FOCUS Ireland

Challenging homelessness. Changing lives.

Multidisciplinary Team for Homeless Families Feasibility Study

ISBN 978-1-7399825-3-9

February 2023

FOCUS Ireland

Challenging homelessness. Changing lives.

Multidisciplinary Team for Homeless Families Feasibility Study

Contents

Foreword

Families with wide-ranging and complex support needs – what we might call 'vulnerable families' – have always been a core part of Focus Ireland's work.

Since family homelessness began to increase significantly from about 2014, the proportion of families who are homeless primarily because of economic issues, such as the shortage of affordable housing, has increased and such families have been in the majority for several years.

However, Focus Ireland research indicates that, on average, between 20% to 25% of the families entering homelessness have complex support needs.[1] Since such families find it harder to exit homelessness and sustain a new tenancy, they may well comprise a much higher proportion of the total of currently homeless families. These families comprise a disproportionate number of families with young parents.[2]

In the early 2000s, prior to the rapid increase in family homelessness, Focus Ireland introduced a multi-disciplinary team (MDT) approach to supporting homeless families, involving not only skilled case managers but also qualified child support workers and accommodation finders. This project – part of the Government's pilot Social Impact Bond project – was delivered in partnership with the Homeless Agency (now the Dublin Region Homeless Executive) and the Department of Environment (now the Department of Housing, Local Government and Heritage) and was very successful. Since then, having specialised child support workers as part of the family team has been a core element of Focus Ireland's response to family homelessness.

The core of Focus Ireland's work is always supporting families and individuals *out of homelessness* into secure and sustainable homes. The family team's experience over intervening years has shown that, for families with complex support needs, this is more likely to be successful with a team expanded to include other disciplines, particularly in clinical and therapeutic fields. The objective of making all Focus Ireland activities 'Trauma Informed', as set out in the organisational strategy 'Restating our Vision 2021–25', reinforces the importance of this broadening of the teams supporting families with complex needs. The importance of this approach in supporting children in vulnerable families is also well established[3].

The challenges facing these families is also recognized in the Government's 'Housing for All' Strategy[4] which states: *'One notable issue that is evident concerns the length of time that some families (many with support needs requiring a multi-agency approach) spend in emergency accommodation. We will work with Local Authorities and NGOs to*

1 Long, A. et al. (2019) Family Homelessness in Dublin: Causes, Housing Histories, and Finding a Home. Focus Ireland
2 Lambert, S. et al. (2018) Young Families in the Homeless Crisis: Challenges and Solutions. Focus Ireland
3 Siersbaek, R. and Loftus, C. (2020) Supporting the mental health of children in families that are homeless: a trauma informed approach. Focus Ireland
4 Government of Ireland (2021) Housing for All: A new Housing Plan for Ireland Government of Ireland: Dublin. p54

identify families experiencing long-term homelessness that have complex support needs. Those that do will be provided with enhanced tenancy sustainment supports to help them exit homelessness and maintain their homes'.

This is the context in which Focus Ireland has commissioned this study into the potential, and challenges, of establishing 'multi-disciplinary teams', including clinical and therapeutic components, to support this group of vulnerable families.

It is an unusual piece of research because, while there are those who warn about expecting too much from MDTs and others who caution about the challenges of establishing them effectively, there is almost universal recognition that such teams, if established with the right protocols, resources and commitment, are a more effective and efficient means of providing support. As such, the research takes the form of a 'feasibility study' which draws together the evidence of potential success and looks in detail at the institutional, financial and clinical challenges of establishing such a team. Crucially, while the study sets out clearly that supports are needed from the health and social care agencies, it also charts a pathway for Focus Ireland to take its own steps in bringing such a team together.

The project would not have been possible without the support of our expert advisory group who provided oversight and guidance at every stage of the research. The group comprised a wide range of clinical and social care professionals including Dr. Ellen Crushell, Dr. Joanne Fenton, Dr. Joanna Fortune, Dr. Kate Frazer, Dr. Austin O'Carroll, Dr. Fiona O'Reilly, Dr. Angy Skuce, along with Focus Ireland's Director of Advocacy, Mike Allen, and Heads of Services, John O'Haire and Adrian Quinn. This in-depth research was diligently conducted by S3 Solutions and we are particularly grateful to Patricia Magee, Project Consultant, for the empathetic and sensitive approach she took when it came to conducting the research with customers, staff and other stakeholders.

I would particularly like to thank Daniel Hoey, Focus Ireland's Research Manager, for his conscientious dedication and care with this report.

Ciara Carty
Director of Services, Focus Ireland

Acknowledgements

The authors would like to extend a special thanks to the participants in this research. We would also like to acknowledge the strategic oversight, guidance and counsel provided by the Research Advisory Group listed below.

- Dr Ellen Crushell, Pediatrician and Clinical Lead National Clinical Programme
- Dr Austin O'Carroll, Granby Primary Care for Homeless & HSE Lead on Dublin Homeless Mortality Review
- Dr Joanne Fenton, Psychiatrist, Coombe Women & Infants University Hospital
- Dr Joanna Fortune, Psychotherapist, Solamh
- Dr Kate Frazer, Associate Professor School of Nursing, Midwifery and Health Systems, UCD
- Dr Fiona O'Reilly, CEO, Safetynet
- Dr Angy Skuce, Medical Director, Safetynet

About the Authors

S3 Solutions is an independent consultancy company. Our aim is to leave a positive, lasting impact on the people, communities, and organisations we work with, supporting social change.

The research was led by Patricia Magee, a Senior Consultant who leads the Research and Evaluation team at S3 Solutions. With a background in youth work and over 10 years' experience working with the third sector, Patricia leads on several, independent evaluations and research projects for both funders and public and third sector organisations.

The research was supported by Georgia O'Kane, a Project Consultant within the Research and Evaluation team at S3 Solutions. Georgia's background is in research and policy development in the areas of equality, community relations and social welfare.

A Quick Guide to the Multidisciplinary Team for Homeless Families Feasibility Study

Summary

The current approach to homelessness does not adequately address the needs of the 10–20% of homeless families who have complex support needs. This reduces the chance of them making a sustained exit from homelessness and exacerbates their existing needs. There is a strong consensus among professionals in health, homelessness, and family services that a multidisciplinary team (MDT) approach would deliver better outcomes. This report draws from the experiences of homeless families, reviews international and Irish experience of establishing such teams, and presents a consensus on the disciplines that should be part of such teams. Taking into account the constraints and challenges facing all public services at this time, it proposes a practical model for Focus Ireland, in partnership with Government agencies and other NGOs, to pilot a MDT to support homeless families with complex needs.

The Challenge

The number of families that are homeless is increasing again, after falling during the pandemic. As of December 2022, there were 1,594 families reported as homeless in Ireland (including 3,442 children and 2,619 adults), compared to 344 families in July 2014. For the majority of these families, availability and affordability of suitable housing is the primary or only issue. However, a minority of families who are homeless (estimated at between 10–20%) have complex support needs.

Consultation with families, staff and stakeholders highlights that the current 'single case management approach' does not adequately respond to the needs of families who have complex needs, for the following reasons:

- Lack of capacity at Needs Assessment stage
- Lack of available services to refer to, particularly in regards to mental health and disability
- Absence of Continuity of Support due to fragmented services across different agencies, exacerbated when families have to move emergency accommodation
- Lack of capacity and resources in services working to support homeless families

This reduces the chances of these families making a sustained exit from homelessness and also increases the likelihood of their complex needs becoming deeper.

Benefits and Challenges of a MDT approach

The study comprises:

- An international literature review
- Interviews with 21 individuals (20 parents and one adult child) in families that are homeless and have complex support needs
- Consultation with staff in Focus Ireland Family Homelessness Services
- Consultation with stakeholders in statutory health, family, childcare, and homeless sectors

A strong consensus from all these strands emerges that responses of homeless and social services to families with complex needs is frequently fragmented, resulting in resources not being deployed efficiently and producing poor outcomes. The creation of effective MDTs can use resources more efficiently and deliver more consistent, positive outcomes. These outcomes are not only in sustained exits from homelessness but also in dealing with other social and health issues in a cost-effective way.

It is not necessarily desirable, and frequently not feasible, to establish a MDT where all the components are employed within the same organisation. So, a MDT is normally composed of a mixture of staff employed by the lead organisation along with staff employed by other agencies but engaged with the team through a Memorandum of Understanding (MOU). The exact structure of staffing and engagement is important and a number of lessons emerge:

- MDTs take time to establish, and the cost savings and effectiveness take time to deliver.
- Misaligned performance indicators and accounting practices can make it difficult for some stakeholders to transfer essential resources from their own agency into a MDT.
- It is important to define the membership and roles within the MDT from the start. When team members have differing commitments, problems may occur when the demands of line-managers conflict with the team's aims and objectives.
- It is essential to create a shared evaluation and learning culture for the MDT, even though members are employed in different organisations with distinct cultures.
- Uneven work distribution, poor case coordination within the team, a lack of continuing education and personal development, and difficulty in formulating and agreeing upon priorities, leads to fractured, inadequate services and team breakdown.
- Maintaining good working relationships with colleagues is important in providing an overall service to patients. Teams should be aware of perceived elitism and alienation which may occur if there appears to be exclusiveness.

Recommendations for Action

The report looks at five potential models for establishing a MDT. It considers the practical issues and constraints and recommends a model where Focus Ireland *employs* a multidisciplinary team to deliver services in house as required. It also recommends working *in partnership* through a MOU with other stakeholders and services to make referrals to services as appropriate (See Section 9.4 of this report).

As recommended in the literature, to effectively deliver care through a MDT approach, a single identified individual should oversee and facilitate the work of the whole team.

The research also highlighted that a key consideration for Focus Ireland when forming an in-house MDT is ensuring appropriate clinical governance for relevant staff. It is therefore proposed that clinicians form part of the multidisciplinary team through a MOU. This will allow for full clinical governance.

An additional consideration is the language barrier faced by migrant families with complex needs. To ensure the needs of this cohort of families are met, translation services should be available as and when required.

Informed by the consultation process and the key challenges identified for families with complex needs, the following staff roles were prioritised to be employed by Focus Ireland:

- Project Leader
- Addiction Support Worker
- Family and Child Support Worker
- Translator

While the roles identified to be included through a MOU were:

- Clinical Psychologist
- Child Psychologist
- Public Health Nurse
- General Practitioner
- Psychiatrist

Steering Committee

The research highlighted a need for better interagency collaboration and coordination. Therefore, it is also recommended that a steering group is established comprising of representatives within the following organisations:

- Focus Ireland
- SafetyNet Primary Care
- Relevant Mental Health Organisation/s
- Health Services Executive Social Inclusion Unit
- TUSLA
- Local Authority/DRHE

The purpose of the steering group is to oversee the work of the MDT model, share information, reinforce clinical governance and to utilise their networks and experience to expediate referrals to relevant support and services where relevant. The steering committee should also raise awareness across health and housing so that services and departments supporting vulnerable individuals are aware of its presence.

As complex needs for families may change over time, the steering committee will have a key role in assessing the extent to which the MDT meets the needs of those requiring support. Where demand for a specific area of expertise or speciality is high, the steering committee should consider how best to integrate this service in the MDT e.g. via service brokerage, MOU or employment.

Section 1: Introduction

1.1 Introduction and Objectives of the Research

S3 Solutions was commissioned by Focus Ireland in June 2021 to undertake research exploring the feasibility of applying a multidisciplinary team approach for families experiencing homelessness or who remain at risk of a return to homelessness due to complex needs. The objectives of the research were to:

- Examine best practice and alternative approaches in supporting homeless families with complex needs
- Assess current service provision for currently homeless and recently housed families with additional and complex needs
- Appraise the value and impact of a MDT approach to families experiencing or at risk of homelessness with additional and complex needs including a detailed operational plan for a MDT service.
- Produce a comprehensive and robust report to inform Focus Ireland management and potential funders of such a service.

This report sets out the research findings.

1.2 Rationale and Context to the Study

In March 2021, there were a total of 913 families living in emergency accommodation in Ireland, including 2166 children. 618 (75%) of these families were living in the Dublin region. Emergency accommodation provided for homeless families is intended to be a temporary measure. However, there is a significant cohort of families who experience homelessness for more than 12 months (319 families as of March 2021, with around half of these having been homeless for over 24 months).

Focus Ireland works with homeless families in a variety of ways including a combination of case management approaches and supported housing models. Through this work, Focus Ireland identified a cohort of families (approximately 10–20% of families experiencing

homelessness) whose capacity to exit homelessness and sustain stable accommodation was negatively impacted not only by broader housing circumstances, but also additional and complex needs.[5] These included: mental health difficulties, addiction, child welfare concerns, prior difficulties sustaining a tenancy, and money and home management concerns. One possible approach to adequately support this cohort of families to exit homelessness is through the establishment of a multi-disciplinary team (MDT) to deliver integrated health and mental health support. A multi-disciplinary team approach aligns with Focus Ireland's strategic direction of increasing the organisation's ability to respond to the complex needs of identified priority groups accessing and needing its services. Thus, this research aims to appraise the value and feasibility of such an approach.

1.3 Report Structure

The report structure is as follows:

- Section 2 sets out the legislative and policy context for family homelessness in Ireland, the prevalence of the issue and the impact of COVID-19.
- Section 3 presents the research methodology including approaches to data collection and analysis and limitations.
- Section 4 defines the concept of complex needs and the challenges faced for service providers and service users.
- Section 5 explores the use of and applicability of multidisciplinary team approaches to address family homelessness with the benefits, impact and challenges outlined.
- Section 6 presents findings of the consultation process with homeless families and families at risk of return to homelessness in terms of their experiences of services.
- Section 7 presents findings of the consultation process with staff including their views on homeless families and complex needs, the challenges and barriers for service providers and opinions on a multidisciplinary team approach.
- Section 8 provides findings of the consultation process with stakeholders including their views on family homelessness and complex needs, the challenges and gaps in service provision and the value of adopting a multidisciplinary team approach.
- Section 9 concludes on the appropriateness of a MDT model for addressing the complex needs of homeless families in Ireland and presents a possible operational plan for such an approach.

5 There is no reliable data on the proportion of homeless families that have such pre-existing complex support needs. However, estimates range from 10–20% of all families becoming homeless, with a higher prevalence in the 'stock' of homeless families, as many of them find it difficult to achieve sustained exits from homelessness.

Section 2:
Background and Context

2.1 Introduction

This section presents a review of the legislative and policy context to family homelessness in Ireland, the extent of the issue and its causes at a national level.

2.2 Legislative Context

Irish legislation considers an individual homeless if, in the opinion of their local authority, they are unable to provide accommodation from their own resource; there is no accommodation available that they could reasonably remain in; or if they are living in a hospital, county home, night shelter or other such institution because they have no suitable accommodation.[6]

Ireland has a statutory legal system for homelessness services and housing provision for the homeless.[7] The Housing (Miscellaneous Provisions) Act 2009 places the statutory obligation on local authorities to provide housing for adults who cannot afford it[8] and an integrated 2003 statutory response for local authorities and the HSE places responsibility for the provision of emergency hostel and temporary accommodation for homeless persons on local authorities as part of their overall housing responsibility.[9] This can involve arrangements and funding to voluntary housing organisations for emergency accommodation and for long-term housing for homeless people.

6 Government of Ireland (1988)
7 European Social Policy Network (2019)
8 Government of Ireland (2009)
9 Government of Ireland (1988) and Government of Ireland (1953)

This legislation obliges local authorities to assist the homeless, but there is no obligation to house homeless people.[10] There is no legally protected right to adequate shelter and housing In Ireland,[11] therefore homeless families are not guaranteed housing. Homeless families can be refused emergency accommodation if they do not meet the Housing Act 1988's definition of homeless or if they do not comply with the rules and conditions of the accommodation.

Social housing is also allocated on eligibility criteria which differs between local authorities. For example, in Dublin City Council, in determining the need of homeless households, whether the applicant has voluntarily surrendered a tenancy and whether they were asked to leave a tenancy by reason of a breach of tenancy agreement is considered. Whilst in practice, families are often prioritised for housing, there is no specific statute or regulatory requirement which requires local authorities to provide accommodation for families ahead of single-person households.[12] In the case of the Choice Based Letting System in Dublin,[13] factors such as household size, the age of the family and medical/welfare are generally taken into account, but the authority is under no obligation to do so.

2.3 Homelessness Policy Context

Homelessness has a significant policy mandate in Ireland. In recognition of the persistent homelessness issue, the **2013 Homelessness Policy Statement** aimed to refocus resources towards providing for homeless individuals.[14] This included a goal to end long-term homelessness by the end of 2016 through reconfigurations of existing homeless facilities to provide a greater number of secure long-term tenancies and devolved funding arrangements to improve efficiency, value for money, and provide greater local decision making in homeless services.

In 2016, the Department of Environment, Community and Local Government published the **Laying the Foundations Housing Actions** which committed the Irish Government to address the homelessness problem through rapid build housing, a Housing First[15] approach in Dublin, and increased funding for homeless services. Similarly, 2016 saw the launch of the **Rebuilding Ireland Action Plan for Housing and Homelessness** which had several aims including addressing the unacceptable level of households, particularly families, in emergency accommodation, maturing the rental sector so that tenants see it as secure and providing quality and delivering housing in a way that meets current needs.

In 2017, the **Policy and Procedural Guidance for Housing Authorities in Relation to Assisting Victims of Domestic Violence with Emergency and Long-term Accommodation**

10 O'Sullivan, E. (2008)
11 Citizens Information (2022)
12 Focus Ireland (2020)
13 Choice Based Letting System lets local authorities advertise some of their social housing so approved social housing applicants can express their interest in the available properties.
14 Department of Environment, Community and Local Government (2013)
15 Housing First is a housing-led approach that enables people with a history of rough sleeping or long-term use of emergency accommodation, and with complex needs, to obtain permanent secure accommodation, with the provision of intensive supports to help them to maintain their tenancies.

Needs highlighted the important role of Housing Authorities in preventing homelessness and placing victims of domestic abuse in both emergency accommodation and new independent tenancies. Furthermore, the **Residential Tenancies (Amendment) Act 2019** provided the Residential Tenancies Board with more effective powers to directly regulate the rental sector, particularly in relation to Rent Pressure Zones and associated Rent Exemptions, and in relation to Notice of Terminations.

The **2020 Programme for Government** includes a concentration on homelessness under the Housing for All mission which comprises actions to "increase funding and work with stakeholders, case workers and homeless people on a suite of measures to help rough sleepers into sustainable accommodation," and "ensure that the HSE provides a dedicated funding line and resources to deliver the necessary health and mental health supports required to assist homeless people with complex needs." These priorities are also reflected in the **2021 Housing for All strategy**. The strategy resets Ireland's target to end homelessness to 2030 in line with the Lisbon Declaration on the European Platform on Combatting Homelessness and includes multiple targets which have a specific focus on homelessness. These include but are not limited to increasing Housing First targets to 1,200 occupancies over 5 years, a new National Homeless Action Committee, and delivering an appropriate range of housing and related support services, in an integrated and sustainable manner. Two actions also relate to enhancing support for homeless families, one of which highlights the applicability of using a multidisciplinary team approach:

- **Action 3.16:** Enhance family support and prevention and early intervention services for children and their families through a multiagency and coordinated response, and disseminate innovative practice
- **Action 3.18:** Identify and provide enhanced tenancy sustainment supports to families experiencing long-term homelessness to help them exit from homelessness and maintain their homes

In 2022, the Dublin Regional Homeless Executive launched its **Homeless Action Plan Framework for Dublin 2022–2024**. This is the first plan to be put in operation since Ireland signed the Lisbon Declaration and includes an aim to 'achieve a significant reduction in the number of families in emergency accommodation for longer than 12 months and a corresponding action to 'pilot a dedicated service to support families with high support needs facing barriers to sustained exit from homelessness' (Action 3.7).

Research into the use of multi-disciplinary teams to address family homelessness therefore aligns with the policy context in this area.

2.4 Health Policy Context

Research into the use of multi-disciplinary teams to address family homelessness is also closely aligned with the HSE's transformation agenda in the reorientation of the health service model of care towards a primary and community care approach of the 'Right Care, Right Place, Right Time'. In 2017 the Oireachtas Committee on the Future of Healthcare set out, in the **Sláintecare Oireachtas Report**,[16] their vision to deliver safe, quality health and social care services. The vision of Sláintecare is to achieve a universal single-tier health and social care system, where everyone has equitable access to services based on need, and not ability to pay. **The 2021–2023 Sláintecare Implementation Strategy**[17] sets out the out priorities and actions for the next phase of Sláintecare and prioritises two Sláintecare Reform Programmes:

- Reform Programme 1: Improving Safe, Timely Access to Care and Promoting Health & Wellbeing and
- Reform Programme 2: Addressing Health Inequalities — towards Universal Healthcare.

The strategy also sets out several projects under each programme. Project 1 of Reform Programme 1 explicitly references the need to progress plans for the rollout of high quality, accessible and safe care that meets the needs of the homeless population and reduces dependency on EDs and Acute services.

The Healthy Ireland Strategic Action Plan 2021–2025[18] further strengthens the policy context for addressing family homelessness. It builds on the first seven years of work to implement Healthy Ireland's Framework for Improved Health and Wellbeing and highlights strategic priorities for action for the next 5 years. Applying a multi-disciplinary team approach to deliver integrated health and mental health support to homeless families aligns with its goals:

1. Increase the proportion of people who are healthy at all stages of life
2. Reduce health inequalities
3. Protect the public from threats to health and wellbeing
4. Create an environment where every individual and sector can play their part in achieving a healthy Ireland

It also directly aligns with two of its key actions: ensure that the HSE provides a dedicated funding line and resources to deliver the necessary health and mental health and wellbeing supports required to assist homeless people with complex needs (4.4.4) and provide additional supports for students who are homeless, resident in family hubs, or in direct provision (2.1.4).

16 Houses of the Oireachtas (2017)
17 Department of Health (2021)
18 Department of Health (2021)

Furthermore, the **HSE Corporate Plan 2021–2024**[19] sets out the key actions that the Health Services Executive will take over the next three years to improve Ireland's health service and the health and well-being of people living in Ireland. It acknowledges the challenges faced by those who have complex needs in accessing health care and its aims for an Irish health service where:

- people can access the right care, at the right time and in the right place, and feel empowered, listened to and safe
- people have trust and confidence that the organisation is run well,
- people are supported to live well and feel connected with their community

It sets out 6 key objectives, five of which directly align with the goals of applying a multi-disciplinary team approach to deliver integrated health and mental health support:

- Objective 2: Enhance primary and community services and reduce the need for people to attend hospital
- Objective 3: Improve scheduled care to enable more timely access and reduce the number of people waiting for services
- Objective 4: Prioritise early interventions and improve access to person-centred mental health services
- Objective 5: Work to reimagine disability services, to be the most responsive, person-centred model achievable with greater flexibility and choice for the service user
- Objective 6: Prioritise prevention and early intervention services focusing especially on children's health, obesity and alcohol harm

A Vision for Change[20] sets out the direction for Mental Health Services in Ireland for a ten year period and describes a framework for building and fostering positive mental health across the entire community and for providing accessible, community-based specialist services for people with mental illness. Homelessness is referenced extensively in the report, along with the risks associated with mental health, which can result in or contribute to homelessness. Building on this policy framework, **Sharing the Vision**[21] continued the development and enhancement of mental health services in Ireland from 2020 to 2030. Homelessness is referenced in relation to specific mental health supports in this policy document.

Lastly, the importance of homelessness services and substance misuse services working together in a collaborative way is highlighted under Goal 2 of the **National Drugs Strategy: Reducing Harm, Supporting Recovery**[22] – a health led response to drug and alcohol use in Ireland 2017–2025. This strategy also outlines the need to improve the range of problem substance use services and rehabilitation supports for people with high support needs who are homeless, together with the availability of drug and alcohol, mental health and community integration services.

19 HSE (2021)
20 Department of Health (2006)
21 Department of Health (2020)
22 Department of Health (2017)

2.5 The Extent of the Family Homelessness Issue in Ireland

There is no universally accepted or legislated definition of homelessness across the EU. The most systematic conceptual framework for defining homelessness and housing exclusion is ETHOS (the European Typology of Homelessness and Housing Exclusion). This includes four distinct categories of homelessness and housing exclusion: 'rooflessness', 'houselessness', living in 'insecure' accommodation and living in 'inadequate' accommodation.[23] According to the literature, family homelessness implies a family unit consisting of at least one adult and one minor child or one pregnant woman.[24] Homeless families in emergency shelters, temporary accommodation, hostels and other specific accommodation provision for homeless people are included in this definition.[25]

Although ETHOS provides a useful framework for understanding levels of family homelessness, research shows that women at risk of domestic violence, who have dependent children with them, and who use domestic violence services such as refuges are not recorded as homeless in Ireland. The same situation is found in those who are hidden homelessness, i.e., a family, without their own housing, staying with friends, relatives or acquaintances because they have no alternative.[26] This leads to potential undercounting of family homelessness.

Despite inaccuracies in the data, a summary of current reported family homelessness in Ireland provides useful context for this study. In Ireland, the Department of Housing, Local Government, and Heritage publishes the latest statistics on homelessness every month.[27] As of December 2022, there were 1,594 families reported as homeless in Ireland; this includes 3,422 children and 2,619 adults. 72% lived in Dublin, 54% were single parents and data from Focus Ireland reveals that approximately 12% of children were born into homelessness.[28] Data from 2017 also reveals that one third of new families presenting to homeless services are non-Irish,[29] with individuals from the Roma Community experiencing significant levels of homelessness. Research shows that 6% of the Roma population in Ireland are reportedly homeless with 46% homeless at some stage of their life.[30]

While strategies are in place to prevent families from requiring emergency accommodation, and to support families to exit emergency accommodation, the number of families presenting as homeless in Ireland has increased by 363% since July 2014.[31] In Dublin the number of families presenting as homeless each month has risen from an average of 34 in 2014 to 92 in 2018. A distinctive feature of family homelessness in Ireland, especially in Dublin, is the length of time that families remain homeless. According to

23 Developed by the European Federation of National Organisations Working with the Homeless (FEANTSA) and the European Observatory on Homelessness.
24 University of Oxford Department of Social Policy and Intervention (2017)
25 European Observatory on Homelessness (2017)
26 Ibid
27 Department of Housing, Local Government and Heritage (2022)
28 Focus Ireland (2022c)
29 European Commission (2018)
30 Department of Justice and Equality, and Pavee Point (2018)
31 Focus Ireland (2022a)

Focus Ireland, the reason Dublin holds such a high percentage of Ireland's homeless is that there is a slower progression from emergency accommodation to secure accommodation compared to other areas of the country.[32]

In 2018, Focus Ireland published a report on the causes of family homelessness with a specific focus on Dublin.[33] While this report found that the most common triggers of homelessness among families related to insufficient housing supply and private rented sector issues, family circumstances were found to be a cause of homelessness in 30% of cases. These circumstances included relationship breakdown (11%), family violence (6%), and family conflict (4%). Similarly, the Dublin Region Homeless Executive (DRHE) found that family circumstances were the cause of homeless in 42% of cases, and included relationship breakdown, overcrowding, and family reunification.[34] Causes of homelessness for families in 8% of cases could not be attributed to family circumstances or issues with the private rented sector, but rather issues such as property damage due to fire, no income source, anti-social behaviour, and leaving direct provision with permission to remain. This is matched by Focus Ireland research which found that anti-social behaviour, loss of work/cut hours, and instability due to frequent transitions between living situations can contribute to a family becoming homeless.[35]

The housing shortage coupled with increasing housing costs are pushing homeless families into temporary accommodation arrangements for longer periods of time.[36] The experience of homelessness over this period may result in the emergence of complex support needs.[37] Where complex and chaotic lifestyles are the cause of homelessness, the traumatic experience of homelessness can exacerbate pre-existing issues. Although international research highlights that homeless families are generally not a high-need group, with characteristics such as high rates of drug and alcohol misuse, severe mental illness, criminality and poor physical health largely absent from adults in homeless families, there exists a small proportion of homeless families where high and complex support needs are present.[38] It is in this context that the need for this research emerged.

32 Focus Ireland (2021)
33 Focus Ireland (2018)
34 DRHE (2019)
35 Ibid
36 European Observatory on Homelessness (2017)
37 Culhane, D.P and Metraux, S. (2008)
38 European Observatory on Homelessness (2017)

2.6 The Impact of COVID-19

In March 2020, a national lockdown was introduced in Ireland in response to the COVID-19 pandemic. The lockdown required all citizens to stay at home, only leave for essential purposes, and maintain social distancing. For homeless families, lack of access to adequate housing and sanitation facilities placed them at greater risk of infection. To address this, a number of measures were put in place to support the homeless population. Social housing lettings and Housing Assistance Payments were prioritised for homeless households,[39] and efforts were made to reduce overcrowding in emergency accommodation.[40] For the duration of the pandemic, all residential accommodation for homeless families and individuals was moved to 24-hour access in efforts to reduce the public health risk to homeless persons.

These measures represent a stark contrast to pre-pandemic norms. Prior to the pandemic, a household was required to present to the Housing Authority within whose functional area they resided to access homeless services.[41] To access support, families were required to prove they were normally resident in this area, and that they had a right to access homelessness supports. For migrant families, this often presented a challenge as they frequently faced difficulties proving they had become homeless in their local authority area, particularly if they were newly resident. Many migrant families were also prevented from accessing homeless services prior to the pandemic as a result of a Housing Circular from 2012.[42] The Circular states that EU citizens living in Ireland must be in employment or unemployed due to illness, accident or involuntarily unemployed after being in employment for over a year in order to be assessed for social housing support. Migrants who did not meet these criteria could not access homeless supports or housing assessments.[43] With the suspension of normal operations in favour of the measures outlined above, newly resident migrant families were able to avoid these barriers, and experienced rapid access to accommodation.[44]

Included in the research sample were individuals who had arrived in Ireland prior to and during the COVID-19 pandemic. This offers useful context to their experiences of homelessness and homeless services in Ireland.

39 Focus Ireland (2022)
40 Irish Centre for Human Rights at the National University of Ireland Galway (2020)
41 Pavee Point Traveller and Roma Centre (2018)
42 Department of Environment, Community and Local Government (2012)
43 Department of Justice and Equality and Pavee Point (2018)
44 Mercy Law Resource Centre (2020) *Minority Groups and Housing Services: Barriers to Access.*

Section 3:
Research Methodology

3.1 Introduction

This section sets out the research methodology. The research findings are informed by the following activity carried out between June 2021 and July 2022.

3.2 Phase 1: Desk Based Review

The researchers carried out a rapid review of the literature relevant to family homelessness in Ireland. This was used to gain insight to the prevalence of the issue and its causes. It was also used to better understand the concept of 'complex needs' in homeless families and examine best practice approaches in service provision. The use of and feasibility of multidisciplinary teams was a key area of focus throughout. To begin, key search terms were identified including family homelessness, complex needs and multidisciplinary team approaches. This provided a range of data sources including journal articles, evaluations, news articles, and government reports. The researchers then presented preliminary findings to the Research Advisory Group to identify any gaps in information and areas that required greater exploration.

3.3 Phase 2: Primary Data Collection

A qualitative research design was adopted and the scope of the research was limited to Dublin given that more than three quarters of homeless families resided here. Initially the research aimed to consult with twenty families in total, all of whom had complex needs. This comprised:

- Five families supported by the Family Centre in Dublin's North Inner city
- Ten families supported by the Family Homeless Action Team and
- Five families who have exited homelessness to secure housing within 6 months of the research but who remained at risk of a return to homelessness

It also sought to capture a sample of participants from migrant and Roma backgrounds to understand a range of service user experiences.

Recruitment was initiated in January 2022 when contact was made by Focus Ireland's Research Unit to each of its services working with families. Together they identified an initial list of 21 families to participate in the research. A participant information sheet and corresponding consent form was co-designed by Focus Ireland Research Unit and S3 Solutions. This was shared with families via case managers to secure their consent to participate in the research.

Interviews were facilitated with eleven participants who were identified within the initial list. The remaining families opted out of the research. A second recruitment process was undertaken in March 2022 and an additional eleven families were identified to participate, ten of which participated in an interview.

The research included the following methods:

- 4 online focus groups with 14 staff across six Focus Ireland services including: The Family Homeless Action Team, Aylward Green, George's Hill, DOSH, Stanhope Green and the Family Centre. The interviews sought to capture staff experiences of supporting families with complex needs including the challenges and barriers they faced, the key areas for improvement and their views on applying a multidisciplinary team approach.
- 21 telephone interviews with families experiencing homelessness with additional or complex needs. A translator was used in nine of the interviews with families from a Roma background who did not speak English. The interviews were facilitated between February and March 2022 and sought to gain insight from families about their experiences of services and the extent their needs were met.
- 5 one-to-one interviews with key stakeholders including the Head of Family Services at Focus Ireland, Head of Housing Supports at Focus Ireland, Safety Net Primary Care, Paediatrician at Temple Street and Dublin Region Homeless Executive. These interviews sought stakeholder views on the extent existing provision met needs of homeless families with complex needs and their views on applying a multidisciplinary approach.

3.4 Data Analysis

Qualitative data analysis was conducted using a thematic approach.[45] Categories were developed, coded, and reduced. Interview data and information from secondary data sources were cross referenced to identify emergent themes and issues and to explore the relationships between issues.[46] The researchers adopted an inductive approach, focused on wide ranging engagements with key stakeholders to build an abstraction and describe the key concepts relating to family homelessness, in an Irish context.

45 Lewis-Beck, M. S et al., (2004).
46 Morgan, D. L. (1997)

3.5 Limitations

We note the following research limitations:

- A proportion of the research on the impact of multidisciplinary teams in the literature review was conducted in the United States of America. This is less desirable than research conducted within a similar set of circumstances as in Ireland. Much of this research also lacked long term follow up thus it was not possible to make conclusions about the long-term effectiveness of multi-disciplinary teams.
- A systematic review by Bassuk et al[47] highlights the underdeveloped and neglected nature of effectiveness research to end family homelessness and the methodological limitations among existing studies that make comparison difficult. Therefore, the research could not assess the effectiveness of multi-disciplinary teams compared with other models.
- Data collection occurred during COVID-19 restrictions, thus the researchers relied on telephone to carry out interviews with families. The potential to develop a positive rapport with research participants was hindered, some of the interviews took place at home with children and subsequently the ability of all participants to contribute fully to the interviews was affected.
- Research participants were offered an incentive. Thus, incentive caused bias is a possible limitation of the research.
- The research involved interviews with a sample of five stakeholders. Despite efforts to engage with Public Health Nurses, this was unsuccessful. The research may have benefited from greater insights from a health perspective.

47 Bassuk, E., et al (2014)

Section 4: Homeless Families and Complex Needs

4.1 Introduction

This section of the report defines complex needs and the impact for service users and service providers. It also explores some of the complex needs that can be found in homeless families.

4.2 Defining Complex Needs

Complex needs are intricate and multi-layered, thus hard to define.[48] In lieu of an agreed and consistent definition, this research will be working under the following definition given its close alignment to the research participants: *People with complex needs experience a constellation of social and personal problems that co-exist, overlap and interlock to create a complex profile*[49] *such as mental ill health, homelessness, addiction, offending and family breakdown.* A definition of multiple and complex needs implies both:[50]

- **Breadth of need** – multiple needs that are interrelated or interconnected
- **Depth of need** – profound, severe, serious or intense needs[51]

48 Dobson, R. (2022)
49 Shelter Scotland (2016)
50 Bromfield, L et al., (2012)
51 Rankin, J and Regan, S (2004)

4.3 Who Has Complex Needs?

The following individuals are identified as having multiple and complex needs:[52]

- People with mental health problems, including 'severe and lasting' problems
- Those disadvantaged by age and transitions – young and older people
- Those fleeing abuse and violence – mainly women and refugees
- Those culturally and circumstantially disadvantaged or excluded – minority ethnic groups; travelling people
- People with a chronic disease
- People with a disability, including those with sensory disabilities
- People who present challenging behaviours to services, for example in schools, within residential services/ hostels or in their own neighbourhoods
- People who are multiply disadvantaged by poverty, poor housing, poor environments or rural locations which mean they are distant from services
- People who are 'marginal, high risk and hard to reach', who may be involved in substance misuse, offending and at risk of exclusion
- People who have a 'dual diagnosis' e.g., mental ill health and substance misuse

4.4 Complex Needs and Services

The literature sheds light on how people with complex needs fare in terms of their awareness, access and experience of the services they need. Some of the key problems identified are presented below:[53]

Service User Awareness

- Lack of accessible information, poorly advertised services and low awareness of what services can offer; a particular problem for BAME communities, refugees, and asylum seekers.
- Shortfalls in interpretation and translation services and a lack of awareness among individuals and agencies about how to access these
- Service users/carers are often unaware of entitlements to assessment

Service User Access

- Services tend to treat problems in isolation; advice can be hard to access and referral mechanisms inefficient
- Service exclusion due to criteria governing service use or needs assessed as 'too complex'.
- Some targets undermine the will to work with clients with multiple needs
- Lack of referrals between agencies/inappropriate referrals limit access to services they need
- Long waiting lists worsen problems for those with multiple needs

52 Rosengard, A., et al (2007)
53 Rosengard, A. et al (2007)

Service User Experience

- Some feel staff attitudes are insensitive/unhelpful which prevents trust
- Inflexible service criteria prevent continuity of care
- Many receive repeated assessments which is stressful
- A 'silo mentality' works against co-ordination of support and risks people receiving inappropriate services with poor outcomes
- Medical 'dual diagnosis' labels limit the range of options
- Assessment, support planning and resources can be inadequate for people affected by transitions, delaying access/limiting people's rights
- When service users/carers disagree with professionals' assessments, options appear to be constrained by resources or limited vision
- Minority ethnic communities, refugees and asylum seekers do not always receive sensitive assessment or access interpreters/translators
- Non-engagement with services occurs because lack of trust and confidence, cultural insensitivities, services' systems or cultures being incompatible with lifestyles, poverty impacts, and people not being ready to address problems. In turn, nonengagement may exacerbate low level problems and exclusion. For some, persistent exclusion may result, interspersed with crises related to health or homelessness for example.

In addition to the above, homeless people often must prioritise provision for basic human needs (e.g., finding shelter and food) over accessing health and social care[54] and are often care avoidant, despite requiring specific care. Their complex and multiple needs can be stressful and make it difficult to find solutions and/or cause them to enter 'survival mode' requiring them to focus on basic needs and day-to-day living.[55] This relates to Maslow's hierarchy of need, a five-tier model of human needs which suggests that basic needs such as physiological needs (food, warmth, shelter) and safety needs must be addressed as a priority before a person can focus on their psychological needs and self-fulfilment. This is augmented by research which shows the strongest needs identified among the homeless are basic needs with very few expressing needs in the higher-order categories of love and belonging, self-esteem, and self-actualisation.[56]

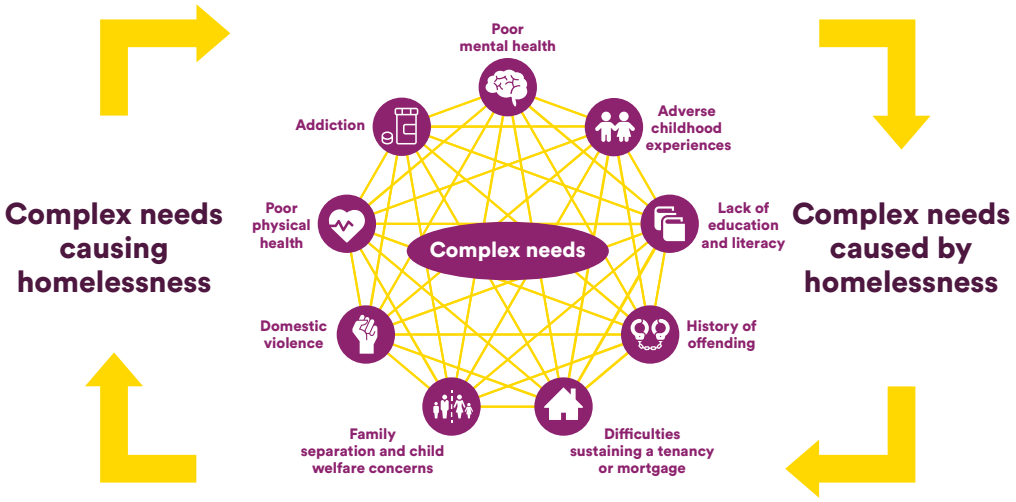
Service Provider Challenges

Gaps in health and social care services and a lack of housing and employment services that are integrated into health and social care services are cited as a key challenge for providers when working with individuals who have complex needs.[57] Research also shows that in Ireland, there is a specific struggle for services to support the complex needs of homeless families. This is due to stretched resources matched with the growing length of time that families are spending in homeless situations and the subsequent increased development of complex needs.[58]

54 Omerov, P. et al. (2020)
55 Klop, H.T. et al. (2018)
56 Fleury M.J. (2021)
57 Rankin, J. and Regan, S. (2004)
58 Focus Ireland (2020)

4.5 Complex Needs of Homeless Families in Ireland

In some instances, families may enter homelessness because of complex personal and social problems while in others, the traumatic and sustained experience of homelessness and adversity can result in the development of complex support needs.



A comprehensive review of the evidence on complex needs found in homeless families is presented in Appendix 1. These include but are not limited to:

- **Physical Health:** Homeless families have worse physical health than the general population and the foreclosure or repossession of one's home is shown to have an adverse impact on physical health.
- **Mental Health:** Homeless parents and children are at increased risk of anxiety, depression, substance misuse and suicide and experience greater difficulties with accessing services such as a GP or mental health team because they do not have a fixed addressed registered.
- **Addiction:** Homeless people are more likely to be problem gamblers and suffer from alcohol and drug addiction and children of parents suffering addiction experience poorer mental health.
- **Experience of Domestic Abuse:** Foreclosure or repossession of one's home has an adverse effect on domestic violence and/or child abuse and victims of domestic abuse and children who have witnessed domestic abuse suffer poorer mental health.
- **Poverty and Unemployment:** Homeless families, especially single parent families are more likely to be in debt and lack financial resources with childcare a key barrier to employment.
- **Education and Illiteracy:** Homeless people are more likely to be illiterate and have lower educational attainment. Homeless children are more likely to have their education interrupted.

- **Family Separation and Child Welfare Concerns:** Families who have experienced homelessness are at a greater risk of separating and there is a link between parental homelessness and prolonged stays in the care system for children.
- **Adverse Childhood Experiences and Developmental Delays:** For children growing up with parents who have multiple and complex problems, their needs for secure attachment and developmentally appropriate experiences may be compromised. Adverse effects for children include higher risk of maltreatment, abuse and neglect, and increased risk of attachment difficulties, psychological and emotional disturbance and developmental delay.
- **Migrant Status:** Non-Irish individuals may have lower than average levels of English language comprehension which can create language barriers and subsequently limit access to the services and information that they need. Language barriers can result in "hidden" homelessness, due to their inability to communicate effectively with service providers.

4.6 Conclusion

Despite many strategies in place to prevent family homelessness and to support families to exit emergency accommodation, the causes and consequences of homelessness can result in high support needs among families. These needs often interact in ways that are specific to the individual and are therefore challenging to diagnose or treat. Where someone's needs aren't understood, complex needs can present as challenging behaviour, resulting in services not being delivered in a way that meets the person's needs. These individuals tend to fall through the gaps between services because no one takes overall responsibility for helping them to break the cycle they are in. They can find themselves in a downward spiral, living chaotic lives and experiencing poverty, stigma and discrimination.[59] One possible approach to adequately support this cohort of families is a multi-disciplinary team (MDT) to deliver integrated health and mental health support.

59 Single Homeless Project (2022)

Section 5: A Multidisciplinary Team Approach

5.1 Introduction

The following section sets out the use of and applicability of multidisciplinary team approaches as found in the literature.

5.2 What are Multidisciplinary Team Approaches?

A significant proportion of local research into the use of multi-disciplinary teams comes from a health perspective as MDTs are largely found in healthcare. In Ireland's health system, MDTs comprise a group of health care workers from different disciplines and professions who each provide a specific service to a patient, whilst working in coordination with the team towards a specific set of goals as outlined by a care plan.[60] In Ireland, multi-disciplinary mental health teams typically include all or a selection of the following: Nurses, Doctors, Psychologists, Psychiatrists, Occupational Therapists, Speech and Language Therapists, Social Workers, Behaviour Therapists, Art Therapists, Music Therapists and Pharmacists.[61] [62]

They key components which research suggests makes for a successful multi-disciplinary team include:[63] [64]

- Patient-centred care
- Physician integration
- Shared goals and objectives
- Co-location / geographical integration
- Deliberate targeting of high-risk populations
- Culture, collaboration and shared decision-making processes

60 HSE (2022a)
61 HSE (2022b)
62 College of Psychiatrists of Ireland (2022)
63 Cordis Bright (2018)
64 Cordis Bright (2018)

- Shared information technology and access to client data
- Including generalists who work alongside specialists
- Having a focus on case management and support
- Performing joint care planning and assessments of needs
- Having personalised care plans

It is also recommended that to effectively deliver care through a MDT approach, a single identified individual, be it a MDT manager, practice leader, or care coordinator, should oversee and facilitate the work of the whole team.[65] Care coordinators also have key purposes which aid in successful MDT delivery:[66]

- Forming a working relationship with clients and acting as a point of contact
- Ensuring a person-centred assessment
- Acting as a client advocate when required
- Assisting clients in the navigation of complex health and social care systems
- Demonstrate local knowledge of the range of local health and care services including VCSE
- Ensuring identified activities, interventions, and treatments take place
- Monitoring care plans and evaluating outcomes

The key challenges to multi-disciplinary teams include:[67] [68]

- **Time:** MDTs are not always immediately sustainable, able to deliver financial benefits, or capable of meeting planned objectives so can be prematurely determined unsuccessful and thus abandoned.
- **Misaligned performance indicators and financial incentives:** Often there is reluctance to shift resources across the sector into these projects which is a key barrier to integration
- **Reluctance to learn from other sources:** Continuous evaluation and sourcing best practice from other contexts is needed for the continued functioning and progress of these services.
- **Initiation of team:** Defining team membership is important in creating an effective working group. When team members have differing commitments, problems may occur when the demands of line-managers conflict with the team's aims and objectives.
- **Failure to plan or agree on a service philosophy:** Uneven work distribution, poor case coordination within the team, a lack of continuing education and personal development, and difficulty in formulating and agreeing upon priorities leads to fractured, inadequate services and team breakdown.
- **Maintaining the team:** Maintaining good working relationships with colleagues is important in providing an overall service to patients. Teams should be aware of perceived elitism and alienation which may occur if there appears to be exclusiveness.

65 Social Care Institute for Excellence (2018a)
66 NHS England (2014)
67 Cordis Bright (2018)
68 Madge S. and Khair K. (2000)

5.3 The Rationale for MDT Approaches in Family Homelessness

In 2017, Crisis commissioned the Social Care Institute for Excellence (SCIE) to conduct a rapid evidence assessment (REA) of current and past services targeted at addressing and reducing homelessness.[69] The review suggests that sustained services, targeted to meet specific needs across time (because needs can change) are effective. It notes that the most effective services for families included multiple components which offered both rapid and sustained support and were delivered within a multiagency framework.

The review also notes that those with complex needs often require responses at multiple points due to the evolving nature of their needs. It stresses the importance of sustained integrated responses and a range of time-critical services of all kinds to support such individuals. It further suggests that suites of services should be brought together in a holistic, integrated, and multi-disciplinary way, and that expert-involved case management works best. It identifies that while tested 'models' for services are useful, local context and person-centered plans are important.

For service users, MDTs have been found to be more flexible and adaptable than other systems of care whilst also offering better continuity of care. MDTs can also improve access to services for services users, with reduced waiting times for referral as all required parties are already involved.[70] For staff and care systems, MDTs promote better communication between professionals from different backgrounds; provide a shared identity and purpose which promotes team cohesion; and result in resources being used more efficiently through reduced duplication, greater productivity and preventative care approaches.[71] Further benefits for workforces include reduced isolation, improved morale and job satisfaction and reduced stress.[72]

There is also economic evidence that homelessness multidisciplinary teams represent value for money and are potentially cost saving.[73] Having specialist multidisciplinary teams or designated leads should mean better integration and efficiency of services, more streamlined and personalised care and improved engagement with care and support, which in turn should lead to reduced morbidity, mortality and associated costs. Such a service model can mean better management of resources, for example, a reduction in inappropriate referrals, inappropriate use of hospital beds, and duplication of effort as well as a reduction in wider public sector costs, including local authority homelessness services, because people will be more likely to maintain their accommodation.

69 Sheik, S. and Teeman, D. (2021)
70 Ainscough Associates (2021)
71 Social Care Institute for Excellence (2018a)
72 NHS England (2021)
73 National Institute for Health and Social Care Excellence (2022)

5.4 Multidisciplinary Team Approaches in Homelessness

The National Institute for Health and Care Excellence published guidelines and principles for the delivery of MDT approaches for homeless populations.[74] These include:

- Co-designing and co-delivering services with people with lived experience of homelessness to improve the quality of care.
- Providing services that are person-centred, empathetic, non-judgmental, psychologically and trauma informed to promote engagement.
- Facilitating longer contact times to ensure the development of trusting relationships between frontline staff and clients and in recognition that people experiencing homelessness need services that provide a long-term commitment to care to promote recovery, stability and lasting positive outcomes.
- Supporting avenues for reengagement with services in recognition that that some people experiencing homelessness may find services difficult to engage with as a result of their circumstances and previous experience.
- Promoting empathetic, non-judgemental, and recovery-oriented language amongst MDT staff.
- Facilitating communication via the client's preferred method, sending clear information about appointments; following with up people who do not attend; providing translation and interpretation services if needed; and providing extra support for people with low literacy levels.
- Promoting the spread of information for homeless clients about their rights to services and how to access services, including; health services, family planning services, local authorities, housing services, and voluntary and charity sector services.

A systematic review by Bassuk, et al[75] highlights the underdeveloped and neglected nature of effectiveness research to end family homelessness and the methodological limitations among existing studies that make comparison difficult. Rather than attempt to assess the effectiveness of various models compared with multi-disciplinary teams, this research presents examples of MDTs in practice and where possible, their impact on homeless individuals with complex needs.

Ireland

In Cork, the Adult Homeless Multidisciplinary Team (MDT) is a partnership between the statutory sector, and voluntary sector, including representatives of local council HSE South, the Simon Community Hostel and Day Centre and the St. Vincent de Paul Hostel in Cork City.[76] The MDT began in 2002 as part of an Integrated Service that provides a full spectrum of addiction, mental health, and medical services on an in-reach and assertive outreach basis to the homeless population in Cork. Surgeries and clinics are located in homeless services and the MDT consists of:

74 National Institute for Health and Care Excellence (2022)
75 Bassuk et al (2014)
76 O'Reilly (2003)

- a full-time public health nurse,
- a part-time registered nurse,
- two full-time community mental health nurses,
- a part-time addiction counsellor provided by Arbour House Addiction Services,
- a part-time Health Promotion Officer provided by the Health Promotion Department,
- a part-time clinical psychologist,
- a part-time consultant psychiatrist,
- a part-time GP, and
- Four community welfare officers.

The GP holds five clinics per week and can refer clients to the psychiatrist as needed. The public health nurse (PHN) sees patients every day in the hostels, triages them according to their symptoms and deals with their problems as appropriate. The PHN liaises with the outpatient departments, dentists, chiropodists and community physiotherapists, arranging appointments for patients and the delivery of medical aids as needed. The PHN also refers people to the CWOs if they are not in receipt of social welfare payments or do not have a medical card. Feedback on the MDT in Cork has highlighted a range of positive impacts for the homeless population:[77]

- The nurse and GP conduct approximately 3,000 consultations per year
- Through regular screening and safe injecting practices, the homeless population catered to by the MDT showed a Hep C rate of 17% below the expected level for this population.
- 90% of clients needing access to methadone substitution treatment access it, compared to 10% prior to the initiative.
- The number of overdoses amongst clients has decreased by half 50% since 2015

United Kingdom

In Newcastle[78], England, the Homelessness Prevention Trailblazer piloted a MDT in homelessness. This included specialist case workers from the following specialities: housing, welfare rights, debt and budgeting, and employment. In the evaluation of the pilot delivery of this service, several key successes were identified:

- The MDT supported residents to reduce arrears by an average of £98.77 whilst individuals who were eligible but did not engage with this service had an average increase in rent arrears of £178.19.
- The MDT reduced household rent shortfall for those who have engaged by an average of £10.51 per week – this refers to the difference between entitlement to housing support and actual housing costs. Comparatively those eligible for the service who did not engage or sustain engagement had their rent shortfall increase by an average of £2 per week.
- The MDT supported 18 households to gain free furniture and white goods with a total value of £13,741.65. For 83% of these families this enabled them to escape the benefit cap as they were no longer having to rent furniture from their landlord.

77 Health Manager (2018)
78 Parker, C. and Harrison, C. (2019)

- 11 households were supported to move closer to work, school, or social networks, and 5 were assisted in moving away from potential harm and harassment.
- The team negotiated with 242 creditors on the behalf of service users. This led to a total debt write off of £141,026.08 across the client group with over £20,000 of this being for a single resident.
- The MDT also secured £288,960.81 in additional benefit entitlement for households who engaged, and 79 residents were given advice or support around their benefit entitlement.
- 11 residents worked with the specialist to search for work, 4 residents gained employment, 1 started volunteering, 1 started a training course, and 61% of residents felt more positive about how they spent their time after working with the team.
- Finally, in terms of wellbeing, the interventions of the MDT have brought about a general improvement in residents' perception of their situation and their wellbeing. The findings of the Newcastle pilot MDT homelessness project suggest that the MDT have produced a measurable reduction in the risk of homelessness for those households who have engaged with them.

In Wales a MDT was set up in Cardiff in 2019 to address the growing number of individuals who were experiencing homelessness.[79] The outreach team included:

79 Kinghorn, P. and Basset, L. (2019)

- A mental health nurse
- An advocate
- A primary care nurse
- A counselling service
- A city centre social work team
- Mental health social workers
- A substance misuse nurse
- A rapid prescribing service
- Therapeutic outreach workers
- Access to ring-fenced psychological services
- Substance misuse outreach workers
- A peer mentor coordinator
- Diversionary activities.

The MDT also partnered with the third sector organisations Breakfast Run, Night Bus, and Day Centre and had plans to expand to include probation officers. The MDT was found to have improved service coordination and enabled better relationships, improved referrals, and joint targets. The MDT received 367 referrals after it began and 293 of these cases were opened to specialist workers. Further, of the 168 cases which have since been closed, 72% of service users have secured or maintained their accommodation.[80]

Two other examples of MDTs in practice in the UK were found in England and Northern Ireland. Although evaluation and impact data was not available for these examples, their key components and teams offer useful insight for the research. For example, in the Bournemouth, Christchurch and Poole council area in England the following were identified as key components of MDT services for homelessness:[81]

- Providing outreach to rough sleepers and people in temporary accommodation.
- Long or short periods of support depending on service user need.
- Building rapport with the individuals, identifying support needs, and working with service users to access mainstream services.
- A case management approach.
- Allowing a housing, social care, or health worker to be the named lead on the case depending on an individual's primary issue.
- An aim to have all professionals co-locate.

Similarly, in Northern Ireland, a multi-disciplinary team ran by Extern[82] is composed of a core team of social workers and a tenancy sustainment and support service which works with those individuals who have complex` needs including: diagnosed and undiagnosed mental health, learning disabilities, physical health issues, offending backgrounds, family issues and substance misuse. The core team has five social workers and a mental health practitioner, and the floating support team has two additional social workers who concentrate on tenancy sustainment and support services for families or individuals with complex needs. In addition, the MDT has partnerships with voluntary organisations, the Housing Executive, and Health and Social Care Trust in Belfast which enables homeless individuals and families to avail of a range of interventions. The MDT works on an outreach model to target and engage the homeless population of Belfast.

America

The Family Assertive Community Treatment (FACT) programme[83] in Chicago, Illinois was

80 Kinghorn, F. and Basset, L. (2019)
81 BCP Council (2021)
82 Extern (2022)
83 The National Center on Family Homelessness (2012)

five-year innovative project providing integrated, family-focused treatment and support services for young, homeless, at-risk mothers, who had at least one child five years of age or younger and a co-occurring mental health and/or substance abuse disorder. Upon entering the program, all were homeless, living in shelters or doubled-up with family or friends in overcrowded apartments. Many of the mothers and children had experienced high rates of traumatic life events including family separation, domestic violence and sexual assault.

FACT featured collaboration among several highly respected organizations in Chicago with expertise in early childhood development, housing and homelessness services, mental health, and evaluation. The program's innovative service model provided families with holistic, individualized care to meet the full range of their needs. Guided by Assertive Community Treatment[84] principles, FACT's multi-disciplinary, highly coordinated team provided intensive care targeted toward each family's individual goals. The specialized expertise of each team member allowed the programme to respond flexibly to families' needs. Therapists provided counselling, parenting education, parent-child therapy, and play therapy to strengthen bonds between mothers and their children and prevent child maltreatment. Staff members also helped mothers maintain or regain custody of their children by guiding them through complicated paperwork, accompanying them to court, and serving as liaisons and advocates with child protection workers. Children received regular developmental screenings from a child development specialist, and those who needed further support benefited from more intensive child clinical services within FACT, services with Beacon's Early Head Start and Little Intensive Outpatient Program, and Illinois Early Intervention System. The most important outcomes include the following:

- Participant's housing stability greatly improved. At baseline, all the women were homeless or precariously housed. One year later 93 percent reported living in their own apartment in the past six months and 80 percent were currently in stable housing.
- Participant's satisfaction with their housing improved from 28 percent to 71 percent over the one-year period.
- Participant's ratings of improved housing increased from 23 percent to 63 percent over the one-year period.
- Participant's level of education increased over the one-year period.
- Participant's level of parental stress decreased over the one-year period.
- Average monthly income increased substantially from $622.08 to $881.33 over the one-year study period.
- One hundred initial ASQ screens were completed. Nineteen percent of the children fell into the developmentally concerning range. Seventy-nine percent of the children that displayed concerns at their first or second screen improved their developmental scores.

In Santa Monica, California, the city put in place a programme called the Homeless Multi-disciplinary Street Team (HMST).[85] This programme adopts the Assertive Community

84 An ACT team typically consists of a psychiatrist, a therapist, a nurse and licensed social worker who together provide a comprehensive treatment approach and assist the patient in accessing community resources.

85 Ashwood et al. (2019)

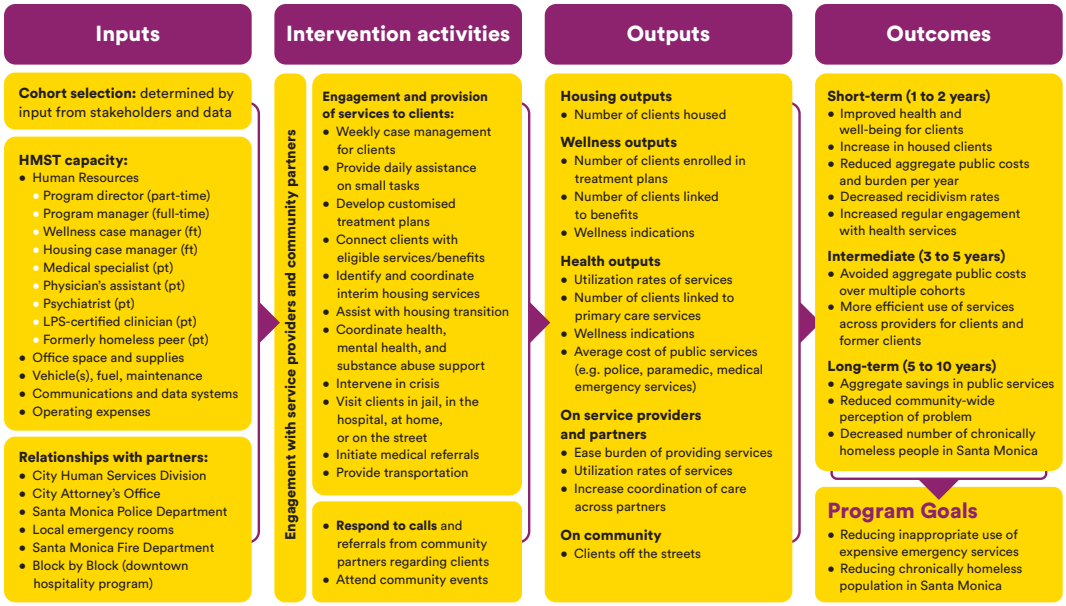
Treatment model of Case Management and includes facilitating interim and permanent supportive housing, connecting clients to existing services, and being responsive to staff at other community organisations such as hospitals, the police department, the city attorney's office, and the fire department. The clients of the HMST have serious medical, substance abuse, mental health, and behavioral challenges and HMST intends to make the appropriate services more accessible wherever the client needs them. In HMST, the caseload of 26 clients is shared, and most services are provided in the field. The HMST team operates from 9 a.m. to 5 p.m., Mondays through Fridays, and includes:

- A fulltime program manager
- A wellness case manager
- A housing case manager, and
- A substance-abuse clinician case manager.

There is also a medical doctor, psychiatrist, physician's assistant, and peer support specialist with lived homeless experience who dedicate between 3 and 16 hours to HMST clients every week. This makes services more accessible to clients and protects staff by mitigating burnout from any member having sole responsibility for a client. The HMST emphasizes coordination across city departments and partners to allow the team to intervene in all parts of the system on behalf of clients. For example, HMST staff can visit with clients when they are arrested or detained or when they are admitted to a local emergency room. These arrangements make it possible for the HMST to easily track and attend to clients, continuing to build working relationships across the team, the clients, and the other departments and organisations.

The evaluation of the Homeless Multidisciplinary Street Team in Santa Monica, California[86], involved the development of a logic model for the intervention (see below). Key outcomes of the approach included improved health and wellbeing for clients, increased housed clients, reduced public costs, decreased recidivism rates, increased regular engagement with health services and, in the longer term, decreased number of chronically homeless people.

86 Ashwood et al. (2019)



Australia

The Inner Southern Homelessness Service (ISHS) in South Australia has found success in using multi-disciplinary teams to improve health outcomes of homeless children and families. ISHS delivers nurse-led interventions with homeless families and has found that when case managers and nurse practitioners work together, the situations of homeless families improve as they are better connected with employment services, health interventions, and prevention programmes, which in turn improves health status.[87]

87 Parry, Y.K., Harryba, S., Horsfall, S. (2015)

Section 6:
Family Perspective

5.5 Conclusion

In response to the growing homelessness problem and the complex needs of the homeless population, multi-disciplinary teams can be used to deliver a range of interventions from a single source of diverse specialists. In Ireland, multi-disciplinary teams have predominantly been used in health care, but there are examples of these teams being used internationally for homeless individuals with complex needs.

While the research could not compare the effectiveness of multi-disciplinary team approaches with other models addressing homelessness, it does highlight the potential positive impact of such approaches when used in a homelessness context, especially where there are individuals who have complex support needs.

Although the Crisis Review (2017) reinforces the rationale for multidisciplinary team approaches in homelessness, it also highlights the importance of local context. Therefore, to better understand the role and value of multi-disciplinary team approaches in an Irish context, and more specifically for Focus Ireland, the following sections present the findings from the consultation process with families, staff and stakeholders.

6.1 Introduction

The following sets out a thematic analysis of the research findings from a family perspective. This is informed by interview data with twenty-one individuals who experienced or were experiencing family homelessness and were identified as having complex needs. For clarity and ease of reference, the thematic analysis is presented under the following headings and subheadings.

- Family Profiles and Complex Needs
- Journeys to Homelessness
- Factors Creating a Positive Experience of Services
- Factors Creating a Negative Experience of Services

Where appropriate, the analysis is cross tabulated with findings from the literature review and is augmented by direct quotes from research participants.

6.2 Family Profiles and Complex Needs

Of the twenty-one individuals involved in the study, thirteen were female and eight were male. The sample included one adult child and twenty parents (one of whom was pregnant at the time of interview). The sample also included representation from two married couples and a mother and a daughter. Table 1 displays a breakdown of the study's families.

Table 1: Profile of Study's Families

Characteristics		No. of Participants
Gender	Female	13
	Male	8
Relationship status	Single	6
	Married	15
Number of children	One	2
	Two	7
	Three	4
	Four	5
	Five	2
Ethnicity	White Irish	4
	Irish Traveller	5
	Ethnic Minority	12
Housing status	Emergency Accommodation	17
	Temporary Accommodation (e.g., George's Hill)[76]	2
	Permanent Social Housing	2
Duration of homelessness	Less than 6 months	5
	6 months – 1 year	8
	1 year – 2 years	4
	2 years – 5 years	0
	5 years +	4
Main service	Family Homeless Action Team[77]	20
	Family Centre[78]	1

88 Focus Ireland provides short and long-term accommodation for families through a mix of congregate housing sites and scatter site tenancies. This includes: Aylward Green, George's Hill, Dublin Off Site Housing (DOSH) and Stanhope Green.

89 Focus Ireland's family case management team was designated by the DRHE as the Family Homeless Action Team (FHAT) to work with families becoming homeless in the four Dublin local authority areas. Family HAT services are provided in 21 Family Hubs and private emergency accommodation in Dublin, and currently support around half the homeless families in Dublin. Family HAT uses a case management model, based on a needs' assessment, with the primary goal of supporting families to exit homelessness ideally within 6 months.

90 In 2020, Focus Ireland opened its Family Centre. This service provides advice and information, laundry facilities, a food service and drop in childcare facility to allow parents some respite while they engage with a support worker or go on a viewing of a potential rental property. The full development of this new service has been delayed due to the Covid-19 pandemic.

As outlined in Section 3, interviewees were asked about their experiences of services and the extent to which their needs were met, not about their personal circumstances. However, many individuals shared insight to the challenges they were experiencing alongside homelessness, which, together, can contribute to complex support needs. For example, twenty individuals were unemployed and of the fifteen individuals who were married, only three had a spouse who was in employment. The majority of families were subsequently dependent on social welfare as an income source. In terms of educational needs, the five individuals from a Traveller background described how they had low levels of education and difficulty with understanding or filling in forms or communicating via email. Of the twelve individuals from a migrant background, nine were from a Roma background and did not speak English.

Four individuals described that they suffered from poor mental health, two of whom also had a child who suffered from poor mental health, with one diagnosed as suicidal and in special care. Three mothers described experiences of domestic abuse, two of which were prior experiences while one was ongoing and linked to their husband's addiction issues. Six individuals also explained that they or their spouse had some form of physical health issue. These included liver disease, epilepsy, psoriasis and back problems. One parent was also pregnant at the time of the interview and two parents described that their children were sick.

Two mothers expressed challenges with their children attending school with one child being expelled. One mother expressed that they were raised in foster care, had experienced family breakdown with their foster parent, and found it difficult to support their child's attendance due to their own depression and subsequently had their own four children placed in care across three separate counties. Two mothers also explained that their children had special or additional needs including autism or attention deficit hyperactive disorder (ADHD).

The above information demonstrates the multiple support needs among the study's sample. To illustrate how such needs can overlap and interlock to create a complex profile, one parent's personal and social problems are presented below:

6.3 Journeys to Homelessness

Although the research did not explicitly ask individuals to describe their journeys to homelessness, eighteen parents offered insight on their causes of homelessness. These are presented in Table 2.

Table 2: Causes of Family Homelessness

Cause of Homelessness	No. of Participants
Family Circumstances	5
Private rented sector issues	3
Immigration	9
Anti-social Behaviour	1

For nine individuals who had a Roma background, their homelessness was caused by their family's recent immigration to Ireland. Difficulty living with relatives and challenges securing employment due to discrimination and illiteracy in Romania coupled with a desire to make a better future for their children were their primary reasons for immigrating to Ireland. Eviction from arranged accommodation with friends and friends not showing up at the airport on their arrival were cited as a cause of their homelessness in Ireland.

> **"I came to Ireland in 2018 and was living with a friend and working. My wife and kids came in 2020 and my friend couldn't provide accommodation for us." (Customer)**

For five parents, family circumstances including overcrowding and relationship breakdown caused their homelessness. Private sector issues such as rental increases or eligibility issues were the cause of homelessness for three families and for one, this was linked to anti-social behaviour with their neighbours.

> **"I was living with my husband, his mother and our four kids. There were too many of us and his mother had a big heart operation so we couldn't stay there." (Customer)**
>
> **"I am from Ghana and before falling pregnant, I was volunteering in a place that I was also lodging and completing a QQI Level 5 certificate. When I became pregnant, the lodger could no longer accommodate me, so I became homeless. It gives me nightmares." (Customer)**
>
> **"We had a two-bedroom house in Dublin and were living there for 14 years. We got into an argument with a neighbour and they left a pipe bomb at the house. We needed to leave, and the council didn't locate me to any other property." (Customer)**

6.4 Factors Creating a Positive Experience of Services

The following factors were cited as creating a positive experience for families when accessing services:

- Attitude and Approach of Key Worker
- Instant Access to Support
- Provision of Practical, Needs Based, Essential Supports

Attitude and Approach of Key Worker

For nine families, the positive approach and attitude of staff, particularly their key worker was noted as facilitating a positive experience of services for them. Their empathetic and respectful nature coupled with their friendly, honest and non-judgemental approach helped families to feel welcome and comfortable when accessing services and support. One parent described how talking with staff made them feel *'more alert, bright and that they are not the only one experiencing homelessness'* while another explained that their key worker gives them 'hope'. The willingness of the key workers to listen and understand all of their needs was also highlighted as beneficial. One parent explained that without this, services would be unable to comprehend what they are going through. For those who experienced challenges or barriers when first seeking support e.g., being ignored by service providers or feeling a sense of loneliness and isolation, the approach and attitude of staff was vital for rebuilding trust in service providers.

> **"Asking you (about) the needs that you have [....] supporting you. She calls on the phone. She brings me into the office. Listening to me. Without that they cannot know what you're going through." (Customer)**
>
> **"When I was first connected with Focus Ireland – I felt scared because of my experience with [Service]. I had no hope. It went better than I thought though. They really made that effort." (Customer)**

Instant Access to Support

Six families also described that instant access to support and the immediate availability of their key workers helped to facilitate a positive experience of services for them. Parents described that their key workers were 'there the whole time if you really need them' and that 'they would struggle without this access to support'. One parent described how beneficial and important it was that their key workers office was based in the same building as they lived therefore, they 'only had to make a quick call to get instant support'. For those who were not based in the same office, having access to their key worker's telephone number to call as needed was important. This ease of access and responsive approach was also considered paramount for one family who had exited homelessness. This parent described that they felt lucky because they had immediate access to a key worker who was available to call to their house and help with her husband while also

attending important health related appointments or meetings:

> **"There the whole time if you really need them. Would struggle without Key Worker. Lucky that I have a key worker. Helps with husband drinking – come round the house and ring police if I can't manage him. Attends all meetings with me. Attends hospital appointments." (Customer)**

Provision of Practical, Needs-Based, Essential Supports

Nearly all families (n=16) identified that the provision of practical, hands-on, needs based support was important for facilitating a positive experience for them. Fourteen families described how services had provided vital income supports in the form of vouchers or donations to help with the cost of essential items. This included food hampers, electric and gas and supplies for their children e.g., prams, nappies and back to school packages. Several parents also noted how they received vouchers to help them provide activities for their children throughout the summer or provide toys at Christmas. Also related to income, parents highlighted the support they received to complete important paperwork related to social welfare entitlements such as registering for a public personal service number (PPS), child benefit and income support.

Twelve families also described the importance of the housing related support they had received. Reference was made to the provision of temporary accommodation as well as the support from the key worker e.g., contacting the council, providing references for housing, arranging viewings, as well as completing important paperwork for access to the housing assistance payment or securing residency permits.

A smaller proportion of families (n=5) reported that they received positive, practical support to help them to travel e.g., bus passes. This was considered helpful as families lacked income thus it offset the costs for their children to attend school or for parents to attend relevant meetings. Some families (n=4) also reported that they received positive, essential supports related to education. This included registering children at school or after school clubs and activities and for one parent, this also included exploring education options to further their employment. Some families (n=3) from a Roma background who did not speak English also reported that they had recently been offered access to English classes.

Families highlighted that in the absence of services and support provided, especially that which was linked with paperwork and navigating a complex system, they would have experienced significant difficulty in these areas. This was especially the case for migrant families who did not speak English and those who had low literacy levels.

6.5 Factors Creating a Negative Experience of Services

While families did report some positive experiences with services, they offered greater insight on elements of services that did not work well. The following factors were cited as creating a negative experience for families:

- Low Awareness of Services
- Slow Service Responsiveness
- Navigating the Housing and Social Welfare System
- Experiences of Emergency and Temporary Accommodation
- Lack of Holistic Support and Unmet Needs
- Staff Changeover

Low Awareness of Services

Consistent with the findings from the literature review, nine families made explicit reference to a low level of awareness of services and supports when they first became homeless. This created a negative experience for individuals, exacerbating feelings of isolation and loneliness during a time of crisis. Although several families reported that their friends made them aware of supports, for those with no or limited support networks, the situation was worse.

> **"I came to Ireland in 2018 and was living with a friend and working. My wife and kids came in 2020 and my friend couldn't provide accommodation for them. We had to stay outside in the car. It broke my heart. I didn't care about myself but my children, they were attending school but had no place to wash, eat or do their homework. I didn't know how or who to ask for help" (Customer)**

It is important to note, six individuals from a Roma background had arrived in Ireland during the COVID-19 pandemic and subsequently they were placed immediately into a hotel to quarantine followed by emergency accommodation. Their initial experiences of homelessness and subsequent experiences of seeking support and navigating the homeless system in Ireland differed to their counterparts who had arrived prior to the pandemic. Low level awareness of services was not identified as an issue for them.

> **"I arrived in Ireland 6 or 7 months ago. We had to quarantine on arrival due to COVID-19. A lady called me from the hotel and told me she was my key worker, so I wasn't worried. Overall, a positive experience." (Customer)**

Slow Service Responsiveness

For eight parents, a negative experience of services was attributed to the slow responsiveness and poor communication from services. For five parents this was linked to experiences with their key worker while for three this was related to experiences of seeking support. Families conveyed a level of frustration with the unavailability of services and those in place to support them. They described experiences of reaching out for support, not receiving a response, or being told that they will hear back only to receive no response. In one family's example, after they made contact for support, there was nothing immediately available for them. In other examples, parents felt ignored and unsupported. This diminished hope and exacerbated worry. One parent acknowledged that their key worker was not as responsive as they would like due to being busy.

> **"Our first attempt was [service] but we didn't hear anything back from them. Gave us information that we could do this, this and this but then never got back when we called. So, when I first connected with Focus Ireland, I felt scared and had no hope." (Customer)**

Navigating the Housing and Social Welfare System

The most prominent issue creating a negative service experience for families was the duration of their homelessness. This was compounded by the uncertainty, challenges and barriers they faced when navigating the housing and social welfare system. Despite receiving support from key workers in the areas of housing and social welfare, housing ambiguity and system related barriers heightened feelings of frustration, hopelessness, stress and sadness. For example, the length of time to receive an application decision, difficulty with meeting eligibility requirements, applications being turned down and the requirement to complete a new application for support in each county were described. This was a particular challenge for families from an ethnic minority background who were newly resident in Ireland. A lack of available landlords willing to accept the Housing Assistance Payment (HAP), the demand for housing and lack of appropriate housing to accommodate family needs were also noted.

> **"I am here in Ireland on my own. Looking everyday for accommodation. Focus Ireland have helped with getting HAP but now landlords don't accept HAP payment. Focus Ireland are trying to identify suitable landlords for me." (Customer)**
>
> **"I am very upset that the HAP wasn't approved yet – husband working, child in school, prepared all the documents- don't know what else we can be doing." (Customer)**

Experiences of Emergency and Temporary Accommodation

While overall, families expressed a level of gratitude with being placed in emergency or temporary accommodation, nine parents conveyed frustration and challenges with their current situation. They described accommodation as 'too small', 'busy' or overcrowded, 'uncomfortable' and 'inconvenient'. In some circumstances, families described that their accommodation lacked cooking facilities or food storage facilities which created further strain on their income and in others, the lack of onsite parking facilities had imposed risks of fines or created difficulty for them to rest. One family described how the current conditions of their accommodation meant that their children had no space to play, while another described how they did not have access to hot water or heating and that this was having an adverse effect on their child's breathing. For two families with experience of congregate housing, they described how they and their children were exposed to even greater trauma citing that people around them often had poor mental health, psychiatric disorders, suffered addiction or were suicidal. Being moved from place to place was also cited as creating a negative experience for families as were the curfews imposed in some temporary accommodations.

"Where I am right now, we don't have access to a kitchen, only a bedroom and bathroom. It's winter and there's no heating or hot water. I have to eat outside every day, and I have to pay for this. So cold, it's starting to affect my child's breathing," (Customer)

"Very bad first experience. I was placed in a hotel with 5 kids. There was no space to cook and we had to eat out all the time. I struggled. When we moved to [congregate housing], it's a small complex and you are looking at other people living there who are suicidal and suffering from drugs abuse." (Customer)

Staff Changeover

Although many individuals reported a positive experience with their key worker, for three research participants, the changeover or turnover of key workers created a negative experience for them. Varying spirit levels, interest, concern and ability or readiness to help were reported. Resultantly individuals compared key workers as 'good' and 'bad'. In one case, the changeover of staff before the closure of their case created a feeling of 'abandonment'.

Lack of Holistic Supports and Unmet Needs

Despite recognition that services had provided essential support across important areas of housing, health and income, fifteen individuals identified areas where their needs remained unmet. For seven families, this related to physical health needs. Completing forms for medical cards themselves and a lack of access to GP while homeless were cited as key challenges. One individual was unaware that they could receive support for health while another described how a lack of access to medical support while homeless has resulted in mobility issues for her husband. They noted a key area of improvement for services should be provision of GP or Public Health Nurse services as this is particularly challenging to access without an address. Another parent who was pregnant described

that they did not have a medical card and had not been offered support to get one so relied on hospital when she felt sick.

> **"They try to help all my problems. But not all are as holistic. They have not helped me. I need a medical card." (Customer)**

Similarly, six families highlighted how theirs or their child's mental health needs had not been met by services with the experience of homelessness compounding their needs. For example, one parent described how they were suffering from depression and when their child was taken into care, they weren't offered any mental health support; blame was placed on the key worker for not reaching out to have a chat during this time of crisis. Another parent described how their children had entered homelessness at the age of five and six and that due to the trauma they had experienced during this time, they were now in special care after attempted suicide. This was attributed to an inability to get out of the house when the children were young due to limited income/resources, lack of access to a GP due to no fixed address, and a lack of access to mental health services due to long waiting lists resulting in slow assessments. In another parent's experience, despite being supported in the area of mental health, the level of service provided was deemed inadequate and not meeting their needs. They stated the following:

> **"Being in this situation is a trauma for everyone, it's not easy on the children and no one is happy. They sent me a mental health person, but they just gave me some numbers to call." (Customer)**

For four individuals, unmet needs related to education. For example, one parent from a minority ethnic background described how their child was expelled from school due to problems with other students and that she had received no help to find an alternative school. She expressed desire for support in this area. Similarly, a mother and daughter from a Traveller background noted how they had communicated their interest in receiving educational support from their key worker but had received no help while a father from a Traveller background indicated that he was unaware that he could receive support in this area and that such support would be important for him in terms of supporting his child's education and understanding important letters.

> **"I haven't received any support for education. Would love to do this. To learn how to read and write and understand letters etc in the future. A few times my kids have come home from school. My 9-year-old does his homework. I tell him good boy – can't tell him if its right or wrong. Could Focus Ireland help me with my child's homework? After schools' clubs and education for myself." (Customer)**

Section 7:
Staff Perspective

Interestingly, despite facing a language barrier, four families from a Roma background did not feel they needed educational support or had no interest in learning English. One father who had already secured employment at a recycling centre indicated that he did not need it for his work and although he acknowledged the challenges they might face with navigating life in Ireland once housed, he explained that his son could help. Another parent from a Roma background reported a similar intent to rely on their child for translation in the future.

There was consistent perception among families from a Roma background that everything would be fine once housed and that their language barrier would not present any challenges in terms of theirs and their child's health or their child's education. Their inability to identify additional needs beyond housing mirrors the findings in the literature review where basic human needs such as finding shelter and food are prioritised.

7.1 Introduction

The following sets out a thematic analysis of the research findings from a staff perspective. This is informed by four online focus groups with fourteen staff across six of Focus Ireland's services including: The Family Homeless Action Team, Aylward Green, George's Hill congregate housing site, Dublin Off Site Housing (DOSH), Stanhope Green congregate housing site and the Family Centre. For clarity and ease of reference, the thematic analysis is presented under the following headings and subheadings. Where appropriate, the analysis is cross tabulated with findings from the literature review and is augmented by direct quotes from research participants.

- Family Homelessness and Complex Support Needs
- Impact of Complex Needs on Homeless Families
- Challenges and Impact on Service Providers
- MDT Approach

7.2 Family Homelessness and Complex Support Needs

Staff experiences of homeless families with complex needs were discussed at length. Young people, single mothers, members of the Traveller community, and an increasing number of migrant families were most frequently reported as having complex needs. Areas of need included mental health, physical health, addiction, poverty, unemployment (exacerbated by a lack of childcare), domestic violence and family functioning difficulties, including parental relationship breakdown, reduced parenting capacity, and children entering the care system.

In general, staff noted that families with complex needs often had poor coping skills, existing in crisis and living in circumstances which they struggle to cope with. The trauma associated with prolonged homelessness coupled with affordability of counselling, long waiting lists for treatment and intervention were noted as exacerbating mental health conditions. Reference was made to services exposing families to other families with complex needs and placing a singular family unit in a dwelling which is too small to comfortably accommodate. This was described by staff as causing "continued exposure to trauma" and exacerbating challenges with exiting or sustaining an exit from homelessness.

> **"A lot of homeless families have mental health issues which make it difficult to manage a property." (Staff)**

It was also highlighted that homeless families with complex needs often did not have a medical card and were unable to access basic health support. This was cited as contributing to the onset of preventable illnesses and injuries.

> **"Homeless families can go to [local medical charity] clinic but struggle to get linked into GP services. This increases potential health issues." (Staff)**

Literacy was also identified as a complex need which exacerbates the conditions which render families homeless. It was noted that many homeless families have low levels of educational achievement having left school early, with illiteracy compounding difficulty in accessing services. Staff explained that poor literacy created barriers to communicating with local authorities about their case, with schools about their children and with medical services about their needs. Staff highlighted that there are instances where parents are unable to register their children with schools or keep up with school correspondence. This creates a cycle whereby children miss out on education, heightening the likelihood that they themselves will also have trouble in this area. This was noted as a specific difficulty for migrant families, with staff indicating that a high portion of service needs revolve around translation services to overcome language barriers. Further adding to complexity, staff noted that a proportion of migrant families depended on their children as translators; staff emphasised that this could impact on a child's development and cause trauma, particularly when they are involved in important conversations around homelessness which they otherwise would not be.

> **"When parents don't have English, their children translate. I think this impacts on the child's development." (Staff)**
>
> **"There are migrants from Somalia who are homeless, and they have a great difficulty communicating their medical needs." (Staff)**

There were also further discussions about the specific complex needs of migrant families. It was noted that Roma families often come to Ireland to seek work but are unsuccessful or lose their home after a landlord sells the property. There are other migrants who arrive in Ireland already homeless, intensifying demand on the system. For the Roma community, a lack of skills to manage a property, poor employment history, and experiences of racial discrimination are specific complex needs.

In terms of practical barriers for homeless families with complex needs, staff explained that often families are referred to many different services, making it difficult to keep track of who they are referred to and why. Practical barriers also exist around location. Hubs for services to address complex needs are largely located in city centres. Families become dependent on these services, making it difficult for them to relocate and engage with other services elsewhere, particularly when moving services requires joining a waiting list. Other practical issues surround the contacting of services, with families who have experienced trauma linked to domestic violence requiring help to contact support services.

> **"There's a major barrier for homeless families in moving areas. The hubs are in the city centre. They make links in these services and then have to move on." (Staff)**

7.3 Challenges and Impact on Service Providers

The impact on staff of addressing the complex needs of homeless families was a central topic of discussion. As with the impact of complex needs on families, the impact on staff is wide-ranging.

Expertise and Experience: Staff reported that they were expected to "wear many hats," listening to and responding to those with a range of needs, from mental health conditions, trauma, and addiction, to support with housing forms and education and employment. Staff frequently lacked the expertise necessary to adequately handle these issues. Staff commented that this makes it difficult for families to be fully assessed and supported, leading to undiagnosed needs such as mental health conditions and learning difficulties which will have a knock-on effect on the life of the homeless individual and their family.

> **"We know about independent living skills; we're not mental health experts." (Staff)**
>
> **"Don't have time, resources, knowledge, trying to be everything to that one person." (Staff)**

Expectations of Customers: Further to issues surrounding staff expertise, staff also noted that some families have unrealistic expectations of what staff can provide. It was highlighted that homeless families with complex needs often want the staff to "do all the supports for them,"; an expectation which staff are unable to meet.

> **"Some families want everything done for them and there's an expectation that the services will." (Staff)**

Capacity: Staff reported that they were also unable to investigate and fully understand the complex needs of homeless families due to the demands on their time created by the volume of families requiring multiple supports coupled with low levels of resources. Staff described that it can 'feel like firefighting' and that contact with families can often be less than 15 minutes at a time. In addition to this, staff noted the difficulty they faced in managing the multiple services families require and monitoring the policy and operational changes of these services and local authorities. Staff reflected on spending *"hours ringing around different places"* to ascertain which services their clients could access. Difficultly arises in this area when families are moved around as catchment areas for services are different, and policies *"never stay the same."* The consensus from staff on this topic was that it is a slow process, and more support is needed as their services currently *"never have enough staff"*.

> **"We often have to 'hand hold' people to parent their children." (Staff)**
>
> **"With the volume of needs and the cases that the staff have, I don't think we are even getting to the bottom of the needs that families might have. We're firefighting and responding to crisis." (Staff)**
>
> **"The number of services a family needs can be challenging to manage.**

One of the families I support has four public health nurses for their children alone; one for each child." (Staff)

"My caseload is supposed to be capped at 25 but I'm at 30. The children caseload is supposed to be 15 but I'm up to 17." (Staff)

Availability of Services: Whilst constraints on the capacity and expertise of staff make it difficult for complex needs to be fully addressed, the lack of available services further compounds this issue. Services are in high demand, there are not enough spaces for support, and there is a lack of provision in areas outside of Dublin. Resultingly, staff attempt to keep families within their services, compounding pressure on waiting lists.

"There's nowhere to signpost those who live outside of Dublin. There's a lack of referral options. We keep them to try and help them." (Staff)

"There are no real services to send families onto. For example, I work with families in Wicklow and Meath by default as we can't find appropriate services for them locally." (Staff)

Accessibility of Services: Staff reflected that it is often difficult to understand the criteria for accessing support, noting criteria "change all the time." The thresholds for social workers and housing were highlighted as unclear and staff felt that relationships between social workers, local authorities, and staff require development to add consistency to the service and awareness across the team. Staff reflected particular difficulty in arranging PPS numbers for their clients, noting that it is a *"long process"* and *"a hassle due to waiting times"*. Staff expressed frustration with this as families are unable to access any support until this number arrives; further compounding demand on services and intensifying of complex needs.

Suitability of Current Offering: There are also issues surrounding the suitability of current service offering. It was felt by staff that current provision *"sets families up to fail"*, as it does not address the breadth of customer's complex needs. Firstly, as reflected in previous sections, services are not set up to deal with multiple languages or illiteracy. Resultingly, those with literacy issues are unable to understand key forms, documents, and appointments, reducing the likelihood that they will receive the support they need. Second, staff felt that current service offering relies on Housing Assistance Payments which is not tenable as families with complex needs have additional problems which are not addressed. Resultingly, families are placed in a home with no independent living, money management, or home management skills and struggle to maintain their tenancy.

> **"There is a perception that once a family are receiving support, they are fine. We might meet basic needs, but what about everything else?" (Staff)**
>
> **"Families with complex needs mostly need supported housing but are forced to take HAP and then have problems regarding childcare, living independently, health and parenting." (Staff)**
>
> **"For years families are homeless and not doing any money management, cooking or independent living skills. Can they sustain the house?" (Staff)**

Finally, staff reflected that many current services are not trauma informed and do not account for the range of family complex needs, including mental health problems and practical considerations such as childcare arrangements. As a result of these issues, families who miss appointments with services can be moved back to the bottom of the waiting list as demand for support is so high. This creates an endless cycle of high demand with some families unable to access the support they need.

> **"One of the children in a family I'm responsible for had their psychiatric case closed because their parent has complex needs and couldn't attend their psychiatric appointment." (Staff)**

Impact on Staff: The additional pressures created on the services and system for addressing the complex needs of homeless families also has a measured impact on staff. It was noted that there are professional impacts such as more pressure at work, challenging paperwork, and a loop of repeating steps over and over to little benefit. Staff highlighted that they often felt like they had "no time" and would easily burn out in the job. There are also personal impacts. Handling cases of complex needs creates job stress, and negatively affects staff mental health. Staff commented that they often felt *"drained," "frustrated,"* and internalised the problems of their clients.

> **"What happens when we drop the ball? It's a family's life. Managing their life becomes our problem. You internalise this." (Staff)**
>
> **"It has a negative effect on our mental health. It's so draining and frustrating because we want a house for the families, but you're just not able to provide one." (Staff)**

7.4 Multidisciplinary Team Approach

Considering the current pressures on services, and the impact of complex needs on both staff and homeless families, staff discussed the merit of a MDT approach for homeless families.

MDT vs. Current Provision

It was reported that an approach to addressing complex needs that could connect services, reduce waiting times, and address a wide range of complex needs through a menu of supports was needed. Staff noted that a MDT approach would allow them to compile a *"proper picture of the needs"* of homeless families and put the appropriate supports in place to enable families to manage their needs. It was reported that this process would be aided if it was delivered alongside a Housing First approach.

> **"MDT might work well. Having all services together once a month would bring it all together." (Staff)**
>
> **"MDT makes sure everyone is on the same page and creates a collective team. It provides faster support and there is less duplication of services." (Staff)**

Staff reported that a MDT approach would make their jobs less difficult, remove pressures on their time, and *"remove the struggle"*, meaning homeless families are more likely to get the support they need. Staff highlighted that a MDT approach would facilitate skill sharing across their team, partially addressing the lack of experience staff have in some areas and better enabling them to address complex needs. Staff also stated that multi-dimensional work would facilitate connections with other staff members, giving them a better sense of what is going on and focusing services. This was highlighted as important as the long-term strategy for a service can be lost when the focus is on responding to high demand in the moment.

> **"MDT would make our jobs easier. It would take less time and be more efficient, giving clients the support they need. We could do the job we were employed for." (Staff)**
>
> **"I think that a MDT approach would give all services a focus and give us somewhere to go." (Staff)**

Section 8:
Stakeholder Perspective

MDT Components

Staff were asked what the core components of a MDT approach for the complex needs of homeless families would be. The elements noted as necessary were:

- Housing supports
- Primary care supports (i.e., GPs/Public Health Nurses)
- Mental health supports/Psychotherapy
- Occupational therapy
- Speech and language therapy;
- Addiction counselling;
- Family support (including parenting support);
- Language and translation support;
- Childcare;
- A focus on skills such as independent living and money management;
- Relationships with local authorities.

It was felt that the inclusion of primary care and mental health supports would rectify the lack of communication staff have with these services. Staff placed a premium on a MDT service model that would address needs *"right away," "put follow-on in place"* and *"adopt a trauma-informed approach."*

Impact of MDT for Homeless Families

Staff noted that a MDT approach would benefit homeless families with complex needs in a number of ways. Firstly, facilitated by the interlinking of staff, homeless families may need to access fewer appointments as knowledge can be shared amongst staff. This addresses how complex needs impact abilities to keep appointments. Fewer appointments were also highlighted by staff as reducing the likelihood of homeless families being re-traumatised by having to repeat their experiences and complex needs over and over again.

> **"I find that customers get frustrated with always having to repeat themselves." (Staff)**

Staff commented that a MDT approach would be a mechanism for facilitating early intervention, particularly for children, with early interventions reducing the likelihood of adverse childhood experiences, enabling early diagnosis, and reducing the number of children taken into care. This would have knock on effects for schools which could then apply for supports to address the needs of these children, which in turn would improve their experience of education and increase their likelihood of employment, breaking the cycle of homelessness for families.

> **"Early intervention is key. It stops further homelessness and trauma and diminishes adverse childhood experiences." (Staff)**

Ultimately, staff reported that a MDT approach would have a *"knock on effect to support the sustainment of tenancies long-term."*

8.1 Introduction

The following sets out a thematic analysis of the research findings from a stakeholder perspective. This is informed by five one-to-one interviews with Head of Family Services at Focus Ireland, Head of Housing Supports at Focus Ireland, Safety Net Primary Care, Paediatrician at Temple Street and Dublin Region Homeless Executive.

For clarity and ease of reference, the thematic analysis is presented under the following headings and subheadings. Where appropriate, the analysis is cross tabulated with findings from the literature review and is augmented by direct quotes from research participants.

- Family Homelessness and Complex Needs
- Challenges and Gaps in Provision for Families with Complex Needs
- Views on Adopting a Multidisciplinary Team Approach

8.2 Family Homelessness and Complex Needs

Stakeholder perspectives on the complex needs of homeless families mirror the findings from the literature. Mental ill health, addiction, malnutrition, low literacy levels, a history domestic violence, low income, family separation, development delays and learning difficulties were reported as the personal and social issues that combine to create a complex profile. Stakeholders also acknowledged that not all homeless families have complex needs. For some, the challenge is not the breadth or severity of needs, but that the needs of parents and their children are multiple, overlap, and present at the same time.

Stakeholders reported that homeless families with complex needs often faced greater difficulty with parenting and fulfilling basic needs for their children. These families were reported as less likely to have a medical card or access to a GP. Low health literacy levels, language barriers and the transience associated with homelessness compounds their ability to navigate the health system and as a result, they are more likely to miss health related appointments or to rely on emergency departments for minor ailments and manageable conditions. Stakeholders reported that as a result, homeless children's vaccination rates were lower and pre-existing conditions in both parents and children were often exacerbated. Akin to staff, stakeholders also highlighted the distinct, but nonetheless complex, needs of homeless families from a migrant background in this area. It was noted that while these families did not typically present with addiction or mental health concerns, language barriers created an inequity in access to health services, thereby compounding need.

> **"In clinics you can predict what children won't attend. If their address is a B&B or their surname is from a Roma or Traveller background, you aren't surprised when they don't show up. They usually have low health literacy levels, or the appointment letters are written in English and so it's difficult for them to understand." (Stakeholder)**

The role of language barriers and illiteracy among homeless families with complex needs in creating challenges with navigating the school system for their child and creating uncertainty with regards to social welfare entitlements was also highlighted. This was underscored as a more pronounced issue for migrant families.

> **"It's difficult navigating the systems. They're in a new country with a different language." (Stakeholder)**

Stakeholders noted that a lack of access to appropriate kitchen or cooking facilities coupled with the affordability of healthy food comprised another issue for homeless families with complex needs. This was linked to malnutrition, dietary problems, and the creation of development and growth delays among children.

> **"We often see a lack of red meat in the diet of homeless children and nutritional problems which lead to children experiencing development problems." (Stakeholder)**

The experience of homelessness alongside a range of other personal and social issues such as family separation and those outlined above was also linked to adverse childhood experiences for children, school interruption, and the onset of mental health challenges and learning difficulties.

8.3 Challenges and Gaps in Provision for Families with Complex Needs

The challenges and gaps in provision for homeless families with complex needs were discussed with stakeholders. The following issues were identified:

Coordination, Communication and Continuity of Support: Understanding the extent to which the issues faced by homeless families are intrinsic or the result of their environment requires input and expertise from a range of professionals. Stakeholders felt interagency communication in this area was lacking, highlighting that the current system is fragmented, that services and departments typically operate in silos, and don't know what the other is doing. This presents a challenge to coordinated responses, particularly when services for families with complex needs are required simultaneously. The continuity of support provided for homeless families who are moved from place to place was also noted as inhibitive. Examples of current practice such as 'case conferences' were recognised as positive steps in this area, but there was a consistent view that communication between and across services was lacking and that such examples were not common practice.

> **"Understanding children's issues relies on the expertise of other professionals such as occupational therapists and speech and language therapists. There is no easy way for different areas to communicate among and between themselves. We try our best but we each have individual approaches." (Stakeholder)**

Capacity and Resources: Stakeholders noted that all services working to support homeless families are under resourced and lack capacity to support individuals and families with complex needs, citing that they often have 'to take account of additional needs or logistics beyond their reach.' The rate at which people in distress were entering Ireland was said to be overwhelming the systems and responsible departments and the range of support needs between and among homeless families with complex needs was considered particularly challenging. There are 'traditional homeless and marginalised' people who have different healthcare seeking habits and who require access to healthcare 'where they are at' and there are homeless families from a migrant background who require a completely different model of support in the form of employment and housing. Adequately supporting these families requires different skill sets.

Availability and Accessibility of Services: Families with complex needs typically require immediate access to a variety of supports across multiple disciplines. Stakeholders identified that these supports are either not readily available or are inaccessible. Mental health, dentistry, and disability services were noted as key gaps in provision, with lengthy waiting lists, service criteria, and regulations noted as barriers. Furthermore, it was noted that some mainstream services will only work with an individual once other needs are being met, thereby creating access challenges. An example of this challenge is highlighted below:

> **"There was a vulnerable family who did get access to a public health nurse and occupational therapist. They suffered from poor mental health, had hoarding issues, and addiction. They did get an appointment but due to the parent's health and reduced ability to look after the home, health and safety regulations meant that the public health nurse was unable to work in that space." (Stakeholder)**
>
> **"It can be frustrating when you know what is needed but it doesn't happen quick enough." (Stakeholder)**

Responsibility: The lack of single or collective responsibility for families with complex needs at a national level was also highlighted as a core challenge for services in effectively meeting needs.

8.4 Views on Adopting a Multidisciplinary Team Approach

Considering the complex needs of homeless families and the current challenges and gaps in provision to address these needs, stakeholders discussed the merit of a MDT approach for homeless families.

MDT Approach

Stakeholders acknowledged the benefits of a MDT approach for homeless families with complex needs and highlighted current MDT examples which are working well:

"The Dublin Region Homeless Executive are becoming more interlinked with the HSE. Things are more streamlined, and everyone knows who does what. It shows that formalised network approaches can work really well." (Stakeholder)

One stakeholder reflected that after the COVID-19 pandemic, there would be wide-spread support for a new approach to tackling homelessness:

"Society has taken homeless and health to their core. They don't want to be a society where people are living on street or where there is social injustice. There is a collective movement that has a huge impact, and politicians are responsive and follow the needs of the people." (Stakeholder)

Stakeholders reported that a structured and cohesive MDT approach would help address current pressures on services which address the complex needs of homeless families. It was noted that it would not only provide access to services but enable interventions to be put in place as rapidly as possible which would in turn support an exit from services. Whilst it was acknowledged that current services are addressing needs, it was evidenced that there exists a current lack of coordination between services which could be streamlined to promote communication.

"We need a coordinated structured team to share information. I'm not currently aware of all the relevant agencies operating in this space that families I support may need." (Stakeholder)

"The next stage for any service is coordination. We need to encourage case conference as it's not currently common practice." (Stakeholder)

Benefits of a MDT Approach

Stakeholders reported that the adoption of a MDT approach would have a range of benefits:

Service Usage: It was noted that a MDT approach which addresses the multiple needs of homeless families could improve service usage, with access to support in turn reducing the impact of complex needs and increasing sustainable exists from homelessness.

> **"There are already examples in practice. The Housing First model for singles addresses their mental health needs. The degree of progress is quicker and smoother for the homeless individual." (Stakeholder)**

Reduction in Cost: Stakeholders reported that for some services, the employment of a MDT approach would lead to reductions in cost. The example was provided of supports which address both housing and health. If the impact of health as a complex need is reduced and health status improved, stakeholders highlighted that there would be a reduction in unnecessary suffering which further compound needs. This would in turn lead to a reduction in costs for the health service as demand decreased.

Availability of Services: Stakeholders highlighted that a MDT approach would improve timeframes for accessing support, reduce waiting times, and pressures on services. If support was provided in-house, the burden of ensuring an appointment was attended by a customer was removed as when a family needs support, the support team are "already there."

> **"If homeless families have access to all the disciplines that they need and then further access to supports in the community then wait times would start to go down." (Stakeholder)**

Relationships with Service Providers: A second benefit of a MDT service model that includes dedicated in-house supports for families with complex needs was that families would be able engage the same professionals at each of their appointments. This would allow families to build trusting relationships with those providing support which in turn would increase service usage and reduce the need to repeat experiences which are linked to trauma.

> **"In-house provision builds trust and relationships. Families don't need to go to someone else that they don't know or trust." (Stakeholder)**

Expertise: The qualifications and abilities of case managers were recognised, but stakeholders highlighted that they are not supposed to provide more than generalist support. A need for specialist expertise was noted as important for addressing the complex needs of homeless families. A MDT which case managers could tap into and then coordinate supports through was highlighted as a remedy to current issues in this area.

Section 9:
A MDT Model for Family Homelessness in Ireland

Anticipated Challenges

Whilst acknowledging the benefits of a MDT approach, stakeholders reported that the implementation and delivery of MDT provision would not be without challenges. Key challenges identified included:

- **Cost:** The cost associated with developing, implementing, and delivering a MDT approach was highlighted as a potential challenge. However, stakeholders did identify the following avenues for investment: HSE, Dublin Region Homeless Executive, TUSLA, and Rethink Ireland.
- **Expertise:** Stakeholders questioned whether Focus Ireland had the relevant expertise to develop, implement, and deliver a MDT approach. It was noted that support would be needed for recruitment and clinical governance, with reference to a need for an advisory group or steering committee to mitigate these challenges.
- **Managing Expectations:** Stakeholders noted that whilst a MDT approach would improve the current situation, it remains to be seen how extensive this improvement would be. It was highlighted that there would be a need to manage expectations and communicate that this may not "solve all problems."
- **GDPR:** Stakeholders reported that GDPR would need to be explored to ensure that the sharing of information between services was not in breach of guidelines.

Key Considerations for Successful Delivery of MDT

Stakeholders were asked to consider what the critical success factors of delivering a MDT approach would be.

Buy-In and Coordination: Stakeholders noted that for a MDT approach to address the complex needs of homeless families, buy-in from key stakeholders and services would be critical. Once families are accessing care, the focus should be on progressing their support to a point where the family is no longer unduly impacted by complex needs and therefore no longer needs to avail of the MDT service. Stakeholders highlighted that this would require high-level, even national coordination, so that existing systems of support could assume responsibility for families once their complex needs are addressed.

> **"There is a need for stakeholder representation and buy-in among key areas of expertise." (Stakeholder)**

Communication: Stakeholders noted that communication across the MDT would be key to successful delivery. It was highlighted that the MDT approach should include a system which promotes ease in the sharing of salient information. This is true of both information pertaining to the family, but also the sharing of key knowledge, expertise, and learning which will promote a high standard of care and improve the capacity of staff. It was suggested that a structure of regular meetings be implemented to encourage lines of communication.

> **"Staff should become better educated and learn from the other members of the MDT." (Stakeholder)**

Networks of Expertise: Stakeholders felt that a MDT approach should heavily rely on the expertise of specialists in respective areas, allowing for the construction of a network of local support and the promotion of knowledge about what is available. This would allow case managers to direct families with complex needs to the most appropriate supports.

Steering Group: Stakeholders reported that the creation of a steering group would be essential to ensuring a MDT approach could be designed, implemented, and delivered. This would address gaps in the knowledge of services about how to implement an effective MDT approach and provide oversight on the management and allocation of resources.

Case Management: It was noted that existing assessment structures and case managers should be able to adapt to a new operating system. Stakeholders reported that it would be important to ensure that each case was managed by a singular case manager, who then draws on the support of the MDT and focuses the direction of support. This would ensure a level of coordination in the unique care of each individual family, with a focus on both immediate and longer-term needs.

Equitable Access: Stakeholders reported that whilst access to services for families with complex needs would be a success in itself, there would need to be a consideration of equal access for migrant and native populations. This is true of where the complex needs of these populations overlap, but also where they differ and require specific support.

Key Components of a MDT Approach

Stakeholders were asked to consider what they felt were the key components of a MDT approach. The following key roles were identified:

- Primary care supports such as GPs
- Public Health Nurses
- Mental Health Nurses
- Child and Adult Clinical Psychologists
- Psychiatrist
- Addiction Specialists
- Counsellors
- Child and Family Support Workers
- Case Manager
- Peer Worker

It was reported that some of the roles identified did not require a full-time position and

could be provided by other services through a blend of in-house and partnership delivery. For example, a GP could form part of the MDT but participate on a part-time basis alongside their responsibilities in their GP practice, or the MDT could work with the GPs which homeless families are already registered with.

Additionally, whilst stakeholders did not feel certain organisations should form part of the core MDT, it was noted that they could be involved in an advisory capacity, in partnership, or as part of the steering committee. Key suggestions in this instance included:

- Representatives from local hospitals
- HSE Social Inclusion
- Representatives from disability service community network
- Safetynet
- Pavee Point
- International Protection Accommodation Services

9.1 Introduction

The purpose of this report is to appraise the value and impact of a multidisciplinary team approach to families experiencing or at risk of homelessness with additional and complex needs including a detailed operational plan for a MDT service. The following section summarises the need and demand for this approach and sets out the possible service model options. An operational plan with cost projections for a preferred option is presented.

9.2 Review of the Current Situation

To date, Focus Ireland services have adopted a single case management approach to supporting homeless families in Ireland, combined with supported housing models and specialised child support workers where funding permits. In this model, when a family is referred to Focus Ireland, a case manager assesses their needs. In some instances, families presenting as homeless have complex needs e.g., language barriers, unemployment, illiteracy, disability, while in others, the prolonged experience of homelessness exacerbates existing needs or contributes to the onset of new needs e.g., poor mental and physical health.

In the current situation, it is the case manager's responsibility to directly manage all of the needs of the family. This may include the provision of direct support e.g., making applications for a Personal Public Service (PPS) number, the Housing Assistance Payment or other welfare entitlements on their behalf and identifying suitable and affordable long-term accommodation as well as making referrals to other relevant supports and services they require e.g., counselling, disability services and hospitals/GPs.

However, consultation with families, staff and stakeholders highlights that the current approach is not effective at supporting families who have complex needs. Some of the key challenges identified through consultation are presented below:

- **Needs Assessment:** With the volume of needs and cases the staff have coupled with a lack of expertise and experience in the areas of mental health, disability, developmental needs, addiction, some family's needs are not being assessed/ addressed e.g., undiagnosed learning difficulties and undiagnosed mental

health problems.

- **Availability of and Access to Services:** There is a lack of available services to refer on to and lengthy waiting lists are creating barriers to access especially in areas related to mental health and disability. This means that immediate access to some services is not available and that homeless families with complex needs don't get access to vital services when they need them. As a result, the complexity of their needs worsens. Travel, childcare, illiteracy and language barriers create challenges for families when accessing services and some services in the community are not trauma-informed and do not account for the complex profile of some homeless families for example, medical forms delivered in English by post which can result in missed appointments when a family moves address, when a family is illiterate or faces a language barrier or other complex needs contributing to reasons of non-attendance. As a result, families are moved to the bottom of already lengthy waiting lists.
- **Continuity of Support:** The current system is fragmented and services operate with limited communication/shared learning or knowledge about one another, this presents a challenge to coordinated responses, particularly when services for families with complex needs are required simultaneously and when families are required to move location/address during homelessness.
- **Capacity and Resources:** Services working to support homeless families are under resourced and lack capacity to support individuals and families with complex needs and often have 'to take account of additional needs or logistics beyond their reach.'

These challenges manifest in staff burnout, staff dealing with issues they don't feel qualified to deal with and homeless families who have complex needs that a) do not get identified or b) addressed. This reduces the long-term prospect of addressing homelessness among these families; according to Focus Ireland, it is estimated that these issues impact circa 10–20% families per annum.

9.3 Assessment of Need and Demand

This report concludes that:

a) There is a clear need to consider a new way to support homeless families with complex needs

b) There is sufficient evidence in the literature and in the research findings to support the potential of MDTs as an effective approach to supporting homeless families with complex needs

The following sub section sets out a range of options for the establishment of a MDT approach, each of which is aligned to the research findings and the review of literature.

9.4 Multidisciplinary Team Approach: Options

There are several models of multidisciplinary service provision that could be implemented to better address the complex needs of homeless families. These are listed below:

Options	Description
1	A multi-disciplinary team that operates under a Memorandum of Understanding (MOU) with representation from key stakeholders and services whose responsibility is to share information, inform robust needs assessment and make referrals to external services/ existing provision in line with needs assessment.
2	A multi-disciplinary team that operates under a MOU with representation from key stakeholders and services whose responsibility is to share information, inform robust needs assessment and who make referrals to a link worker (employed by Focus Ireland) who has programme money to buy in/pay for services.
3	A multi-disciplinary team employed by Focus Ireland and who undertake a needs assessment and deliver services in house.
4	A combination of Option 1 and 3 where Focus Ireland employ a multi-disciplinary team to deliver services in house as required and work in partnership through a MOU with other agencies to make referrals/deliver services where appropriate.
5	A combination of Option 4 where Focus Ireland employ a multidisciplinary team to deliver services in house as required and have a service level agreement with relevant providers to deliver all necessary services.

To short list options, each were 'sifted' against the following key criteria:

- Extent to which option allows for early identification of family's needs
- Extent to which option promotes immediate access to key services as required
- Extent to which option promotes coordinated, interagency working across the sector
- Extent to which option reduces pressures on case managers and existing staff
- Extent to which option complements rather than displaces existing provision
- Extent to which the option is sustainable

Using the above criteria, the Research Advisory Group reviewed consultation findings and options and subsequently identified a preferred model for an operational plan to be developed. **The preferred option was Option 4 whereby Focus Ireland employ a multidisciplinary team to deliver services in house as required and work in partnership through a memorandum of understanding with other stakeholders and services to make referrals to services as appropriate.**

9.5 Implementation Plan

Implementing a Multidisciplinary Team

The model requires investment in a multidisciplinary team to act as experts, providing and coordinating care in line with family's needs. The research identified a long list of staff who could form part of a multidisciplinary team approach for homeless families with complex needs. These include:

- Psychiatrist
- GP
- Pediatrician
- Public Health Nurse
- Occupational Therapist
- Mental Health Nurse
- Child and Adult Clinical Psychologist
- Peer Worker
- Speech and Language Therapist
- Addiction Specialists
- Counsellors
- Family Support Worker
- Child Support Worker
- Money Management Expert
- Interpreter/Language Support

The above list represents an 'ideal' list of experts to assist with the management of homeless families with complex needs. However, the employment of all would require significant investment thus would not be feasible. Informed by the consultation process and the key challenges identified for families with complex needs, the following staff roles have been prioritised:

- General Practitioner
- Psychiatrist
- Public Health Nurse
- Clinical Psychologist
- Child Psychologist
- Addiction Support Worker
- Family and Child Support Worker
- Translator

Furthermore, as recommended in the literature, to effectively deliver care through a MDT approach, a single identified individual, should oversee and facilitate the work of the whole team.

The following table presents a core staff team for the initial formation of a MDT in Focus Ireland. This includes a combination of employed staff and access to key experts through a memorandum of understanding. The research highlighted that a key consideration for

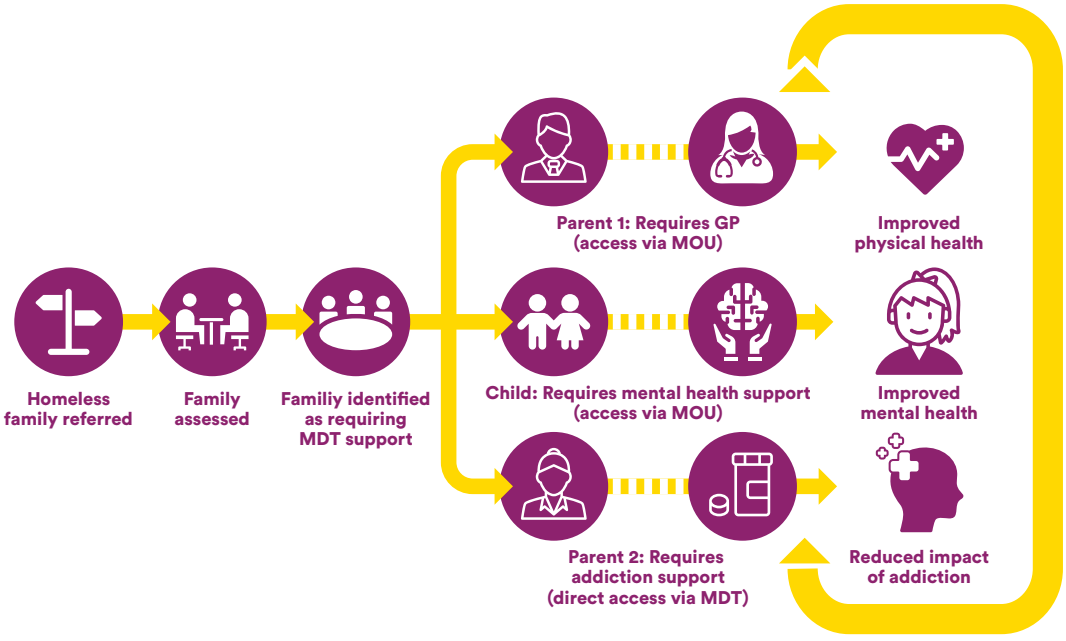
Focus Ireland when forming an in-house MDT is ensuring appropriate clinical governance for relevant staff. It is therefore proposed that clinicians form part of the multidisciplinary team through a memorandum of understanding. This will allow for full clinical governance.

Multidisciplinary Team	
Clinical Psychologist*	MOU
Child Psychologist*	MOU
Addiction Support Worker	1 Full Time Employed
Family and Child Support Worker	1 Full Time Employed
Public Health Nurse*	MOU
Project Leader	1 Full Time Employed
GP Access	MOU
Psychiatrist Access	MOU
Total	

An additional consideration is the language barrier faced by migrant families with complex needs. To ensure the needs of this cohort of families are met, translation services should be available as and when required. Focus Ireland already 'buy in' translation support as part of its service provision. Families being supported by the MDT should also have access to this service.

An example of a client journey through this MDT model is illustrated below:

Homeless Family with Complex Needs Journey through a MDT Service Model



Steering Committee

The research highlighted a need for better interagency collaboration and coordination thus, it is also recommended that a steering group is established comprising representatives within the following organisations:

- Focus Ireland
- SafetyNet Primary Care
- Relevant Mental Health Organisation
- Health Service Executive Social Inclusion Unit
- TUSLA
- Local Authority

The purpose of the steering group is to oversee the work of the MDT model, share information, reinforce clinical governance and to utilise their networks and experience to expediate referrals to relevant support and services where relevant. The steering committee should also raise awareness across health and housing so that services and departments supporting vulnerable individuals are aware of its presence.

As complex needs for families may change over time, the steering committee will have a key role in assessing the extent to which the MDT meets the needs of those requiring support. Where demand for a specific area of expertise or speciality is high, the steering committee should consider how best to integrate this service in the MDT e.g., via service brokerage, MOU or employment.

9.6 Guiding Principles

Informed by NICE,[91] homelessness multidisciplinary teams should:

- Provide care through specialist homelessness multidisciplinary teams across sectors and levels of care, tailored according to local needs.
- Act as expert teams, providing and coordinating care across outreach, primary, secondary and emergency care, social care and housing services.
- Have protocols and systems in place for communication and sharing information to support integrated working within the team and between services.
- Identify people experiencing homelessness through outreach or when they present to health and social care services
- Support mainstream providers to identify and refer people to the homelessness multidisciplinary team
- Undertake and support assessments for safeguarding, physical and mental health, alcohol and drug treatment needs, and social care, including informing Care Act assessments (see the section on assessing people's needs)
- Support mainstream providers to ensure safe, timely and appropriate hospital discharge and engagement with onward care (see the section on transitions between different settings).
- Offer person-centred case management by a designated practitioner within the multidisciplinary team and ensure continuity of care for as long as it is needed by the person

91 National Institute for Health and Social Care Excellence, 2022

- Offer wraparound health and social care support that encompasses the person's needs, including:
  - physical health
  - mental health and psychological support (such as psychological therapies)
  - physical rehabilitation (such as occupational therapy and physiotherapy)
  - drug and alcohol treatment
  - social care
  - palliative care
  - communication support
  - practical support, such as help with benefits, housing and referral for legal advice.
- Engage in reflective practice, including opportunities to share experience and learning with other relevant teams, including homelessness multidisciplinary teams, and to review complex or difficult situations.
- Directly contribute to local needs assessments, service quality improvement, and reviews of complex or difficult situations including Safeguarding Adults Reviews.
- Advise homelessness leads, when needed, in nearby areas that do not have a homelessness multidisciplinary team and share examples of good practice.

The following table outlines additional guiding principles and recommendations for homeless multidisciplinary teams, also informed by NICE:[92]

Area of Focus	Actions/Guiding Principles
Needs Assessment	Assess the health and social care needs of the person experiencing homelessness. When carrying out the assessment: take account their capacity, rights to autonomy and self-determination, and any safeguarding issues and avoid unnecessary and potentially distressing repetition of their history if it is already on record. Involve peers or advocates as appropriate. Include in the assessment: A comprehensive assessment of the person's physical and mental health needs (including acute and long-term conditions) and social care needs. This should take into consideration their housing and benefits situation, how their children's or dependent's needs affect their needs. Understanding the historical context of their situation, including past psychological trauma and experience of services. In assessments to inform a health and social care plan for people who might benefit from high levels of support, use a multidisciplinary approach to enable a comprehensive and holistic assessment of their needs, involving: input from professionals with specialist expertise and practitioners who have detailed knowledge of the person's health and social care needs, including staff working in homelessness and housing services. Review the person's needs, strengths and aspirations whenever their circumstances change or whenever they request a review, rather than using standard review periods.

92 National Institute for Health and Social Care Excellence, 2022

Area of Focus	Actions/Guiding Principles
Access to Services	Provide intermediate care services with intensive, multidisciplinary team support for people experiencing homelessness who have healthcare needs that cannot be safely managed in the community but who do not need inpatient hospital care. Plan long-term engagements for people who struggle to engage with services, to help them meet their needs at their own pace. Give priority to building a relationship of trust and recognise that people experiencing homelessness do not always follow a linear recovery journey. Provide support as the homeless family transitions between settings with a key coordinator directing care, developing trust, and providing links to services in the community. Gradually lower the intensity of support as appropriate. Provide pre-emptive and structured support before, during and after transitions, recognising that people are vulnerable during periods of transition.
Communication and Information	Take into account each person's communication and information needs and preferences, and their circumstances. For example: provide translation and interpretation services if needed, ensure that written information is available in different formats and languages, including Easy Read, provide extra support for people with low literacy levels or with speech, language and communication difficulties and consider the person's access to phone or internet. Share information about: the family's rights to health and social care services, including for those with no or limited recourse to public funds, how to access health and social care services, including: – primary care services and how to register with a GP without a permanent address – specialist health services that can be accessed directly, such as maternity, bloodborne virus, drug and alcohol recovery, mental health, sexual health, and family planning services – outreach services – local authority services, including housing services and social care, voluntary and charity sector services.
Accommodation	Recognise that providing accommodation suitable for the person's assessed needs can support access to and engagement with services and long-term recovery and stability. Provide emotional and practical support for as long as it is needed in recognition that that moving to independent accommodation with tenancy responsibilities can be an extremely challenging, stressful, and isolating experience for some people. Assess risks associated with new living arrangements when a family experiencing homelessness moves into new accommodation, while also recognising their strengths, and planning ways to mitigate the risks.

Area of Focus	Actions/Guiding Principles
Safeguarding	Designate a person to lead on safeguarding the welfare of people experiencing homelessness, including engagement and face-to-face practical safeguarding support. MDT members and service providers should support staff to understand and apply laws relevant to people experiencing homelessness and who are in need of safeguarding. This should include ensuring that they can recognise signs of abuse and neglect (including self-neglect) and how to make a safeguarding referral.
MDT Staff	Provide training for all MDT members which promotes understanding of: › The needs of people experiencing homelessness and their right to access services; › Equality and diversity, including responsiveness to health inequalities, diversity issues, inclusion needs and understandings of the impact of discrimination and stigma; › How intersectional, overlapping identities can affect people experiencing homelessness; › Psychologically informed environments and trauma-informed care; › Legal duties and powers; › Legal entitlements for migrants.

9.7 Measuring Success

The purpose of the MDT is to enhance access to services and support for families with complex needs. The measures of success of MDTs relate to the following key indicators:

› Length of time families spend in homelessness
› Speed at which families access key services
› Families' perception of their experience/support

To effectively evaluate the success of the MDT, appropriate evaluation practice should be implemented from the outset.

9.8 Next Steps

The proposed model depends on investment, employing relevant staff and establishing appropriate links with key professionals and organisations. It is therefore recommended that Focus Ireland use the findings of this research to secure buy in from key stakeholders and lobby or engage with funders to secure investment.

Appendix 1: Complex Needs and Homeless Families

Area of Need and Findings

Physical Health

- Homeless people have worse physical health than the general population and the foreclosure or repossession of one's home is shown to have an adverse impact on physical health.[93]
- Having a mother who is pregnant and in temporary accommodation is associated with an increased risk of premature birth and low birth weight.[94]
- Poor quality accommodation often contains hazards which create unsafe environments for children, increasing their risk of injury.[95]
- Homeless conditions result in poor diet, disturbed sleep, co-sleeping, poor hygiene, and reduced immunity due to exposure to infections in overcrowded environments.[96]
- Homeless children experience greater risk of respiratory problems, general health issues and sudden infant death syndrome.[97]

Mental Health

- The experience of losing a home was linked to increased rates of anxiety, depression, substance misuse, and suicide and a sense of failure and of letting the family down for parents, and a loss of friends, health issues, and emotional insecurity among children.[98]
- Homelessness has been blamed for the induction of a profound sense of abandonment, loneliness, stress and anxiety, increasing the chances of one's mental health deteriorating and contributing to the onset of new mental health difficulties or the exacerbation of pre-existing conditions.[99]
- In the case of a mentally ill parent, parents may blame themselves for the experiences their children have as a result of their mental illness, worrying that they may somehow pass on their mental ill health to their children.[100]

93 Tsai, A.C., Coyne, J. (2015)
94 Faculties of Public Health Medicine and Paediatrics, Royal College of Physicians of Ireland (2019)
95 Ibid
96 The Queen's Nursing Institute (2018)
97 Ibid
98 Joseph Rowntree Foundation (2020)
99 Murphy, R., Mitchell, K., & McDaid, S. (2017)
100 Mental Health Foundation (2022)

- Women who enter a homeless shelter during pregnancy or shortly after giving birth have reportedly higher rates of anxiety and depression disorders than pregnant women who do not use shelters[101] and the stress experienced during pregnancy has adverse effects on the emotional, cognitive, and physical outcomes for infants.[102]
- Children living for over a year in temporary accommodation were found to be three times more likely to experience mental health problems, with two thirds of rehomed children still suffering from mental health and developmental problems a year after being rehoused.[103] Merchants Quay Ireland highlights that for those individuals who are homeless and experiencing mental health difficulties, it can be a challenge to access their GP or local mental health team because they do not have a fixed address to be registered at or because they have drug and alcohol dependencies.[104]

Addiction

- Homeless people are, in comparison to the non-homeless population, ten times more likely to be problem gamblers[105] and children of gambling addicts are more likely to develop gambling addictions.[106]
- Alcohol and drug dependency have been cited as a cause of homelessness among some homeless families[107] and homelessness is identified as a route into addiction. Those with addictions may find it more difficult to sustain or access employment.[108]
- Children who live with an alcoholic parent have a greater tendency to internalise sadness and worry, and to externalise their anger and aggression.[109]
- Drug use in families is associated with increased risk of family estrangement, conflicting relationships and loss of contact with children.[110] Children with drug dependent mothers have been found to be more aggressive, withdrawn, and not as well-adjusted when compared to their counterparts.
- Children being aware of a parent's addiction can lead to experiences of guilt[111] which builds on the guilt associated with not being able to provide a home for the child.[112]

101 Clark, R.E., WeinREB, L., Flahive, J.M., & Seifert, R.W. (2019)
102 Bergman, K., Sarkar, P., O'Connor, T.G., Modi, N., & Glover, V. (2007)
103 Faculties of Public Health Medicine and Paediatrics, Royal College of Physicians of Ireland (2019)
104 Merchants Quay Ireland (2022)
105 University of Cambridge (2014)
106 Dowling, N. (2014)
107 National Advisory Committee on Drugs (2005)
108 Local Government Association (2020)
109 National Advisory Committee on Drugs (2011)
110 de Espíndola, M.I., Bedendo, A., da Silva, E.A. et al. (2020)
111 Wellness Retreat Recovery Centre (2018)
112 Safeguarding Network (2022)

Domestic Abuse

- Foreclosure or repossession of one's home has an adverse effect on domestic violence and/or child abuse.[113]
- Women in homeless couples with men are particularly vulnerable to being targeted by abusive and exploitative partners.[114]
- Victims of domestic abuse are at greater risk of mental illness and have higher incidences of mental illness including, depression, anxiety, PTSD, eating disorders, self-harm, and suicide.[115] [116] This can compromise their parenting capacity.[117]
- Women who experience domestic abuse are twice as likely as non-abused women to experience chronic health conditions.[118]
- Unborn babies of pregnant mothers who are domestically abused are at a higher risk of fetal morbidity, preterm delivery, low birth weight and are also more likely to die as a result of blunt trauma enacted on the mother's abdomen.[119]
- Children who have witnessed domestic abuse have been known to develop psychosomatic conditions, increased anxiety around strangers, and problems with insomnia and nightmares.[120]
- Additional effects include frequent antisocial behaviour, increased instances of mental ill health, increased fearfulness, and a greater occurrence of using violence as a means of resolving conflict.[121]
- Domestic violence is an under-recognised factor in the housing problem in Ireland as local authorities do not view victims of domestic violence as homeless because they have a home which they have decided to leave.[122]

113 Tsai A,C., Coyne, J. (2015)
114 St Mungo's (2020)
115 Women's Aid (2022)
116 Safe Ireland (2022)
117 Scottish Women's Aid (2017)
118 Safe Ireland (2022)
119 Cook, J., & Bewley, S. (2008)
120 Stiles M.M. (2002)
121 The National Centre of Family Homelessness (2011)
122 Safe Ireland (2016)

Poverty and Unemployment

- The lack of financial resources and the inability to attain more due to unemployment and other factors is key to creating the circumstances where a family becomes homeless.[123]
- Despite making up only 20 per cent of families in Ireland, one-parent families currently make up 55 per cent of homeless families[124] and experience the highest deprivation rate of all families in Ireland at 45.4%. In Ireland, single-parent families have an average net worth which is 7 times smaller than that of the average household, have 10% less in savings than others, were 23.7% more likely to experience credit constraints, and are less likely to own their own homes, facing significant barriers to owning property.[125]
- A contributory factor to unemployment for parents in Ireland is childcare. In 2021, Ireland was ranked 33rd out of 41 countries in terms of affordable childcare.[126] Almost 60% of lone parents could not afford to access childcare services, three times the rate of two parent families[127] and Ireland is the worst performing country in the EU with regard to affordability for lone parents.[128]

Education and Literacy

- In 2016, 38% of homeless people in Ireland did not have educational qualifications beyond lower secondary school level, with over 36% of this group having not progressed past the primary school level. Nearly 5% had no educational qualifications at all.[129]
- Individuals who live with literacy difficulties are faced with the prospect of dependency on social welfare, poor health outcomes, a higher level of crime and lower self-esteem.[130]
- There is a correlation between a child's educational attainment and their parents[131] and homeless children are more inclined to experience absenteeism and to face long or challenging journeys to school, which can increase levels of tiredness, lateness, and anxiety.[132]

123 Crisis (2022)
124 One Family (2020)
125 Staunton, C (2015)
126 Unicef (2021)
127 SVP Ireland (2019)
128 National Women's Council for Ireland (2020)
129 CSO (2016)
130 World Literacy Foundation (2018)
131 CSO (2019)
132 McCallum, A. and Rich, H. (2018)

Family Separation and Child Welfare Concerns

- Families who have experienced homelessness are at a greater risk of separating than low-income families who do not experience homelessness.[133]
- The experience of losing a home was linked to parenting difficulties, marital breakdown or relationship tension.[134]
- Families living in homeless accommodation are subject to the rules of the shelter, with many instituting strict policies to ensure safety which may include that men, and as an extension fathers, cannot enter the accommodation.[135]
- There is also a link between parental homelessness and prolonged stays in the care system for children.[136]
- Children can be taken into care as a result of abuse or neglect and whilst poverty is not a necessary component to the incidence of child abuse or neglect, it has been found to be a pervasive factor.[137]
- For children, the factors which contribute to and the act of entering care can cause poor emotional wellbeing and mental illness, often as a result of separating from parents or siblings or having to attend a new school.[138]
- Separation from parents has been found to cause post-traumatic stress disorder in children which can include physical symptoms, intrusive thoughts, nightmares, negative beliefs about oneself, changes in behaviour, and self-destructive thoughts.[139]
- Spending time in foster care placements as a child increases the likelihood that they will become homeless in adulthood and at an earlier age than those who did not come through the foster care system.[140]
- Parents can experience sadness, struggle to sleep and keep up with their daily routine following a separation from a child.[141] In cases where the parent does not have a concrete list of steps to take to regain custody of the child, these feelings multiply to turn into post-traumatic stress disorder with experiences of nightmare, emotional numbness, and reliving the separation over and over. These parents experience ambiguous loss because whilst their child is still out there, they are powerless to get them back into their care.

133 The National Centre of Family Homelessness (2011)
134 Joseph Rountree Foundation (2020)
135 Faed, P., Murphy, S., & Nolledo, R. (2017)
136 Child Care Law Reporting Project (2018)
137 Joseph Rowntree Foundation (2016)
138 Become (2022)
139 The National Child Traumatic Stress Network (n.d.)
140 The National Centre on Family Homelessness (2011)
141 Ibid

Adverse Childhood Experiences and Development Delays

- For children growing up with parents who have multiple and complex problems, their needs for secure attachment and developmentally appropriate experiences may be compromised. Adverse effects for children include higher risk of maltreatment, abuse and neglect, and increased risk of attachment difficulties, psychological and emotional disturbance and developmental delay.[142]
- Homeless infants have also been found to be at an increased likelihood of suffering developmental delays by the time they are 18 months compared to the general population.[143]
- Homeless children are also more likely than their non-homeless counterparts to have higher rates of developmental, emotional, and behavioural problems with 38% of homeless children found to have diagnosable disorders. Homeless families therefore commonly require support regarding family functioning and relationships, parenting, child behavioural issues and child development.[144]
- Homelessness is also associated with adverse childhood experiences[145] which are linked with increased self-harm, suicidal thoughts, younger abuse of alcohol or drugs and ill health.[146] Termed 'toxic stress', ACE's can derail healthy brain development and undermine the ability to regulate emotions, cope, form relationships, and can impair cognitive functions.

Migrant Families

- 16% of Roma in Ireland could not understand English well, 47% could only sometimes understand English and 71% reported difficulty reading English forms.[147]
- Language barriers can result in people becoming "hidden" homeless, due to their inability to communicate effectively with service providers.[148]
- Language is the most significant barrier to accessing services when little or no English is spoken.[149]
- Irish health service providers see communication and language as a key concern when working with members of the Roma community.[150]

142 Bromfield, L et al., (2012)
143 Faculties of Public Health Medicine and Paediatrics, Royal College of Physicians of Ireland (2009)
144 Sen, R., Smeeton, J., Thoburn, J. & Tunstill, J. (2022)
145 Adverse Childhood Experiences (ACE) are defined as stressful events which occur in childhood and can include violence, parental abandonment, a parent with a mental health condition, being a victim of abuse or neglect, and homelessness.
146 Cork Simon Community (2017)
147 Department of Justice and Equality, and Pavee Point (2018)
148 Simon Community and Ulster University (2021)
149 Belfast Health Development Unit (2010)
150 Department of Justice and Equality, and Pavee Point (2018)

Bibliography

Ainscough Associates (2021) The Benefits of Multidisciplinary Teams for People with Complex Needs and Long-Term Conditions. Available at: https://www.ainscoughassociates.co.uk/2021/05/06/the-benefits-of-multidisciplinary-teams/

Ashwood, J.S., Patel, K., Kravitz, D., Adamson, D.M, and Audrey Burnam, M. (2019) *Evaluation of the Homeless Multidisciplinary Street Team for the City of Santa Monica.* Available at: https://www.rand.org/content/dam/rand/pubs/research_reports/RR2800/RR2848/RAND_RR2848.pdf?fbclid=IwAR1fB8CzgXZT4nO5J4RJrzmzTwxAXGZF_pPdGWfpZQuKGwtyYn-riBqjyyk

Bassuk, E.L, DeCandia, C., Tsertsvadze, A., Richard, M. (2014). 'The Effectiveness of Housing Interventions and Housing and Service Interventions on Ending Family Homelessness: A Systematic Review.' *American Journal of Orthopsychiatry*, 85(4), pp.457–474. [Online] Available at: https://www.researchgate.net/publication/266264576_The_Effectiveness_of_Housing_Interventions_and_Housing_and_Service_Interventions_on_Ending_Family_Homelessness_A_Systematic_Review

BCP Council (2021) *Establishing a Multi Disciplinary Team and a Homeless Health Centre*. Available at: https://democracy.bcpcouncil.gov.uk/documents/s25983/Enhancing%20health%20and%20homeless%20provision%20V2.pdf

Become (2022) *Mental Health and Wellbeing*. Available at: https://www.becomecharity.org.uk/care-the-facts/the-big-issues/mental-wellbeing/

Belfast Health Development Unit (2010) *Barriers to Health: Migrant Health and Wellbeing in Belfast*. [Online] Available at: https://hscbusiness.hscni.net/pdf/Migrant_Health_Strategy_Belfast.pdf

Bergman, K., Sarkar, P., O'Connor, T.G., Modi, N., & Glover, V. (2007) "Maternal Stress During Pregnancy Predicts Cognitive Ability and Fearfulness in Infancy." *Journal of the American Academy of Child & Adolescent Psychiatry*, Volume 46, Issue 11, pp.1454–1463. [Online] Available at: https://www.jaacap.org/article/S0890-8567(09)62042-6/pdf

Bromfield, L., Sutherland, K., Parker, R. (2012) *Families with complex needs: best interests case practice model*. Melbourne: Dept of Human Services.

Child Care Law Reporting Project (2018) *Case Reports 2018 Volume 2*. [Online] Available at: https://www.childlawproject.ie/archive/#V22018

Citizens Information (2022) *Homelessness and the Right to Housing*. Available at: https://www.citizensinformation.ie/en/housing/losing_your_home/homelessness.html

Clark, R.E., WeinREB, L., Flahive, J.M., & Seifert, R.W. (2019) "Homelessness Contributes To Pregnancy Complications." *Health Affairs*, Volume 38, Issue 1. [Online] Available at: https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2018.05156

College of Psychiatrists of Ireland (2022) *What is a Multi-Disciplinary Team?* Available at: https://www.irishpsychiatry.ie/external-affairs-policy/public-information/what-is-a-multidisciplinary-team/

Cook, J., & Bewley, S. (2008) "Acknowledging a persistent truth: domestic violence in pregnancy." *Journal of the Royal Society of Medicine*, Volume 101, Issue 7, pp. 358–363. [Online] Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2442136/#b17

Cordis Bright (2018) *What are the Key Factors for Successful Multi-Disciplinary Working?* Available at: https://www.cordisbright.co.uk/admin/resources/05-hsc-evidence-reviews-multidisciplinary-team-working.pdf

Cork Simon Community (2017) *ACEs at Cork Simon*. [Online] Available at: https://www.corksimon.ie/Handlers/Download.ashx?IDMF=7236cdda-ef47-4420-95f9-bb3f052870f1

Crisis (2022) *About Homelessness*. Available at: https://www.crisis.org.uk/ending-homelessness/

about-homelessness/

Crisis (2022) *Drugs and Alcohol*. Available at: https://www.crisis.org.uk/ending-homelessness/health-and-wellbeing/drugs-and-alcohol/

Crisis (2022) *Prison Leavers*. Available at: https://www.crisis.org.uk/ending-homelessness/law-and-rights/prison-leavers/

CSO (2016) *Census of Population – Profile 10 Education, Skills, and the Irish Language*. Available at: https://www.cso.ie/en/releasesandpublications/ep/p-cp10esil/p10esil/ees/

CSO (2016) *Census of Population 2016 – Profile 5 Homeless Persons in Ireland*. Available at: https://www.cso.ie/en/releasesandpublications/ep/p-cp5hpi/cp5hpi/es/

CSO (2019) *SILC Module on the Intergenerational Transmission of Disadvantage 2019*. Available at: https://www.cso.ie/en/releasesandpublications/ep/p-smitd/silcmoduleontheintergenerationaltransmissionofdisadvantages2019/resultsandanalysis/

Culhane, D.P & Metraux, S. (2008) 'Rearranging the Deck Chairs or Reallocating the Lifeboats?: Homelessness Assistance and Its Alternatives.' *Journal of the American Planning Association*, 74(1). [Online] Available at: https://repository.upenn.edu/cgi/viewcontent.cgi?article=1119&context=spp_papers

de Espíndola, M.I., Bedendo, A., da Silva, E.A. et al. (2020) "Interpersonal relationships and drug use over time among homeless people: a qualitative study." *BMC Public Health* Volume 20, Issue 1746. [Online] Available at: https://bmcpublichealth.biomedcentral.com/track/pdf/10.1186/s12889-020-09880-2.pdf

Department of Environment, Community and Local Government, 'Access to social housing supports for non-Irish nationals – including clarification re Stamp 4 holders' (2012) Housing Circular 41/2012.

Department of Environment, Community and Local Government (2013) *Homelessness Policy Statement*. Dublin: Department of the Environment, Community and Local Government.

Department of Health (2006) *A Vision for Change – Report of the Expert Group on Mental Health Policy*. Available at: https://www.hse.ie/eng/services/publications/mentalhealth/mental-health---a-vision-for-change.pdf

Department of Health. (2017) Reducing harm, supporting recovery. A health-led response to drug and alcohol use in Ireland 2017–2025. Dublin: Department of Health.

Department of Health (2020) *Sharing the Vision – A Mental Health Policy for Everyone*. Available at: https://www.hse.ie/eng/about/who/mentalhealth/sharing-the-vision/sharing-the-vision.html?gclid=EAIaIQobChMIr7alyN3r-gIVh6ztCh2mPwOlEAAYASAAEgLgj_D_BwE&gclsrc=aw.ds

Department of Health. (2021) Healthy Ireland strategic action plan 2021–2025. Dublin: Government of Ireland.

Department of Health. (2021) Sláintecare implementation strategy & action plan 2021–2023. Dublin: Department of Health.

Department of Housing, Local Government and Heritage (2021) *Housing for All: A New Housing Plan for Ireland*. Available at: https://www.gov.ie/en/publication/ef5ec-housing-for-all-a-new-housing-plan-for-ireland/

Department of Housing, Local Government and Heritage (2022) *Monthly Homeless Report March 2022*. [Online] Available at: https://www.gov.ie/en/press-release/e4cbe-monthly-homeless-report-for-march-2022-and-homeless-quarterly-progress-report-for-quarter-1-2022/

Department of Justice and Equality and Pavee Point (2018) *ECRI Preliminary points for consideration*. [Online] Available at: https://www.paveepoint.ie/wp-content/uploads/2013/11/Pavee-Point_Preliminary-Points-Recommendations-for-Consideration_July-2018.pdf

Dobson, R. (2017) *Complex Needs of Homelessness in Practice: A Review of New Markets of Vulnerability*. [Online] Available at: https://www.tandfonline.com/doi/full/10.1080/02673037.2018.1556784?needAccess=true

Dowling, N. (2014) *The Impact of Gambling Problems on Families*. [Online] Available at: https://aifs.gov.au/agrc/sites/default/files/publication-documents/agrc-dp1-family-impacts_0.pdf

European Commission (2018) *Ireland: Non-Irish Over-Represented Among Homeless Population*. [Online] Available at: https://ec.europa.eu/migrant-integration/news/ireland-non-irish-over-represented-among-homeless-population_en

European Observatory on Homelessness (2017) *Family Homelessness in Europe*. Available at: https://www.feantsaresearch.org/download/feantsa-studies_07_web3386127540064828685.pdf

European Social Policy Network (2019) National Strategies to Fight Homelessness and Housing Exclusion. [Online] Available at: https://ec.europa.eu/social/BlobServlet?docId=21604&langId=sl#:~:text=The%20general%20strategy%20in%20place,pillars%20of%20the%20Irish%20approach.

Extern (2022) *Multi-Disciplinary Homeless Support Team*. Available at: https://www.extern.org/multi-disciplinary-homeless-support-team

Faculties of Public Health Medicine and Paediatrics, Royal College of Physicians of Ireland (2019) *The Impact of Homelessness and Inadequate Housing on Children's Health* [Online] Available at: https://rcpi-live-cdn.s3.amazonaws.com/wp-content/uploads/2019/11/Impact-of-Homelessness-full-position-paper-final.pdf

Faed, P., Murphy, S., & Nolledo, R. (2017) *Child Homelessness and Trauma*. [Online] Available at: https://www.first5la.org/files/ChildHomelessnessTrauma.pdf

Fleury M.J. (2021). 'Met and unmet needs of homeless individuals at different stages of housing reintegration: A mixed-method investigation.' *PLoS ONE*, 16(1). [Online] Available at: https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0245088

Focus Ireland (2018) *Causes of Family Homelessness in the Dublin Region during 2016 and 2017* Available at: https://www.focusireland.ie/wp-content/uploads/2021/09/Gambi-Sheridan-and-Hoey-2018-Insights-into-Family-Homelessness-No-16-Causes-of-family-homelessness-in-the-Dublin-region-during-2016-and-2017-Final-2.pdf

Focus Ireland (2020) *Supporting the Mental Health of Children.* [Online] Available at: https://www.focusireland.ie/wp-content/uploads/2021/09/Supporting-the-mental-health-of-children_FINAL.pdf

Focus Ireland (2021) *Focus on Homelessness* Available at: https://www.focusireland.ie/wp-content/uploads/2021/06/Focus_On_Homelessness_Final.pdf

Focus Ireland (2022a) *About Homelessness*. Available at: https://www.focusireland.ie/resource-hub/about-homelessness/

Focus Ireland (2022b) *Latest Figures on Homelessness in Ireland* https://www.focusireland.ie/resource-hub/latest-figures-homelessness-ireland/

Focus Ireland (2022c) *Homelessness*. Available at: https://www.focusireland.ie/press-release/focus-ireland-launches-urgent-christmas-appeal-as-new-figures-show-12-of-children-in-families-it-supports-were-born-into-homelessness/#:~:text=Focus%20Ireland%20launched%20an%20urgent,services%20were%20born%20into%20homelessness.

Government of Ireland (1953) *Health Act*. [Online] Available at: https://www.irishstatutebook.ie/eli/1953/act/26/enacted/en/html

Government of Ireland (1988). *Housing Act*. [Online] Available at: https://www.irishstatutebook.ie/eli/1988/act/28/enacted/en/html

Government of Ireland (2009) *Housing (Miscellaneous Provisions) Act*. [Online] Available at: https://www.irishstatutebook.ie/eli/2009/act/22/enacted/en/html

Health Manager (2018) *Serving the homeless population in Cork*. Available at: https://healthmanager.ie/2018/03/serving-the-homeless-population-in-cork/

Houses of the Oireachtas Committee on the Future of Healthcare. (2017) Houses of the Oireachtas

Committee on the Future of Healthcare Sláintecare report. Dublin: Houses of the Oireachtas

Housing First (2022) Focus Ireland. Available at: https://housingfirsteurope.eu/organization/focus-ireland/

HSE (2021) HSE corporate plan 2021–2024. Dublin: Health Service Executive

HSE (2022a) *Multi-Disciplinary Team*. Available at: https://www.hse.ie/eng/services/list/4/mental-health-services/dsc/communityservices/multidisciplinaryteam.html

HSE (2022b) *Mental Health Professionals and Team: Dublin South Central Community*. Available at: https://www.hse.ie/eng/services/list/4/mental-health-services/dsc/communityservices/proffesionalsandteams.html

Irish Centre for Human Rights at the National University of Ireland Galway (2020) *Direct Provision's Impact on Children: A Human Rights Analysis*. [Online] Available at: https://www.nuigalway.ie/media/irishcentreforhumanrights/files/reports/Direct-Provision-Report_-ICHR_Final-23.09.pdf

Joseph Rowntree Foundation (2016) *The relationship between poverty, child abuse and neglect: an evidence review*. Available at: https://www.jrf.org.uk/report/relationship-between-poverty-child-abuse-and-neglect-evidence-review

Joseph Rowntree Foundation (2020) *The social consequences of mortgage repossession for parents and their children*. [Online] Available at: https://www.jrf.org.uk/file/35236/download?token=Ysl-1CWp&filetype=findings

Kinghorn, F. and Basset, L. (2019) *The Need to Change - A Multi Disciplinary Team Approach with People Experiencing Homelessness in Cardiff*. Available at: https://www.cymorthcymru.org.uk/files/9215/8134/0360/Fiona_Kinghorn.pdf

Klop, H.T. et al. (2018) 'Care avoidance among homeless people and access to care: an interview study among spiritual caregivers, street pastors, homeless outreach workers and formerly homeless people.' *BMC Public Health*, 18(1095) [Online] Available at: https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-018-5989-1#citeas

Lewis-Beck, M. S., Bryman, A. & Liao, T. F. (Eds.) (2004). The SAGE encyclopaedia of social science research methods (Vols. 1–3). Thousand Oaks, CA: SAGE Publications

Local Government Association (2020) *The Impact of Homelessness on Health*. Available at: https://www.local.gov.uk/sites/default/files/documents/22.7%20HEALTH%20AND%20HOMELESSNESS_v08_WEB_0.PDF

Madge S. and Khair K. (2000). 'Multidisciplinary teams in the United Kingdom: problems and solutions. *J Pediatr Nurs*, 15(2), pp.131–4. [Online] Available at: https://pubmed.ncbi.nlm.nih.gov/10808630/#:~:text=Issues%20such%20as%20uncertainty%20of,work%20distribution%20may%20cause%20disruption.

McCallum, A. and Rich, H. (2018) *The Impact of Homelessness and Bad Housing on Children's Education*. Available at: https://assets.ctfassets.net/6sxvmndnpn0s/AZvOBS2tanDweEV0cKiiP/71a9a9d622c24680c358fb49b7c7094c/Teachers_Research_Report.pdf

Mental Health Foundation (2022) *Parenting and Mental Health*. Available at: https://www.mentalhealth.org.uk/a-to-z/p/parenting-and-mental-health

Merchants Quay Ireland (2022) *Homelessness and Access to Mental Health Services*. Available at: https://mqi.ie/homelessness-and-access-to-mental-health-services-burke/

Mercy Law Resource Centre (2020) *Minority Groups and Housing Services: Barriers to Access*. [Online] Available at: https://mercylaw.ie/wp-content/uploads/2021/03/ML_2020_Minority-Groups-and-Housing-Services_Report_D6.pdf

Morgan, D. L. (1997). Focus groups as qualitative research (2nd ed.). Thousand Oaks, CA: Sage

Murphy, R., Mitchell, K., & McDaid, S. (2017) *Homelessness and Mental Health*. Available at: https://www.mentalhealthreform.ie/wp-content/uploads/2017/06/Homelessness-and-mental-health-report.pdf

National Advisory Committee on Drugs (2005) *Drug Use Among the Homeless Population in Ireland.*

[Online] Available at: https://www.drugsandalcohol.ie/5950/1/NACD_homeless_population.pdf

National Advisory Committee on Drugs (2011) *Parental Substance Misuse: Addressing its Impact on Children.* Available at: https://www.drugsandalcohol.ie/16114/1/NACD_parental_substance_misuse_impact_children_litreview.pdf

National Institute for Health and Care Excellence (2022) *Integrated health and social care for people experiencing homelessness.* [Online] Available at: https://www.nice.org.uk/guidance/ng214/resources/integrated-health-and-social-care-for-people-experiencing-homelessness-pdf-66143775200965?fbclid=IwAR1QaG9LSdI_ib_xoRq2Xlz3XXuuGL7_bvSAoBVpeUdYVtm9UEhVx5FcphE

National Women's Council for Ireland (2020). *Submission to the Citizens Assembly on Gender Equality.* [Online] Available at: https://www.citizensassembly.ie/en/previous-assemblies/2020-2021-citizens-assembly-on-gender-equality/about-the-citizens-assembly/public-consultation/submissions%20received/national-women-s-council-of-ireland-ca30179.pdf

NHS England (2014) *MDT Development*. Available at: https://www.england.nhs.uk/wp-content/uploads/2015/01/mdt-dev-guid-flat-fin.pdf

NHS England (2021) *Multidisciplinary Team Toolkit.* [Online] Available at: https://www.hee.nhs.uk/sites/default/files/documents/HEE_MDT_Toolkit_V1.1.pdf

Omerov, P. et al. (2020) 'Homeless persons' experiences of health- and social care: A systematic integrative review.' *Health and Social Care in the Community,* 28(1) [Online] Available at: https://onlinelibrary.wiley.com/doi/full/10.1111/hsc.12857#:~:text=The%20findings%20highlight%20that%20persons,to%20health%2D%20and%20social%20care.

One Family (2020) *Facts & Figures* Available at: https://onefamily.ie/media-policy/facts-figures/

O'Reilly (2003) *Improving health access for homeless people in Cork.* Available at: https://www.healthequity.ie/original-article-4

O'Sullivan, E. (2008) "Sustainable Solutions to Homelessness: The Irish Case." *European Journal of Homelessness,* 2(1), pp. 205–232.

Parker, C. and Harrison, C. (2019) *Homelessness Prevention Trailblazer Multidisciplinary Team Summative Review.* Available at: https://www.newcastle.gov.uk/sites/default/files/Housing%20and%20homelessness/Homelessness%20Prevention%20Trailblazer/Multidisciplinary%20team%20-%20Summative%20Report.pdf

Parry, Y.K., Harryba, S., Horsfall, S. (2015) 'Improving Outcomes for Families Experiencing Homelessness: Working Together as Multi-Disciplinary Teams to Increase Health Outcomes for Children and Families.' *Parity*, 28(9). [Online] Available at: https://www.researchgate.net/publication/286151965_Improving_Outcomes_for_Families_Experiencing_Homelessness_Working_Together_as_Multi-Disciplinary_Teams_to_Increase_Health_Outcomes_for_Children_and_Families

Pavee Point Traveller and Roma Centre (2018) er and Roma Centre (2018). *The National Roma Needs Assessment: Accommodation Briefing.* [Online] Available at: https://www.paveepoint.ie/wp-content/uploads/2015/04/Rom_Accommodation_web.pdf

Pollak, S. (2022) *Number of Homeless People in State Passes 9,000*. Available at: https://www.irishtimes.com/news/social-affairs/number-of-homeless-people-in-state-passes-9-000-1.4771257

Public Health Scotland (2022) *Adverse Childhood Experiences*. Available at: http://www.healthscotland.scot/population-groups/children/adverse-childhood-experiences-aces/overview-of-aces

Rankin, J. and Regan, S. (2004), «Meeting complex needs in social care», *Housing, Care and Support*, 7(3), pp. 4–8.

Rosengard, A., Laing, I. Ridley, J. (2007). *A Literature Review on Multiple and Complex Needs.* [Online] Available at: https://www.researchgate.net/publication/242483070_A_Literature_Review_on_Multiple_and_Complex_Needs

Safe Ireland (2016) *No Place to Call Home: Domestic Violence & Homelessness the State We Are In.* [Online] Available at: https://www.safeireland.ie/wp-content/uploads/Final-Homeless-Report-.pdf

Safe Ireland (2019) *Policy and Publications.* Available at: https://www.safeireland.ie/policy-publications/

Safe Ireland (2022) *Impact of Domestic Violence.* Available at: https://www.safeireland.ie/get-help/understanding-domestic-abuse/impact-of-domestic-violence/

Safeguarding Network (2022) *Homelessness and Safeguarding.* Available at: https://safeguarding.network/content/safeguarding-resources/parental-issues/homelessness/

Scottish Women's Aid (2017) *Mothering and Domestic Violence.* Available at: https://womensaid.scot/wp-content/uploads/2017/09/MotheringDomesticAbuse.pdf

Sen, R., Smeeton, J., Thoburn, J. & Tunstill, J. (2022) Social work with families who are homeless or who have housing needs: A reflective guide for social workers and social work managers. Full Version. Birmingham: BASW England.

Sheik, S. and Teeman, D. (2021) *A Rapid Evidence Assessment of What Works in Homeless Services.* Available at: https://www.crisis.org.uk/media/238843/a_rapid_evidence_assessment_of_what_works_in_homelessness_services_2018.pdf?fbclid=IwAR2B-CYPVMTFy-PU4JIUQFSITksDGmELXDqxi1G8Ooq0YfMDOXw53SgvaSU

Shelter Scotland (2016) *Complex Needs: Homelessness Services in the Housing Options East Hub.* Available at: https://assets.ctfassets.net/6sqqfrl11sfj/7pic5p3lrZ1UeNhUf03BGV/4fde8d410a6c8eb0ad8f92bbc9408dba/8421_Policy_Report_Complex_Needs_SCOT.pdf

Simon Community and Ulster University (2021) *Hidden Homelessness in Northern Ireland*. [Online] Available at: https://simoncommunity.org/assets/pdfs/Hidden-Homelessness_Report_FINAL.pdf

Single Homeless Project (2022) *Support and Accommodation*. Available at: https://www.shp.org.uk/pages/category/support-and-accommodation

Social Care Institute for Excellence (2018a) *Delivering Integrated Care: The Role of the Multidisciplinary Team*. [Online] Available at: https://www.scie.org.uk/integrated-care/workforce/role-multidisciplinary-team

Social Care Institute for Excellence (2018b) Multi-Disciplinary Teams. [Online] Available at: https://www.scie.org.uk/integrated-care/research-practice/activities/multidisciplinary-teams.

St Mungo's (2020) Homeless Couples and Relationships Toolkit. Available at: https://www.mungos.org/publication/homeless-couples-and-relationships-toolkit/#:~:text=The%20St%20Mungo's%20Homeless%20Couples,working%20in%20the%20homelessness%20sector

Staunton, C (2015). *The Distribution of Wealth in Ireland.* [Online] Available at: https://www.tasc.ie/assets/files/pdf/the_distribution_of_wealth_in_ireland_final.pdf

Stiles M.M. (2002) "Witnessing domestic violence: the effect on children." *Am Fam Physician.* [Online] Available at: https://www.aafp.org/afp/2002/1201/p2052.html

SVP Ireland (2019). Working, parenting and struggling? An analysis of the employment and living conditions of one parent families in Ireland. [Online] Available at: https://issuu.com/svp15/docs/working__parenting_and_struggling-_

The National Center on Family Homelessness (2012) Strengthening At Risk and Homeless Young Mothers and Children. Outcome Evaluation: Family Assertive Community Treatment, Chicago, Illinois

The National Centre of Family Homelessness (2011) *The Characteristics and Needs of Families Experiencing Homelessness*. Available at: https://files.eric.ed.gov/fulltext/ED535499.pdf

The National Child Traumatic Stress Network (n.d.) *Children with Traumatic Separation: Information for Professionals.* [Online] Available at: https://www.nctsn.org/sites/default/files/resources/children_with_traumatic_separation_professionals.pdf

The Queen's Nursing Institute (2018) *Addressing Health Inequalities in Homeless Children, Young People, and Families. Available* at: https://www.qni.org.uk/wp-content/uploads/2018/10/FINAL-HomelessToolkit_links.pdf

Tsai, A.C., Coyne, J. (2015). 'Home Foreclosure, Health, and Mental Health: A Systematic Review of Individual, Aggregate, and Contextual Associations.' *PLoS One*, 10(4). [Online] Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4388711/

Unicef (2021) *Where Do Rich Countries Stand on Childcare*. [Online] Available at: https://www.unicef-irc.org/publications/pdf/where-do-rich-countries-stand-on-childcare.pdf

University of Cambridge (2014) *Gambling Among Homeless Population*. Available at: https://www.cam.ac.uk/research/news/new-study-reveals-scale-of-problem-gambling-among-homeless-population

University of Oxford Department of Social Policy and Intervention (2017) *Tackling Family Homelessness in the UK.* [Online] Available at: https://www.spi.ox.ac.uk/sites/default/files/spi/documents/media/spa_family_homelessness.pdf

Wellness Retreat Recovery Centre (2018) *Parents in Recovery: Eliminating the Inheritance of Guilt.* Available at: https://wellnessretreatrecovery.com/parents-recovery/

Women's Aid (2022) *National and International Statistics.* Available at:

https://www.womensaid.ie/about/policy/natintstats.html#X-2012091712364110

World Literacy Foundation (2018) The Economic and Social Cost of Illiteracy. Available at: https://worldliteracyfoundation.org/wp-content/uploads/2021/07/TheEconomicSocialCostofIlliteracy-2.pdf

focusireland.ie

FOCUS Ireland

Head Office
9–12 High Street
Christchurch, Dublin 8
D08 E1W0

T 01 881 5900
LoCall 1850 204 205
F 01 881 5950
E info@focusireland.ie

Registered Charity CHY 7220