Working with families who are experiencing homelessness, poverty, marginalisation and the seductiveness of substance use

Introduction

The number of children and young people in Ireland who are experiencing poverty, homelessness or accommodation insecurity and associated educational, social and health related impact is on the rise. In the circumstances it is important that professionals working with young people and their families do not participate in shaming or silencing the voices of those affected. Rather it is incumbent on services and professionals to develop an ethic of hospitality and supportive relationships which may help to create a buffer from adverse circumstances. Practitioners also carry a responsibility to identify, quantify, describe and publicise the range of issues/factors they encounter that are causing distress in the lives of the people they meet in order to generate debate, inform policy and maintain solidarity in context of social injustice.

Mapping the landscape

There is growing evidence of the incidence of child homelessness and poverty in Ireland. Official Statistics from the Department of Health showed 6,480 adults and 3,784 children/dependants accessed emergency accommodation during the week beginning 18th February 2019, a total of 10,264 people (Irish Times, March 27th 2019). Reports indicate that the rate of child homelessness rose by two hundred and eighty seven per cent in three years and that child homelessness accounts for one third of the country's homeless population (Irish Times, November 8th 2017). A report by DePaul Trust on activity within their homeless services during 2018 stated that there were fifteen babies born into its services during 2018 (DePaul, 2019). According to Peter McVerry Trust (2018) the number of people accessing State funded emergency accommodation rose from 7,167 in January 2017 to 9,104 in January 2018, an increase of twenty seven per cent. In this practitioners experience these statistics do not reflect the full extent of homelessness or accommodation insecurity as they do not take into account the number of individuals and families who are being accommodated within their extended family or by friends.

Defining homelessness

In considering homelessness, most people think of individuals who are sleeping rough or who are accessing night shelters. However, FEANTSA, the European umbrella organisation for agencies working with homeless, highlight that many more people live in vulnerable situations that equate to homelessness (Edgar, 2005, p.14). In an effort to broaden the concept of homelessness, FEANTSA, established a way of viewing people's circumstances that allows for better-quality data collection, known as the European Typology on Homelessness and Housing Exclusion (ETHOS). In this framework, the theoretical understanding is that 'there are three domains which constitute a home, the absence of which can be taken to delineate homelessness' (ibid, p.14). Within the typology emphasis is on physical domain, having an

acceptable dwelling or place to live within which people can exercise exclusive possession; social domain, relates to the maintenance of privacy and relationships and legal domain, refers to legal title. Also, Edgar (2005, p.15) clarifies that ETHOS sets out four main concepts related to homelessness, including; roof-less-ness, rough sleeping; house-less-ness, which relates to accessing hostels or temporary accommodation; insecure housing, which includes no tenancy or living under threat, and inadequately housed, which relates to squatting, overcrowding or unfit for habitation. This definition provides insight into the pathways leading to homelessness as well as the circumstances people encounter once becoming homeless and is useful as it allows for the identification of risk factors leading to homelessness and creates opportunities for the development of protective and preventative interventions.

Circumstances leading to homelessness

The circumstances leading to people becoming homeless are multiple and varied. Research carried out by Lawless and Corr (2005, p.53) highlight that 38% become homeless before age nineteen years. Among all respondents within research, 24% reported family conflict as the main reason for becoming homeless in the first place, followed by personal drug use 19%; alcohol use 13%; relationship breakdown 8%; money problems 5%; domestic violence 5%; mental illness 3% and other 23%. Among other reasons given were bereavement, eviction, physical/sexual abuse, asked to leave, unfit accommodation, institutional discharge, alcohol abuse in family, unemployment, intimidation and personal choice (ibid, pp.54-55). The research also highlighted that the prevalence of drug use within the homeless population was high with lifetime (74%), recent (64%) and current (52%) rates substantially higher than those found in the general population (19%, 6% and 3% respectively) and that alcohol remains the primary drug of choice among the homeless population (70%). Over half (52%) of the homeless population surveyed were reported as current drug users; 36% of those surveyed were problematic drug users; 19% of the study population were currently injecting drugs. The majority (87%) first used drugs prior to homelessness and over two thirds (68%) of current users were less than 16 years when they first used drugs and cannabis was the first drug used (76%). Over the course of 2018 DePaul Trust witnessed a huge rise in the number of suspected overdoses within its services. The number of suspected overdoses stood at 127, reflecting an eighty one percent increase on 2017 (DePaul, 2019).

In a study commissioned by Focus Ireland into Young Families in the Homeless Crisis (Lambert, O'Connell & Jump 2018), substance misuse by a number of participants' parents was a recurrent theme, which led to departure from family home. It is reported that frequently parents and care-givers created hostile environments due to their use of alcohol and/or drugs (ibid, p.25). Also within the study one participant was reported to be in and out of his mother's supported accommodation and moved around between different family members as a result of his mother's opiate dependence. Another participant, who had been in care, left one of her foster homes due to her foster carer's use of alcohol, having been placed in care because her biological parents also struggled with substance misuse. A study by the Irish Society for Prevention of Cruelty to Children (ISPCC) found that one in eleven children in Ireland is impacted negatively by parental alcohol problems (ISPCC. 2010). A report by Health Services Executive in relation to activity within an Adolescent Addiction Treatment Service (Murray,

2017a) highlighted that in some communities families were facing threat of eviction due to landlords using excuse of anti-social behaviour by young people as competition for accommodation escalates.

Impact of poverty on homelessness and wellbeing

Poverty figures published by Central Static Office (2017) taken from Survey on Income and Living Conditions (SILC) in Ireland, indicate that in 2016 eleven point one per cent of children live in consistent poverty which equates to approximately one hundred and forty thousand children. Consistent poverty can mean going 24 hours without a substantial meal or being cold and not having a warm jacket or two strong pairs of shoes and that families are not able to replace worn out furniture or have people over for a meal. These deficits can cascade into further impacts on health, behaviour, educational and economic outcomes throughout one's life (Garner et al., 2012; Shaw & Good, 2008). Research carried out in the 1970s identified that families are much more likely to experience mental health problems and physical illness in circumstances of unemployment and poverty (Brenner, 1973). The research identified that a one per cent increase in unemployment is followed by a six per cent increase in mental health issues and a four per cent increase in suicide. Additionally, distress my result from a loss of joy in life and new awareness of the degradation and pain one has suffered and the degradation one may have caused especially in circumstances where substance use is/was part of a person's life (Zackon, 1988). A nurse working for DePaul Trust is quoted within their Annual report for 2018 as stating that experiencing dependency and homelessness can have a huge detrimental impact on an individual's health stating "We're seeing the health problems that people would typically get in their 80's, suffered by people in their 50's. We are caring for a much younger, ageing population" (DePaul, 2019).

A study into adverse childhood experiences (ACE) provides insight into the impact of early adverse experiences on children's health and developmental outcomes (Felitti et al., 1998). The study was carried out in USA and conducted between 1995 and 1997 in a sample of 17,000 people. It found that 87% of respondents who had been exposed to one type of adversity reported being exposed to at least one other type and that exposure to multiple adversities is more likely to have a negative impact on children as they grow up. The incidence of poverty, homelessness or accommodation instability increases the likelihood of children, and young people experiencing stress and lack of enriching environment which may adversely affect their development on many levels, including attention, memory, cognition, executive functioning and language development (Lipina & Colombo 2009). As a result children and young people face poor social, emotional, educational and behavioural outcomes and neurobiological research highlights that poverty negatively impacts brain development (Lipina & Posner, 2012). Within ACE study it is proposed that the enhancement of supportive relationships among parents and other significant adults may help to buffer children and young people from the worst effects of deprivation

Contemporary research in the field of neuroscience provides insight into how people with trauma histories in addition to activating fight-or-flight responses associated with sympathetic nervous system may also activate a lesser known system of immobilization/dissociation linked with the vagal pathway. Polyvagal theory emphasise that in addition to fight-or-flight

responses there is a second phylogenetically newer circuit in mammals that is associated with physiological states related to spontaneous behaviour and feeling safe (Geller & Porges, 2014). The theory has been used to explain the biobehavioral shutting down that comes about following trauma and emphasises the importance of practitioners creating optimal conditions for client safety in order to inhibit client defences and encourage trust and spontaneous participation necessary to engage in effective therapeutic work.

Implications for practice

Given the evidence identifying the adverse effects of poverty, homelessness or accommodation instability it is important for practitioners to give consideration to the fact that many of the problems that families present to services result from experience of disempowerment, prejudice, discrimination, poverty, inadequate housing, unemployment and other social/structural problems and ought not be considered to be personal or intra-psychic disorders. Interventions that are directed at relieving mental health symptoms in isolation of their context may inadvertently entrench the primary causes of people's problems (Waldergrave & Waik, 2009).

When working with children, young people and families, assessment is central to the identification of needs in order to distinguish between different levels and types of support or intervention required (Hardiker, Exton and Barker 1991). It is understood that not all families who encounter poverty, homelessness and housing insecurity will experience problems but routine assessment will help to identify those who do. The involvement of different professionals in addition to family members and concerned other people is viewed as central to achieving better outcomes for children (Devaney, 2008). Additionally, it is understood that parents' ability to carry out their parenting role is enhanced by the extent of their social networks and level of social support (Chaskin 2008; Dolan *et al.,* 2006; Heenan, 2004). From a therapeutic perspective it is important to acknowledge family strengths and focus on improving functioning within family and social context (Carr, 2010).

As an approach to establishing relationship with clients as short a period of time between referral and initial meeting is found to enhance potential for engagement as well as making contact by phone, where possible to set up initial appointment. Also, flexible working is essential as is the cultivation of relational presence in session in order to promote safety and the engagement necessary to facilitate change. In addition to promoting safety and optimal engagement Polyvagal theory suggests that a safe therapeutic environment can facilitate the development of positive social interaction and can contribute to the repair of attachment injuries and new neural pathways essential for health and neural growth (Geller & Porges, 2014). To be therapeutically present requires practitioners to be grounded, centred and steady as well as open and receptive to the lived experiences of clients.

In circumstances where parents and other adults experience safety and engagement as a result of their contact with services, then there is high level of probability that they might bring that same level of attention to children and young people who are in their care. Bert Hellinger (1998) highlights the bonds of attachment between children and their parents and the sense that being similar will reinforce these bonds. Hellinger, promotes the view that from a position of love children often imitate their parents even in suffering as if being different would lead to separation and loss, and emphasises that "children are unable to balance out the great disparity

of giving and taking in their relationship with their parents" (ibid, p.93). It is for this reason work with families ought to focus on the improvement of interpersonal relationships, family functioning and parental supervision in order to increase responsiveness as a protective factor for children and adolescents and to enhance social supports. From a position of safety and support opportunity exists to increase the capacity for enhanced decision making by children and young people and thus potentially delaying or inhibiting their engagement in risky behaviours or harmful activity including the seductiveness of substance misuse. Additionally good communication and relationships are central to effective intervention at all levels and collaboration between all agencies involved in a child's or young person's life.

The process of removing risks and the introduction of social supports as well as improving patterns of interaction and improving communication in addition to increasing awareness of choice introduces change at a direct level which is termed first order change (Keeney, 1983). As a result of changed circumstances and establishment of trust and stability there is potential for conditions to exist for clients to have new experiences and opportunity to build skills, knowledge and develop new relationships as well as accessing additional resources, resulting in improving coping capacity and achieving greater understanding of issues/events impacting their lives which may hopefully encourage belief for a better future and inspire imagination, creativity, flexibility and humour. This is what Keeney refers to as second order change as it relates to the change involving the comparison of different context, frames or punctuations (ibid, p.157). To give visual expression to this process I formulated a model as illustrated in diagram 1.

Diagram.1

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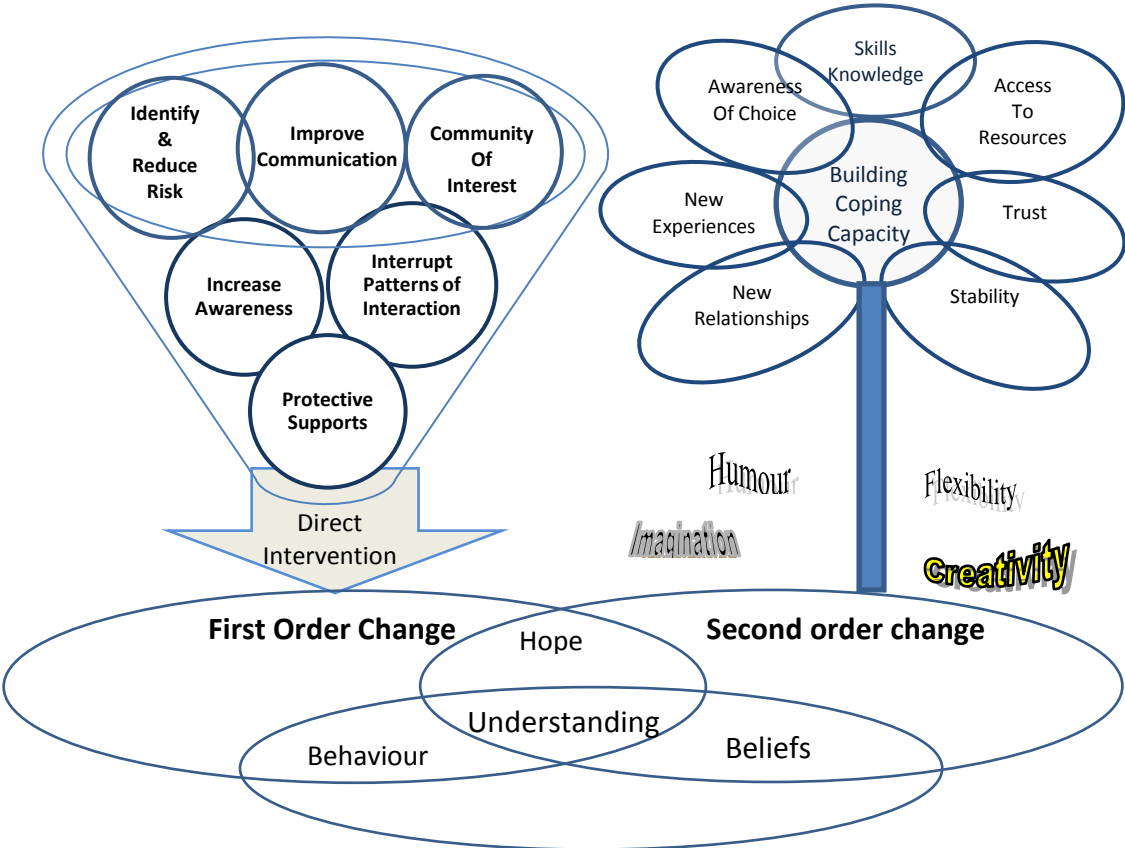
Informed by Narrative Therapy and the work of White and Epston (1990) the potential exist to externalise presenting problems and engage in conversations around social and structural issues impacting family life and to honour family member's capacity to cope in such circumstances. In this way it becomes possible to rally people against the problem and to become allies in addressing social inequity in order to achieve points of connection and better outcomes from the work while also avoiding the potential for 'ethical trespass' which is viewed as the harmful effects that inevitably follow not from our intentions and malevolence, but from our participation in social processes' Orlie, 1997, quoted in Weinberg, (2005, P. 331). The creation of a just society is a collective responsibility that requires us to become activists for change both in our work and in our personal lives. Reynolds (2012) encourages us to engage in reflective practices as she asks the following questions:

a. How can we stay alive and of use working in contexts of social injustice?

b. How can we do this work in accord with our collective ethics and our commitment to social justice?

c. How can we hold on to solidarity in political context that set us up against each other?

d. How can we experience sustainability and transformation collectively across time?

Embracing a not-knowing stance in therapy is an ethical position that allows for discussion and open enquiry without erasing a practitioners knowledge and expertise (Larner, 2000). Mapping the effects of a problem across different domains and between various relationships opens up a broad field in which to identify situations of marginalisation and social inequity impacting people's lives and contributing to presenting problems such as mental ill health, trauma, homelessness and substance use. Interweaving external circumstances into therapeutic goals and providing information in relation to resources within community as well as addressing the educational deficits and the psychological/physical challenges associated with poverty overcrowding and/or homelessness acknowledges clients resilience in the face of such difficult and challenging circumstances. Instilling hope and optimism that things can turn out all right may give people belief that in the face of adversity they have the capacity to be their own self healers. As in times of adversity optimism and humour can protect against despair (Frankl, 2004).

Essentially, practitioners who are working with people on the margins of society can become active in identifying, quantifying and describing issue that are causing people distress and pain in order to advocate for resources. Practitioner research can make a significant contribution to practice as key finding from research and practice can be updated to inform policy, practice and service plans towards addressing inequalities and focusing on improving access to healthcare (Murray, 2017b). As such practitioner research ought to be viewed as a work in progress and be made available to the widest possible audience in order to inform practice and decision making at an individual level and between practitioners/agencies especially when the welfare of children is considered. As highlighted by Dulwich Centre (1990), it is important not to separate clinical knowledge from cultural, social, economic or gender knowledge as to do

so could have the effect of silencing the voice of the main victims of inequitable economic policies.

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