

The Mental and Physical Health and Well-being of Homeless Families in Dublin: A Pilot Study

A Report by Focus Ireland, the Mater Hospital and the Northern Area Health Board

Justin O'Brien, B.A., Diploma in Child Care, Diploma in Social Work (CQSW), Focus Ireland

Dr. AnneMarie Waldron, Ms. Genevieve Tobin, Dr. Paul McQuaid, Dept. of Child & Family Psychiatry, Mater Misericordiae Hospital, Dublin.

Dr. Siobhán Perot and Liz Pigott-Glynn PHN, Northern Area Health Board

**Frank Houghton
MA., MSc.**

Steering committee

Feehan Siobhain, Focus Ireland
Hilton Gráinne, Focus Ireland
Houghton Frank, Focus Ireland
Kennedy Stanislaus, Focus Ireland
King Aoibhinn, Focus Ireland
McQuaid Paul, Mater Hospital
O'Brien Justin, Focus Ireland (chair)
Perot Siobhán, Northern Area Health Board
Pigott-Glynn Liz, Northern Area Health Board
Tobin Genevieve, Mater Hospital
Waldron AnneMarie, Mater Hospital

Acknowledgements

Focus Ireland expresses its gratitude to all members of the steering committee for giving their time and commitment so generously and unsparingly to this project. Focus Ireland also wishes to thank the staff in Focus Ireland, the Mater Hospital and the Northern Area Health Board who assisted and worked so tirelessly in the background to bring the project to completion; Frank Houghton for his analysis of all the data; Siobhán and Orla Parkinson for assisting with the editing of this report; and Gráinne O’Grady, Claire Hickey, and Pauline Costello for preparing the report for publication.

We would also like to express our thanks to the Combat Poverty Agency for its financial assistance towards this research project.

Finally, Focus Ireland would like to acknowledge and thank all the families and their children who were willing to participate in the study.

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Introduction

Stanislaus Kennedy, President, Focus Ireland

Focus Ireland, founded in 1985, is now one of the largest national voluntary agencies in Ireland working with homeless people. It provides a very wide range of services and housing to respond to the different needs of individuals and families at different stages of their homelessness.

Since its inception, Focus Ireland has been concerned about the effects of homelessness on families and their young children. At a very early stage it became aware that if the social and personal factors that caused families to become homeless were not addressed, the families were unlikely to settle into new accommodation and would be likely to find themselves re-entering the cycle of homelessness again and again. Their children also tend to repeat that pattern.

To help families resettle in the community, Focus Ireland established its first family transition unit in Stanhope Green in Dublin in 1991. Since then, it has extended its transitional housing to George's Hill in Dublin and to Waterford city. Family transitional housing is unique to Focus Ireland. Its objective is to provide participants with good-quality accommodation so that they can experience what it is like to live in a house on their own. During their time in the family transition unit they are provided with time, space and an educational and supportive programme which helps them to prepare to move to new accommodation and access local community support services.

Pilot study

This pilot study came about as a result of concern within three agencies – the Department of Child and Family Psychiatry at the Mater Hospital in Dublin, the Housing Division of Focus Ireland and the Area Medical Services, Community Care Area 6, of the Northern Area Health Board – about the effects of homelessness on families and their children, the lack of adequate support services and how the mental health of parents impacts on children, especially in homeless families. This pilot study was carried out in Dublin through the collaboration of these three agencies. The aim of this pilot study was to examine the mental health status of homeless children and their families who were living in Focus Ireland's transitional housing projects in Dublin. The survey population comprised fourteen homeless families with thirty-one children. Of the fourteen families, twelve were headed by mothers alone; only two had both parents.

The design of the pilot study was influenced by a study carried out by Vostanis (1996 and 1997) in Birmingham. Vostanis examined the psychological status of homeless children and their families. Vostanis' design was modified and adapted to the Irish context. The findings of this pilot study are compared with the population and control group of Vostanis' study. The pilot study, though a small one, was very time-consuming and took many hours of work from each of the members of the three teams involved. Each team studied the aspect that related to their field of work. Focus Ireland was concerned with the social aspect, the Northern Area Health Board with the health of the families and the Department of Child and Family Psychiatry at the Mater Hospital with the mental health of the families and children. The teams worked very closely together, met regularly and exchanged information.

This report is a composite of all three, with papers by representatives of the three organisations concerned and a contextualising historical appendix by Justin O'Brien of Focus Ireland.

Findings

The findings of this pilot study are both interesting and disturbing. The pilot study confirms the fears that already existed of the vulnerability of children and families who are homeless. It highlights the social isolation and lack of support from their family of origin and from the fathers of the children. It shows that the women and children had been homeless for approximately 8.5 months on average prior to entering the Focus Ireland family transition units and intermittently homeless for 26 months on average before living in the family transition units. Twenty-one per cent of the mothers reported they had experienced homelessness as a child.

This pilot study also shows up high addiction levels amongst parents and poor parenting skills. Forty-three per cent of the women had an addiction relating to alcohol or drugs. Over 30 per cent of the families had difficulties with their families of origin. The majority of the families have been in a homeless cycle for lengthy periods of time, which is related partly to the personal situation of families but also to structural factors such as the absence of adequate housing. Poverty and the lack of affordable and available housing means that homeless families can remain in this homeless cycle for long periods. All the families indicated they were less stressed while living in the family transition unit than they had been before they arrived.

The findings on the health status of the children are significant. Almost half the children, 44 per cent, were reported to have been born from pregnancies with complications including nausea, pneumonia and toxæmia. Twenty-nine per cent of the children were reported not to be normal at birth, 16 per cent required admission to a special care baby unit. Fifty per cent of the children were at risk of contracting a number of infectious diseases because of incomplete or no immunisation. Only 50 per cent of the children had attended their nine-month developmental check-up. Fifty per cent of the children were attending General Practitioners (GPs) with symptoms of respiratory tract infection. These findings are very disturbing. There is a consistent picture of highly stressed parents caring for their young children. On the Parenting Stress Index (PSI), all scored at the critical range or very close to it, indicating multiple stresses in the immediate close family. On the Child Behaviour Checklist (CBCL), the behavioural and emotional problems of the children were at a much higher level and rate than the population norm. They also present at a higher level and rate than the Vostanis study of homeless families and children in Birmingham. The father was present only in the case of two families in the population studied, and most of the literature on families enduring homelessness mirrors this situation.

On a positive note, what also comes through the pilot study, in spite of the vulnerability of the mothers and their children, was an attachment between mothers and their children. This indicates the strong motivation of the mothers to take on the parenting role.

Homeless families are like you and me: they have the same hopes, fears and aspirations. They want to give their children the best, to bring them up well. They want them to be happy and cherished. But, like the rest of us, when families fall on hard times, they need all the cushioning they can get against the worst aspects of their

situation. There is little cushioning for these families, though, as they are pushed by circumstances into greater insecurity and instability. The most appalling aspect is that their number is increasing. In 1984 there were 37 women with 93 children in hostels in Dublin and no family was homeless for more than six months (Kennedy 1985). By 1999 there were 540 families with 990 children (530 under 5 years of age) assessed as being homeless in the ERHA region (Williams & O' Connor, 2000).

All these families came from disadvantaged areas and this pilot study points to the urgent need for good-quality affordable housing, education, health opportunities and employment and a wide range of accessible, well-integrated supportive services, including social and mental health services in local areas for all children and families at risk, to prevent the cycle of poverty and homelessness continuing. This pilot study confirms that some families have multiple problems and that without a sustained and accessible integrated response from housing authorities, education, primary and specialist health services, schools, social work and family support services and the provision of good-quality pre-school and nursery care, these children and their parents are destined for chaotic, troubled and unstable lives, a pattern that is likely to be repeated in the next generation.

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Preface

Focus Ireland undertook this pilot study with the Department of Child and Family Psychiatry at the Mater Hospital, and the Area Medical Services, Community Care Area 6, of the Northern Area Health Board.

The aim of this pilot study was to assess and establish the psychosocial and medical well-being of homeless families and their children in Dublin. No research of this nature had been previously undertaken in Ireland and the only comparative research study was that of Panos Vostanis and colleagues in 1996, 1997 and 1999 in Birmingham, England.

Vostanis and colleagues initially undertook a sample study of 19 homeless families with 50 children aged 2-15 years to identify their psychosocial characteristics. A semi-structured interview with the parent, the General Health Questionnaire (GHQ) and the Child Behaviour Checklist (CBCL) were used. The findings indicate high levels of stress for the parents, and high clinical CBCL scores for some of the children in the majority of the families.

A more extensive study was undertaken by Vostanis in 1997 of 113 homeless families with 249 children aged 2-16 years and 29 comparison families with 83 children. A semi-structured interview, the GHQ, the CBCL, the Interview Schedule for Social Intervention (ISSI), the communication domain of the Vineland Adaptive Behaviour Scales, and height and weight percentiles were used.

The findings were that the majority of homeless families constituted lone-parent families who had become homeless primarily because of domestic violence. The homeless mothers reported high rates of previous abuse, current psychiatric morbidity, and poor social support networks compared with housed controls. The homeless children were more likely to have histories of abuse, being in care, delayed communication, and higher CBCL scores than domiciled children. They were also less likely to have attended school while homeless.

As Vostanis' study was the first of its type in England, in this pilot study the three agencies involved decided to use similar instruments. The semi-structured interview format was adapted to the Irish context. This study is a small-scale pilot one of fourteen families who were homeless and resident in Focus Ireland's two family transitions units in Dublin. All the parents who participated in this pilot study did so voluntarily, signed a consent form, and co-operated with it enthusiastically and fully. The research methodology was broadly similar to the research methods used by Vostanis. It comprised a demographic, social and accommodation profile of the families, their contact with community-based health and social services prior to becoming homeless and when they became homeless. This aspect of the pilot study was undertaken by Focus Ireland.

The Mater Hospital Child Guidance Clinic used an adapted version of the interview developed by Vostanis, the GHQ, the CBCL and the Parenting Stress Index (PSI). The PSI was not included in the Vostanis study. The Vineland Adaptive Behaviour Scale was omitted from this pilot study.

The Area Medical Team in Community Care Area 6 devised their own questionnaire which comprised the weight and height, centile measurement of the children aged from 2-16 years, and the mother's account of their obstetric, immunisation histories and access to the general medical and accident and emergency hospital services. The medical component was not included in the Vostanis study.

Social and Accommodation Status of Homeless Families in Dublin: A Pilot Study

Justin O'Brien, B.A., Diploma in Child Care, Diploma in Social Work (CQSW)

ABSTRACT

Aim

To examine the social and accommodation status of homeless families and their children living in supported temporary housing projects.

Method

This included the completion of a questionnaire on the accommodation history, the reasons for being homeless, the income and educational status of the parents, the services used by the parents both prior to and when they were homeless. Other data on the family transition units was also included, in particular data on where people who had been resident in the unit moved to, on leaving the unit.

Results

Fourteen families participated in the pilot study. The significant findings were that twelve of the families were lone-parent families and the fathers were not supportive to their children. The majority of the families had been homeless for an average of 8.5 months prior to entering the family transition units and had been intermittently homeless for the preceding two years. The reasons for their presenting as homeless related to relationship difficulties with their family of origin, drug addiction and domestic violence. The families were educationally disadvantaged. While resident in the family transition unit the families increased their usage of the generic and specialist services.

Conclusion

The pilot study showed that the families were extremely socially disadvantaged had been intermittently homeless for long periods of time and had a range of personal and social needs.

REPORT

Focus Ireland established the family transition units in Stanhope Green, Dublin in 1991 at a time when public housing was available and homeless families could be housed within a two- to three-month period. The project was established because experience had shown that families re-housed in the community often became unsettled later because the social and personal factors that had caused the families' homelessness were not addressed, and difficulties emerged that caused a repeat of the cycle of homelessness.

Vulnerable families with the following types of experiences were identified as being at risk of settlement breakdown:

- families who had become deskilled as a result of long periods of homelessness
- families who had experienced difficulties such as addiction or abusive relationships
- first-time young mothers who had experienced homelessness and needed to develop skills to establish and maintain a home.

Focus Ireland currently has three family transition units, two in Dublin and one in Waterford totalling 22 units of accommodation. The families are offered accommodation for a period of six months to one year, with the aim of being re-housed on a planned basis. Over 120 families have availed of this service since 1991. The participants in this pilot study were residents of the two family transition units in Dublin.

Objectives of and methods used by the Focus Ireland family transition units

The objectives of the family transition unit are to:

- provide participants with good-quality accommodation so that they can experience what it is like to live in a house on their own and to give them an opportunity to assess their situation and needs in a relatively stress-free environment.
- provide participants with time, space and a supportive programme that helps them to prepare to move to new accommodation and to access local community support services.
- allow participants to benefit from group discussion with staff and other families on the programme.
- co-ordinate the delivery of services provided by the local authorities and the health board to the family leaving the programme, thus providing an integrated planned approach to housing and settlement.

There is a defined referral and admission process involving completing referral and application forms, interviewing the family and the referral agent and selecting families for the unit on the basis of need, motivation and compatibility with the programme. There is a very defined filtering process. The family transition units, in effect, take defined sectors of the homeless family population.

The methods of programme delivery comprise:

- groupwork sessions on personal development

- groupwork sessions on practical skills development
- individual sessions with key workers
- recreational and social activities
- community living
- tenancy and licence agreement
- a nursery service for children under five years of age.

The family transition units are located within larger housing projects. A separate transition-unit team of staff works with the families and aims to engage with the adults on some of the personal difficulties that have contributed to their homelessness. The families are assisted in taking responsibility for the management of their accommodation and the care and welfare of their children. A nursery is provided five mornings per week for children under five years of age. Children over five years of age are linked to local schools. The local national and secondary schools have always been very responsive to the children.

A key component of the work is an integrated service approach whereby the transition unit staff, the family and external agencies such as drug treatment centres and the Public Health Nurse (PHN) work together. At three-monthly intervals the family, Focus Ireland and relevant external agencies review the work and progress. As the families progress, they are re-housed on a planned basis by the local authorities. Focus Ireland's Community Settlement Team visits and supports the family for a period of six months afterwards. A key element of the work at this stage is linking the family with the relevant community-based services.

Socio-demographic profile of the families who participated in this pilot study

The families who participated in this pilot study have come through a selective filtering process, which is based on Focus Ireland's policies, referral agents' knowledge of Focus Ireland and their clients' needs and the families' own acknowledgement of their situation and their need for the programme. Thus the social characteristics of these families are not representative of homeless families in general. The units prioritise the more disadvantaged families.

A total of 14 families, out of a population of 20 families who availed of the family transition units during the research period, participated in the pilot study. These comprised 12 lone-parent and two two-parent families. The ages of the mothers ranged from 20 to 35 years with the mean average being 28 years.

Previous residence – duration of homelessness

There is a major difference between this pilot study population and that of the Vostanis (1997) study, in terms of the previous residence of the participants (see Table 1.1):

Table 1.1 Previous Accommodation of Participants

Type of Residence	This study 2000 (%)	Vostanis Study 1997(%)
Rented house/apartment	7	82
Own house/apartment	0	12
Lodging with friends/family	14	4
Hotel/B&B	36	0
Drug treatment centre	7	0
Other homeless facility	29	1
Multiple moves	7	0
Total	14	113

Source: Vostanis, 1997; Focus Ireland, 2000

The Vostanis studies of 1996 and 1997 interviewed families within two weeks of their entry into the homeless hostels/refuges, and indicated that the families came directly from rented and owner occupied accommodation.

The families in the Focus Ireland pilot study had been homeless immediately prior to entering the family transition unit for approximately 8.5 months on average. They had been intermittently homeless for 26 months on average. The majority of the families in the pilot study had been housed in hostels and B&B facilities for the homeless prior to entering the family transition units.

Reasons for homelessness

The following are the reasons for the families becoming homeless and entering a cycle of homelessness (See Table 1.2):

Table 1.2 Reasons for leaving their most recent accommodation/reasons for homelessness

Reasons for Leaving	Focus Ireland 2000 (%)	Vostanis 1997 (%)	Vostanis 1996 (%)
Domestic violence	29	56	74
Mortgage arrears	0	1	5
Left voluntarily	0	6	21
Drug dependency	36	0	0
Relationship difficulty with family of origin	36	0	0
Relationship difficulty with partner	7	0	0
Other	0	37	0
Total	14	113	19

Source: Vostanis, 1996; Vostanis, 1997; Focus Ireland, 2000

In the Vostanis study, the main reason for families entering the hostels and refuges was domestic violence. In the Focus Ireland study, drug dependency, that is heroin addiction, was the major reason for four of the families becoming homeless. The largest single contributory factor, for five of the families, was a breakdown in relationship with their family of origin. This breakdown in relationship obviously led the families into a cycle of homelessness. Domestic violence was less dominant in precipitating homelessness but was common to half the families as a factor.

Income

Information was collected on the occupational status of 12 of the mothers. Ten of the mothers were engaged in looking after their family full-time, while two held part-time positions. The income of the group (information was available on 11 of the mothers) ranged from £77.70 to £185.00 a week. The main income source for the group was the Lone Parent Allowance, which was collected by half of the mothers.

Educational status

The educational status of this relatively young group of mothers depicts them as a severely disadvantaged group. A third of the group on which details were taken (12 in total) had completed only primary school education, either in National Schools or Special National Schools. Five more individuals (42 per cent) had completed Secondary Schools or Special Secondary Schools without either taking or passing any exams. The highest educational level of the remaining three mothers consisted of one having passed the Group Cert, another having obtained the Leaving Certificate, while the last had a City & Guilds apprenticeship. From the information collected (on 10 individuals) the average age this group left school was 14.6 years.

Social/personal factors

Twelve of the 14 parents were lone parents and the fathers in all twelve cases were not engaged in supportive relationships with either their ex-partner or their children. A substantial number of the mothers (43 per cent) had an identified addiction relating

to alcohol or heroin. Three of the mothers (21 per cent) reported they had experienced homelessness as a child, and four of the mothers (29 per cent) reported they had experienced some form of abuse.

The evidence suggests two groups – one with multiple needs and episodic cycles of homelessness, and another group with fewer needs and less experience of homelessness.

Needs identified

The following table (Table 1.3) outlines the primary needs that the staff in the family transition units attempted to address with the families:

Table 1.3 Needs identified for work in the family transition units

Need	No of families
Drug dependency	3
Parenting/care of children	4
Relationship difficulty with family of origin	4
Domestic violence	2
Self-esteem/trust-building	1
Total	14

The range of primary needs was evenly spread. Drug dependency normally required stabilising the parent on a drug maintenance programme or staying drug-free. Parenting/care of the children usually required developing parenting skills and parent-child relationships. Some parents entered the programme as a place of safety where their children, who were currently in care, could be reunited with them. Relationship difficulty with family of origin usually required re-exploring and restoring broken relationship with their parents. Domestic violence entailed getting assistance with the effects of violence from a partner and the “damage of that relationship”. The thrust of the programme is to provide a stable environment and rebuild the family’s self-esteem and capacity for healthy family living.

A key need and component for family transition unit work is developing the mother’s self esteem and thus enhancing family capacity. A common secondary need spread across the families was budgeting/homemaking and parenting.

Services

The pilot study analysed the services used by the families prior to homelessness, while homeless and while in the transition housing (See Table 1.4):

Table 1.4 Service use by the parents

Service use	Before becoming homeless (%)	While homeless (%)	Since joining the family transition unit(%)
General Practitioner	57	57	79
Public Health Nurse	50	50	79
Hospital outpatient service	21	14	21
Hospital inpatient service	29	14	7

Service use	Before becoming homeless (%)	While homeless (%)	Since joining the family transition unit(%)
Psychology/psychiatric service	0	0	52
Community Psychiatric Nurse	0	0	29
Social worker	0	0	0
Addiction services	7	21	29
Day services	0	0	0
Eastern Health Board	0	36	0
Local authority	0	43	14
Hostel	0	21	0
Focus Ireland	0	29	43

The evidence indicates an increased access to both generic and specialised services when the families were resident in the family transition unit. The Vostanis study indicated a reduction in accessing services when homeless, particularly with regard to access to education. In Dublin, the local schools have been accessible to the children of homeless families resident in the family transition units.Length of stay

The majority of the families who have been in the family transition unit reside there for nine months to one year. This is partly related to their needs, but is primarily determined by the lack of move-on accommodation. This is in total contrast to the Vostanis study, where homeless families moved from hostel accommodation, on average, within an eight-week period. The housing system in Dublin is radically different to Birmingham where the Vostanis study took place, especially in terms of scale as Birmingham has a far greater number of local authority housing units than Dublin. Of the 14 families who participated in the pilot study, nine have moved into local authority accommodation on a planned basis, one returned to live with parents, one moved back into a hostel/homeless situation and three are still resident in the family transition units.

The facts and figures above give a clear but incomplete picture of the lives led by these homeless families. The following case studies illustrate further, and perhaps more forcefully, just how vulnerable these homeless families are.

Case study 1

Joan comes from a family where her parents were separated and her father was an alcoholic. As a child Joan attended a special school. At the time of her initial interview for this pilot study, Joan and her five children had been resident in the family transition unit for one month. Her children ranged in age from two months to eight years of age. All of the children have the same father. Joan, in her thirties, had parented alone for the last seven years.

The family had previously lived in local authority housing in a low-demand inner city area and then moved to England following relationship difficulties and conflict with neighbours. Rent arrears had also accrued on the property. On returning from England, the family moved into homeless hostel accommodation before again being housed by the local authority in a low-demand suburban area. Following a fire in

their accommodation, the family moved again to emergency accommodation where they lived in one room for a year.

During the period they resided in the suburban estate the family were reported to the relevant health authority. A skip had to be ordered so that a roomful of black bags of rubbish and belongings could be removed. The oldest child, in particular, was displaying difficulties and was referred to various voluntary agencies for intervention work. Once the family moved to homeless accommodation, the health authority were no longer involved with the family.

After moving into the family transition unit the family presented as follows:

- the oldest child was constantly involved in misbehaviour incidents in the public areas
- the second child displayed regular tantrum fits in the public areas and appeared intensely unhappy and distressed
- the third child appeared totally withdrawn and again intensely unhappy
- all the children were bed-wetting, unkempt in appearance and psychologically neglected
- the accommodation became extremely dirty very quickly, unsafe, and held many black bags of belongings
- all of the family slept in one room
- rent arrears accrued.

A programme of intense intervention was put in place for the family including:

- referral to the health authority
- assignation of social workers: one to work with Joan, one to work with the oldest child and one to do mother/child work with the eldest child
- play therapy sessions with the second child
- referral of the third child to local after-school groups, and sessions between all the children and parent
- referral to child guidance for the oldest child and the assignation of a childcare worker
- weekly practical assistance with household chores such as shopping, budgeting and so on
- putting in place a system of regular reviews, goal setting and apartment checks.

This work together with other interventions happened on a planned and phased basis. One-and-a-half year's later, the children are attending school regularly; they all sleep in their own beds; the apartment is clean both internally and externally; rent arrears have been cleared; the children appear much more contented and are happy and cheerful. There are still issues concerning the oldest child who appears most damaged by the events of his past and present. At this point the appropriate intervention lies with the health authority. It is the unit's recommendation that Joan and her family be offered a house in an area where she feels that she could settle and where her oldest child, who resides mainly with his maternal grandmother, could be near.

Case study 2

Caroline and her family had been resident in the family transition unit for approximately one month when her research interview for this pilot study took place. At the time of interview Caroline was 30 years of age. Her children ranged in age from 11 months to ten years: daughter Sharon aged ten, son Paul aged seven, son Shane aged three and daughter Mary aged 11 months. At the time of interview Caroline was pregnant but she subsequently had a miscarriage.

Caroline and her family lived in local authority accommodation for six years. They became homeless due to ongoing violence from Caroline's partner and the children's father. They left owing substantial rent arrears to the local authority. The family then moved to Caroline's mother's house but due to family difficulties moved to a homeless hostel where they stayed for two months. Caroline and her family did not have a health board social worker but a local authority welfare officer worked closely with them prior to their admittance to the family transition unit.

On arrival in the family transition unit Caroline's children displayed behaviour causing concern. Sharon, the eldest was a suspicious, cautious child. Paul regularly displayed frustrated and upset behaviour. He appeared to be a very unhappy child. Shane's most notable difficulty was his lack of speech, and Mary was an extremely withdrawn, lifeless child. Caroline herself lacked confidence. Her budgeting skills were poor and she was lacking in home management skills.

Caroline was helped in managing both her finances and home management on a weekly basis. She was also helped to examine her life experiences and develop coping strategies. Caroline was referred to a local family centre but her attendance there has been very poor.

Over the past thirteen months, Caroline has become a much more confident woman. While she still has difficulties, her ability to cope with issues has improved. Weekly practical assistance with housework, budgeting, and so on has helped Caroline develop her home management skills. While all her rent arrears have not been cleared, a sizeable proportion has been paid off.

The older school-going children attend the local primary school. Paul's attendance has been excellent although Sharon's attendance has been consistently poor. Her behaviour appears to have deteriorated over the past year. She has experienced difficulties with many of the other children resident in the family transition unit. In recent months she has attended a family centre but little progress is evident yet. Paul, on the other hand, appears to have benefitted greatly from his recent experiences. His behaviour has improved, and overall he appears to be a happier child.

Shane and Mary's attendance at the unit's nursery has been very good and marked differences have occurred. Shane has attended speech therapy on a regular basis and shows marked improvement. Mary has developed into an animated toddler.

The family is now ready to move to local authority accommodation. They will continue to receive support from the community settlement service and it also recommended that they continue to attend a family centre.

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Mental Health Status of Homeless Children and Their Families: A Pilot Study.

Dr. AnneMarie Waldron, Ms. Genevieve Tobin, Dr. Paul McQuaid, Dept. of Child & Family Psychiatry, Mater Misericordiae Hospital, Dublin.

ABSTRACT

Aim

To examine the mental health status of homeless children and their families living in a supported temporary housing project.

Method

The population studied consisted of 14 families with 31 children. Children aged 2-16 years were eligible for the pilot study. Most of the families (12 out of 14) assessed were lone-parent (mother only) family units.

The assessment measures used included:

- a semi-structured interview
- General Health Questionnaire (GHQ)
- Child Behaviour Checklist (CBCL)
- Parenting Stress Index (PSI).

Results

The GHQ was completed by the 14 mothers and the 2 fathers. Twenty-eight per cent of the mothers indicated the presence of psychiatric “caseness”.

The CBCL was completed by each mother on the 31 children. More than a third of the children had a Total Problem Score above the clinical threshold, indicating the presence of mental health problems of sufficient severity to merit referral for treatment. Forty-five per cent of the children manifested Externalising problems in the deviant range, while 29% of the children manifested Internalising problems in the clinical range. Overall, 78% of the families had at least one child with a CBCL dimension of clinical significance.

The PSI was completed by each mother. Seventy per cent of the mothers obtained scores in the critical range. They reported feeling incompetent in their parenting role, being dominated by their children’s needs, and social isolation from relatives and peers. Their scores also indicated poor self-esteem and significant depressive symptoms. The peak score was for the lack of emotional and active support from the other parent.

Conclusion

This pilot study revealed a high level of stress and clinical morbidity in this group of homeless mothers and their children and the need to provide appropriate mental health supports and services for this vulnerable group

Research background

The most common profile of homelessness today is that of poor, female-headed families with pre-school children. (Victor, 1992; Wright, 1993; Scott, 1993; American Academy of Paediatrics, 1988; Bassuk & Rubin, 1987; Bassuk, Rubin & Lauriat, 1986; Wright, 1993). Studies over the last decade of homeless children have found that:

Homeless children..	Source
present more often with acute and chronic illnesses, such as respiratory and gastrointestinal conditions, hearing and vision problems, and skin conditions	Miller & Lin, 1998; Efron et al, 1996; Hu et al, 1989; Wood & Valdez, 1991
often have incomplete or delayed immunizations	Alperstein, Rappaport & Flanigan, 1998; Efron et al 1996
often suffer accidental injuries and burns	Parker et al, 1991
often fall within lower height percentiles than the housed population	Fierman et al, 1991
are more likely to use the Accident & Emergency (A&E) Departments, GP, and hospital services than the housed population	Victor C 1992; Black et al, 1991; Miller & Lin, 1998; Alperstein, Rappaport & Flanigan, 1998

In the US, the declining number of children covered by health insurance was noted and how this had a direct effect on the baseline health status of the children (Wright, 1993). In one study it was estimated that at least a third of the homeless children had no health insurance and that these children used the hospital A&E Department at a rate two to three times higher than the US general population (Miller & Lin, 1998). With regard to mental health and well-being, Zima et al (1996) wrote that “Homeless families embody two generations at risk for mental problems and limited access to care” (Zima et al, 1996: 332).

Research conducted in various countries consistently reports a number of consequences of homelessness for children. Higher rates of developmental delay and behavioural and emotional problems have been found in this population when compared to that of housed families (Vostanis et al, 1996; Wright, 1993; Zima et al, 1994; Bassuk, Rubin & Lauriat, 1986; Bassuk & Rubin, 1987; Bassuk & Rosenberg 1990; Efron et al, 1996; Parker et al, 1991; Hu et al, 1989). These include deficits in reading and language abilities, hyperactivity, aggression, depression and anxiety. Fox et al (1990) reported that almost two-thirds of the homeless children in their study had evidence of developmental delay and more than one-third exhibited emotional and behavioural problems. Similar findings were described by Parker et al (1991), Bassuk, Rubin & Lauriat (1986) and Rescorla, Parker & Stolley (1991). Zima et al

(1997) concluded that more than half of the children that they assessed were in need of special education evaluation. The same authors reported these children as having emotional and behavioural problems.

Bassuk & Rubin (1987) reported that approximately half of the homeless children they assessed needed referral for psychiatric evaluation. The children presented with higher rates of depression, anxiety and fear than their housed counterparts. Similar findings have been reported elsewhere (Zima et al, 1996; Menke, 1998; Efron et al, 1996; Masten et al, 1993).

Factors influencing mental health

Mental health is influenced by a number of factors. For a child this may include the:

- mental and physical health of carers (especially mothers)
- the quality of care
- the number of carers
- stability and quality of attachment relationships
- adverse life events
- major stressors.

The long-term implications for a child whose mental health needs are not met may be predicted, to some extent, as a spiral of conduct disorder, emotional disorder, school difficulties and drop-out, substance abuse, and anti-social behaviour. For a child in a homeless family the situation may be worse.

Effects of mother's mental health

How a mother's mental health impacts on that of her child has been well documented. Chronic maternal depression results in long-term effects on the child with regard to developmental delay and also in an increased risk of emotional and behavioural problems, such as depression and conduct disorder (Lang et al, 1996; Zima et al 1996). Leff (1993) reported that psychiatric morbidity was more prevalent in the homeless population.

A number of studies have reported that homeless mothers have a higher rate of mental disorder than housed impoverished mothers. Figures of between 50 per cent and 80 per cent have been quoted for homeless mothers presenting with depression, anxiety and substance abuse (Bassuk & Rosenberg, 1988; Bassuk, Rubin & Lauriat, 1986; Zima et al, 1996; Adams et al, 1996; Parker et al, 1991). As well as mental health problems, these mothers also more commonly report spousal abuse, child abuse, drug abuse, and weaker support networks (Wood et al, 1990a; Efron et al, 1996).

However, Zima et al (1996) found that few mothers (15 per cent) who were in need of services actually received mental health care.

Pilot study

There is limited data available on the effects of homelessness on mental health in an Irish context and none that looks specifically at children and their families. With this in mind, the pilot study reported on here was set up to examine these issues in families who had entered Focus Ireland's supported housing project. The hypothesis

is that these families present with more psychological and emotional difficulties than the housed population. If this is true, then this information is essential for appropriate service planning to meet the needs of this vulnerable population.

Methodology

The survey population comprised 14 homeless families with 31 children participating in Focus Ireland's transitional residential programme. Families who had children between the ages of two and sixteen were considered for the pilot study. In all cases, the children lived with their mothers, but in the case of only two families were the fathers co-habiting in the family transition units.

The key-worker from Focus Ireland approached the appropriate families and invited them to participate. The aim of the pilot study was explained to the parent(s) and a consent form was signed. The families were reassured of the confidential nature of the pilot study and informed of the option to withdraw from it at any time if they wished.

The assessment measures included the following:

- A semi-structured interview with the mother

An adapted version of the interview developed by Vostanis et al (1997) was used. The interview yields information on socio-demographic variables, circumstances leading to homelessness, previous and current life, health problems among the mothers and children, and contact with health and social services.

- General Health Questionnaire (GHQ)

This widely-used self-administered screening instrument is aimed at detecting adult mental health problems in the general population (Goldberg, 1978, 1991). The 28-item version was used in this pilot study. There are four sub-scales assessed in the GHQ:

- somatic symptoms (A)
- anxiety (B)
- social dysfunction (C)
- depression (D).

Cut-off scores have been established to identify possible mental health disorders. The simple Likert scoring method (0-1-2-3) was used, according to which a total score of over 39/40 indicates the presence of psychiatric disorder. Reliability and validity studies have shown the GHQ to be a useful screening instrument.

Fourteen mothers and two fathers completed the GHQ.

- Child behaviour checklist (CBCL)

The CBCL is a detailed and well-established instrument designed to record in a standardised format parents' ratings of the competencies and emotional and behavioural problems of children (Achenbach, 1991). T-scores are derived from raw scores. In the version for children aged 4–18 years the items are classified into the following four scales:

- Competence scale (activities, social and school)

Competence T-score scale of...	Range
below 37	clinical
37-40	borderline
above 40	normal

Competence scales are not scored for children aged 4–5 years and the CBCL version for the children ages 2–3 years does not have a competence scale.

- Internalising problems scale (withdrawn, somatic complaints and anxious/depressed)

Internalising T-score scale of...	Performance
above 63	clinical
60-63	borderline
below 60	normal

-
- Externalising problems scale (delinquent and aggressive behaviour)

Externalising T-score scale of...	Performance
above 63	clinical
60-63	borderline
below 60	normal

Norms are available according to age and gender groups. Reliability and validity studies have supported the effectiveness of the CBCL scales.

The CBCL was completed by the mothers of the 31 children in this pilot study.

-
- Parenting Stress Index (PSI)

The PSI is a screening and diagnostic instrument designed to yield a measure of the magnitude of stress in the parent–child relationship (Abidin, 1995). It was standardised for use with parents of children ranging in age from one month to 12 years. Percentile scores are used to interpret a respondent’s performance:

Percentile score	Performance
within the 15th to 80th percentiles	normal
at or above the 85th percentile	critical

The 101-item PSI yields child domain, parent domain and total stress scores together with an optional 19-item life stress scale. The child domain and parent domain characteristics are measured in the following sub-scales:

Child domain sub-scale	Code	Parent domain sub-scale	Code
Distractibility/hyperactivity	DI	Competence	CO
Adaptability	AD	Isolation	IS
Reinforces parent	RE	Attachment	AT
Demandingness	DE	Health	HE
Mood	MO	Role restriction	RO
Acceptability	AC	Depression	DP
		Spouse	SP

The life stress scale provides an index of the amount of stress outside the parent–child relationship.

A number of studies provide evidence for the construct and predictive validity of the PSI and correlation’s of the PSI with other measures.

The PSI was completed by the 14 mothers in this pilot study.

Results

GHQ results

16 questionnaires were completed (14 mothers, 2 fathers). The mean age of the parents was 27.8 years (range 20–35). The mean score attained was 25.87. Twenty-nine per cent of the mothers had scores which indicated the presence of psychiatric caseness (scoring more than 39/40). These findings are compared to the findings of the Vostanis study (1997) in Table 2.1.

Table 2.1 Results of GHQ - percentage indicating psychiatric caseness

Study	Mean score	% Scoring >39/40
Focus Ireland 2000	25.87	28.6
Vostanis 1997 – control group	14.6	0
Vostanis 1997 – homeless group	36.1	49.1

The Dublin pilot study showed a clinical case rate for the mothers which was considerably higher than that of Vostanis’ control group. However, when compared to his homeless group, the Dublin findings indicated a lower case rate. The difference may be due to the fact that in Vostanis’ study the homeless families were assessed within two weeks of admission to local authority hostels, whereas in the Dublin pilot study all of the families had been in temporary supported housing for at least six weeks.

Table 2.2 Results of GHQ - overall results

Code	D.O.B.	Age at assessment		Total score	A	B	C	D
		Years	Months					
A1	06/09/74	23	7	64*	13	17	19	15
B1	26/05/69	29	6	12	4	3	5	0
C1	31/05/78	20	1	41*	9	8	13	11
D1	10/10/65	32	10	24	7	9	5	3
E1	03/11/67	30	10	24	7	9	5	3
F1	01/05/70	29	7	6	0	1	4	1
G1	13/03/79	20	0	10	2	6	1	1
H1	07/05/75	23	10	13	4	1	6	2
I1	19/12/77	21	2	35	13	6	12	4
J1	16/06/70	29	10	33	10	15	6	2
J2	17/07/67	31	8	10	2	4	4	0
K1	15/08/72	26	8	28	10	12	4	2
L1	28/11/69	29	6	40*	9	15	14	2
M1	19/02/64	35	2	8	2	0	6	0
M2	20/02/65	34	2	17	9	4	3	1
N1	10/09/72	26	8	32	10	13	6	3
Total		445	1	414	114	133	117	50
Mean				25.87	7.12	8.31	7.31	3.12
SD				15.7	4.04	5.95	4.65	3.97

CBCL results

A total of 31 children, 19 boys and 12 girls were assessed. The mean age was 6.3 years (range 2–15).

Ten of the children had a total problem score in the clinical range (T-score >63). Two of the children had a total problem score within the borderline clinical range (T-score 60–63). Taken together, 12 of the children in this homeless population exhibited signs that they were likely to present with mental health problems of sufficient severity to merit referral for psychiatric assessment.

T-scores for the externalising and internalising dimensions for the CBCL were estimated. Fourteen of the children (45 per cent) had externalising T-scores in the clinical (n=9), or borderline (n=5) range, while nine children manifested Internalising problems in the clinical (n=7) or borderline (n=2) range. In all, when the CBCL scores were examined within each family, 11 of the 14 families (78 per cent) had at least one child with a CBCL dimension of clinical significance.

Prevalence studies assessing the rate of psychiatric disorders in children vary between five and 26 per cent depending on the population studied and the measures used (Rutter, Taylor & Hersov, 1994). Both the Dublin pilot study and that of Vostanis estimate the rate of disorder amongst the population of homeless children to be considerably higher. When the Dublin pilot study is compared to Vostanis, the case rate for both externalising and internalising T-scores were between three and four times that of his control population. This would concur with our hypothesis that the rate of psychiatric disorder is higher amongst homeless children than that of their housed counterparts.

Table 2.3 CBCL - External and internal T-test scores

Study	External T-test score	Internal T-test score
Focus Ireland 2000	58.5	55.2
Vostanis 1997 – Control group	49.8	48.1
Vostanis 1997 – Homeless group	55.3	53.5

PSI results

One child per family (14 children) was selected by the mothers for assessment using this instrument. The ages of the children ranged from two to ten years. Ten boys and four girls were assessed. Where there was more than one child in a family, the mother was asked to choose the child about whom she had the most concern. In each case where there was a choice between a boy or girl, each of the mothers chose the boy. The results of the PSI are of particular concern. With regard to the child domain, seven out of the 14 children (50 per cent) were scored as being in the critical range. Five of the six sub-scales were reported by the mothers to be of notable concern in contributing to the stress of the mother/child relationship:

Table 2.4 PSI results — child domain sub-scales

Child domain sub-scale	Code	% of children in critical range	Mothers reported....
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Child domain sub-scale	Code	% of children in critical range	Mothers reported.....
Adaptability	AD	57	great difficulty on the part of the children to adapt to changes and transitions.
Reinforces parent	RE	64	that they did not experience their child as a source of positive reinforcement.
Demandingness	DE	64	constant demands by their children for their attention and service.
Mood	MO	57	the children show frequent signs of unhappiness and crying.
Acceptability	AC	57	

Within the parent domain scale, ten of the 14 mothers (71 per cent) reported experiencing very high levels of parenting stress and obtained scores in the critical range. Five of the seven sub-scales of the parent domain were of particular concern:

Table 2.5 PSI results — parent domain sub-scales

Parent domain sub-scale	Code	% of mothers in critical range	Mothers reported.....
Competence	CO	57	a sense of incompetence in relation to their parenting role.
Isolation	IS	50	experiencing social isolation from their relatives and peers.
Role restriction	RO	64	seeing themselves as dominated by their children's demands and needs.
Depression	DP	57	poor self-esteem and the presence of significant depressive symptoms.
Spouse	SP	64	lack of emotional and active support from the other parent.

One very positive and significant finding was that the score on which the parents as a group were within the average range was in the domain of attachment to their children (attachment sub-scale). This indicates that the mothers were strongly invested in caring for their children and strongly motivated to fulfil their parenting role. The life stress scale, which provides an assessment of the situational stressors that moderate or exacerbate parenting stress, yielded a picture of multiple stresses in the immediate family associated with life events such as separation from or death of a close relative, loss of employment and financial difficulties, alcohol, drug and legal problems. Ten of the 14 mothers (71 per cent) yielded scores in the critical range. Overall the results from the PSI are alarming. With the exception of four sub-scales (distractibility/hyperactivity, acceptability, attachment, and health), all of the sub-scales had an average score in the critical range. Even the four sub-scales in the normal range are close to the critical range.

Table 2.6 PSI results — overall results

Sub-scale	Mean (SD)	Normal	Critical	Case Rate (%)
Child domain				
Distractability/Hyperactivity (DI)	28.14 (7.46)*	20-28	29-36	43
Adaptability (AD)	32.07 (7.95) *	20-28	30-38	57
Reinforces Parent (RE)	12.86 (3.74) *	7-11	12-18	64
Demandingness (DE)	24.5 (8.32) *	14-21	22-31	64
Mood (MO)	13.21 (4.1) *	7-11	12-18	57
Acceptability (AC)	15.86 (4.57) *	9-15	16-21	57
Parent Domain				
Competence (CO)	35.93 (7.37) *	23-34	35-45	57
Isolation (IS)	17.93 (6.33) *	10-16	17-22	50
Attachment (AT)	14.71 (5.73) *	10-15	16-22	36
Health (HE)	15.71 (5.58) *	9-15	16-21	57
Role Restriction (RO)	26.21 (5.89) *	14-23	24-32	64
Depression (DP)	26.50 (7.63) *	16-24	26-36	57
Spouse (SP)	25.50 (6.32) *	12-21	22-28	64
Totals				
Child Domain	126.64 (28.8) *	82-114	116-145	50
Parent Domain	162.50 (33.36)*	102-142	148-188	71
Total Stress	289.14 (58.03) *	188-252	258-320	71
Life Stress	27.93 (16.58) *	2-12	14-27	71
Total				14

*= critical range.

Discussion

The number of single-parent (usually mother-only) families with young children who find themselves in the vulnerable position of homelessness has increased at an alarming rate. The impact of this disruptive, unstable and often chaotic situation on young lives is becoming clear from research in various countries. Physical ill-health, developmental delay, emotional and behavioural disturbance, loss of contact with friends, disruption to education are significant challenges in themselves but with the added stress of homelessness the effects are even more worrying.

This pilot study is a new venture than families. The process has certain limitations with regard to conclusions and comments. The number of families and children who participated was small. The families involved had achieved some degree of accommodation stability in the family transition unit of Focus Ireland. This contrasted to some extent with the study by Vostanis (1997) where the families assessed were placed in short-term accommodation hostels. In that study they were assessed within two weeks of entering the hostels whereas in the Dublin pilot study the majority of the mothers interviewed had been in their accommodation for a number of months. At interview, the mothers spoke of their situation having changed since entry to the transitional residential project. They reported that the level of distress and concern about the well-being of their children had been significantly worse on initial arrival to the project. With regard to their responses to the GHQ, they

also reported a considerable improvement in their own mental health since obtaining some degree of stability of accommodation.

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Health Status of Homeless Families and Their Use of Medical Services: A Pilot Study

Dr. Siobhán Perot and Liz Pigott-Glynn PHN, Northern Area Health Board

ABSTRACT

Aim

To establish the health status of homeless children and to determine their use of health-care services.

Method

The surveyed population comprised 32 children, who were aged between two and 16 years, residing with their parent(s) in transitional accommodation. Information was obtained from the main carer, on demography, measurements of height and weight, obstetric and prenatal care, immunisation history, diet and use of health-care services.

Results

The key findings were that:

- there was a high prevalence of smoking by the mothers during pregnancy
- more than half the surveyed children could be at risk of contacting infectious diseases as a result of incomplete or no immunisations
- more than half of the children in the six months prior to being surveyed attended the general practitioner or the accident and emergency department with either respiratory or gastrointestinal tract infections
- there was underutilisation of some health-care services and questionable use of others.

Conclusion

The main recommendations include the need for further studies to validate the findings and the need for the development of a service tailored to meet the needs of homeless families.

REPORT

Introduction

There is little information available focussing on the health needs of homeless families in Ireland. The aim of this pilot study is to establish the health status of homeless children and to determine their use of health-care services.

Resolution 30.43 of the World Health Assembly (1977) stated that “the main social target of governments and of the World Health Organisation (WHO) in the coming decades should be the attainment by all citizens of the world, by the year of 2000, of a level of health that will permit them to lead a socially and economically productive life” (World Health Organisation, 1986).

In support of this resolution, the Irish Department of Health published *Shaping a Healthier Future—A Strategy for Effective Healthcare in the 1990’s* (Department of Health, 1994). This document established targets for health in Ireland, which were to be achieved through a philosophy of primary health care. The chief principles of this philosophy are equity, accessibility, empowerment, cultural sensitivity and self-determination. If these principles are to be put into practice, the health status of marginalised groups in contemporary society, because of their susceptibility to ill health, must be examined. Although *Shaping a Healthier Future—A Strategy for Effective Healthcare in the 1990’s* does not directly identify homeless people as a marginalised group, Houlihan (1997) suggests that they provide us with a good example of such a group.

The increase in the number of homeless families in recent years (Lowry 1996) is a source of concern for health professionals. This is due to the anecdotal and empirical observations from around the world which have demonstrated that certain facets of being homeless, including inadequate diet and sleeping location, limited facilities for daily hygiene and exposure to the elements can have a devastating impact upon the physical health of men, women and children.

There is a high morbidity within homeless families and this manifests itself in a variety of acute and chronic health problems. Homeless children¹ are more likely to have a history of anaemia, dental decay, impaired vision and delayed immunisation (Page et al, 1993) than domiciled children. Lower height percentiles and a greater degree of nutritional stress are also evident (Fierman et al, 1991). The study undertaken by Parker et al (1991) suggests that homeless children are more likely to suffer accidents, injuries and burns than domiciled children are. Alperstein et al (1988) noted that the health problems of homeless children were of greater frequency and severity, and that hospital admissions were more frequent than those of a comparison group of domiciled children.

The parents and children of homeless families are highly vulnerable to illness and fail to receive timely and continuous health care. This is illustrated by both Miller and Lin (1988) and Roth and Fox (1990). Their data suggests that homeless children do not utilise primary care or preventive care on a regular basis.

¹ For the purpose of this study the term homeless children refers to children within the context of a homeless family.

Being the first study of its kind in Ireland, this pilot study is broad and general in nature. Although the number of participants is small and care should be taken when interpreting the findings, we trust that this pilot study will help facilitate and prioritise further research into this area. It is also hoped that the information provided will help to influence the development of services in relation to homeless families, thus ensuring progress towards the principles outlined earlier.

It should be noted that a number of these families may not have been homeless at the time of some of their children's births or early childhood, and that residence in the family transition units would mean that families had a solid base from which to work, greater accessibility to primary health-care services and improved nutritional and hygiene facilities. The results of the pilot study might have been different if all of the children were born into a homeless situation and all the interviews had taken place whilst the families were living in emergency accommodation.

Methodology

The survey population for this pilot study comprised of children between two and 16 years of age. This age group was chosen to coincide with those selected by the team from the Department of Child Psychiatry. The subjects were residing in one or other of the two Focus Ireland family transition units in Dublin. A total of 15 families with eligible children were invited to participate in the pilot study. Only one family declined.

A questionnaire specifically designed for the purpose of this pilot study was used to acquire information. This information was obtained during a semi-structured interview that was conducted with the parent, by either an Area Medical Officer (AMO) or a Public Health Nurse (PHN).

The questionnaire was divided into six sections that sought information on:

- demography
- measurements of height and weight
- obstetric and prenatal care
- immunisation history
- diet
- use of health-care services.

Height and weight measurements were converted to age appropriate centiles using the Irish Clinical Growth Standards (Hoey, Tanner and Cox 1986).

Written consent was obtained from the parent by Focus Ireland staff whose role it was to explain the purpose of the pilot study. Confidentiality was maintained by the use of codes for all interviewees.

A feasibility study was carried out in early January 1998. One family was interviewed by all three agencies. This led to some alterations in the questionnaires to aid understanding by the interviewer. It also allowed a time plan to be drawn up (20 minutes per child for the Community Care Area 6 (CCA6) team). Data collection continued until May 1999.

All responses were recorded as reported by the mothers. None of the information was cross-checked against medical or other such records. It was not always possible to

compare many of the findings with those of the general population as relevant data could not be found.

Results

Demography

Information was obtained on 32 of the 38 children of the 14 participating families' children. (The remaining six children did not satisfy the age criteria.) Of these 14 families, two were nuclear (two-parent) families, and a lone female parent headed the remaining 12.

Table 3.1 Demography

Topic	Details*
<i>Average number of children per family</i>	2.7 (62.5% ** male, 37.5% female)
<i>Prior accommodation type</i>	63% emergency (B&B, hostel) 16% family home 7% refuge 7% mother and baby 7% United Kingdom At least 11 of the families were residing in some form of temporary accommodation prior to admission to the family transition unit.
<i>Prior accommodation location</i>	35% Dublin north inner city 28% Dublin south inner city 7% United Kindom 30% various suburbs of the greater Dublin area.

* Unless otherwise stated, percentages refer to the number of children.

** Percentages were rounded to the nearest whole figure.

Measurements of height and weight

Three of the children either declined to be weighed and measured or were unavailable to partake in this part of the pilot study. Eighty-seven per cent of the children were measured (Table 3.2) and weighed (Table 3.3). These measurements were converted to age-appropriate centiles, as set forth by Hoey, Tanner and Cox (1986).

Table 3.2. Children’s height centile score

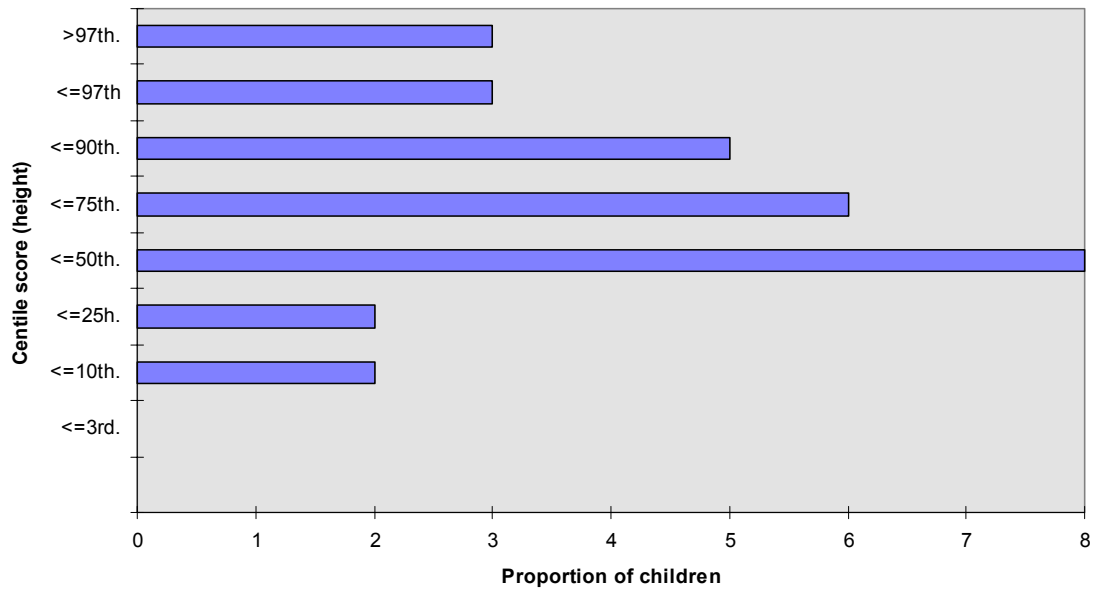
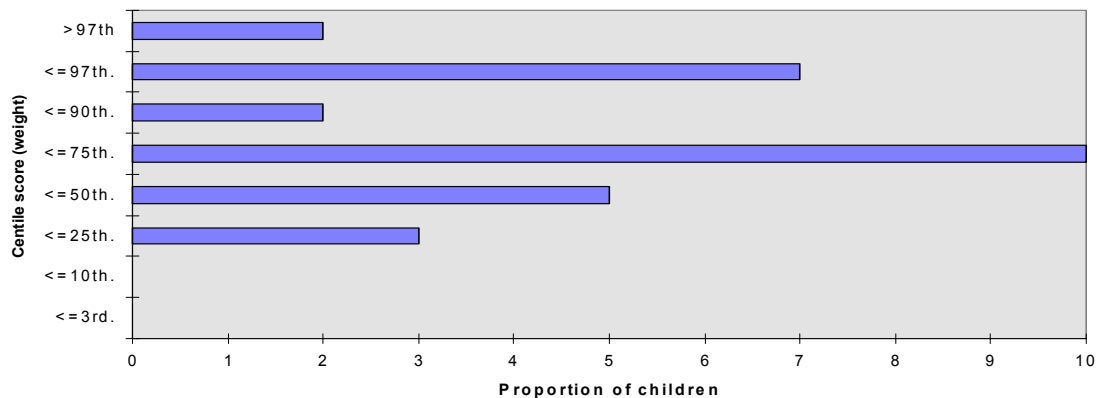


Table 3.3 Children’s weight centile score



When interpreting these findings Hoey, Tanner and Cox suggest that as a rough guide children outside the area of the 10th and 90th centile range for this average development should be regarded with slight suspicion. Those below the third and above the 97th centile may be regarded as unhealthy until proven otherwise. What is of interest is that none of the children were below the 3rd centile in terms of height and weight. Within the surveyed group, 41 per cent were on or below the 50th height centile and 27 per cent were on or below the 50th weight centile. Ten per cent of the children were above the 97th height centile, while 7 per cent were above the same weight centile.

Obstetric history and prenatal care

When asked about their obstetric histories in relation to each of their children, mothers reported the following:

Table 3.4 Obstetric history and prenatal care

Topic	Details*
<i>Antenatal care</i>	81%** had mothers who received regular antenatal care, attending either their GP or the hospital as requested. One mother stated that she avoided using obstetric services as she was abusing drugs at the time and feared both that her addiction would be discovered and that she would be harassed by midwives/doctors.
<i>Pregnancy complications</i>	44% were born from pregnancies with complications, including nausea, pneumonia and toxemia. 38% were born as a result of pregnancies that required hospital admission during the antenatal period.
<i>Use of alcohol, cigarettes, and drugs while pregnant</i>	19% were born to mothers who abused drugs and/or alcohol while pregnant. 87% of the mothers smoked cigarettes while pregnant. Almost all of the children were exposed to the adverse effects of passive smoking, while in utero.
<i>Condition at birth</i>	28% were not normal at birth. Of these 66% were admitted to the special care baby unit (SCBU). The reasons cited for these admissions included: <ul style="list-style-type: none"> ▪ breathing difficulties ▪ drug withdrawal ▪ infection ▪ reason unknown.

* Unless otherwise stated, percentages refer to the number of children.

** Percentages were rounded to the nearest whole figure.

Immunisation history

Table 3.5 Immunisation history

Topic	Details*
<i>Immunisation status</i>	44%** completed their primary immunisation programme. 27% did not complete their primary immunisation programme. 13% had no immunisations at all. 16% had an unknown immunisation status. The primary immunisation programme referred to is that offered by the Eastern Regional Health Board (EHRA), formerly the Eastern Health Board (EHB). The programme includes immunisation against diphtheria, pertussis and tetanus (commonly known as 3-in-1 or the 2-in-1 if the pertussis is

Topic	Details*
	<p>omitted), polio, haemophilus influenza (Hib), tuberculosis (BCG) and measles, mumps and rubella (MMR). The MMR and Hib vaccinations were only introduced to Ireland in the late eighties and early nineties.</p>
<p><i>Immunisation status of those who had not completed the EHRA primary immunisation programme</i></p>	<p>Of the 56% of children who had not completed their primary immunisation programme:</p> <ul style="list-style-type: none"> ■ 63% had not received the BCG ■ 42% had not received the MMR ■ 35% had either, not received or not completed the 3 in1 or 2 in1 and the Hib ■ 35% had an uncertain immunisation status ■ 28% had received no immunisations at all. <p>More than half of the children in the pilot study may be at risk of contracting a number of infectious diseases as a result of incomplete, or no, immunisation.</p>

* Unless otherwise stated, percentages refer to the number of children.

** Percentages were rounded to the nearest whole figure.

Diet

Information was sought to establish:

- breast feeding patterns
- use of formula milk and weaning history
- current dietary habits and diagnosis of anaemia

Table 3.6 Diet

Topic	Details*
<i>Breast feeding patterns</i>	27%** of the children were breast fed at birth. Of these, the length of time they were breast fed varied from between two weeks and four months, with: <ul style="list-style-type: none"> ▪ 33% breast fed for between two weeks and two months ▪ 33% breast fed for two months ▪ 22% breast fed for three months ▪ 11% breast fed for four months
<i>Use of formula milk</i>	54% fed formula milk until they reached the recommended age of one year. 38% fed with formula milk for less than 12 months, it being replaced with cow's milk in each case. 4% had a mother who was uncertain as to how long she had fed her child with formula milk. 4% were never given formula milk.
<i>Weaning</i>	53% were introduced to solids at the recommended age. Of the 47% who were introduced to solids before the recommended age, 25% were given them before they were two months old. The recommended age for the introduction of solids is four months.
<i>Daily dietary habits</i>	97% consumed milk products. 87% consumed meat, chicken, fish, eggs, lentils, or beans. 72% ate fruit and vegetables. All ate some or all of bread, cereal, rice, potatoes, and crackers.

* Unless otherwise stated, percentages refer to the number of children.

** Percentages were rounded to the nearest whole figure.

Use of health-care services

Information was sought on the use of health-care service, the uptake of some of the primary health-care services, and the follow-up of specialist referrals.

Table 3.7 Use of health-care services

Topic	Details*
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Topic	Details*
<i>Where children were taken in times of illness</i>	<p>13%** were routinely brought to the local accident and emergency department (A&E). 34% were brought to either the General Practitioner (GP) or A&E. 53% were usually taken to the GP.</p>
<i>Use of GP and A&E services in previous six months</i>	<p>41% availed of the local GP services. 27% were brought to the A&E department in the local children's hospital.</p>
<i>Use of GP services in previous six months</i>	<p>Of the children who were brought to the GP in the previous six months:</p> <ul style="list-style-type: none"> ■ 43% were seen once. ■ 43% were seen twice. ■ 14% were seen four times. <p>The reasons cited for attending the GP were:</p> <ul style="list-style-type: none"> ■ 50% symptoms consistent with respiratory tract infections (RTI) ■ 25% vomiting and diarrhoea ■ 12% symptoms suggestive of urinary tract infections (UTI) ■ 12% eye injury.

Topic	Details*
<i>Use of A&E services in previous six months</i>	<p>Of the 27% of children who were brought to the A&E department in the previous six months:</p> <ul style="list-style-type: none"> ■ 55% were brought once ■ 11% were brought twice ■ 33% were brought four times. <p>The sources of the referral to this department varied and included, the GP, the public health nurse (PHN) or self-referral by the mother.</p> <p>Self-referrals by the mothers were for the following reasons:</p> <ul style="list-style-type: none"> ■ 33% unintentional injury ■ 22% RTI symptoms ■ 11% symptoms suggestive of a UTI. <p>Reasons given for referrals from other sources included:</p> <ul style="list-style-type: none"> ■ 11% referred by GP for a mid-stream urine specimen (MSU) ■ 11% referred by the GP with meningeal symptoms ■ 11% referred by the PHN for attention to be given to severely overgrown toenails.
<i>Rate of hospital admissions</i>	<p>Half of the children were admitted to hospital at some stage in their lives:</p> <ul style="list-style-type: none"> ■ 62% were admitted once ■ 34% were admitted twice ■ 14% were admitted on at least three occasions. <p>The reasons mentioned for these admissions included:</p> <ul style="list-style-type: none"> ■ 37 % unintentional injuries ■ 24% respiratory illness ■ 18% social admissions ■ 7% management of gastrointestinal obstruction ■ 7% management of anaemia ■ 7% routine surgery. <p>Unintentional injuries included burns, head injuries and road traffic accidents.</p>
<i>Nine-month developmental assessment</i>	<p>50% had their nine-month developmental assessment. 22% did not have this developmental check-up. 28% of the mothers could not recall bringing their child for this assessment.</p>

Topic	Details*
<p><i>Contact with the Public Health Nurse (PHN)</i> This contact relates to contact with the PHN for each child from birth and up to the age of 3–4.</p>	<p>80% were visited by the PHN on at least one occasion. 65% of these were seen regularly (this was interpreted as being more than six times during the first four years of the child's life). One mother reported that she avoided all services offered.</p>
<p><i>Specialist referrals</i></p>	<p>25% were referred for specialist treatment at some stage in their lives. Of these:</p> <ul style="list-style-type: none"> ■ 35% Ear Nose and Throat specialist ■ 13% to the each of the following specialists: <ul style="list-style-type: none"> ■ Orthopaedic ■ Opthamology ■ Psychology ■ Paediatric ■ Respiratory.

* Unless otherwise stated, percentages refer to the number of children.

** Percentages were rounded to the nearest whole figure.

Discussion

Dublin's north and south inner city have a high and increasing number of units (hostels and B&B) for the accommodation of the homeless – the reported last place of residence for most of the families. (Many of the families had a history of multiple accommodation moves.) It is not uncommon for families to be required to vacate many of these premises during the daytime hours. This, coupled with the fact that homeless families are often less likely to have stable and supportive relationships (Bassuk et al, 1986) often results in families having no dependable ongoing place to live, or base to operate out of. Consequently, many spend their days walking around the city in order to access service providers in both the voluntary and statutory sector and could be at risk of exposure to the elements, noise and air pollution:

- The Standing Conference on Public Health (1994) stresses that people who live in these types of accommodation live in more overcrowded conditions than any other tenure type. Overcrowding leads to an increase in infectious diseases amongst children, particularly gastroenteritis, skin disorders and chest infections (The Royal College of Physicians, 1994). It is significant that almost half of the children attended either the GP or the A&E department with such conditions within the six-month period prior to the parent being interviewed.
- Pleace and Quilgars (1996) have highlighted the high rates of accidents amongst homeless children and have expressed concern that the cramped environment hinders the development of children in areas such as walking, co-ordination and speech skills. According to the Department of Health (2000) unintentional injuries account for up to 20 per cent of childhood hospital admissions. It is unknown what percentage of these admissions were from the homeless population as this

information is not available. However, it is worth noting that in this pilot study 37 per cent of the hospital admissions were as a result of unintentional injuries.

- Stone (1997) stresses that many temporary accommodations lack adequate bathrooms and toilet facilities, sinks and food preparation facilities. This basic lack of amenities makes it hard for families to keep clean and eat well-balanced, nutritional, affordable meals. Families are often forced to rely on food from cafes, food centres and take-aways, which could have an impact on the height and weight of the children.

All the participants in this pilot study were from a low socio-economic group. It has been documented that children from this group tend to:

- be of lower birth weight (Alberman, 1981; Dowding, 1982)
- be shorter and lighter than comparable children from higher socio-economic groups (Owen 1974; Donnet et al, 1981; Hoey et al, 1987)
- exhibit a pattern of stunting without wasting which is characteristic of poor children experiencing moderate, chronic nutritional stress (Fierman et al, 1991).

Sufficient information was not available from this pilot study to make any concrete comparisons with the above-mentioned findings.

Obstetric history and prenatal care

Almost one fifth of the children who participated in this pilot study were born to mothers who had misused drugs or alcohol during pregnancy. But what was more disturbing was the high prevalence of mothers who smoked whilst pregnant.

Smoking

It is known that cigarette smoking is common among the homeless as documented by Houlihan (1997) and Gelberg and Linn (1989) – 78 per cent of the surveyed population in each study smoked.

There are no annual statistics currently available on how many women in Ireland smoke during pregnancy. In this pilot study 84 per cent of the mothers reported to have smoked cigarettes whilst pregnant. This number is almost more than 30 per cent higher than the number of smokers recorded in the recently evaluated Rotunda Stop Smoking Program (1997) and in a survey on smoking habits of adolescents whilst pregnant as reported in the *Department of Public Health Annual Report* (2000).

Smoking in pregnancy affects the physical, intellectual and emotional development of a baby. The Royal College of Physicians, England (1996) report that:

- Maternal smoking during pregnancy and infancy is one of the most important avoidable risk factors for Sudden Infant Death Syndrome.
- Infants of parents who smoke are twice as likely to suffer from serious respiratory infection and asthma. (Within the six-month period prior to completing this survey more than half of the children who attended the GP and one-quarter who attended the A&E, had symptoms suggestive of respiratory tract infection.)
- One-third of cases of ‘glue ear’, the commonest cause of deafness

in children, is attributable to parental smoking.

- Children of parents who smoke more than ten cigarettes per day are shorter than children of non-smokers.
- Parental smoking is responsible for at least 17,000 admissions to hospital each year of children under the age of five years.

As a result of this high prevalence of smoking in the mothers whilst pregnant, almost all of the children surveyed would have been, and most likely continue to be, exposed to the risks of passive smoking.

Immunisation history

An appalling statistic gleaned from this pilot study was that only half of the children were reported to have completed their primary immunisation. Consideration has been given to the fact that the reason some of the older children may not have received the MMR vaccine is because it was not introduced to Ireland until the late eighties.

MMR

One of the targets of the Department of Health (Department of Health, 1994) immunisation program was the elimination of communicable disease such as pertussis, measles, mumps, rubella, poliomyelitis and haemophilus influenza. In order to achieve this target a vaccination rate of 95 per cent is the minimum required.

According to the Department of Health and Children (1999) statistics the national uptake rate for children born in the calendar year 1996 for full courses of vaccine were as follows:

- 3/2 in 1, polio, Hib 84%
- MMR 77%

While these national figures appear to be moving towards the target of 95 per cent, the results in our pilot study fall very short of this.

According to O'Flanagan (2000) the outbreak of measles in North County Dublin in the first six months of 2000 was a direct result of falling immunisation rates. Media reports linking the MMR vaccine with autism, asthma and Chrons disease, which may have led to a fall in vaccination rates, have now been proven to be unsubstantiated (O'Flanagan, 2000).

TB

30% of the children in this pilot study did not receive the BCG.

The WHO criteria for discontinuing this vaccination are as follows:

- The average annual notification rate of sputum positive pulmonary tuberculosis should be five cases per 100,000 or less during the previous three years.
- An average annual notification rate of tuberculosis meningitis in children under five years of age should be less than one case per ten million general population over the previous five years.

In 1998 there was one case of TB meningitis in a child who had not received BCG vaccination and eight cases of pulmonary TB in children up to the age of four years. A total of 154 cases of TB were notified to the Eastern Health Board. This is an increase of 25

notifications from 1997. In the light of these figures and the failure to satisfy the WHO criteria, BCG vaccination is unlikely to be discontinued for the foreseeable future.

It is difficult to ascertain how susceptible the surveyed children would be to contracting any of these diseases. However, a primary risk factor for exposure is contact with an infected person. This would be more prevalent as a result of living in overcrowded and unsanitary conditions.

Diet

Main sources

There is a dearth of information on the dietary habits of the homeless population. The main sources of data on the modern Irish diet are the:

- Irish National Nutrition Survey (Irish Nutrition and Diabetic Institute, 1990)
- Slán study (Friel NicGabhainn and Kellegher 1999): a survey of lifestyles attitude and nutrition in adults aged 18 years and over
- Health behaviour in school-aged children aged 9-17 years (Health Promotion Department of EHB, 1999).

These were not seen as applicable to this pilot study as the children interviewed in these surveys were either too old or did not necessarily belong to a disenfranchised section of the general population.

Studies on diet of low socio-economic groups

A number of Irish studies have focussed on the diet of low socio-economic groups. The nearest comparable papers for this pilot study were those carried out by Lee (1988), which highlighted the nutritional status of pre-school children in disadvantaged areas of Dublin and by Lee & Gibney (1989), which focussed on the nutritional status of a population with chronically high unemployment living in a suburb in Dublin.

Among the dietary findings were an adequate intake of protein but a very low intake of iron, zinc, folic acid and vitamins C and D. There was a very poor variety of foods being offered, a heavy reliance on milk as a source of protein, energy and vitamins and a very low consumption of meat, fruit and vegetables. There is little to suggest that the homeless children residing in the family transition unit ate differently from those in Lee's study. However, one would wonder what the diet of these children was like when the families were not in the relatively stable environment of the family transition units. Further research is required to establish the nutritional status of homeless children whilst living in emergency accommodation.

Anaemia

Evidence of poor iron intake was noted in ten per cent of the children who were diagnosed as having suffered from iron deficiency anaemia at some stage in their lives. The consequences of anaemia as identified by Gill (1995) include pallor, pica,

tiredness, anorexia and delayed psychomotor development. Gill (1989, 1995) and Gill & Segal (1997) state that iron deficiency anaemia affects ten per cent to 30 per cent of all infants and toddlers. He suggests that anaemia is often not diagnosed and most often nutritional in origin.

According to Gill (1995), breast-feeding provides adequate iron intake up to six months of age. It is very encouraging to note that almost one-third of the mothers in this pilot study reported to have breast fed all or some of their children. This means that over one-quarter of the surveyed children were breast fed, the length of time varying from two weeks to four months. Only nine per cent of these children were breast fed for three months or longer. However, these figures fall short of the targets set by the National Breast Feeding Policy (Department of Health, 1994) which are that half of the mothers giving birth in the year 2000 would breast feed their babies and that a third would still be breast feeding at four months.

Another cause of anaemia as identified by Gill (1995) is the early introduction of cow's milk to infants under the age of one year and that the use of either regular formula or follow-on formula milk will prevent the occurrence of anaemia during this period of rapid growth. Over one-third of the children were given cow's milk before the recommended age of 12 months. This is comparable with Lee's study (1988) which noted that the use of cow's milk instead of formula milk was very common in the lower socio-economic groups. The normal recommendation when an infant is fed on cow's milk before one year is that vitamin and iron supplements be added to the milk. In this pilot study, only nine per cent of the infants who were transferred to cow's milk at an early age received vitamin and iron supplements.

In view of the above findings it is possible that a number of the children in this pilot study could have suffered from the adverse consequences of undiagnosed anaemia at some stage during their early childhood.

Introduction to solids

Further dietary information revealed that almost half of the children were introduced to solids before the recommended age of four months. Over 50 per cent of this group were introduced to solids before two months of age. Early introduction of solids is associated with massive salt and water retention resulting in damage to the heart and kidneys. The recent tragic death of an infant in England who had been introduced to adult food at a very early age serves to highlight the importance of following dietary guidelines for babies.

Use of health-care services

This pilot study found that some health-care services were being under-utilised and a questionable suitable use of others.

Nine-month developmental This developmental examination is carried out by an Area Medical Officer (AMO) in a local health centre. It is a free service, offered to

assessment

all babies at nine months, irrespective of socio-economic circumstances. The objective of this service is to ensure early detection of developmental delay and physical and mental disability. Uptake of this service is varied throughout the region and ranges between 62 per cent and 92 per cent of eligible babies. Only 50 per cent of the children in this pilot study were reported to have had this examination.

The ERHA has a computerised child recording system, (Regional Interactive Child Health Surveillance system – RICHES) that details a child's birth history, address and immunisation status. This system generates invitations for attendance at developmental clinics that are sent out to the mothers. Many of the families in this survey had frequent changes of addresses and this could have led to the mothers not receiving their appointments for attendance at these clinics.

Contact with PHN

Most of the mothers who participated in this pilot study were visited on at least one occasion following the birth of their child by a PHN, but only a little over half remember being visited regularly.

The public health nursing service is a community-based service. The role of the PHN is to promote the health and social gain of clients, be they individuals, families or communities. This is achieved by working in partnership with clients to assess their needs and to plan and provide appropriate interventions.

The PHNs visit all newborn babies and their parents. They are often the first point of contact for people seeking services. The Child Care Act requires health boards to identify children who are at risk or who are not receiving adequate care and attention. The PHNs are best placed to identify such children in the first instance and when necessary to make referrals to other disciplines and agencies (EHB, 1998).

One of the components to working successfully with families is the building of trust between the parents and the PHN. This occurs over time with regular contact with parents. This contact may occur in the family home, at clinics or in other community settings. However, many of the PHNs who meet homeless families describe the obstacles they face, not alone in trying to maintain contact with families but also in providing them with continuous health care.

These obstacles include the frequency of changes of address, the requirement for parents to visit many other service providers or the necessity to leave their accommodation early in the mornings. Other circumstances that make it difficult to provide health care to homeless families include inappropriate living conditions, lack of resources, clients' perceptions of their own health status and needs, clients' fear of statutory services, and other far more pressing needs in their lives. Consequently, it is not always possible for a PHN to gain access to families and institute referrals where necessary.

Use of A&E hospital

Houlihan (1997) suggests that many homeless people use A&E hospital services, even for minor illnesses, because it provides

services

immediate access to health care. A&E departments are high-tech environments with highly trained staff set up to respond to acute emergencies and are not supposed to be used for dealing with minor or chronic illnesses.

In the US, homeless children use the A&E department at a rate two to three times higher than the general population (Miller, 1988). This pilot study noted that between 35 and 45% of the children were routinely brought to the A&E department in the local children's hospital instead of visiting a local GP.

Within the six-month period prior to being surveyed, almost one-third of the children were seen in the local A&E department. The reasons cited for these attendances were the common ailments of childhood – upper and lower respiratory tract illnesses, gastrointestinal upsets and accidents. It is very possible that many of these conditions could have been managed by the GP.

It is not surprising that many of the children in this pilot study are disenfranchised health wise. Not alone are they casualties of homelessness, poverty and lone-parenting but they are also exposed to health-damaging factors such as overcrowded conditions, poor sanitation, inferior nutrition, passive smoking and incomplete immunisation.

Recommendations

The available emergency and hostel accommodation for homeless families is often inappropriate and unsuitable for the families, and their needs are often not met. The prevention of homelessness for families should be a key target for service planners and providers. In response to the health needs of homeless families, as identified in this pilot study, the following recommendations are made:

- Any health promotion activities planned for homeless families should be specifically tailored to meet their identified needs and the goals set for these activities should be realistic. For example, would it be better to have a harm-reduction programme in relation to cigarette smoking as well as a cease-smoking programme?
- Immunisation uptake amongst the homeless must be improved. An immediate response to this should be the provision of resources to the relevant community care area staff so that opportunistic vaccination can take place.
- The recommendations made by the multidisciplinary group, established by the Chief Executive Officer of the EHB, in 1999 to identify the gaps in service provision for the homeless, should be implemented as soon as possible, especially the following:
 - Two multi-disciplinary primary care teams should be established specifically for the homeless, (one team in the north inner city and the other in the south inner city).

- At community care level a designated person from each of the professional groups should be made responsible for the homeless in each area.

This would hopefully ensure that all homeless families are assessed appropriately, linked to necessary services and that there is a continuum of care at all levels.

- Homeless families, with their frequent changes of address, require dedicated services for their specific needs. They often have little access to traditional health-care services. Consequently it is imperative that all those involved in their care collaborate to provide education, support and advice in order to obtain a greater degree of well-being amongst this deserving population and so prevent further jeopardy to this disenfranchised group. There is also a need for a database accessible by all relevant people in the health-care services
- The RICHS system, currently being updated, should include details of the accommodation status, drug and alcohol history of the parents and results of screening for Hepatitis B and C and HIV where necessary.
- Early intervention is the best intervention and parent education is an essential factor in this. Leaflets in health centres and surgeries are useless unless they are carefully designed, easily accessible and their contents explained by the primary health care team. The Health Promotion Unit has produced many useful and informative videos on all aspects of health promotion and health care. Accessibility to these videos in all health centres surgeries and homeless units would be a means of providing homeless people with relevant information on health in a form that does not rely on literacy skills.
- Further research should be carried out to validate the findings of this pilot study.

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Summary Recommendations of the Research Group

CONCLUSIONS

This pilot study, though small in scale, confirms its basic thesis that homeless families are more disadvantaged than comparative families on low incomes. It confirms very high levels of parental stress and strong attachment by the mothers to their children. One third of the children have clinical needs on the child behaviour checklist. The families are primarily lone-parent families who are isolated with poor social support and little support provided by the fathers to the mother and their children.

Most of the families have been in a cycle of homelessness and accommodation breakdown for lengthy periods of time. The current housing crisis clearly contributes to the duration of homelessness. The families use of health services is poor, as is the completion of immunization for the children. This pilot study confirms that some homeless families have multiple problems which require a sustained and integrated response from housing authorities, primary and specialist health services, schools, social work/family support services and the criminal justice system.

In the past year, there have been two important policy responses from relevant statutory agencies:

- In March 1999, the Eastern Health Board adopted a policy paper on the homeless – *Homelessness in the Eastern Health Board, Recommendations of a Multidisciplinary Group*. One of the central recommendations of this report was the establishment of two primary health care teams in Dublin specifically for the homeless, one for the north side and one for the south side. The primary health care team are to include the following disciplines: medical, social work, community welfare service, drugs service, psychiatric service and a care attendant. These teams have yet to be established.
- The Department of the Environment published a policy paper that has been adopted by the government – *Homelessness – An Integrated Strategy*. This policy document outlined the responsibilities of government departments and the government's commitment to reduce homelessness by increasing funding for services and providing accommodation.

The following section lists recommendations to improve the level of intervention with the vulnerable families with the aim of improving the families' capacity and providing services to the children. Key working principles should be early detection early prevention, and early intervention.

Recommendations

Prevention of homelessness

- 1) All the families have come from community-based situations; there should be targeted and interagency services supporting vulnerable families so they do not enter a cycle of homelessness. This prevention strategy should range from increased family support to protecting families from violence and intimidation from partners and neighbours.

Accommodation

- 1) Additional emergency accommodation should be provided for homeless families with adequate facilities and staffing to provide the accommodation and support the families' needs.
- 2) More transitional housing for families should be provided as the current supply cannot meet demands.
- 3) A substantive house-building programme should be undertaken to provide long-term move-on accommodation for the families thus reducing both the scale and duration of homelessness.

Medical

- 1) Any health promotion activities planned for homeless families should be specifically tailored to meet their identified needs and the goals set for these activities should be realistic.
- 2) Immunisation uptake amongst the homeless must be improved. An immediate response to this should be the provision of resources to the relevant community care area staff so that opportunistic vaccination can take place.
- 3) The primary care teams for the homeless population should be established as a matter of priority.
- 4) The RICHS System being adopted by the ERHA. and the Regional Health Boards should include details of the accommodation status, drug and alcohol history and results of screening for Hepatitis B and C and HIV where necessary.
- 5) Homeless families, with their frequent changes of address, require dedicated services for their specific needs. They often have little access to traditional health-care services. Consequently it is imperative that all those involved in their care collaborate to provide education, support and advice in order to obtain a greater degree of well-being amongst this deserving population and so prevent further jeopardy to this disenfranchised group.
- 6) Early intervention is the best intervention and parent education is an essential factor in this. Leaflets in health centres and surgeries are useless unless they are carefully designed, easily accessible and their contents explained by the primary health care team. The Health Promotion Unit has produced many useful and

informative videos on all aspects of health promotion and health care. Accessibility to these videos in all health centres surgeries and homeless units would be a means of providing homeless people with relevant information on health in a form that does not rely on literacy skills.

- 7) Further research should be carried out to validate the findings of this pilot study.

Services

- 1) Once families are in a cycle of homelessness a comprehensive assessment of their needs should be undertaken in an integrated manner by the relevant agencies. This assessment should include relevant child guidance and mental health components. The aim should be to identify the needs of the families and target services to these needs.
- 2) Nursery care for the children should be an essential component of service, with properly-resourced nursery provision for families living in hostels and B&Bs. Staffing for such nursery care needs to be increased to provide the necessary care for the homeless children as their needs are greater than those of housed children.
- 3) If family/childcare needs are identified, addressing these needs must be given priority. These services should be continued as families move into their new community.
- 4) A comprehensive and integrated approach by all services incorporating housing, family supports, childcare, and education should be introduced to target services to vulnerable families and to address their needs.

Research

- 1) A more comprehensive research study should be undertaken to measure the extent of the psychosocial needs of homeless families and there should be a follow-up study after their rehousing to establish the levels of psychosocial needs
- 2) The increased prevalence of mental health problems among the homeless, suggested by this pilot study, should be examined in a larger study. Intensive support services should be provided for these families and both children and parents should be encouraged to access mental health services.

Appendix A: Homelessness in Context

Justin O'Brien, B.A., Diploma in Child Care, Diploma in Social Work (CQSW)

Historical context

There has been remarkable change and significant improvement in both the nature and quality of Irish housing provision during the course of the twentieth century. It has changed from being primarily a rented sector to an owner-occupied one.

The basic objective of Irish housing policy, stated in the 1969 White Paper on Housing, was “to ensure that as far as the resources of the economy permit, every family can obtain for their occupation a house of good standard at a price and rent they can afford”. The 1966 Housing Act, a composite body of legislation, focussed on the relief of overcrowding and bad housing conditions. It made it obligatory for local authorities to adapt a scheme of priorities for the allocation of tenancies.

Priority was given to families and the elderly, and priority was normally given on the basis of size of the family, overcrowding, medical grounds and length of time on the waiting list. The policy objective stated in the 1969 White Paper has been affirmed by policy statements of the Department of the Environment in 1991 and 1995.

In broad terms public housing provision has been successful. At the turn of the century, Dublin was known for having slums with overcrowded, squalid living conditions for its poor, but by 1999 one researcher was able to say “local authority housing amounted to a central and largely successful pillar of Irish social policy” (Fahey, 1999:4). Since the foundation of the state, local authorities have constructed over 330,000 units of accommodation with some 230,000 units being purchased by tenants.

A feature of Irish public housing provision has been its cyclical nature. There were large scale building programmes in 1932–8, 1948–56 and 1967–87. Recessional periods occurred in 1939–45, 1955–9 and 1987–93. These cycles have been determined by political process, by economic growth or recession and emigration. In times of economic growth, in the 1960s and 1990s, the demand for public housing in the Dublin area has increased and supply has been less than demand. From the period of 1967–87 public housing outputs accounted for 20 to 30 per cent of total housing completions annually. Since 1987 it has been less than 10 per cent of total new annual completion (*Annual Housing Statistics Bulletins*, Various Years).

The reduction in the provision of public housing, both nationally and in Dublin, over the last 15 years is striking (See Table A.1). As the table indicates there has been an absolute decline in public housing provision since 1987 primarily because of the reduction in monies for public housing.

Table A.1 Provision of public housing (national figures)

Year	Local authority letting vacancies	Houses constructed	Total new lettings
1986	6,404	5,517	11,791
1999	2,939	3,121	6,060

Source: *Annual Housing Statistics Bulletins, Various Years*

In the Dublin region, in particular, increased demand for housing has led to increased housing costs and the ratio of house prices to the average industrial wage is at a ratio of 8.2:1 in the Dublin area.

Table A.2 Provision of public housing (Dublin figures)

	Local authority letting vacancies	Houses constructed	Total	Regionally
1986				
Dublin Corporation	2,284	1,358	3,522	3,522
1993				
Dublin Corporation	77	71	148	263
1999				
Dún Laoghaire Rathdown	204	42	246	
Fingal	84	47	131	
South Dublin	241	124	365	
Dublin Corporation	770	360	1,130	1,872

Source: *Annual Housing Bulletins, Various Years*

This has created a major increase in the demand for public housing and the scale of homelessness both nationally and regionally.

The number of households nationally in urgent need of rehousing has risen from 11,000 households in 1989 to nearly 29,000 in 1993 to 27,427 in 1996 to 39,176 households in 1999. The number of family household units with dependent children in need of housing has risen from 10,966 families in 1989 to 25,185 families in 1999, effectively a 130 per cent increase in 10 years.

The assessment of housing need for 1999 undertaken by the Dublin local authorities has established the following housing demands regionally:

Table A.3 Dublin Housing Need Assessment

1999	Single adults	Couples	Families	Regional total
Dún Laoghaire Rathdown	339	86	938	1,363
South Dublin	218	60	996	1,274
Fingal	335	126	1,935	2,396
Dublin Corporation	2,218	310	4,249	6,777
Total	3,110	582	8,118	11,810

Source: *Annual Housing Bulletin*, 1999

In the Dublin region there are a total of 8118 families with children on the housing waiting list including the 660 families who are assessed as being homeless. The correlation between public housing provision and housing need is very evident.

Legislative context

Homelessness was not defined or dealt with in Irish housing legislation until 1988. Under Section 53 of the 1954 Health Act, health boards had a duty to “provide institutional assistance to those unable to provide shelter for themselves”. Shelter and maintenance were to be provided in county homes or similar institutions run by the health authority. This statutory obligation had its origins in the Poor Law provision of the 19th century whereby destitute families, single adults and children were placed in the workhouse.

The 1988 Housing Act was passed by the Dáil after considerable lobbying by the voluntary sector for the recognition of homelessness within legislation and of the rights of single men/women to public housing. This campaign was a reaction to the lack of clarity surrounding the role and responsibilities of local authorities and health boards on these issues (O’Brien, 1981; Shannon, 1987).

Section 2 of the 1988 Act has the following definition of homelessness:

“A person shall be regarded as homeless for the purposes of this act if:

- there is no accommodation available which, in the opinion of the authority, he, together with any other person who normally resides with him, or who might reasonably be expected to reside with him, can reasonably occupy or remain in occupation of,
- or he is living in a hospital, county home, night shelter or other such institution, and is so living because he has no accommodation of the kind referred to in paragraph a) and he is, in the opinion of the authority, unable to provide accommodation from his own resources.”

This is a liberal definition of homelessness. Under Section 11 of the Housing Act, local authorities have a statutory obligation to assess the extent of homelessness and housing need at least every three years. Section 10 of this Act enables local authorities to respond to homelessness rather than obliging them to do so.

Reasons for homelessness

Homelessness occurs for a variety of reasons, some structural and some socially determined. The structural factors are usually related to lack of affordable housing, unemployment, emigration, poverty, social policy and institutional provision in the

areas of mental health, childcare and so on. The social factors are related to family conflict, relationship breakdown, domestic violence and the breakdown of the personal and professional support networks of the individual and family (NESC Report, 1989; ESRI, 1995; Blackwell & Kennedy, 1987).

Categories of homelessness

There are complex reasons why people become homeless and there has been insufficient research undertaken to identify the primary and secondary factors. The available research indicates three broad categories of homelessness:

- Visible homelessness – people living rough or sleeping in designated homeless hostels
- Hidden homelessness – people who 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
- People at risk of homelessness – people who have housing but are likely to become homeless because of economic difficulties or the threat of violence.

The homeless are not a homogeneous group and are not a stable one. Experience indicates that people may be at different stages of a homeless cycle: short-term, long-term and episodic homelessness. Both individuals and families may move from one cycle to another for a variety of reasons relating to structural and social/personal factors.

Measuring homelessness

There has been very little research undertaken in Ireland on homeless families and as a result there is an absence of information. Homeless families' needs have primarily been measured in the wider context of housing need. The 1966 Housing Act, as a composite legislation provision, clearly gave priority to the housing of families by local authorities.

Most studies on homelessness in the 1970's were of a quantitative nature, their focus being on counting the number of homeless people at particular periods of time. The main research undertaken by Ó Cinneide (1971), Hart (1978), Leahy (1974) and the Simon Community (1977) focussed on the single homeless population and found that the vast majority of the homeless population was male, 92 per cent, 87 per cent, 86 per cent and 84 per cent respectively in each survey group.

Kennedy's pioneering study on homeless women in Dublin in 1984 *But Where Can I Go?* revealed a different situation. This study found that the scale of need was much greater than had previously been thought and that there was both a visible group of homeless women – that is women living in hostels – and a larger, invisible group of women, who stayed with family or friends in overcrowded conditions.

Kennedy found that the reasons young women became homeless were “severe family disruption involving violence and incest; where women with children were concerned family disputes were the main cause of homelessness”. Once homeless, she found, they tended to get trapped in a cycle of homelessness, which is very difficult to break out of. This was because of their poverty, not having access to adequate income,

unavailable and unaffordable long-term accommodation, and inadequate information, advice and support services.

The Kennedy study established that in 1984, 384 homeless women were staying in hostels, 280 in long-term and 104 in short-term hostels. It found an average of ten newly homeless women being accommodated each week and ten women leaving the hostel each week suggesting an average of 520 women emerging as homeless in Dublin annually in 1984. Upon examination of the housing waiting lists and other services, an estimated 9000 hidden homeless women were indicated.

At that time there were four emergency hostels available to homeless families in Dublin. A total of 37 families or women with children were in hostel accommodation on 1 December 1984. The reasons for being out of home were domestic violence (66 per cent) and relationship difficulties with partner/parental family (20 per cent). The duration of homelessness was for a period of a month or less for one-third of the group. All the families were homeless for periods of less than six months and had moved out of the cycle.

A research study on hostel usage in Dublin undertaken in 1992 *Focus on Hostels* found a changing situation in terms of the scale of need. The research was conducted over two separate three-week periods and found that a total of 75 women with 196 children availed of the hostels. During a three-week period a total of 33 families with children entered hostels and 37 families with children left the hostels. This indicates a high rate of mobility of families in and out of hostels. Only two families spent more than four months living in hostels. These figures indicate that, on average, 600 families entered and left the hostel/refuge system annually. At that time there were five hostels/refuges with places available to homeless families. All of the hostels/refuges have a policy of not accepting male partners.

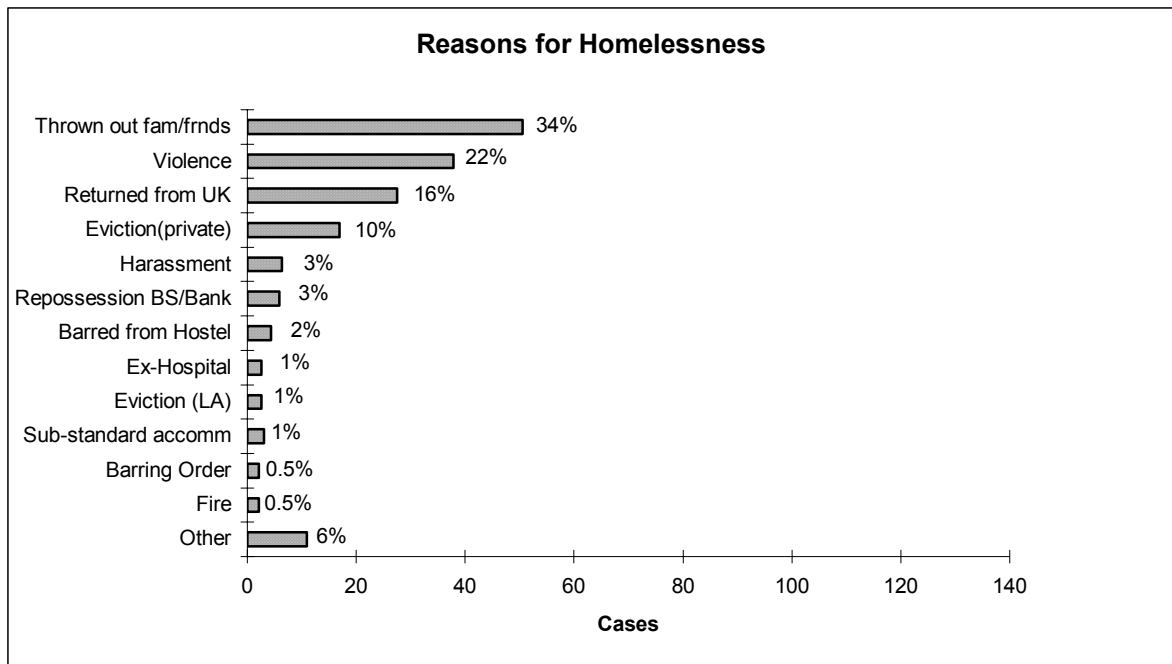
The study also established that the hostels for families were full to capacity and that a total of 122 families with 146 children could not be accommodated. This would suggest that over a thousand families annually sought emergency accommodation but could not get it. Some 16 two-parent families were placed in B&B accommodation. The reasons why families became homeless related primarily to domestic violence and relationship breakdown in the family.

Much of the debate on the measurement of the scale of homelessness has centred on the accuracy of the official assessment conducted by the local authorities. Voluntary agencies have criticised the measurement of the scale of homelessness as seriously underestimating the scale of need. This has been verified in the ESRI report *An Analysis of Social Housing Need* (1995), which confirmed great variations between local authorities as to how they counted the numbers of homeless persons. A significant feature is the use of a stock or flow measure to establish the numbers and consequent needs.

Current context: use of B&Bs

During the course of the 1990s, B&B accommodation has grown as a form of emergency accommodation provision because of the lack of available hostel accommodation. In 1992 a total of 355 homeless families availed of B&B accommodation, 254 lone-parent families, 101 two-parent families. The reasons for presenting as homeless were as follows:

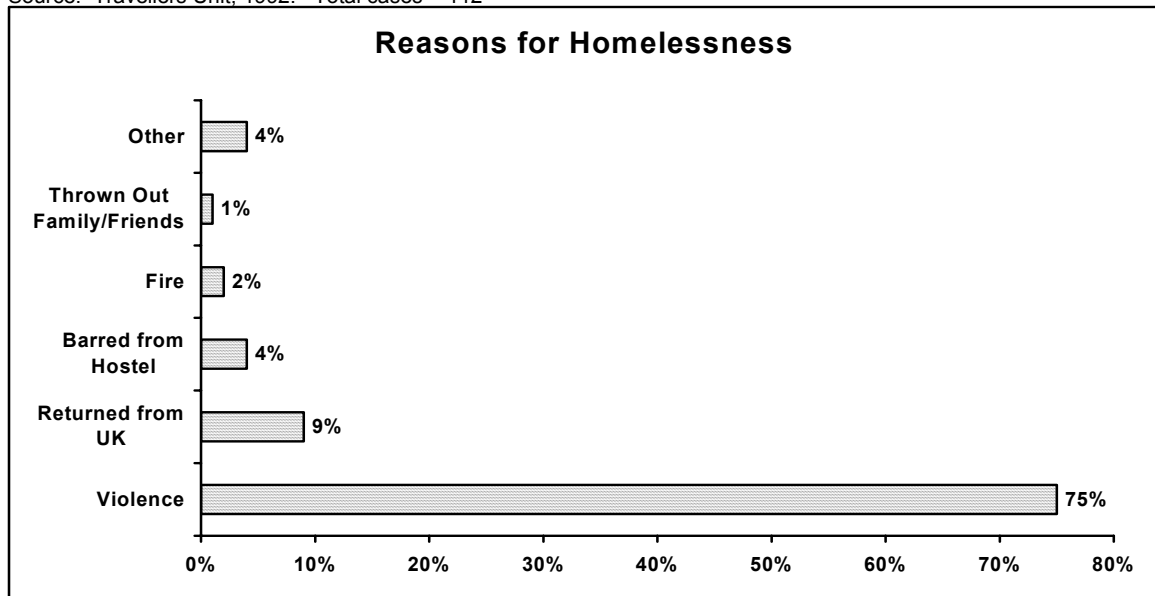
Table A.4 Reasons for homelessness among the settled community



Source: Moore (1994) Total Cases = 391

Table A.5 Reasons for homelessness among the travelling community

Source: Travellers Unit, 1992. Total cases = 112



In 1993 a total of 342 families were placed in B&B accommodation, comprising 231 lone-parents and 111 two-parent families.

In 1992 the overall length of stay in B&B accommodation was 12 nights and 20 nights respectively for one- and two-parent families. In 1993 this increased to 14 and 22 nights respectively. In 1998, 819 households comprising families and single people were placed in B&Bs because of the lack of available hostel accommodation.

In 1999, a total of 691 families were placed in B&B accommodation (Houghton et al, 2000).

Current context: recent figures

The most recent assessment of homelessness, *Counted In*, was carried out in 1999 by the Economic and Social Research Institute for the Homeless Initiative on behalf of the local authorities in the EHRA (Williams J. and O'Connor M., 2000). A total of 2900 households were assessed as being homeless, only two per cent of whom were in the Kildare and Wicklow County Council areas. Dublin Corporation had 95 per cent of the homeless population. A number of salient findings emerge:

- Of a total population of 2900 adults some 64 per cent were male and 1050, 36 per cent, were female (ESRI, 1999:22).
- The population defined itself into two broad categories: those who availed of homeless services (90 homeless families with 270 children) and those who did not have any contact with homeless services (570 homeless families) during the survey week. Of the population who availed of homeless services: 75 per cent were male and 24 per cent were female.
- A total of 660 families with 990 children were assessed as being homeless. Of the 990 children, some 530 (54 per cent) were under five years of age, 280 (28 per cent) were aged 6–11 years and 130 (13 per cent) were aged 12-15 years. This indicates a very young population of children within these families.
- Some significant differences emerge in the types of accommodation used by those accessing homeless services and those who did not. While the data did not indicate the accommodation status of the homeless families, the majority of the female population constitute females with children. The contrasts are very evident for the female population.

Table A.6 Homeless service use by females

	Slept rough (%)	Hostel (%)	Refuge (%)	B&B (%)	Friend's home (%)	Own accom. (%)	Transition supported accom. (%)
A	14	52	7	10	7	1	1
B	3	17	3	37	37	0	0

Source: (Williams J. and O'Connor M., 2000).

A = Availing of homeless services in the survey week

B = Not availing of homeless services in the survey week

Sixty per cent of the female population who availed of homeless services used hostel/refuge accommodation, 10 per cent used B&B and 7 per cent used a friend's home. Of the female population who did not avail of homeless services, only 20 per cent used hostels/refuges, 37 per cent used B&B and 37 per cent used a friend's home respectively.

This indicates very different patterns of support networks, accommodation provision and links to professional and informal support systems. It is also notable that 54 per cent of the females who are not availing of homeless services are actually living in designated hostels and B&Bs. Presumably they are not engaged

with designated homeless services either out of choice or because there are insufficient services accessible to them.

The contrast with the reliance on informal networks of friends for accommodation is significant: only 7 per cent of the homeless service users availed of friends accommodation, in contrast to 37 per cent from non-homeless service users.

Features of homelessness amongst families today

The evidence available on homeless families indicate some of the following features:

- The scale of homelessness is clearly related to the level of access to affordable and public housing provision.
- The families are mobile, that is they move in and out of the hostels, B&Bs and accommodation provided by family/friends.
- The majority of homeless families are not linked to homeless services. A smaller section of homeless families are linked to homeless services.
- The factors causing homelessness are primarily related to relationship breakdown with family/friends, domestic violence, and eviction from private rented sector. Drug addiction has emerged as a significant factor now causing homelessness.
- The number of homeless families has progressively increased throughout the past decade. The absolute increase in the number of families becoming homeless and remaining homeless must be linked to the decline in available local authority and affordable private rented accommodation.
- The available evidence indicates a total population of 37 homeless families in 1984 on a particular night and 660 families assessed as being homeless during a seven-day period in 1999.
- Because of their mobility and variety of needs, it is a major challenge to provide services to homeless families.

Summary

Since 1984 there has been a qualitative increase in the scale of homelessness among families in Dublin that is clearly related to the severe reduction in public housing provision by successive governments since 1987, changing patterns of household formation, and the increased demand for, and cost of, housing in the Dublin area. A housing crisis exists for those on average income and particularly for families who are poor. The personal factors precipitating homelessness have also changed with more families becoming homeless because of addiction problems. What is evident is the absolute increase in the number of families who are out of home, the lack of emergency hostel units and the placement of families in a range of B&B accommodation. The lack of available public housing has meant that families are remaining homeless for long periods of time in hostels and B&Bs (six months to over one year).

The challenge now to government, the public and voluntary sectors and the community is to plan effectively and respond to the crisis that exists today. The commitment by the present Government for the provision of public and voluntary housing under the National Development Plan and the enactment of the Planning Act 2000 is to be welcomed and hopefully will begin to address the problem.

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Main office: Focus Ireland
14a Eustace Street
Dublin 2
Telephone (01) 6712555
Fax (01) 6796843
e-mail: focusirl@indigo.ie
Website: www.focusireland.ie

This research was generously funded by the Combat Poverty Agency

The views expressed in this research are those of the authors and do not necessarily reflect the views of the Combat Poverty Agency