agreed that they felt they had a purpose in life; 88% felt better prepared to overcome challenges, and 92% felt more confident that they could succeed at what they put their mind to as a result of the PLAN project. **Satisfaction forms showed a positive change in self-esteem and confidence for over 80% of surveyed participants.**

The PLAN project also helped many participants to feel connected to others and build a sense of community, both as a standalone outcome and as a means to greater mental health and wellbeing. The Participant Exit Survey showed strong outcomes related to social connections and relationships: 88% of respondents agreed or strongly agreed that they feel more confident interacting with others, and 76% had been able to develop a support network. Seventy-seven per cent had been able to make new friends.

In the focus groups, many participants felt they had stronger self-awareness, life awareness, and confidence in themselves as a person capable of achieving things. Often, this translated to optimism for the future and ambition to set and reach new goals independently.

Career development outcomes

Data indicated that career development was a strong outcome for many PLAN participants. In many cases, vocational and non-vocational barriers to economic independence were addressed and sometimes removed completely. Often this was a product (at least in part) of improvements in confidence, self-esteem, mental health and life circumstances; in other cases, it was largely a result of equipping a participant with opportunities for training, study and skills-development, or mentorship for finding a job.

Of the 67 participants who were enrolled and took part in targeted support activities, 23 were previously unemployed and gained employment with the assistance of the PLAN project. This represents 34% of all participants. Many also acquired additional employment or undertook further studies and trainings. Domain assessment form data showed that of the participants for whom the domain was a priority area, 60% had a positive change in education and skills training, 63% had a positive change in their employment status, and 78% in further studies.

Some participants obtained employment within weeks of entering the project, revealing that change could happen quite quickly with the right support and sequencing of steps. Having "someone to restore a bit of faith and confidence", in the words of one focus group member, was a common theme among the qualitative data and this indicated the importance of the relational support provided by the PLAN project mentors in addition to the practical training and activities offered for career development.

Overall, Participant Exit Survey respondents said that as a result of the PLAN project, they felt more confident to get a job (92% agreed or strongly agreed), and they felt more knowledgeable about how to look for a job (92% agreed or strongly agreed). Eighty-one per cent of respondents felt more aware of the different career pathways available to them and 88% had identified the career pathway they would like to take.

The PLAN project offered education and skills training activities to support participants with their career development, including an in-house training project for employment as a disability support worker which 21 participants had completed; of these, 7 had obtained employment in the industry and 6 were ready to seek employment.

> *"It has been so life changing from being so depressed to being fully employed – [I've] done a 180 turn" – Survey respondent*

For some participants, employment outcomes had not been achieved but they reported feeling able to explore the possibility of being engaged in the workforce in the future, even when some barriers (such as mental health difficulties) still remained.

Life circumstances outcomes

The PLAN project improved participants' life circumstances most strongly in the domains of housing, family relationships, parenting and children, finance, physical health, disability and law involvement. A positive average change was evident across all domains related to life circumstances from the domain assessment data for whom the domain was a priority area, with the biggest average improvements being in housing, finance and disability. **All participants for whom the domain was a priority had a positive change in housing, 90% had a positive change in finance, and 89% had a positive change in their experience of disability.** Over three-quarters of people for whom the domains were a priority had

a positive change in the physical health, parenting and children, and law involvement domains, and 67% had a positive change in the family relationships domain.

> *"I feel supported mentally, emotionally, physically… The things that had built up, they're not a problem anymore" – Focus group member*

Typically, the combination of one-on-one mentoring sessions, group training sessions, referral to support services and access to brokerage funds helped to address immediate as well as longer-term concerns for participants, which often had positive effects in multiple areas of life. Many participants come to the project overwhelmed and in crisis, or at risk of crisis. It is notable that many participants gained a sense of stability through participation in the project and had overcome considerable barriers to improving their life circumstances. Participants worked with their mentor to, for example: find secure accommodation; obtain a driving license; obtain a Violence Restraining Order; pay off debts; navigate the service system; and make a plan for the future.

Focus group data found that some participants had improved housing outcomes with the help of the PLAN project by securing a new stable rental home; remaining in their existing home by avoiding eviction; or beginning the process of owning or, in one case, building a home**. Three-quarters of Participant Exit Survey question respondents agreed that they felt more confident about their financial situation, and over 60% agreed that they were better able to address debts (the remainder possibly did not have debts to address).** Eighty per cent of question respondents felt better able to plan their budget and better able to access help with their finances when they need it.

Positive effects on children

The anecdotal evidence gathered among focus group members indicates that the positive domino effects of the PLAN project's impact on parents and children has been considerable, and this is not captured fully in the quantitative data. Some ways this happened include: through the improved mental wellbeing of parents; greater 'presence' and parenting capacity; greater means to support children (including financial); the parent exiting them and their child(ren) from unstable or unsafe living circumstances or relationships; making appointments for children (e.g. counselling and NDIS support); a greater felt sense of security and stability; and a reduced stress load which created opportunities for fun and play in the household. This suggests that the PLAN project is influential in helping to prevent and address the intergenerational transmission of trauma.

Summary of findings

The evaluation found that the PLAN project was effective for supporting vulnerable parents to identify and progress towards goals and achieve positive outcomes across their identified priority areas. Particularly strong improvements were made in the domains of housing, finance, disability, mental health, further studies, law involvement and parenting and children. Participants were given "a chance to be empowered", as one focus group member put it, to move forward positively in multiple ways including through building confidence and self-esteem, feeling a sense of connectedness, gaining more financial stability, engaging in training, obtaining or making steps towards employment, and working towards other longer-term goals. For many participants who were experiencing overwhelming circumstances, there was a sense of the PLAN project being able to bring order to the chaos and illuminate a way forward with well-sequenced and achievable steps.

> *"All this mess, over time it all got smoothed out. I don't have savings but I'm not at threat of eviction. Our house is happy… We laugh, we play board games, there's a garden, we grow things now. I didn't fully understand that my role as a mother was so foundational… We can see future possibilities now" – Focus group member*

The factors which particularly promoted successful project delivery were: the lived experience of the mentors; a sense of connection and safety with the mentors; building self-worth and confidence; practical support and planning; the individualised, holistic nature of the project; the speed of access and financial help; and feeling able to engage with the world again. These factors promoted a sense of feeling seen, heard and understood among participants, and a feeling of being genuinely supported.

For most participants, rapid help with immediate, pressing concerns was fundamental to alleviating some degree of stress, and this opened up opportunities to work towards bigger medium- and long-term goals. The domino effects this had, or may have in the future – including through improved family relationships and parenting, confidence in taking independent action, engagement in the workforce and reducing burden on services – may be significant. In the context of a lack of comparable support options in the Peel region, the PLAN project was attractive to many participants and provided a sense of hope, at the very least, almost immediately.

> *"I'm so empowered as a person now, I look up now... This project gives you the ability to walk on your own" – Focus group member*

The evaluation showed that the PLAN project offers a unique model of holistic support that provides a sense of safety, connection and relationship that could not be found elsewhere. Although not a replacement for other services, there is strong evidence to suggest that the PLAN project is a necessary support in the area to 'fill the gaps' as a model for wraparound high-touch case management support for vulnerable parents in the Peel region and beyond.

Recommendations

Based on the data collected, our recommendations are as follows:

1. The PLAN project be continued in the Peel and southwest region to improve the circumstances and wellbeing of parents and their children;
2. Recruitment methods be improved to identify vulnerable individuals who are not already linked in with services, or may not know of any support options available to them;
3. That men experiencing FDV as a parent be actively identified and supported as a vulnerable group;
4. Additional, tailored support be provided to single parents, CALD parents, Indigenous parents, parents experiencing un/underemployment, and parents experiencing housing vulnerability;
5. Where necessary, high-need individuals be co-case managed with other service providers and government departments;
6. That there be outreach to communities beyond the Mandurah, Rockingham and Kwinana local government areas, in addition to Pinjarra;
7. That access barriers for vulnerable parents who disengage, do not engage at all, or have not discovered the PLAN project, be addressed;
8. That barriers faced by enrolled participants to engage in project activities (e.g. lack of transport) be addressed.

1. INTRODUCTION

1.1 Background

Bridging the Gap's (BTG) Parents, Learning, Advancing, Nurturing (PLAN) project is designed to help vulnerable parents with crisis prevention and early intervention in order to help them and their children gain financial and emotional stability. PLAN was scheduled to run for 21 months, from October 2021 until June 2023 for vulnerable parents living in the Mandurah, Rockingham, or Kwinana local government areas.

The PLAN project is an offshoot of the Career Readiness for Young Parents' (CRFYP) project which was delivered by BTG under the Department of Social Services Try, Test and Learn Fund and ran from 2018 to 2021. CSI UWA evaluated the processes and impact of the project and found that, overall, the project was able to support young parents improve their job readiness through a high-touch case management model that focused on both non-vocational and vocational barriers to employment. The project offered peer support and activities, personalised advocacy and services to address non-vocational barriers, and some work immersion or experience.

While the CRFYP project targeted a cohort of young parents up to the age of 25, PLAN is open to parents of ages 18 to 64, with a target to recruit and support 90 vulnerable parents across the project. Vulnerable parents are identified as parents experiencing one or more of the following: family and domestic violence, homelessness or housing instability, long-term (or recent) unemployment, mental health issues, or financial hardship. The project is delivered on a rolling start basis and the length of time in the project varies between participants due to the bespoke suite of support activities offered based on a participant's individual goals as identified in their Personal Life Plan.

1.2 Evaluation scope

CSI UWA was contracted by BTG to conduct an evaluation of the PLAN project to assess its activities and outcomes, and to develop tools to facilitate evaluation processes. The aim of the evaluation is to understand the effectiveness of PLAN in terms of meeting the needs of its target audience and helping participants to achieve outcomes in the three focus areas of mindset and self-development, career development and life circumstances, and whether this may be indicative of long-term social wellbeing and economic independence for the vulnerable parents who participated in the project. CSI UWA undertook a process evaluation to determine whether the project was operating effectively in terms of inputs and activities, and an outcomes evaluation where the outcomes achieved among participants were analysed, quantified and interpreted to understand the impact of the project. The findings are presented in this report.

1.3 Structure of report

This evaluation report is structured as follows:

Chapter 1: Introduction – presents the background to the study as well as the evaluation scope.

Chapter 2: Literature Review – presents the findings of a rapid literature review exploring key themes informing the evaluation and contextual information for the project.

Chapter 3: Conceptualising the PLAN project – presents key conceptual information that has guided the evaluation design.

Chapter 4: Methodology – outlines the methodological approach followed and the main data collection methods and data analysis approaches.

Chapter 5: Process Evaluation – presents the findings of the process evaluation.

Chapter 6: Outcomes Evaluation – presents the findings of the outcomes evaluation.

Chapter 7: Conclusion and Recommendations – presents and overview of the evaluation findings and recommendations.

2. LITERATURE REVIEW

This section presents a rapid review of the literature to contextualise the PLAN project in order to understand the components of the project and how they relate to broader research findings. Key themes addressed by the project were examined and the findings are presented below.

2.1 Vulnerability and parenthood

The literature shows a strong link between an individual's level of vulnerability and their social and emotional wellbeing, economic stability and general life circumstances. 'Vulnerability' is a multifaceted concept which is often associated with powerlessness, dependence and low mental, financial and social resilience, particularly in the context of abusive relationships. While these terms often do not attribute individuals with the power and capability which they possess, a range of factors can lead to an individual being or becoming materially and psychologically vulnerable and this understanding is integral to planning, maintaining and adapting effective interventions. Practically, vulnerability is about a person's risk of exposure to crises or adversity; the risk of not having adequate resources to cope with these situations; and the risk of being subject to the consequences that may arise from such situations (Chambers, 1983; Watts & Bolhe, 1993).

Parenthood can bring a number of risks which can make an individual vulnerable to a range of adverse material and psychological circumstances. Postnatal depression and anxiety can affect both women and men (Almond, 2009; Edward, et al., 2015; Reck, et al., 2008), and many new parents experience mental health issues not captured in the data. The strain that parenthood can put on a relationship can be considerable, not just through the effects of mental health issues but also financial strain, time pressure, fatigue, a change in family dynamics and the difficulties of adjusting to a new way of life (Monaguchi & Milkie, 2003; Boath, et al., 1998; Ruppanner, et al., 2018; Delicate, et al., 2018). Stress is a commonly reported aspect of parenthood, sometimes severe enough to impair judgement and affect physical as well as mental health, and single parenthood can raise even more problems (Cairney, et al., 2003). The stress of single parenthood likely increases allostatic load, i.e. the physiological burden from the accumulation of demands and life stresses, and more stress-related health issues and unhealthy coping behaviours as a result (Johner, 2007). Allostatic load is often particularly high in instances of un/underemployment and financial strain (McEwen & Wingfield, 2003), and parents with lower income and education levels may also be at greater risk of experiencing adverse effects of parenthood (Field, et al., 2006), particularly in less-resourced communities lacking adequate social supports and services. There is evidence to suggest that the transition to parenthood can present more negative effects for women than men, owing partly to gendered expectations of caregiving and insufficient supports (Baxter, et al., 2008) and a change in employment status and hours (Hynes & Clarkberg, 2005). There is thus a strong association between parenthood and physiological stress, particularly in instances where social and economic conditions are not supportive of health and stress-mitigation. Unfortunately, this can engender or coincide with multiple other issues and experiences, including family and domestic violence (FDV), housing instability and homelessness, mental illness and distress, alcohol and other drug (AOD) issues, and chronic un/underemployment. Combined with insufficient support and high levels of loneliness and disconnection, which we know anecdotally to be the case for many vulnerable parents, particularly in less-resourced communities, this presents a level of complex vulnerability that can easily become an intergenerational problem.

At the most basic level, Maslow's (1943) hierarchy of needs is a good reference point for understanding the level of unmet need that many vulnerable parents may face: these needs are physiological (food, shelter etc.); safety (personal safety, financial and job security); love and belonging (connectedness and relationships); esteem (respect, self-esteem, recognition); and self-actualisation (fulfilling one's

potential).[1] The range of experiences and risk factors associated with vulnerability threaten an individual's ability to meet these needs.

2.2 Experiences of family and domestic violence

Among the issues that many individuals who are parents may experience is FDV. FDV refers to acts of physical, sexual or psychological abuse, or coercive control, in a current or former intimate partnership or between other family members. Women are disproportionately affected by FDV globally and in Australia (WHO, 2016; ABS, 2017) but men also experience FDV, particularly in the form of coercion and control of their relationships with their children. The ABS 2016 Personal Safety Survey (the PSS) found that 3.6 million Australians have experienced emotional abuse from a partner and 2.2 million Australians have experienced physical and/or sexual violence from a partner (ABS, 2017), signalling the prevalence and magnitude of the issue at a national level. The 2016 PSS estimated that 1 in 6 women and 1 in 16 men experienced physical or sexual violence by a current or former intimate partner, but there are likely gaps in this data.

The effects of FDV are well evidenced. FDV is associated with mental health issues such as depression, anxiety and suicidal intention (Karakurt, et al., 2014; Ellsberg, et al., 2008; Bacchus, et al., 2018); trauma and posttraumatic symptoms, including acquired brain injury (Wuest, et al., 2009; Bean & Moller, 2002); physical illness and chronic health problems (Bonomi, et al., 2009; Vives-Cases, et al., 2010; Wuest, et al., 2008; Humphreys & Lee, 2009); cognitive impairment and decline (Williams, et al., 2018); AOD issues (Williams, et al., 2020); and death through homicide. It is generally understood that the hypothalmo-pituitary-adrenocortical axis stress response is negatively impacted in response to severe and chronic stressors, such as abuse, potentially causing ongoing post-traumatic physical and psychological issues if the stress response does not return to normal (Chapman, et al., 2008; Crofford, 2007; Herman, 2013). For some women, the stress of physical violence is more tolerable than the stress of psychological abuse and persistent degradation that they experience (Cromwell & Burgess, 1996). Additionally, FDV can cause social isolation either directly through the coercive control of a partner, or due to experiences of anxiety and poor mental health as a result of experiencing FDV. The consequences of this are significant, and social isolation can be a source of stress in and of itself.

The mechanisms by which the co-occurrence of risk factors can increase an individual's level of vulnerability are often complex and can happen in many ways. For instance, there is a well evidenced link between economic stress and FDV: financial strain is a known risk factor for FDV (Smith & Weatherburn, 2013; Pattavina, et al., 2015) and physical violence tends to occur at a greater rate in areas of lower socioeconomic status (SES) (Hulme, et al., 2019; Kessler, et al., 2001).[2] There is also a well evidenced phenomenon of 'learned helplessness' among people with depressive and/or traumatic symptoms, where feelings of lack of control over a stressful situation can generate a belief that the situation is inescapable (Seligman, 1975). This is closely connected to feelings of entrapment and defeat, and can mean that people do not seek supports, or are not willing or able to engage in them when they are offered. Learned helplessness and feelings of entrapment and defeat are closely connected to experiences of FDV, particularly through symptoms of trauma and depression (Bargai, et al., 2007; Aguilar & Nightingale, 1994). Seeking an exit from FDV can also make an individual susceptible to other risks, including housing insecurity and homelessness, financial difficulty, childcare

[1] This five-stage model was later adapted to include three more types of need: cognitive, aesthetic and transcendence (Maslow, 1987).

[2] However, this is not always the case: FDV is prevalent across all socioeconomic groups.

concerns, violence escalation and even death, and these are among the practical reasons why many women (and men) choose to remain in abusive relationships (WHO, 2002). In many cases, not only is there a perceived lack of safe and economically viable alternatives, but there is a lack of *awareness* about, or confidence in, possibilities for exit and independence.

2.3 Effects on children and the intergenerational transmission of risk

A child's exposure to, or lived experience of, things such as FDV, homelessness and mental health dysregulation (including parental) is broadly referred to as an Adverse Childhood Experience (ACE) and is strongly associated with future issues including depression, suicide, physical health problems, AOD problems, and violence (Dube, et al., 2003; Dube, et al., 2001; Hughes, et al., 2017). The effects of FDV on children are well evidenced, particularly psychological effects and effects on housing. The literature is clear that exposure to FDV is associated with a number of behavioural, emotional and cognitive-functioning problems among children, including more fearful and inhibited behaviours, more antisocial behaviours, more anxiety, depression and trauma symptoms, and greater risk of hospitalisation and disease burden (Orr, et al., 2020; Flaherty, et al., 2009; Olofsson, et al., 2011; Edleson, 1999; Richards, 2011). For this reason, children have been referred to as the 'forgotten' victims of FDV (Stainton, 2016).

The link between children's exposure to FDV and homelessness is also troubling. A breakdown in familial relationships often causes young people to become homeless (Mackenzie, et al., 2016) and experiencing or being in a home where FDV is present has a strong association with homelessness (Kaleveld, et al., 2018). Chamberlain and Johnson (2013) identify two key ways that FDV can generate vulnerability to homelessness among children and women: no longer having a sense of safety and belonging in the home, and needing to physically exit the home to escape violence. In The Cost of Youth Homelessness Study, over half (56%) of homeless youth surveyed had left home at least once due to FDV being present (Mackenzie, et al., 2016). Thus, childhood exposure to FDV is a key driver of homelessness among young people in Australia and in many cases this can lead a young person down a path of out-of-home care, social and economic exclusion, and longer-term housing instability (Kaleveld, et al., 2018; Mackenzie, et al., 2016; Campo & Commerford, 2016; Johnson, et al., 2010).

The trauma that is experienced by FDV victims, and the effects this has on other life areas which can be traumatic in and of themselves (e.g. becoming homeless), can also be passed down intergenerationally from parent(s) to child. Results from the Australian Intergenerational Homelessness Survey administered in 2009-10 showed that almost half of respondents and over two-thirds of Indigenous respondents (i.e. participants accessing homelessness services) had parents who had experienced homelessness at some point in their lives (Kaleveld, et al., 2018) and, given the strong association between FDV and homelessness, this is significant. Thus FDV is not just a serious issue for the individuals experiencing it, or who have experienced it in the past, but also for their children and for future generations. Supporting people to safely exit FDV situations and achieve economic independence may thus be crucial for helping to prevent a significant number of parents and children from perpetuating a cycle of vulnerability.

2.4 Homelessness and housing instability

Being homeless, or being at risk of homelessness, is a major aspect of vulnerability among both men and women – particularly those experiencing FDV, mental health issues and job insecurity. Structural drivers of homelessness are the socioeconomic conditions that enable (or not) a person to maintain

secure housing (Kaleveld, et al., 2018), and there is a general consensus that adverse structural conditions interact with individual risk factors to cause homelessness (Wood, et al., 2015; Lee & Tyler, 2010; O'Flaherty, 2004; Pleace, 2000). Key factors and experiences associated with becoming homeless include unemployment, low educational attainment, FDV, AOD issues and undiagnosed/unsupported mental health issues (Johnson, et al., 2015; Flatau, et al., 2022). Of the people who accessed Specialist Homelessness Services (SHS) in Australia from 2021-22, the majority of participants were female (60%) with 1 in 79 females receiving SHS support compared to 1 in 118 males (AIHW, 2022).[3] Forty-one per cent of female SHS participants were living as a single parent, compared to 25% of males who were living as a single parent. Across both genders, around 2 in 5 participants had experienced FDV, around 2 in 5 had experienced a mental health issue, and approximately 1 in 10 had experienced problematic alcohol or drug (AOD) use. Over one-quarter of participants identified as Aboriginal or Torres Strait Islander (despite making up around 3% of the population). Significantly, the most common reason for seeking assistance from SHS was FDV – this was the case for over a quarter of participants. Of these participants, 41% had mental health issues and 11% had AOD issues. Financial difficulties were also cited among the top four reasons that people sought assistance from SHS in 2021-22. This shows that FDV is a main driver of homelessness among women and children in Australia and that there is a significant link between homelessness, FDV, economic instability, mental health and substance abuse, often overlapping with parenthood/being a single parent or being indigenous. The layering of these risk factors deepens an individual's vulnerability and may see them entrenched in "the system" for some time.

These patterns are reflected in Western Australia: most likely to be represented in the homeless population in the state are indigenous people; people experiencing FDV; people living with mental health issues; young people presenting alone (15-24); and people with AOD issues (Kaleveld, et al., 2018). Indigenous people may also experience the additional burden of 'spiritual homelessness' due to a disconnection from traditional lands and separation from family/kinship networks, which can pose more risks including feelings of vulnerability, resistance to engaging in mainstream services, and potentially difficulty sustaining tenancies (Young, 1998; Spinney, et al., 2016; Flatau, et al., 2005). Being an immigrant or culturally and linguistically diverse (CALD) person is also associated with homelessness/housing instability, in part because of language barriers, difficulties attaining education and employment, and social isolation, which may be compounded by FDV and discrimination (Kaleveld, et al., 2019). Given that FDV has the strongest association with homelessness for women and children in Australia across cohorts, it requires particular attention.

However, we also know that specialist homelessness services for women experiencing FDV in Australia are not moving people along housing pathways as anticipated (Flanagan, et al., 2019). There have also been concerns raised in the literature around the efficacy of FDV perpetrator projects and models aimed at preventing FDV recidivism (Stover, 2005; Vlais, et al., 2017; Vlais, 2014), indicating that an exclusive focus on behavioural change and legal protection is not always effective or enough.

2.5 Implications for services and support-seeking

In recent years there has been a growing emphasis on addressing vulnerability and risk among diverse cohorts in Australia (Parliament of Australia, 2021; Department of Health, 2021; Victorian Government, 2012; McLachlan, et al., 2013), and empowerment to overcome barriers to independence and

[3] Note that other data sources, for example Registry Week data, reflect a higher proportion of males experiencing homelessness than females. The general population of homeless males in Australia is also higher than females, however females are more likely to access services.

wellbeing has been a major focus area (see for example Dudgeon, et al., 2014; Commonwealth of Australia, 2013). On FDV, the National Plan to Reduce Violence against Women and their Children 2022-2032 (the National Plan) set out a vision and plan for the prevention and reduction of FDV, emphasising 'person-centred coordination and integration' and a holistic, culturally informed approach to supporting FDV victims and ending violence against women and children (Commonwealth of Australia, 2022, p. 70). Strategies to reduce, prevent and end homelessness are also embedded in Australia's political architecture with growing recognition that a co-occurrence of risk factors can create complex vulnerability and place people at risk of homelessness (Parliament of Australia, 2021). Western Australia's strategy on homelessness, *All Paths Lead to a Home*, has embedded the necessity of lived experience voices in its 10-year plan to 2030 which prioritises a whole-of-community approach to reducing homelessness based on collaboration, and place-based responses informed by local needs and contexts (Department of Communities, 2020). There have been many other iterations of models and approaches to mitigate and address vulnerability: the indigenous social and emotional wellbeing model is a helpful way to conceptualise the role of social, historical and political determinants of health and the necessity of elevating the role of connection to body; mind and emotions; family and kinship; community; culture; country; and spirit, spirituality and ancestors (Commonwealth of Australia, 2017). This type of holistic understanding incorporating psychology, culture and socioeconomic factors, provides a foundation for efforts to address individual and community wellbeing.

While frameworks and action plans have helped produce good practical outcomes in some focus areas and communities, progress is slow and many individuals continue to cycle between services or do not access services at all, placing burden on the economy and posing serious risk to psychological wellbeing, personal safety and financial and housing security. Much of the research and many projects have focused exclusively on vulnerability among women and children, particularly in the context of FDV (Commonwealth of Australia, 2022; Bacchus, et al., 2018). This has sometimes come at a cost: some cohorts, including men, often stay 'hidden' in the statistics and evidence base around who is affected, how they are affected, and why, by FDV, economic problems, mental health issues and a host of other risk factors. COVID-19 also delivered higher rates of social isolation and financial stress among Australians, and we know this increased the risk of violence in cohabiting relationships (Morgan & Boxall, 2020). The effects of the pandemic are enduring, particularly among families with higher levels of vulnerability, and this may have impacted support-seeking behaviours beyond what has been researched.

The reality of seeking and accessing support is not easy for many – if not most – vulnerable individuals. Service delays and gaps are a reality of Australia's service system, spanning housing services, legal assistance, the justice system, child protection, clinical mental health support and counselling, financial support, and protection for migrants (Flanagan, et al., 2019). Even before this point, there are many barriers an individual may face in accessing adequate support, and these include lack of knowledge or awareness of supports and services, cost barriers, mental health issues, being in a controlling relationship, and practical issues such as transport. In the case of FDV, perpetrators often control the housing and financial situation of their partners (Lester, et al., 2021) and this can make it difficult for an individual to seek support or leave a relationship safely and with the assurance of adequate shelter, money and support. The social isolation that many people in abusive relationships face also, in many cases, limits opportunities for option-seeking and information-gathering around possibilities for exit and independence, or support generally. A combination of these factors can lead to an individual choosing to stay in an FDV situation because it is deemed safer than the alternatives. Additionally, higher levels of depressive and PTSD symptoms can decrease an individual's ability to maintain separation from an abusive partner, access resources and practice safety behaviours, and this makes management of trauma and mental health problems a high priority among FDV victims (Alhalal, et al., 2012; Symes, et al., 2013). This is true for any individual or parent who is experiencing

adverse circumstances and mental health issues, given the effects of chronic and acute stress explored earlier.

This reflects a need for more holistic support for vulnerable individuals to achieve the things which will allow them to ensure their personal safety and improve their life circumstances, for example secure employment, stable and safe accommodation, financial stability, psychosocial wellbeing, cultural and spiritual connection, mentorship, and knowledge of (and confidence in) their options. The role of mentorship and relational support in helping to address vulnerability is both an under-researched and highly significant aspect of this. Empathy and a display of genuine support, care and acceptance are widely understood to be important in bringing about change in individuals or participants (Warner, 1996) and this is particularly relevant for those experiencing adverse life circumstances and complex vulnerability. There is evidence to suggest that a therapeutic relationship is very helpful for supporting FDV victims (Roddy, 2013): Flanagan et al. (2019) also found that productive, supportive working relationships and a display of care are crucial for supporting women experiencing FDV. It is also essential to improve social supports and networks in the context of experiences such as FDV and homelessness where a loss of, or lack off, effective social supports is common (Goodman, et al., 2016; Goodman & Smyth, 2011). Building on the understanding of vulnerability presented above, Brené Brown (2012) conceptualises vulnerability as uncertainty, risk and emotional exposure: it is a *felt* experience and in it lies the possibility for change, connection and meaningful human experience. When vulnerability is viewed as a rich ground for possibility and 'building back better', to adopt terminology from disaster risk thinking, the significance of efforts to build empowerment and confidence among vulnerable individuals cannot be overstated.

Practically, the idea of 'matching' people with different supports depending on their unique stressors has been explored through different lenses (Cutrona & Russell, 1990), and central to this idea is the fact that no two experiences of adversity and risk are the same: support must be tailored to the individual to be truly effective. Judy Chang et al's (2005) study of women experiencing FDV found that perceptions of the efficacy of a support – and the likelihood of utilising it – depended on several key factors, including a woman's readiness for change and the ability for a support to not require disclosure as an FDV victim; to present multiple options; and to preserve respect for autonomy. The need for an individualised approach to assisting FDV victims which puts safety and autonomy front and centre is reflected elsewhere in the literature (Ford-Gilboe, et al., 2020; Nolet, et al., 2021), and, more generally, providing individualised support affords an opportunity for a display of care and connection that may not otherwise be available to vulnerable individuals. Sensitivity to an individual and their unique circumstances and lives, in addition to the practical elements of providing support and 'getting things done', is foundational to addressing vulnerability and risk.

Thus, it is not just policy at the systems level that requires attention, but the ways in which on-the-ground support is offered and delivered. There is strong evidence to suggest that wraparound support which is holistic, person-centred, practically-oriented *and* therapeutic is essential to produce and sustain self-directed change among vulnerable individuals. This report offers a unique insight into how this model of support can work for vulnerable parents, helping to build the evidence base for the potential of such an approach.

3. CONCEPTUALISING THE PLAN PROJECT

The PLAN project was designed to help vulnerable parents with crisis prevention and early intervention in order to help them and their children gain financial and emotional stability. This section presents a number of tools that help to explain how the project was conceptualised and developed. They are useful in clarifying what change the project is designed to address and the activities that make up the project.

3.1 PLAN Theory of Change

The Theory of Change describes the mechanism through which processes are delivered to achieve the desired outcomes. As illustrated in Figure 1, through the project's interventions, a participant receives sustained and personalised support to address needs and barriers in order to improve their life circumstances, mindset and self-development and career development (where appropriate). The ultimate aim is for vulnerable parents to have long-term social and emotional wellbeing and economic independence. There are a number of assumptions underpinning the Theory of Change, such as: eligible individuals are interested to participate in the project; service providers are available to provide assistance to participants in need; and participants are able to engage in the project long enough to have their needs addressed. External factors also have a bearing on the Theory of Change and may affect how the project unfolds, including the participants' life circumstances and stage of parenthood.

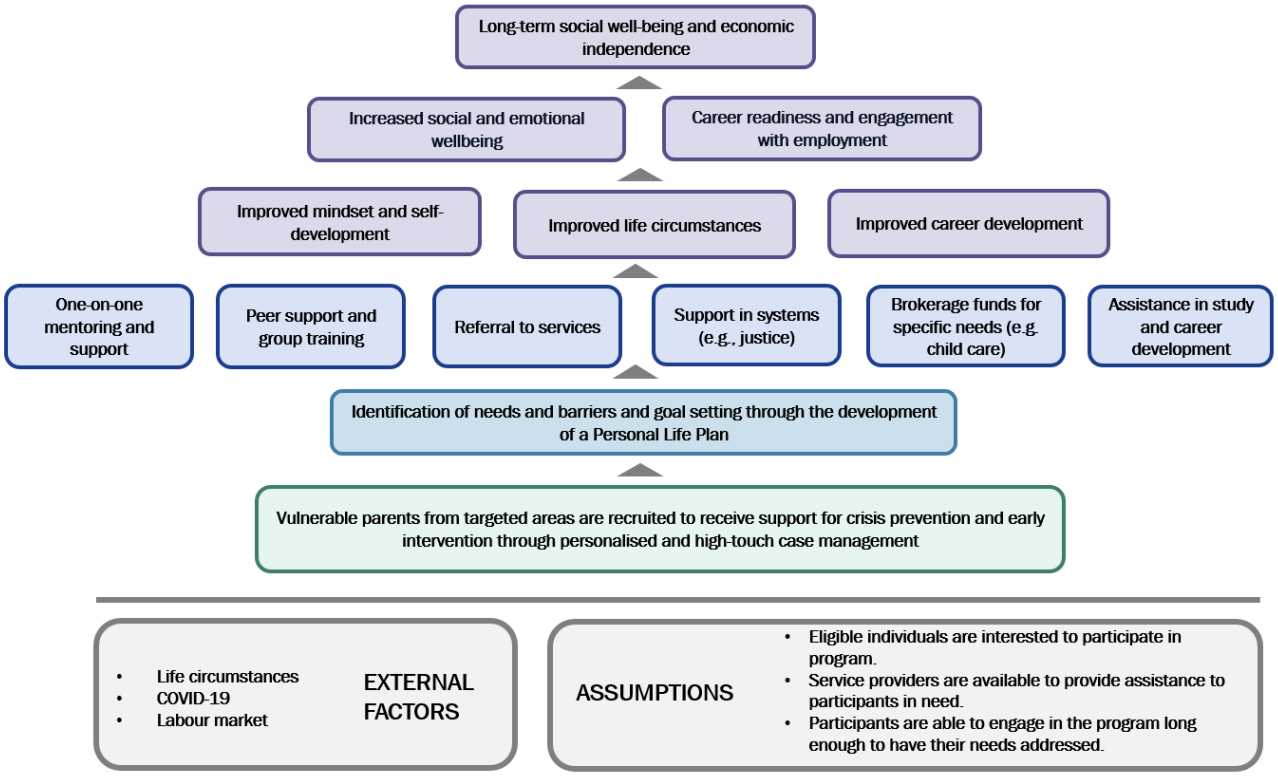

Figure 1: PLAN Project Theory of Change

3.2 PLAN program model

The program model visually represents the project processes, as seen in Figure 2, which details the project's structure and intended impact of the intervention. Vulnerable parents from targeted areas are recruited into the project to receive support for crisis prevention and early intervention through personalised and high-touch case management. Upon recruitment, their needs and the barriers they face are assessed as they work with their case worker to develop their Personal Life Plan and begin working towards goals.

Targeted support is offered to address a variety of needs. Activities include:

- A guided self-assessment of participants' current situation;
- Development of a Personal Life Plan with immediate, medium, and long-term goals;
- Personalised advocacy through one-on-one mentoring sessions;
- Peer supported training sessions to increase knowledge, confidence, self-belief, and resilience;
- Referral to services (such as housing support services and financial counsellors);
- Support in systems (such as providing participants support in the justice system);
- Brokerage funds for specific needs (such as childcare or transport); and
- Assistance in study and career development.

The PLAN program model assumes that individualised mentorship enables participants to receive holistic support that looks at the 'whole picture' of an individual's life circumstances and challenges. As a result of this, participants have increased social and emotional wellbeing and career readiness and engagement with employment (where applicable). Ultimately, this leads to participants having long-term social and emotional wellbeing and economic independence, and the possibility of maintaining stable and safe living arrangements, healthy relationships, and improved parenting capacity.

The program model also illustrates the elements of the project that are captured in the process evaluation, and those that fall under the outcomes evaluation. It is important to note that the impact of the project is captured in the long-term, outside the timeframe of the evaluation.

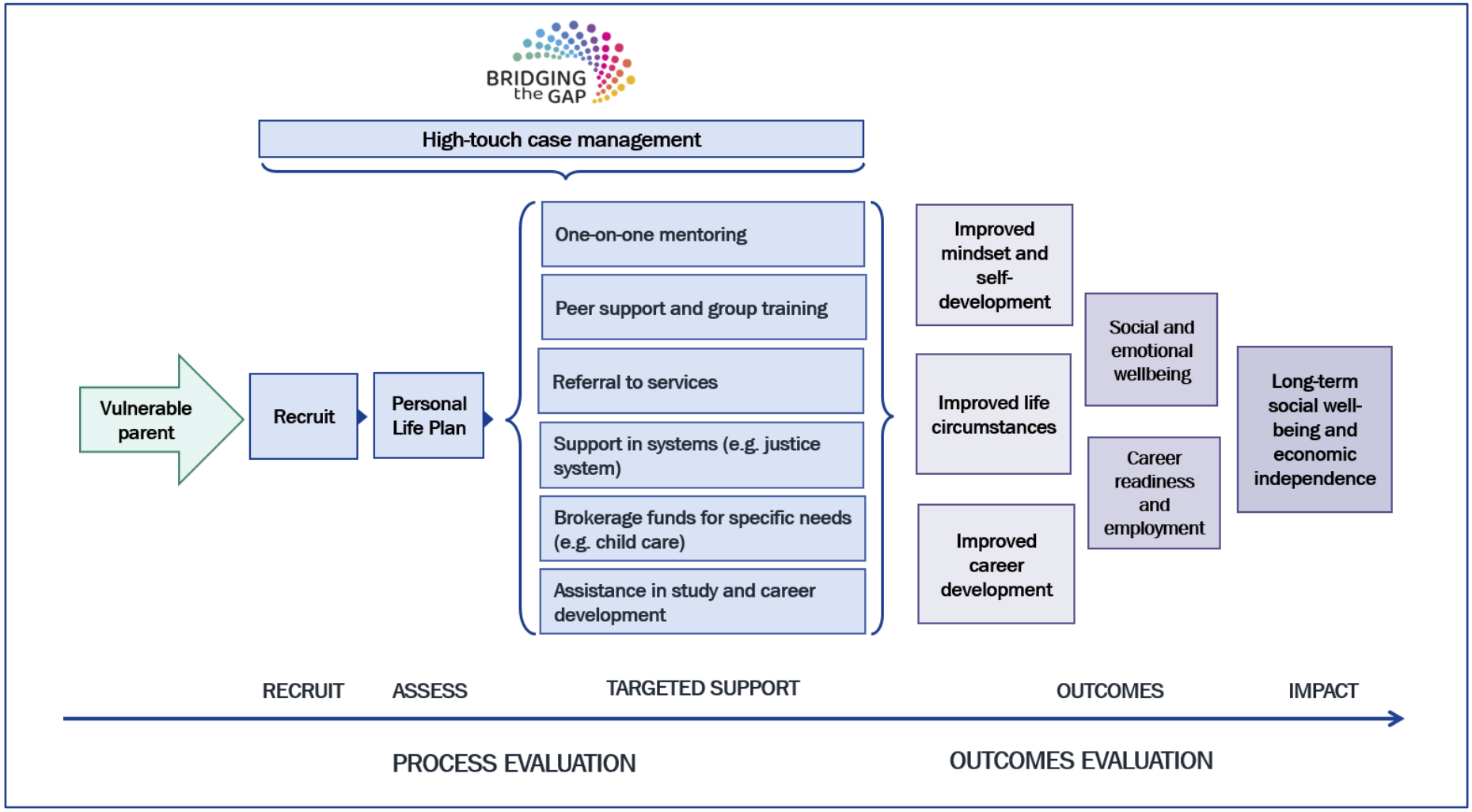

Figure 2: PLAN program model

4. METHODOLOGY

This section outlines the PLAN project evaluation design and evaluation methodology, including the key questions relating to the process and outcomes evaluations, a description of the evaluation participants, and an outline of the data collection methods and data analysis approaches.

4.1 Evaluation design

This report evaluates the extent to which the PLAN project's Theory of Change has been successfully implemented, and if the project achieved its intended outcomes. The evaluation questions were framed around the objectives and goals of the project. This formed the basis of the measurement framework and subsequent data analysis. Process evaluation was used to assess the efficacy of targeted support activities, and outcomes evaluation was used to assess the extent to which PLAN was able to promote positive outcomes among its participants in the areas of mindset and self-development, career development and life circumstances. Qualitative and quantitative data from multiple sources was used, and these sources are described in Sections 4.6 and 4.7.

4.2 Process evaluation questions

The following process evaluation questions were structured around the recruitment, assessment and delivery of targeted support through the project to understand the effectiveness of PLAN's model in recruiting, assessing and providing targeted support for participants:

- To what extent did the project recruit the intended target audience?
- To what extent did the development of a Personal Life Plan allow for relevant support and progress towards participants' goals?
- Were project activities implemented as intended?
- Which project activities were most beneficial for participants?
- How satisfied were participants with the delivery of the project?

4.3 Outcomes evaluation questions

The following outcomes evaluation questions were structured around three main priority outcome areas of the PLAN project. These questions investigated how effectively the project promoted positive change to participants' mindset and self-development, career development and life circumstances.

4.3.1 Mindset and self-development

The following questions addressed the project's impact on participants' ability to confidently feel an improvement in their confidence and sense of self:

- How effectively did the project create positive change in participants' sense of identity and belonging?
- To what extent did the project improve confidence in parents around their capabilities?
- To what extent did the project improve self-esteem levels for participants?
- To what extent did the project, improve community participation and social connection?
- To what extent did the project improve participants' mental health?

4.3.2 Career development

The following questions addressed the project's impact on participants' vocational barriers to understand the effectiveness of the project's model in addressing barriers leading to career readiness for employment or study:

- To what extent did the project increase career readiness of participants through relevant skills and training?
- To what extent did this project help parents find and sustain employment?

4.3.3 Life circumstances

The following questions addressed the project's impact on participants' life circumstances, many of which were also non-vocational barriers to employment:

- To what extent did the project address any barriers around housing?
- To what extent did the project address any barriers around family relationships?
- To what extent did the project address any barriers around physical and mental health?
- To what extent did the project address any barriers around financial hardship?

4.4 Impact evaluation questions

Following the direction of the Theory of Change presented in Figure 1, the subsequent evaluation question examines the desired long-term impact goal of the project when all conditions (activities and outcomes) are in place: To what extent did the project help vulnerable parents move towards long-term social wellbeing and economic independence?

4.5 Evaluation participants

Table 1 presents the key evaluation participants, comprising of project participants, key stakeholders and delivery partners.

Table 1: Evaluation participants and their characteristics

Evaluation participants	Description
Project participants	Vulnerable parents were recruited to take part in the PLAN project across a number of sites: Mandurah, Rockingham, Kwinana and, in later stages of the project, Pinjarra. Selection criteria for inclusion in the project included parents who were experiencing or were at risk of experiencing adverse circumstances, including FDV, homelessness or housing instability, un/underemployment, mental health issues and significant relationship or financial issues.
Key stakeholders	Key stakeholders for the project included staff from service provider agencies who referred participants to the project.

PLAN staff	Key staff members (e.g. PLAN mentors) from BTG who helped recruit, mentor and deliver on-going support throughout the project.

4.6 Data collection methods

For both the process and outcomes evaluation, project participant data was extracted from the data sources presented below in Table 1.

Table 1: Primary data sources and characteristics

Data source	Description	Participant (n)
Administrative data	Administrative data contains general information collected about the participants, including detailed demographic data, referral information, Personal Life Plans, priority areas and career readiness. General information is also collected about the project including attendance, assistance provided, and funding provided. Activity work plan reports are completed monthly using administrative data, containing descriptive and quantitative updates of the project, along with participant testimonials and Good News Stories. Updates include: • Recent intakes and exit numbers; • Non-vocational and vocational barriers; • Type of support provided by the project; • Numbers of job-ready participants; • Changes to the project; and • Challenges faced by the project.	Project participants
Domain assessment forms	Domain assessment forms reveal the status, strengths and risks of participants within different life domains, providing a useful basis for discussion in mentoring sessions. The PLAN mentors utilise the same assessment form during participants' initial assessment, three-month review, and case closure with participants. This ensures consistency and allows for mentors to capture and track the progress of participants through the project. Embedded within the assessment form is a Common Assessment Tool used to assess participants' strengths and risks and inform support	Project participants (n=31) 31 participants completed both the initial and case closure domain assessment form.

	planning.[4] The tool provides an indicator for the status of various life domains during their initial, three-month review, and case closure assessments.	
Participant Exit Surveys	The Participant Exit Survey developed by CSI UWA and hosted on the Qualtrics online platform contains self-reported outcomes, levels of satisfaction, and feedback about the delivery of the project. Specifically, the exit survey helps determine whether the project helped participants build confidence and self-esteem, addressed non-vocational barriers, and increased career readiness. It also investigated project delivery elements that did/did not work well for participants.	Project participants (n=26) 26 participants completed the exit survey.
Focus groups	Focus groups discussions captured participants' experience of the project and outcomes achieved. It offered an opportunity to reflect on the change they have experienced as a result of participation in the project. It also enabled participants to give in-depth feedback on the process of the project delivery. A set of questions was used to guide discussion, and a flexible approach was adopted to capture rich qualitative data.	Project participants (n=14) A total of 14 participants across two separate in-person focus groups: • Mandurah = 8 • Rockingham/Kwinana = 6
Satisfaction forms	"How are YOU doing?" (HAYD) and "How are WE doing?" (HAWD) forms administered by mentors throughout the project to track participants' opinions, confidence and self-esteem levels, and satisfaction with the project.	Project participants • HAYD form (n=50) 50 participants completed both pre- and post-project engagement forms. • HAWD form (n=36)
Self-Esteem Scale forms	The Rosenberg Self-Esteem Scale (SES) has been adopted for this project to help determine the self-esteem levels of participants at both the pre/post stages of the project.[5] The SES presents a list of statements which guide participants to assess their overall opinion of themselves, their abilities and any limitations they may feel.	Project participants (n=49) 49 participants completed both pre- and post-project self-esteem scale forms.

[4] The State of Queensland (Department of Child Safety, Youth and Women), 2018. *Youth Wellbeing Assessment Common Assessment Tool (CAT) Guide*. Brisbane.

[5] Rosenberg, M. 1989. *Society and the Adolescent Self-Image*. Revised edition. Middletown, CT: Wesleyan University Press.

Semi-structured interviews	Semi-structured interviews captured insights around the change experienced by participants from the perspective of key stakeholders and project mentors, including those in referral organisations. Information and learnings about project activities and limitations were also captured in these interviews. The service providers interviewed were two child health nurses; a clinical nurse; a family support worker; a community outreach worker; a financial counsellor, and a police officer.	Key stakeholders (n=7) 7 stakeholders from service provider agencies were interviewed online. Delivery partners (numerous across the project life cycle)

4.7 Data analysis and interpretation

4.7.1 Quantitative data

Data collection tools informing quantitative analysis include:

- Administrative data;
- Domain assessment forms;
- Participant Exit Surveys;
- Satisfaction forms; and
- Self-Esteem Scale forms.

Administrative data

Descriptive statistics collected as part of the project's ongoing management and operations around project engagement, demographics, priority issues, funding assistance, training assistance and employment numbers have been summarised in the report.

Domain assessment forms

Results from the Common Assessment Tool embedded within this form has been analysed to inform project outcomes. The self-reported tool asks 'how participants are doing' within 14 different life domains, allowing them to assess their position using a scale from 1 to 5 (e.g. for financial situation domain, 1 = financial hardship and 5 = financially secure). Given the array of different domains assessed, it is important to note that each scale varies in wording but generally, a score of 1 means they are in need of assistance whereas a score of 5 means they are tracking very well and are not in need of assistance in this given domain.

As each participant engages in support activities relevant to their own personal situation, for the purpose of this analysis, participants who assess 1 to 3 in any domain were tracked throughout the project. Defining priority domains minimises any positive skew towards no change, as participants that were not receiving assistance in selected domains were excluded.

Domain assessment forms were delivered at initial, 3-month and case closure time points during the project. Descriptive statistics summarise the change experienced from initial to case-closure within all domains for participants who have indicated that they wanted to work on these domains as a matter of priority. As a cohort, findings include the average score change for participants in all

domains. At an individual-level summary data around the relative frequencies of participants who experienced positive, negative or no change in each domain is provided.

Participant Exit Surveys

The exit survey provides a post-project measure for participants to provide feedback on the project and any outcomes achieved as a result of the project. Findings include a summary of responses to Likert scale measures relating to various project components and anticipated outcomes.

Satisfaction forms and Self-Esteem Scale forms

Findings include a pre-post analysis of confidence and self-esteem levels to observe any differences as a result of the project's intervention. Satisfaction levels during their time in the project with various components of the project are also summarised.

4.7.2 Qualitative findings

Data collection tools informing quantitative analysis include:

- Focus groups;
- Semi-structured interviews; and
- Participant Exit Surveys.

Focus groups, semi-structured interviews and exit surveys

Thematic analysis was used to analyse themes and patterns using focus group notes, transcribed interview data and open-ended survey questions to draw out relevant evaluation evidence, learnings and findings.

4.7.3 Limitations

Limitations exist when considering the availability of outcomes data at the time of data collection for reporting, as some participants have been excluded from analyses due to having missing data (i.e. not yet completed case closure assessments). This reflects current discrepancies in sample sizes for completed domain, satisfaction and self-esteem forms. In particular, limitations to the interpretation of domain assessment form findings include low sample sizes when only considering the priority domains of participants. The approach to defining priority for analysis of domain assessment forms also has its limitations as this report assumes that low scores (1 to 3) translates to level of need. Additionally, low response rates for Participant Exit Survey has been attributed to the difficulties in engaging participants once they have left the program and the naming of the survey – later named as the Participant Progress Survey for the ease of participants and to encourage higher response rates. Not all survey participants answered every question, and where the number of question respondents is less than the overall number who completed the survey, this has been noted in the interpretation of results in Sections 5 and 6.

Given the individualised nature of the program's model to support participants at various levels of engagement and need, limitations also exist in the timing of data collection. This can be attributed to the varying time it may take for participants to achieve their personal outcomes (goals) and subsequently undertake case closure assessments. This reflects differences in three-month and case-closure assessments revealing that some participants were able to achieve their personal outcomes within three months of entering the program.

5. PROCESS EVALUATION

In this section we assess the operational effectiveness of the PLAN project in terms of its inputs and processes. To do this, we compared our findings against the program model and Theory of Change to understand how the project may or may not be fulfilling its aims and operating with functional integrity. This approach is broadly known as process evaluation.

Data sources used for the process evaluation were:

- BTG administrative data;
- Participant Exit Surveys;
- 'How are WE doing?' forms;
- Focus groups; and
- Stakeholder interviews.

The remainder of this section will explore the process evaluation questions presented in Section 4. We also explore the key factors that mediated the success of the activities and support provided by the PLAN project, to understand the 'how' of effective project delivery.

5.1 Success of project recruitment

The PLAN project intended to recruit and support vulnerable parents who were experiencing, or were at risk of experiencing, adverse circumstances, including FDV, homelessness or housing instability, un/underemployment and significant relationship, financial and/or psychological issues.

In total, the PLAN project recruited 118 parents experiencing at least one of these markers of vulnerability – often several or all of them – but not all of these individuals remained in the project. Reasons for disengagement or non-engagement are explored below in Section 5.2. In this section, we explore more generally the methods of project recruitment which attracted the project's target audience, as well as the gaps in recruitment which may have 'missed' subsections of the community.

Examination of the PLAN project database revealed that the individuals recruited by the PLAN project included people with the following characteristics:

- Single parents;
- Parents in a partnership;
- Parents experiencing or who had experienced FDV or a coercive intimate relationship;
- Parents experiencing or who had experienced diagnosed or undiagnosed mental health issues, including depression, suicidal ideation, anxiety and PTSD;
- Parents who were experiencing physical health issues or suspected brain injury;
- First-generation immigrants, often living in social isolation;
- Parents identifying as Aboriginal or Torres Strait Islander;
- Parents of children with diagnosed or undiagnosed disability and/or mental health issues;
- Unemployed or under-employed parents;
- Parents experiencing housing instability, or who were living in a refuge and/or at risk of homelessness;
- Parents who had experienced an adverse childhood experience (ACE);
- Parents who were struggling with life circumstances and relationships generally, and/or who were experiencing loneliness;
- Parents who had little or no access to their children; and
- Parents receiving NDIS or other social support payments.

5.1.1 Demographic characteristics of participants

Location

Of the participants who enrolled in the project after being referred (n=84), 46 were enrolled in Mandurah and 30 were enrolled in Rockingham and Kwinana. The PLAN project also conducted one outreach day per week in Pinjarra from April 2022, in which office space of a local service provider was used for one-on-one mentoring appointments for an additional 8 participants. However, most of the Pinjarra participants did not engage in other PLAN activities due to transport barriers. Mandurah and Pinjarra participants together comprised 64% of PLAN participants, and Rockingham and Kwinana comprised 36% (see Figure 3).

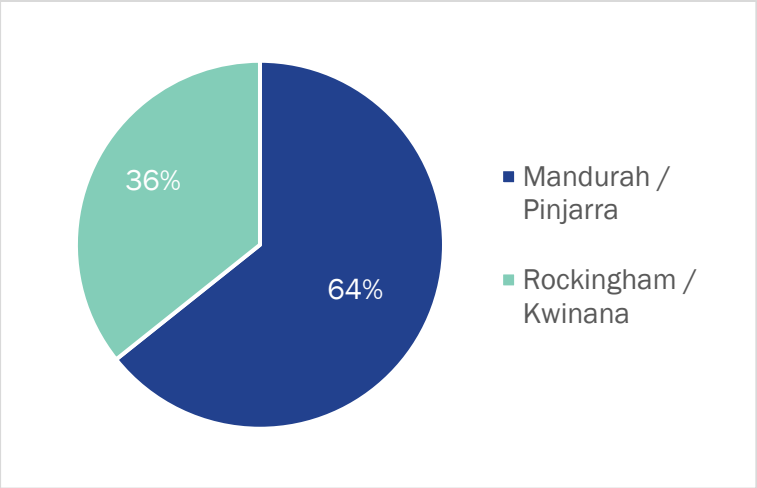

Figure 3: PLAN project enrolment locations (source: BTG administrative data)

Gender and age

Ninety per cent of enrolled participants (76) were female and 10% (8) were male (see Figure 4). The majority of participants were in the 25-34 age range (33 participants) and the 35-44 age range (29 participants). Twelve participants were in the 18-24 age range, ten were in the 45-54 age range and there were no participants above the age of 54 (see Figure 5). The men who enrolled in the PLAN project experienced a number of aspects of vulnerability, including, in some cases, FDV. Based on conversations with project mentors, it was evident that men are often 'missed' in understandings of who FDV affects; several examples were provided of males who had been referred to, or had engaged with, the PLAN project and were experiencing serious and sustained psychological abuse from current or former partners. The 'downstream' effects this had on housing, finances, mental health, and relationships with children were significant.

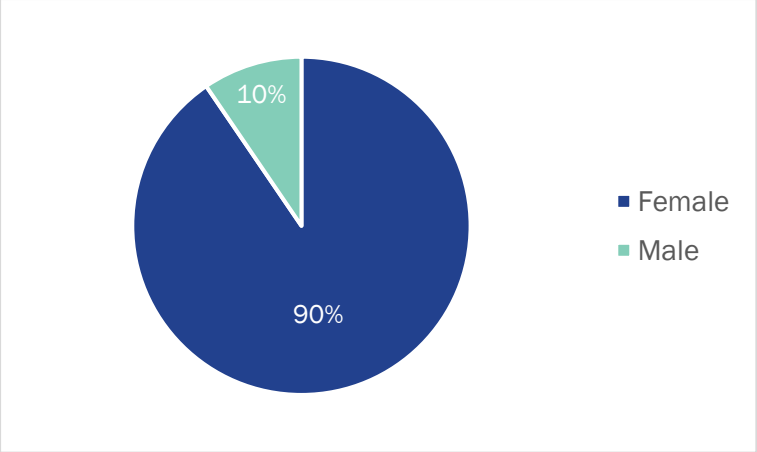

Figure 4: Gender of enrolled participants (source: BTG administrative data)

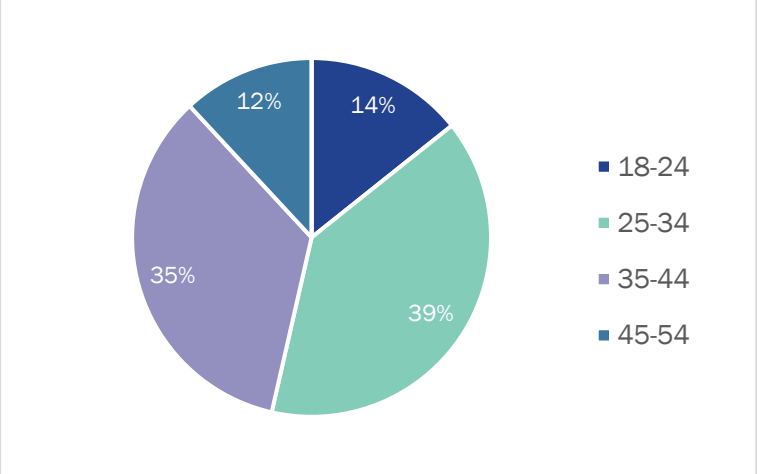

Figure 5: Age of enrolled participants (source: BTG administrative data)

Cultural background and carer status

Most enrolled participants were born in Australia (73%) or New Zealand (10%), and 17% were from other countries, i.e. identifying as being from culturally and linguistically diverse (CALD) backgrounds. These countries were: Chile, Ireland, the United States, Zimbabwe, Sierra Leone, Malaysia, Bali, Ethiopia, the Philippines, Vietnam, Malaysia, India and Poland. Ninety per cent of participants spoke English as their main language. Twelve per cent identified as Aboriginal or Torres Strait Islander (ATSI), 6% had a disability and 10% were carers (see Figure 6).

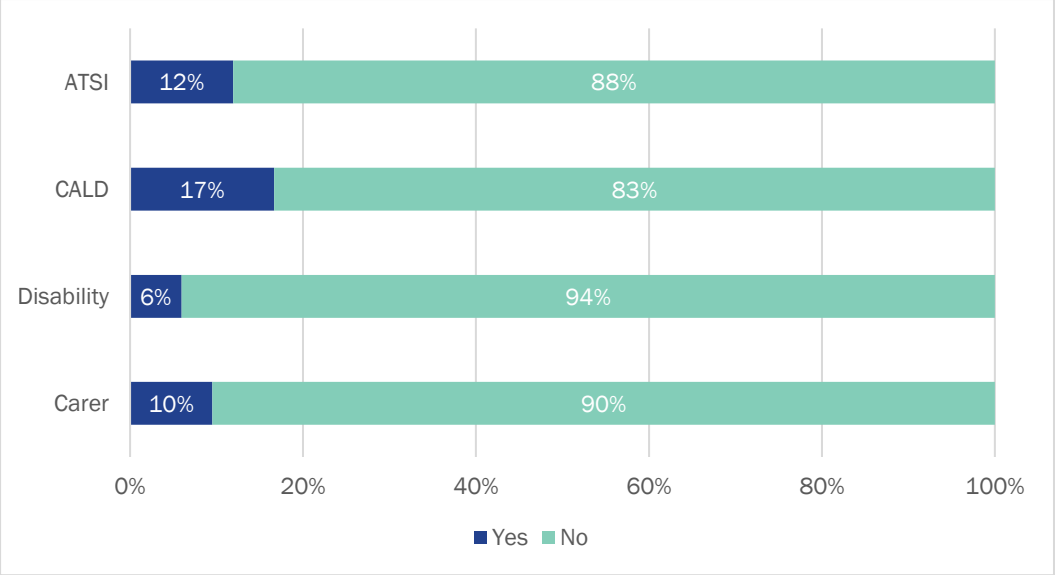

Figure 6: Cultural background and carer status of enrolled participants (source: BTG administrative data)

Household composition

Seventy per cent of enrolled participants were single parents with primary caregiving roles (see Figure 7). An additional 4% were single parents with access to children (i.e. had visiting rights or a shared parenting arrangement for children with a former partner), and another 4% were single parents with mixed or no access to children (i.e. were denied access by their partner to at least one of their children). Thirteen per cent of participants were partnered and 10% were married.

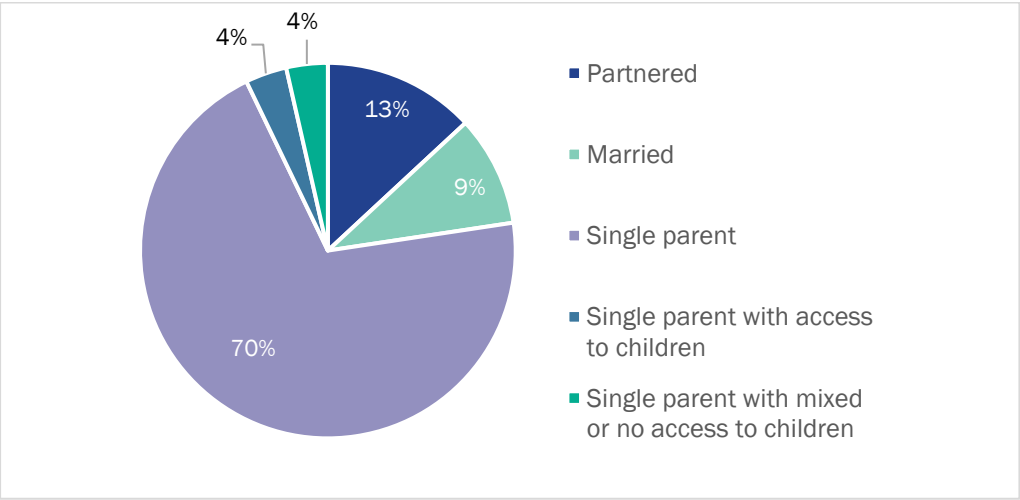

Figure 7: Household composition of enrolled participants (source: BTG administrative data)

Educational attainment

The highest level of educational attainment among enrolled participants varied considerably. Most participants had either completed Year 10 (19%) or a Certificate III (18%) as their highest level. For 8% of participants it was Year 9, for 11% of participants it was Year 11, and for 13% it was Year 12. Seven per cent of participants had completed a Certificate IV as their highest level, and 8% had completed a Diploma. The highest level of educational attainment for remaining participants was Year 6 (one participant), Year 8 (one participant), Certificate II (one participant), an Advanced Diploma (one

participant), a Bachelor's degree (3 participants) and a Master's degree (2 participants). There were four unknown cases.

Employment status

At the time of commencement in the PLAN project, the majority of enrolled participants were unemployed (79%). Seventeen per cent were employed casually, 2% were self-employed, and 2% were taking a break from employment (see Figure 8). The main income source for most participants (88%) was government payments (e.g. Centrelink). Wages were the main income source for 6% of participants, a partner's wages for 5% of participants, and one participant cited savings as their main income source.

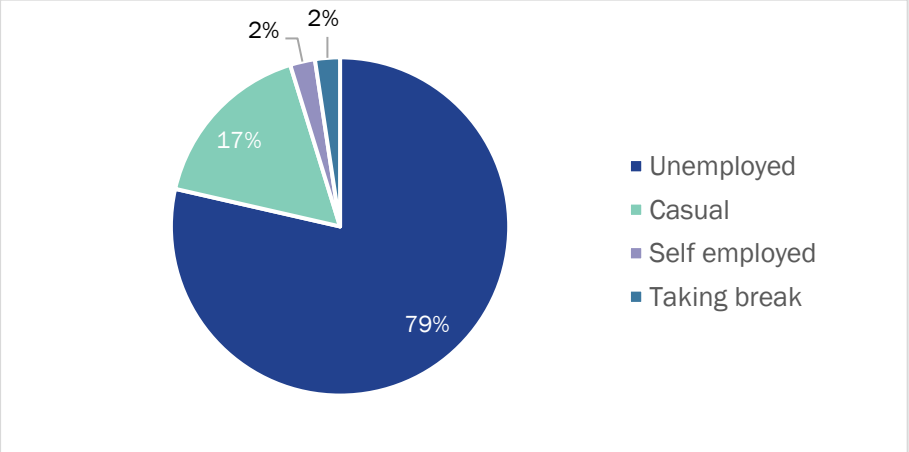

Figure 8: Employment status of enrolled participants (source: BTG administrative data)

Homelessness indicators

Figure 9 presents the homelessness indicators for the enrolled participants. Twenty-nine per cent presented with a homelessness indicator, i.e. they were sleeping rough, couch surfing, or living in unstable accommodation. A further 6% were living in a refuge at the time of commencement with the PLAN project. Moreover, thirteen per cent were at risk of homelessness. Over half of the enrolled participants (52%) were not experiencing, or were not at risk of experiencing, homelessness at the time of commencement with the project.

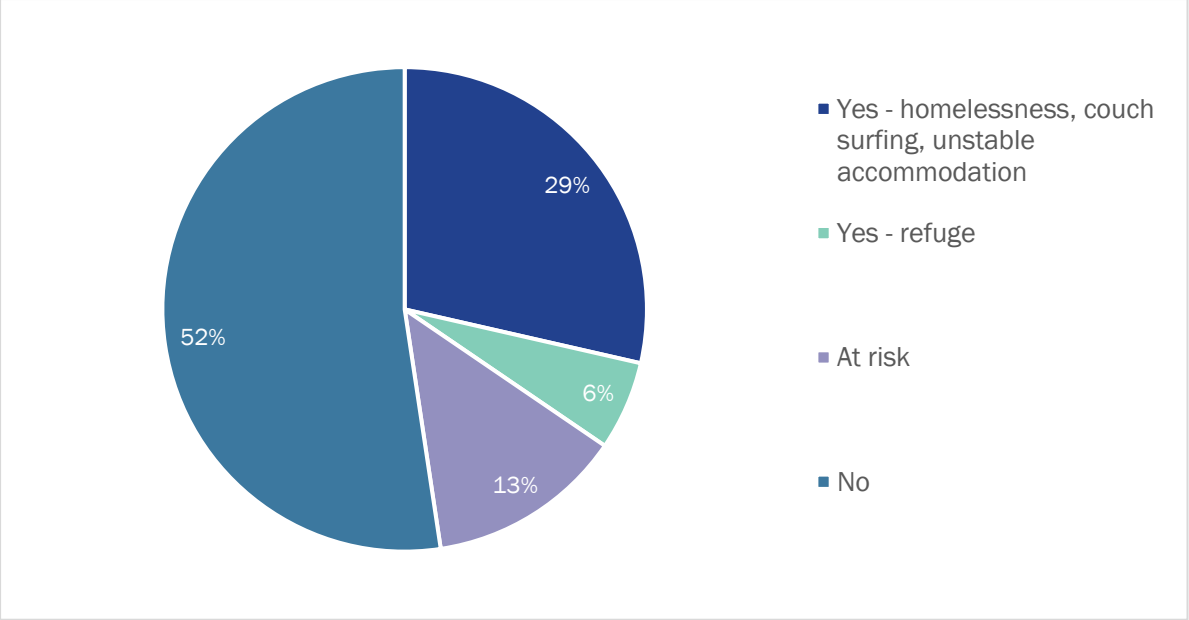

Figure 9: Homelessness indicators for enrolled participants (source: BTG administrative data)

5.1.2 Methods of recruitment

Administrative data revealed that PLAN recruited clients through the following referral pathways (see Figure 10):

- Self-referral (7%)
- Referral from a women's centre, family centre or FDV support service (28%)
- Referral from a child health centre or nurse (18%)
- Referral from youth support service (4%)
- Referral from a refuge (8%)
- Referral from a mental health service (1%)
- Referral from a clinical nurse (1%)
- Referral from a jobs and skills centre (2%)
- Referral from a child contact centre (8%)
- Referral from other community services provider (20%)
- Referral from a government department or program (3%)

This represents all recruited individuals (n=118), not all of whom engaged in the program. Focus group data revealed that participants who self-referred either discovered the project through a friend, through seeing a flyer, or in one case, by walking into the BTG office during a conflict with a partner.

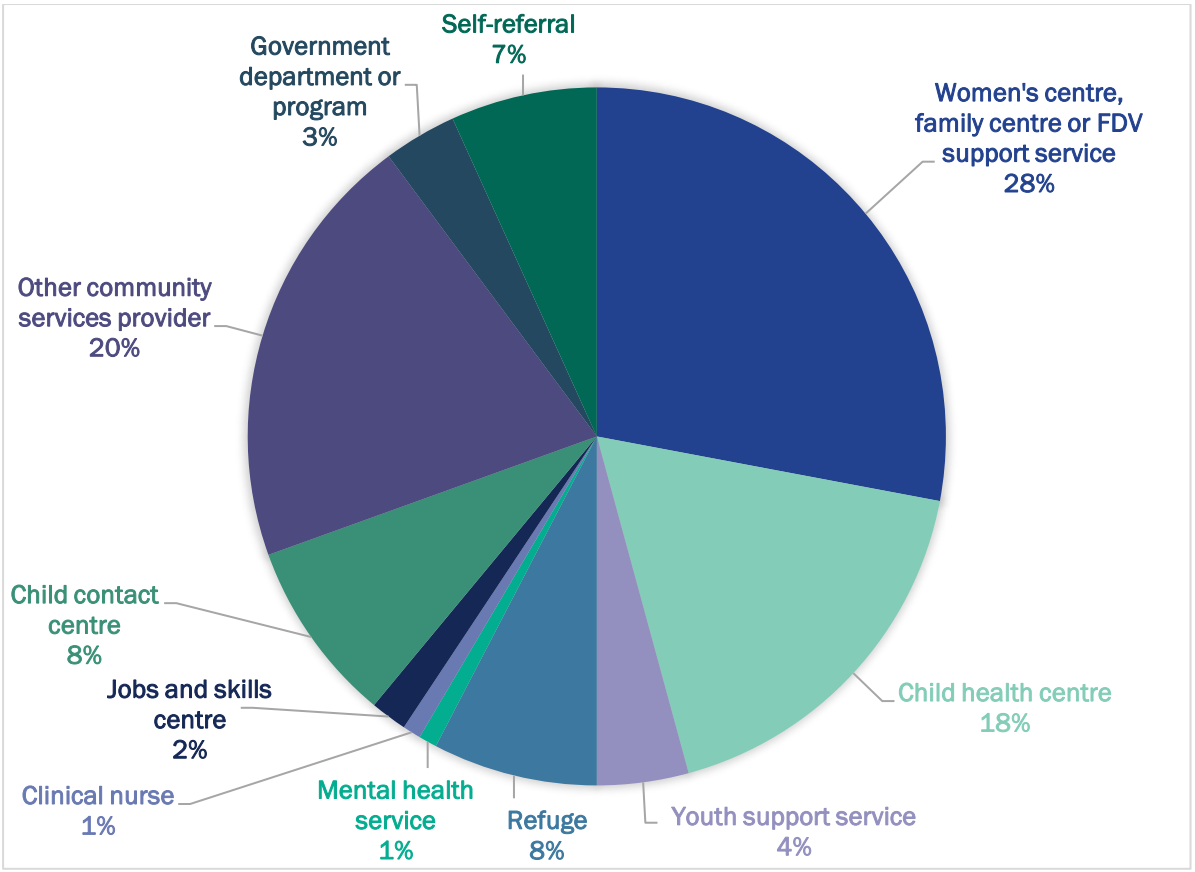

Figure 10: Referral pathways for enrolled participants (source: BTG administrative data)

It is likely that many PLAN participants would not have known about the project had it not been for referrals from local service providers. Several focus group participants commented on a wider lack of knowledge and awareness around support options for the type of people that the PLAN project assists, and most focus group participants agreed that this was a problem. They indicated that many vulnerable individuals simply do not know where to go, who to ask, or what their options are when it comes to escaping FDV (in particular) and making steps to independence and wellbeing. This suggests that referrals from other services are a vital part of recruitment for the PLAN project, and also that other methods for recruitment may be necessary to broaden the scope for engagement among other vulnerable parents in the area who are not already in contact with services.

The role of trust with a referring service provider appeared to be an important factor in individuals feeling able to join the PLAN project. Where a client had a positive relationship with a service provider and trusted their judgement, they seemed more willing to accept their referral to the PLAN project and begin engagement, even if it did not last.

> *"[I'll say to a client] 'I know PLAN and I can speak really positively about PLAN' and the client might be like, 'OK, yeah you're telling me [and] I trust you about this thing so I feel safe to access it' and then they link in with PLAN and then PLAN have their fingers in a lot more different pies" – Service provider*

5.1.3 Benefits and limitations of recruitment

The perceived uniqueness and value of the PLAN project in terms of being emotionally supportive, action-oriented and holistic was attractive to the participants we spoke to in the focus groups, and this

gave it a point of difference which helped to recruit many vulnerable individuals once they became aware of it. In the context of a lack of comparable support options in the Peel region, the participants stated that the PLAN project was extremely attractive and provided a sense of hope, at the very least, almost immediately. For some individuals it was 'easy' to join the PLAN project, in the sense that they had no or few barriers to doing so, or the barriers were easy to overcome. For others it was more difficult, for example due to needing to make an excuse to leave the house (if they were in a controlling FDV relationship), not feeling mentally well enough to leave the house, or not otherwise feeling able or ready to make changes in their life. Regardless of where they were on this spectrum, crossing the threshold into the PLAN project seemed to be a significant practical and symbolic milestone for all of the participants we spoke with for the purposes of this evaluation:

> *"It gave me hope… It took a lot for me to come here, because of a lot of issues – pride being one of them" – Focus group member*

The fact that PLAN was not advertised as an FDV service, or a service specifically targeting mental health, unemployment or homelessness, was possibly more attractive to PLAN's target audience and helped to recruit participants. The handout that PLAN developed for prospective participants was described as "very safe" by one stakeholder because it did not mention FDV, and several stakeholders suggested that prospective at-risk participants may be put off by a project that was more targeted; possibly in part because of an unwillingness to recognise a problem or seek help, and at other times because of safety issues. Thus, the framing of PLAN as a parenting project was potentially very significant for recruiting the target audience:

> *"If they're fearful of their partner, they will be fearful of the partner finding out that they're talking to anybody… [it's] fantastic it's not advertised as an FDV project. It's a family project… all of the other FDV things out there are very clearly for FDV and would be very confronting if anything was found on their phone or on paper" – Service provider*

However, stakeholder interviews indicated that there were some subgroups of the community who were not being reached. Two stakeholders commented that more regional communities in the Peel region were being 'missed', for example Waroona and Boddington, where FDV was prevalent and unmet need among vulnerable parents and their children was high. In these communities in particular, stakeholders indicated that there was potentially a greater unwillingness to engage with support services and a more 'behind closed doors' feeling in the community.

In the case of FDV, which "strips away the client's capacity to do things" as one service provider reflected, the ability to engage with services and supports such as PLAN was compromised – more so when additional barriers such as location, lack of transport, stigma, and mental health issues existed. The stakeholders who mentioned these barriers, including service providers who saw their prevalence and impact during home visits and client sessions, raised concerns over unmet need among some community members who would benefit from PLAN's support. This suggests that although the PLAN project does reach its intended target audience successfully in many instances, issues of project scope and capacity, combined with barriers to service access, mean that many vulnerable parents are not being reached. This is explored further below.

5.2 Engagement data

There were a number of participants who disengaged from the PLAN project early on, or who never engaged after being referred into the project. Of the 118 participants recruited (i.e. referred) to the project, 34 never engaged (29%). Of the 84 who enrolled (71% of recruited participants), 3 withdrew from the project, and 21 were exited by project staff due to disengagement. Eighty per cent of enrolled participants (67 in total) took part in targeted support activities. Of these, 31 participants (37% of enrolled participants) achieved case closure (i.e. they achieved their personal outcome/s) and 19 participants (23% of enrolled participants) completed and exited the project after completing their personal outcome/s (see Table 2). Of the 21 participants who were exited by project staff, 17 were exited due to being uncontactable, 3 moved away from the area, and one was exited for health reasons.

Table 2: Engagement data (source: BTG administrative data)

Engagement stage	n	% of recruited	% of enrolled
Recruited	118		
Enrolled	84	71%	
Never engaged	34	29%	
Exited by project staff	21		18%
Targeted support activities	67		80%
Case closure	31		37%
Project completion	19		23%
Withdrew from project	3		4%

Note: There were a number of participants who were near project completion at the time of data collection

Most service providers interviewed had clients who they had referred to the PLAN project but who had not engaged in the project despite high need, and not all stakeholders could explain why. One service provider stated that she had referred approximately fifteen clients to PLAN, and most of them did not engage (but some had engaged and had positive experiences). Another service provider had referred three clients in total to PLAN, and of those three, two disengaged early on and one did not engage at all, prompting her to cease client referrals for a period until recently when she felt one of her participants was "ready" (see Section 5.8).

Several indicative reasons for non-engagement and early disengagement were provided by interviewed service providers:

- Mental health issues including anxiety and depression;
- Confidence was too low to engage;
- Lack of motivation and self-worth to follow through;
- Participant felt they were being pushed towards employment too soon;
- Transport barriers – too far to travel and no transport available;
- Feeling trapped by a controlling relationship;
- Participant had too much going on in their lives;

- Participant was simply “not ready”;
- Other barriers such as childcare obligations; and
- Recently becoming a new parent and therefore having no “mental space”.

Participants feeling overwhelmed and like they had too much going on to engage with the PLAN project was not uncommon. Some stakeholders said that they had clients who would have benefitted from the project but their priority was coping with the day-to-day survival of FDV and making ends meet, or supporting a newborn child, and engagement with the project did not feel practicable for them. Often, this coincided with poor mental health and low confidence which compounded reticence to engage or take action:

> *“Lots of referrals and lots of things you do, the parents just never get to that first step of actually helping themselves… If I can get them in there [to the PLAN project], they seem to be really loving it. It's just, you know, getting them over that little step of getting them in there” – Service provider*

> *“To actually initiate this project is a struggle for a lot of [my clients] and I had some that I thought would so benefit from this project, but they would just say ‘Not yet, no, I'm not ready for that’” – Service provider*

> *“I have quite a few clients with FDV and they’re just existing, they're just keeping their head above the water. And so, whilst this might be a project that would be great for them, they're just trying to keep themselves safe and that's their priority. [They don’t yet] have the mental capacity to start thinking about themselves” – Service provider*

However, the overwhelm of being in ‘survival mode’ and having multiple, urgent needs was also a strong reason why many participants *did* engage and continue their journey with the PLAN project and go on to achieve positive outcomes. This is a reflection that there are certain variables beyond the control of the project, and that the ‘ideal participant’ cannot always be successfully recruited even if they fit the criteria. Although the evidence collected for this evaluation indicated that the sequencing of activities and supports at PLAN guided participants appropriately and effectively to achieve positive outcomes, several barriers to engagement prevented many referred participants from progressing.

Transport was a notable barrier to engaging in the project and this was raised by multiple stakeholders, particularly for individuals located outside of Mandurah and Rockingham. Many service providers’ clients needed the support of the PLAN project but were unable to get to Mandurah, Rockingham or Pinjarra if they did not have a car/could not drive, were not located within walking distance, or public transport was not possible. Even where public transport was an option, the time taken to navigate busses and cater to the needs of their children was a barrier for some people. Logistical barriers, such as transport and the location of services, including possible outreach services, is thus an important consideration:

> *“Transport probably would be the one barrier that I would identify… for my clients [with] social anxiety, it's just one more reason for them not to go” – Service provider*

5.3 Meeting the needs of participants

Given the breadth of experiences and characteristics of parents in the PLAN project’s target audience, participants often entered with high levels of unmet need. Data across multiple sources indicates that many needs were met for participants who engaged in the project, including needs which they were not necessarily cognisant of or ready to address at the time of starting the project.

The main domains that participants who enrolled in PLAN (n=84) reported seeking help with at the time of commencement in the project were: mental health (77% of enrolled participants); financial hardship (73% of enrolled participants); FDV (62% of enrolled participants); employment (55% of enrolled participants); housing (50% of enrolled participants); self-development (49% of enrolled participants); and education and skills training (11% of enrolled participants) (see Figure 11). Many participants also required assistance with other issues (e.g. legal assistance and learning to drive) however this is not captured in the quantitative data.

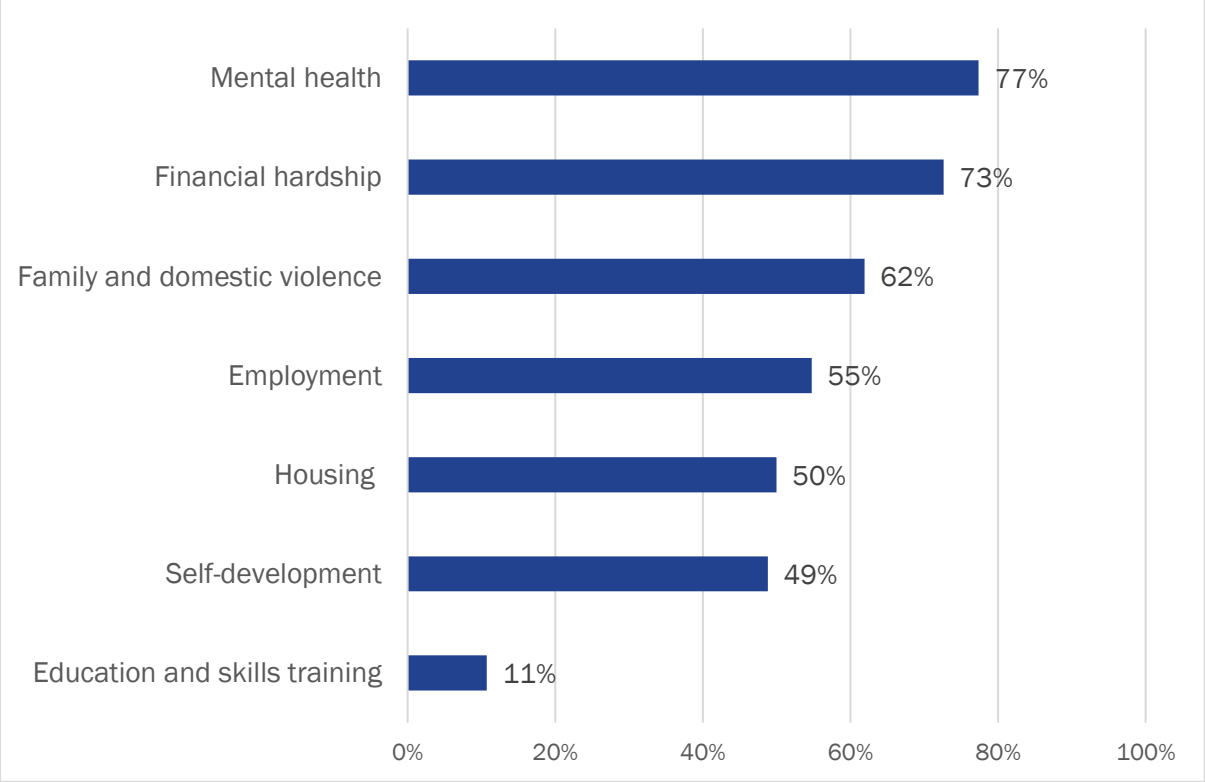

Figure 11: Priority areas that enrolled participants sought help with (source: BTG administrative data)

Note: Multiple responses permitted

Many individuals recruited to the PLAN project had a complex history of traumatic and destabilising circumstances. In the focus groups, the most common combination of experiences among participants was: being a mother; experiencing or having had experience of FDV and attempted or sustained separation from an abusive partner; experiencing or having had experience of mental health issues and some level of trauma; and experiencing or having had experience of employment and/or housing instability. In the focus groups, many participants did not talk freely about the mental health issues that they were currently experiencing, or had experienced in the past, and a certain degree of inference was required during the research process (e.g. by picking up on some of the cues and indications in how people talked during focus groups). Sometimes certain experiences were mentioned briefly in passing, as if eclipsed by other more front-and-centre issues being experienced at the time.

Participants' lives often changed rapidly in response to job, housing and relationship insecurity, and for some participants it appeared they had reached 'breaking point' when they joined the PLAN project. Many focus group participants articulated how, in this context, that they felt overwhelmed, confused, and unable to move forward. In many cases severe mental health distress was also present. Other participants had already made some changes in their lives before they joined the project, for example escaping FDV and moving to a refuge, while others were in the throes of FDV and unable to see

possibilities for the future. Parents therefore joined the project at different stages in their journeys and with different needs. All of them were vulnerable, but some were recruited further on in their journey towards stability, independence, safety and wellbeing than others.

Participants often had a range of additional non-material needs which were not being met, including those identified in Maslow's hierarchy of needs, such as belonging, esteem and self-actualisation needs (Maslow, 1943). The extent of PLAN's ability to meet the needs associated with the three target areas of mental health and self-development, career development and improved life circumstances is explored in more detail in Section 6. Overall, the evidence points to a strong ability of the PLAN project to meet needs in each of these areas.

"[I realised there were] different avenues… I came in for one thing then I realised there was more" – Focus group member

---

It is significant that many participants came to the PLAN project with one idea about what they might achieve through the project – or even without a clear idea of what they wanted or needed – and exited with something different or unexpected. In all cases, this was perceived positively by participants. The unexpectedness of the support received, the actions taken, and the outcomes achieved, often in a time frame that was shorter than anticipated, boosted confidence and optimism among many participants. This is particularly beneficial in the context of FDV victims who may be experiencing mental health issues and trauma symptoms which affect cognitive function, including the 'learned helplessness' phenomenon explored in the literature review. Having an 'advocate' to help achieve goals by anticipating needs and assisting with practical steps was a powerful aspect of the project. It was evident that many participants came to the project overwhelmed, confused and with little hope for the future, particularly for participants experiencing FDV or participants who had immigrated to Australia from another country. Some appeared to have been let down by the public service system and had little fighting energy left, and there was generally a high incidence of loneliness and disconnection.

Identifying the individual needs of participants allowed progress to be made quickly. Pivotal to this was the mentors' ability to understand what participants might be going through at a material and psychological level (which was often possible through the mentors' own lived experiences of issues such as FDV); recognising possible needs, even when they were not overtly stated; and responding to the complexities and uniqueness of every individual case. This allowed mentors to create a workable and individualised plan with appropriate steps in which participants were "not set up for failure", as one focus group member put it:

> *"When you think about a parent that's had a really troubled start to life, they just really don't know where to start and if they've got that [PLAN mentor] there, that's all they need to just get them started and give them some kind of a direction and motivation… Giving them a phone number is not really helping. They are the ones that need hand holding the most because they are quite swamped with the emotional, negative spiral of domestic violence" – Service provider*

The expansion of awareness and options among participants was a major aspect of the efficacy of the PLAN project in helping to meet participants' needs, reflecting the fact that often an individual's actions and choices are constrained by lack of knowledge of the options available, as well as barriers posed by mental health difficulties. Broadening a participant's awareness of options and introducing to them the tangible possibility of achieving different outcomes seemed to improve many participants' outlooks almost immediately, even before actually experiencing those material outcomes:

"It felt exciting… like I could get the ball rolling with my life. You go in with one thing but she's like, 'there are other options here'" – Focus group member

*"She asked me: 'What do **you** want?' Nobody's ever asked me that before… It was a life-changing moment. I just broke down; I don't even know who I am" – Focus group member*

Sequential ordering of action steps helped to meet participants' needs effectively. Participants often commented on the necessity of addressing urgent issues first, and the relief that was provided when these were taken care of. This may have been as simple as paying for a power bill, organising and paying for a learner's driving license, or assisting with an application for NDIS payments. Simple as these things may have been to organise and fund for the participants, they had a significant impact on their lives: payment of bills prevented eviction; obtaining a learner's permit offered steps to independence and freedom for a woman in a controlling relationship; and receiving NDIS payments took some financial burden off struggling parents. Focus group participants reflected that once these things were under control, they could turn to the 'bigger' issues such as escaping FDV, getting job-ready, building confidence and self-esteem, creating a sense of community and becoming more resourceful parents.

Further critical success factors in PLAN's ability to meet participants' needs are explored in Section 5.6.

Service provider perspective

"I've got an example of a mother. I came into the home visit a few months ago and literally the police had just been into the home and removed the father, which was a bit daunting. And she was sort of sitting on the bed and just swamped in her emotional state. And I remember I had to call the police to let them know what was going on and speak to them after the fact. And they started talking about family court. And I said, at the moment she can't get out of bed. She can't. She's just given birth. She's breastfeeding this little baby. And I really can't see her going down to the family court right now. And that's when I referred her to PLAN.

The thing with domestic violence is you often see the cycle of the violence happening and then the parent goes back to the perpetrator, allows that perpetrator back into the home – which is what happened with this mother. But she is much more positive now [after PLAN]. She feels that there's someone there supporting her and she was very grateful.

I think the fact that someone in the community is saying 'I'm here to support you' has changed her. She had no one. She had no family. All her family is in the Philippines. She was saying 'I'm too embarrassed to tell my friends about this'. So she had no one to talk to. And she had five children. So now she's got someone there and she can talk to me and she can talk to PLAN. And she just – you could see the difference in a couple of months… You know, she's got other people supporting her now."

5.4 *Assessing the implementation of activities and supports*

The translation from an individualised needs-assessment to action-oriented support and case management was perhaps the strongest aspect of the PLAN project in terms of producing outcomes. Many focus group members agreed that the 'holistic' nature of the project was its strength, in the way that it provided wraparound support that was individualised and transcended traditional barriers (i.e. participants did not have to "bounce around" between services, as one participant put it). The activities and supports that the PLAN project offered included:

- The creation of a Personal Life Plan;
- One-on-one mentoring sessions;
- Group training sessions;
- Referral to support services;
- Access to brokerage funds for immediate needs; and
- Assistance in developing career-ready skills and gaining employment.

The success of the implementation of these activities and supports is explored below.

5.4.1 The Personal Life Plan

The Personal Life Plan is a physical two-page document created in collaboration with a participant when they commence the PLAN project, with the help of a mentor. In it, immediate-, short-, medium- and long-term goals are developed and listed along with action steps to achieve them and a space for completed goals to be recorded. These are framed as follows:

- An immediate goal *(Something small, simple, easy, I can do in the next 24 hours)*
- Short term goals *(Things I can do over the next few days and weeks)*
- Medium term goals *(Things I can do over the next few weeks and months)*
- Long term goals *(Things I can do over the next few months and years)*
- Completed goals

All participants who completed the Participant Exit Survey (n=26) recorded a positive response when asked about the Personal Life Plan; 7 agreed and 19 strongly agreed that the process of setting goals was useful, and that having goals helped identify their needs. Focus group members described the Personal Life Plan as a foundational part of their journey towards independence and wellbeing: words that were commonly used to describe perceptions of the Personal Life Plan in the focus groups included 'realisation', 'awareness' and 'options', pointing to an important awareness-building and confidence-boosting function.

The Personal Life Plan captured the essential elements of a participant's journey toward economic independence, stability and psychosocial wellbeing, and in many cases, participants had the opportunity to consider options that they previously thought were unavailable to them (or had no knowledge of). For some people this included learning to drive, for others it was enrolling in a training course and gaining meaningful employment, and for others still it was buying a home. Often, building social engagement skills, boosting confidence and self-esteem, and improving mental health were 'by-products' of material goals even if they were not initially recorded as separate goals. The positive outcomes of this domino effect are explored more in Section 6:

"[It's about understanding] you don't have to stay stuck on one line… Realising you weren't stuck in the category your brain put you in" – Focus group member

The strength of the Personal Life Plan was the ability of the mentor to help participants to identify the needs that can "unblock a person and enable them to move forward" in the words of one focus group member. The Personal Life Plan provided the foundation for this, and subsequent mentoring sessions and other activities continued to build on the initial needs-assessment to make tangible progress towards goals. Setting up a plan was powerful in and of itself and for many people it provided the hope that they needed to see the possibility of a viable future.

A valuable aspect of the Personal Life Plan is that it is 'live' and can be updated with new goals and populated with goals that have already been completed. Having a visual record of achieved goals and being able to celebrate these milestones with a mentor, as well as expand the realm of possibility, may be an important reference point for participants to pause, reflect and re-orient with their mentors.

A visual representation of the Personal Life Plan was also created for one participant who was experiencing chronic mental health issues, PTSD, ADHD and severe anxiety, and this was very helpful in helping her to organise her days and work towards goals. An external community services support worker for this participant commented on the value of this visual plan and the difference she saw it making, indicating the potential for different physical formats of the Personal Life Plan to suit diverse needs.

5.4.2 One-on-one mentoring sessions

The PLAN project's one-on-one mentoring sessions provided individualised support and a therapeutic relationship for participants. In these sessions, which were offered on a weekly basis, mentors helped participants to work towards the goals identified in the Personal Life Plan and take positive action. Sessions were tailored to what a participant's needs were at that point in time, and were practically-oriented but also provided emotional support where appropriate. This dual function transcended traditional service boundaries which many participants had, in the past, found frustrating, ineffective and sometimes distressing.

When asked 'Overall, how satisfied were you with your mentor?', Participant Exit Survey respondents (n=26) were all very satisfied (25) or satisfied (1). Twenty-three respondents strongly agreed and three agreed their mentor helped them to set personal goals and develop strategies to meet these. The following quotes reflect participants' perspectives on the mentoring sessions:

"I would never have enough words to express my gratitude to my mentor. I found myself, and she helped me get my wings to fly and overcome the impossible" – Survey respondent

"I love the mentoring experience. I really needed guidance and someone to look up to and know that I am valued and my future can get better" – Survey respondent

"My mentor helped me gain confidence and self-esteem and helped build me up from being in a FDV relationship" – Survey respondent

PLAN project participants often needed someone who provided structured support and guidance in a way that felt personal and genuine. This was affirmed by the stakeholders we interviewed who, on the whole, felt that many of their vulnerable clients needed "someone to hold their hand", as one service provider put it. The participants we spoke to in the focus groups shared this sentiment, saying that they needed ongoing support and reassurance to keep them on track in working towards a better future. Practically, making changes is often overwhelming for vulnerable individuals. The 'hand-holding' aspect

of the mentoring sessions is thus not demeaning but empowering, allowing participants to take positive action and have hope for the future with the safety net and support of a mentor along the way. Many participants already possessed an idea of what they wanted for their future and their children's future, but with little understanding of how to get there or the confidence to move forward. The mentoring sessions provided an essential space for follow-through and clarity.

> *"It was a non-judgmental place to sit and talk and get a result… To arrive fully broken and with nothing, and come out whole… It catered for MY needs, it wasn't a cookie cutter approach. It was versatile and there was always a fast result. You need fast results because you're so desperate" – Focus group member*

Sessions were delivered in a way that enabled this to happen. Because of the individualised nature of the sessions, mentoring could be guided by a participant's goals and the insights of the mentor, including the mentors' expertise and lived experience around the issues that participants might be going through. This meant that mentors could take a lead in identifying and anticipating needs, sequencing actions, and providing the right support. Overall, we found that the mentoring sessions were fundamental to participants being able to achieve and sustain positive outcomes:

> *"It opened up the possibility to get back into the workforce in a job I want to do… [My mentor] is like, 'We can do it and this is how we're going to do it together'. Someone's there going 'You can do it, we can do it'" – Focus group member*

> *"Half of us probably wouldn't be sitting here if it wasn't for [our mentors]" – Focus group member*

5.4.3 Group training sessions

Many PLAN participants came to the project with trauma, extremely difficult life circumstances, low confidence and self-esteem, and few job-ready skills. Additionally, many participants experienced high degrees of social isolation and a lack of positive social supports, often coinciding with shame and few (if any) opportunities to talk to others with similar experiences. For these participants – which were the vast majority of PLAN participants – there was a significant level of unmet need in these domains. In this context, the group training sessions offered by the PLAN project fulfilled several functions which included: facilitating connection and socializing; creating a space for sharing experiences and advice; offering practical training, skills and ways of thinking; and providing an opportunity for emotional support.

Participants were invited to attend group training sessions where appropriate that aligned with the goals identified in the Personal Life Plan. The following group sessions were provided in-house, either facilitated by a mentor or an external facilitator. For the Introduction to Disability Support Training, which comprised multiple mini-courses to get participants job-ready, external organisations were involved in delivering some of the practical trainings. These were funded by the PLAN project.

Table 3: PLAN project group training sessions (source: BTG administrative data)

Course	Duration	Topics covered	Participants
Self-Development Group Training	8 weeks	• Self-esteem • Confidence • Beliefs and values • Goal setting • Motivation • Stress and effects on your body • Interpersonal communication • Emotional resilience • Vision board • Inner child • Personality profiling • Meditation and breathing exercises • Hygiene and personal presentation	37
Introduction to Disability Support Training	8 weeks	• General introduction • Interpersonal and communication skills • Challenging behaviours • A day in the life of a disability support worker • Professional boundaries • Work health and safety • National Disability Standards 1-6 • 13x free online e-Learning certificates, including food safety, best practice in disability advocacy, health and community care, human rights, disability awareness • First aid and CPR training course (external) • Manual handling course (external) • Medication assistance course (external) • NDIS Quality and Safeguard Commission 'NDIS Worker Orientation' module	18
Cooking (Rockingham/ Kwinana)	6-8 weeks	• Basic cooking • Healthy food choices • Measurements in cooking • Pantry checklist • Meal planning	9

Healthy Living Healthy Food (Mandurah)		• Hands on cooking basic foods • Take home foods cooked • Recipe book for participants to keep	
Budgeting	6 weeks	• Managing money • How to budget • How to keep your budget on track • Using cash instead of cards • Planning meals to save money and waste • Having financial goals • Positive daily habits • Saving for a holiday • Handling money • Referrals to financial counsellor (where applicable)	12
Women's Empowerment Project	6 weeks	• Gender equality • Rights • What is sexuality • What is a respectful relationship • LGBTIQA+ diversity, understanding and inclusivity • Sexual health and wellbeing • Bodies • Changes through life: puberty, menstruation & menopause • Sexual health • Contraception • Sexually transmissible infections • Safe sex • What is a sexual health check • Where to go • Consent and communication • Porn and sexting	7

Of the participants who completed the Participant Exit Survey and had attended the PLAN project group training (n=22), 15 strongly agreed that the sessions were helpful, six agreed and one neither agreed nor disagreed. All participants felt the sessions provided a safe space to learn and that they were well facilitated by the trainers. The most common things that survey respondents reported to be most helpful about the group training sessions were: being able to socialize and make friends; a non-judgmental space; having guidance and encouragement; building confidence; sharing lunch together; and hearing other perspectives. One survey respondent commented that "After group training, I leave with a 'can do' attitude", indicating that it helped promote positive action-taking.

Several focus group members said it was powerful to receive insight and perspectives from other people who were experiencing similar things, and that it made them feel less alone, as well as provided them with helpful advice and support. Peer support can offer a unique way for individuals to feel understood and 'seen' in a way that might not otherwise be possible. It also provided a space for meaningful connection which in many cases was an essential form of support, particularly for individuals experiencing high levels of social isolation. This connection function is discussed further in Section 5.6.

> *"It was brilliant. It wasn't all about work – we had breaks, and it wasn't just one-to-one, we were in groups and all helping each other… One-to-one was great, but [the group helped with] being able to see what you need to work on from multiple perspectives" – Focus group member*

> *"You can sit in a room with people who are maybe going through the same things, or can give you a perspective from what they've experienced" – Focus group member*

However, group sessions were not always received well by participants. One survey respondent mentioned the budgeting course was too basic. Some people, particularly in the early stages of their time in the PLAN project, did not feel able to join a group setting due to anxiety, and for others it felt overwhelming when they were already coping with their own problems. One woman shared that her experiences of complex trauma meant that group settings did not feel available or helpful to her and contributed to feelings of overwhelm:

> *"I really needed help on a level where I didn't want to divulge in front of people… At the beginning I didn't want to know everybody else's stuff and problems – I had enough in my head" – Focus group member*

This highlights that peer supported training sessions are not always appropriate for all participants at all points of their journey with PLAN. This understanding is already incorporated in PLAN's model, with no pressure or expectation that participants will utilise every aspect of the activities and supports offered, and we found this to be an important feature of project delivery. Working with participants to build confidence and work towards goals in achievable ways *without pressure* – but with positive encouragement – is an essential part of this. In the above example, the participant shared that she was able to adjust her plan with her mentor in a way that felt less confronting and overwhelming. Another focus group member reflected: "It's comfortable to be here because there are no obligations – it's for you". Thus, flexibility and adaptability to respond to personal experiences and challenges associated with all activities (not just group sessions) was essential, and anecdotally we found that PLAN mentors achieved this well and were able to respond to needs as they arose. A lack of pressure and judgement was mentioned by several focus group members as being important.

5.4.4 Referral to support services

Mentors referred participants to external support services where appropriate and available. This was done in collaboration with the participant based on the participant's needs and goals, including psychological, economic, and material. Examples of referrals made by mentors for participants included:

- Doctor and medical services;
- Child health nurse;
- Dentist;
- Psychologist or counsellor;
- Department of Housing;
- Real estate and rental services;

- Other accommodation services;
- Financial counsellor;
- Driving instructor;
- FDV support services;
- Parenting courses and support groups;
- Legal aid services;
- Daycare or childcare services;
- Holistic healing practitioners; and
- Food hampers and welfare support services.

PLAN mentors were able to help participants access other support services and navigate the service system where necessary, and all participants who completed the Participant Exit Survey (n=26) felt that their mentor helped them to gain confidence to interact with other support services. This holds significance given that many participants reported negative experiences with accessing services in the past, and many had considerable barriers to service access when they joined PLAN. Particularly for individuals experiencing complex vulnerability, simply referring a participant to a service is not always enough to get them 'over the line' to engaging with the service and receiving effective support. Of the participants who had been referred to other support services and completed the Participant Exit Survey (n=23), 30% agreed and 70% strongly agreed that they were referred to services that addressed their needs, and 35% agreed and 65% strongly agreed that they were now better able to access the help they need.

Some focus group participants commented that the relationship they had with their mentor was important for referrals to feel appropriate and trustworthy. Once a relationship was built in which the participant felt known and understood, they were more likely to feel like they could trust their mentor's referrals or suggestions. One focus group participant commented that her mentor "advocated for us and linked us to valuable things". Another participant said, in reference to her experience with referrals made by her mentor: "It was so well done. I'm quite a transparent person but I can't trust people… When it comes to a psychologist I can't just talk to anyone". She felt that her mentor referred her to "the right person" with a warm approach, and this helped her to understand what was going on and what she needed.

The practical assistance that mentors provided in helping a participant to navigate the service system to find the right support was also very important. This was a point of difference in PLAN's approach to service referral; because of the high-contact mentorship model, participants were provided with ongoing support to ensure that service access was achievable and that barriers were removed. For instance, many participants were overwhelmed by the service system and did not have the mental capacity to cope with applications or attend appointments. Where needed, PLAN mentors assisted participants with applications and communication with services, and even at times went to appointments with participants or helped them to physically access the service.

> *"PLAN has been very good, from what I hear, about breaking down the barriers of access to the service, or childcare and just little things like that where people say 'I can't do that, because I've got a child to look after, or I can't drive…'. [The PLAN mentor] has been really good with that" – Service provider*

> *"A lot of the participants have said to me that when they haven't been able to get to the service for any reason, they've supported them to be able to get there, or if they've stopped coming to the service, [the mentor] is quite good at encouraging them back. And I think by referring them onto other pathways with other issues… [the mentor] has been trying to sort those things out as well" – Service provider*

5.4.5 Access to brokerage funds

PLAN participants were able to be supported financially through a brokerage fund that could pay for urgent or important things that participants could not otherwise afford or would have difficulty affording. Examples of things that PLAN paid for included:

- Food hampers;
- Household bills;
- Bed linen;
- Dental appointments;
- Counselling sessions;
- Rental bond;
- Expenses related to moving house;
- Birth certificate;
- Police clearances;
- Working with Children's Check;
- Driving licenses and lessons;
- Chiropractor appointment;
- Podiatrist shoes;
- NDIS screening;
- Work uniforms;
- Emergency accommodation;
- Car repairs;
- Secondhand laptop;
- Glasses;
- Smart rider and top-up;
- First aid training;
- Manual handling training;
- SIM card and phone data;
- Internet;
- Laundromat expenses;
- Baby formula;
- Fuel vouchers to attend appointments;
- Nappies;
- Crèche and childcare fees;
- Textbooks for children;
- Children's clothing;
- Gap fee for child's psychology appointment;
- Fuel to attend training course;
- Professional clothing for court appearances and interviews;
- Vehicle inspection;
- Car battery; and
- Cleaning products for own business.

Access to brokerage funds was an essential and highly regarded aspect of PLAN for many participants. Of the participants who completed the Participant Exit Survey and had received financial assistance (n=23), 91% found the financial assistance very helpful to their financial situation and 9% found it helpful. Focus group participants reported feeling grateful that immediate needs could be taken care of through the provision of financial (and logistical) assistance. This lifted some burden which allowed

other goals to become more achievable, and for participants to feel less overwhelmed by financial hardship. Often, this overwhelm and strain was an aspect of being caught in an abusive relationship where economic control and dependence made it difficult for people (mainly women) to pay for the things that they needed for their own welfare and independence, and for the welfare of their children. Sometimes this included 'essential' items for basic security and wellbeing (e.g. food and household bills), other times they were things which unlocked further opportunities (e.g. a driving license, a SIM card and professional clothing for court appearances). This was the case for participants experiencing FDV and those who were not, particularly where the threat of eviction or worsening mental health was present.

In all cases, the main function of the brokerage fund which seemed to appeal most strongly to the PLAN participants we spoke with was that it *enabled* them to do other things. Once basic, immediate concerns were taken care of, attention could be turned to the 'bigger' things, i.e. medium and long term goals, through which stability and wellbeing could be achieved. Immediate financial assistance lifted significant burden from PLAN participants and allowed them, where possible, to focus their energies on creating a secure financial future with the guidance of their mentor and other PLAN activities.

Part of this effect was that it "enabled control" for individuals. This happened in two key ways which the below quotes illustrate:

> *"I didn't have to justify to my partner why I spent money getting a driving license..." – Focus group member*

> *"First of all there is shame, like when the power is about to be cut... but a barrier is lifted when the power bill is sorted. It enables control" – Focus group member*

Thus, one aspect of control was gaining more independence in a FDV relationship – which could position an individual well for exiting that relationship safely – and another aspect of control was gaining a sense of 'control over' a seemingly out-of-control and stressful financial situation. Multiple women in the focus groups emphasised that barriers were lifted by finance, and this opened up opportunities which had a positive knock-on effect in multiple areas of their lives; success begets success.

> *"The pool of funding is so broad and so diverse to meet these really diverse needs of these [parents], where other organisations don't have that diversity of funding. And so when these immediate and legitimate needs [have] costs that can be covered – like 'Oh, I've got mental health [issues], but I can't afford a psychiatrist for an assessment...', PLAN could potentially fund that. They've just got this broad access to funding and that really helps participants have their immediate needs met so that they don't have to focus on those. [Then they can say] 'Ohh now I can let go of that, my rent is paid... and OK they've helped me budget and now I can keep on top of that, and OK what's the next thing for me? What's the next thing?' So the funding really helps just that it's broad" – Service provider*

5.4.6 Assistance in developing career-ready skills and gaining employment

Building on the success of the Career Readiness for Young Parents (CRFYP) project run by Bridging the Gap previously, PLAN helped to build participants' readiness for gainful employment in the workforce. Mentors worked with a participant to identify opportunities, recognise and overcome barriers, and work towards a suitable level and type of employment. As outlined above, the removal of barriers was one

of the most influential factors in a participant's progress in any domain, and PLAN incorporated this understanding into the project model by recognising, recording and responding to vocational and non-vocational barriers to employment.

Vocational barriers to employment included:

- Lack of skill, training or knowledge;
- Low educational attainment;
- Poor English proficiency;
- No employment history; and
- Unrecognised qualifications (e.g. overseas).

Non-vocational barriers to employment included:

- Experiences of FDV;
- Mental health issues;
- Low confidence and self-esteem;
- Housing issues;
- Transport issues;
- Physical health issues;
- AOD and addiction issues;
- Lack of suitable clothing;
- Incarceration or possessing a criminal record;
- Childcare issues;
- Poor social skills; and
- Potential reduction or loss of Disability Support Pension.

We found that PLAN was able to effectively address most of these barriers, and in some cases remove them completely, to help participants obtain and sustain employment. Vocational barriers were addressed by: working with a participant to identify their strengths; broadening a participant's awareness about career options; helping to enrol participants in trainings, such as the disability support training (with a pathway to employment) and other industry trainings including TAFE courses; and helping to facilitate enrolment into other projects such as English certificate courses.

Non-vocational barriers were addressed by: improving self-esteem, confidence and social skills through the self-esteem course and other group trainings provided by PLAN; organising and paying for a Smartrider for public transport and/or a driving license; providing a therapeutic relationship and emotional support; referring participants to other service providers where needed (e.g. for specialist mental health support and housing assistance); helping participants obtain a police clearance; paying for professional clothing (e.g. for interviews); funding childcare where necessary; and general mentoring support around a participant's personal circumstances in order to overcome barriers to employment.

> *"PLAN is one of those services that's at the forefront before clients go onto other services. A lot of the clients I've had, they've gone through Centrelink and they've gone through the system and no one has really grabbed them to the side and said, 'Well how come you can't get a job, what's stopping you?'. Whereas I feel PLAN is the one that steps in and says, 'OK, well what is wrong here? You can't get to the job – OK, I can help you do that. You're having problems with your children, some of them have disabilities – well I can help you. You can't get this job because you can't drive, or you need to see a financial counsellor…' [The mentor] instils confidence in them that they're really worthy to go on and get a job" – Service provider*

The holistic nature of the supports offered by PLAN, and the range of activities catered to addressing discrete areas, increased the potential for participants to find success in their journeys to gainful employment. Outcomes associated with employment and economic independence are assessed in Section 6.

5.5 Participant satisfaction

On the whole, PLAN participants were very satisfied with the delivery of the project and its activities. Ninety-seven per cent of participants who completed the 'How are we doing?' form (n=36) agreed, and 3% tended to agree, that they were satisfied with the service they had received at PLAN. All respondents agreed that 'The service listened to me and understood my needs', and 81% agreed and 19% tended to agree that 'I am better able to deal with issues that I sought help with'.

Participant Exit Survey data did not directly ask participants about their satisfaction levels, however, all participants who completed the survey (n=26) felt that the project supported them to achieve their goals (20 strongly agreed, 6 agreed), and these participants also said they would recommend the project to family and friends (23 strongly agreed, 3 agreed). Other survey and domain data collected captures significant improvements for most participants in the areas of mindset and self-development, career development and improved life circumstances, and anecdotal evidence from focus groups and written testimonials indicates strong participant satisfaction based on the outcomes achieved as well as the way the project was delivered.

> *"Life before the project was so dark – now it's so good. This project has pulled something out of me" – Focus group member*

Many focus group participants commented that they felt understood and heard (perhaps for the first time in their life) and that this was powerful and helped lift some burden. Practically, it meant that support could be tailored to the individual and thus more effective. The mentors' proactiveness around responding to participants' needs based on this engaged listening, and the mentors' own lived experience, also meant that they could anticipate participants' needs before they became urgent. Many participants felt that this was a strong point of the project in the way it supported them to have their needs met in a practical, timely way. The key factors contributing to participant satisfaction and the general success of the project delivery are explored below.

5.6 Key factors mediating success

In understanding how project activities and supports were experienced and perceived by participants, a number of factors mediating positive experiences emerged:

- The speed of initial access to the project;
- The lived experience of the mentor;
- A sense of connection, safety and warmth with the mentor;
- The professionalism upheld by the mentor;
- The individualised, holistic nature of the project;
- Emotional support provided by the mentor;
- Practically oriented and proactive planning for independence;
- Well-sequenced steps towards goals with the support of a mentor;

- The advocacy role of the mentor;
- The ability to pay for things requiring immediate attention;
- An opportunity for socialising and laughter;
- Help with navigating the service system;
- The ability to build a sense of self-worth and confidence; and
- Access to a physical and emotional 'safe place'.

This reflects that the success of PLAN activities and supports was as much about the personal qualities and approaches of mentors as the practical implementation of activities. This was alluded to time and again throughout the data collection process. The most-mentioned factors were the lived experience of the mentor; a sense of connection and safety with the mentor; building self-worth and confidence; practical support and planning; the individualised, holistic nature of the project; the speed of access and financial help; and feeling able to engage with the world again. These are explored in greater detail in the sub-sections that follow.

"I'm that piece of paper that you tick the boxes and put on the pile with everyone else. It's not like that here, you're validated" – Focus group member

---

5.6.1 Lived experience of the mentor

> *"The lucky thing for me is [my mentor]. I want to have more people like her to help more people like us… She understands our situation" – Focus group member*

The fact that PLAN mentors had lived experience of the issues that were commonly affecting participants, including FDV, was highly valued among focus group participants. There were several reasons for this: first and foremost, seemed to be the comfort that this provided, in the way that participants felt they were not alone and that others whom they looked up to had been through the struggle and come out the other side. There was a "power" of lived experience that meant the mentor "can connect with you", in the words of one focus group member. Another cited the "knowing and understanding" of the mentor, and some focus group participants said that there was a certain intuitiveness that came with this. At a practical level, the mentors' lived experience also meant that they had an understanding of the issues affecting participants, an insight into the service system, and an awareness of potential issues and needs that may arise in a participant's journey. Thus, the mentor could guide a participant on this journey more effectively and often with greater levels of trust and confidence on the part of the participant:

> *"[My mentor's] lived experience makes it real, safe and targeted" – Focus group member*

> *"Relating to my personal story [was important]… My counsellor and psychologist could provide advice but no lived experience" – Focus group member*

> *"It's because she's got lived experience, she's one of us… You need a person whose heart is in it – if you can't relate, you can't make a difference" – Focus group member*

One participant, who had a complex history of childhood abandonment, foster care, FDV and anxiety, shared that the gratitude she felt for her mentor, and the progress she had made in her own life, had deeply inspired her to follow in the footsteps of her mentor by supporting people who have been through similar circumstances. Her mentor had 'modelled' to her the possibility of using lived

experience for a fulfilling career: this provided a great sense of hope and purpose in the participant, which inspired a vision for her future.

5.6.2 Connection and safety with the mentor

> *"I don't think some of these parents have had proper parents themselves. So, you know, it's really just someone focusing on them and paying attention... Sometimes that's all they need to just get started" – Service provider*

All of the participants who completed the Participant Exit Survey (n=26) strongly agreed (24) or agreed (2) that their mentor provided a positive relationship experience based on respect and trust, and that their mentor provided them with guidance and encouragement. This was reflected among focus group participants. Building a sense of connection and safety with the mentor was an essential part of feeling supported to make change and achieve goals among all the PLAN participants we spoke to. Some framed this in terms of building a bond – even friendship – with the mentor; others emphasised the professionalism of the relationship. The fact that the mentors could bridge both of these relational aspects of supporting participants in their journeys was a particular strength. One service provider who worked with many vulnerable clients who were often experiencing mental health challenges as well as adverse life circumstances, reflected that "everyone wants someone to chat to", indicating the importance of informal, interpersonal aspects of support:

> *"It was like finding a friend... you have a friend to call on and they're going to talk sense to you" – Focus group member*

> *"Don't ask a vulnerable person what they need. Get to know the person, build a rapport" – Focus group member*

The feeling of safety and trust that the participant-mentor relationship provided was integral to this. Generally, participants felt safe to disclose personal and traumatic information about their lives, and often this helped to lift a burden as well as allow mentors to provide the best guidance and also support them emotionally. Because of the common presence of shame, stigma and trauma in experiences of adversity and mental health challenges, it is not always easy for individuals to disclose sensitive information. A felt sense of safety in the relationship with the mentor appeared to be fundamental to a productive and supportive relationship for most, if not all, participants. This safety was also a product of the professional nature of the relationship and feeling supported by a professional 'safety net':

> *"You know it's their job, and they have a set of rules – you know they're not going to lead you astray" – Focus group member*

> *"She holds it together... she is professional, and makes you feel you are not alone" – Focus group member*

The mentor being non-judgemental helped to build safety and trust between mentor and participant. Many of the project participants spoke about having experienced dismissive and judgemental interactions with staff members of service providers, including outreach workers and mental health professionals. Many had been re-traumatised by these experiences and the service system generally. The relief they felt in being able to develop a safe, understanding and non-judgemental relationship with their mentor when they arrived at PLAN was emphasised strongly. In contrast to many service providers who were constrained by bureaucracy, the mentors at PLAN had "the freedom to understand individuals" as one focus group member reflected:

"It wasn't as a teacher-student [relationship], it was us working together as a team" – Focus group member

"[I valued] how easy it was to ask for help, without strings attached" – Focus group member

5.6.3 Building self-worth and confidence

Self-worth, self-esteem and confidence was a strong project outcome (see Section 6), but it was also a mechanism that was built into the project delivery and implementation of activities. It was thus a strong mediating factor for the success of the project and helped strengthen the basis for the theory of change to be realised. This happened in three key ways: firstly, confidence in the sense of hope and possibility for the future; secondly, in the self-esteem and self-worth built through the mentoring and group sessions; and thirdly, in the achievement of goals and the ability to keep building on small, achievable steps:

"I needed self-confidence first of all – what are my strengths, what do I need to do to get to the place I want to go?" – Focus group member

"[PLAN helps with] realising there's a lot of authenticity and strength in you, it's ok to think about yourself… and there are just no barriers to what you can do" – Focus group member

"[PLAN] is my only support network… [my mentor] made me believe in myself" – Focus group member

Several women in the focus groups commented on how their mentor promoted a feeling of ownership among participants over what they had achieved, emphasising that *they* (the participant) had achieved what they had achieved (rather than the mentor). The women we spoke to said this helped boost confidence and self-esteem, and this likely helped them to independently work towards goals within and after being in the PLAN project. This relied on well-sequenced steps that the mentor helped to plan, where 'wins' could be experienced from very early on. The optimism and motivation this generated boosted self-perception, action and positive self-belief:

"[My mentor] gives us credit… She says 'I didn't do it, <u>you</u> did'" – Focus group member

5.6.4 Practical support and planning

Because of the nature of vulnerability, adverse life circumstances and mental health issues – including trauma – practical support and structured assistance with planning for the future was essential for PLAN participants. Focus group participants emphasised that this practical support was timely and well-sequenced and jumped straight to the heart of the issue rather than getting held up by excessive administration and bureaucracy, or even by well-intentioned but ineffective supports such as education:

"We know FDV, we live FDV… we don't need more education" – Focus group member

"Sometimes you get referred [to services] and don't hear for 6 months… Waving papers is enough for someone to say 'nevermind'" – Focus group member

In contrast to "waving papers" in the service industry and a narrow focus on education that many participants had experienced, the practical (and emotional) support, planning and advocacy received in the PLAN project was received very well by participants. There was a sense of it being a significant relief to arrive somewhere that knew how to effectively offer practical support in a way that had an

immediate positive impact and lifted barriers to achieving other things. For example, coming to a PLAN mentoring session and getting a bill paid on the same day was a "small thing [that could] alter the whole system" of an individual's circumstances, as one focus group member shared. Planning for the achievement of short-, medium- and long-term goals also helped to build and sustain hope and confidence among participants, and the momentum required to keep reaching milestones.

5.6.5 Individualised and holistic support

The support offered by the PLAN project is individualised and holistic, and this was mentioned multiple times by focus group members as the unique factor in the project's success and its point of difference. This was often presented as a contrast to experiences with other organisations, including community services and women's refuges. Of the participants we spoke to, none had ever experienced, or knew of, any similar projects that offered wraparound, holistic support that was entirely catered to the individual and their unique set of circumstances. This was evidently powerful for the participants we spoke to, many of whom had previously felt like "a statistic" and celebrated the fact that through the PLAN project they felt seen, understood and supported *as an individual.* The PLAN project's holistic approach meant that participants could be supported in a way that suited their circumstances, preferences, hopes and needs, and support options could be tailored accordingly. The novelty of this model in the local area was verified through stakeholder interviews, and none of the stakeholders we spoke to knew of comparable models operating more widely in Western Australia:

> *"I had no results [with other services] until I came here. The wraparound services [at the refuge] were nothing compared to this" – Focus group member*

> *"Other outreach supports do not make you feel like what you're going through is valid… [They had] no funding, no scope, no results" – Focus group member*

> *"I felt that [my mentor] actually saw me. She was able to give me a holistic approach to my whole life – I wasn't just a piece of paper. She had the ticket to give me my life" – Focus group member*

> *"Most of the clients I've [referred to PLAN] have been mums with mental health issues who have just not been able, for one reason or another, to access another service. And I think probably the bit that they've enjoyed the most is that it's been local and someone to be able to share their story with" – Service provider*

5.6.6 Speed of access and financial help

A significant proportion of PLAN's target audience had urgent unmet needs, including physical and psychological safety, and were extremely vulnerable. Others may not have been traditionally classified as having "urgent" needs but were nonetheless highly vulnerable, particularly in the context of un/underemployment, potential accommodation issues and moderate mental health issues. People in this group were at-risk and experiencing difficulties but may not have been able to access services in the same way as those experiencing immediate threats to their safety and wellbeing. Nevertheless, across the whole spectrum of unmet need and vulnerability among PLAN's participants, there were considerable service access issues, usually due to delays, overwhelm, confusion, lack of awareness, or ineligibility. Often this left people demoralised and without adequate support – sometimes desperate and at imminent threat of physical harm. As one focus group member reflected: "When you're in a FDV situation you don't know how to move… It's hard to make those decisions".

In this context, the speed at which vulnerable individuals could access the PLAN project and be supported almost immediately was extremely important; in some cases, even life-saving. Focus group participants consistently extoled the value of rapid access to the project: "I didn't have to wait" was the common theme. Many participants had an initial appointment within one week of being referred or having self-referred and said that it was essential that this first point of contact was accessed quickly:

> *"I was in a place of suicide… I could not think. I would have ended my life" – Focus group member*

> *"In the beginning I broke down – finally someone was listening. As emotional as it was, it gave me hope… I knew it was the right place for me" – Focus group member*

One participant shared that she discovered PLAN through the signage outside the Bridging the Gap premises while she was being abused by her partner in public, and after running from her partner to hide, "came in and spent two hours" then had a formal appointment two days later.

Focus group members also commented on the benefit and relief of immediate actions throughout the duration of their time on the PLAN project, for instance "going to license centre *today* [to get a driving license] and having it paid for" and "paying for my power bill on the same day", or the support to make a counselling appointment for their child or start an application for NDIS payments quickly.

Access to brokerage funds was explored in Section 5.4.5; fundamental to the success of this activity was the speed of being able to access funding and have things paid for. As discussed earlier, funding could 'unlock' the ability to meet other needs and achieve goals on the road to stability, independence, and wellbeing. Given the urgency of many of the financial matters facing participants, including the payment of bills to prevent eviction, the speed at which finance was available was a fundamental success factor of the brokerage fund and the project generally.

Invariably, the participants we spoke to in the focus groups were grateful that they could access support and financial assistance so quickly and that there was a mentor ready to help them. The relief this provided in the initial stages of a participant's journey on the project, and the motivation this gave them to continue, likely promoted better outcomes.

Service providers also spoke positively about the speed of access that the PLAN project offered. One reflected:

> *"Every time I've asked PLAN for help, they don't hesitate to say yes. They make it really easy. A lot of the time when we're writing [other] referrals, it's a very long process and it takes a very long time for anything to happen and that's why I love PLAN. It's because as soon as I ask them, as soon as they've got time, they're out there visiting the family, and it's usually within a week" – Service provider*

5.6.7 Engaging with the world again

For participants who are isolated and socially disconnected, the opportunity to engage with others and build connections and social skills is invaluable. One participant framed this in terms of "stepping stones" after the trauma of FDV which "takes away 'normal' – you're in survival mode every minute of every day". She felt strongly that being around people again was essential for thinking about getting back into the workforce. There is a wealth of evidence in the literature which demonstrates the power of connection and social engagement for mental health and the alleviation of trauma symptoms (see Section 2). The experiences of focus group participants supported this, with the additional function of shared lived experience helping to generate feelings of mutual understanding and support. For some

women there was a strong sense of 'realisation' that community and connection was integral to their wellbeing and that they wanted to continue being socially engaged:

> *"Covid has disconnected us, but women need to be together… I don't want to live like that any more" – Focus group member*

5.7 Project limitations and suggestions

In addition to what has already been described in earlier sections, focus group participants and service providers mentioned several limitations of the project, or things which could be improved upon. These were:

- Needing a gradual transition out of the project;
- Needing other days and times for group training sessions;
- Some group trainings should be a longer duration;
- Suggestion to offer in-house employment training in other areas, not just disability support;
- Needing outreach to other communities such as Waroona to address transport and access barriers;
- Participants needing to come in at the 'right' stage of confidence and self-esteem;
- Service providers should ideally be provided with feedback about the clients they have referred; and
- Potentially needing more PLAN mentors/staff to cope with greater demand – one service provider mentioned limiting her referrals because she did not think the mentors had capacity for more participants.

Further perspectives from service providers specifically are presented below, including negative experiences of referrals.

5.8 Service provider perspectives

Interviews conducted with service providers who referred participants into the PLAN project revealed unique perspectives on both the power and the limitations of the project. The service providers we spoke to were two child health nurses; a clinical nurse; a family support worker; a community outreach worker; a financial counsellor, and a police officer. The nature of their work means that these service providers can 'discover' vulnerable parents, and also comment on the level of unmet need in the community and the ways that PLAN may help, or has already helped, their clients. Often, they were the essential touch points that recruited vulnerable and high-need participants into PLAN:

> *"That is the thing that a lot of people don't know – there is help out there" – Service provider*

Mental health issues, poor confidence and self-esteem, FDV, housing instability/unsuitability, low educational attainment and financial literacy, and un/underemployment were the key issues in the community that were mentioned by service providers. Service providers generally felt that the PLAN project offered a unique, holistic model of support that was flexible enough to move beyond the bureaucracy, red tape and lengthy wait times of the service industry. PLAN offered immediate and impactful support beyond what the service providers could provide in isolation, and this included being able to help link a participant to other needed supports as well as improve their ability to take positive, independent action in the long-term:

"[PLAN helps to] build their capacity to be able to start doing these things by themselves as they're increasing their confidence, but they've got that person who can help them touch base with all these different services and kind of get them on that path and rolling again until they've built their capacity" – Service provider

"[PLAN is useful for] when clients have reached all their goals with us and no longer require the parenting support but require a little bit more... self-empowerment, confidence building, self-esteem building and just needing someone to walk alongside them a little bit longer" – Service provider

It also seemed to be an essential support for dealing with complexity in a way that service providers felt they could not:

"The clients that we're sending in [to PLAN], they've got complex and diverse needs and I have no funding to be a complex and diverse worker. So, you know, PLAN is like that gap filler. I can deal with your FDV stuff, but the other things, other goals that you have or the other needs that you have – I don't have the capacity to meet those needs, but they're very legitimate and they need to be addressed" – Service provider

"I guess because government agencies... can only focus on what they have to focus on at the time. So I think PLAN is an extra support for the [individual], it's bit more direct" – Service provider

Service providers generally knew about the PLAN project from the promotion that Bridging the Gap staff had done at the inception of the PLAN project. They thus understood it as a local support option which they could refer eligible clients to. A summary of the reasons for referring clients to PLAN, and the expectations around the outcomes and impact that were discussed by service providers in the data collection for this report is presented below in Table 4.

Table 4: Service provider motivations and expectations for referring participants

Service providers' reasons for referring clients to the PLAN project	Expectations for what clients will receive from the PLAN project	Anticipated impact for clients as a result of the PLAN project
Something to fill the gaps beyond what service providers can deliver – "extra guidance" for vulnerable clients Consistent support after engagement with services has ended A flexible pool of funding that can be utilised quickly for a range of needs A project that can support clients to achieve life outcomes and "help them grow"	"Someone to hold their hand" Comprehensive and holistic case management that can work with complexity A therapeutic, compassionate, ongoing and high-touch point 1-1 mentoring relationship Practical assistance for navigating the service system and accessing other forms of support Emotional support	Sustained confidence and self-esteem Improved mental health Greater ability to access other formal and informal supports/services where required Stable employment and economic independence – when they're ready and if applicable Greater physical and psychological safety as a result of improving life circumstances

Potential to build clients' confidence, self-esteem and sense of empowerment A project that is not labelled as a mental health or FDV service, but will help in these areas – accessibility for participants A way to reduce burden on service providers Clients have been unable to access appropriate support elsewhere or do not have family support	Life support for a range of issues and needs including housing and employment Empowerment to "start building their lives again" and increased capacity to do things independently A sense of belonging, self-worth and connection Reduction of overwhelm and the feeling of being "stuck" Regular check-ins and someone to "hold them while they're on their journey"	An ongoing sense of connection and motivation Improved parenting skills and ability to nurture children and grow a healthy family Ability to continue setting goals and achieving things independently Better accommodation and living situation Financial stability

Although comprehensive co-case management of a project participant with other service providers was not part of PLAN's model, indicative evidence suggests that this could be something to build on for greater impact:

> *"There's one particular client we've got, we kind of co-case manage and she's very scattered. And so we've kind of come up [with a way of] doing it together, like 'OK, I'm working on this. You're working on these things. How can we help keep that client stay on track with their goals and... empower the client to go and do what they need to do with that?' So without that, this client I think would be completely lost... It's actually like she's taking these small steps, but that's actually big progress for her" – Service provider*

Interestingly, both the community outreach worker and police officer discussed (separately) one case of a "very complex family" with high need. Together with PLAN mentors, service providers were able to co-case manage a single mother who was struggling deeply, and this more holistic, relationship-based support network with PLAN at the center allowed for progress to be made for the woman and her children.

One service provider commented on how referring clients to the PLAN project has made a positive impact in her own life, particularly on her work-life balance and wellbeing as she now no longer needed to be a "counsellor" for her clients in addition to a clinical nurse. Prior to the PLAN project, the burden this placed on her was considerable, creating health challenges as a result of the additional hours and stress of supporting her participants beyond the scope of her role. Knowing that she now has PLAN to refer clients to, she felt that she could avoid burnout and was positive about the support she saw her participants receiving through the PLAN project.

> *"I did write to the city of Kwinana to ask: can we put more money into PLAN? And I explained to them how effective it was and how much it was needed in the community" – Service provider*

However, not all service providers we spoke to had positive experiences with referring clients to the PLAN project. One service provider had referred three clients to PLAN over the past year, and of those three, two disengaged early on and one did not engage at all after being referred. The reasons she stated for this include those discussed in Section 5.2, in particular the individuals' feelings that they were "not ready" for employment or independence. Because of this, the service provider had stopped referring clients to the PLAN project. When prompted to consider the value and place of PLAN, she communicated that PLAN was still a valuable support but that individuals should be "ready" for it, which she believed required a level of self-esteem and motivation prior to engagement. Multiple service providers insinuated or stated directly that the PLAN project is most valuable for helping participants after, or alongside, engagement with the services they provide, to "help them grow" in the words of the outreach worker we spoke to. This indicates the ideal role of partnership between PLAN and service providers.

Another service provider reflected that the PLAN project was more appealing to many of her clients compared to the Career Readiness for Young Parents (CRFYP) project prior to PLAN because it was not so focused on employment, reflecting that it was "hard to sell" when it was more career-focused.

5.9 Summary

The PLAN project offers holistic, wraparound support to vulnerable parents experiencing, or at risk of experiencing, serious adverse circumstances including FDV, homelessness or housing instability, un/underemployment and mental health issues. Often these experiences co-occur and can entail the presence of trauma and difficulty taking positive action; feeling "trapped" and hopeless is a common experience. In this context, the individualised support provided by the project is highly valuable. We know that children experience the knock-on effects of the wellbeing and life circumstances of their parent(s), and thus PLAN's tailored approach to supporting vulnerable parents with a suite of activities is of significance beyond the effects on the individual.

The data suggests that PLAN's activities had good uptake and were utilised effectively by participants. This was dependent on several key factors mediating the successful implementation of activities, including the lived experience of the mentor; the sense of connection and safety between participant and mentor; building self-worth and confidence in participants; practical and results-oriented support and planning; the provision of individualised and holistic support; the speed of initial access and financial help; and providing opportunities to engage with the world again. Without these factors and the personal qualities of the mentors which facilitated feelings of safety and understanding, the activities offered by PLAN would likely not have been as successful.

Overall, participants were very satisfied with their experiences with the PLAN project and many could not imagine having achieved what they had without the support of the project and, specifically, their mentor. PLAN recruited its target audience successfully; however, there is possibly untapped opportunity to recruit vulnerable parents who are 'hidden' and currently disengaged from services. The PLAN project also did not feel suitable to some participants who had been referred, leading to early disengagement or no engagement at all, and thus the barriers to participation should be considered. There is evidence to suggest that PLAN is most effective as an additional, individualised support that can bridge the gap between service providers and provide essential support to vulnerable individuals with immediate effects.

6. OUTCOMES EVALUATION

This section reports on the outcomes experienced by the participants as a result of participation in the PLAN project. Outcomes were examined through the three main priority outcome areas of the PLAN project, examining how effectively the project promoted positive change to participants in the following areas:

- Mindset and self-development;
- Career development; and
- Life circumstances.

Data sources used to evaluate outcomes were:

- BTG administrative data;
- Participant Exit Surveys;
- Domain assessment forms;
- 'How are YOU doing?' (HAYD) forms;
- Focus groups; and
- Stakeholder interviews.

In many cases, the rich qualitative data gathered served to validate quantitative findings and exemplify the ways in which outcomes in the focus areas were achieved.

The overall outcomes findings are first discussed then the priority areas are discussed in turn, with the use of case study[6] examples to illustrate the findings.

6.1 Overall outcomes findings

Our research found that the PLAN project is effective for supporting vulnerable parents to progress towards goals (and indeed helping to 'discover' those goals) and achieve positive outcomes across the priority areas. Overall, the PLAN project helped participants achieve a range of positive outcomes. On average, participants who completed the initial and case closure domain assessment forms (n=31) reported positive improvements within all 14 life domains assessed during their time spent engaged in the project. Moreover, when the three-month domain assessment responses were included in analysis (n=23), findings suggested that the majority of this positive change occurred within the first three months of participants entering the project. Figure 12 shows the average change in the 14 domains captured in the domain assessments between the initial and case closure assessments for the participants who listed the domain as a priority (note: participants could list up to five priority domains).

[6] All case studies draw on real examples but have had the names changed for confidentiality.

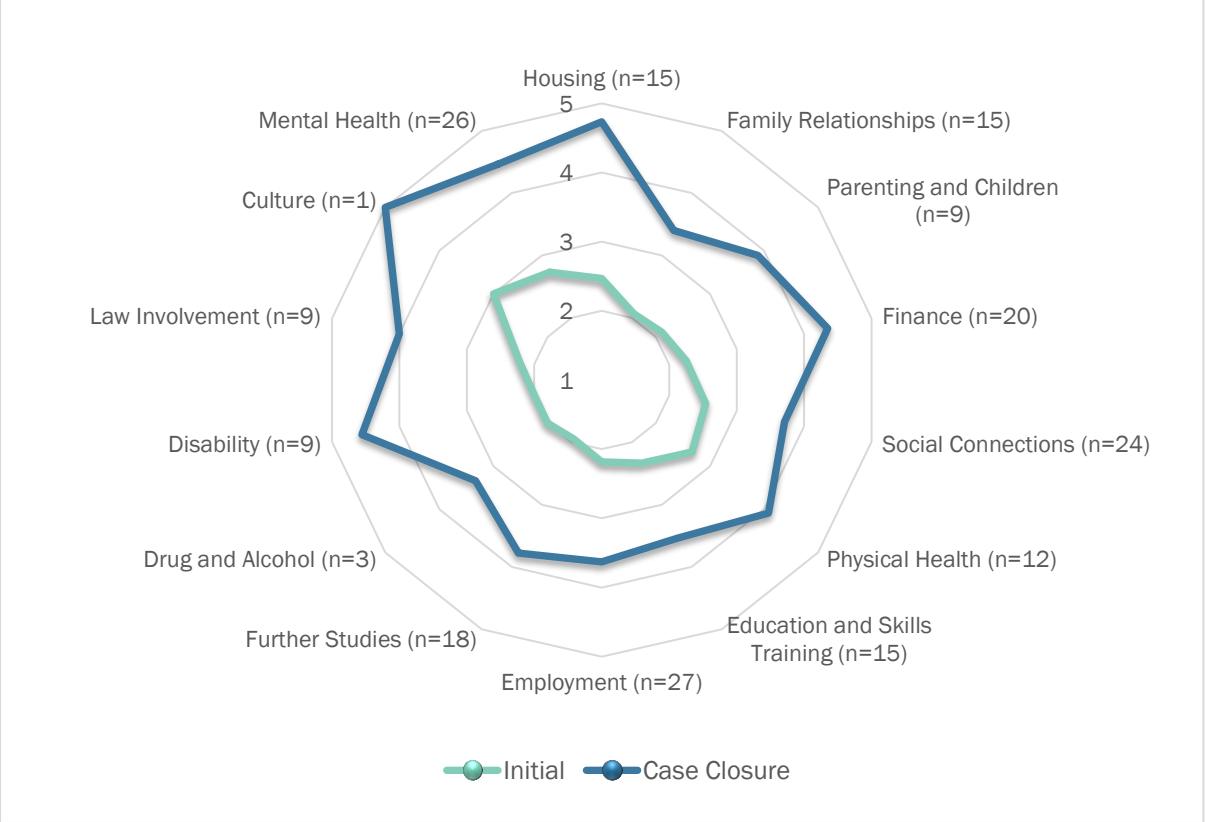

Figure 12: Average improvements in domains among participants (source: domain assessment data)

Particularly strong average change improvements were made around the following domains:

- Housing;
- Finance;
- Disability;
- Mental health;
- Further studies;
- Law involvement; and
- Parenting and children.

However, it is difficult to make generalisations about outcomes across different groups. The extent to which positive outcomes were achieved for specific individuals or sub-groups (e.g. immigrants, people identifying as Aboriginal or Torres Strait Islander, people experiencing severe mental health issues or FDV) is explored in this section in as much detail as the data allows. Furthermore, many of the effects of the project will not be known for some time or could not be articulated at the time of data collection. The data sources also contained a relatively small sample size, and thus the findings here are indicative but not conclusive of PLAN's capacity to generate positive outcomes among its participants.

Findings across multiple data sources are presented in the following subsections according to the three focus areas. For the purposes of analysis, the domains which were captured in the domain assessment were grouped into the following categories:

- Mindset and self-development: mental health; drug and alcohol; culture; social connections
- Career development: education and skills training; employment history; further studies
- Life circumstances: housing; family relationships; parenting and children; finance; physical health; disability; and law involvement

Note that in the focus groups, it was clear that there was a difference in the degree of clarity and sense of control between individuals who had been in the project for several months and had made significant changes in their lives, compared to those just arriving who were overwhelmed and had high levels of unmet need. Furthermore, many of the effects of the project will not be known for some time or could not be articulated at the time of data collection. Thus it is likely that the extent of the outcomes we present here is an underestimation of what was actually achieved through the PLAN project for participants and the wider community. This section uses data from participants who were (or had been) engaged in the project as enrolled participants.

6.2 *Improved mindset and self-development*

> *"[Before the project] I felt worthless. I felt like a failure, that there was no hope for me. The project helped me realise that I am cool, I am boss… I don't have any reassurance [in my personal life] that I'm on the right track. Then I came here and [my mentor] helped me organise all that. You need to fix the small things first" – Focus group member*

The evidence indicating that PLAN participants had improved in the domain of mindset and self-development was significant. This happened through helping to alleviate symptoms and causes of mental health distress, building confidence and self-esteem, and achieving outcomes related to life circumstances (explored in Section 6.4); all of these things were closely connected and influenced each other.

Domain assessment data also showed a positive overall change in all the domains associated with mindset and self-development (social connections, drug and alcohol, culture and mental health), with the biggest improvements being in mental health (+1.73) and culture (+2.00) for participants who listed these as priority areas at the time of commencement in the project (see Figure 13). Data showed that of the participants for whom the domain was a priority area, 88% had a positive change in mental health, 67% had a positive change in their social connections, 67% in drug and alcohol use, and 100% (one Indigenous client) in their connection to or sense of culture (see Table 5).

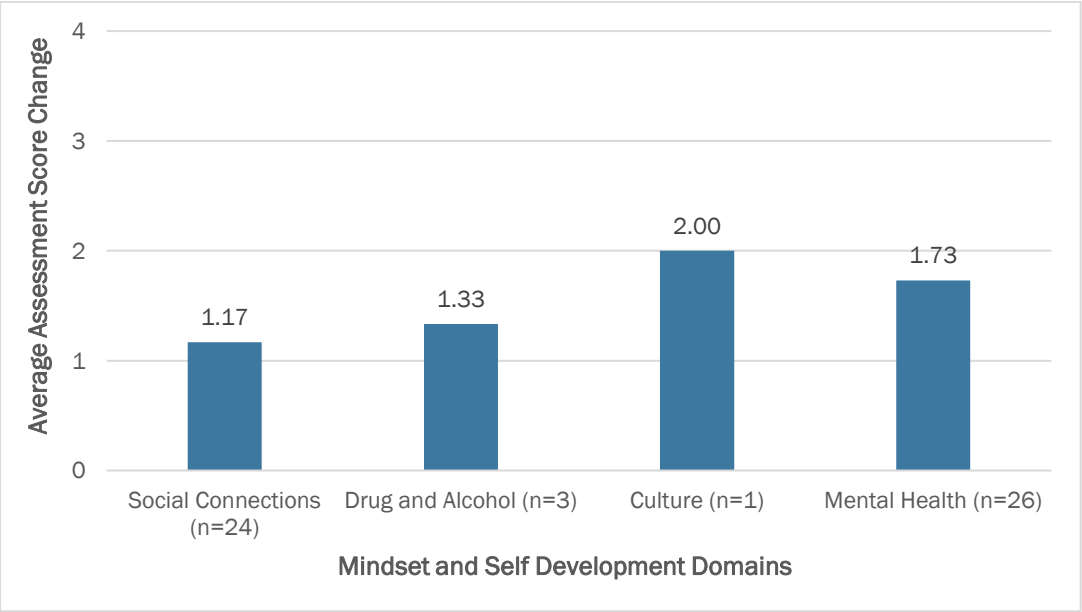

Figure 13: Average improvements in mindset and self-development domains (source: domain assessment data)

Table 5: Changes in mindset and self-development domains (source: domain assessment data)

Domain	Change	n	%	TOTAL
Social Connections	Positive	16	67%	24
	Negative	0	0%	
	No change	8	33%	
Drug and Alcohol	Positive	2	67%	3
	Negative	0	0%	
	No change	1	33%	
Culture	Positive	1	100%	1
	Negative	0	0%	
	No change	0	0%	
Mental Health	Positive	23	88%	26
	Negative	0	0%	
	No change	3	12%	

Some specific themes that were mentioned by focus group members around mindset and self-development outcomes achieved through the PLAN project included:

- Knowing I'm not alone;
- Having a burden lifted;
- Breaking through barriers;
- Feeling empowered;
- Being shown how to regulate emotions;
- Feeling "better in myself";
- Having quick 'tools' to use in moments of anxiety;
- Understanding that "You are not just what's happened to you";
- Having a stronger sense of self;
- Feeling like a 'good' parent;
- Seeing purpose in struggle;
- Feeling that "I can make people laugh and that's enough";
- Realising I'm not stuck;
- Realising I can achieve and do things;
- Having goals for the future;
- Thinking bigger;
- Understanding there is always something I can do; and
- Feeling hopeful and confident.

Below we explore in more depth three key areas related to mindset and self-development; mental health, confidence and self-esteem, and social connections and relationships.

6.2.1 Mental health

Data shows that the majority of surveyed PLAN participants improved their mental health as a result of the PLAN project. Participant Exit Survey data showed that, of the participants who answered the respective questions, 92% of respondents (n=13) agreed or strongly agreed that they felt more satisfied about their physical and mental health after joining the PLAN project, 62% per cent of respondents (n=13) strongly agreed and 31% agreed that they were better able to access help with

their physical and mental health when they need it as a result of the PLAN project, and 83% of respondents (n=12) had accessed support from mental health and/or medical services as a result of being in the PLAN project (see Figure 14). Additionally, as outlined above, 88% of participants for whom mental health was a priority domain (n=26) had a positive change in their mental health as a result of the PLAN project.

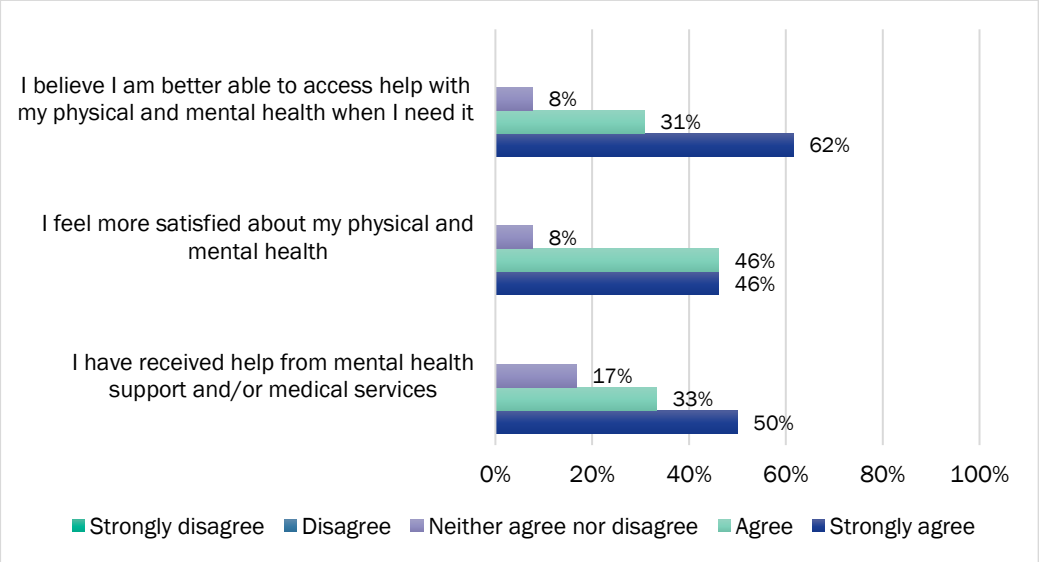

Figure 14: Mental health agreement scales (source: Participant Exit Survey)

The focus groups revealed very positive outcomes among participants. Some participants disclosed that they had intent of suicide and/or harm to self or others prior to commencement of the PLAN project, but at the time we spoke to them, several months into their time on PLAN project, they no longer felt at risk of these things. Many participants were not necessarily at the stage of suicidal intent before entering the project, but were experiencing moderate to severe mental health distress, often clinically diagnosed but sometimes not diagnosed or sub-clinical, including depression, anxiety, ADHD and PTSD. Most participants we spoke with were experiencing, or had recently experienced, at least one of these conditions. Almost all of them indicated that their mental health had improved considerably since being in the project, and this tended to be referred to in terms of feeling positive/optimistic, having a healthy mindset, feeling hopeful, being able to achieve goals, having a stronger sense of identity and self-worth, feeling less anxious and overwhelmed, and having confidence and self-esteem.

> *"I'm a single mum and I've never been happier. You can't look after anyone if you don't look after yourself" – Focus group member*

There was a strong sense of structure and positive outlook for the journey ahead. Overall, participants felt supported to continue making improvements in their lives in multiple areas and had the confidence to do so. This points not only to an improvement in mindset and self-development during participants' time on the project, but also beyond the formal project duration, as the following quotes indicate:

> *"Instead of spiralling, you're actually on a road" – Focus group member*

"You're stronger, you're your better self. I feel more confident in working through my [bad] days better... I feel better, I feel I'm on the right track. I was on the brink of Graylands – I'm not like that anymore. It's all down to the project" – Focus group member

"It's been huge... I could probably go to the extent of saying life altering. I don't feel burdened as I was before" – Focus group member

Data was not collected on the extent of clinical mental health distress before and after engagement with the PLAN project (e.g. clinical measures of depression, anxiety or PTSD), but there is indicative evidence to suggest that many participants experienced improvements around these things; the quotes presented throughout this report are particularly illustrative of this.

6.2.2 Confidence and self-esteem

Improved confidence and self-esteem was a strong outcome for over three-quarters of PLAN participants who completed the satisfaction forms and Self-Esteem Scale form. The HAYD form data showed an overall positive change in both confidence and self-esteem among participants (n=50), with an average improvement of +1.52 for confidence and +1.5 for self-esteem (on a scale from 1 to 5; see Figure 15). Eighty-four per cent of respondents had a positive change in their confidence level and 84% had a positive change in their self-esteem level. Twelve per cent of respondents had no change in their confidence level and 14% had no change in their self-esteem level; two respondents had negative changes in confidence, and one had a negative change in self-esteem. However, self-reported scores are not always reflective of actual changes, since they can be influenced by many factors including the participants' state on a given day or a misremembering of the initial score given.

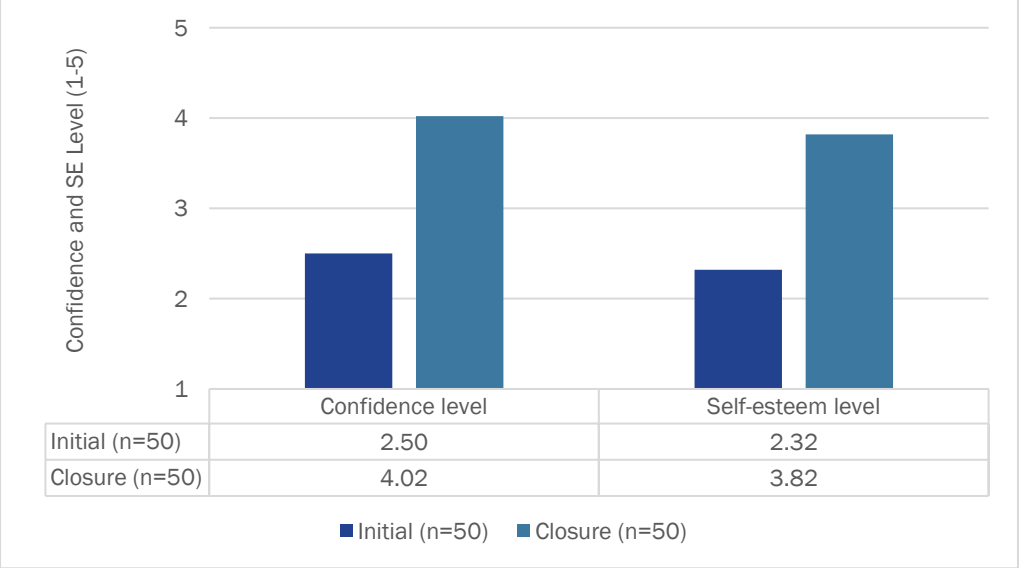

Figure 15: Average improvements in confidence and self-esteem (source: HAYD form)

The Rosenberg Self-Esteem Scale was utilised to triangulate findings, and asked participants (n=49) in a separate form, usually administered alongside the HAYD form, validated questions to do with their self-esteem to provide a score between 0 and 30. Using this scale, overall positive change was evident for 88% of participants, negative change for 4% of participants and no change for 8% of participants. On average, the overall improvement in self-esteem for participants was +8.38 (from an average of 13.78 to 22.16; see Figure 16).

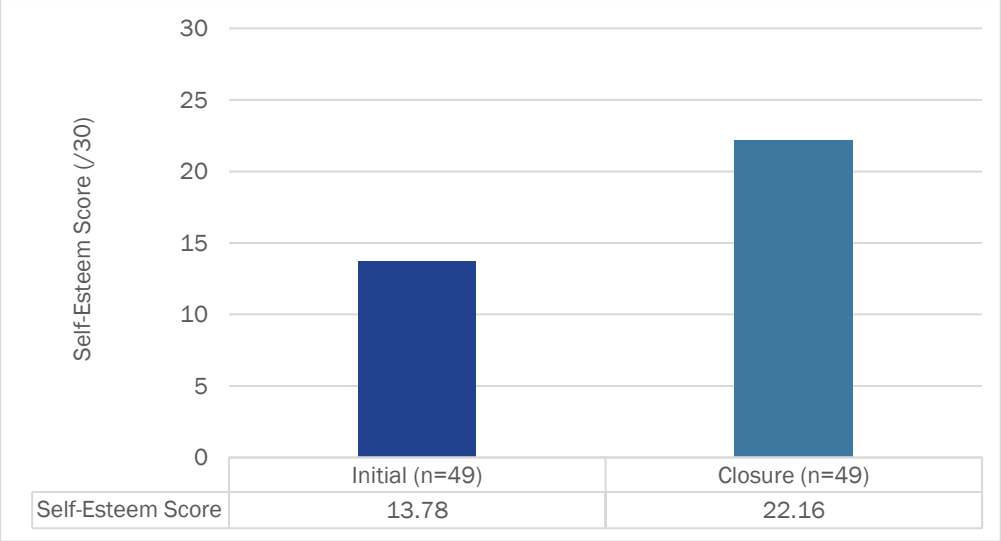

Figure 16: Overall improvement in self-esteem according to Rosenberg Self-Esteem Scale (source: Rosenberg Self-Esteem Scale form)

The Participant Exit Survey data also showed notable outcomes associated with confidence and self-esteem. Ninety-six per cent of respondents (n=26) agreed or strongly agreed that they felt they had a purpose in life; 88% felt better prepared to overcome challenges, and 92% felt more confident that they could succeed at what they put their mind to (see Figure 17).

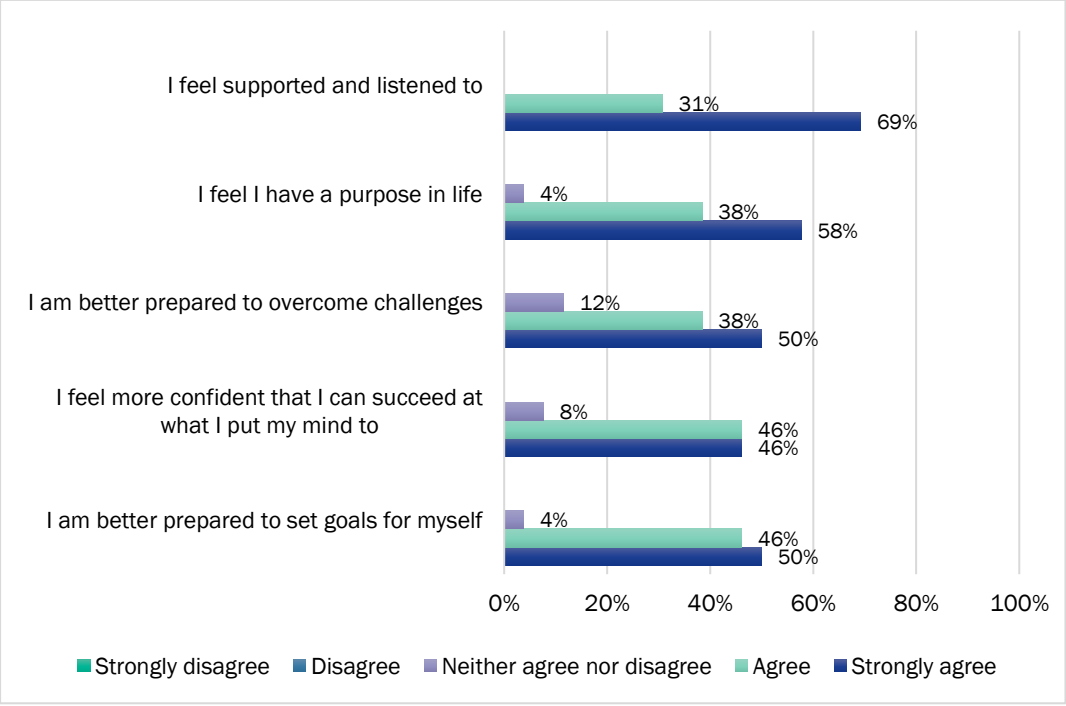

Figure 17: Confidence and self-esteem agreement scales (source: Participant Exit Survey)

In the focus groups, many participants felt they had stronger self-awareness, life awareness, and confidence in themselves as a person capable of achieving things. The seeds of confidence and positive mindset were also evident among some participants who had only recently started their engagement with the PLAN project, indicating the potential of the project to help generate a shift in mindset very quickly:

"I wouldn't know half the things I know about myself and life if it wasn't for coming here… [It's powerful] knowing there's no barrier whatsoever to do the things you want to do, [and] not having to justify it" – Focus group member

"I feel full of hope [having just started the project]. You realise 'I can do this and this and this'… I feel confident now" – Focus group member

Reflections from service providers also indicated that improved confidence was a strong outcome for clients who had been referred to the PLAN project:

"A previous client of mine who had finished their parenting journey with me… had nothing but positive things to say about [PLAN]. Her experience is really positive as it supported her confidence and self-esteem. That helps with other things as well, so basic care things like getting to the dentist because that was a big barrier for her. So for her, it really supported her and her outcomes… the confidence to participate in society and take her baby out has just skyrocketed as well. Because she has that extra support" – Service provider

"It's a confidence thing. So many of them have had so many barriers for so long, a lot of them have been quite disadvantaged and haven't had a proper education or been pushed very far… [the mentor] really instils confidence in them" – Service provider

Case study: Kathryn

Kathryn was an indigenous woman in her late-forties who came to PLAN feeling suicidal. She was experiencing severe depression, anxiety, FDV, unemployment, and potential homelessness due to an increase in rent. She was also a single mother and a carer for her adult son with PTSD and had no family in the surrounding areas who she could rely on for support or financial assistance. At the beginning of her time with the PLAN project she said she was "living week to week" and in crisis with her mental health, with few social connections. She scored her confidence and self-esteem as 1 out of 5 (very low).

Kathryn shared that she had several barriers to joining the project, including pride, but once she had embarked on her journey and received support from her mentor, she had a very positive experience and described it as "healing on a soul level". She experienced immediate relief when she felt listened to and understood by her mentor, inspiring hope and possibility for the future. These feelings were deepened as positive progress was made and she started to build the capacity for reflection and self-empowerment. Reflecting on her experiences, she stated "I had to take accountability for what got me there in the first place". Kathryn was referred to multiple services by her mentor, including a dentist, a psychologist and a financial counsellor, and she spoke positively about the referral process.

Three months into her time at PLAN, Kathryn had begun seeing a counsellor and said her mental health was improving. She had also improved her housing situation and was in a stable rental. Her parenting capacity had increased from 'some parenting capacity' to 'good parenting capacity' and she was less stressed now that her son was also seeing a counsellor. Her self-reported confidence and self-esteem levels increased from 1 to 3 out of 5 during this period. Her financial situation also improved enough to self-report as financially stable at the three-month assessment, having completed the PLAN's budgeting project and working on paying off debts and her bond loan.

Being exposed to different ideas and supported with strategies to address her mental health and life circumstances helped to generate the momentum to set and achieve goals both during her time on the project and beyond. This included revisiting her business proposal to start her own small business, which she felt both enthusiastic and hopeful about. At the focus group, almost a year after she commenced with the PLAN project, she reflected:

> *"Because I can see other options, I can bring that forward into other areas in my life. I can do stuff, it's the capacity to work – I need a strategy of achievable goals, start simple then build"*

The PLAN project gave her this strategy and the essential support that facilitated progress and a shift in mindset. Although hesitant to engage with others at the beginning of the project, Kathryn also developed a willingness to try new modes of support as her mental health and confidence improved and she commented that "I used to struggle [with groups], now I don't". Interestingly, she also commented on a greater connection to Country as a result of her journey with PLAN:

> *"I've always felt connected to the Land, but it feels stronger now that I've developed through this healing process"*

Kathryn had a much more optimistic life outlook and mindset after the project and was able to speak positively about the compassion and empathy she has as a result of her life experiences. She felt that she was a better mother, daughter and friend as a result of the positive progress she had made through the project, and she was looking to the future with her ambition to start a business.

> *"The last hurdle is in sight, I'm so grateful for this project"*

The case study of Kathryn is indicative of the cultural appropriateness of the PLAN project for diverse groups, and its potential to facilitate a sense of cultural connectedness and healing among indigenous people. This can be a protective factor against mental health distress, as conceptualised in the indigenous social and emotional wellbeing framework.[7]

> *"It's transformative… The person I was when I came into the project is not the same as who I am now. I feel empowered – there's that inner conviction that I'm willing and determined to win the day" – Focus group member*

6.2.3 Social connections and relationships

> *"For a lot of parents [that I work with], they're very isolated. And so it's providing them with social contact and to feel heard and validated… one of the most important things that would come out of PLAN would be relationship" – Service provider*

The PLAN project helped many participants to feel connected to others and build a sense of community, both as a standalone outcome and as a means to greater mental health and wellbeing. Sixty-seven per

[7] Commonwealth of Australia, 2017. *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023,* Canberra: s.n.

cent of domain assessment respondents who listed the domain as a priority area (n=24) recorded a positive change in social connections after starting the project, with an average change of +1.17. The Participant Exit Survey also showed strong outcomes related to social connections and relationships: 88% of respondents (n=26) agreed or strongly agreed that they feel more confident interacting with others, and 76% had been able to develop a support network. Seventy-seven per cent had been able to make new friends (see Figure 18).

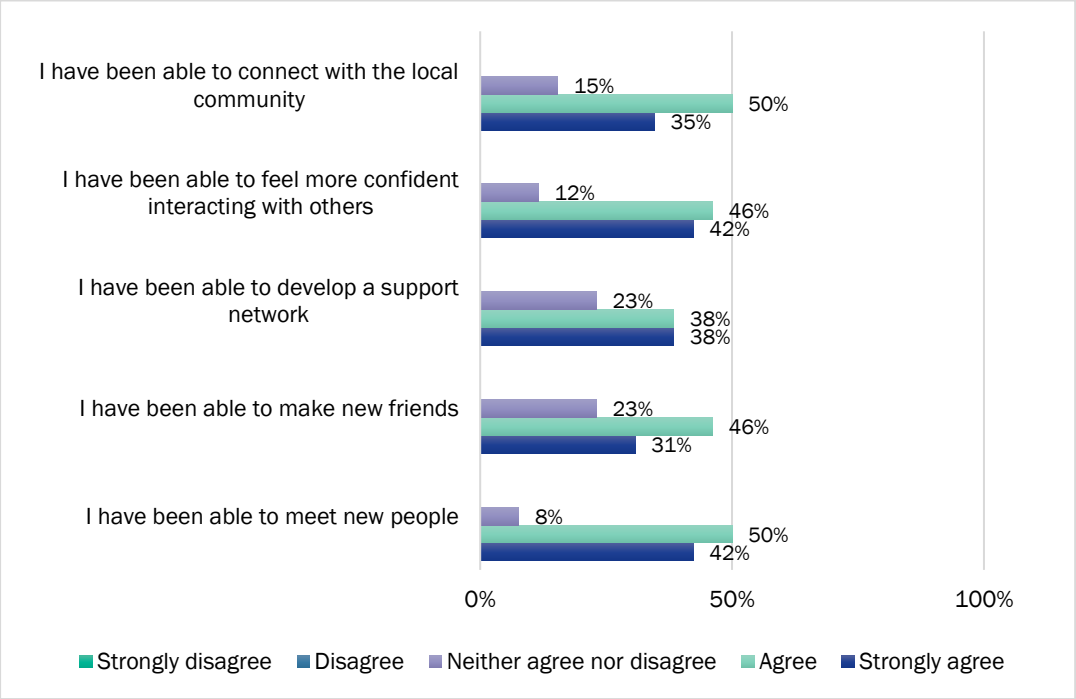

Figure 18: Social connections and relationships agreement scales (source: Participant Exit Survey)

Focus group participants mentioned a number of times the power of connection through the PLAN project, and also in many instances how confidence was built in interacting with groups. The case study of Kathryn above was one example of how this happened. Another indigenous woman we spoke to, who had one young child and had experienced severe anxiety and FDV for a number of years, and did not have any family support, also shared that her confidence and sense of connection was improving through engagement with the project. Generally, most focus group members across diverse cultural backgrounds shared a sense of feeling more connected as a result of the PLAN project. In the focus groups themselves, which also served as a 'model' depicting the ways that PLAN participants interacted, there was shared emotion, support and even laughter, revealing a sense of connectedness and mutual trust:

> *"It's an empowering thing to be in a group of women going through the same thing. One day I'll be crying, the next I'll be laughing" – Focus group member*

6.3 Improved career development

Data indicated that career development was a strong outcome for many PLAN participants. In many cases, vocational and non-vocational barriers to economic independence were addressed and sometimes removed completely. Often this was a product (at least in part) of improvements in confidence, self-esteem, mental health and life circumstances; in other cases, it was largely a result of equipping a participant with opportunities for training, study and skills-development, or mentorship for finding a job.

6.3.1 Employment status

Employment status captures full-time, part-time and casual jobs. Administrative records show that of the 67 participants who had engaged in targeted support activities through the PLAN project, at the time of data collection, which was at the end of January 2023, there were 32 participants employed (52% of participants), 14 were job ready, 15 were not job ready and 6 were unknown (see Figure 19). It is important to note that of the 32 who were employed at the time of data collection, 9 were already employed prior to commencing the project. Hence, 23 of the participants (34% of all participants) were previously unemployed and gained employment after commencing the PLAN project. Of these, 12 acquired additional jobs throughout their involvement with PLAN. Of the 9 participants who were already employed prior to commencement with PLAN, three acquired additional jobs through PLAN.

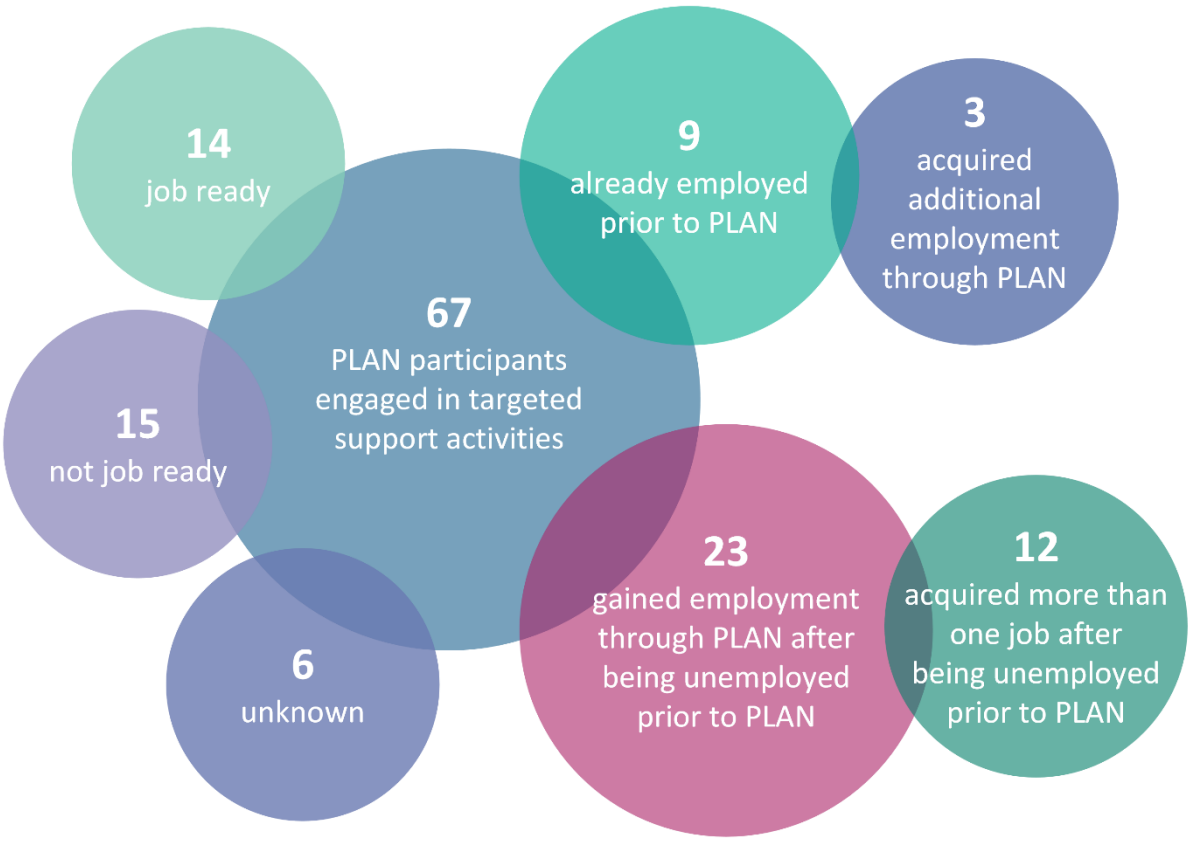

Figure 19: Employment status of PLAN participants (source: BTG administrative data)

Two participants had completed work experience/industry visits and of the 14 participants who were job ready but not yet employed, most were searching for employment and/or obtaining necessary documentation such as police clearances.

As seen in Table 6, over half of respondents in the domain assessment forms for whom employment was a priority area (n=27) recorded a positive change in their employment status (63%), indicating that they had transitioned from un- or under-employment to casual, part-time or full-time employment during their time in the PLAN project.

Table 6: Changes in career development domains (source: domain assessment data)

Domain	Change	n	%	TOTAL
Education and Skills Training	Positive	9	60%	15
	Negative	0	0%	
	No change	6	40%	
Employment Status	Positive	17	63%	27
	Negative	1	4%	
	No change	9	33%	
Further Studies	Positive	14	78%	18
	Negative	1	6%	
	No change	3	17%	

Figure 20 shows improvements in the domains associated with career development from domain assessment data. On average, among the participants who had listed the domain as a priority area, there was a +1.20 average change in the education and skills training domain; a +1.44 average change in employment and a +1.83 average change in further studies. Of the participants for whom the domain was a priority area, 60% had a positive change in education and skills training, 63% showed a positive change in their employment status, and 78% in further studies (see Table 6).

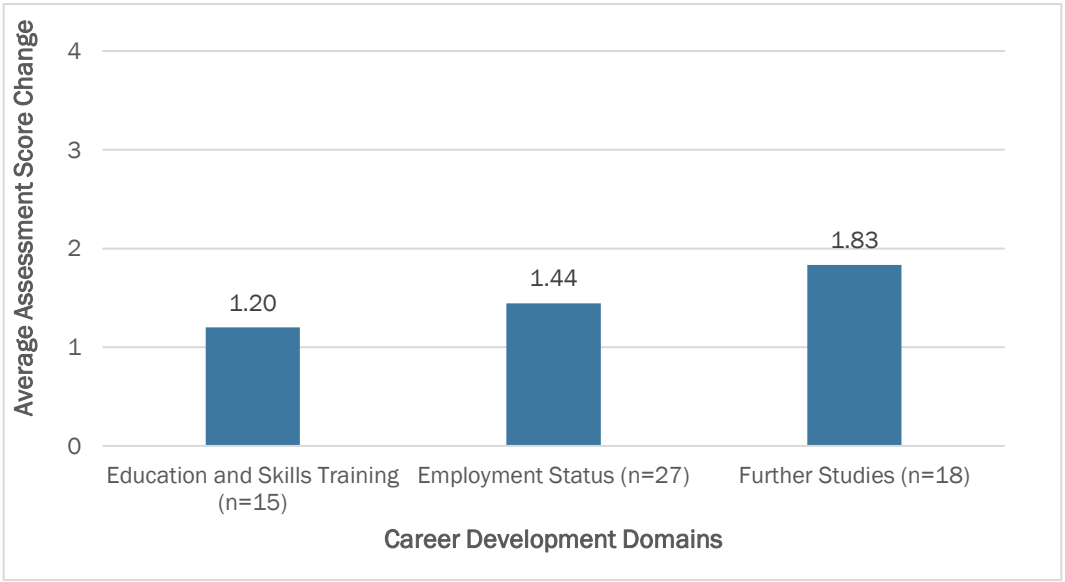

Figure 20: Average improvements in career development domains (source: domain assessment data)

Some participants obtained employment within weeks of entering the project. One focus group participant said she "needed someone to restore a bit of faith and confidence" to help her successfully obtain employment, having been through a tumultuous abusive relationship where her confidence and self-esteem had been affected, and the PLAN project was able to provide this very quickly.

"It has been so life changing from being so depressed to being fully employed – [I've] done a 180 turn" – Survey respondent

Focus group and survey data revealed positive outcomes in multiple domains once employment had been secured, reflecting that employment status is a determinant of mental health and can have considerable effects on life circumstances, and vice-versa. The following quote is illustrative of the interplay between employment, life circumstances, and mindset and self-development; improvements in one of these areas alone was rare, and obtaining employment was often a product of a holistic approach:

> *"I can remember one question that changed my life: 'what do YOU like or want?' I never really looked at myself or what I wanted. I was always [consumed by] my domestic violence relationship or the kids that I never really thought about what I wanted. This PLAN course changed that and now I'm always looking at becoming a better me. I'm full time employed, happy, and have a really good outlook for my future. I cannot wait for my next adventure of owning my own house" – Survey respondent*

6.3.2 Job readiness

The data shows that most PLAN participants improved their job readiness as a result of the project. When asked 'Do you believe you are career ready?', 69% of Participant Exit Survey respondents (n=26) said yes, 23% were uncertain and 4% (one participant) said no (see Figure 21). The participant who said no stated that this was because she was pregnant. Of the participants who were uncertain (n=6), three did not give a reason, one cited that language was a barrier, one cited needing stable accommodation first, and one said she was mentally ready to start work but was unable to do so due to being pregnant and caring for her two older children.

> *"I feel eager and empowered to commence employment. PLAN helped me regain hope that I can undertake work experience or employment and I look forward to my exciting future now" – Survey respondent*

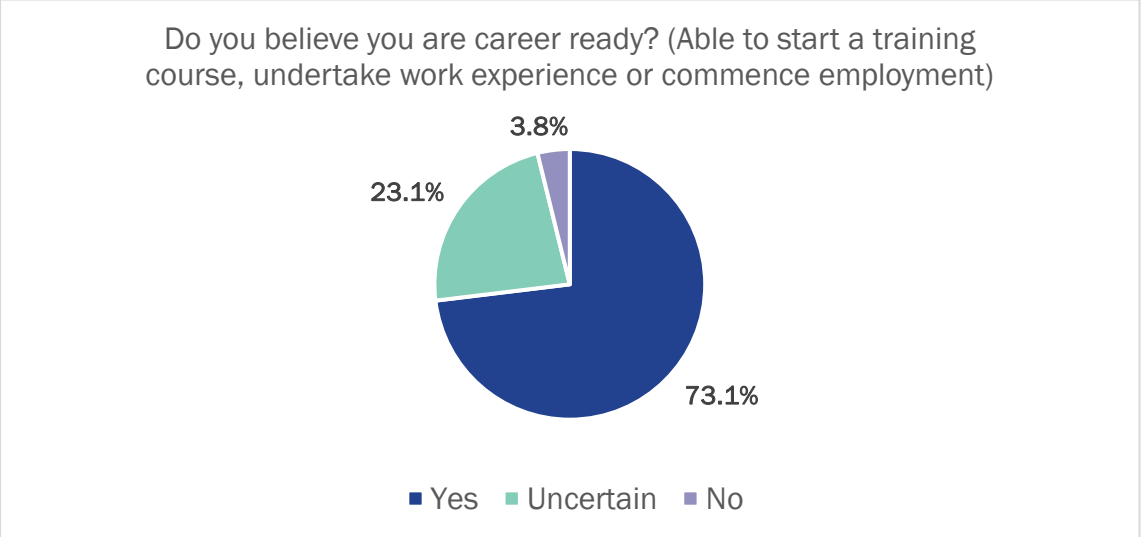

Figure 21: Job readiness (source: Participant Exit Survey)

On the whole, Participant Exit Survey respondents (n=26) said that as a result of the PLAN project, they felt more confident to get a job (92% agreed or strongly agreed), and they felt more knowledgeable about how to look for a job (92% agreed or strongly agreed). Eighty-one per cent of respondents felt more aware of the different career pathways available to them and 88% had identified the career pathway they would like to take (see Figure 22).

> *"I have just been offered a job. Without this course I wouldn't have even applied" – Survey respondent*

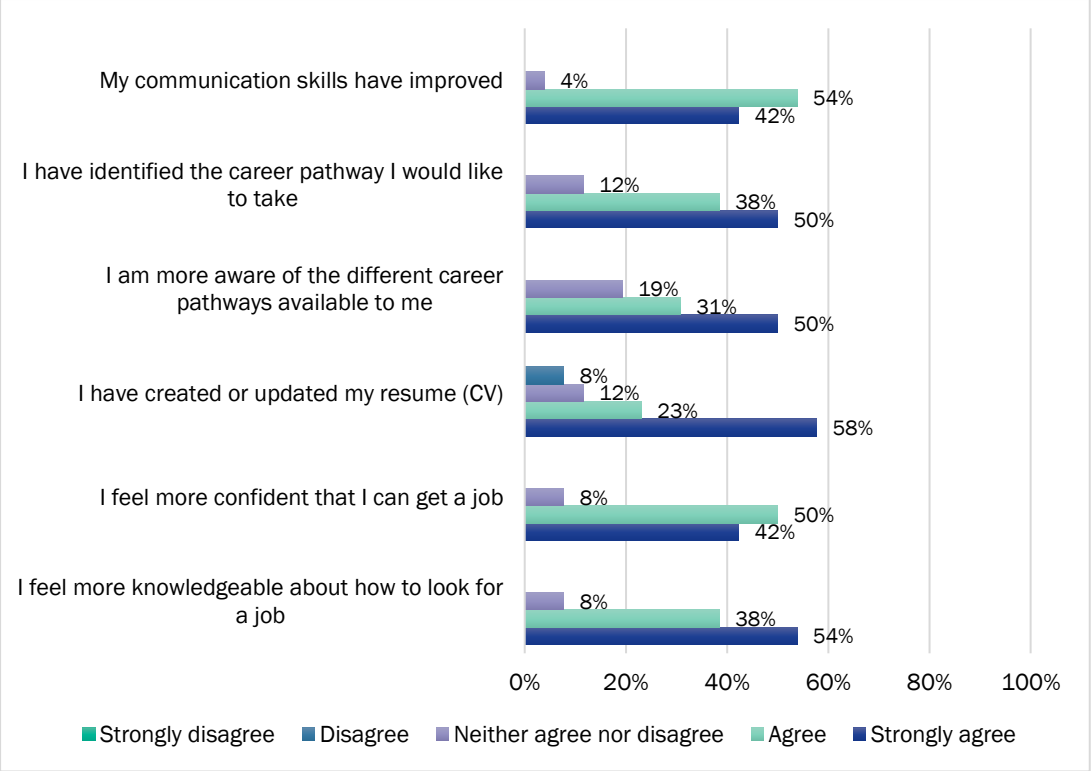

Figure 22: Job readiness agreement scales (source: Participant Exit Survey)

Case study: Kiri

Kiri was a young mother-of-four in her twenties who had experienced FDV for several years after immigrating from New Zealand. Notably, she came from a family where FDV was also prevalent and commented on the fear that she was reproducing intergenerational trauma by repeating what her mother had done when she was her age. Kiri had been psychologically worn down by her abuser but was also motivated to improve her circumstances, provide for her child, and achieve financial stability independently of her partner. Notably, Kiri had discovered PLAN by walking in from the street mid-crisis to hide from her abuser. When she began the project, she reported her self-esteem as very low (scoring 5 out of 30 on the Rosenberg Self-Esteem Scale) and that she was struggling with her mental health and was in financial hardship.

Kiri identified multiple needs with her mentor, including a need to seek employment quickly in order to separate from her partner and earn an independent income. In the short term, Kiri's mentor helped her to write a resume and distribute it and obtain a driving license and learn to drive so that she could be more independent and easily get to work (this included paying for a learner's permit and driving lessons). The PLAN project also paid for two days of childcare and helped Kiri apply for an Additional Child Care Subsidy so that

she could attend work freely. Kiri soon found a job that allowed her to engage with people by working in a shop, and at the time of the focus group, she had ambitions to become a store manager.

> *"By the first week [in the project] I knew I needed a job and childcare. By the second week I had written a resume and handed it around… I had 100% confidence in getting results with [my mentor]. Things just start happening. It didn't take long before I had a job, I had my license, [and] my son was in day-care"*

Kiri was also supported to safely leave her abuser and move to medium-term shelter accommodation at a local women's refuge, where she was living at the time we spoke to her. She reflected on the role of the PLAN project in helping her achieve this:

> *"I was in a FDV situation for 11 years, I just thought that was how life was meant to be until I came here. I felt so comfortable staying in that situation until I walked in here. [I realised] that it's not a healthy environment… In the first 3 months of working with [my mentor], I built confidence. I felt confident to leave my relationship. I have so much pride… I never thought I would be where I am now. I'm thriving, my son's thriving"*

Kiri's financial situation domain score increased from 2 out of 5 at the time of starting with PLAN, to 4 out of 5 at her three-month review and case closure. She had also commenced an online Certificate IV in Mental Health and a TrainSmart Family and Domestic Violence Skill Set course. Kiri spoke very enthusiastically about her job and newfound independence, evidently feeling a sense of pride and ownership over it. She was optimistic about the future and felt that her children had a much better life now, despite living in a shelter temporarily. After 6 months in the project, her Rosenberg Self-Esteem Scale score increased to 22 out of 30, and after just three months her mental health domain score increased from 2 to 5 out of 5.

> *"You really think you can do anything… I think I'm accomplishing everything I want to do. There's a lot of things that I thought I'd never be able to do that I've done now"*

6.3.3 Education and skills training

The PLAN project helped participants to engage in education and skills training through a number of different avenues. Sixty per cent of domain assessment respondents for whom the domain was a priority area had a positive change in education and skills training, and 78% recorded a positive change in the further studies domain. PLAN worked with participants to identify external training and education opportunities (e.g. TAFE courses), and helped participants enroll in such opportunities, where appropriate. At the time of data collection, 10 participants were enrolled in external training after commencing the project. This included:

- Certificate III Individual Support;
- Certificate III English;
- Forklift Training;
- Diploma Beauty Therapy;
- Certificate IV in Mental Health;
- H&R Block Tax Return Course; and
- Diploma Graphic Design.

"I was grateful for all the courses I completed, because when I got out into the workforce I was qualified and equipped to take on the roles. This project took the holistic approach and covered my whole [life] and every need was met, physically and emotionally" – Survey respondent

The PLAN project offered an in-house training project for employment as a disability support worker, the Introduction to Disability Support Training (see Section 5.4.3). Once participants completed this training if they wanted to work in the industry they were referred to the project's network of Disability Support Employers to apply for work. At the time of data collection, 21 participants had completed the Introduction to Disability Support Training. Seven of these participants commenced employment after completing the training, and 6 were currently completing the training and looking for employment in the industry. Five of the participants had commenced a Certificate III in Individual Support after completing the training, and 8 had not decided if they wanted to enter the industry.

Of the respondents in the Participant Exit Survey who had completed the Introduction to Disability Support Training (n=15), 14 strongly agreed and one neither agreed nor disagreed that the training course improved their knowledge and skills and helped them to complete useful certificates. Twelve respondents strongly agreed, two agreed and one neither agreed nor disagreed that the training course helped them to feel more confident.

In the focus groups it was discussed that several participants were working as disability support workers after completing the Introduction to Disability Support Training course. These women had experienced issues including mental health issues, low confidence, FDV, trauma, financial insecurity, and social isolation (e.g. as an immigrant). While it was not the case that all these issues 'disappeared' through participation in the PLAN project, it was significant that all the women who were employed as support workers felt positive and confident about their work status. One woman shared her excitement and surprise that through obtaining employment as a disability support worker, she now had savings and an achievable dream of owning a home, and she reflected that "I can fully say it's because of this project".

Being able to help others as a support worker also felt meaningful to the PLAN participants we spoke to. It is possible they would not have discovered or had the confidence or means of taking up this opportunity without the support of PLAN. The confidence gained from being employed also sowed the seeds of greater ambition, for example a desire to move from a support worker to support coordinator, suggesting longer-term positive effects of the initial employment gained through working with the PLAN project.

One service provider reflected:

> *"One of my clients had the New Zealand partner visa, so they're not eligible for any Centrelink payments in Australia. She was in our women's refuge for a year, went into our transitional housing and then was still at a roadblock because obviously… she really couldn't afford any housing. So once she finished this disability course she started to get out there and work more and more and save and she's in her own private rental now. She wouldn't have been able to really have achieved that without the support of PLAN"*

The in-house training provided by the PLAN project, in addition to the mentor's assistance in helping participants enroll in external training and education projects, provided participants with a strong foundation for obtaining meaningful employment and progressing their career.

6.3.4 Working towards employment

For some participants, employment outcomes had not been achieved but they reported feeling able to explore the possibility of being engaged in the workforce in the future, even when some barriers (such as mental health difficulties) still remained. The following quotes are illustrative of this:

> *"In my circumstance I can't work, I'm on disability. In the medium term the plan is to focus on what I can do; I've got a good transferable skills set… I sat down with [my mentor] to make a plan" – Focus group member*

> *"[My mentor] has listened to my interests – what are my passions? So I'm going to set up a business… If it comes to fruition that would be great. To be able to dine out and buy clothes… Having that gone [when I stopped working] was a hard adjustment. But to be in a position where that's possible again…" – Focus group member*

> *"We're technically homeless at the moment. But [the project has helped with] being able to see the positives… Being able to figure out how to get myself in a position where I can get a job" – Focus group member*

> *"Since I've come [to the project] I've got my purpose back… I feel like next year I'm ready to get back into the workforce. I feel like there's nothing I can't do now" – Focus group member*

Several service providers also reflected positively on the PLAN project being able to gently encourage and support participants on their journey to employment and training:

> *"I'd say to [my clients] – you don't need to be ready to go to TAFE yet. This is really promoting you to be able to go to TAFE at the time that that suits you. And this is to help you be in a position where one day that becomes what you can do. Then it will help you, you know, maybe even examine and find out what you might want to do down the track when you are able to work" – Service provider*

It was not the case that all PLAN participants were ready for employment even after several months in the project. Various reasons for not seeking employment were cited in the Participant Exit Survey, such as pregnancy, mental health issues, disability, language barriers and parenting. Thus, 'no change' responses in the domain assessment data are not necessarily a reflection of the ineffectiveness of the project. Focus group evidence revealed that even for the participants for whom employment was not a possibility in the near-term, there was often a sense of opportunity and optimism about future options around work.

6.4 Improved life circumstances

The ability for the PLAN project to improve participants' life circumstances, mainly in the domains of housing, family relationships, parenting and children, finance, physical health, disability and law involvement, was significant. A positive average change was evident across all domains related to life circumstances from the domain assessment data for participants for whom the domain was a priority area, with the biggest average improvements being in disability (+2.56), finance (+2.10), and housing (+2.27).

For those participants for whom the domain was a priority area, an average improvement of +1.78 was seen for both the parenting and children domain and the law involvement domain. There was an average improvement of +1.42 for physical health and +1.33 for family relationships (see Figure 23).

All participants for whom the domain was a priority area had a positive change in housing, 90% had a positive change in finance, and 89% had a positive change in their experience of disability (see Table 7). Over three-quarters of people for whom the domains were a priority had a positive change in the physical health, parenting and children, and law involvement domains, and 67% had a positive change in the family relationships domain.

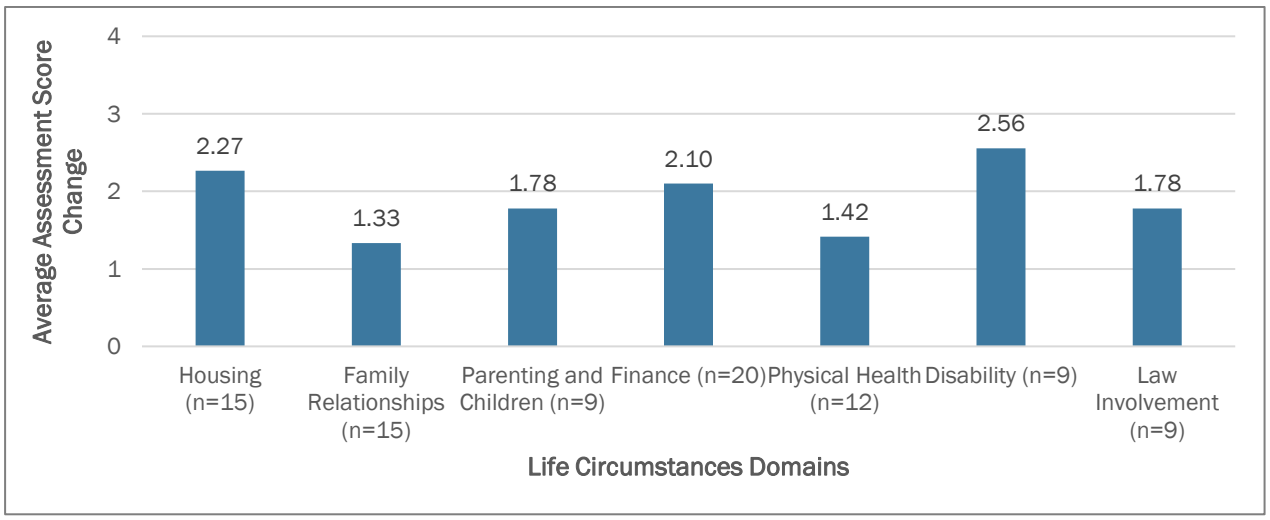

Figure 23: Average improvements in life circumstances domains (source: domain assessment data)

Table 7: Changes in life circumstances domains (source: domain assessment data)

Domain	Change	n	%	TOTAL
Housing	Positive	15	100%	15
	Negative	0	0%	
	No change	0	0%	
Family Relationships	Positive	10	67%	15
	Negative	0	0%	
	No change	5	33%	
Parenting and Children	Positive	7	78%	9
	Negative	0	0%	
	No change	2	22%	
Finance	Positive	18	90%	20
	Negative	0	0%	
	No change	2	10%	
Physical Health	Positive	10	83%	12
	Negative	0	0%	
	No change	2	17%	
Disability	Positive	8	89%	9
	Negative	0	0%	
	No change	1	11%	
Law Involvement	Positive	7	78%	9
	Negative	0	0%	
	No change	2	22%	

The PLAN project helped to improve life circumstances in multiple ways. Typically, the combination of one-on-one mentoring sessions, group training sessions, referral to support services and access to brokerage funds helped to address immediate as well as longer-term concerns, which often had positive effects in multiple areas of life. As discussed earlier, many participants come to the project overwhelmed and in crisis, or at risk of crisis. It is notable that many participants gained a sense of stability through participation in the project and had overcome considerable barriers to improving their life circumstances, as the focus groups revealed:

> *"[The refuge staff] were so shocked that I'd had all these barriers taken out so quickly" – Focus group member*

In one-to-one mentoring sessions, mentors could work with participants to identify ways to improve life circumstances in the short, medium and long term. This included actions on the part of the participant (e.g. starting to save), as well as actions on the part of the mentor (e.g. the PLAN project paying for urgent needs). Some examples of how participants were assisted include:

- Pay for urgent needs (e.g. household bills);
- Find secure accommodation (e.g. through referrals);
- Obtain a driving license and learn to drive;
- Clean a home to prevent eviction;
- Access NDIS payments and counselling for children;
- Navigate the service system to get the right support;
- Obtain a Violence Restraining Order and protect children;
- Obtain legal representation;
- Write a Victim Impact Statement for criminal sentencing;
- Pay off debts;
- Learn English;
- Start saving to buy a house;
- Safely exit an abusive relationship;
- Make and attend needed appointments;
- Get ongoing help with bills from an energy provider;
- Obtain employment;
- Provide a more stable home for their children; and
- Make a plan for the future.

Because the PLAN project offered a person-centred approach to case management, the outcomes relating to life circumstances differed according to the individual's needs. Quantitative and anecdotal evidence indicated that the ability for project to produce lasting, longer-term effects in participants' life circumstances was potentially significant:

> *"There was a point before when we didn't have Bridging the Gap or PLAN and I found that difficult. But now that we've got PLAN, things are much better for the families in this community" – Service provider*

Below we explore changes in the domains of housing, finance and family relationships/parenting, as well as less-quantifiable aspects such as effects on children and the sense of stability, control and optimism about the future that many participants experienced through the project.

6.4.1 Housing and finance

All domain assessment respondents who had listed housing as a priority domain had a positive change in their housing status as a result of participation in the PLAN project. Whilst the quantitative data does not show how this was achieved, anecdotal evidence from focus group participants sheds light on this. Some participants had secured a new stable rental home; some had remained in their existing home by avoiding eviction; and others had begun the process of owning or, in one case, building a home. The project provided assistance in relation to housing in the following ways:

- Logistical assistance to move (e.g. truck, trailer hire, fuel);
- Bond payment;
- Short-term rent payment;
- Assisted to move into transitional housing;
- Assisted with WA Housing application;
- Assistance to find a private rental;
- Assistance with rental applications;
- Assistance to obtain birth certificates required for rental applications;
- Referral for housing assistance (e.g. Housing Authority, crisis housing or refuge); and
- Referral to National Rental Affordability Scheme.

Ninety-four per cent of Participant Exit Survey question respondents (n=17) felt better informed about their housing assistance options as a result of the PLAN project.

Case study: Dianna

Dianna was a woman in her late twenties with a history of abuse and trauma. She was experiencing severe mental health distress and anxiety and had three children. They lived in a town near Mandurah in the rental property where Dianna's husband, who was also her abuser, had passed away. When this happened, according to one service provider, "her life fell apart"; Dianna did not know how to live independently and was both unemployed and mentally unwell. In the wake of dealing with the death of her husband, Dianna was violently attacked outside her home in the presence of her children, and this compounded her fear and mental distress.

Dianna was referred to the PLAN project by a police officer who assisted her after the attack and felt that Dianna required the holistic, practical and compassionate support that a PLAN mentor could provide. Because of the complexity of Dianna's situation, and her and her children's level of vulnerability, at least six government agencies were involved. Dianna was both traumatised and overwhelmed by her circumstances and mental health, and thus although she urgently required help, she was not accessing or maintaining contact with services due to multiple barriers. According to a service provider, the agencies were "all working independently" and "no one was connected", creating further administrative and logistical barriers. Dianna was also at imminent threat of eviction from her home due to not allowing anybody into the property and not keeping it clean.

Dianna was able to make progress in her life circumstances and level of confidence through the support that the PLAN project offered generally, and through the role her mentor played in helping her to navigate different agencies and avoid further crisis. The project's individualised, person-centered case management could provide the relational and practical support that Dianna needed to cope, heal and improve. The PLAN project was able to support Dianna to make small, positive

steps to improve the family's circumstances (as well as Dianna's confidence levels). This included immediate support:

> *"[Her mentor] picked up on the social issues that victims of crime experience. [Her mentor] was able to take her to hospital appointments, complete the victim impact statement, and get essentials that she needed just to get through each day" – Service provider*

A key priority was ensuring that Dianna and her children would not become homeless due to eviction. Dianna's PLAN mentor was able to build a relationship with Dianna and successfully enter and clean her home to allow a rent inspection to take place. This included filling a skip with rubbish, and also providing new bedding for Dianna's children – both of which were paid for by the PLAN project's brokerage fund without unnecessary delay. This has allowed Dianna and her children to remain in their home until a more suitable dwelling without traumatic associations can be found. Service provider evidence indicates that Dianna is now keeping her home at an improved standard. Working with PLAN has had positive effects on Dianna's mental health as well as the lives of her children:

> *"She's gradually getting back some confidence. She was excited about taking her kids to Skyworks – that's the first time she's left the house" – Service provider*

The PLAN project also helped Dianna to engage with the Department of Justice by writing a victim impact statement with her mentor which she was "incapable" of writing by herself, and this allowed court sentencing and will enable Dianna to apply for government compensation.

It is significant that Dianna has been able to achieve positive outcomes with PLAN, both materially and psychologically, given the state of crisis she was in at the point of referral. The sense of trust built between Dianna and her PLAN mentor allowed for "consistent engagement" over a long period, both with PLAN and other services:

> *"It's been extraordinarily difficult to engage this client for a lot of services. There are multiple services involved… She's still connecting with [her PLAN mentor] and I won't say it's all smooth sailing and all the outcomes have been achieved, but just the fact that there has been a consistent engagement across six or seven months with this participant, there has been some improvements with how she's keeping her home. And you know, with the kids and setting up their home environment, making it a better place because [PLAN has] been able to fund a skip" – Service provider*

When prompted to think about what would happen to Dianna without the support of PLAN, one service provider said:

> *"She would be forgotten. All the government agencies would say, 'Well we sent her an email, we tried to call her, we've done our bit…'. And her eldest son's going to be a criminal, he's going off the rails – the three children witnessed her having her face slashed. It would just get worse… Everybody kind of says, 'Well we've tried to help her, but she doesn't want help.' What happens is the next case comes along, and she just gets forgotten" – Service provider*

Thus, the ability for PLAN to be an advocate for Dianna has been significant in helping her to access appropriate services and avoid worsening crisis. The informal co-case management that Dianna received from PLAN and at least two other service providers allowed for greater progress and less

overwhelm, indicating an important function of the PLAN project in helping to provide wraparound support in collaboration with other services to address complexity and crisis.

The finance domain in the domain assessment data displayed the third-strongest average change in the life circumstances category among participants for whom it was listed as a priority area. Of these participants, 90% had a positive change in their financial situation as a result of the PLAN project and 10% recorded no change. As seen in Figure 24, the Participant Exit Survey also showed strong outcomes related to finance: 55% of question respondents (n=20) strongly agreed and 20% agreed that they felt more confident about their financial situation, and 55% strongly agreed and 10% agreed that they were better able to address debts (the remainder possibly did not have debts to address). Eighty per cent of question respondents felt better able to plan their budget and felt better able to access help with their finances when they need it.

> *"I feel supported mentally, emotionally, physically… The things that had built up, they're not a problem anymore" – Focus group member*

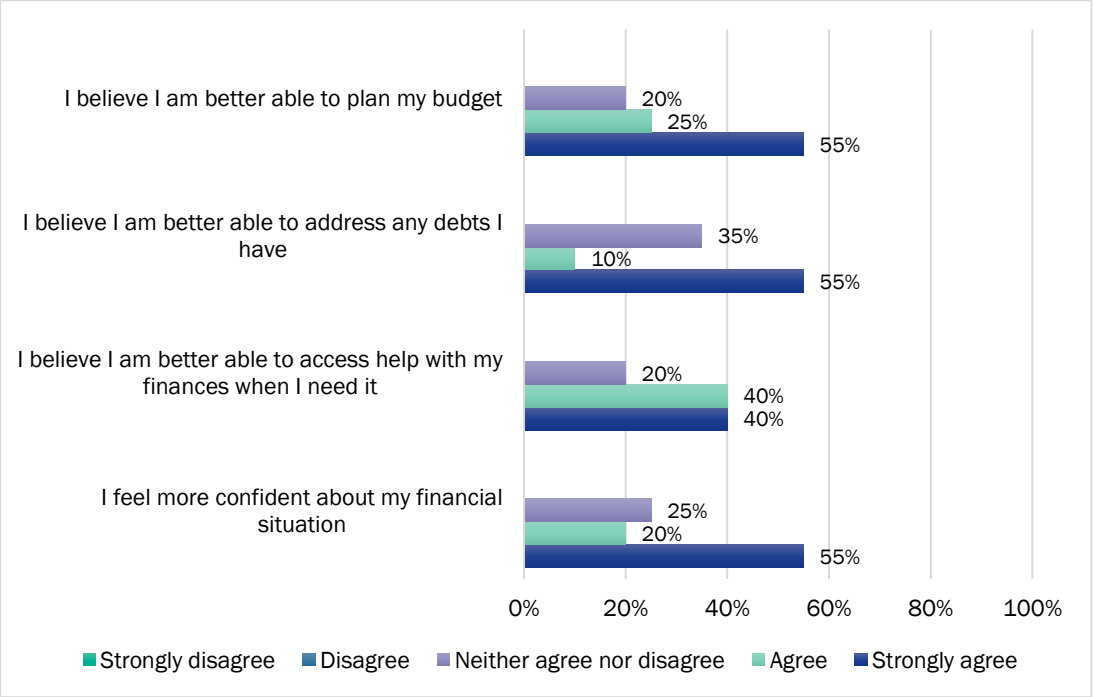

Figure 24: Financial situation agreement scales (source: Participant Exit Survey)

Immediate concerns such as financial issues were addressed by brokerage funds and one-on-one mentorship in particular. In some cases, this prevented crisis or an escalation of issues, particularly for concerns related to housing (e.g. being unable to pay household bills and being at risk of eviction):

> *"Without the project I probably would have lost my license [and] I wouldn't have seen a way to manage my bills with the finances I have" – Focus group member*

> *"We were about to be evicted, couldn't pay bills, winter was coming… through the project all the mess was gathered up, everything was smoothed out" – Focus group member*

Many participants were supported to address short-term financial concerns; Section 5.4.5 explored how brokerage funds provided essential assistance. In many cases, addressing these immediate concerns allowed for attention to be turned to medium- and long-term financial issues and goals, including paying off debt, obtaining secure employment, and saving for a house.

6.4.2 Family relationships and effects on children

Almost three-quarters of domain assessment respondents for whom this domain was a priority area had a positive change in their family relationships as a result of engaging with the PLAN project, and 33% recorded no change. For the parenting and children domain, 78% of respondents for whom the domain was a priority recorded a positive change and 22% recorded no change. The quantitative data does not show in what ways this was achieved; however, other data sources (particularly focus group data) indicate that positive changes were usually a product of either leaving an abusive relationship, and/or improving parenting skills or relationships with children as a result of improved mental health and addressing stressful life circumstances. Figure 25 shows a positive average change of +1.33 in the family relationships domain and +1.78 in the parenting and children domain for people whom it was a priority area.

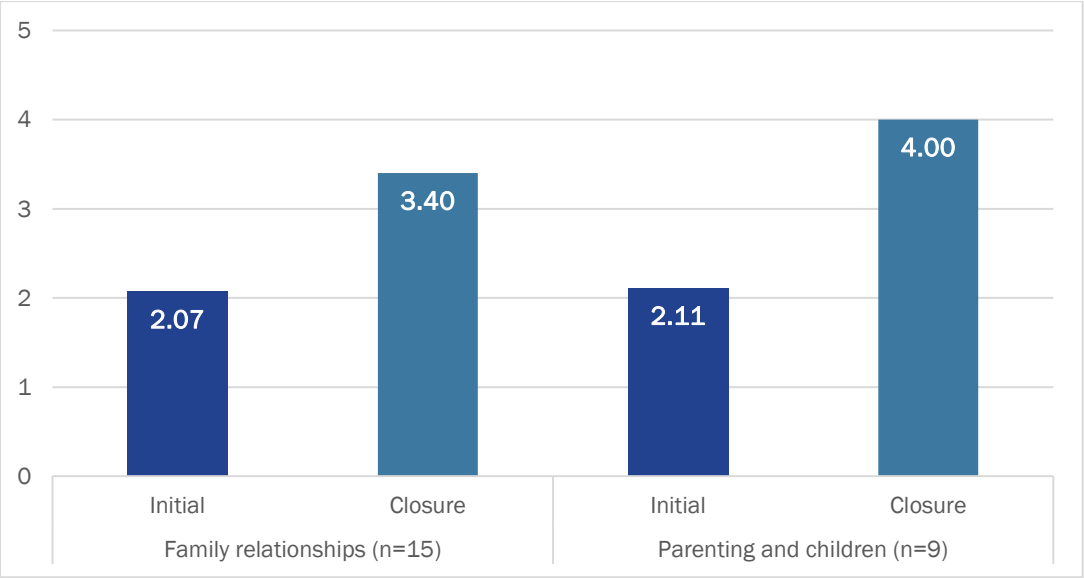

Figure 25: Average change in family relationships and parenting and children domains (source: domain assessment data)

Participant Exit Survey data also showed that 100% of question respondents (n=13) felt better able to manage their family relationships after participation in the PLAN project, and 100% felt better informed to access help with their family relationships.

It is significant that the positive effects of participants' progress in the domains described above is passed down to children. The opposite is also true, as the literature review explored (see Section 2). The anecdotal evidence gathered among focus group members indicates that the positive domino effects of the PLAN project's impact on parents and children has been considerable, and this is not captured fully in the quantitative data. Some ways this happened include: through the improved mental wellbeing of parents; greater 'presence' and parenting capacity; greater means to support children (including financial); the parent exiting them and their child(ren) from unstable or unsafe living circumstances or relationships; making appointments for children (e.g. counselling and NDIS support);

a greater felt sense of security and stability; and a reduced stress load which can create opportunities for fun and play in the household. The below quotes present some evidence for this:

> *"I'm a better mother, sister, daughter… It's affected every aspect of my life because of forgiveness and healing. I've got the skills to stand up [now]" – Focus group member*

> *"For women [PLAN] is so good because we're the key people in the household… we're complete proof that it's worked" – Focus group member*

> *"Not only is it empowering women, but the children underneath" – Focus group member*

> *"All this mess, over time it all got smoothed out. I don't have savings but I'm not at threat of eviction. Our house is happy… We laugh, we play board games, there's a garden, we grow things now. I didn't fully understand that my role as a mother was so foundational… We can see future possibilities now" – Focus group member*

This suggests that the PLAN project is influential in helping to prevent and address the intergenerational transmission of trauma, which we know from the literature can be 'make or break' for an individual and community in terms of life outcomes and mental health and wellbeing.

> *"If the parents are struggling, then what's going to happen to those children growing up? And we already see it. We see that mental health is blowing out of proportion and generally, it's linked to trauma as children… There really isn't much at all out there [to support children] and we do have some very traumatized children. So through this project we might think we're helping the parents – and we are helping the parents – but we're really helping the children" – Service provider*

> *"This is a great form of guidance. I have grown and achieved a lot thanks to [my mentor's] positivity rubbing off. This project benefits the community so much, pretty much coaching people into becoming role models for future generations" – Survey respondent*

6.4.3 Stability, control and looking to the future

A feeling of greater stability and control was a significant theme that ran through many of the stories we heard. One focus group participant said that the PLAN project provided "steps to stability" and helped with "not letting the stress build" – this was foundational to being able to achieve many short- and longer-term goals. A significant part of this was feeling able to plan for the future and having the confidence to take steps forward independently, without the ongoing support of a mentor. One focus group participant reflected: "We're all capable, we just need a kick to do it". Although many focus group members felt worried about the discontinuation of their mentor's support – which seemed to be a lifeline for some – there was also a sense of growing confidence in their own strength and abilities:

> *"I don't like new things, but when I did start [the project], it was the best thing I've ever done. My life has been a lot better since… [My mentor] made me believe in myself" – Focus group member*

> *"PLAN offers life management… it's about the future, not just this week" – Focus group member*

> *"I thought I was someone who couldn't do anything by myself – but I realised that's not true… Now I'm building a house by myself, I didn't think I could do that" – Focus group member*

Another way that focus group participants framed what they got from the PLAN project was in terms of "thinking bigger": through the mentorship provided and the steps they took towards goals, there was a realisation that there could be more to life than making ends meet and merely surviving. One participant commented that the project had provoked her to think, after successfully obtaining employment, "Why not get a $60-70k job and build a house?". Another reflected that "You want to go further and further [ahead], you don't want to be stuck in the same spot". The confidence to be ambitious in improving life circumstances will likely have impacts beyond what is captured here.

> *"I'll never go back there [to my previous life/problems] because I'm so empowered as a person now, I look up now… This project gives you the ability to walk on your own" – Focus group member*

Many service providers also reflected that their clients had been supported to improve their life circumstances and gain a sense of stability through the PLAN project, particularly in the context of poor mental health and low self-esteem:

> *"I remember one family that came to me. And when I went to the home, you know, there was a referral from Child Protection saying that this family had very limited financial means and they had very limited supplies for their newborn baby, both parents were unemployed, both parents couldn't drive… So I referred that family to PLAN and I've since caught up [with them]. I think the baby's now about one year old, and I remember when I first met the mother, she was quite a depressed young mum with her little baby. But when I saw her [recently] after being with PLAN for a year, she was really bubbly, she was learning to drive. And that was because of PLAN. She had finished a course in childcare. And she [had a] plan for the future. And I just felt like that mother when I first met her, didn't have a lot of hope for the future, and because of PLAN she now has some direction for herself" – Service provider*

When prompted to consider what life would be like for their clients if they could not refer them to the PLAN project, service providers indicated that clients would have a much higher level of unmet need and would be "touching base with lots of different other services" to try and have their needs met. Because of the PLAN project many participants were able to make progress relatively quickly in multiple areas and have a positive outlook for the future. When asked what would happen without PLAN, one service provider reflected:

> *"I could imagine that the ability to overcome the impact of FDV on these clients' lives would last a lot longer. These clients probably wouldn't be getting back into the workforce or able to support themselves… They wouldn't be ready to do these things as quickly as they could if [they didn't have the] wraparound support from PLAN. For the clients that have been involved with PLAN we kind of just see that change happening… Their capacity to look after themselves and function in society again starts building a lot quicker than it would if they were having to try and access this and that service to meet these different needs and then not necessarily having them met" – Service provider*

Case study: Helen

Helen was a young, single mother who described herself as "severely depressed" before joining the PLAN project. She had grown up in an abusive foster care home after being abandoned by her biological family, and was experiencing anxiety, social isolation, low confidence and low self-esteem, and had been involved in a ten-year FDV relationship. She also had a physical disability for which she required medical attention. She could not work due to her difficulties and had a ten year-old daughter. She commented on her deep frustration with the support she had attempted to seek elsewhere over the years, particularly around her mental health.

Through her time on the PLAN project, Helen developed more confidence and a stronger sense of self, and her mental health improved significantly. Her self-esteem score on the Rosenberg Self-Esteem Scale had improved from 12 to 28 (out of 30) after 3 months in the project, and her self-assessed mental health score improved from 3 to 4 (out of 5). After 3 months her disability score also improved to 4 (out of 5) from 1 at her initial assessment. At the time of the focus group, Helen had started casual employment as a cleaner for a few hours a week as a way to slowly enter the workforce. Her employment domain score improved from 2 to 4. Helen was extremely enthusiastic about following in her mentor's footsteps and supporting other women who had been through similar circumstances, and this was a longer-term goal she was working towards:

> *"Psychologists and counsellors keep you in a prison… I wanted to die, and I told [my psychologist] that every time I went to see her. She told me I had to stay that way… But [my mentor] gives everyone the key to ourselves. She unlocks us… I feel like I've got my boat by the steering wheel and I can go where I want to go. It's so cool. Psychologists just told me to take a pill"*

She felt that the power of PLAN lay particularly in "uncovering who you are" and "rewriting beliefs". This included beliefs about herself and finding "self-love" for the first time:

> *"I grew up not asking for anything. I can use my voice now. I had no identity. [PLAN helped with] getting to know me at the deeper level"*

Helen said she needed the ongoing support of "a constant" to help her move forward from a dark and overwhelming place, as well as a sense of connection. She was extremely grateful for the PLAN project and attributed her progress to it, and at the time of her three-month review, her parenting capacity had improved from a 4 to 5 (out of 5):

> *"My little girl says, Mum you're so happy… She's witnessed me going from rock bottom to this"*
>
> *"I'm willing to do the work, I just needed someone to walk with me… PLAN has given me the confidence to go back into the world and not hide anymore"*

6.5 Summary

The outcomes of the PLAN project for vulnerable parents have been strong in the three domains of mindset and self-development, career development, and life circumstances, with particularly strong outcomes in the domains of housing, finance, disability, mental health, further studies, law involvement and parenting and children. Participants were given "a chance to be empowered", as one focus group member put it, to move forward positively in multiple ways including through building confidence and self-esteem, feeling a sense of connectedness, gaining more financial stability, engaging in training, obtaining or making steps towards employment, and working towards longer-term goals (e.g. around housing and career). For many participants who were experiencing overwhelming circumstances, there was a sense of the PLAN project being able to bring order to the chaos and illuminate a way forward with well-sequenced and achievable steps. More than once, people (both participants and stakeholders) commented on the "hand-holding" function of the project in the way that mentors could provide much-needed emotional and practical support for participants experiencing difficulties. For most participants, rapid help with immediate, pressing concerns was fundamental to alleviating some degree of stress, and this opened up opportunities to work towards bigger medium- and long-term goals. The domino effects this had, or may have in the future - including through improved family relationships and parenting, confidence in taking independent action, engagement in the workforce and reducing burden on services - may be significant:

> *"After three months I was flying… I never would have thought I would be where I am now" – Focus group member*

7. CONCLUSIONS AND RECOMMENDATIONS

The findings suggest that the PLAN project is achieving positive impact for its participants and that its unique model of holistic support assists vulnerable individuals in ways that other services perhaps cannot. Triangulation of quantitative and qualitative data strengthened the basis for findings, and overall, the evaluation found the project to be an effective model of providing support in a range of areas to address unmet need in vulnerable parents across different demographics. The priority areas that most individuals presented with were: mental health, financial hardship, FDV, employment, housing, self-development, and education and skills training.

To capture the measurable shifts in these areas, through the PLAN project's three overarching focus areas of mindset and self-development, career development and life circumstances, the initial, 3-month and case closure domain assessments administered to participants were utilised to show changes in 14 domains on a scale of 1 to 5. This data revealed that the biggest improvements among the participants were in the domains of housing, finance, disability, mental health, further studies, law involvement and parenting and children. A positive change in self-esteem and confidence occurred for over 80% of surveyed participants, and the majority of participants felt career ready after their time in the project.

Of the 67 participants who were enrolled and took part in targeted support activities, 23 were previously unemployed and gained employment with the assistance of the PLAN project. This represents 34% of all participants. Many also acquired additional employment or undertook further studies and trainings. Focus group participants spoke of the hope and optimism they felt as a result of being involved in the PLAN project, and the confidence they felt in being able to take independent action. Participants' life circumstances also often improved significantly, with 100% of participants for whom housing was a priority domain having a positive change in their housing situation and over-three quarters achieving positive change in their financial situation, physical health, disability, law involvement and parenting.

The below quote captures the heart of the project's impact on the vulnerable parents that it supported and potentially on their children as well:

> *"Before I attended PLAN I needed all this help, I was depressed and not coping. I was overwhelmed and wanted to focus on bettering my future, but I had so many questions and no-one to ask or even know where to go to get help. PLAN is continuing to build my confidence… I am moving in the right direction to better my life for my children" – Survey respondent*

Although not all participants achieved all of their goals within the timeframe of the project, significant progress was often made in at least one domain which tended to have a positive 'domino effect' in other domains, the long term impact of which cannot be captured here. However, as the above quote demonstrates, outcomes achieved is not always the best measure of success. Some impacts are less tangible and measurable: "moving in the right direction" may be incremental but still significant given the complex vulnerability and trauma that many PLAN participants were experiencing.

The process evaluation showed that the PLAN project offered a unique model of holistic support that provided a sense of safety, connection and relational support that could not be found elsewhere. Although not a replacement for other services, there was strong evidence to suggest that the PLAN

project was a necessary support in the area to 'fill the gaps' that service providers could not. Almost three-quarters of the people who were referred to the project enrolled in it, and of these, 80% took part in targeted support activities. However, there were barriers that prevented some from engagement or led to early disengagement from the project, and these included mental health issues, overwhelming life circumstances, transport barriers, and new parenthood. While overwhelm was a barrier to engagement for some individuals, it was also a factor promoting engagement for other individuals who often reported lacking the clarity and means to move forward.

Overall, we found that the PLAN project met participants' needs well and that participants were very satisfied with the project delivery and what they were able to achieve through it. The factors which particularly promoted successful project delivery were: the lived experience of the mentors; a sense of connection and safety with the mentors; building self-worth and confidence; practical support and planning; the individualised, holistic nature of the project; the speed of access and financial help; and feeling able to engage with the world again. These factors promoted a sense of feeling seen, heard and understood among participants, and a feeling of being genuinely supported.

The balance of relational and practical elements of support made the PLAN project particularly effective for addressing material concerns as well as social and emotional wellbeing. The bespoke suite of activities offered to clients was adapted to their needs, and we found that progress often happened quite quickly for participants, and this was strongly supported by the one-to-one mentoring and the brokerage funds. Group sessions often built on this foundation by offering participants meaningful skills, knowledge, and opportunities for connection. This, together with other activities provided, equipped participants with a whole-of-person approach to addressing vulnerability and risk.

Ultimately, the anticipated impact of the PLAN project is long-term social wellbeing and economic independence for vulnerable parents. The evidence collected for this evaluation showed that through improving the mindset and self-development, career development, and life circumstances of participants, the PLAN project helped to create social and emotional wellbeing for clients as well as – and often as a precursor to – career readiness and employment. The quality of the anecdotal evidence collected is indicative of the strong potential for sustained change in many participants' lives. Although it was beyond the scope of this work to provide analysis of potential cost savings to the economy and the service industry based on the needs that the project was able to address for vulnerable parents, this is another impact which likely holds significance.

> *"I will no longer be a statistic; I won't go back there – now the world is my oyster" – Focus group member*

Based on the data collected, our recommendations are as follows:

1. The PLAN project be continued in the Peel and southwest region to improve the circumstances and wellbeing of parents and their children;

2. Recruitment methods be improved to identify vulnerable individuals who are not already linked in with services, or may not know of any support options available to them;

3. That men experiencing FDV as a parent be actively identified and supported as a vulnerable group;

4. Additional, tailored support be provided to single parents, CALD parents, Indigenous parents, parents experiencing un/underemployment, and parents experiencing housing vulnerability;

5. Where necessary, high-need individuals be co-case managed with other service providers and government departments;

6. That there be outreach to communities beyond the Mandurah, Rockingham and Kwinana local government areas, in addition to Pinjarra;

7. That access barriers for vulnerable parents who disengage, do not engage at all, or have not discovered the PLAN project, be addressed;

8. That barriers faced by enrolled participants to engage in project activities (e.g. lack of transport) be addressed.

Overall, the evaluation found that the PLAN project is having a positive impact on vulnerable parents and transforming families in the Peel region. Vulnerable parents in other localities could benefit from this innovative service delivery model.

"It's still new to me, [but] I love this normal feeling… I live in such a better way. I have confidence to go back out into the world" – Focus group member

---

REFERENCES

ABS, 2017. *Personal Safety, Australia, 2016.* [Online]
Available at: www.abs.gov.au
[Accessed 23 January 2023].

Aguilar, R. J. & Nightingale, N. N., 1994. The impact of specific battering experiences on the self esteem of abused women. *Journal of Family Violence,* 9(1), pp. 35-45.

AIHW, 2022. *Specialist homelessness services annual report 2021–22,* s.l.: Australian Institute of Health and Welfare .

Alhalal, E., Ford-Gilboe, M., Kerr, M. & Davies, L., 2012. Identifying factors that predict women's inability to maintain separation from an abusive partner. *Issues in Mental Health Nursing,* 33(12), pp. 838-850.

Almond, P., 2009. Postnatal depression: A global public health perspective. *Perspectives in Public Health,* 129(5), pp. 194-240.

Bacchus, L. J., Ranganathan, M., Watts, C. & Devries, K., 2018. Recent intimate partner violence against women and health: a systematic review and meta-analysis of cohort studies. *BMJ Open,* 8(7), pp. 1-20.

Bargai, N., Ben-Shakhar, G. & Shalev, A., 2007. Posttraumatic Stress Disorder and depression in battered women: The mediating role of learned helplessness. *Journal of Family Violence,* 22(5), pp. 267-275.

Baxter, J., Hewitt, B. & Haynes, M., 2008. Life course transitions and housework: Marriage, parenthood, and time on housework. *Journal of Marriage and Family,* Volume 70, pp. 259-272.

Bean, J. & Moller, A. T., 2002. Posttraumatic stress and depressive symptomatology in a sample of battered women from South Africa. *Psychological Reports,* Volume 9, pp. 750-752.

Boath, E. H., Pryce, A. J. & Cox, J. L., 1998. Postnatal depression: The impact on the family. *Journal of Reproductive and Infant Psychology,* 16(2-3), pp. 199-203.

Bonomi, A. E. et al., 2009. Medical and psychosocial diagnoses in women with a history of intimate partner violence. *Archives of Internal Medicine,* 169(18), pp. 1692-1697.

Brown, B., 2012. *Daring Greatly: How the Courage to Be Vulnerable Transforms the Way We Live, Love, Parent, and Lead.* New York: Gotham Books.

Cairney, J., Boyle, M., Offord, D. R. & Racine, Y., 2003. Stress, social support and depression in single and married mothers. *Social Psychiatry and Psychiatric Epidemiology,* Volume 38, pp. 442-449.

Campo, M. & Commerford, J., 2016. *Supporting young people leaving out-of-home care,* s.l.: Australian Institute of Family Studies.

Chamberlain, C. & Johnson, G., 2013. Pathways into adult homelessness. *Journal of Sociology,* 49(1), pp. 60-77.

Chambers, R., 1983. *Rural development: Putting the last first.* Harlow: Prentice Hall.

Chang, J. C. et al., 2005. Health care interventions for intimate partner violence: What women want. *Women's Health Issues,* 15(1), pp. 21-30.

Chapman, C. R., Tuckett, R. P. & Song, C. W., 2008. Pain and stress in a systems perspective: Reciprocal neural, endocrine, and immune reactions. *The Journal of Pain,* 9(2), pp. 122-145.

Commonwealth of Australia, 2013. *A national framework for recovery-oriented mental health services: Policy and theory,* Canberra: s.n.

Commonwealth of Australia, 2017. *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023,* Canberra: s.n.

Commonwealth of Australia, 2022. *National Plan to End Violence against Women and Children 2022–2032,* Canberra: s.n.

Crofford, L. J., 2007. Violence, stress, and somatic syndromes. *Trauma Violence Abuse,* 8(3), pp. 299-313.

Cromwell, N. & Burgess, A. W., 1996. *Understanding violence against women.* Washington(DC): National Academy Press.

Cutrona, C. E. & Russell, D. W., 1990. Type of social support and specific stress: Toward a theory of optimal matching. In: B. R. Sarason, I. G. Sarason & G. R. Pierce, eds. *Social support: An interactional view.* New York: John Wiley & Sons, pp. 319-366.

Delicate, A., Ayers, S. & McMullen, S., 2018. A systematic review and mata-synthesis of the impact of becoming parents on the couple relationship. *Midwifery,* Volume 61, pp. 88-96.

Department of Communities, 2020. *All Paths Lead to a Home: Western Australia's 10-Year Strategy on Homelessness 2020–2030,* s.l.: Government of Western Australia.

Department of Health, 2021. *Prioritising Mental Health (Pillar 4) – Supporting vulnerable Australians (Budget 2021-22),* Canberra: Commonwealth of Australia.

Dube, S. et al., 2001. Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the life span: Findings from the adverse childhood experiences study. *JAMA,* 286(24), pp. 3089-3096.

Dube, S. R. et al., 2003. Childhood abuse, neglect, and household dysfunction and the risk of illicit drug use: the adverse childhood experiences study. *Pediatrics,* 111(3), pp. 564-72.

Dudgeon, P. et al., 2014. Enhancing Wellbeing, Empowerment, Healing and Leadership. In: P. Dudgeon, H. Milroy & R. Walker, eds. *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice.* 2 ed. Canberra: Commonwealth of Australia, pp. 437-448.

Edleson, J. L., 1999. Children's Witnessing of Adult Domestic Violence. *Journal of Interpersonal Violence,* 14(8), pp. 839-870.

Edward, K. et al., 2015. An Integrative Review of Paternal Depression. *American Journal of Men's Health,* 9(1), pp. 5-85.

Ellsberg, M. et al., 2008. Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: an observational study. *Lancet,* Volume 371, pp. 1165-1172.

Field, T., Hernandez-Reif, M. & Diego, M., 2006. Risk factors and stress variables that differentiate depressed from nondepressed pregnant women. *Infant Behaviour & Development,* 29(2), pp. 169-174.

Flaherty, E. et al., 2009. Adverse Childhood Exposures and Reported Child Health at Age 12. *Academic Pediatrics,* 9(3), pp. 150-156.

Flanagan, K., Blunden, H., valentine, k. & Henriette, J., 2019. *Housing outcomes after domestic and family violence,* Melbourne: Australian Housing and Urban Research Institute Limited.

Flatau, P. et al., 2005. *Indigenous access to mainstream public and community housing,* Melbourne: Australian Housing and Urban Research Institute.

Flatau, P. et al., 2022. *Ending Homelessness in Western Australia 2022,* Perth: Centre for Social Impact, University of Western Australia.

Ford-Gilboe, M. et al., 2020. Longitudinal impacts of an online safety and health intervention for women experiencing intimate partner violence: randomized controlled trial. *BMC Public Health,* 20(260).

Goodman, L. A. et al., 2016. Bringing a network- oriented approach to domestic violence services: A focus group exploration of promising practices. *Violence Against Women,* 22(1), pp. 64-89.

Goodman, L. A. & Smyth, K. F., 2011. A call for a social network-oriented approach to services for survivors of intimate partner violence. *Psychology of Violence,* 1(2), pp. 79-92.

Herman, J. P., 2013. Neural control of chronic stress adaptation. *Frontiers in Behavioral Neuroscience,* 7(61), pp. 1-12.

Hughes, K. et al., 2017. The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis. *Lancet Public Health,* 2(8), pp. e356-e366.

Hulme, S., Morgan, A. & Boxall, H., 2019. Domestic violence offenders, prior offending and reoffending in Australia. *Trends & issues in crime and criminal justice,* Volume 580.

Humphreys, J. & Lee, K. A., 2009. Interpersonal violence is associated with depression and chronic physical health problems in midlife women. *Issues in Mental Health Nursing,* Volume 30, pp. 206-213.

Hynes, K. & Clarkberg, M., 2005. Women's employment patterns during early parenthood: A group-based trajectory analysis. *Journal of Marriage and Family,* Volume 67, pp. 222-239.

Johner, R. L., 2007. Allostatic Load: Single Parents, Stress-Related Health Issues, and Social Care. *Health and Social Work,* 32(2), pp. 89-94.

Johnson, G. et al., 2010. *Pathways from out-of-homecare,* Melbourne: Australian Housing and Urban Research Institute.

Johnson, G., Scutella, R., Tseng, Y. & Wood, G., 2015. *Entries and exits from homelessness: A dynamic analysis of the relationship between structural conditions and individual characteristics,* Melbourne: Australian Housing and Urban Research Institute.

Kaleveld, L., Atkins, M. & Flatau, P., 2019. *Homelessness in culturally and linguistically diverse populations in Western Australia,* Perth: Department of Communities.

Kaleveld, L. et al., 2018. *Homelessness in Western Australia: A review of the research and statistical evidence,* Perth: Centre for Social Impact, University of Western Australia.

Karakurt, G., Smith, D. & Whiting, J., 2014. Impact of intimate partner violence on women's mental health. *Journal of Family Violence,* 29(7), pp. 693-702.

Kessler, R. C., Molnar, B. E., Feurer, I. D. & Appelbaum, M., 2001. Patterns and mental health predictors of domestic violence in the United States: Results from the National Comorbidity Survey. *International Journal of Law and Psychiatry,* 24(4-5), pp. 487-508.

Lee, B. & Tyler, K. W. J., 2010. The new homelessness revisited. *Annual Review of Sociology,* Volume 36, pp. 501-21.

Lester, L. et al., 2021. *Supporting women and children experiencing family and domestic violence: the Zonta House impact report,* s.l.: s.n.

Mackenzie, D., Flatau, P., Steen, A. & Thielking, M., 2016. *The cost of youth homelessness in Australia research briefing,* Melbourne: s.n.

Maslow, A. H., 1943. A theory of human motivation. *Psychological Review,* 50(4), pp. 370-396.

McEwen, B. S. & Wingfield, J. C., 2003. The concept of allostasis in biology and biomedicine. *Hormones and Behavior,* 43(1), pp. 2-15.

McLachlan, R., Gilfillan, G. & Gordon, J., 2013. *Deep and Persistent Disadvantage in Australia: Productivity Commission Staff Working Paper,* Melbourne: Commonwealth of Australia.

Monaguchi, M. & Milkie, M. A., 2003. Costs and rewards of children: The effects of becoming a parent on adults' lives.. *Journal of Marriage and Family,* 65(2), pp. 356-374.

Morgan, A. & Boxall, H., 2020. Social isolation, time spent at home, financial stress and domestic violence during the COVID-19 pandemic. *Trends & issues in crime and criminal justice,* Volume 609.

Nolet, A., Morselli, C. & Cousineau, M., 2021. The Social Network of Victims of Domestic Violence: A Network-Based Intervention Model to Improve Relational Autonomy. *Violence Against Women,* 27(10), pp. 1630-1654.

O'Flaherty, B., 2004. Wrong person and wrong place: for homelessness, the conjunction is what matters. *Journal of Housing Economics,* Volume 13, pp. 1-15.

Olofsson, N. et al., 2011. Physical and psychological symptoms and learning difficulties in children of women exposed and non-exposed to violence: a population-based study. *International Journal of Public Health,* 56(1), pp. 89-96.

Orr, C. et al., 2020. Exposure to family and domestic violence is associated with increased childhood hospitalisations. *PLoS One,* 15(8), pp. 1-18.

Parliament of Australia, 2021. *Inquiry into homelessness in Australia,* Canberra: Commonwealth of Australia.

Pattavina, A., Socia, K. & Zuber, M., 2015. Economic stress and domestic violence: Examining the impact of mortgage foreclosures on incidents reported to the police. *Justice Research and Policy,* 16(2), pp. 147-164.

Pleace, N., 2000. The new consensus, the old consensus and the provision of services for people sleeping rough. *Housing Studies,* 15(4), pp. 581-94.

Reck, C. et al., 2008. Prevalence, onset and comorbidity of postpartum anxiety and depressive disorders. *Acta Psychiatrica Scaninavica,* 118(6), pp. 459-468.

Richards, K., 2011. *Children's Exposure to Domestic Violence in Australia Trends & issues in crime and criminal justice no. 419,* Canberra: Australian Institute of Criminology.

Roddy, J. K., 2013. Client perspectives: The therapeautic challenge of domestic violence counselling - a pilot study. *Counselling and Psychotherapy Research,* 13(1), pp. 53-60.

Ruppanner, L., Perales, F. & Baxter, J., 2018. Harried and unhealthy? Parenthood, time pressure and mental health. *Journal of Marriage and Family,* 81(2), pp. 308-326.

Seligman, M., 1975. *Helplessness: On depression, development and death.* San Francisco: Freeman.

Smith, N. & Weatherburn, D., 2013. Personal stress, financial stress, social support and women's experiences of physical violence: A longitudinal analysis. *Crime and Justice Bulletin,* Volume 169.

Spinney, A., Habibis, D. & McNelis, S., 2016. *Safe and sound? How funding mix affects homelessness support for Indigenous Australians,* Melbourne: Australian Housing and Urban Research Institute.

Stainton, L., 2016. Children as the forgotten victims of domestic and family violence: Time for reform in Western Australian Refuges. *The Australian Community Psychologist,* 28(1), pp. 79-88.

Stover, C. S., 2005. Domestic violence research: What have we learned and where do we go from here?. *Journal of Interpersonal Violence,* 20(4), pp. 365-519.

Symes, L. et al., 2013. The association of pain severity and pain interference levels with abuse experiences and mental health symptoms among 300 mothers: Baseline data analysis for a 7-year prospective study. *Issues in Mental Health Nursing,* 34(1), pp. 2-16.

Victorian Government, 2012. *Family Violence Risk Assessment and Risk Management Framework and Practice Guides 1-3: Edition 2,* Melbourne: s.n.

Vives-Cases, C., Ruiz-Cantero, M. T., Escribà-Agüir, V. & Miralles, J. J., 2010. The effect of intimate partner violence and other forms of violence against women on health. *Journal of Public Health,* 33(1), pp. 15-21.

Vlais, R., 2014. *Domestic violence perpetrator projects: Education, therapy, support, accountability 'or' struggle?,* Melbourne: No to Violence.

Vlais, R., Ridley, S., Green, D. & Chung, D., 2017. *Family and domestic violence perpetrator projects: Issues paper of current and emerging trends, developments and expectations,* s.l.: Stopping Family Violence Inc..

Warner, M. S., 1996. How does empathy cure? A theoretical consideration of empathy, processing and personal narrative. In: R. Hutterer, G. Pawlowsky, P. F. Schmid & R. Stiptits, eds. *Client-Centrered and Experiential Psychotherapy: a Paradigm in Motion.* Frankfurt-am-Main: Peter Lang.

Watts, M. J. & Bolhe, G., 1993. Hunger, famine and the space of vulnerability. *Geojournal,* 30(32), pp. 117-125.

WHO, 2002. *World Report on Violence and Health,* Geneva: World Health Organization.

WHO, 2016. *Global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children,* Geneva: World Health Organisation.

Williams, J. R., Cole, V., Girdler, S. & Cromeens, M. G., 2020. Exploring stress, cognitive, and affective mechanisms of the relationship between interpersonal trauma and opioid misuse. *PLoS ONE,* 15(5), pp. 1-19.

Williams, M. R. et al., 2018. Intimate Partner Violence Victimization and Cognitive Function in a Mixed-Sex Epidemiological Sample of Urban Adults. *Violence and Victims,* 32(6), pp. 1133-1148.

Wood, G., Batterham, D., Cigdem, M. & Mallett, S., 2015. *The structural drivers of homelessness in Australia 2001–11,* Melbourne: Australian Housing and Urban Research Institute.

Wuest, J. et al., 2009. Abuse-related injury and symptoms of posttraumatic stress disorder as mechanisms of chronic pain in survivors of intimate partner violence. *American Academy of Pain Medicine,* 10(4), pp. 739-747.

Wuest, J. et al., 2008. Chronic pain in women survivors of intimate partner violence. *Journal of Pain,* 9(11), pp. 1049-1057.

Young, K., 1998. *Homelessness in the Aboriginal and Torres Strait Islander Context and its possible implications for the Supported Accommodation Assistance Project (SAAP),* Sydney: Department of Family and Community Services.

CENTRE for SOCIAL IMPACT

THE UNIVERSITY OF WESTERN AUSTRALIA