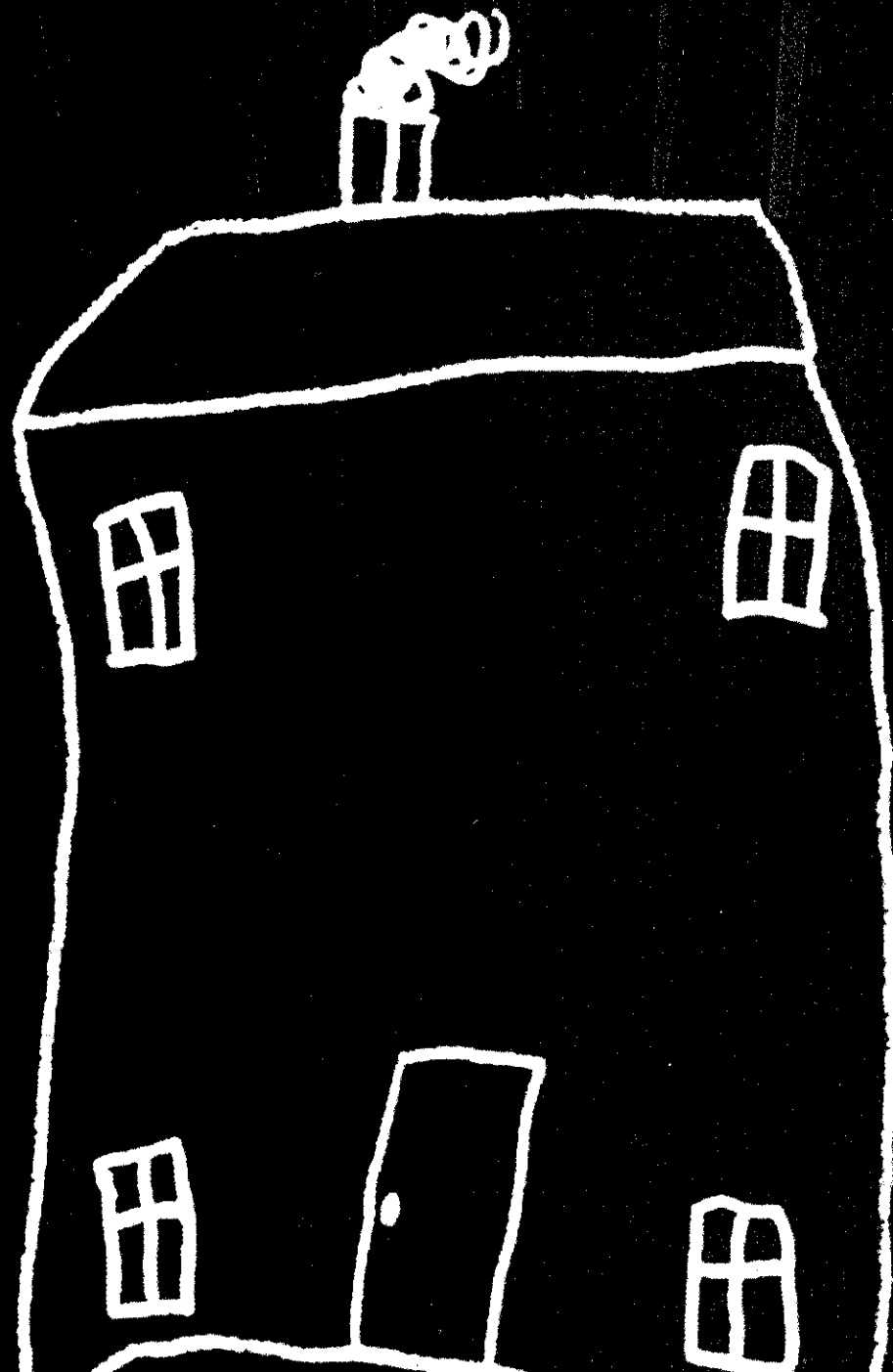


CHILDREN OF HOMELESS MOTHERS

The daily life experiences and well-being of children in homeless families



Chris Mox

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The Children's Research Centre was set up by Trinity College in 1995 as a joint initiative of the Department of Psychology and the Department of Social Studies. The Centre undertakes research and evaluation on issues and policies concerning children and young people. The Centre is multidisciplinary in approach and works in close collaboration with other members of the University, practitioners and policy makers, and international colleagues. It also works through partnerships with statutory, voluntary and community bodies concerned with children and young people. The Centre has a range of publications.

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The daily life experiences and well-being of children in homeless families

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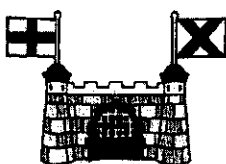
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EXECUTIVE SUMMARY

Background

This report presents methods and findings from a two-phase study of homelessness in Dublin. In the first phase, one hundred homeless women were interviewed with regard to their health status and their access to health services for both themselves and, where relevant, their children. This investigation was undertaken by the Royal College of Surgeons in Ireland (RCSI). These homeless women were living in emergency bed and breakfast (B&B) accommodation and hostel settings. Eighty of these women were mothers, with a total of 173 children under the age of 18.¹

The second phase of the study was undertaken by The Children's Research Centre, TCD. This phase involved conducting more in-depth, qualitative interviews with ten mothers and their children. The focus of these interviews was on the impact of homelessness on family life, in terms of living conditions, education, family relationships and relationships with friends.

The present report contains findings about the impact of homelessness on the mothers (N = 80) in the initial study, and on their children. The main focus of this report, however, is on the 10 homeless mothers and children who participated in the follow-up study.

Method

In the first phase of the study, 100 women (including 82 mothers) were interviewed, using a structured questionnaire, about their socio-demographic background, details of homelessness, lifestyle, general health status and the use of health services for themselves and, where relevant, their children. In the second phase of the study, ten mothers and their children (N= 22) were interviewed by researchers from the Children's Research Centre, Trinity College, Dublin (TCD). Semi-structured interviews were used to explore aspects of their daily lives. Standardised measures were also used to assess aspects of children's emotional and cognitive development.

¹ A full report on the first phase is contained in a companion publication 'One Hundred Homeless Women' (Smith, McGee, Holohan & Shannon, 2001).

Results

Demographic characteristics

The majority of the women who took part in the initial study were young (under 35 years of age) and single. Of those women who were married, the majority had separated. Eighty of these women had a total of 173 children under the age of 18 (94 females, 79 males). In the follow-up study, the socio-demographic profiles were similar. Half of the women were under the age of 35, six were single, three were separated and one was widowed. The children were aged between 4 and 16 years of age (12 females, 10 males).

Reasons for becoming homeless

For the purposes of the present study, long term homelessness was defined as being homeless for one year or longer duration. According to this definition, just over half of the 100 women participants were categorised as being long-term homeless and seven out of the ten families who participated in the follow-up study fell into this category. Women were asked to identify the 'main reason' for becoming homeless in the first part of the study. Lack of affordable housing, domestic violence, child sexual abuse and alcohol or drug addiction were among the reasons identified. In many cases, women felt that their homelessness had multiple causes.

Accommodation

Not having access to essential facilities within their accommodation represented a major disruption to the daily routines of both mothers and their children. Most notably, findings highlighted a lack of adequate cooking facilities, lack of facilities for food storage and refrigeration, overcrowding with regard to sharing bathrooms and bedrooms and a lack of any opportunity for privacy within these accommodation settings. Some mothers were required to vacate their accommodation during the day. Women emphasised the negative effect that this lifestyle had on their health and on the health of their children. Their limited financial resources added to the difficulties they encountered in raising children in these circumstances.

Children's experiences of emergency accommodation

Children had mixed views about their current accommodation. On the one hand, some of them perceived positive aspects to these living arrangements, and appreciated having somewhere to live. On the other hand, many children had difficulties with the constraints which this type of regulated accommodation placed on their daily lives. There were also differences among the

children in the meaning they attached to 'homelessness'. Some children did not consider themselves homeless, defining homelessness as the total absence of accommodation. Other children focused on aspects of homelessness such as instability and described homelessness as having to move from one place to another.

Children's relationships with family and friends

In the initial study, a substantial proportion of the 173 children for whom mothers reported information had not had regular contact with their father (45%). With regard to contact with mothers, 23% had not had regular contact in that same period. Maintaining good relationships with their children was a challenge for many mothers. One obstacle to providing a comfortable living environment for children was the fact that families had little or no opportunity to be together, unless they were in cramped or overcrowded conditions. In addition to this, the opportunity for mothers and children to spend time together in their own space was denied in B&B accommodation, in cases where occupants were obliged to leave the premises during the day. Finding the time and space necessary to give their children the attention they needed was also a concern for these mothers, who emphasised the increase in pressure and stress in their role as parents. Some mothers felt that their children blamed them for their homeless situations and described a sense of failure at not being able to provide their children with a stable, secure home. However, it was evident that children's well-being was a priority for these mothers despite the adverse circumstances in which they were raising their children.

Most families managed to keep up contact with extended family members such as grandparents, aunts, uncles and cousins. This contact provided support for both mothers and children in terms of sometimes providing meals, allowing children some consistency in relationships and allowing families have some respite from the restricted space of their accommodation. With regard to relationships not being able to invite friends in, having to be in hostels and B&Bs by an early hour and, in some cases, frequent changes of address were also barriers to initiating and developing long-term friendships.

School

Many children were attending school on a regular basis and this provided these children with some constancy in their daily lives in contrast to the disruption and instability which accompanied their homeless situation. Some mothers emphasised the fact that their children's education was a priority regardless of difficulties preparing children for school and providing children with a suitable space for doing homework. However, a number of children had left

school early and some children were not attending school at all at the time of interview. Reasons for this included having to move house frequently and children's behaviour problems which some mothers attributed to their homelessness. In the second part of the study, measures which assessed the extent of English vocabulary acquisition were used and findings suggested that the majority of these children were doing less well than average on these measures.

Assessment of children's well-being and behaviour

In the second part of the study, mothers were asked to talk about the impact of being homeless on their role as parents and many women talked about a change in their children's behaviour since becoming homeless. In most cases this was seen as a deterioration in behaviour patterns and many children were described as being less co-operative and more irritable than they had been previous to becoming homeless. Measures assessing children's behaviour patterns and emotional development were also used in this part of the study. A wide range of scores was recorded on these scales but a number of children had scores indicative of the presence of behaviour problems.

Mothers' perceptions of their children's health status and use of health services

Mothers' perceptions of their children's health status were generally positive. However, approximately half of the children in the study had not received their full vaccinations and other health care services were under-utilised by these homeless families. Reasons for this may include the fact that families have to re-locate frequently and, therefore, there is no opportunity to develop an ongoing relationship with a health care provider. Frequent changes of address also make it difficult for families to be contacted with regard to advising them about keeping appointments.

Incidence of physical and sexual violence

In One Hundred Homeless Women (Smith, McGee, Holohan & Shannon, 2001), 40% of these women reported having experienced physical violence in childhood while just over half of the women reported experiencing physical violence in adulthood. With regard to sexual violence, almost half of these women reported having experienced some form of serious sexual violence, assault or abuse in their lifetime. The majority of these women had been abused before becoming homeless. Mothers were also asked about incidents of physical abuse concerning their children. Seven mothers (8%) said their children had experienced severe physical abuse, and five women stated that this was before becoming homeless. Eight mothers (10%) reported

that they knew or strongly suspected that their child(ren) had been sexually abused and two of these mothers stated this was after becoming homeless. Most of these women had themselves experienced sexual violence and the majority said they had become homeless as a consequence of removing their child(ren) from the abusive situation.

Recommendations

- Recommendations must take into account measures which can be adopted to prevent homelessness and these include effective support for 'vulnerable families' experiencing crisis or transition.
- Current homeless accommodation must be improved to cater for the needs of homeless families and their children. These improvements should include the possibility of parents living together within homeless accommodation, facilities for cooking and storage of food and access to safe play areas for children.
- Health care services should be more focused to take into account the particular needs of homeless families and their children. This would involve an awareness of the many demands within homeless situations and the difficulties associated with frequent changes of address. Health promotion programmes must continue to be developed at community level.
- The important role that education can play in the lives of these homeless families must be recognised. School attendance can provide children with consistent daily routines and allow them the opportunity to break a cycle of poverty and disadvantage.
- Social support for homeless mothers and their children must be improved in terms of offering childcare facilities, including facilities for children's play , and providing a space within which homeless families can meet.

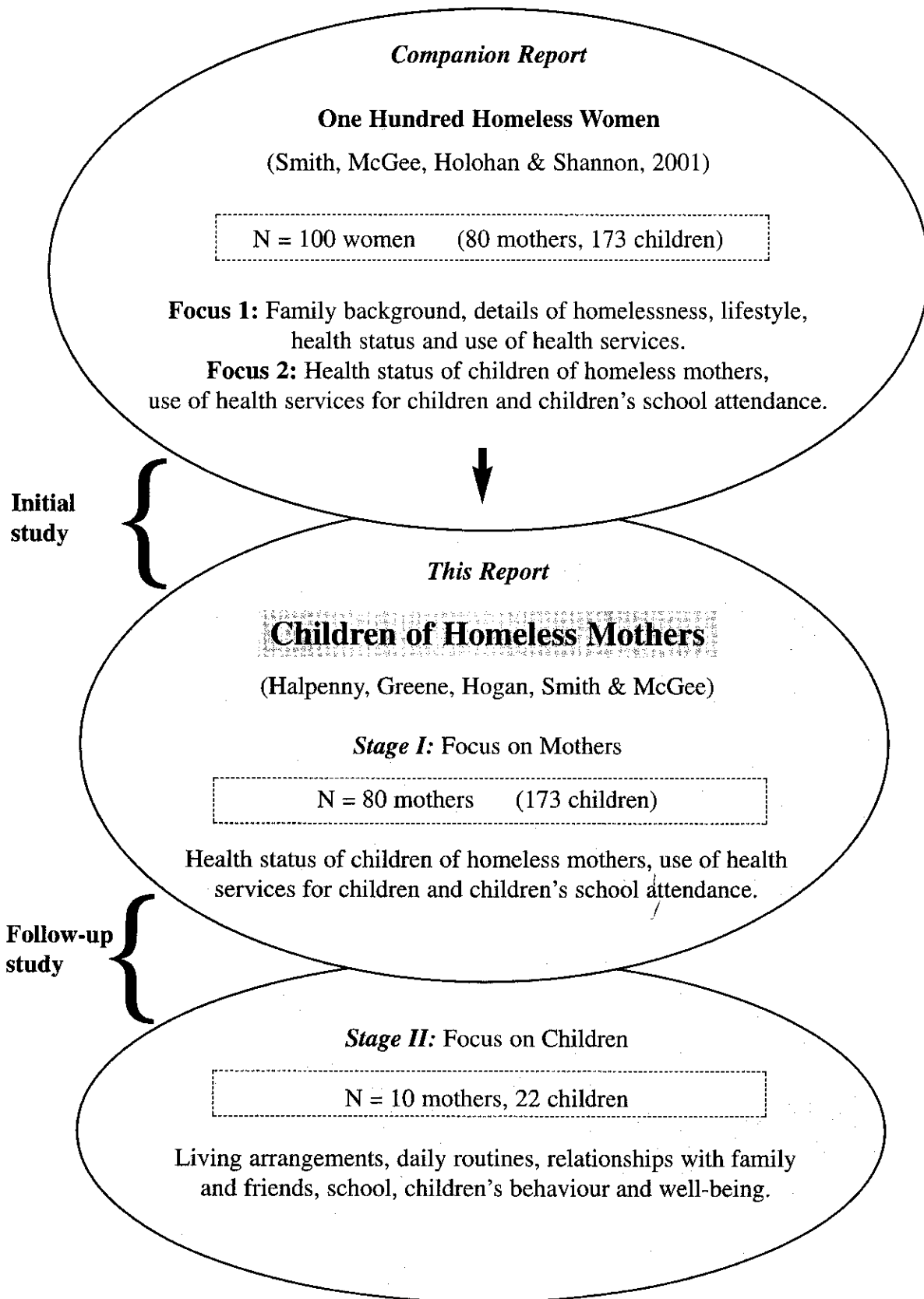
BACKGROUND TO STUDY

Children of Homeless Mothers outlines and discusses findings on the experiences of homeless mothers and their children living in emergency B&B and hostel accommodation in Dublin. These findings are based on data collected in interviews with eighty homeless mothers on the health status and access to health care services of their children, and subsequent intensive interviews with a sub-sample of ten homeless mothers and their children on aspects of the children's daily lives within these accommodation settings.

An initial study² on the health status and access to health care services of homeless women living in Dublin was carried out by the Royal College of Surgeons in Ireland (RCSI). In this study, 100 homeless women living in Dublin were interviewed. The focus of these interviews was the family background of these women, the history of their homelessness, lifestyles, their health status and their use of health services. In a second focus of this initial study, 80 of these 100 women were interviewed. These eighty women were mothers with children under the age of 18 years (173 children in total). These interviews covered information on the health status of their children, their use of health services for their children, mothers' reports of child physical and sexual abuse, and children's school attendance. Findings from this initial study are reported and discussed in a companion report *One Hundred Homeless Women* (Smith *et al.*, 2001). Findings from the interviews with these eighty mothers relating to their children are also reported and discussed in Chapter 2 of the present report.

Following on from this initial study, a study of ten homeless mothers (eight of whom had participated in the prior investigation) and their twenty-two children under the age of 18 was carried out by The Children's Research Centre, Trinity College Dublin. Mothers and children were interviewed. The focus of these interviews was child-centred, with particular reference to living arrangements within their emergency accommodation, the daily routines of these children, their relationships with family and friends, school attendance and children's behaviour and well-being.

² For the purposes of clarity in this report, the interviews carried out with the 100 homeless women (including 80 homeless mothers) by the Royal College of Surgeons in Ireland will be called "the initial study". Interviews with the 80 mothers about the health status and access to health care services for their children will be referred to as "stage one of the present study" and interviews with the 10 homeless mothers and their children, carried out by The Children's Research Centre, will be referred to as "stage two of the present study".



Relationship of this report (*Children of Homeless Mothers*) to the companion report (*One Hundred Homeless Mothers*).

CHAPTER 1: INTRODUCTION

Homelessness is not an easy condition to define. It is a condition which takes a number of different forms and does not have predictable antecedents and consequences. There are many factors which may lead, directly or indirectly, to people becoming homeless. Similarly, the experience of homelessness may affect people's lives in a number of different ways in terms of their daily routines, relationships, education, health and their sense of belonging to a particular community. In some cases, homelessness may be experienced not so much as a state but rather as a stage as, although some people experience homelessness for years, many experience it periodically or enter the homeless population for a period and then leave it (Anderson, Kemp & Quilgars, 1993; Pleace, Burrows & Quilgars, 1997). When we think about homeless people, we may think about men being homeless, alone, and living on the streets. Or we may think about young people who have left home for one reason or another, or who have left public care and end up "sleeping rough". We are less likely to think about women, and even less likely to think about women with children not having their own home. The present study looks at the experiences of mothers and their children who are living in emergency accommodation.

Accommodation for homeless families in Dublin

Over the last decade, there has been a substantial rise in the use of Bed & Breakfasts (B&Bs) for emergency accommodation of homeless families in Dublin. A recent report by Focus Ireland, entitled *Focussing on B&Bs: The Unacceptable Growth of Emergency B&B Placement in Dublin*, emphasises that prolonged use of such accommodation can have implications for the health of these families, the stability of their family life and their sense of connection or belonging to the community (Houghton & Hickey, 2000). The authors point out that, in 1990, only five households were placed in emergency B&B accommodation by the Eastern Health Board. By 1999, this figure had risen to 1,202 households and this included 1,262 children. The length of placement rose from an average of 12 nights in 1992 and 16 nights in 1993 to 81 nights (a provisional estimate) in 1999.

In *Shaping the Future: An Action Plan on Homelessness in Dublin 2001-2003* (Homeless Agency, 2001), objectives to ultimately reduce the length of stay in emergency accommodation to a number of weeks are outlined. By the end of 2003, it is hoped that emergency accommodation will only be used for short periods (i.e. less than six months). This is a welcome proposal. However, the reality at present indicates that many homeless families are obliged to live for substantial periods of time in such emergency accommodation, where inadequate facilities lead to a severe disruption in the daily lives of homeless parents and their children.

Categories of homelessness

In a recent pilot study carried out by Focus Ireland, the Mater Hospital and the Northern Area Health Board, entitled *The Mental and Physical Health and Well-Being of Homeless Families in Dublin*, three categories of homelessness are identified. The first of these is *visible homelessness*, where people are sleeping rough or in designated homeless hostels or B&Bs. Vostanis and Cumella (1999) suggest that public policy in Western Europe and North America has largely been directed at this category. Less attention has been paid to the second category, referred to as *hidden homelessness* – where people are staying with relatives or friends because of the lack of alternative accommodation, or remaining in institutional care because of the lack of affordable accommodation. This group is diverse and the reasons that lead to such homelessness are complex. The final category includes people who are *at risk of homelessness* and, who despite being housed at present, are likely to become homeless because of economic difficulties or the threat of violence.

This broadening of the definition of homelessness to include such categories is reflected in the publication of a policy document, *Homelessness – An Integrated Strategy* (Department of the Environment and Local Government, 2000), which, in addition to recognising the homeless status of those living in temporary accommodation such as B&Bs or hostels, further defines homelessness as affecting *persons living in insecure accommodation and victims of family violence*. The present study includes families falling into the first category – those who are living in designated hostels for homeless persons and B&B accommodation.

Prevalence of homeless families with children

Estimating the number of homeless people can be difficult, given the variety of definitions which are used. However, research studies in the US and UK suggest that homeless families with children constitute a rapidly increasing section of the homeless population. In the US, 40% of the homeless population are family units with children (Shinn & Weitzman, 1996). An analysis of official statistics in the UK indicates that, each year, local housing authorities accept about 143,000 families as homeless, which includes over 170,000 children (Victor, 1999). Another reason for the difficulty in estimating the prevalence of homelessness is that there is a constant turnover in the homeless population, which means that many more children will experience at least one episode of homelessness before adulthood (*ibid.*, 1999).

A survey published by the Dublin Homelessness Initiative in 1999 found a total of 2,900 homeless adults in the Dublin area, including 660 families with a total of 990 children (Williams & O'Connor, 1999). Of these 990 children, 530 (53%) were under five years of age, 280 (28%) were aged 6-11 years and 130 (13%) were aged 12-15 years of age (Williams & O'Connor, 1999; O'Brien, 2000).

Characteristics of homeless families

Despite the fact that there is a variety of dimensions, causes and consequences of homelessness, findings from international and Irish studies reveal some consistency with regard to the characteristics of homeless families. In the UK, a large proportion of homeless families (75%) are single parent families, and, in most cases, this parent is an unemployed single mother. In addition to this, a substantial minority have histories of family breakdown, physical and sexual abuse, and psychiatric disorders (Bassuk & Browne, 1996; Cumella, Grattan & Vostanis, 1998; Herman, Susser, Struening & Link, 1997).

The picture is very similar in Ireland. In a paper presented to the *Housing and Women Conference* in Galway (2000), Mary Higgins points out that the majority of homeless people on the Local Authority homeless list who were *not* using services were women, and where there were families, many were female-headed, single parent families. A substantial number (32%) of homeless women were under 20 years of age, and characteristics included high levels of poverty, low experience of work, and few or no job skills. In addition, many of these women were likely to have had an experience in care and/or been exposed to violence and sex-abuse at some stage in their lives.

Possible causes and consequences of homelessness in families

Causes

It would seem that there are numerous factors that can bring about or precipitate homelessness in families. Information regarding the numerous routes into homelessness in the UK is provided in a survey of homeless centres in Birmingham (Vostanis, Grattan & Cumella, 1998) which involved 168 homeless families with 249 children between the ages of 2 and 16 years. According to this survey, almost all families (96%) had been in stable housing as owners (8%) or tenants (88%) a year before admission to a homeless centre. The remaining families were lodging, usually on a long-term basis, with family or friends. A substantial majority of these families (89%) chose to become homeless to escape from violence, while smaller numbers left to avoid sexual or other physical abuse of their children (5%). Violence was either in the form of direct assaults, threats of violence or sustained harassment. Direct violence and the abuse of children were most frequently committed by partners, threats of violence were from neighbours, and harassment was by ex-partners. Three families became homeless because their house had been burnt down by others. The authors point out that the majority of families, therefore, had left their last stable housing as a means of escape.

There appear to be many factors leading to homelessness in Ireland. The Focus Ireland study on the growth of B&B homeless accommodation indicates that family conflict (non-violent disputes with parents or siblings) accounted for a substantial proportion (20.6%) of homeless families. This was closely followed by drug addiction (14.4%), particularly among single homeless adults. Domestic violence was reported to be the primary cause of homelessness for 7% of cases, and was most prevalent among lone parents, with 11.1% of lone parents reporting it as primary cause. Eviction from private rented accommodation was also a major factor leading to homelessness in Ireland, with 16% of cases reporting it as the primary cause of homelessness. The family status group most affected by this kind of eviction was lone parents, especially those in the age category 26 to 40 years. Other factors leading to homelessness included release from prison, leaving care, sexual abuse, leaving psychiatric care and completion of a detoxification programme.

Consequences for children

Previous research in the UK and US suggests that children in homeless families have a high risk of physical and mental illness. A study of the mental health of children in 113 homeless families in Birmingham, and an investigation into their contact with health, education and social services (Cumella, Grattan & Vostanis, 1998), found a high prevalence of mental health problems among children and parents in homeless families. Rates of mental health problems significantly exceeded those rates found in low-income families who were not homeless (Cumella, Grattan & Vostanis, 1998). However, the authors caution against any assumptions regarding the effects of homelessness, without considering a variety of other factors which may be at play. The fact that the children in the sample had been exposed to a number of risk factors, such as family disintegration and/or physical or sexual abuse, in addition to the loss of their home, must be considered. The dangers of assuming a causal relationship between homelessness and poor physical or mental health have been emphasised by other researchers, when they point out that factors leading to risks of health problems are rarely unique to homeless people as a group (Pleace & Quilgars, 1997). Any relatively economically deprived section of the population is exposed to similar and often identical risks to health. It is possible that psychological problems found in previous studies with homeless families may have been present prior to these families becoming homeless.

The particular circumstances associated with homelessness may result in a loss of control over planning daily routines in family life. In addition to this, support from family and other informal social networks may become fragmented and this, in turn, can exacerbate the pressures experienced by homeless families. The importance of the role and functioning of family and informal networks of homeless families has been emphasised (e.g. Avramov, 1999), since an absence of family and social support may have negative effects on parenting practices.

Findings from UK studies of women living in a hostel for homeless families indicated that almost half of the mothers were identified as having mental health problems (Vostanis, Grattan, Cumella & Winchester, 1997; Vostanis, Cumella, Briscoe & Oyebode, 1996). Moreover, lack of privacy and space in temporary accommodation may contribute to increasing the pressure placed on parents, and these factors have been associated with punitive parenting (Newson & Newson, 1965; Peterman, 1981).

These findings have been supported, to some extent, in the Irish context, as parents in homeless families have been reported to be highly stressed while caring for their young children (Waldron, Tobin & McQuaid, 2000). The same study, however, found that levels of these children's attachment to their mothers were similar to those found in the general population, and the authors suggest that this indicates a strong investment on the part of these mothers in caring for their children. Similarly, in the UK, many homeless mothers have been found to demonstrate a high level of resilience in the face of their difficult circumstances and to direct their resources into protecting their children from potential risk and harm (Barnes, 1999).

The health status of homeless people in Dublin

An overview of recent research findings on the health status, needs and use of health services of people who are homeless in Dublin is presented in *Shaping the Future* (Homeless Agency, 2001). Key findings include higher levels of psychological distress, dental problems, hazardous alcohol consumption and drug abuse among homeless people than in the rest of the population. Other findings outlined in this report indicate that homeless people have lower levels of social support than the general population, tend to use medical services (i.e. general practitioner [GP], outpatient and accident and emergency services) to a greater extent than the general population, and have particular difficulties accessing services organised on Community Care area basis, as homeless people may experience frequent changes of address.

Child health and well-being

While homelessness is a stressful experience for most children, it would seem to be just one among many stressors affecting the lives of children in poverty. Other strains, such as experiences of physical and sexual abuse, violent domestic conflict and parental substance use, explain differences in the mental health and behaviour of these children (Buckner & Bassuk, 1999). However, US studies, which have compared samples of homeless families and low-income families who were not homeless, have found that children in homeless families had

higher rates of behavioural problems (Wood, Valdez, Hayashi & Shen, 1990) than children in poor families who were not homeless. Research into the health problems of homeless children suggests that there are a number of factors involved. These often result from the inadequate features of emergency accommodation, which can put child health and safety at risk. Some of these features include inappropriate cooking and heating arrangements, overcrowding, and lack of safe, outdoor play areas (Hutchinson, 1999). A recent study of the health status of homeless children in New York City found that 61% of homeless children had not received their proper immunisations (compared to 23% of all New York City two-year-olds); 38% of homeless children living in the city's shelter system had asthma (four times the rate of that for all New York children), and homeless children suffered from middle ear infections at a rate that was 50% greater than the national average (National Coalition for the Homeless, 1999). Other findings suggest that a substantial number of homeless children have delayed development compared with children of a similar age in the general population (Vostanis, 1990; Bassuk & Rosenberg, 1990). These include both specific developmental delays, such as in receptive and expressive language (Fox, Barnett, Davies & Bird, 1990), and more general delays in educational attainment (Finkelstein & Parker, 1993; Parker *et al.*, 1991). A study carried out in the US revealed that only 42% of homeless children were reading at the level expected for their age (Rafferty, 1991).

Information on the health status of homeless children in Dublin is similar. A recent Focus Ireland pilot study included 32 children, aged between two and sixteen years and residing with their parent(s) in transitional accommodation (Perot & Pigott-Glynn, 2000). Details were provided by the main carer on aspects of their children's health, including obstetric and prenatal care, immunisation history, diet and use of health-care services. Findings revealed that mothers of almost half the children (44%) had experienced complications in pregnancy, including nausea, pneumonia and toxæmia. In addition to this, 50% of the children had incomplete or no immunisation, and 50% were attending GPs with symptoms of respiratory tract infection. A related Focus Ireland study on the mental health status of homeless children and their families (Waldron, Tobin, & McQuaid, 2000) investigated the behavioural and emotional problems of 14 families with a total of 31 children. Scores on the Child Behaviour Checklist (Achenbach, 1991) suggested that these homeless children had higher rates of behavioural problems than those found in population norms.

The present study

This report (*Children of Homeless Mothers*) outlines and discusses findings on the experiences of homeless mothers and their children living in emergency accommodation in Dublin. An initial study on the health status and access to health services of 100 homeless women in Dublin, carried out by the Royal College of Surgeons in Ireland, included interviews with 80

homeless mothers on the health status of their children, their use of health care services for their children, their children's experience of physical or sexual abuse, and their children's school attendance. Findings from interviews with these mothers are outlined and discussed in a companion report *One Hundred Homeless Women* (Smith *et al.*, 2001). Child-related findings from interviews with 80 of these women, who were mothers, are also reported and discussed in Chapter Two of the present report.

In the follow-up study, interviews with ten homeless mothers and 22 of their children living with them in emergency accommodation were carried out by The Children's Research Centre, Trinity College, Dublin. Eight of these homeless mothers had taken part in the first stage of the study. Two families were recruited independently. Interviews with both mothers and children covered information on daily routines while living in emergency B&B and hostel accommodation, relationships with family members and friends, and attendance at school. Standardised measures were also used to determine the extent of the children's behaviour problems, indications of child depression and levels of self-esteem.

The aim of the study is to investigate the health status and access to health care services of children living with their mothers in emergency B&B and hostel accommodation in Dublin, and to gain insight into the everyday experience of homeless families. What effect does living in emergency accommodation, such as hostels or B&Bs, have on the daily lives of families and on the well-being of children living in these families? This question is explored with reference to relationships with family (including mother-child relationships and effects on parenting), relationships with extended family and friends, education, and the general well-being of these homeless mothers and their children. The present report contains information relating to the health and well-being of mothers and children from the initial study (80 mothers and 173 children)³. The main focus of this report, however, is on the ten families that took part in the follow-up study.

³ For a comprehensive report on the initial study see *One Hundred Homeless Women* (Smith, McGee, Holohan & Shannon, 2001)

CHAPTER 2: FOCUS ON MOTHERS

This chapter outlines and discusses findings from interviews with 80 homeless mothers⁴ on information relating to their children under 18 years of age (173 children in total). Findings cover details of homelessness and information relating to children's health and school attendance.

Design and Methodology

Sample

The sample of homeless mothers (N=80) in the initial study was drawn from the population of homeless women who had been provided with emergency accommodation. At the time of interview, they were housed in emergency accommodation – B&Bs or hostels for homeless people. Other members of the homeless women population, for example those sleeping rough or those not accessing area health boards under the ERHA, were not included in the initial study. Of the 100 women originally sampled, 82 women were mothers. Eighty of these mothers had a total of 173 children *under the age of 18* (79 male, 94 female) ranging in age from 2 months to 17 years.

The sample was obtained with the co-operation of staff in the Homeless Persons' Unit, Charles Street, who made available the addresses of hostels and B&B owners providing emergency accommodation for homeless women and their children. Owners of these establishments were requested (by letter) to allow researchers access to residents, in order to invite them to participate in the study. Women interested in participating indicated their willingness either by returning a freepost acceptance form or, in some cases, agreeing in person when the researcher visited their accommodation. Full details of the project were provided to all participants, approaches to confidentiality and anonymity were agreed, and informed written consent was obtained. A token of IR£10 was offered to all participants, in appreciation of the time taken.

Research instruments

In the initial study, a questionnaire-based interview was carried out with 100 homeless women, covering demographic details, the history of their homelessness (how long they had been homeless, on how many occasions, etc.), lifestyle (alcohol, smoking and drug-use), general health status, the health status of their children and involvement with health care services⁵. With regard to the health status of their children, 80 mothers (those with children under the age

⁴ Sub-sample of 100 homeless women interviewed in a prior investigation by the Royal College of Surgeons in Ireland.

⁵ For details see companion report "*One Hundred Homeless Women*" (Smith, McGee, Holohan & Shannon, 2001).

of 18), were asked to outline any physical or psychological problems experienced by their children, and what treatment they had received for these problems. They were also asked to rate their level of satisfaction with children's access to, and frequency of contact with, health care services (i.e. GP, Accident & Emergency Departments, Outpatient Departments and In-Patient services). In addition, mothers were asked to state whether their children had been victims of sexual abuse or exposed to domestic violence. Most of the interviews with homeless mothers accommodated in B&Bs were conducted in their living area, which in most instances was a single room. The circumstances in which these mothers were caring for their children were very obviously unsatisfactory, in terms of inadequate facilities for cooking and storing food, lack of living space (which frequently involved many people sharing kitchens, bathrooms and bedrooms) and, in some cases, families having to vacate the premises during the day.

Results

A total of 100 homeless women participated in the first part of this study and of these women, 82 were mothers. A cumulative total of 173 children *under 18 years of age* was recorded for 80 of these mothers (94 females, 79 males). The modal age of these children was 6 years (average age 6:8; SD 4.6; range 2 months to 17 years). The modal number of children recorded for each family was 2 (mean 2.2; SD 1.3; range 1-7). Findings indicate that many of these homeless women are young mothers (under the age of 35) who come from disadvantaged backgrounds in terms of poverty and social deprivation (Smith *et al.*, 2001).

Current and previous accommodation settings

Of the 100 women originally interviewed, 67% were living in emergency B&B accommodation, while the remainder (33%) were living in hostels. Information regarding their accommodation over the previous seven nights revealed a similar pattern of accommodation, with 68% living in B&Bs, 32% in hostels, and a further 3% living with friends, "sleeping rough" or living in circumstances categorised as "other". With regard to the accommodation used over the previous five years, these women had lived in a number of different types of accommodation. The majority had lived in hostel (61%) and B&B (87%) accommodation at some time during this period. A substantial number of women had lived with friends (48%), in the family home (45%) or on the street (47%). Other accommodation types used by women were local authority housing, private housing and squatted housing. Smaller numbers of women had spent some time in prison and in hospital over these five years prior to being interviewed, while other women had lived in accommodation provided by the health board under exceptional circumstances, or had spent some time in a rehabilitation centre. Some women had also lived abroad during this period (see Table 2.1).

Table 2.1: Types of accommodation used by homeless women in previous five-year period and previous seven-night period

Accommodation used by respondent in previous 5 years		Accommodation used by respondent in previous 7 nights	
<i>Accommodation type</i>	<i>%</i>	<i>Accommodation type</i>	<i>%</i>
Bed & Breakfast	87	Bed & Breakfast	68
Hostel	61	Hostel	32
Friend	48	Street\Slept rough	1
Street\Slept rough	47	Friend	1
Family home	45	Other	1
Local authority housing	29		
Private rented housing	28		
Squatted housing	23		
Prison	22		
Hospital	20		
Lived abroad	18		
Health board provided	9		
Rehabilitation centre	4		

Duration of homelessness

The median duration of the current episode of homelessness for these women (N=100) was 72 weeks (mean=88 weeks; range: 2 weeks to 6 years). Smith *et al.* (2001) defined homelessness, for the purposes of further analysis in their companion study, as involving a current period of homelessness of one year or longer duration. Just over half of the women who participated in their study (54%) were, therefore, categorised as being long-term homeless.

Reasons for becoming homeless

Women were asked to identify the 'main reason' for becoming homeless at the initial stage of the interview. Responses were mixed and, in some cases, the women perceived certain events, such as eviction and domestic violence, as being responsible for their homeless situation. Other women identified a range of complex and interacting factors as underlying causes of being homeless. One woman, who initially stated that she became homeless because she "did not get on with the family", later indicated that the sexual abuse of her children by her father, with whom she shared the family home, was her reason for leaving that home and this had resulted in her becoming homeless. See Table 2.2 for an outline of the reasons for becoming homeless as identified by the women and later categorised by the researchers into 12 domains.

Table 2.2: Categories of 'main reason' for becoming homeless (as identified by women)

Reason	N
Failure to find affordable accommodation	18
Domestic violence (includes sexual abuse of children in 3 cases)	14
Family problems (complex and/or unspecified)	13
Addiction problems	11
Multiple and complex reasons; 'other'; no reason offered	10
Overcrowding in family home	8
Eviction (3 for rent arrears; 4 for anti-social behaviour)	7
Mental illness	5
Thrown out of family home (due to pregnancy in 3 cases)	4
Bullied /harassed in neighbourhood	4
Sexual abuse of children	3
Problems with standard of previous accommodation (vermin infestation)	3

The failure to find affordable accommodation was the most common reason given for becoming homeless. People affected were almost equally divided between

- a. those who had been in accommodation and had been faced with unaffordable increases in rent and/or given notice to quit (or, in some instances, illegally evicted) by the landlord; and
- b. those who were coming into the housing market for the first time (e.g. returned immigrants, young families needing housing).

Eviction for anti-social behaviour had impacted on families, displacing mothers with children because of the activities of other household members. In one instance, a family of six had been evicted from their home of 30 years because of the drug-dealing behaviour of the adult sons, now resident in the UK.

Child care arrangements

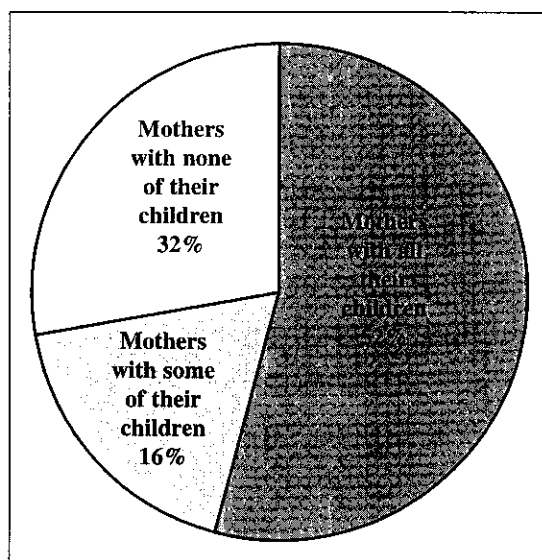
Women were asked to indicate:

- a. how many of their children (under 18 years of age) were currently living with them; and
- b. what proportion of the previous year each child had lived with them.

With regard to the first question (a), just over half of the group (52%) had *all* of their children (under 18s) living with them; 13 women (16%) had *some* of their children living with them, while the remainder (32%) had *none* of their children in their day-to-day care. When asked to indicate the proportion of the previous 12 months that each child had lived with them (b), 55

of these 173 children (32%) had lived with someone other than their current carer in the previous 12 months. A total of 90 children were living with their mothers (N = 55) in emergency accommodation. Of these 90 children, 64 (36%) were living with their mother as lone parent, 27 children (14%) lived within a family unit consisting of mother, father (acting or biological father), and two children had been adopted – one living with a grandmother and the second with an aunt as lone parent.

Figure 1: Percentage of mothers whose children are currently living with them



Care arrangements for remaining children (N=83) included living with their father as lone parent for 27 children (16%); living with foster parents or in care for 22 children (13%); living with other members of mother's family for 17 children (10%); and living with other members of father's family for 15 children (9%). In addition to this, one child (0.5%) was living in sheltered accommodation and one child (0.5%) in long-stay hospital care. See Tables 2.3 and 2.4 for details of these arrangements.

Table 2.3: Number of children living with mother

Living with Mother	Previous 12 months	
	N	%
All the time	86	50
More than 50% of time	10	6
Less than 50% of time	9	5
Not at all	68	39

Table 2.4: Living arrangements for children of homeless women (currently and within past 12 months)

Adult(s) caring for child	Currently		*Within past 12 months	
	N	(%)	N	(%)
Mother as lone parent (homeless)	64	36	17	10
Father as lone parent	27	16	11	6
Family unit (mother, surrogate/father & (some cases) siblings)	24	14	10	6
In care / fostered	22	13	4	2
With other members of mother's family	17	10	10	6
With other members of father's family	15	13	2	0
Adopted	2	1		
In sheltered accommodation	1	0.5		
Long stay hospital care	1	0.5		
Total	173		54	

* These figures indicate others, besides the current carer, with whom a child lived in the past 12 months.

School

A total of 52 children of school-going age (age 4 and over) were living with their mothers in emergency accommodation. Among these children, seven were in secondary school, 22 in primary school and 13 in 'infant' school. The remaining ten children were no longer in school and, among these, seven children had left school before the age of 15. In addition to this, two children had left school at the age of 16, one because of pregnancy.

When asked about their children's school attendance, a total of 21 mothers (40%) of the 52 children of school-going age reported that their children attended school almost all the time. A total of eight mothers (15%) indicated their children attended school for less than half the school year. Finally, two mothers (4%) indicated their children did *not* attend school at all and one mother reported her child had just started school. The attendance level for individual children, based on mothers' reports, is outlined in Table 2.5.

Table 2.5: Individual child's school attendance record in the recent past

Attendance level	Past year		Past month	
	N	(%)	N	(%)
Almost every day	33	64	38	73
More than 50% of the time	3	6	2	4
Less than 50% of the time	9	17	4	8
Not at all	7	13	8	15
Total	52		52	

Mothers were also asked about the number of schools which their children had attended over the past two years. Findings revealed that 37 children (80%) had only attended one school in the two years prior to the interview. A further 7 children (16%) had attended two schools over the previous two years, and 2 children (4%) had attended at least 3 schools over that period. Details of the number of schools attended in the past two years are outlined in Table 2.6. A total of 8% of children living with their mother in these challenging accommodation circumstances had not been to school in two years, and this represents a clear marker of possible continuation of disadvantage into the next generation.

Table 2.6: Number of different schools attended over past two years

No. of Schools	Children (N)	%
1 school	37	80
2 schools	7	15
3+ schools	2	5
Total	46	

Note: 4 children had not attended school in the previous two years (ages 16, 14, 11 and 9)

Financial problems contributed to the difficulties of these mothers keeping their children in school. In many cases, demands, such as buying shoes and other clothes for school-going children, and providing them with the "extras that the other kids have in school", represented an added burden to these women, who felt their children could be "marked out" and embarrassed by their status as poor and homeless in school. One woman explained how she had to spend almost £6 per day on bus fares to keep her daughter in the school she had attended since the age of 5. This was due to the fact that the homeless accommodation they had been provided with was 15 miles from their original home, from which they had been evicted.

Health

Mothers were asked to talk about the health of their children (those under 18 years). Information about children in the care of their mothers was more complete than for children who were being cared for elsewhere. Table 2.7 outlines mothers' perceptions of their children's health status, rated on a five-point scale, ranging from *excellent to poor*. Where information was known, most children (56%) were rated as having very good or excellent health. Fifteen percent of mothers stated that they were not in a position to evaluate the health of their children, as these children had not been living with them on a regular basis.

Table 2.7: Child's health status as perceived by mother, by location of child's home

Mother's perception of child's current health status	Not living with mother	Living with mother	All children	
	N	N	N	%
Excellent	14	18	32	18
Very good	12	29	41	24
Good	16	36	52	30
Fair	4	4	8	5
Poor	2	3	5	3
Missing data/unknown	35		35	20
TOTAL	83	90	173	100

Immunisation and vaccination status of homeless children

Mothers were also asked about the immunisation and vaccination status of their children. Their responses revealed that 94 children (54%) had received all vaccinations, 16 children (8%) had received some of their vaccinations, while 8 children (5%) had not received any vaccinations. Data was missing or reported as unknown for 55 children (32%). Details of these findings are presented in Table 2.8. Less than full uptake rates for vaccination programmes are a cause for concern, particularly for children living in conditions that may expose them to greater risk of infectious diseases. Whereas the target rate for uptake of the Department of Health and Children's (DOHC) vaccination programme is 95%, only approximately 80% uptake is achieved nationally (DOHC statistics). By parents' reports, only about half of the children in this study have been fully vaccinated. This is marginally better than the 44% rate in the Focus Ireland pilot study (Perot & Pigott-Glynn, 2000), but both studies demonstrate the scale of the problem in achieving full uptake among homeless families.

Table 2.8: Mothers' reporting of uptake of childhood immunisation & vaccination programme

Vaccination status	Children living with mothers		Children not living with mothers		All children	
	N	%	N	%	N	%
All vaccinations received	72	81	22	27	94	54
Some vaccinations received	9	10	7	8	16	9
No vaccinations received	4	4	4	5	8	5
Missing data or unknown	5	5	50	60	55	32
Total	90	100	83	100	173	100

Particular health problems of homeless children

While mothers reported that most children for whom information is available (N=138) were healthy, a number of health problems were reported. At least one health problem was reported for 58 children (42%) and some children had multiple problems. These problems included asthma (18%) and other chest problems (4%), injuries resulting from severe trauma (6%), skin problems (3%), bone or joint problems (3%), psychiatric problems (4%) and recurrent head lice (25%). Table 2.9 outlines these health problems and Table 2.10 outlines information on medical treatment children received for their health problems.

Table 2.9: Health problems of children in homeless families

Type of problem	N	%
Asthma	25	18
Recurrent head lice	25	18
Injuries resulting from severe trauma	8	6
Psychiatric problems	6	4
Other chest complaints	5	4
Skin problem	4	3
Bone / joint problems	4	3

It should be noted that most interviews were conducted during the summer months and many mothers remarked on the seasonal variations in their children's health, much of which they ascribed to being outdoors in favourable weather conditions – their children being healthier in summertime.

Table 2.10: Treatment for health problems of children in homeless families

Treatment	Children	(%)
Accident requiring hospitalisation	12	(7)
On-going counselling	9	(5)
Requiring treatment for at least one health problem	58	(34)
Getting treatment for at least one health problem	49	(28)

The additional health problems of individual children reported included: hole in the heart, hepatitis C, hydrocephalus, heroin addiction, attention deficit disorder, muscular dystrophy, eating disorder, metabolic disorder, severe head injury.

In one instance, a mother reported that one child was in hospital as a result of trauma sustained through physical abuse by his father, while, in another case, an infant was in hospital recovering from injuries sustained *in utero* as a consequence of trauma sustained by his mother in the context of 'domestic violence'. Children suffering from psychiatric disorders included one child taken by his father to accompany him on the occasion of his (the father's) suicide. Another child's disorder is understood by his mother to be related to bullying and physical abuse which the child experienced in a hostel for the homeless.

Use of Health Services

General Practice (GP) Services

In the previous 6 months, GP services were accessed for one or more of their children by almost two-thirds of those mothers (N=32; 60%) who were the primary carers of all or some of their children. In the Focus Ireland pilot study, 41% of the children had visited a GP in the previous 6 month period (Perot, Piggott-Glynn, 2000). The majority of visits were for chest infections (39%), followed by skin complaints (36%). Other complaints included recurrent gastroenteritis, head-lice and other infections (ear, throat etc). In a six-month period, the average number of visits per family for one or more children was 3.6 (SD: 4.1; median 2; range 1-20).

Accident and Emergency (A&E) Services

Sixteen of the women (29% of primary carers) had been to an A&E Department in the previous 6 months with one or more of their children. Twelve families had visited once, one family had visited twice, one had visited three times and two families had visited five times each. The first of these two families with five visits had visited for repeated instances of self-harm by one child, while the second was attending because of one child's recurrent asthma

attacks. In the Focus Ireland pilot study, 27% of children had been treated in an A&E Department over a six-month period (Perot, Piggott-Glynn, 2000).

Out-patient Department Services

Eleven mothers (20% of the primary carers) had attended an out-patients department in the previous 6 months with regard to problems concerning one or more of their children. Eight families had attended on one or two occasions, while three families had between three and eight visits each. Most visits were follow-ups relating to medical or surgical treatment in the recent past; one was for psychiatric treatment.

In-patient hospital stay

Of the 90 children living with their mother, 9 children (10%) had been an in-patient in hospital, for between one and 14 nights, in the previous twelve month period. One child, aged 13, had been admitted for an attempted suicide. The remainder were receiving treatment for a variety of medical and surgical complaints.

While it is difficult to evaluate the level of service use by these children in comparison with Irish children generally (because of the absence of overall national data), figures indicating that 10% of this sample of children had received in-patient hospital care in the past year appear very high. Combined with information on the variable level of school attendance of these children, it suggests a substantial group of children whose health and education is at considerable risk.

Aspects of emergency accommodation which may impact on child health

Children's health problems may be exacerbated by the often inadequate and inappropriate nature of the emergency accommodation provided. The following section outlines aspects of this accommodation which mothers highlighted as having potentially negative effects on their own health and that of their children. Comments made by the women are quoted or synthesised with researcher observations considered relevant to child health in this setting.

One mother of a young infant complained about the quality of the water available in her room in the B&B. She explained that, in the daytime, she had permission to fill a kettle in a kitchen not usually accessed by the residents, but that, in the evening and night-time, this access was denied. Another woman said that one of her small children sustained a fractured arm when he fell down a steep flight of stairs in the B&B. She explained that this was "the sort of stairs you'd have to put a barrier on if you had your own place". Many women complained about the cost of eating out. Some had minimal cooking facilities in their rooms – a kettle and a small fridge; most had no facilities for food preparation or storage. Providing hot meals for their

children was possible only by using take-away restaurants, which the women considered not only very expensive, but offering food of poor quality. Laundry was another considerable expense for most women, since many lacked any facilities other than a hand basin and radiator, for either washing or drying clothes.

One woman said her laundry bill at the local launderette

was more than a quarter of her income that week, as she had extra laundry when her children

Mother

“Burgers and chips is what they get mostly. I don’t know how long it is since they had a decent meal with real meat and vegetables.”

had been ill with gastro-enteritis for a number of days. Almost half of the owners of B&B accommodation providing places for the women in the sample require that their residents vacate the premises for a given period of time during the day – usually from around midday to between 5.00 p.m. and 7.00 p.m. Walking the streets or finding an available place to sit and rest during these times, especially with young children, was one of the most difficult

aspects of their lives. Women expressed concerns about needing to leave their accommodation during cold or inclement weather. During these times they worried about having nowhere for toddlers to nap or play, the dangers of traffic, and the stress and exhaustion of having to be constantly on the move. It was not only the younger families that were affected in this way – one woman complained that, for her 15-year-old son, life was becoming impossible as she was

Mother

“He doesn’t want his pals to see him always hanging ’round with his ma – and what am I supposed to tell him – go and hang around the streets by yourself? That’s exactly what the guards will tell him not to be doing.”

worried about him being alone on the streets yet she recognised the difficulty for him as a teenager being constantly seen in the company of his mother. Two women in their sixties who were rearing children also complained of the toll that being outdoors in all weathers took on their own energy levels, and how, in turn this affected their relationship with the children in their care. “I just don’t be able for them” is how one grandmother put it.

For women who were allowed to remain in their room throughout the day, the burden of “finding somewhere to go” was replaced by the stress of a cramped, confined environment.

Their children, in most instances, had no play area outside of their room. The sense of isolation, the lack of a supportive environment and any respite from the demands of young children, were reported as a source of considerable distress to most of the women. Many were

being treated for depression, few had access to getting what most said they wanted, which was “... a break from the kids, even for an hour ...” as one woman put it. Their lack of ability to access help with child care and to be able to have “... some life for myself ...” was a

Mother

“The water from the tap in the room doesn’t taste right ... I always boil it before making the baby’s bottles, but you wouldn’t know how long them pipes have been there or what’s in them ...”

Mother

“Kids shouldn’t have to say, ‘Mammy what are you crying for?’ or get shouted at for doing nothing except being kids.”

complaint common to many of these women who acknowledged that these factors impacted on the way they related to their children. These women expressed general concerns about the effect of their environment on their own psychological well-being and that of their children.

Mother

“... we’re always going to his house and he never comes to mine – his mother wants to know why ...’ That’s what he said to me the other day ... It’s as if we’re being punished for being homeless.”

In B&B accommodation most families were not allowed visitors to their room (in some instances this included the researcher). Some women remarked on the way this stigmatised not just them, but their children also. One woman complained of how, although she was delighted to have recently been accommodated in an ‘apartment’ instead of a single room, her 9-year-old son complained about not being able to bring his friends to his home.

Physical abuse of children⁶

Mothers were asked about incidents of physical abuse concerning their children. Seven mothers (8%) said their children had experienced severe physical abuse, and five women stated that this was before becoming homeless. Two of these mothers said their children experienced the abuse as a result of becoming homeless – one in a hostel for homeless people and one by carers in a State-run institution.

Sexual abuse of children

Mothers were also asked to report on incidents of sexual abuse concerning their children. Eight mothers (10%) reported that they knew or strongly suspected that their child(ren) had been sexually abused and two of these mothers stated this was subsequent to their becoming homeless. Seven of these women had themselves experienced sexual violence. Six women had become homeless as a consequence of removing their child(ren) from the abusive situation. As found in previous studies, homelessness may be a consequence, for some mothers, of trying to find a safer place for their children than in their own homes.

According to the mothers, perpetrators of the sexual abuse included family or surrogate family members in four cases and carers in two cases, as described above. There was one incident of gang rape of a 14-year-old child by neighbourhood youths and one case where a trusted neighbour was the abuser. Within the family, perpetrators involved the child’s natural father in one case and, in another case, a surrogate father. In a third case, the abuse was perpetrated by a grandfather and a final case involved an uncle to the children concerned. One brother and

⁶ It should be noted that, as part of a good practice protocol by the researchers, women were cautioned that reports of previously unreported abuse would be passed on to the authorities. The lack of reporting must be considered in this context.

sister had been severely sexually abused by their biological father and, subsequently, the boy experienced severe physical abuse by his stepfather.

One homeless woman said that she had put her child into care because she felt the environment in the B&B was unsuitable for her child. She strongly suspected that her child was sexually and physically abused while in care. A second woman placed her child in care for 'safe-keeping' as another of her children had been sexually abused within the family home. She suspected the child was subsequently sexually abused while in care.

Mothers seeking help for sexual abuse of their children

All the mothers whose children had experienced sex abuse (10%) had reported the problem and sought help, though one woman delayed seeking help because she feared "... the children would be taken from me". The help they received was usually of more than one form, and can be categorised as follows to include medical help, help from legal/justice system, counselling and social worker intervention. Six of the women found the help they received satisfactory while two did not (one of these reported that she had her children taken from her by a social worker).

Interviews with 100 homeless women, in the initial study, explored their own experience of physical and sexual violence, both in childhood and in adulthood. These findings are reported and discussed in detail in a companion report "One Hundred Homeless Women" (Smith *et al.*, 2001). Forty of these women reported having experienced physical violence in childhood. Of the 55 women who reported experiencing physical violence in adulthood, the majority (62%) had experienced violence in childhood. Violence in adulthood was experienced in the context of a single long-term relationship with a husband or partner in 80% of these 55 cases.

With regard to sexual violence, 49 women reported having experienced some form of serious sexual violence, assault or abuse in their lifetime. Most of these women (69%) had been abused before becoming homeless. Of these 49 abused women, 40 women had a total of 86 children under the age of 18. Sixteen of these women (33%) had all of their children with them, and five of these women (10%) had some of their children living with them. These details, and details of the help sought and received by these women for their experiences of physical and sexual abuse, are reported in *One Hundred Homeless Women* (Smith *et al.*, 2001).

CHAPTER 3: FOCUS ON CHILDREN

This chapter outlines the methodology used in the follow-up study involving in-depth, qualitative interviews with ten homeless mothers and their children. Interviews focus on the daily life experiences of these mothers and their children while living in emergency B&B accommodation.

Design and methodology

Sample

Eight of these ten homeless families (mothers and children) were drawn from a larger sample of homeless women (N=100) who had participated in a prior investigation and whose findings are reported and discussed in the companion report entitled "*One Hundred Homeless Women*" (Smith *et al.*, 2001). A further two families were recruited independently. The present sample comprises 10 mothers and 22 children, ranging in age from 4 to 16 years (10 male, 12 female). Nine of the ten families were living in hostels or B&Bs at the time of the study. All accommodation was located within a 2-mile radius of the city centre. One family had been housed since the first part of the study.

It is important to point out that although 80 mothers, who had taken part in this initial study, were invited to participate with their children in a further stage of interviews, almost 90% of these women were unwilling to do so. Among the reasons put forward for this unwillingness was the difficulties that families had experienced both before and during being homeless. Many mothers understandably felt that their children had been exposed to a lot of hardship and wished to protect them from any further discomfort. It is important to point out, therefore, that this sub-sample of ten homeless families is not representative of the original sample in the initial study.

Names and contact numbers for those women who agreed to participate further were passed on to the Children's Research Centre, TCD by the RCSI researcher. Families were then contacted and a suitable time and location for the interview was agreed. In most cases, interviews took place in the accommodation in which families were living at that time, which involved either a B&B or hostel setting. Two families were interviewed in a café as they had to be out of their accommodation (B&B) during the day. Settings were not always ideal for conducting interviews, particularly where there were a number of children involved. Occasionally interviews with mothers and children took place simultaneously – in the one room. Researchers brought along a number of drawing materials (coloured markers, colouring books, stickers, etc.) in order to amuse children while their parent or sibling was being interviewed. A

token of IR£10 was offered to mothers in appreciation of their contribution to the study. Each child participant was also presented with a IR£4 voucher for McDonalds.

Research Instruments

Qualitative interviews with both mothers and their children examined the impact of living in emergency B&B and hostel accommodation on their daily life routines.

Interview with mothers

The semi-structured interview with mothers explored information on family background, details of the children's daily life, the impact of homelessness on their children, on their role as parents, family relationships and school performance. The interview schedule was developed by the researchers. Interviews were tape-recorded and later transcribed.

In addition to interview questions outlined, two standardised measures (parent scales) were used: *The Revised Rutter Parent Scale for School-Age Children* and *The Child Self-Esteem Parent Scale*. Researchers explained instructions clearly to the participants and read the items aloud to them. Mothers indicated their rating on each item and researchers filled this information in on the appropriate forms.

Revised Rutter Parent Scale for School-Age Children

This scale examines different aspects of children's behaviour and is a revision of the original Rutter Parents' and Teachers' Scales (Rutter, 1967). The original scales focused mainly on emotional and conduct problems. The revised scales incorporate pro-social items and include a small number of additional items to provide a better coverage of behaviours shown by younger children. The scale provides a total score ranging from 0 to 52, and higher scores on this total score indicate poorer outcomes for children's emotional/behavioural development. If there is a need to pick a score that indicates possible clinical significance, it is suggested that a cut-off of 11 or more may be used.

Child Self-Esteem Parent Scale (extract from Child Health Questionnaire – Parent Form)

The Child Health Questionnaire Parent Report (CHQ-PF50) was developed in the US and aimed at giving a voice to children and their families in the area of health care (Landgraf & Ware, 1996). This instrument has been used across a variety of healthcare settings and applications, including academic research, clinical trials, hospitals and health maintenance organisations. The sub-scale administered in the present study examines child's satisfaction with self, school and others. Satisfaction is rated on a five-point scale from 'very satisfied' to

'very dissatisfied' on the following aspects of the child's daily life: school, athletic ability, friendships, appearance, family, and life overall.

Interview with children

The semi-structured interview (with children aged 4-16) explored information on family background and relationships, daily routines, school, understanding of being homeless, impact of being homeless on friendships and other relationships. At the end of each interview, children were asked to draw a picture of their family and of their home. Children were also invited to describe three wishes about their lives. The interview schedule was developed by the researchers. Interviews were tape-recorded and later transcribed.

Two standardised measures were also used with the children: *The Birlson Depression Scale* and the *British Picture Vocabulary Scale-II*. Instructions were explained to the children, items were read aloud to them and researchers noted their responses on the appropriate forms.

The Birlson Depression Scale

This scale was developed as a clinical instrument to be completed by children and adolescents to assess the degree of their depressive feelings (Birlson, 1981; Birlson, Hudson, Buchanan & Wolff., 1987). However, the authors caution against using this scale for the purposes of a clinical diagnosis. A total of eighteen items is included in the scale and these are worded in a child-friendly way. These items cover the most common symptoms of depression reported in children. The scale correlates highly with other measures of depression such as the *Children's Depression Inventory* (Kovacs, 1983). The score is the total score, and higher scores indicate a stronger possibility that children may suffer from depressive symptoms. Previous studies have found that only those children who had scores over 17 had been diagnosed with clinical depression.

The British Picture Vocabulary Scale-II (BPVS)

The *BPVS-II* assesses vocabulary levels and is strongly linked with the *Peabody Picture Vocabulary Test (PPVT)*. The *PPVT* has been well-established in the US since 1959. The original *BPVS* (Dunn *et al.*, 1982) was based on the second edition of the *PPVT*, known as the *Peabody Picture Vocabulary Test – Revised (PPVT-R; Dunn & Dunn, 1981)*. The *BPVS-II* is an updated version of the *BPVS*. It is partly based on the third edition of the *PPVT* (Dunn *et al.*, 1997) and has been developed in close collaboration with the authors. The *BPVS* is widely recognised as a valuable assessment instrument for educational, clinical and research purposes.

Participation in interviews and assessment using standardised measures

Of the 22 children in the sample, two children were unable to be interviewed. These children were aged 5 (female) and aged 6 (male) and, perhaps because of their young age, and the less than ideal circumstances in which they were assessed, they were unable to concentrate on and fully understand the interview questions. In the course of interviews, mothers were asked to complete the *Revised Rutter Parent-Scale for School-Age Children*. In the case of one mother, this form was left with hostel administration for the mother to complete and return. However, this form was not returned. All mothers completed the *Child Self-Esteem Parent-Scale* (extract from *Child Health Questionnaire – Parent Form*). The Birleson Depression Scale was not administered to six of the 22 children, as it was considered that they were too young or were not able to concentrate sufficiently to complete it. All children completed the *British Picture Vocabulary Scale*.

On the whole, mothers and children responded positively to being interviewed and to completing the standardised scales. The fact that mothers and children were often in the one room while being interviewed may have impacted on how they responded to certain questions and tasks. Other unintended influences must also be considered, such as the possibility that mothers believed that their participation in the research might improve their prospects of being housed and, therefore, responded in a particular way to certain questions. Similarly, in some cases, when standardised measures were being used with children, mothers prompted children and this may have impacted on how these children scored. Most children enjoyed the tasks involved. In particular, children were very enthusiastic when working with the *BPVS-II* and were reluctant to finish even when tasks had been completed. In cases where children were tired or too distracted by what was happening around them, researchers did not proceed with interviews.

CHAPTER 4: FOCUS ON CHILDREN: Family profiles

This chapter presents information on the demographic and social characteristics of ten homeless mothers and their 22 children under the age of 18. A profile of each individual family is also provided.

Demographic and social characteristics

Characteristics of families in the homeless children sample are summarised in Table 4.1. A total of 10 mothers and 22 children (10 male, 12 female) participated in the study. All of the families were headed by a female parent. Six of these ten mothers were single, three of them were married but separated, and one woman was a widow. Four of the ten women mentioned input into the children's upbringing from their present partner. These ten mothers had a cumulative total of 31 children. However, only 22 of these children participated in the present study and reasons for this included children being too old (three children), too young (one child), children being ill (one child), not living with the mother (three children) and children being in care (one child). The modal number of children of all ages was three (range 1-7) and the average age of the children interviewed was nine years (range 4-16). The majority of families (six) were living in B&B accommodation and three families were living in hostels. One family had been housed since the first part of the study. The average length of stay in present hostel/B&B was 9 months (range 1-24 months).

Table 4.1: Characteristics of families

Characteristics	Mothers (N=10) Children (N=22)
Mothers	
Single	6
Separated	3
Widow	1
Modal number of all children	3 (range 1-7)
Mean age of children	9 years (range 4-16 years)
No. of children	
Male 10	
Female 12	
Accommodation type	
Living in B&B	6 families (60%)
Living in hostel	3 families (30%)
Housed	1 family (10%)

Current and previous accommodation settings

Six of the ten families were living in B&Bs, while three families were living in hostels. As mentioned previously, one family had been housed since the first part of the study. When asked about their accommodation arrangements for the previous seven nights, all mothers stated that they had been living in the same accommodation for that period as they were at the time of the initial interview. With regard to types of accommodation used over the previous five years, eight of these ten families had spent some of this time in B&B accommodation, seven families had spent some time in private rented accommodation and five families had stayed in hostel settings. Three families had stayed some time in the previous five years with friends and three families had stayed with a friend in situations where they had nowhere else to go. Other types of accommodation or settings used by these ten families during this period included family home (two families), local authority housing (two families) and lived abroad (two families). See Table 4.2 for details of this accommodation.

Table 4.2: Types of accommodation used by families in previous five years

Accommodation used by respondents in previous 5 years	N	(%)
Bed & Breakfast	8	80
Private rented housing	7	70
Hostel	5	50
Friends	3	30
Family home	2	20
Local authority housing	2	20
Living abroad	2	20
Squatted housing	1	10
Hospital	1	10
Health Board provided	1	10

Reasons for becoming homeless

The main reason identified by women as being responsible for their homeless situations was lack of affordable accommodation. Five women identified this as the main reason. Three of these five women had returned to Dublin having lived elsewhere for some time. Another family had been living in private rented accommodation and found it impossible to find affordable accommodation when the landlord sold the house they were living in. Lack of affordable accommodation was identified as the main reason for being homeless by a fifth family that had previously lived with friends but this was now no longer possible. Other reasons which women perceived as being mainly responsible for their homelessness are outlined in Table 4.3.

Table 4.3: Categories of 'main reason' for becoming homeless (as identified by women)

Reason	N	(%)
Failure to find affordable accommodation	5	50
Eviction	2	20
Addiction problems	1	10
Overcrowding in family home	1	10
Bullied /harassed in neighbourhood	1	10

Profiles of individual families

Family 1	<p>Mother (33) and four children (F12, F9, M7, F5). One of these children (F12) lives with her father for part of the week and spends the rest of the week in the hostel with her mother and siblings. This family had been living in a hostel for eight months at the time of the second interview. All the family sleep together in one room. Dinner is available between one o'clock and eight o'clock in the hostel. However, the children don't like this food, so the mother prefers to cook something for them herself. Cooking can be difficult, as the kitchen is shared with four other families. The children go to school during the day. At week-ends and during holidays, mother and children walk around town or go to the park. Hostel regulations require them to be in by 8.30 p.m. but in general they must be in before this as regulations require that younger children must be in bed by 8.30 p.m. Previous accommodation was in local authority housing but the family was evicted due to non-payment of rent.</p>
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Family 2	<p>Mother (37) and one child (F14). The family had been living in B&B for ten months at the time of interview. Their accommodation consists of a small living room and one bedroom. The mother in this family has been ill and sometimes sleeps in the sitting-room as there is more space there. There are no cooking facilities, except for a microwave oven, so meals generally consist of take-away or frozen food. The child is not attending school at present, but her mother was making arrangements for her to return to school at the time of interview. The child generally spends her day watching television and sometimes goes into town to walk around. Both mother and daughter expressed some concern about security in the house, as some other occupants in the house are believed to be involved in drug abuse. There are no time restrictions in the B&B, although occupants must stay in their accommodation overnight. This family had stayed with the mother's family outside Dublin but had to move as there was no longer enough space for them there.</p>
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Family 3	<p>Mother (34) and 3 children (F12, M11, F8). This family had been living in a B&B for ten months at time of interview. All the family sleep together in one bedroom. There are no cooking facilities within their accommodation, apart from a microwave oven, so meals generally consist of take-away or frozen food or the children sometimes eat in their grandfather's house. All the children are attending school at present. The lack of space is difficult as the older children need more space for themselves. There is a common room within the accommodation where children can watch television. There are no time restrictions in this B&B, but occupants must stay there overnight. This mother had left her partner to return to Dublin, and the family had lived with her parents for a short while, until they were forced to move as the living conditions were overcrowded.</p>
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Family 4	<p>Grandmother (61) and granddaughter (F14). This woman had raised her granddaughter since birth. The family had been living in B&B accommodation for two years at the time of interview. An older daughter (28) also shares their accommodation. All three share a bedroom. There are no cooking facilities within their accommodation, and regulations require them to be out of the B&B between 12 p.m. and 5 p.m. As a result, the grandmother spends her day in cafés or walking around shopping centres in an effort to keep warm. The granddaughter goes to school during the day and spends much of her free time with her friends and her relations who live nearby. Occupants must stay overnight in this B&B. Previous accommodation for this family was in private rented accommodation, but they had to move as they could no longer afford to pay the rent.</p>
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Family 5	<p>Aunt (65) and nephew (M15). This woman had raised her nephew since birth. The family had been living in a B&B for over two years at the time of interview. There are no cooking facilities within their accommodation and regulations require them to vacate the premises between 12 p.m. and 5 p.m. The aunt spends most days walking around the city or staying in cafés. Meals usually consist of take-away food. The boy had left school when he was 14 and was attending Outreach services at the time of the interview. He spent much of his free time out with his friends, as he found the circumstances restrictive within the accommodation. This family had lived in a council house in England for many years and found it impossible to find affordable accommodation in Dublin on their return.</p>
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Family 6	<p>Mother (42) and four children (M16, F7, M6, F4). This mother has three other children. One of these is her daughter (21 years of age) who has a young baby and also lives with them. The second is her eldest son who is living with relatives and the third child (F9) is in voluntary care. The family has been living in a B&B for six months. Accommodation consists of one living room and one bedroom. Five people and the baby share a bedroom. The 16-year-old son sleeps in the living room. There are no cooking facilities within this B&B, so meals consist of dried food or take-away food. The younger children are attending school. There are no time restrictions in this B&B during the day but all occupants must return by 12.30 a.m. The family had been living in local authority housing prior to becoming homeless but had left this accommodation due to trouble with neighbours.</p>
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Family 7	<p>Mother (31) and child (M9). There was one other child (M6) living in this family but the mother felt this child might be too young to be interviewed. This woman was living with her partner in a B&B and had been there for one year at the time of interview. The accommodation consisted of a sitting room and one bedroom. All four members of the family shared the bedroom. There were cooking facilities in this B&B so all meals could be prepared there. The children are in school during the day. There are no time restrictions during the day in this B&B, but all occupants must return to their accommodation by 12.30 a.m. Previous accommodation for this family involved staying in friends' houses.</p>
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Family 8	<p>Mother (28) and two children (F10, F6). This family had been rehoused since the interview in the first stage of the study. Prior to that, they had been homeless for one year and living in a B&B during that time. Although there were no time restrictions in this B&B, the mother explained that she preferred to be there as little as possible as she did not want her children to have contact with others living there, many of whom were involved in drug abuse. The children were attending school and she spent most days walking around the city. After school she stayed in cafés with the children to feed them and do homework with them. This woman had previously been living in Northern Ireland but had to return to Dublin and was unable to find affordable accommodation on her return.</p>
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Family 9	<p>Mother (29) and two children (M7, F5). The family had been living in a hostel for six weeks at the time of interview but had been staying in this hostel on and off for five years. Dinner is provided within the hostel. The mother, her sister and two children sleep in one bedroom. The children are attending school and regularly spend part of the day in their grandfather's house. They can come and go as they wish during the day but hostel regulations require them to be in by 8.30 p.m. Prior to living in the hostel, the family had lived in a private rented flat. The mother feels that her drug addiction was the main reason for her becoming homeless.</p>
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Family 10	<p>Mother (42) and three children (M13, M12, F9). This family had been living in this hostel for two weeks at the time of the interview but had been homeless for over three years. There are three other children in the family. Two of these are daughters (aged 18 and 17) who also live with their mother in the hostel. The third, her eldest son, has lived with his maternal grandmother since birth. The mother and four children sleep in one bedroom which can be very difficult at times, as the mother is being treated for TB. At the time of interview, the children were not attending school although their mother was making arrangements for them to return to school. Dinner is provided in the hostel and the mother cooks other meals herself in a kitchen shared by other families. There are no time restrictions during the day but hostel regulations require them to be in by 8.30 p.m.</p>
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CHAPTER 5: FOCUS ON CHILDREN: Daily lives

This chapter presents findings on aspects of the daily life routines of mothers and children living in emergency B&B and hostel accommodation. Findings are based on interviews with ten mothers and 22 children.

Eating and sleeping arrangements

Mothers and children were asked to describe typical daily routines while living in emergency homeless accommodation. Two aspects of these routines which they described were eating and sleeping arrangements within this accommodation. With regard to sleeping arrangements, in the case of all ten families, bedrooms were shared among family members and this often involved four people (in the case of four families) or five people (in the case of three families) sleeping in one room. In the case of two families, this resulted in a situation where an adult (mother), young children and teenage children shared one bedroom.

Restrictions with regard to cooking facilities and a lack of control over planning on a day-to-day basis were mentioned frequently by mothers as a serious disruption to both their own and their children's daily routines. Most notably, women expressed their frustration with the absence of any or adequate cooking facilities in their accommodation, especially within B&B

Mother

"It's changed everything ... it's changed the way we live our life. Like I always cooked ... made sure we had a proper dinner on the table with no snacks in between but there's no proper cooking facilities so that's changed all that. You're stuck with dried food, take-away food, whatever."

settings. Families living in hostels could have their meals in their accommodation, as dinners were provided on a daily basis and there were also facilities for cooking there. However, these facilities were shared among several families and this made it difficult to avail of them with ease. Families staying in B&B accommodation were able to have breakfast in the house but, as there were no adequate cooking facilities available to most of them, they were obliged

to eat other meals in cafés or buy take-away meals. In addition to the cost of having to provide meals in this way, the lack of nutritional value provided by such food, and the barriers which these conditions presented to creating a sense of normal family life, were a concern for many mothers. Mothers felt that the pressure and stress caused by this disruption to their daily routines, in turn, affected their own and their children's physical and mental health.

This is very clearly expressed by one woman when speaking of her grand-daughter, whom she has raised since birth. She described how her

Mother

"I find that the children because they're eating lots of take-aways, they're not eating properly. They need a Sunday lunch ... you know the usual, a roast and so on. They don't get that ... they get the chipper."

grand-daughter had lost weight since they had become homeless. In this particular situation, the family were required to leave their B&B accommodation during the day. Another woman who lived in a B&B with her five children, ranging in age from 4 to 21 years of age, pointed out that the stress and pressure caused by living without essential facilities could be somewhat reduced by the provision of some kind of family centre, where meals

Mother

“That’s what worries me ... she’s [her daughter] so thin. She’s like a wire and not a pick on her. I notice she’s gone down a lot in weight and that’s since she became homeless because you can’t live out of McDonalds every day ... It’s destroying children being homeless and then you wonder how kids go on drugs and are sleeping in doorways.”

Mother

“... somewhere to go, somewhere we can go and have a proper meal like a proper family. So you’re not all over the place sort of thing. Somewhere we could feel a little more settled.”

would be available, and children and parents would have the opportunity of meeting other families.

Financial difficulties

Most of the women interviewed were unemployed and were, therefore, raising their families entirely on money they received from unemployment and child benefit. As mentioned previously, lack of adequate cooking facilities meant that most families had to eat in cafés or buy take-away food. This was an expense which many of them could ill afford and which placed a strain on their limited finances. Finding money to pay for other essentials, such as clothes for the children and themselves, was also a struggle for many mothers. Older children were particularly difficult to provide for as they were more self-conscious and aware of their appearance. One mother spoke of having to buy second-hand clothes for her daughter, but having to pretend that they had belonged to other family members as her daughter refused to wear second-hand clothes. Buying clothes for teenagers and paying for school uniforms

Mother

“I get £17 a week for [my daughter]. I have to give her a fiver every day going to school. £3 for her lunch in school and £3 for McDonalds, it’s really hard.”

Mother

“Your health and all deteriorates ... it does, there’s no saying it doesn’t, it does. I mean you’re eating here [café] every day ... it costs a bomb in here ...”

Mother

“Like I get £13.20 to keep my daughter a week. I don’t know how you’re supposed to keep any 14-year-old – small or big – now my young one is tall. I don’t know how anyone is supposed to keep a child on £13.20 a week.”

contributed to the burden of surviving financially from day to day.

Children's responses to present accommodation

Children's responses to their present accommodation situations were mixed. Some children described having lived previously in conditions which were far worse than their present surroundings, while other children expressed their desire to return to a more stable, supportive environment and this was mainly in cases where the family had previously lived with or near other family members, such as grandparents, aunts or uncles. Children described their difficulties with having to obey strict regulations, not being able to invite their friends to their accommodation, and sometimes feeling threatened or bullied by others in their accommodation.

Child (F16)

"I'm actually happy because there is people in worse situations. I mean they're actually out on the streets and they have nowhere to live at all ..."

Some children appreciated and enjoyed certain aspects of their present accommodation and one of the reasons cited in support of this was simply having somewhere to live. The kindness of certain members of staff working in hostels or B&Bs was also mentioned by some children. In some cases, children enjoyed the opportunity to play with other children

Child (M16)

"The staff and all are real nice ... I've no problems with them or anything."

within both the hostel and B&B settings. One child (12) described how she enjoyed watching television in the company of other children in the TV room and being able to "play with the little kids".

Having a secure area to play in with other children was important to those children living in

Child (M7)

[living in hostel]
"What I like about it here is that you get nice dinners and there's a play area."

one hostel, where there was a dedicated children's play area. Toys and games were provided for the children to share and this allowed these children the opportunity to play with and get to know other children living in their accommodation. In contrast, however, most accommodation settings involved very restricted space and many children had little or no access to areas

suitable for safe play activities. This difficulty was further compounded by the fact that mothers worried about their children's safety, both within and outside of their accommodation, as neighbourhoods were not familiar to them, and problems such as alcohol and drug abuse were common within their accommodation.

Child (F9)

"I found the top off a needle in the room that I was in and that's why I hate it."

Interviews with both mothers and children revealed this concern for their safety and security within the environment they were living. Fears were related specifically to alcohol and drug abuse by other occupants in their accommodation, and mothers reported anxiety with regard to their children mixing with other children in neighbourhoods which they felt were not always

Mother

"You have to worry about the kids here because a lot of their parents are drug abusers. 90% of people would be like that and we don't want our kids to become that way from mixing with them."

appropriate for them. One mother described her fears about simply allowing her 14-year-old daughter to go out in their neighbouring area. She compared her situation with that of living in a familiar environment where, to some extent, you could rely on neighbours to

supervise children and could, therefore, allow children to go out and play with friends without having to be constantly concerned about their safety. Problems arose within accommodation in some cases. In one instance, a woman described how her two children, aged 10 and 6 years of age, had witnessed a young woman attempting suicide by cutting her wrists in the emergency

Mother

"Like you'd look out your window and you'd know your child ... who she's with and what they get up to ... like you'd know by their parents what they're like. Here, I can't let her outside the door because I don't know what's around ... it's too dangerous. So she's stuck here."

Mother

"Like one of the girls cut herself up and came into the living room. She's suicidal and she just slit her wrists and walked out and we went out to me ma's and me ma sat them down and told them 'where you're living is not the right place'."

accommodation. The children were confused and distressed and it was difficult for this mother to explain to them what was happening.

Another aspect of emergency accommodation which seems to impact adversely on children's

daily lives is the existence of strict regulations in both hostel and B&B settings. Mothers and children reported increased pressure in their daily lives due to these restrictions. For younger children, having to be in bed by a certain hour and being told what to do by members of staff working in hostel accommodation were mentioned as particular difficulties. The effects of other restrictions, in terms of confined space and freedom to come and go, seemed to have more serious implications for older children (teenagers), who were unable to stay out late with friends and who had no access to private spaces within their accommodation. One boy (15) pointed out

Mother

"Bedtime is tension now. Not just fun and games like it used to be. It's little things they miss like getting a jockey back up the stairs ... they can't just shout out for a glass of water and come downstairs again for a while ..."

that he was constantly worried about making too much noise or upsetting other occupants in the B&B where he was staying. His mother described how he spent as much time out with his friends as possible, in order to avoid having to return to his accommodation.

Child (M15)

"You have to keep the noise down at all times, you know, you've got to sneak around ... you can't really do anything here."

School

In the present study, mothers were asked to provide information with regard to their children's attendance at school (a) in the past

month and (b) in the past 12 months. Sixteen of the 22 children were reported to have attended school *regularly* in the previous month. Five children were reported not to have attended school *at all* during this previous month and one child was in contact with outreach services. With regard to the previous 12 months, interviews revealed that 13 children were reported to have attended school *regularly* in this period, while one child was reported *not* to have attended school *at all*.

When asked about the numbers of schools their children had attended over the previous two years, mothers reported that 16 of the 22 children had attended the same school, three children had attended two schools, one child had attended three schools and one child had attended four schools over this two-year period. One of the children had left school prior to this period. One 16-year-old boy who had left school at the age of 14 described how difficult it was to “get his life together” given the uncertainty of his family’s accommodation and the constant threat of

Child (M16)

“We were being moved around a bit at the time ... I was a bit wild at that time but I’ve calmed down a lot now and I’m trying to get me life together but I can’t really in here ... hopefully when we get a house.”

being moved to a new place. Another child (14) was trying to get into a school in a particular area in Dublin not far from her present accommodation. Her mother expressed concern at her absence from school and of the possible negative consequences for her future.

With regard to patterns of early school leaving, two of the 22 participant children had left school before the age of 16.

Changes in the location of their accommodation can also represent an obstacle to regular attendance at school. Present findings, however, suggest that a majority of children in these homeless families who were attending school (80%) had been going to the same school over the two years prior to being interviewed.

Mother

“She is very good at school, even at the age of 7, like she was a great writer and speller ... like I left school when I was very young ... she’ll be going into her second year this year and I think she’s very good. I think she’ll go far if she’s given a chance.”

Constraints, in terms of insufficient cooking and washing facilities, added to the burden of preparing children for school in the mornings. Practical difficulties, in terms of getting children ready for school, and finding an appropriate space and time for children to do homework, were concerns expressed by some women. One mother reported difficulties with regard to preparing

Mother

“If you needed to get washed in the mornings, you’d find it very hard so there was mornings where you’d wipe the kids down with a baby cloth rather than use the bathroom where somebody could be asleep.”

children for school as bathrooms were shared with a number of others and sometimes unfit for use. She went on to explain how she was often forced to do

homework with her children (aged 6 and 10) in a café, as it was not possible to find a suitable place in her accommodation. Most of the children interviewed did homework in bedrooms or on a table in a communal kitchen.

Despite the practical difficulties described above, in-depth interviews with these ten families revealed that, for some of these families, education is a priority. Some mothers pointed out that, regardless of the difficulties involved, they were very anxious that their children would have the opportunity to obtain an education, which they themselves very often had not had. In

Mother

“My motto is even if you’re dying, you go to school. You like it or lump it.”

addition to this, some children recognised that school could offer them some form of stable routine which was absent from much of their daily lives.

Child (F16)

“I like school because you know where you’re going to and you’ve something to occupy yourself for a couple of hours.”

Twenty-two children in the second stage of the study were assessed for levels of English vocabulary acquisition (BPVS-II), and their levels of self-esteem with regard to a number of aspects of their lives, including school (extract from CHQ-Parent Scale). Scores on the BPVS-II indicate that 17 of these 22 children (77%) had scores which suggest that these children were not doing as well as other children of their age on this measure of vocabulary acquisition. With regard to self-esteem levels related to school abilities, mothers reported a high proportion of children (43%) to be either very satisfied or somewhat satisfied with this aspect of their lives (see Table 7.6 for details of scores on BPVS-II and Table 7.4 for details of scores on *Child Self-Esteem – Parent Scale* (sub-scale of *Child Health Questionnaire*)).

Children’s understanding of homelessness

How do children understand the concept of homelessness and respond to the homeless situations in which they are living? This question was explored in the interviews with children, and a variety of explanations and responses were recorded. Children were asked if they had previously heard the word ‘homeless’ and whether they understood it. Only three of the 22 children stated that they had not heard the term homeless previously and, therefore, had no understanding of it. All of these children were less than 7 years of age. The remaining children expressed their understanding of being homeless as “having no home” or “not having anywhere to live” and some children, therefore, emphasised that they didn’t consider themselves as being homeless. Among the children who offered a definition of

Child (F12)

“Someone with no home ... it means someone who has nowhere to go but I have here ...”

Child (M, 13)

“Yes [we are homeless] and no ’cos we have somewhere to stay but we don’t have a house.”

Child (F7)

“You have no money, you don’t have a house, you’ve to sleep on the streets and you’re very tired and you can’t go to sleep or nothing and you can’t eat and you have no money to eat ...”

homeless, four children

defined it further as “having to sleep on streets” while three of the children highlighted lack of stability as being central to the concept.

Child (M15)

“[Homeless is] that people don’t have a place to settle down in” and “it means that you go from one place to another.”

Children’s wishes

Some children (N=16) were invited to imagine three wishes. A majority of children, 11 out of 16, wished for a house as either their first or second wish (7 children as first wish and 4 children as second wish). Some children specified where they would like their house to be and areas included Dorset St., Clondalkin and Darndale. Reasons for these choices were sometimes because other family members such as grandparents or cousins lived there. For the older children who were interviewed,

Child (M9)

“I wish mammy to have a house in Clondalkin and that nanny could come up to see us ...”

Child (M16)

“I’d wish for loads of money ... and to keep me and me family safe at all times.”

the safety of their families was very prominent in their wishes. Three of the 16 children expressed the wish that their family would be safe and well, and all of these children were 15 years of age and over.

Child (M11)

“I’d like to be rich and to live in a mansion.”

Many children (50%) also expressed the wish that they and their families could “have loads of money”. Among the other things children described in their

wishes were “loads of little dolls ...

communion dolls to play with” and “to have a whole collection of Furbies”. One child (16) commented that she hoped she would never be homeless when she was older.

Child (F9)

“I’d like to have a house and loads of money and to have waitresses coming in to the house to cook and things...!”

Child (F14)

“I wish to do well and I hope I’m never in this situation [being homeless] when I’m older.”

CHAPTER 6: FOCUS ON CHILDREN: Relationships

This chapter presents findings from interviews with ten homeless mothers and 22 of their children on aspects of children's relationships with family and friends.

Relationships between mothers and children

A total of 22 children under the age of 18 were living with their mothers in emergency homeless accommodation in the second stage of the study. Interviews with these ten families revealed that, in the case of four families, one child in each family was not living with their mother on a full-time basis. However, three out of these four children were reported to have regular contact with their mother and with other members of the family.

The disruption of family routines and the difficulties in maintaining some form of stable family life while living in emergency accommodation settings appeared to place an additional strain on the relationship between mothers and their children. When asked to describe their children's feelings about being homeless, mothers reported that children asked persistently

Mother

"They [children] keep asking me when are we going to get a house and it's wearing a bit thin now ... I'm on two lists now -- the priority list and another list and we're going to be put on another list to say how long we've been on the homeless list."

when they would be housed, and felt angry and disheartened when nothing was done to help them. Some mothers also spoke of how their children were angry with them, and blamed them for not being able to

provide them with a home. In turn, some mothers reported feeling a sense of frustration and failure as a parent because they were unable to provide their children

Mother

"They're always asking 'when are we going to get rehoused?' Why is it our friends have got a house and we haven't?"

Mother

"I suppose I feel something of a failure ... it's just I do get depressed and then I do be in bad humour."

with a stable home.

These mothers reported feeling depressed and bad-humoured as a result of this feeling of frustration and this had negative consequences for how they responded to the demands of their role as parents.

Mother

"It frustrates me because I feel I'm not doing the things I should be doing for them ... that's why I'm trying to push to get a house and ... make it better for them and make life easier for them. It's very frustrating being a parent in this position."

Barriers to parenting

All mothers interviewed in this second stage (N=10) emphasised the negative effects that being homeless had on their role as parents. Most notably, 80% of mothers reported having less patience in their everyday interactions with their children and children, in turn, were described as being less tolerant and less understanding than previously. One reason suggested for this difficulty was that mothers and

Mother

“If we had had a break from each other, like if they had their own bedroom and I had my own bedroom and they came in to show me a picture, I’d be able to see it and be interested in it whereas when we were in the same bedroom, I seen them drawing it and I’d be like ‘yeah, that’s alright, it’s grand, I seen you doing it’ and they felt the effects of that as well.”

children were forced to be together at all

times, apart from when children were at school. In addition to this, confined space and lack of privacy within the accommodation itself contributed to feelings of frustration. Mothers reported being more irritable with their children in some cases, and an increase in conflict between their children, which they felt was due, to some extent, to their living conditions. While most mothers believed they were able to continue giving children adequate

Mother

“She gets cranky. She was always very loving and quiet. I think it’s made her a bit wilder as well. She’s inclined to say ‘I don’t care’.”

attention, many of them remarked that the quality of this attention was diminished by the fact that they had little control over their daily lives.

Other factors which were highlighted by mothers as contributing to the increase in pressure and stress in their role as parents included having to adhere to strict regulations (especially within

Mother

“If I’d me own house I’d be up and doing things ... like doing our own bit of housework, you wouldn’t have anybody to tell you what to do ... you just can’t do them here, you just can’t ... there’s just a pressure on you all the time, just pressuring me all the time.”

Mother

“He’ll still come and talk to me but he doesn’t do it as much as he used to do and I suppose it’s more difficult for me to be able to know where he is and to keep an eye on him ...”

hostels), and worrying about security within the accommodation and in the surrounding areas. Finding time and appropriate space to give children attention was also mentioned as a problem for many mothers. One mother explained how she felt her son had grown away from her and was less likely to confide in her, which she felt was largely due to the circumstances of their homelessness.

Children’s behaviour problems

In the present study, many mothers described how their children’s behaviour had deteriorated since becoming homeless, and this added to the difficulties and pressures they were already trying to cope with. This deterioration manifested itself in a number of ways, including

increased fighting and squabbling among the children themselves, mothers reporting less thoughtful and caring behaviour on behalf of their children, and increased irritability on the part of the children and themselves. In some cases, this deterioration in children's behaviour was apparent largely through a change in their moods and this had consequences for how the mother related to the child. Several mothers also highlighted increased irritability and fighting among their children since they had become homeless.

Explanations offered for this included the absence of a stable daily routine and lack of space or privacy. Another consequence of the lack of space and privacy was that mothers found they had less patience and tended to lose their tempers with children more easily and this, in turn, had a negative effect on the children's behaviour. In one case a mother described being unable to cope with the negative effects which being homeless had on children's behaviour and having to seek help from school services as a result. This family had been re-housed since the

Mother

"She's after changing an awful lot. She's not as active as she was when we moved here. She's got a lot more grumpy."

Mother

"Like there's just no privacy and at that age (16) you need to have privacy. And the younger kids can't really go out and play on the road like they used to ... you can see the way they fight more together because they just don't have enough space for themselves."

Mother (re-housed)

"I went and I was telling them they had to take the kids off me hands because I just couldn't handle them... Now (since being rehoused) it's just so relaxed, not tensed up ... I was really losing my tether ... I would be squealing and shouting whereas I don't have that here but it was just the build-up. I couldn't handle the build-up and a lot of it would come out on the kids then. I've noticed them settle down now ... they're just more relaxed."

interview in the first stage of the study had been carried out. The mother went on to describe how different the situation was from when they had been homeless. Looking back, she was able to understand how her behaviour and the behaviour of her children had been negatively affected by the circumstances of their living

conditions while being homeless. In contrast to this, since moving to their new home, this mother described generally feeling more relaxed and a noticeable improvement in her children's behaviour.

Children's contact with fathers

All families in this second stage of the study (N=10) were headed by a female parent. These mothers were asked to indicate whether their children had contact with their fathers. Almost

Child (F, 12)

"Me mam and dad used to be able to see each other as much as they wanted ... we went on our holidays and me mam and dad were allowed to stay together, that's what I like."

half of these children (45%) had some contact with their fathers, although only 4 out of these 22 children (18%) had regular contact

with their fathers. This lack of contact was not a direct result of being homeless but due to a variety of circumstances including death, domestic violence, mothers becoming pregnant at an early age and losing contact with the father of their children, etc. One child, however, when asked about likes and dislikes of her present accommodation, pointed out that she disliked the fact that her Mum and Dad could not be together in the hostel.

Children's contact with other family members

A high proportion (77%) of the children in the sample (N=22) had regular contact with grandparents, the majority of these being maternal grandparents. A smaller but substantial proportion (54%) had regular contact with other family members such as aunts, uncles and cousins. Contact with family members was generally maintained through visits to grandparents' houses and, in some cases, children were provided with at least one meal there daily. Despite the fact that many families had some contact with other family members, it was evident from the interviews that mothers within the sample felt that at times they were a burden on their families, and had difficulty coping with the lack of independence which accompanied their homeless situation.

In some cases, where previous accommodation had been with the mother's family, children continued to go to school in this area, and this allowed for contact on a daily basis between children and their grand-parents and other family members. Many of the neighbourhoods in which

Mother

"Other members of my family found that the kids were aggravated and like they'd go to me mam's and they'd be annoying me brothers and before we lived in the hostel there wouldn't be any of that."

these women and their children were living were unfamiliar to them, as they were likely to be

Mother

"She was seeing him (grandfather) every week but I had to put a stop to it because she was staying overnight and we were having trouble with the welfare so she hasn't seen him in five weeks and I think she misses him ..."

living there for short periods of time. They, therefore, lacked local support which might generally be available from the sense of belonging to a

particular community. Contact with other family members might help to compensate, to some extent, for this absence of social support. However, this contact with other family members was not always easy to maintain, especially if relations lived outside Dublin, as regulations in both hostel and B&B settings required occupants to stay there overnight at all times.

Contact with friends

Mothers

With regard to making and maintaining friendships, there were a number of difficulties within these homeless situations. In many cases, mothers had sole responsibility for their children and as there were no child-minding facilities available within the accommodation, they were often

Mother

“It’s just that when I close my eyes they [the children] are there... I wake up in the morning they’re there ... constantly”

obliged to be with their children at all times apart from when they were in school. Getting out and meeting others was especially difficult for mothers living in hostels as they were required to be in by

8.30 p.m. A combination of these restrictions on their freedom to come and go as they wished and the necessity of having to be with all of their children most of the time presented obstacles to their establishing friendships outside their immediate environment.

Mother

“If we were allowed to babysit for each other and allowed out for a couple of hours at night or in the day. The kids have to come everywhere with me, even to the Corporation and even in the rain ...”

Children

The impact of homelessness on children’s friendships was explored in interviews with these ten families, and both mothers and children indicated a number of difficulties for children in terms of making new friends and being able to meet with friends on a regular basis. As

Mother

“She hates it [being homeless] ... she really does. She hates it. I’d say a few of her friends know she’s homeless but she’d never tell them ... she’d never admit to anything. They kind of look down on homeless, so they do ...”

mentioned previously, visitors were not allowed in hostels or B&Bs, which made it impossible for children to invite their friends to play in these settings. Contact with friends was generally maintained in schools in cases where children had been attending the same school for a regular period. Friendships within

their accommodation were sometimes easier for children to form, especially in hostels where certain areas were designated for children to play together. However, the transient nature of this accommodation makes it difficult for children to keep up contact on a more permanent basis.

As mentioned previously, mothers’ concerns regarding children’s welfare, in an environment where some occupants were involved in alcohol or drug abuse, added to the difficulties experienced by children in their

Child (F12)

[speaking about frequent moves and leaving friends]

“‘Why are you not crying?’ they [friends] said because they were crying ... and I said, ‘because I’m used to it’.”

daily contact with other children. With regard to maintaining contact with friends from previous accommodation, 55% of children reported being able to do so and this was mainly achieved through visits to grandparents' houses where children had lived before becoming homeless, or through attendance at school. However, mothers added that although children might be able to continue friendships to some extent and managed to have regular contact with other members of the family, they were not able to participate fully in activities, as they did not belong to a particular community. In one case, where children tended to play with other children living near their grandfather's house, their mother explained that they were often excluded from communal activities in the area. "It's just that if there is something going on over in the flats (grandfather's), they just can't go but yet they're over there a lot."

The stigma attached to being homeless also represented a problem for children's relationships with other children, and this was particularly so in the case of older children, who were, perhaps, more aware of how they might be perceived by others.

Many children, especially older children, felt embarrassed about being homeless and refused to let their friends know where they lived. This,

coupled with the fact that it was not possible for them to invite their friends in to the hostel/B&B at any time, represented a major obstacle to children establishing or forming stable

Child (F, 9)

"My friends wouldn't come up here ... they think it's a dump."

Mother

"She won't tell people that she's homeless because she's embarrassed about it ... I don't blame her, I would be as well."

friendships. Older children also had difficulties with time restrictions imposed by B&B/hostel as they had to be back in their accommodation at a certain time, usually early in the evenings.

CHAPTER 7: FOCUS ON CHILDREN: Health and behaviour

This chapter outlines findings from interviews with ten mothers and 22 of their children on aspects of children's health, behaviour and general well-being.

Mothers perception of Children's Health Status

Mothers were asked to rate the status of their children's health on a five-point scale, ranging from excellent to poor. In most cases, children were rated as having excellent, very good or good health – five of the 22 children were rated as having *excellent* health, seven children as having *very good* health and nine children as having *good* health. Only one of the 22 children interviewed was rated as having *fair* health and none of the children was rated as having poor health. See Table 7.1 for details.

When asked to comment on particular aspects of their child's health problems, mothers reported seven of the 22 children currently suffering with head lice, while four children suffered from asthma; one of these was rated as *very bad* asthma. In all cases where health problems were noted, children were reported to be receiving treatment. Two of the participant children were reported to be receiving counselling. The above ratings were for those children who took part in the present study. For various reasons, some children belonging to these families were not interviewed – due to their age, the fact that they were living with someone other than their mother, or other circumstances. One of these children (aged 17 years) was involved in drug abuse and had taken an overdose on two occasions.

With regard to children's immunisation and vaccination status, mothers reported that nine of the 22 children had received *all* their vaccinations, 10 children had received *some* of their vaccinations and in the case of three children, mothers were unable to say. See Table 7.1 and 7.2 for details of children's perceived health status and reports of vaccinations received.

Table 7.1: Child's health status as perceived by mother

	Excellent	Very Good	Good	Fair	Poor
Mother's perception of child's current health status (N = 22)	22%	32%	41%	5%	0%

Table 7.2: Mothers' reports of vaccinations received

	All	Some	Don't Know
Mother's reports of vaccinations received	41%	45%	14%

Use of General Practice (GP) services

Mothers were also interviewed with regard to the frequency of visits to their GP for health problems experienced by themselves and their children. Regarding their own health problems, 6 of the 10 mothers had attended their GP at least once in the six months prior to being interviewed. An average of six visits per mother was recorded over this period (range 1-12 visits). Reasons for attendance included repeat of prescription (three mothers), post-operative care and respiratory problems (one mother), routine check-up (one mother) and tuberculosis (one mother).

With regard to their children, six mothers reported having attended their GP for treatment concerning their children. An average of three visits per mother was recorded (range 1-6) and health problems among children included asthma, adenoid problems, coughs and colds.

Mothers were also asked to rate their satisfaction with GPs under the following headings: *Satisfied/ Dissatisfied/Neither one or other/Other*. Eight out of ten mothers had attended their GP in this period and they rated their satisfaction as follows: five mothers reported being *satisfied*, two mothers reported being *neither one nor the other* and one mother reported being *dissatisfied*.

Information regarding instances of physical or sexual abuse in the case of these 22 children was not reported or discussed in this part of the study, as it was felt that, given the relatively small number of children involved, individual children and families might be easily identifiable.

Standardised measures of children's behaviour, well-being and vocabulary acquisition

Revised Rutter Parent Scale for School-Age Children

A total of 18 children (9 male, 9 female) were assessed, using the *Revised Rutter Parent Scale for School-Age Children*, to determine whether there was evidence of emotional or behavioural problems. Results revealed that just over half of the children sampled in the present study had scores indicative of the presence of behaviour problems. Using a cut-off of 11 points or more, 12 of the 22 children scored above this, with a mean score of 17 points (SD: 9.2; range 3-36 points). However, it is important to point out that a wide range of scores was recorded on this particular scale. Further breakdown into sub-scales revealed a mean score of 4.7 (SD: 2.3;

range: 1-8) for emotional difficulties (possible total 10), a mean score of 3.7 (SD: 2.9; range 1-10) for conduct difficulties (possible total 10), a mean score of 2.5 (SD: 2.5; range 0-6) for hyperactivity/inattention (possible total 6), and finally a mean score of 17 (SD: 2.3; range: 13-19) for pro-social items (possible total 20). See Table 7.3 for details.

Table 7.3: Revised Rutter Parent Scale for School-Age Children (N = 18)

Total	Mean	Standard Deviation	Range	Critical Range	% Critical Range
	17	9.2	3-36	11-52	67
Sub-scales					
Emotional	4.7	2.3	1-8	-----	-----
Conduct	3.7	2.9	0-10	-----	-----
Hyperactive	2.5	2.5	0-6	-----	-----
Pro-social	17	2.3	13-16	-----	-----

Child Self-Esteem Parent-Scale – (Extract from *Child Health questionnaire – Parent Form*)

A total of 22 children (10 male, 12 female) were assessed on this scale to establish their level of satisfaction with self, school and others. Mothers' reports of their children's self-esteem tended to be reasonably high in most of the areas involved. The majority of children (15 out of 22 children) were perceived to be either *very satisfied* or *somewhat satisfied* with their school abilities. Thirteen children were rated as *very satisfied* or *somewhat satisfied* with their athletic abilities, 15 children with their friendships, 16 children with their appearance, 12 children with family relationships and finally 12 children were reported in these categories with regard to their feelings about their life overall. None of the children was reported to feel *very dissatisfied* with regard to family relationships. However, seven children (32%) were reported to feel *somewhat dissatisfied* with their family relationships. See Table 7.4 for details of these reported scores.

Table 7.4: Child Self-Esteem Scale (Extract from CHQ-Parent Form)

(N = 22)	very satisfied %	somewhat satisfied %	neither satisfied nor dissatisfied %	somewhat dissatisfied %	very dissatisfied %
School	36	7	18	9	5
Athletic ability	54	5	32	9	0
Friendships	50	18	9	14	9
Appearance	50	23	9	14	5
Family	27	27	14	32	0
Life overall	9	41	14	23	9

Birleson Depression Scale

This scale assesses the extent to which children may suffer from depressive symptoms. The authors point out, however, that a clinical diagnosis must not be made on the basis of a high score alone (Birleson, 1978, 1981). The score is a total score and higher scores are more indicative of the presence of depressive symptoms. A total of 16 children (7 male, 9 female) were assessed on this scale. The remaining six children were unable to complete the assessment, as they were either too young or could not concentrate sufficiently to complete it. A mean score of 9.4 (SD: 6.3; range 1-21) was recorded for those children assessed. In the normative data, the mean scores for boys and girls aged 11-15 years of age ranged between 8.24 and 10.96, with girls reporting more depressive symptoms (mean: 9.30; SD: 4.71) than boys (mean 7.76; SD: 4.14). Consistent with these norms, girls assessed in the present study (N = 9) recorded higher scores on this scale, with a mean of 12.6 (SD: 5.24) while boys (N = 7) recorded a mean of 7.28 (SD: 5.99). Birleson (1978) reports that, in the original small study conducted for the development of the scale, only children with a clinical diagnosis of depression scored over 17.

Table 7.5: Birleson Depression Scale (N = 16)

Mean	Standard Deviation	Range	Critical Range	Critical Range	
				N	%
9.4	6.3	1-21	17-36	3	19

Scores on the *BPVS II* have already been discussed in Chapter 5, in the context of children's school attendance. The majority of children (82%) recorded scores which suggest that their vocabulary levels are lower than average for their age groups (see Table 7.6 below).

Table 7.6: British Picture Vocabulary Scale – II (N=22)

Mean standardised score	Standard Deviation	Range	% below age equivalent
87	11.3	72-111	82

CHAPTER 8: DISCUSSION

In this chapter, findings from both the initial study⁷ and the follow-up⁸ study are discussed. In the initial study, findings based on mothers' reports provide information on the possible adverse consequences, for children's health and school attendance, of living in homeless circumstances. In the follow-up study, qualitative interviews with ten homeless mothers and their children enable us to gain further insight into the particular stresses and demands on their daily lives, such as the uncertainties of living in emergency accommodation and the impact of this on children's relationships with family and friends. Standardised measures in this second stage also provide us with information on these children's behaviour and emotional well-being. It is important to reiterate at this point that the sub-sample of ten families, who were interviewed again in the second stage, represents a small proportion of the original sample. Many families were unwilling to take part in the second stage, and reasons for this included the difficulties they had experienced while being homeless, and their desire to protect their children from the possibility of any further distress. This sub-sample is, therefore, not representative of the original sample.

Homelessness in Dublin

Approximately two-thirds of the women in both stages of the study were living in B&B accommodation while the remainder were living in hostels. Many of these participant families in the original sample had been homeless for an extended period of time. In *One Hundred Homeless Women* (Smith *et al.*, 2001), based on a definition of *long-term* homelessness as being one year or longer, just over half of the homeless women who took part in the study fall into this category. Of the ten families interviewed in the follow-up study, the majority had been living in their current emergency accommodation for over six months and some families had been there for up to two years. The Focus Ireland report *Focussing on B&Bs: The Unacceptable Growth of Emergency B&B Placement in Dublin* expresses concern about living for extended periods of time in emergency accommodation (Houghton & Hickey, 2000). The authors suggest that the increase in the number of nights spent in B&Bs by homeless households reflects the lack of move-on accommodation for both hostel and B&B users, and slows down the possibility of movement through the cycle of homelessness. In *Shaping the Future: An Action Plan on Homelessness in Dublin 2001-2003*, a recent publication by the Homeless Agency (2001), this concern about the long-term use of emergency accommodation

⁷ In this report, we present findings from interviews with 80 mothers on information relating to their children.

⁸ Further interviews with ten homeless mothers and 22 of their children living with them in emergency accommodation.

is acknowledged. The ultimate aim of the plan is to reduce the length of stay in emergency accommodation to a number of weeks at most. A more immediate aim is that, by 2003, no one will be in emergency accommodation for longer than six months. However, the point is also made that, as there is a lack of immediately accessible move-on accommodation, it will take some time for these changes to be implemented. It is, therefore, important to have a clear picture of the impact of living in this accommodation on the lives of those families currently being housed there.

The majority of participants in this study perceived “lack of affordable housing” as the most common reason for their homelessness. Domestic violence, family problems and addiction problems were the next most common reasons cited. These latter findings echo findings in the Focus Ireland report (Houghton & Hickey, 2000), which indicated that the principal reasons for becoming homeless were family conflict, drug addiction and domestic violence. Findings from both these studies indicate clearly, therefore, that a combination of social factors, such as the high cost of housing and, more particularly, individual problems such as family conflict and addiction, continue to place these vulnerable families at risk of homelessness. Consistent with these findings in an Irish context, there is growing recognition in the UK that homelessness often arises where families have to leave stable accommodation to escape from situations of family conflict, particularly domestic violence (Vostanis, Cumella & Grattan, 1999; Watson, 1999).

It is evident from these studies, therefore, that it is necessary to respond more effectively to the needs of individuals and families who are forced to leave their homes under such conditions. One such response is outlined in the *Shaping the Future* (Homeless Agency, 2001), where the importance of providing more refuges for women is emphasised, as is the necessity of offering active support and training to these women, in addition to shelter. It is essential that counselling is easily available for these women, and for the children in their care who may be witnesses to such abuse. With regard to the link between addiction and homelessness, mothers described how their addiction to drugs and/or alcohol, or the addiction of one of their children, made it impossible for them to find stable accommodation. One mother described how her teenage daughter’s drug-use was the reason for the family’s eviction from previous accommodation. This daughter had attempted suicide on two occasions around the time of the eviction. In another case, a mother described how the family had been evicted from their home of 30 years due to the drug-dealing behaviour of her adult sons. Stories such as these underline the fact that the possible causes of homelessness are complex and often involve a combination of adverse circumstances often beyond the control of those on whom they impact. In addition, these stories highlight the importance of responding in a more holistic way to the needs of homeless people, and others living in circumstances of poverty and disadvantage, by taking

these circumstances into consideration, and by providing support and protection for the children in their care. It is worth noting at this point that the ERHA has agreed that 52% of current childcare service finances will be specifically allocated to prevention and early intervention work with vulnerable families in communities. The aim is to offer support to these families within their own communities at an early stage, rather than focusing exclusively on crisis management.

Living conditions within emergency accommodation

Interviews with mothers revealed that not having access to essential facilities within their accommodation represented a major disruption to their daily lives and those of their children. Most notably, findings highlighted a lack of adequate cooking facilities and an absence of facilities for food storage and refrigeration. As a result, most families were obliged to eat in cafés or to buy take-away meals, which were expensive and so added to the difficulties of raising children on very limited financial resources. The lack of nutritional value provided by such food, and the barriers which these conditions presented to creating a sense of consistent family life, were concerns for many mothers. In addition, findings from interviews with 80 homeless mothers in the initial study revealed that half of these families were required to leave their accommodation during the day (Smith *et al.*, 2001). These mothers described spending much of their time walking around shopping centres, sitting in cafés, often trying to keep warm or dry, especially during the Winter. All the mothers living under these circumstances emphasised the negative effect that this lifestyle had on their health and on the health of their children. However, it should be pointed out that since these interviews with homeless mothers were carried out, Dublin Corporation has recently changed its service arrangements with B&B owners so that they must now allow homeless users of their facilities to stay in their accommodation during the day.

Studies in the US and UK have documented the inadequacies of facilities within temporary living situations and these include lack of cooking facilities, lack of facilities for food storage and refrigeration, overcrowding with regard to bathroom and sleeping areas, and the absence of any opportunities for privacy within the accommodation (American Academy of Paediatrics, 1996; Vostanis & Cumella, 1999). Similarly, in Ireland, previous reports of daily living conditions for children and families in homeless accommodation show that, although efforts have been made to improve the standards of accommodation, many shortcomings can still be identified (Moore, 1994; Houghton & Hickey, 2000). It is difficult to estimate the importance of a home as a setting where parents and children can develop familiar routines, where there is adequate space for essential activities such as eating, sleeping and children's play, and where families can feel that they have some control over the planning of their daily lives. The absence of such an environment is likely to create barriers to providing children with the setting they need in order to negotiate their role within their families and in the wider

Overcrowding within both hostel and B&B accommodation added to the strain, for mothers and children, of coping with these inadequate facilities. In general, families shared one bedroom and a living-room area, and this made it impossible for older children and adults to have any private space or time for themselves. Barnes (1999) highlights research which indicates that crowded conditions alone can have an impact on the quality of parenting, and concludes that a combination of these conditions and the added pressures which accompany homelessness are likely to have an even greater impact. The author also draws attention to parent-child conflicts which may emerge as a result of overcrowding and what she terms “unwelcome proximity” to other families in emergency accommodation such as hostels or B&Bs. A deterioration in children’s behaviour since becoming homeless was reported by many mothers, and some children were reported as being “more irritable” and “less thoughtful” than previously. In turn, some mothers were aware that they themselves had less patience with their children and this was attributed to the pressures they were experiencing as a result of being homeless. Many mothers were not happy to allow their children out to play alone in the surrounding neighbourhood and this meant that these children were forced to spend a lot of time in their accommodation. Spending large amounts of time in a confined space added to the pressure for mothers coping with children’s behaviour problems, and contributed generally to the strain on family relationships.

Children’s responses to living in emergency accommodation

Particular problems for children

A number of problems for children living in emergency accommodation settings were evident from interviews with both mothers and children in the second stage of the study. One such problem was anxiety about their safety within their accommodation. For mothers, this concern was largely to do with the welfare of their children in both hostel and B&B settings where other occupants were involved in drug or alcohol abuse. In addition, neighbourhoods were often unfamiliar to families and, in some cases, mothers clearly did not wish their children to go out unaccompanied. Some children described feeling intimidated and bullied by other occupants. Many mothers and children also mentioned finding it difficult to live comfortably with strict regulations within their accommodation. For mothers, this was explained largely in terms of feeling a pressure on them to behave in a particular way, and not being able to develop their own routines and have some control over the planning of simple, everyday activities. For children, the main restriction highlighted in interviews was the fact that they were not allowed to invite friends or other family members into their accommodation and that, within hostel settings, they had to be in bed by a certain hour. Older children (teenagers) also spoke of feeling unhappy with regulations which required them to return to their accommodation by a particular hour in the evening, and described having to worry constantly about disturbing other occupants within their accommodation.

One of the most positive findings regarding children's responses to their temporary accommodation was in relation to play facilities within one of the hostels where three of the participant families in the second stage of the study were living. In this particular hostel, an area was dedicated to children's play and toys were provided for children to share. Most of the children interviewed living in this hostel highlighted this facility and this was in contrast to the lack of provision for children's play in B&Bs where there was little or no appropriate space for children to engage in safe play either within or outside their accommodation. One interesting recent development within some B&Bs is the provision of toys and organised activities for children by the Ana Liffey Play Project. This has been very well received by children and parents in these B&Bs, but the project has had very limited access to most B&Bs, as landlords have refused to allow the service to be provided within their accommodation. Investment in similar projects, offering children an opportunity for simple, creative play activities, either within their own accommodation or through the development of family programmes, could help to alleviate some of the frustration children experience within the confined space of their accommodation. Mothers would also have the possibility of spending some time apart from their children, which may also help them to cope with the limitations of their accommodation.

Social isolation

Children's contact with parents

An important finding in the present study is the fact that many of these children of homeless mothers did not have regular contact with one or other of their parents. In the first stage of the study, 83 of the 173 children did not live with their mothers as primary carer, and half of these 83 children had not had regular contact with their mothers in the 12 months prior to interviews. Just under half of these 173 children had had no recent contact with their fathers during the same period. Findings from qualitative interviews in the second stage of the study revealed a similar picture with regard to children's contact with fathers, with only four of the 22 children having regular contact with their fathers. A previous study in an Irish context reflects these findings, with 12 out of 14 homeless families being headed by a lone female parent and, in each of these 12 families, fathers were reported not to be engaged in supportive relationships with either their ex-partner or their children (O'Brien, 2000).

Contact with other family members and friends

Contact with and support from other family members, such as grandparents, aunts and uncles, seemed to be quite positive for many of the ten families who participated in the second stage of the study, with some children visiting their relatives on a regular basis. Undoubtedly, this contact with extended family could provide some relief from the disruption and uncertainty of living in emergency accommodation. However, it is not clear to what extent this family contact

provided support, as a number of the homeless mothers pointed out that they felt they were a burden on their families. Living in accommodation where regulations require occupants to be in before a certain time in the evening, and which did not allow them to stay away overnight, meant that children were seriously restricted with regard to how much contact they could have with other family members. Interviews with the children confirmed the importance of contact with extended family for these children and their sense of frustration at not being able to spend as much time as they wished with their relations. The importance for the children of contact with other family members was also apparent when they were invited to describe their three wishes. Many children wished that they and their families could have a house of their own, and some children specified the locations in which they would like to live. When asked to comment on why they had chosen certain locations, a number of children mentioned the fact that they wanted to be near their relatives.

Homelessness may also represent a serious obstacle to children making and maintaining friendships, as strict regulations prevent children from inviting friends into their accommodation and, consequently, affect the development of friendships in a natural context. Changing frequently from one location to another meant that children had no opportunities to see their friends on a regular basis, unless they continued going to the same school. A further problem identified in the present study is the stigma which some children perceive as being attached to being homeless, and the subsequent effect which this may have, particularly with older children, on making lasting friendships. Mothers also described their strong sense of social isolation. Living within emergency accommodation settings forced them to be with their children at most times of the day and night, with no opportunity to go out on their own. Problems of dealing with inadequate space and facilities were not helped by the fact that families were often living in unfamiliar neighbourhoods, where they had no connection to or contact with other members of the community.

The contribution that contact with family members can provide for parents and children in homeless situations is likely to be substantial, and the importance of other social support networks has been highlighted by a number of previous studies. In the USA, it was found that lack of social support was a crucial difference between homeless mothers and their housed low-income counterparts (Bassuk & Rosenberg, 1988). Barnes (1999) draws attention to what is termed "psychological homelessness", a possible outcome of living in neighbourhoods where families have no connections, and points to research which indicates that this sense of isolation and lack of attachment to the community may contribute to feelings of powerlessness within the family (Gill, 1992). Frequent changes in address and being located in neighbourhoods which often lack a sense of belonging to the community make it difficult for families being housed temporarily to interact and make connections with other members of the

community. This lack of local support can serve to increase the stress and pressures which these homeless families are already facing.

Social support

Some mothers felt that support could be provided through the development of social centres or family centres where they and their children would have an opportunity to make contact with other families and to escape from the constraints of daily routines within their accommodation settings. An example of such support is the recently established *Family Programme* which has been developed by Focus Ireland and is designed for homeless families who need somewhere to go during the day. Most of those who are availing of the programme are homeless mothers, who participate in organised activities within the centre. A crèche is also provided for children under five years of age.

Children's health and well-being

We cannot assume that being homeless causes a deterioration in health status, although some of the conditions associated with homeless accommodation may represent an increased risk to health (Pleace & Quilgars, 1999). These conditions often include inadequate facilities for eating and sleeping, overcrowding and, in some cases, being obliged to leave the premises during the day.

Children's health

While mothers perceived that most of their children were healthy, at least one health problem was reported for almost half of these children and some children had multiple problems. These problems included asthma and other chest problems, injuries resulting from severe trauma, skin problems, bone or joint problems, psychiatric problems and recurrent head lice. Mothers also expressed their concern that many of the features of emergency B&B and hostel accommodation, such as inadequate cooking facilities and overcrowding, might serve to exacerbate their own and their children's health problems.

In the US, a recent study of the health status of homeless children in New York found that 61% of homeless children had not received their proper immunisations (Redlener & Johnson, 1999). Findings in the present study are relatively similar, with 46% of the 173 children in the first stage of the study not having had full immunisation, but with a figure of 59% of the 22 children in the second part of the study. Other findings from this New York study indicated that 38% of homeless children in the City's shelter system had asthma (four times the rate for all New York City children) and they suffer from middle ear infections at a rate that is 50% greater than the national average (Redlener & Johnson, 1999).

As mentioned in *One Hundred Homeless Mothers* (Smith *et al.*, 2001) and in Chapter 3 of the present report, the target rate for uptake of the Department of Health and Children's (DOHC) vaccination programme is 95%, although only approx. 80% uptake is achieved nationally. Findings in the present study indicate that numbers of children in these homeless families receiving full vaccinations are considerably lower than these figures. One reason for this low uptake may be the difficulties caused by frequent changes of address. Perot & Pigott-Glynn (2000) point out that the ERHA uses a computerised child recording system (Regional Interactive Child Health Surveillance system – RICHES). This system details a child's birth history, address and immunisation status. Invitations for attendance at developmental clinics are then generated from this system. Frequent changes in address among homeless families will, therefore, prevent them from benefiting from this service. In *Shaping the Future* (Homeless Agency, 2001) particular difficulties with regard to homeless people accessing essential health care services are acknowledged and strategies to improve and broaden the focus of these services have been incorporated into the *Action Plan on Homelessness in Dublin*. The establishment of multi-disciplinary health care teams, who will work to improve links between homeless people and mainstream health care services more efficiently, is one such strategy.

Previous findings in an Irish context from the Focus Ireland pilot study indicated that certain health care services were under-utilised by homeless families (Perot & Pigott-Glynn, 2000). Only 50% of the children in this study had availed of the 9-month developmental assessment service carried out by an Area Medical Officer and aimed at ensuring early detection of developmental delay and physical and mental disability. Few of the mothers who participated in the study had been visited regularly by a Public Health Nurse and reasons put forward for this were frequent changes of address, demands related to attending other service providers and the necessity to leave accommodation early in the morning.

Children's well-being

Particular problems may arise for parents trying to raise their children in homeless situations. As mentioned previously, findings from the initial study indicated that a substantial number of the homeless women interviewed had experienced physical or sexual violence at some stage in their lives (Smith *et al.*, 2001). These experiences may have had an impact on the quality of their relationships with their children. The authors also point out that their findings confirm that the women caring for children have a higher prevalence of psychiatric morbidity according to scores recorded on the *General Health Questionnaire* (GHQ-12). However, the difference between these women and women not caring for children was not statistically significant.

Standardised measures

Scores on the standardised measures administered to children who participated in the second stage of the study reflect, to some extent, previous findings with regard to the emotional and cognitive development of children in homeless families. As mentioned previously, problems associated with being homeless as, for example, lack of adequate facilities within homeless accommodation, can have negative effects on children's health and well-being and these factors may also have negative implications for children's cognitive development (Vostanis & Cumella, 1999; Fox *et al.*, 1990).

Many of the mothers in this second stage of the study commented on how they felt that their children's behaviour had deteriorated since they had become homeless. A number of possible reasons were mentioned as contributing to this deterioration including the disruption to everyday family routines and the overcrowded accommodation conditions in which most families were living. Scores on the *Revised Rutter Parent Scale for School-Age Children* would appear to support these homeless mothers' perceptions of their children's behaviour. The majority of these 18 children (67%) who were assessed on this scale recorded scores which indicated the possible presence of behaviour problems. However, high scores were also recorded on pro-social items for the majority of these children. This highlights the fact that most of these children are also displaying many positive social behaviours and may indicate that this perceived deterioration in their behaviour is a temporary one. It should also be pointed out that one mother commented on how her ten year old son's behaviour had, in fact, improved since they had entered emergency accommodation and this suggests that for some children, homeless accommodation may provide more stability than they have experienced in previous situations.

A smaller proportion of children (19%) recorded scores which indicated possible depressive symptoms on the *Birleson Depression Scale*. In *One Hundred Homeless Women*, 70% of women who were interviewed reported depressive illness (Smith *et al.*, 2001) and it is possible that mental health problems of these mothers will impact on some of their children. Living within accommodation settings where the freedom to come and go is restricted, where space is confined and where it is not possible to meet with friends and other family members may have negative consequences for the psychological well-being of these children. Mothers' reports of their children's self-esteem were generally quite high and this would suggest that many of these children are quite satisfied with most aspects of their lives. Perhaps not surprisingly, the area where children scored highest in terms of being *somewhat dissatisfied* was with regard to family relationships. Living together in overcrowded conditions, not having the freedom to visit and invite other family members and, in some cases, blaming mothers for their homeless situations, may go some way to explaining this dissatisfaction.

Scores on the *British Picture Vocabulary Scale – II* are discussed below in the context of education.

Education

Homeless school-aged children may be at risk of not receiving the education needed to break their cycle of poverty, as a result of erratic school attendance and poor school achievement (Zima, Bussing, Forness & Benjamin, 1997). Educational achievement may offer children in homeless families the possibility of breaking a cycle of poverty and disadvantage. In addition, regular attendance at school can provide a useful counterbalance to the instability and disruption to daily routines and the uncertainties of living in often inadequate temporary accommodation (Power, Whitty & Youdell, 1999). Findings in the present study also show that children's opportunities for making and maintaining friendships were often only in school settings. Although the school attendance of the homeless children in this study (64%) was higher than findings in the US (57%) (Stronge, 1992), the fact that a substantial number of children in this study are not attending school regularly is a cause for concern.

In *Homelessness – An Integrated Strategy* (Dept. of Environment & Local Government, 2000), attention is drawn to the fact that, within an overall hierarchy of needs, homeless people are not likely to attach prime importance to access to education, given their more urgent and fundamental needs, such as food and shelter, emotional stability, and help with addiction or health and welfare problems. Despite these difficulties, the resilience and determination of these women was apparent in qualitative interviews with the ten homeless families in the second stage of the study. Many of these mothers expressed a desire for their children to have access to education which, in many cases, they, themselves, had been denied. They described how, regardless of the many demands on their lives in emergency accommodation, their children's attendance at school was a priority for them. The introduction of innovative strategies, such as the provision of homework supervision within schools or within accommodation settings, may support such families in maintaining their children's routine in education.

Information on children's performance at school is not available from the present study.

However, measures which assessed

- a. the extent of English vocabulary acquisition (BPVS-II) and
- b. children's levels of self-esteem with regard to a number of aspects of their lives, including school (extract from CHQ-Parent Scale)

were administered to 22 children in the second part of the study. Scores on the first of these measures indicate that a majority of these children were doing less well than average.

Vocabulary has been found to be the best single index of school success (Dale & Reichert,

1957), and the extent to which children are able to acquire and make use of language may have implications for skills including reading, comprehension and communication. However, the scores in the present study need to be interpreted with caution, as a number of factors were at play. First of all, the particular scale used measures only hearing vocabulary. Secondly, the circumstances in which the measure was administered were often far from ideal, in that participants were generally interviewed in their accommodation which, in many cases, was a single room and therefore involved an amount of distraction where a number of children were present. With regard to self-esteem levels related to school abilities, mothers perceived a substantial proportion of children (43%) to be either *very satisfied* or *somewhat satisfied* with this aspect of their lives.

Conclusions

Consistent with previous findings, the present study found that homelessness arises as a result of a combination of social factors such as the high cost of housing and more particular circumstances such as domestic violence, family breakdown, and alcohol or drug addiction. Many families will, therefore, have experienced high levels of stress in coping with these problems before becoming homeless. Problems specific to living arrangements within emergency accommodation were identified, including lack of adequate cooking facilities, overcrowding, lack of space and facilities for children's play, concerns about security within the accommodation and in the surrounding neighbourhood, and strict regulations in both hostel and B&B settings. Mothers emphasised an increase in stress and pressure while trying to look after their children in these circumstances. Many mothers also described a deterioration in their children's behaviour and this was attributed, to some extent, to the strain of living in very restricted space.

Social isolation was a problem identified by both mothers and children. Most families were living in an environment where there was little opportunity for interaction or involvement with other community members. Mothers and children were obliged to be together at all times and this was often in the confined space of their accommodation. Children had difficulties making and maintaining friendships, due to frequent moves, not being able to invite friends to their accommodation, and the perceived stigma attached to being homeless. Relationships with other family members were a support to many of these families, although contact with them was not always easy to maintain, due to strict regulations and the fact that some mothers felt they were a burden upon these relations.

Mothers' perceptions of their children's health status were quite positive, although a number of health problems were identified. Most notably, almost half of the children in the present study had not received their full vaccinations. Scores on standardised measures indicated poor

outcomes for some children with regard to behavioural development. These scores supported perceptions by some mothers of a deterioration in their children's behaviour. Problems maintaining regular school attendance were also identified. Key problems included frequent changes of address, difficulties preparing children for school, and the supervision of homework in the confined space of emergency accommodation.

The present findings highlight the importance of a co-ordinated and comprehensive response to the needs of homeless families living in emergency accommodation. These findings indicate that more consideration must be given to creating a suitable environment for parents and their children within this form of accommodation, most notably in terms of the provision of adequate cooking facilities and more appropriate space, where families can have some control over the planning of daily routines. Findings also point toward the need for active support for these families, and this could be in terms of the development of creative family programmes in neighbouring communities, where children would have access to safe play activities and parents would have the opportunity for making contact with other members of the community. In addition, health care and educational services could include more integrated strategies to support these families.

CHAPTER 9: IMPLICATIONS AND RECOMMENDATIONS

The publication of *Homelessness – An Integrated Strategy* (Department of Environment and Local Government, 2000) and the more recent publication of *Shaping the Future: An Action Plan on Homelessness in Dublin 2001-2003* represent a positive response to many of the key issues for homeless people, including accommodation needs, health and welfare services and education and training. Findings in the present study support the need for the implementation of many of the strategies outlined in these publications. The following sections outline particular issues for further consideration which emerged from the present study.

Possible causes of homelessness

Consistent with previous findings, the present study found that homelessness arises as a result of a combination of social factors, such as the high cost of housing, and more particular circumstances such as domestic violence, family conflict and marital breakdown, child sexual abuse, and alcohol or drug addiction. Many families will, therefore, have experienced high levels of stress in coping with these problems before becoming homeless. Strategies are needed, therefore, which focus, not alone on improving conditions for those currently in homeless situations, and on providing long-term housing, but also on reducing some of the possible causes of homelessness.

Recommendations

- Access to professional counselling and therapy for both parents and children must be provided for families in crisis or transition. Support services, such as parenting programmes for families experiencing difficulties, could help parents to become more aware of their strengths and weaknesses in caring for their children.
- Interventions for those involved in alcohol or drug abuse could be more effective where an integrated approach is adopted. Such an approach would take into consideration the many demands upon homeless parents in caring for their children.

Accommodation needs

Findings in the present study indicate clearly that living in homeless emergency accommodation (hostels or B&Bs) represents a serious disruption to the daily lives and well-being of those homeless families currently living there. Among the factors which families identified as contributing to this disruption were lack of any or adequate facilities for storing and cooking food, overcrowding, lack of appropriate space for children's play (especially within B&B settings), restrictions with regard to entering and leaving the premises, and concern for children's safety in cases where other occupants were involved in alcohol or drug abuse.

Recommendations

- The *Action Plan* for the Dublin area, as outlined in *Shaping the Future* (Homeless Agency, 2001), should be implemented to eliminate the use of B&B accommodation for families other than for emergencies and only for very short-term use (i.e. not more than six months).
- Existing homeless accommodation (both hostels and B&Bs) should aim to offer an environment in which parents and children have some control over planning their daily routines. Such accommodation would facilitate:
 - partners living together rather than living in separate accommodation, which would allow for better and more regular contact between children and both parents;
 - families being able to stay in their accommodation, rather than having to vacate the premises during the day;
 - families preparing meals within their own accommodation, with the provision of/adequate cooking and food storage facilities;
 - children having access to safe areas for play and, where possible, provision of imaginative resources for children's activities;
 - improved security considerations to prevent harassment or intimidation from other occupants in homeless accommodation.

Health care

The findings of this study suggest that demands on homeless families, such as the pressure to find suitable accommodation for themselves and their children, and trying to ensure that children eat well, attend school and are safe within their accommodation, represent a challenge to the health and well-being of many of these families. Frequent changes of address may also make it difficult for homeless families to avail fully of existing health care services, such as the vaccination programme for children.

Recommendations

- Health care services should be more focused, taking into account the particular needs of homeless people and those at risk of becoming homeless.
- Systems should be adapted to facilitate access to services for homeless families in cases where there are frequent changes of address, as this may help to increase the uptake of important services such as the vaccination programme.

Education

Many children in the present study were attending school on a regular basis, and some mothers described how, despite the adverse circumstances in which they were living, the education of

their children was a priority for them. However, a number of children had left school before the age of 16, and some children were not attending school at all. Problems associated with trying to prepare children for school, finding time and space to attend to children's homework, and getting children to and from school in instances where a change of address meant that children were no longer living within easy reach of their schools, were all identified in the present study.

Recommendations

- Promoting an understanding within schools of the specific educational needs of children of homeless families through provision of measures such as specialist training for teachers in schools.
- The appointment of a dedicated home-school-community liaison teacher and the provision of special homework and reading support measures for homeless families in schools or within B&B or hostel settings.

Social support

This study indicates that social isolation, and the absence of somewhere to go outside of the restricted space of much homeless accommodation, represented problems for many families. Most families were living in an environment where there was little opportunity for interaction or involvement with other community members. Children had difficulties making and maintaining friendships, due to frequent moves, not being able to invite friends to their accommodation, and the perceived stigma attached to being homeless. Relationships with other family members was a support to many of these families, although contact with them was not always easy to maintain.

Recommendations

- The establishment of social centres for homeless families, and an opportunity to make contact with other parents and children in homeless situations, could reduce the social isolation of homelessness. The development of family programmes should be encouraged. One such programme has been recently established by Focus Ireland and provides a drop-in service for all families staying in B&Bs or hostels. It also offers a crèche service.
- The need for childcare facilities for mothers in homeless situations must also be examined. This service could be provided within family programmes or family centres, where children and parents could be offered the opportunity to become involved in activities which could help alleviate some of the stresses they face in their daily lives. Childcare could help to provide a more consistent daily routine for young children in

homeless families and allow homeless mothers the opportunity to more easily meet the many demands which accompany their homeless situations.

The present study explored the impact of being homeless and living in emergency accommodation on the lives of homeless mothers and their children. Findings are consistent with previous studies which show that homelessness is a complex issue, often involving a combination of difficult circumstances. It is difficult to draw conclusions about the impact of homelessness as such, rather than the events which occur before entering emergency accommodation. However, accounts, by both mothers and children, of their daily experiences and their feelings about being homeless lend weight to the view that being homeless is in itself a major and very specific stressor in the lives of these children. Further research would be interesting to explore some of the issues raised in the present study in more depth. Further studies could also include a larger sample of homeless families, with a wider range of family circumstances.

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