An Evaluation of the Psychosocial Benefits for Children Experiencing Homelessness Arising from the Introduction of an Integrated Community Care Project Across the City of Cork

Traolach O’ Callaghan
Department of Applied Social Studies, Munster Technological University, Cork, Ireland

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AN EVALUATION OF THE PSYCHOSOCIAL BENEFITS FOR CHILDREN EXPERIENCING HOMELESSNESS-
ARISING FROM THE INTRODUCTION OF AN INTEGRATED COMMUNITY CARE PROJECT ACROSS THE CITY OF CORK

Traolach O’ Callaghan
Department of Applied Social Studies
A thesis submitted to Munster Technological University, Cork, fulfils the requirement for MA Research.

Supervisors: Dr Tom O’ Connor & Dr Judith E Butler
Submission Date: 5th January 2023
ABSTRACT

The purpose of the research is to evaluate an intervention within a new model of family support being delivered in Cork City, on addressing child and family homelessness. This new model is being delivered for the first time in Ireland during ‘Youth Club’ and strives to act as an intervention to assist children experiencing homelessness. The model was first developed by Tusla Springboard Child and Family service and Good Shepherd Services Cork in 2016 in response to the alarming rise in child and family homelessness in Cork city, and the resulting impact of same. The research investigates the model and whether it can be judged a benchmark for child and family homelessness work in Cork city, making suggestions for improvement, if necessary, and where appropriate. The research endeavours to evaluate and measure the significant psychosocial benefits for children impacted by homelessness who engage with the model. The observation study on the model delivered during ‘Youth Club’ indicates that the environment is trauma sensitive, and the key workers are trauma aware ensuring that the needs of the children attending are met in a caring and responsive manner. This child-centred, child-led, and playful approach is rooted in relationships that welcome and honour every child’s lived experience and story (Butler et al., 2022). Moreover, this integrated model helps to establish a team around the child (Siraj-Blatchford et al., 2007) and reflects the spirit of shared responsibility and communal effort. The study findings concur with existing research (Blackman 2002) which has shown how family support and coordinated community involvement are the key to success with intervention for children. This model adopts a bi-ecological systems model of integrated working and operates Bronfenbrenner’s (1979) principle of multi-person systems of interaction. The pivotal points from the primary research very much identify clearly the social and psychological risks of homelessness to children. To coincide with this there is strong evidence of the positive impact that the integrated homeless service model has on the lives of families and children. With a view to policy implications there is a strong transferability of the current integrated service homeless model to other care programmes attempting enhanced integrated care within primary care networks. This evaluation is qualitative in nature and includes focus groups with key stakeholders including service users. Fundamentally, this qualitative approach provides in depth data obtained that allowed the participants to elaborate on their lived experience. Essentially, a deeper and wider exploration of this model, which is still in its infancy and as a result warrants and deserves more critical evaluation but in its present format certainly assists children impacted by homelessness in a holistic manner.
DECLARATION

I hereby certify that the material which is submitted in this thesis for the award of the Masters in Social Care is entirely my own work except where otherwise accredited and that the thesis has not been submitted for an award at any other institution other than the fulfilment of the award named above

Signature of candidate: 

Date: 5th January 2023

Signature of supervisors: 

Date : 5th January 2023
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CHAPTER 1 INTRODUCTION

1.1 Introduction

Homelessness and housing insecurity negatively affect children’s health and development in many ways, with evidence suggesting that children without homes are more likely to have psychosocial development issues than children with homes. (Selznick & Erdem, 2012). People living in overcrowded or poor-quality accommodation are more likely to be in consistent poverty (Social Justice Ireland, 2019). Fundamentally, economically marginalised people whose health and wellbeing are within the expected norms when they first became homeless, appear to experience marked deteriorations in health, including mental illness and addiction, if they cannot exist homelessness rapidly. (Culhane, Metraux, Byrne, Stino & Bainbridge, 2013). Figures offered by Focus Ireland indicates that there were 8,876 registered homeless people in the week of the 25th – 31st of May 2020, across Ireland. Alarmingly, this number of homeless families has increased by 115% since May 2015. There is evidence to suggest that statistics suggest that children account for higher than one in three, housed in emergency accommodation and this standard of accommodation for children and their families is below standard. This research correlates with other research (IHREC, 2017) to show that parents and children are sleeping in the same room in hotels and Bed & Breakfast accommodation with no facilities for cooking meals and must share bathrooms with other residents. This report poses several questions regarding the psychosocial impact on children forced to experiencing homelessness.

1.2 Purpose of this Study

The purpose of this research is to evaluate interventions facilitated by this new model of family support offered in Cork City (being delivered for the first time in Ireland) in its attempt to address child and family homelessness. This research paper investigates this intervention model and whether it can be judged a benchmark-model for child and family homelessness care in Cork City, and suggests improvement, where necessary, and if appropriate.

Research involved examining the impact of youth club intervention inter alia with other interventions within the current model, including individual therapeutic work, homework club breakfast club, boxing, and equine therapy; so as to achieve clear and verifiable conclusions about the psychosocial implication of homelessness on children.
The research further endeavours to evaluate and measure the significant psychological benefits for these families that this new model offers. This model is a revolving hybrid model created by Springboard, Tusla and Good Shepherd Services in June 2016, in response to the alarming rise in child and family homelessness, and the resulting impact of same.

1.3 Background and Aims

This Integrated Community Care Project known as ‘POD’ was established in 2016 by Springboard/Tusla and Good Shepherd Services with the purpose of tackling child homelessness. The model has evolved over time, and staff perceive it as an embryonic citywide Integrated Care Services model in its own right.

The three main aspects of the model involve professional interventions in the mentioned areas below, which are co-ordinated by an Integrated Community Care Team, working closely together, in a highly connected and horizontally integrated way, crystallised as a POD: A Multi/Inter-disciplinary Health and Social Care Team of Professionals:

1. Youth Club
2. Individual Therapeutic Work
3. Bed & Breakfast/ Hotel homelessness accommodation
1.4 Good Shepherd Services/Tusla (Springboard) Collaboration

Youth Club is held every Tuesday night in an Education Training Board (ETB) purpose-built youth facility. It is a multi-agency collaboration of services, involving both Good Shepherd services (homeless service) in conjunction with Tusla Family support services (Springboard), to address the chronic and traumatic social issues experienced by families and children resulting from the current homeless crisis. As a model of family support some very promising and favourable results have been indicated, suggested by the decreasing instance of Child Protection/CAMHS (Child and Adult Mental Health) referrals to the Statutory agencies. (Good Shepherd Services 2018)

A focus of this research has been the youth club intervention among children between the ages of 4 – 16, in conjunction with research into outreach support to families in B&Bs/ hotel accommodation and direct therapeutic work under the current model, in coming to clear verifiable conclusions regarding the psychosocial benefits for homeless children.
Notably the term ‘Youth Club’ is used to normalise the project. However, it is not atypical youth club, as all attendees are homeless. In addition, this Youth Club is strategically planned, to ensure that every child attending has a positive and enjoyable experience where their individual and collective needs are met through interactive, supportive, and respectful interactions and activities. Interactions and activities are developmentally appropriate, child-centred, and always child led.

Integral to the model is the Signs & Safety National Assessment framework approach adopted by Tusla (2017) which emphasises a commitment to building honest compassionate working relationships with children, families, and related service users. In recent months, this model has witnessed the expansion of the Youth Club to include support for Bed and Breakfasts (B&Bs) and to establish clear rapid pathways of support for individual ‘at risk’ children and families that emerge daily within this project.

Overseeing these interventions is a POD framework of staff from the lead agencies (Good Shepherd Services, Springboard and Tusla) who meet on a regular basis to review, evaluate and implement change, as and when the need arises. The staff that are highly skilled and adaptive to the complex and ever-changing needs of the children and families involved in Youth Club.

Individual Therapeutic Work: the POD endeavours to carry out and respond promptly to complex and traumatic situations which present daily in both Youth Club and B&B’s. This individual direct intervention/assessment work is now carried out immediately, as opposed to a typical, often lengthy referral process. In essence the ‘POD’ is a ‘team’ that can be very creative and responsive to the issues. This team consists of a multi-disciplinary group made up of Social Work, Social Care, Psychology, Youth and Community and child Care practitioners. The continued resourcing of the collaborative and integrative work of the POD proves to be crucial to improved outcomes for both Youth Club, B&B’s, and individual work.

At present, Good Shepherd Services supports 70 families in B&B’s and hotels. Tracking and supporting these families can be both challenging and complex, as these vulnerable families are often relocated daily.

The continued, consistent collaboration and integration of lead agencies is a vital link for the families during times of crises and trauma. This support is implemented in both a holistic and therapeutic manner. In essence this is very much what the project sets out to achieve; working
collaboratively with other agencies, devising family support plans/interventions rapidly which best meets the needs of families and young people.

Contemporary thinking by recent policy makers in Ireland is particularly focussed on a universal healthcare system where access to social and health care services is based on need, ensuring timely access to quality, effective, integrated services (Slaintecare 2017). Tusla (2017) adopted Signs & Safety National Assessment Framework which emphasises a commitment to building honest compassionate working relationships with children, families, and related service users. The all-party consensus on this was further reinforced by the position of the committee’s vision that ‘requires a system that is integrated in terms of all stages of an individual’s life, from cradle to the grave’ (ibid).

To conclude the following overall research question and sub research questions is what underpins and guides the research in hand.

An evaluation of the psychosocial benefits for children experiencing homelessness-arising from the introduction of an integrated community care project across the city of Cork.

1. What is the scale of child homelessness problem in Cork City?
2. What social and psychological risks does homelessness present for children?
3. Are there psychological benefits of the new integrated service model in child homeless services?
4. What are the key elements of the integrated homeless service model and merits/challenges associated with this model?
5. What are the public policy implications of the above?
CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

The right to a home is recognized by the United Nations (Article 25 in the Universal Declaration of Human Rights). Moreover, the article 25 UN has recognised homelessness as a violation of human rights with the Office of the UN high Commissioner asserting,

Homelessness has emerged as a global human rights crisis even in States where there are adequate resources to address it. It has, however, been largely insulated from human rights accountability and rarely addressed as a human rights violation requiring positive measures to eliminate and to prevent its recurrence. While strategies to address homelessness have become more prevalent in recent years, most have failed to address homelessness as a human rights violation, and few have provided for effective monitoring, enforcement, or remedies. (OHCHR, 2020)

Evidence has emerged to suggest that family homelessness is due to housing market failure and low and precarious income as opposed to problems within the family. (O’Sullivan, 2017). Despite the cause “Child homelessness has now become normalised in Ireland, but it should be a source of immense shame.” (McVerry, 2019)

2.2 What is the Scale of the Child Homelessness Problem in Cork City?

In researching the scale of homelessness, the researcher deliberates on different definitions and historical comparisons. Cork is be discussed as part of a broad debate of national and international research

According to Focus Ireland (2019) homelessness in Ireland today can mean several things: The traditional view of homelessness is that of adults on the street rough sleeping or staying in state funded emergency accommodation. A lot of these adults both young and old tend to have complex backgrounds including mental health, addiction, or a history of state care services.
Visible forms of homelessness include adults, who, as well as rough sleeping, stay in various forms of state funded emergency shelters and hostels. Hidden homelessness on the other hand is categorized for example as adults staying and sleeping with relatives or friends and who ideally are not availing of state support or intervention.

A third and very significant type of homelessness today in Ireland, is Family Homelessness and forms a substantial part of this research, which is assumed can be either, or, and a combination of hidden and visible homelessness. The impact of the 2008 financial austerity measures resulted in a momentous squeeze on the housing market and led catastrophic implications for children and families, as a result. The Department of Housing (June 2022) reports that latest figures in May show 10,325 homeless adults and children with over 3028 of them children, across the State. This is a 29 percent increase when compared to May of last year (ibid). As a result, thousands of children and families are now presently staying and living in what are known as Family Hubs (shared accommodation), hotel rooms, Bed and Breakfast accommodation and hostels .(IHREC 2017) As a result of this ‘lived experiences’ very often these children have become anxious, withdrawn, isolated, angry and confused, with relationships both immediate and socially becoming severed and damaged, leading to extremely traumatic and complex outcomes (Romero et al 2018, Sacks et al 2014).

The official definition of homelessness used in this country is a legal version (Housing Act 1988) and states that a person should be considered to be homeless if: (a) 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; (b) he is living 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(c) he cannot provide accommodation from his own resources. Interestingly a year later the European Commission (1989) set up The European Observatory on Homelessness operating with FEANTSA (the European Federation of National Organization’s Working with the Homeless) which has a more detailed definition of homelessness Whilst there is no universally accepted definition of homelessness, FEANTSA advocates for a broad understanding which encompasses rooflessness, houselessness and inadequate and insecure housing. This European model is very broad and allows one to use different definitions of homelessness. (Grotti 2018). FEANTSA’s main role is to highlight the vulnerable circumstances surrounding homelessness. To expand on this (Edgar 2004) speaks of ETHOS the European Typology of Homelessness and Housing Exclusion, which was
established to provide a common framework through which to discuss homelessness and to provide better quality data collection. ETHOS attempts to cover all living situations which amount to homelessness or housing exclusion. (ibid).

On the other hand, O Sullivan (2018) declares the Irish version with its routes in legislation very prescriptive

2.2.1 Definitions of Homelessness

The Central Statistics office defined homelessness for the Household Budget Survey of 1980 as “a situation of insufficient accommodation for a person or persons to form a household.” The homeless bill 1983, defined a homeless person, in law, who had no access to accommodation, either by ownership, or rent and who was dependent on shelters or institutions. (Perspectives on Irish Homelessness 2008)

O Giobuin (2015) defines and references homelessness in terms of the structural and individualistic. Structural explanations include the roles played by social and economic structures, poverty, negative market forces, welfare state retrenchment and the lack of affordable or accessible housing (Busch-Geertsema et al., 2010, p. 12). Individualistic explanations focus on the individual characteristics of those who are homeless, suggesting that homelessness arises from personal problems such as mental illness and addiction (Ibid, p. 12).

In the Irish context, while ‘individualistic’ homelessness continues to exist, ‘structural’ homeless appears to be the chief perpetrating factor for the growth of homelessness in the state, “with rising rents and a lack of social housing resulting in people relying on emergency accommodation, increasingly for extended periods of time” (Simon Community, 2015, p. 4)

In practice, the legal definition of the Irish model, Housing Act (1988) translates into different types of homelessness.

The visibly homeless are

• living rough, or
• sleeping in designated emergency accommodation such as a hostel

People at risk of homelessness have housing but are likely to become homeless through:

• economic difficulties, or
• the threat of violence

People rough sleeping are:
• not in contact with emergency services, and
• not staying in emergency accommodation While the 1988 Act does not impose a duty on housing authorities to provide housing to people who are homeless, it does clearly give responsibility to the local authorities to consider their needs and expand their powers to respond to those needs.

From an international angle, the US Department of Housing and Urban Development (HUD 2019) is responsible for creating strong, sustainable, inclusive communities, fair housing opportunities and quality affordable homes for everyone. They have an expanded definition of homelessness that spans individuals to families and youth:

• A person who lacks a fixed, regular, and adequate night-time residence which includes sleeping in a public place, a car, a campground
• A person or family living in a shelter supported by governmental or charitable programs - also includes hotels.

A person or family who officially loses their home and have no permanent place to go, are considered at-risk and homeless. The Housing Act, 1988 was introduced following intensive lobbying by a coalition of voluntary organization’s the National Campaign for the Homeless. The Act provided the first legal definition of homelessness in Ireland and is the basis underpinning how our legislators and City/County Councils are dealing with the present Family and Child homeless crisis

2.2.2 Mapping our Homelessness Crisis

Prior to the Housing Act 1988 the legislative framework for addressing homeless situations for adults was the Health Act (1953) the Housing Act (1966) and for children the Childrens Act (1908). With the emergence of the 1988 Housing Act and the Child Care Act 1991 for children created a lot of change. Mapping the recent history of Child and Family Homelessness is significant. From the 1950/60s homeless was dealt with by both the health boards and the local housing authority (ad hoc Committee 1983). Senator Brendan Kelly in 1983 campaigned in the Senate to have the Homeless Persons Bill (1983) introduced. This bill was rejected by the Government of the day in that its definition of homelessness was too broad and would lead to legal complications in the future. (Perspectives on Irish Homelessness 2008). Even as recent as
2013 our Government launched a 3-year plan to end long term homelessness where the narrative was that no family should be in emergency accommodation longer than 6 months. (O'Sullivan 2016)

With the collapse of building social housing and with the economic downturn, in 2015, only 75 units were built nationally – the lowest number in the history of the State, down from nearly 5,000 in 2008. (ibid) “the unremitting flow into homelessness, driven primarily by a dysfunctional private rented sector and a lack of social housing, has resulted in unprecedented numbers of homeless households in shelters, hostels and commercial hotels at the end of 2016.” Sullivan (2018 p11)

The 2013 report proposed to end homelessness by adopting a ‘housing-led’ approach, which was defined as “the rapid provision of secure housing, with support as needed to ensure sustainable tenancies” (Department of the Environment, Community and Local Government, 2013, p.2) It was a particularly ambitious objective, given the contraction of the Irish economy from 2008, when, in late 2010, the Irish Government being forced to secure a loan – formally known as a ‘Programme of Financial Support’ –

While having limited access to hard data to measure the scale of homelessness at the time, it was noted in the 2013 report that, given the relatively limited scale of long-term homelessness in Ireland, which they estimated at between 1,500 and 2,000, the target of ending long-term homelessness and the need to sleep rough by 2016, was realistic.

With a new Government in May 2016, a new Programme for Partnership Government was announced, (Government of Ireland, 2016, p.19). The Programme committed to publish, within 100 days, a new Action Plan for Housing, to increase the rent limits on the rent supplement scheme and to increase the social housing output substantially. The document also promised that the Action Plan on Housing would contain specific measures to prevent homelessness and to end the use of hostels and bed and breakfast type accommodation as long-term emergency accommodation, primarily through the provision of rapid-build housing (2016).

On 19 July, and within 100 days of the formation of the Government, an Action Plan for Housing and Homelessness, entitled ‘Rebuilding Ireland’ Department of Housing, Planning, Community and Local Government (2016), was launched. The Plan stated that the “long-term solution to the current homelessness issue is to increase the supply of homes” (2016, p.33). The Plan promised to limit the use of hotels for accommodating homeless families by mid2017. Also, under the plan, delivering greater output of social housing was to be the pillar of

Baker and Evans (2016) go further in stating that the ending of homelessness has “gone from politically unthinkable to politically mainstream”. Here, this researcher would argue that this very much ties in with the research question at hand, given the scale of the situation and the political mood or understanding at the time. As noted earlier, one of the consequences of the economic downturn was the virtual cessation of the building of social housing units by Local Authorities.

The Social Housing Strategy (2014) and the Rebuilding Ireland Action Plan (2016) respectively committed to providing 35,600 and 47,000 social housing units.

The recent ten-page critique on Rebuilding ‘Rebuilding Ireland’ JCFJ (2019) cuts right to the core, in its scathing rebuke of the programme “This is not just the failure of one minister, or one department, but a Government wide commitment to bankrupt ideas and crumbling policies. A radical reorientation is required” (JCFJ p2 2019) Here JCFI argue that pillar one is now the ‘Normalisation’ of homelessness and builds on Baker and Evans’ earlier point that it is now politically mainstream. Every month since the initiation of this programme the number of homeless families and children have increased. Very interestingly with reference to pillar two, it develops the argument that social housing is now privately owned with Rebuilding Ireland redefining social housing with the Government’s policies, costing over two million euro a day. JCFJ (2019). The above literature compliments very clearly the scale of the situation and the lack of homes and accommodation for children and families.

2.2.3 Scale of Homelessness

Application Returns made by housing authorities to the Department of Environment, indicated that 392 approved applicants classified as homeless were on the housing authority waiting list in Dec 31st1983 (Ad hoc committee1983). This represented 1.4% of the total approved applicants. Housing authorities made 363 lettings to homeless applicants during 1983 which represented over 4% of the total number of lettings made (these figures include homeless families and single homeless)
The scale of child and family homelessness both in contemporary Ireland and Cork continues to rise. ‘In the space of just one decade, Ireland has experienced an economic crash caused by a credit-fuelled oversupply of property, to a homelessness crisis caused by a lack of appropriate accommodation. Between 2006 and 2011, the housing stock in Ireland grew by 225,232. Between 2011 and 2016 that number was 8,800’. (Logan2018, pi).

In 2011, when the housing market more effectively met housing needs, homelessness was concentrated among those with disabilities or complex needs. Families were much less affected. The recent housing crisis has meant that homelessness has since cast a wider net and has reached previously unaffected groups. Grotti et al. (2018). Department of Housing figures (2015) showed 3625 adults and 1409 children were homeless in December of that year, while in March 2020, 6552 adults and 3355 children were registered as homeless, Department of Housing (2020). A significant increase and clearly reinforces Grotti’s point.

O Sullivan (2016), suggests it is not surprising that the determination to end homelessness in Ireland within a defined time frame has been replaced by a general aspiration to reduce the use of private emergency accommodation for families. In his paper, Ending Homelessness in Ireland (ibid), O Sullivan contends that due to a lack of social housing in the short term and the persistent rise in rents in the private market, as well as the ever decreasing availability of such properties, child and family homelessness will continue to rise.

Department of Housing figures (June 2022) concur with O Sullivan’s indications and show over 10,325 people were homeless during the week of May 23-29, 2022 across Ireland.

This figure includes adults and children. Accordingly, the McVerry Trust (2019) further enhances the scale of homelessness stating the number of homeless families has increased by 348% since August 2014. More than one in three people in emergency accommodation is a child. However, this number does not include ‘hidden homelessness’ which refers to people who are living in squats or ‘sofa surfing’ with friends. Furthermore, women and children staying in domestic violence refuges are not included in these homeless emergency accommodation counts. The national figure also does not include people who are sleeping rough.

Figures released by Temple St (Focus Ireland 2019) show there has been a 29% increase in the number of discharges from Temple St Children’s University Hospitals emergency department, of children, with no fixed home address. The figure of 842 from 2018 discharges of homeless
children compared to 651 discharges of homeless children in 2017, which represents a 29% increase. The majority of those who had no fixed address (85%) had medical complaints including abdominal pain, high temperatures, chest infection asthma, seizures, and vomiting. 23% had trauma including hand and arm injuries, head lacerations, burns and self-harm.

In Cork/Kerry, the earliest records of homelessness date back to the year 1983, Ad hoc committee (1983) where over that entire year a total of 125 males and 35 women were homeless at different stages with Edel House on 14 Dyke Parade, having accommodation for up to 35 girls, woman and children.

In contemporary Cork, the numbers of Child and family Homelessness has risen dramatically with the number of homeless families having more than tripled in the South West region in the past three year. (Focus Ireland 2019)

According to Department of Housing figures released in June (2022), the number of homeless people in Cork has been steadily rising throughout the year and the month of July recorded the highest number of homeless so far this year. Figures released for the South-West region which covers Cork and Kerry showed that 547 people are homeless as of May, with 379 of these being men and 168 being women.

The majority of those in this region are aged between 25 and 44, with 304 people in this age group recorded as homeless with 56 people between the age of 18 and 24 also included in the report. Of the 547 homeless in the region, 350 of these are living in private emergency accommodation such as hostels and B&Bs that are used on an emergency basis, while the other 199 are recorded as living in supported temporary accommodation, such as Family Hubs with onsite support. According to the figures, there are currently 72 families who are homeless in the South West region with 109 children included

The traditional response and to which most of the research points, centres on creating support for families and young people, deemed to have long term complex needs. As stated earlier by Grotti et al (2018), most of the families experiencing homelessness presently have never been in this position before and never thought this could happen to them, which was subsequently strengthened by Focus Ireland (2019). Most literature encountered centred on policy around young people leaving Care or transitioning into the Aftercare services. (Youth Homeless Strategy 2001).
Emily Logan, Chief Commissioner of the Irish Human Rights and Equality Commission captured the scale of homelessness in a foreword (2018 pi) “Addressing housing supply, and in particular the supply of social housing, is essential. However, a one-size-fits-all approach will not meet the needs of an increasingly diverse population. Both the private and public sectors need to step up to their obligations under equality and human rights law if we are to break the cycle of inequality and discrimination in housing.” The Department of Housing published its monthly homelessness report for January 2022. It reported that there were 9,150 homeless adults and children in emergency accommodation in January last, an increase of 236 on December. A total of 1,119 families were homeless, an increase of 42 in a month, with 2,563 children without a home, up 112 since December. (Department of Housing 2022)

2.3 Social and Psychological Risks of Homelessness for Children

2.3.1 Introduction

Evidence has emerged to suggest that family homelessness is due to housing market failure and low and precarious income, as opposed to problems within the family. (O’Sullivan, 2017). Homelessness and housing insecurity negatively affect child health and development in many ways, with evidence suggesting that children without homes are more likely to have psychosocial development issues than children with homes. (Slesnick & Erdem, 2012). People living in overcrowded or poor-quality accommodation are more likely to be in consistent poverty (Social Justice Ireland, 2019). Fundamentally, economically marginalised people whose health and wellbeing are within the expected norms when they first became homeless, appear to experience marked deteriorations in health, including mental illness and addiction, if they cannot exist homelessness rapidly. (Culhane, Metraux, Byrne, Stino & Bainbridge, 2013). The purpose of this section is to identify how homelessness affects the holistic development of children with particular emphasis on the social and psychological domains of development.

Extensive research asserts that toxic stress disrupts healthy child development by interfering with a child’s capacity to develop positive relationships with peers and adults (Jedd, Hunt, Cicchetti, Hunt, Cowell, Rogosch, & Thomas, 2015; Varese, SMEETS, Drukker, Lieverse,

2.3.2 Toxic Stress and Health Risks

Toxic stress, trauma and adversity affect children’s ability to explore, learn and self-regulate including the ability to regulate emotions, behaviour, and attention (Jedd et al., 2015). Similarly, Cairns (2001:199) highlights how trauma disrupts physiological, psychological, and social functioning in children and has the most impact during the first decade of life. She clarifies key areas where traumatised children have specific difficulty which include self-regulating stress, in processing information about the world and their own feelings and presents with the loss of ability to relate to others (ibid:202). Exposure to trauma is unfortunately common in children without a home (Ghosh Ippen, Harris, Van Horn, & Lieverman; 2011) and is certainly worthy of research, discussion and debate due to its significant prevalence, devastating impact and life-long consequences for our youngest citizens. Burns (2019:14) succinctly acknowledges that the impact of homelessness is all-encompassing in a child’s life causing many Adverse Childhood Experiences (ACE’s) and trauma.

2.3.3 The impact of Adverse Childhood Experiences

The Adverse Childhood Experiences (ACEs) study was landmark research conducted by Kaiser Permanente and the Centre for Disease Control and Prevention from 1995-1997. The objective of the study was to investigate the impact of trauma and stressful experiences during childhood on adult health outcomes (Anda, 2009; Felitti et al., 1998). Over 17,000 of Kaiser participants in the first Kaiser, ACEs study demonstrated 63% of participants reported at least one experience of childhood trauma and 20% of the participants reported trauma in three of more categories, which the researchers termed ‘Adverse Childhood Experiences (ACEs). In this original study, 10 family-level ACEs were identified, and findings demonstrate a graded relationship between the number of ACEs with health and behavioural health outcomes in
adulthood. Essentially, childhood trauma increases the risk for immediate and long-term adverse child outcomes (Downey et al 2017)

The original study measured the prevalence of seven adverse childhood experiences enquiring if a child had been exposed to:

1. Physical abuse
2. Sexual abuse
3. Emotional abuse
4. Household substance abuse
5. Household mental illness
6. Domestic violence (mother treated violently)
7. Incarcerated household member

Three additional experiences were subsequently added to include

8. Parental separation or divorce
9. Physical neglect
10. Emotional neglect

Nicholson, Perez, and Kurtz (2019) state that these ten questions have been adapted for international use and have been updated to include additional types of adversity and trauma to now include.

- Racism
- Witnessing violence outside the home
- Bullying
- Losing a parent to deportation
- Living in an unsafe neighbourhood
- Involvement in the foster care system
- Experiencing homelessness
- Living in a war zone
- Being an immigrant
- Witnessing a sibling, father, other caregiver, or extended family member being abused
- Involvement with the criminal justice system
- Attending a school that enforces a zero-tolerance discipline policy

(Nicholson, Perez, Kurtz et al., 2019: ix)

2.3.4 Homelessness and the Risk of ACE Exposure
Burns (2019:4) asserts that the impact of being homeless is essentially *shrouded in stigma and shame*. The landmark reports *No Place like Home* by the Ombudsman for children (2019) concurs, highlighting that children living in family hubs overwhelmingly experience feelings of ‘shame, guilt and anger’. Moreover, the concerns of homeless children have been documented, clearly showing that a lack of privacy, inadequate space, noise, not being able to have visitors/bring home friends, and a lack of quiet space to complete homework were all real challenges. Children as young as five have tried running away from family hubs, while others describe the hubs as “like a children’s jail”. Fundamentally, many challenges exist for homeless children which can all be detrimental to their development, health, and well-being (Ibid). Essentially, homeless Parents are under structural, economic, social, and political pressures which affect their capacity to support their holistic development and wellbeing (Rose, Gilbert & Richards, 2016).

2.3.5 Impact of homelessness on Parenting

Among parents experiencing homelessness, the rate of major depressive disorders is higher than in the general population while traumatic stress is nearly universal. (Poleshuck, Cerrito, Leshoure, Finocan-Kaag, & Kearney, 2013). Evidently, homeless accommodation are facilities that are not conducive to the development of young children, for many reasons, including that these controlled environments impact on the capacity to parent (Swick 2009, Aviles and Helfrich, 2004). The report ‘*No Place Like Home* (2019:43) concurs, highlighting that ‘Rules, policies and procedures vary greatly between Hubs but commonly cause children frustration and confusion’. Similarly, Swick (2009) explains that most homeless environments are controlled, and many regulations can affect family life, even going as far as institutionalising families within this controlled facility (Social Justice 2019; Swick, 2009). In addition, a child’s routine also changes, with evidence suggesting that the stress of these environments elicit behavioural changes in children (Baptista et al., 2017). Restrictions on cooking and limited storage tend to lead to poor diet, resulting inadequate nutrition for both children and parents. Take-away meals and cheap convenience foods are prevalent (Share & Hennessy, 2017) while the nature of communal living in family hubs is identified as a huge cause for concern in the ‘*No Place Like Home*’ Report (2019). The report further identified that children live in very close proximity to each other… it also means that children have no other option but to spend time with each other, which can lead to tensions between children and bullying was reported
by a number of children. (Ibid:47) Moreover, stigma is a recurring theme in the literature. Social stigma of this kind can also affect children; those who attend school may hide their housing status from peers due to fear of social exclusion (Baptista et al., 2017). Children refer to their shame and embarrassed at being homeless while parents felt that they had failed in their role as parents. (Burns, 2019; Ombudsman for Children’s Office, 2019). Fundamentally, these feelings of failure, shame and embarrassment have implications for sense of worth and dignity (Cairns, 2001).

2.3.6 Risk for Immediate and Long-term adverse Child Outcomes

Childhood stress and trauma compromises neurological development and increases risk for immediate and long-term adverse health outcomes (Burke, Hellman, Scott, Weems, & Victor, Carrion, 2011; Cairns, 2001). Extensive evidence suggests that individuals with four or more ACEs are two to five times as likely to develop numerous chronic health conditions, including diabetes, cancer, cardiovascular, and respiratory diseases (Burke, 2011, Cairns, 2001; Felitti et al., 1998). Research further asserts that these individuals are more likely to develop clinical depression, substance use disorders and suicidality, in comparison to people presenting with no ACEs (Lanier, Maguire-Jack, Lombardi, Frey & Rose, 2017); Remigio-Baker, Hayes, and Reyes-Salvail (2015); Burke et al., 2011). Notably, individuals with higher ACE scores are more likely to engage in risky behaviours e.g., substance use (Campbell, 2016) while for those who do not practice risky behaviour but who still present with ACEs, the risk for poor health also exist. (Hunt, Tenah, Slack, & Berger. 2017; Burke et al 2011; Kessler et al., 2010). Children with high ACE scores are more likely to experience depression and anxiety while developmental delay is also more common, including cognitive and socioemotional health issues, academic challenges, behavioural health issues, and specialised health needs (Nicholson et al., 2019). ACEs also increase the likelihood of secondary school non-completion, not achieving a higher-level degree, being unemployed in adulthood, living below the poverty line, and experiencing homelessness. (Nicholson et al., 2019; Almuneef, 2014; Metzler, Merrick, Klevens, Ports, & Ford, 2017; Herman, Susser. Struening & Link, 1997)

The long-term social and economic impact of homelessness on children as they move into adulthood should also not be underestimated (Herman et al., 1997). Essentially, educational outcomes are poorer as are physical and mental health outcomes (Cairns, 2001; Herman, 1997).
Moreover, employment and earning potential for those who have experienced homelessness are negatively impacted for the rest of their lives. (Social Justice, 2019; Slesnick & Erdem, 2012)

The experience of housing insecurity because of rising housing/rental costs, poor quality housing including overcrowding, unstable neighbourhoods, and homelessness place children at risk of ACE exposure (NHCHC, 2019). Similarly, Lanier et al (2017) study posits that different combinations of ACEs are associated with different risks for children’s well-being. These authors expand that children experiencing poverty and parental mental illness were found to have the highest level of risk for health care needs compared to children without ACE’s. Similarly, Morton et al., (2017) research concurs highlighting that timing and pattern of ACE exposure is also significant and can affect health outcomes. The results of this study show that children who only experienced increasing ACE exposure between the years of birth3 years of age, experienced outcomes like children with consistently high ACE exposure, regardless of cumulative difference. While there are many macro factors including class, race and gender that influence a child’s future, poverty has significant implications for a child’s overall development, health, and wellbeing (Owen 2017). Moreover, the longer a child endures poverty, the greater the impact and legacy on their holistic development (Evans et al., 2011) and the same is be said for homelessness, the longer a child is homeless the greater the impact (Culhane et al., 2013).

2.3.7 The Team around the Child

The wraparound team should be composed of people who have a strong commitment to the family’s well-being (Bruns & Walker, 2008:4)

An integrated model that helps to establish a team around the child (Siraj-Blatchford et al., 2007) reflects the spirit of shared responsibility and communal effort. Blackman (2002) has shown how family support and coordinated community involvement, are the key to success with intervention. Adopting a bio-ecological systems model of integrated working and operates on Bronfenbrenner’s (1979) principle of multi-person systems of interaction. ‘Wraparound’ is a process which aims to meet multiple needs and promote engagement through dialogue, collaboration, multidisciplinary practice, and service delivery in communities (Miles, &
Brown, 2011; Walker, 2008). Essentially, with support from a team of professionals, the family’s needs and preferences all drive the work of the ‘wraparound’ approach.

Any intervention to minimise and buffer the traumatic impact of homelessness on children must take cognisance of the whole child and his or her holistic development and wellbeing. Key people have significant roles to support any healing process involving trauma.

2.3.8 Key Person Approach

The key person approach developed by Goldschmied, & Jackson (1994) is a method of care associated with Early Childhood Care and Education (ECEC). The idea is that each child is assigned a particular educator who will act as their ‘go to’ person. This person supports the child and their family and continue to be the key person for key moments of emotional intimacy, building up a secure attachment with the child. For children impacted by trauma their bodies and minds are primed for physiological state of fear and survival (Butler et al., 2022). As a result, they tend to over identify situations as threatening and respond in a state of fight, flight, or freeze, while brain, is altered or impaired. As a result, ACES children can easily misperceive a situation, such as a transition, a look on a teacher’s face, or a difficult assignment, as a threat to their safety (Butler et al., 2022; Romero et al., 2018:69).

2.4 The key elements of the Cork Integrated Homeless Service Model under investigation and the Merits/Challenges Associated with the model.

2.4.1 Introduction

Research has indicated (Slaintecare 2017, Goodwin 2013.) when interventions are based on integration and partnership with service users and where the focus is on practical solutions, relationship building and early intervention, common goals can be achieved. “Integration is the glue that bonds the system together, enabling the achievement of common goals and optimal results” (O Connor, 2013, p195). Equally, in relation to family and child homelessness the approach from services needs to be integrated and preventative, to be effective, thus focusing on the most vulnerable families where using a community model of partnership where ‘the engagement between these informal networks and the more formal state provided services that
A real partnership is developed and sustained and through which people come together in a way that supports and enables communities to meet local needs (Community Healthcare Organizations Report 2014 p32). In essence, an integrative homeless model which sets out to achieve working in collaboration with other agencies, in devising plans for families in an attempt to support and ‘hold it’ very much brings Winnicott’s (1990) ‘Holding Environment’ to the fore. Some of the challenges facing this model is the argument that some existing services wait until a service user need is greatest (Darker 2014). Likewise, another challenge is that one form of integration does not suit all and can take time to become successful (Pike and Mongan 2014). The tenacity of this section is to explore the key elements of the integrated homeless service model and the merits/challenges associated with it. Essential to this is that consistent meaningful positive relationships are achieved with vulnerable children and families who are experiencing homelessness, where trust and reciprocity between family and workers intervening is equally important and can possibly reduce the incidence of trauma (Tobin and Murphy 2013).

2.4.2 Relationships

Research suggests (Butler et al., 2022; Signs & Safety Tusla 2017), the most dynamic ingredient in the success of interventions provided by care professionals, is the quality of their relationship with the family in question. According to The Harvard Centre for the Developing Child (2019) when practitioners know how to connect with families, discover ways to listen, build trust and work and collaborate in finding solutions, then outcomes for children and families can be achieved.

Having the right culture of relationships at all levels be it horizontal or vertical in the integrative process is essential. This means demonstrating the importance of good relationships at all levels, from leaders to frontline practitioners. It means making the quality of relationships a priority for everyone, highlighted within the organization’s vision (Gillison 2017). In addition, for homeless families speaking and connecting to other families in similar situations, can be a significant contributing factor in the healing process and foster a sense of not being alone.
(Tobin and Murphy 2013). Fostering responsive relationships with adults and children is also significant to improving outcomes during the journey through homelessness (Bellis et al, 2014). Concurring with this research, the Harvard Centre (2019), further argues that responsive relationships assist in shielding toxic stress during difficult experiences.

2.4.3 Prevention

Grim experiences such as homelessness, can spiral families into difficult areas such as risk assessment, as these experiences can challenge a parent’s capacity to provide a safe and nurturing environment (Tusla 2019). The Scottish Government (2012) reiterates that approaches from services needs to be integrated and preventative to be effective. Children’s First (2011) is the framework that guides all those working with children, not only in a paid but also voluntary capacity. In 2014 Tulsa and the Department of Children and Youth Affairs developed a new national policy framework for children and young people, called “Better Outcomes Brighter Futures”; its aim seeks ensure young people who are marginalised or 'at risk' or who demonstrate challenging or high-risk behaviour, have access to an integrated range of support and services, to help them achieve their best possible outcomes. It also seeks to ensure that no young person falls through the cracks because of fragmented services (DCYA 2014-2020). Integral to the model is the Signs & Safety National Assessment framework approach adopted by Tusla (2017) which emphasises a commitment to building honest compassionate working relationships with children, families, and related service users.

At a local level in Cork this model has adopted guidelines providing an integrated approach to service users, known as the POD, that best meets their needs. (See diagram 1.1) For the purposes of the literature under discussion here, it sets out the appropriate benchmarks for measuring the merits and challenges of the integrated services model in question, while the primary research which comes later, provides the evidence, allowing this sub-question to be answered by correlating the primary research against these indicators, in the second half of this thesis.

Youth clubs as a model of family support, are indicative of some very promising and favourable results in significantly decreasing the number of Child Protection/CAMHS (Child and Adult Mental Health) referrals, to the Statutory agencies (Good Shepherd Services 2018).
2.4.4 Merits and Challenges of Integrated Care

In order to see the benefits of integrated care, it is useful to view the deficiency within a system that is not integrated to an appreciable extent, which was the case for Irish health and social care services at the beginning of the 1990s. The earliest call for an integrated care system was made in the seminal Department of Health public policy document, *Shaping a Healthier Future* in 1994.

*The system is too compartmentalised to achieve the objective of providing care in an appropriate setting, it is essential that there are effective linkages between the services. Hospitals, general practitioners, and other community services should operate as elements of an integrated system within which patients can move freely as their needs dictate. At present, the system is too compartmentalised to permit this flexibility*  

*(DoH 1994: 26).*

Since then, the benefits of providing integrated care for all population health and social care groups have been strongly highlighted in Irish public policy. The Quality and Fairness (2001) Primary Care Strategy, with its calling for the setting up of Primary Care Teams, which would link in with specialist health and social care services for families and communities, with the family at the centre, was well-established. See fig 2.1
Ten years later, a more detailed integrated service model was set up by the HSE (2011), which placed integrated care as a key objective in putting families, patients and service users at the centre of care delivery, putting a far stronger focus on community care and positing the position that an increased integration Primary Care and Community Health and Social Care Networks, with strong linkages to secondary and tertiary levels of care, would empower service users, improve the organisation and delivery of care, and prevent reduce the number of people who potentially may need to be cared in social care institutions or hospitals.

Some of the merits of a successful integrative care model sets out to address fragmentation of services encountered by families i.e. those experiencing homelessness. According to the kings Fund Trust, concerns about the lack integrated care goes back before the initiation of the NHS. Post-World War 2, when fractures in systems of care delivery needed to be urgently addressed.

According to the Community Health Care Organisations report, the model, rather than look at structural issues, should very much focus on outcomes of care, the patient experience and needs of families where services must be delivered with the service user/patient at the centre (HSE 2013). Achieving integrated care requires those involved to ‘impose the patient’s perspective as the organising principle of service delivery’ (Lloyd et al, 2005: p7)
A key summary of some of the merits associated with a model of integrated care are (HSE 2013, Goodwin 2016, kings Fund, Health Care Report 2012)

- Comprehensive services across the care continuum
- Cooperation between health and social care professionals
- Emphasis on wellness, health promotion and primary care.
- Maximise patient accessibility and minimise duplication of services.
- One standard of care/service regardless of where patients are treated or who is treating them.
- Core principles of good governance should also be considered
- Provide better direct accountability
- Give more decision making back to local areas
- Responsive and flexible services
- Linkages with local communities and public bodies.

The integrative model (POD) is deeply rooted in the implementation of what is termed “Family Support”. “There is no agreed definition of Family Support, but the following is widely used; Family Support is any activity or facility aimed at providing advice and support to parents in bringing up their children” (Audit Commission 1994). In addition, the bio-ecological systems theory’ (Bronfenbrenner & Morris 2006) also comes to the fore. Bronfenbrenner and Morris (2006) assert that to study child’s development, not only must one look at the child and his/her immediate environment, but also the interaction of the larger environment. Essentially, the child grows up in a set of systems. The establishment of formal collaborative structures involving relevant pubbic agencies, the voluntary sector, the local community, and the identification or establishment of a local centre within each community will act as a focal point in delivery of resources for young people (Department of Health and Children 1998). This the researcher found to be very interesting because even as far back as 1998 the thinking was like that of the POD and its response to homelessness.

Even in the high-risk situation of homelessness, however, there are children who hold their own, both in school and at home (Sacks et al 2014). Fundamentally as Larkin et al., (2011) suggests, resilient children from homeless shelters/accommodation have many of the same traits as other competent children growing up in very different circumstances. Most notably, resilient children have competent, caring adults looking out for them and supporting their competence (ibid). Martens (2012) refers to the extraordinary resilience that can be found in
some children, noting that the recovery power by children, arises from ordinary processes. Her evidence indicates that the children who ‘make it’ have basic human protective systems operating in their favour, largely an adult who offers unconditional love and security. Essentially, the adult can act as a buffer. Resilience does not come from rare and special qualities, but from the everyday magic of ordinary human resources in the minds, brains, and bodies of children, in their families and relationships, and in their communities.

Families in homelessness experience huge anxiety issues, lack extended family support, which in times of crisis means they have no family support networks to fall back on. When in crisis it is often difficult to engage or attend appointments especially if experiencing wellness issues which is the case for a lot of these service users. Invariably this is sometimes misunderstood by the prescriptive approach of some professions, and in the social structures of the area, leading to a cultural phenomenon that “the oppressed are allowed once every few years to decide which particular representations of the oppressing class are to represent and repress them” (Lenin 1917). Relating this quote to contemporary homeless families and children in Cork City very much sums up for this researcher how a lot of its inhabitants are viewed, with isolation, extreme poverty, low self-esteem, mental health, and lack of ambition being largely misunderstood and unrecognised.

Going forward, “one of main challenges to developing integrated care is to change provider behaviour.” (Darker 2014, p37). Darker argues that it is pointless waiting until the service users need is greatest before offering an intervention, also of significance is the ongoing issue of duplication of services, in particular assessments for service users with no apparent joined up thinking between services. This is in parallel with some organisational boundaries preventing access to some essential services among service users. This very much resonates with the POD model of early assessment, intervention, planning and collaboration

It is important to note that certain groups have been identified as being most likely to benefit from integration. Collaboration and integration can be extremely important to those who are marginalised, vulnerable and have difficulty in accessing essential services because of learning difficulties and mental health and anxiety issues (Darker 2014).

A note of caution here is that “one form of integrated care does not fit all. There is no one model that is suited to all contexts, settings, and circumstances” (Pike and Mongan, 2014, p.123). Mongan emphasises the point that it’s important to note and acknowledge that
integration takes time to become successful and sustainable and may cost before it pays. The researcher believes this to be a key point in implementing integration/collaboration for it to be a success in social issues such as homelessness. Furthermore, Ireland has gone through a period of sustained economic constriction which has impacted on budgets. Effective integration of services around the individual service user depends on the menu of local services (Darker 2014). Darker noted that resource allocation is a key factor in ensuring a good balance of services and a well-functioning integrated model. The researcher believes this to be of crucial importance in attaining an integrated model of care that improves outcomes for service users (families and young people).

A further interesting challenge that Goodwin alludes too, is that while having the necessary tools for a successful integrated care approach, one of the key unmet challenges, is how to move beyond these descriptive components in offering integrative care. Here Goodwin refers to the ‘softer tissues’ of relationship-building, where nurturing a culture means new ways of working become the norm (Goodwin 2016). An additional and final challenge or limitation to a model of integrative care at this juncture, could be the prevalence of models of integration. (Stuart 2014). With the existing number of several models of integration in Government and NGO policy documents, there may hardly be a need for more. However, no models were discovered that focused on how practitioners delivered services in tandem to children, young people, and families. (ibid 2014).

2.5 Conclusion

The level of accommodation for many families is below standards expected with many parents and children sleeping in the same rooms where they also must make food, eat, do homework, and share bathrooms with other residents. More time is spent on technology as space is limited and children are unable to engage in active play. Participation in meaningful activities generates opportunities of satisfaction as a significant contributor and improves wellbeing. Such interventions benefit the child through increased positive childhood experiences.

On summarising this section as stated earlier, the evidence for the model under consideration comes from the primary research which will be provided later.
2.5 Public Policy Implications for Family and Child Homelessness

2.5.1 Introduction

‘It shall be the first duty of the Government of the Republic to secure that no child shall suffer hunger or cold from lack of food, clothing or shelter, but that all shall be provided with the means and facilities requisite for their proper education and training as citizens’ (Dail Eireann1919). This was the narrative and policy our Government wanted underpinned and embedded, when it came to our children, over a 100 years ago. While it appeared very exemplary, well-meaning, and visionary for its time, this isn’t how it unfolded. The Irish Times (April 2019) reported that there were 10,035 families homeless with over 3,821 of them children across the state (Department of Housing figures April 2019). Recent commentary by the Irish Human Rights and Equality Commission, on its examination of accommodation and homelessness in Ireland, said that its belief that rise in Family and Child Homelessness has been “significantly exacerbated by Government policy choices” (IHREC 2019, P16).

The Government fiscal report (May 2019), indicated that by 2023 there will be 48,000 new house completions, yet the Children’s Rights Alliance (2019) reported that up to the third quarter of 2018, 45 million euro, had already been put into family Hubs. In 2017 the Government began to roll out family hubs only to be used in limited short-term circumstances (ibid), yet by the start of 2019, there were 26 hubs nationwide, to accommodate 600 families, a noticeably clear change in Government policy. With delays in completion of permanent homes for people experiencing homelessness, with only 175 homes due for full completion in 2017 (Rebuilding Ireland progress report 2017), the policy shifted towards family hubs and emergency accommodation, mainly hotels and B&Bs. In 2016, the UN Committee on the Rights of the Child examined Ireland. It expressed concern "at reports of families affected by homelessness facing significant delays in accessing social housing and frequently living in inappropriate, temporary or emergency accommodation on a long-term basis". The UN committee called on the State "to undertake measures to increase the availability of social housing and emergency housing support".

2.5.2 ‘A Right to Housing’
While there is no constitutional right to housing in Ireland, the UN Convention on the Rights of a Child, which Ireland has endorsed, gives children the right to an adequate standard of living, including the delivery of quality housing for those children (Brady 2019). While the convention may not apply directly in Irish law courts, it can use discretion in how much weight they apply to international law (ibid). The United Nations Committee on Economic, Social and Cultural Rights has stated that the right to a house is ‘integrally linked to other human rights’ (United Nations 1991).

It is also significant that the High Court asserted the importance of the constitutional provision on children’s rights; Article 42A of the Constitution of Ireland, when deliberating a matter involving the refusal of emergency accommodation to a homeless family (Gill v Kildare County Council 2017). The “No Child 2020” campaign (Irish Times 2019); Children’s Rights Alliance 2019) called on the Government to put legislation in place that would recognise the best interests of the child, where decision makers, when deciding where homeless families should be placed, take into account the best interest of the child.

Section 10 of the Housing Act 1988 gives an extensive level of discretion to housing authorities nationally on the type of support and accommodation they can offer people but with no duty and no reference to families or children. (Muldoon 2019) argues that existing legislation needs to be changed, to make it more inclusive of children and families, and for housing authorities to consider families with children, when allocating houses. Muldoon further claims that the right to housing in the constitution needs to be advanced with the Oireachtas examining the recommendations in a 2014 report on the eight Constitutional Convention, on economic, social, and cultural rights. To reinforce Muldoon’s argument, the Mercy Law Centre (2019) calls for the right to housing in the constitution, with a shift to a legal rights-based approach in the Housing Act 1988. This will eliminate any discretion in the Act to that of a duty on the housing authority, to provide housing and emergency accommodation to homeless families and children. In comparison the Scottish model does not display a discretionary element, which also includes a best interest component relating to children (Keating, 2019). In conclusion housing policies by this Government prioritise private investment over a lack of commitment to build social and affordable housing, meaning many of the homeless families will remain homeless (SJI 2019). The government’s policy has now switched to invest in increasing the quantity of family hubs as a solution (Ibid).
2.5.3 Family Hubs

‘The long-term solution to the current homelessness issue is to increase the supply of homes’ (Rebuilding Ireland 2016, p 33.). Yet in its third quarterly report in 2017 Rebuilding Ireland suggested that housing authorities will be procuring new buildings and redesigning them as ‘supported temporary accommodation arrangements such as Hubs’, for families in homelessness. (Rebuilding Ireland 2017, p13) Interestingly in July 2017, with only two-family hubs nationwide, and after not meeting its own targets of using emergency accommodation in limited circumstances only, the Government began to roll out the use of family hubs. (Brady 2019).

At the beginning of 2019 there were 26 Hubs nationwide with capacity for 600 families. Regarding policy and provision in this area No Place Like Home outlines the real difficulties that living in family hubs presents for families. (Muldoon 2019, No Place Like Home 2019) argues for an independent, formal evaluation of the suitability of family hubs is needed where timelines of stay also need to be considered. Furthermore, inspection of these hubs through a national implementation quality standards framework for homeless services needs to be addressed. To concur with this (MLRC 2019) look for an independent body also to conduct regular inspections of homeless services and Family Hubs. MLRC also make the point that there is a lack of transparency regarding access to hubs with no published criteria of access from housing authorities. MLRC further go on to say that a shift away from family hubs to the provision of transitional, own door accommodation. There is a lot of variation in type and standard of Family Hubs, with no design model (IHREC 2017).

It is remarkable that in recent times two family hubs were in a former hotel and a former warehouse (Dail Debates 2017). Family hubs are a specific outcome of government policy (focus Ireland 2019). They go on to say that majority of homeless families in homelessness crisis, are in emergency accommodation where they receive a much lower level of accommodation and support residing mainly in hotel/B&Bs. Rather than the focus being on emergency accommodation there needs to be a collaborative concentration on long term solutions, that of an adequate supply of homes (ibid).

2.5.4 Emergency Accommodation
The use of hotels/bed and breakfasts have very much become part of the government response to the family and child homelessness crisis in recent years (No Child 2020). The Democratic Programme of our first Government spoke of no child going hungry or lacking shelter (ibid). In recent years the use of hotels and B&Bs for emergency accommodation in Ireland has become very distorted in what Lee (2016) terms the hotelisation of housing. In their paper The Hotelisation of the Housing Crisis’ (Nowicki, Brickell, Harris 2018), refer to the rise in the use of hotel rooms across many European cities and North America, to address the growing trend of family homelessness. To coincide with this, 12 months on from the tragic Grenfell Tower fire in West London, 42 out of 208 families remained in Hotel accommodation (BBC 2018).

Also, the modern-day depiction of hotels being used in homelessness comes under scrutiny and discussion in the 2017 film ‘The Florida Project’, reflecting on the lives of families living in a motel next to Disneyworld (Nowicki Brickell Harris 2018), reinforces this.

The severity and impact that this crisis continues to have on families and children and its implications for policy going forward, was brought to the fore in 2016, when the United Nations Committee on the Right of the Child, scrutinized Irelands record on children’s rights, including a right to a standard of living. The UN Committee stated ‘it was deeply concerned at reports of families affected by homelessness facing significant delays in accessing social housing and frequently living in inappropriate, temporary or emergency accommodation on a long term basis ’ (United Nations Committee on the Rights of the Child 2016). Building on this point, according to the Housing Agency in 2015, research showed that the standards of emergency accommodation ‘varies significantly from good quality to very poor quality’ (Walsh and Harvey 2015, p36). Another aspect of emergency homelessness is the use of self-accommodation/one night only provision, where the MLRC (2019) sought without success, the legal reasoning and rationale why some families are placed in this predicament and others have a roll over accommodation arrangement. They argue that this system targets the most vulnerable who may not have the language skills or resources to organise accommodation. In comparison to the UK model, the time a vulnerable family can stay in emergency temporary accommodation most notably Hotels/B&Bs is six weeks, in Scotland it is14 day (ibid).

2.5.5 Conclusion

To conclude, several key concerns and issues have arisen (Dail Committee 2019) that should influence and guide public policy going forward mainly the following
• Legislation to take account of the child’s best interests
• A Constitutional Right to Housing
• Legislation to place limits a time a family can stay in emergency accommodation
• The absence of an independent body to conduct regular inspections of homeless services
• Variations in standards of Family Hubs and Emergency Accommodation
• The ongoing practice of utilising one-night only emergency accommodation
• The need for support workers across all sectors of emergency accommodation
CHAPTER 3 INTEGRATION AND FAMILY SUPPORT

3.1 Introduction

This chapter presents a critique of the literature surrounding the need for integrated care in complimenting and enhancing family support. It discusses the aims of integrated care and highlights the importance of collaboration and integration between services and service users will be referenced. Integration of services is the fundamental basis for this study and critical theory is used to analyse the social phenomenon of family support within communities and organisational structures.

Gilligan (1995), states that a key element in the approach of Family Support is that the work is done in collaboration with the family, with the goal being that the family can support their own needs again in the future. Notably, a review of relevant literature highlights the importance working in partnership with other agencies, key groups and individuals in the community resulting in more positive outcomes for families. (DCYA 2014, HSE 2011; Munro 2011, TUSLA 2017)

Furthermore, providing a direct service through a structured package of care, intervention, support, and counselling, to Homeless families and to families in the wider community (Ibid), can improve the wellness of families in difficult situations. Specifically, the literature review looks at the history of family support with a definition of same. A focus on the literature underpinning the work and some of the recent policy developments, such as What Works in Family Support (Tusla,, 2013) and Prevention Partnership and Family Support (Tusla,, 2017) is discussed. Family support operates from a strengths-based approach to families, focusing on being supportive, customer friendly and advocating on behalf of families. Interventions are based on integration and partnership with service users where the focus is on holistic and practical solutions with early intervention being crucial.

3.2 Why Integrated Care?

Calls for an integrated and coordinated way in which services engage is not uniquely Irish. A Kings Fund report “highlights the growing interest in coordinated and person-centred care in both the USA and UK” (Goodwin, 2013, p 40). Integrated Care has been the central policy
driver in health and social care policy in Europe and Ireland for decades, however, in some countries slower than others. ‘Too often, the experience gained at local levels is not fed back into the policy development process. Yet learning from the experience of frontline providers involved in pilot projects is vital. The gap between policy intent and implementation can be closed by harnessing closer links between policymakers, researchers and practitioners involved in integrated care development’. (Lloyd and Wait, 2005: p18).

‘The patient’s perspective is at the heart of any discussion about integrated care. Achieving integrated care requires those involved with planning and providing services to impose the service user’s perspective as the organising principle of service delivery’. (Lloyd and Wait, 2005: p7)

In addition, the HSE (2020) also highlights the importance of integrated care stating that; Integrated Care aims to join up health and social care services with the aim of improving quality and putting patient outcomes and experiences at the centre of practice. Fundamentally, O’Connor (2013) clearly posits that having service users at the centre of the system delivery is paramount noting that wrapping the services around them, such as in an integrated health system empowers people to play a pivotal role in managing their own health and ill-health.

Integrated care has the patient perspective and service user as an organising principle of service delivery. It is based on the principles of illness prevention, patient empowerment, multidisciplinary cross-service care planning and delivery, where all health and social care services work together to provide a flexible network of care responsive to the changing needs of service user and their families. To achieve this, we need all providers such as public and private providers, patient groups, clinicians, and the voluntary sector to be all healthcare stakeholders. (HSE 2014; Kings Trust 2013; Take My Hand, OCO 2018). Integrated care works best when it takes into play the holistic needs of the person, whether it is horizontal, such as health services social services or vertical integration, such as primary, community or hospital or a mixture of both. Notably however, integration without care co-ordination cannot lead to integrated care. Within single providers, integrated care can often be weak unless internal silos have been addressed. Clinical and service integration matters most.

‘Without integration at various levels [of health systems], all aspects of health care performance can suffer. Patients get lost, needed services fail to be delivered, or are delayed, quality and patient satisfaction decline, and the potential for cost-effectiveness diminishes’ (Kodner & Spreeuwenbur, 2002, p2)
There have been several attempts over the years to try and achieve this collaborative integrated approach in working with families. The Task force on Children 1980, Child Care Act 1991 and Children’s First 1999, to name but a few: Fundamentally, the core values of social care and community (Coru, 2015) is to empower people to achieve equality and a better quality of life.

3.3 Psychological and Social Benefits/Core Values
Notably, Springboard-Tusla/Good Shepherd Cork POD, models itself on an integrated approach to working with service users. An integral part of the service is inter-agency cooperation and wider collaboration amongst community, voluntary and statutory services. Here, the service in Springboard-Tusla Family Support Services works to involve all relevant agencies and to promote awareness of the benefits of working in partnership in improving outcomes for service users. In the diagram below (Phillips, Casey, 2015) presents an overall synopsis of the Springboard service.
This diagram puts Springboard at the centre of the community in representing the service user with its core values of a strengths-based approach collaboration and integration to the fore. This model focuses on the 'social' as well as the 'psychological' in its endeavour to work with the community. The diagram also suggests to this researcher that the service is very 'naturalistic' in its setting which concurs with the ethnographical viewpoint of this topic.

The Community Health Care Organisations (CHOs) is a broad range of services that are provided outside of the acute hospital system and include Primary Care, Social Care, and Mental Health. These services are delivered through the HSE to people in local communities as close as possible to their homes, in a suitable setting (HSE 2014). An essential theme underlying this report is the importance of developing an integrated model of care which is responsive to the challenges and needs of local communities, i.e. the ease through which a person can go through the different healthcare services to meet their needs. This very much resonates with the journey and plight of families within homelessness emanating from the themes accruing from the primary research which will be discussed later.
3.4 Merits and Flaws/Challenges of Integrated Care

Going forward, “*one of main challenges to developing integrated care is to change provider behaviour.*” (Darker 2014, p.37). Darker (2014) further proposes that it is pointless waiting until the service users need is greatest before offering an intervention. Of significance is the ongoing issue of duplication of services for service users. This is in parallel with some organisational boundaries preventing access to some essential services among service users (Ibid). The enquirer feels that this resonates with the Springboard model of early intervention, detection planning and integration which can be seen in Fig 3.2 above.

It is important to note that certain groups have been identified as being most likely to benefit from integration. Collaboration and integration can be extremely important to those who are marginalised, vulnerable and have difficulty in accessing essential services because of their existing and presenting circumstances (WHO-UNICEF 2018, Darker 2014).

A note of caution here is that “*one form of integrated care does not fit all. There is no one model that is suited to all context’s settings and circumstances*” (Pike & Mongan, 2014, p.123). Pike and Mongan (2014) further acknowledge that integration takes time to become successful and sustainable and may cost before it pays dividends. The researcher believes this to be a key point in implementing or mirroring models such as CHO and Slaintecare for it to be a success in areas like Family Homelessness. Furthermore, Ireland in recent years has gone through a period of sustained economic constriction which has impacted on budgets. Effective integration of services around the individual patient depends on the available selection of local services (Darker 2014). Darker (2014) noted that resource allocation is a key factor in ensuring a good balance of services and a well-functioning integrated model. Emergent themes from the primary research concur with this and is of crucial importance in attaining an integrated model of care that improves outcomes for service users in homelessness.

Goodwin’s (2013) diagram which this researcher identifies as being quite like that of the Springboard diagram, puts a model of best practice forward that we can all learn from. Here the service user is at the centre maximising the health and well-being of each individual and the population which this researcher believes is achievable.
Research (Slaintecare 2017, HSE 2021) suggests that when interventions are centred on integration and partnership with service users and where the focus is on practical solutions and relationship building, common goals can be achieved.

There is progress within Ireland for an integrated healthcare system, however it is a slow progress. (Oireachtas Committee 2020) Consideration needs to be given to the multitude of barriers to integrated care, such as social economic and political contexts that affect funding streams and broader integrating mechanisms, as they constitute significant determinants of the success of integrated service delivery models. Integration of services requires considerable financial investment in the resources required for successful implementation of integrated care teams, as well as meeting the needs of service users. Integrated care is at the heart of the Government’s health service reform plans with a focus on accessibility, quality and economic sustainability (Slaintecare 2017) however, these reforms must not be considered as end goals.
in themselves, but rather as a means to achieving overall healthcare reform. The end goal must be the measurable and real improvements in health and well-being for all the people of Ireland. (Darker, 2013; HSE 2020).

3.5 Family Support

Family support operates from a strengths-based approach to families, focusing on being supportive, customer friendly and advocating on behalf of families (Gillen et al., 2013). Interventions are based on integration and partnership in community with service users where the focus is on holistic and practical solutions with early intervention being crucial. “Integration is the glue that bonds the system together, enabling the achievement of common goals and optimal results” (O Connor 2013, p195)

3.5.1 Definition and Resolve/Aims

In essence and according to Gilligan (1995; DCYA 2014, 2018; Tusla 2019) this is very much what family support sets out to achieve working in collaboration with other agencies, devising family support plans that best meets the needs of families and young people within their community and where possible by professionals working within community. There are several principles that we use in family support evident from national and international practice that appraises best practice. Gilligan,(1995) outlined ten principles of family support using such language as ‘responding to the needs of the families’, ‘must be supportive and real’, ‘offered and available in the lived reality of the service user’, ‘enhance rather than diminish confidence’ and finally family support needing to ‘wrap around the child’, Winnicott’s 1990 “Holding Environment” comes to mind, for this researcher which aims to develop safe and healthy communities through supporting parents and children, through community action, policy, advocacy, and interagency cooperation.

The Springboard-Tusla/GSC POD/initiative is deeply rooted in the implementation of what is termed “Family Support”. “There is no agreed definition of Family Support, but the following is widely used; Family Support is any activity or facility aimed at providing advice and support to parents in bringing up their children” (UK Audit and Commission HMSO 1994).
Some of the key aims as outlined by the (Department Children 2021; TUSLA 2017) are as follows:

- To identify the needs of parents and children in proposed areas with specific attention given to those families where child protection concerns exist and or families in once off crisis situations.
- To target the most disadvantaged and vulnerable families in the area.
- To work in partnership with other agencies, key groups, and individuals.
- To provide a service through a structured package of care intervention, support and counselling to the targeted families and children and to families in the wider community supported by Government policy and legislation.

3.5.2 Policy Implications for Family Support

The establishment of formal collaborative structures involving relevant public agencies, the voluntary sector, the local community and the identification or establishment of a local centre within each community act as a focal point in delivery of resources for young people (Department of Health and Children 1998, Community Health Care Organisations 2013, Slaintecare 2017,) was also viewed at this time. Interestingly, as far back as 1998 the thinking was like that of the Community Health Care Organisations (Ibid) which was discussed earlier and linked to the integrated community model (POD) of the research topic and where it will be discussed later in the primary research.

Family Support work/projects/interventions have a strategy of being open and available to all families within their communities, as well as working more intensively with those parents of children who are most vulnerable (McKeown, 2006, Munro 2011). The Child and Family Agency Act (2013) which led to the establishment of Tusla, sets out to ensure that services for children and families promote interagency cooperation are coordinated and provide an integrated response to children and families within the community where possible (Tusla, 2013).

In Ireland the rationale for family support services was first articulated over 40 years ago by the Task Force on children’s services, which stated controversially at the time, that ‘the welfare of children in general, is inseparable from the well-being of families and therefore social policy
should begin with families’ (Task Force on Child Care Services, 1980). The report was very critical at the time of how young people were placed in care, where very little effort was channelled into supporting the home. Essentially, this view was greatly strengthened with the introduction of the Child Care Act (1991). This involves a more preventative approach to child welfare concentrating on supporting children and families within their own communities wherever possible. This Act underpins the relevance of family support to vulnerable, at risk families and children where services both voluntary and statutory are to collaborate more effectively in coordinating service delivery locally (Sec8, Child Care Act, 1991). Springboard and similar family support services have very much been influenced by two key principles that emanated from the National Children’s Strategy, that of being 'child centred' and 'family oriented', (National Children’s Strategy 2000). Furthermore, Children’s First (2011) is the framework that guides all those working with children, not only in a paid but also voluntary capacity. This reform marked a significant shift in the structuring of the statutory child protection and welfare system. This led to a complete restructuring of early intervention, child protection and family support all under the one umbrella.

In 2014, Tusla and the Department of Children and Youth Affairs developed a new national policy framework for children and young people called Better Outcomes Brighter Futures its aim seeks to make sure that young people who are marginalised or 'at risk' or who demonstrate challenging or high-risk behaviour have access to an integrated range of supports and services to help them achieve their best possible outcomes. It also seeks to ensure ‘that no young person falls through the cracks because of fragmented services’

(Department of Children and Youth Affairs 2014-2020 p xi)

This has led to more clarity direction and integration of services. The policy sets out clearly six transformational goals and five national outcomes for all our young people regardless. It aspires to a ‘vision for Ireland to be one of the best small countries in the world in which to grow up and raise a family’ (BOBF 2014, p vi). Now we have a system where there is huge clarity of approach. There were several government departments with various statutory responsibilities, all involved in different aspects of a family or child’s life and all working independently. Under the new model (with few exceptions) all services pertaining to children and families come under the direction of Tusla, such as the National Educational Welfare Board, and services responding to domestic, sexual and gender-based violence. The role out of the Prevention
Partnership and Family Support Guidance Document (Tusla 2013) has also put a very clear framework on family support in this country going forward.

3.6. Framework going Forward

This further leads onto the updated Prevention, Partnership and Family Support (PPFS 2017) Programme, which is a comprehensive selection of early intervention and preventative work which has been undertaken by Tusla to improve outcomes for families and children in need of family support. This programme covers 7 main work streams and within these streams, family support is evident within the Area-based approach, early intervention, child, and family support networks and Meitheal, (Tusla 2014).

Tusla has now developed within Family support, Child, and Family Support Networks (CFSNs) across Ireland, totalling 118 networks. The networks aim to ensure that there is no wrong door for families seeking help by directing them in the right pathway for support within their community. There is also 121 Family Resource centre’s (FRCs) nationwide funded by Tusla which are based locally, providing comprehensive support under the National Delivery Framework of PPFS. Some examples include counselling services, mental health supports, practical supports to individuals and families such as Parenting 24/7 (2013), 50 key parenting messages and educational programmes. Furthermore, under the PPFS, Meitheal has been developed. This is an early intervention practice model for all agencies working with family and children. The Meitheal model very clearly is designed to put a ‘wrap around’ a child/family that requires integrative collaboration and support.

A Meitheal model is designed to ensure the strengths and needs of the young person and their families are identified understood and responded to and it is outcome focused. It has been very successful as seen in the evaluation of the model in the Child and Family Support Networks Interim Report on the (Meitheal Process and Outcomes Study 2017). Meitheal brings together people and services that can help make changes in a person’s life.

Of note, Meitheal cannot operate if there is Child Protection social work assessment ongoing while the Children’s First (2017) is significant and must always be adhered to. There are clear response pathways along the continuum of needs and clear thresholds for child protection interventions and it is underpinned by the Hardiker Model (Investing in Parents, Tusla 2013).
The Hardiker model of intervention (Ibid) has been developed over time as a means for setting thresholds and framing the service delivery model in Ireland, level four being high risk/intensive and long-term support and protection for children and families to level one, universal, which is what we all aspire to be. This model is now complemented by the new Signs of Safety framework/tool of intervention (Tusla, 2017). The assessment framework along with its associated tools, assist everyone (the child and their family, social workers, professionals working with the child and their family.) to jointly discuss and record the concerns, worries and strengths that exist about a child. This is achieved with a focus on creating meaningful relationships with families using simple clear language as outlined by the new Signs of Safety framework/tool of intervention (Ibid)

### 3.7 Conclusion

In conclusion, much of the recent selection of policy documents influencing family support such as Child and Family Support Networks and Coordinators, Meitheal, 24/7 parenting and 50 Key Messages, with their focus on integration coordination and partnership, attempt to prevent Families in crisis from escalating into the thresholds of child protection. Also with the new Safeguarding legislation (2017) mandating all agencies and voluntary groups working with young people and children, to display a Child Safeguarding statement, keeps the service and worker focused on the task and reinforces an understanding of the ‘values’ required to keep children safe and families supported. If resourced and funded properly we can aspire to a ‘whole-of-society approach’ (WHO-UNICEF 2018 p 2) to integrated care and family support.
CHAPTER 4 METHODOLOGY

4.1 Introduction

This chapter will outline and describe the methodology deemed most applicable regarding this research. It will review how data is to be collected and analysed where the theoretical perspective of the researcher will be made clear. Also included will be recruitment of participants, sampling, data analysis, ethical considerations and limitations to this research will be outlined.

4.2 Research Questions

This report poses several questions in relation to psychosocial benefits for children experiencing homelessness arising from the introduction of an integrated community care project across the city of Cork

1. What is the scale of child homelessness problem in Cork City?
2. What social and psychological risks does homelessness present for children?
3. Are there psychological benefits of the new integrated service model in child homeless services?
4. What are the key elements of the integrated homeless service model and merits/challenges associated with this model?
5. What are the public policy implications of the above?

4.3 Theoretical Perspective

There is a myriad of theoretical approaches applied when analysing social research such as the Positivistic approach which explains most social situations as a science. Phenomenology on the other hand is the 'lived experiences of people'. Polkinghornes (1989) maintains that when phenomenology is applied to research the lived experiences of the person or the families and children in this instance is what becomes most important. This sets the tone of this research
where the researcher endeavours to illicit the meanings of people’s lived experiences within family and child homelessness.

The collaborative approach of the POD and in particular this researcher, espouses to the ‘phenomenon’ of how people are living their lives and their experiences within homelessness regarding poverty, marginalisation, isolation, detachment and how they are perceived by professions and received by societal structures. In practice the Good Shepherd Services/Springboard Tusla collaboration is very much ‘situated’ in community where the partnership has a deep sense of the everyday lives of the service user. Thus, the positivist view did not suit the study. Polkinghorne (1989) ascertains that when phenomenology is applied to research it is the everyday experiences of the families and children which becomes critical, with the researcher attempting to understand the meaning of the human experience. Furthermore, this researcher takes the view that the research is influenced from a ‘critically ethnographical’ position. By means of ‘Critical’ this explains how deep-seated structural issues in society affect people; in this case, economic inequalities, poverty, lack of housing, poor housing policy, social class, and deprivation, all intersect at the level of the service users. From an epistemological point of view, this study then uses a Critical approach to the research. ‘Ethnographical’ then is the use of direct observation and extended field research to produce a thick, naturalistic description of a people and their culture. Furthermore, it is designed to promote emancipation and reduce oppression; it gives voice to mistreated people and those struggling for social change (Frey et al, 1999). Furthermore the ‘ethnographic’ fieldwork research conducted here has a clear ontology in the site of people’s lived experiences, on the ground, in communities. Qualitative research was deemed most suitable to access this lived experience of people, to access their in-depth understanding of how social conditions impact on them and the meaning they attribute to this dynamic. It was ‘naturalistic’ as a result. This is one element of ethnography. Ethnography is a research approach within the wider epistemology of research. Other key elements of the ethnographic approach in evidence in the research is the fact that the focus groups encouraged reflection and ‘reflexivity’ by the participants. Within the critical ethnographic approach, how the participant ‘interprets’ their world is of great significance to the researcher and this comes from the Weberian, ‘verstehen’ perspective, within a broader Phenomenological approach to social research. This concern with how participants interprets the world, as gleaned from the focus groups within the ethnographic fieldwork, utilises a Phenomenological approach, specifically, utilising a Weberian Interpretative perspective (Harvey & McDonald 1993).
The researcher in adopting this approach can see at first-hand in a 'naturalistic setting', without interference, the lived experiences of families and children in homelessness. This critical approach also helps highlight how interpreting the attitudes, beliefs, behaviours, and practices of people lends to a greater understanding of the barriers facing service users on a continual basis. The Reflexive concept of this approach also helped this researcher to become more aware of aspects of their own value base, background identity and what may influence data collection and interpretation.

4.4 Methodology

There are two standardised methods of data collection, qualitative or quantitative. Quantitative research seeks to produce hard data such as statistics and patterns usually when dealing with large scale numbers. The approach is most frequently administered by using questionnaires or conducting structured interviews on a large scale, consequently requiring less face to face time with individual participants (Dawson 2019). In contrast, a qualitative approach provides more in-depth data obtained using open questioning that allows the participant to elaborate on their responses (Fuller & Patch 1995).

With the research question in mind the preference for a qualitative methodology was an obvious one. Patton (2015) spoke of three types of approach to qualitative research, a holistic view, an inductive approach, and a naturalistic enquiry. This research is most aligned to a naturalistic view. As outlined previously, this type of research focuses on how people behave when absorbed in genuine life experiences in natural settings where the belief is that phenomena should be studied in context (Frey et al 1999). This is very much like the Good Shepherd/ Tusla Springboard collaboration approach daily in providing interventions to improve outcomes.

4.5 Design/Method

This research utilised a combination of both primary and secondary data methods of inquiry. A research method is a means of exploring research questions and collecting and analysing data (Payne & Payne 2004). Primary research entails the study of a subject through first-hand observation and investigation (Dawson 2019). Secondary research usually involves primary
data that has been already evaluated, researched, and published in a book or journal. “Secondary analysis equips the researcher with the ability to scrutinise and probe in theoretical depth by not having the concerns and practicalities of collecting data” (Hakim, 1982, p.71).

Subsequently, primary data was collected through the medium of three focus groups and was then compared to a non-participative observation of the model in action using the aid of a semi structured interview schedule for all four. The purpose of cross referencing one research method with another, known as triangulation, helps provide a more rounded view to the research. Finally, a literature review was also conducted to support all data collected.

4.6 Methods

As informality was a primary goal of the researcher; it was felt that a structured interview where questions are usually very specific and ordered would not be suited (Bryman 2021). This informality allows participants to expand on their specific areas of interest in these interviews where latitude was very much allowed. These areas were then listened to and observed by the researcher which was very much in keeping with the critical ethnographical approach to the research.

The purpose of the focus group method was to help people explore and clarify their views in a way that is less accessible in one to one interviews. Here, participants talk to one another, ask questions, and comment on each other’s shared experiences and points of view (Barbour & Kitzinger, 2000). A downside to focus groups is that dissenting voices can sometimes be silenced through the presence of hierarchal positions within the group i.e. management and staff. However, this researcher was confident that the particular focus groups chosen would be “naturally occurring” (Barbour & Kitzinger, 2000), made up of colleagues who have a long history of working together and who could relate to each other’s points of view and equally challenge each other on points of contradiction. This very much keeps the research in an ethnographical viewpoint and helps validate the data accrued from the focus groups and observations.
The four methods were

- Focus Groups with service users
- Focus Groups with staff members
- Focus Groups with management
- Non participative observation of the model in action (discussed in 4.7 and 5.11 below)

Having examined the focus group schedule for each the following describes in broad terms the essence of the questions asked for each of the focus groups. The semi structured schedule for the focus groups consisted of 14 items. Areas covered in the interview schedule included:

- Scale of Child Homelessness.
- Social and Psychological Risks of Homelessness to Children.
- Integrated Homeless Service Model and Child Mental Health. (2 parts)
- Integrated Homeless Services Model Merits and Challenges. (3 parts)
- Policy Implications.

The items in the semi structured interview schedule, Social and Psychological Risks of Homelessness to Children (part 5), were very much based on (NHCHC, 2019) and its research into family homelessness where the experience of housing- including high housing costs, poor housing quality, unstable neighbourhoods and overcrowding places children at risk of ACE exposure. Equally, the landmark report, No Place like Home by the Ombudsman for Children (2019) concurs, and highlights that children living in family hubs experience overwhelming feelings of ‘shame, guilt and anger’. This is a critical point to the researcher’s enquiry and very much ties in with the overall research topic of the psychosocial risks of children experiencing homelessness. In addition, part 10c of the interview schedule (in improving connectivity and awareness the hope is that homeless family members are confident that all the various health and social care workers are aware of all the family’s needs and made feel the services are coordinated, organised and responsive to their needs) allowed this researcher gather a lot of important and crucial information about the Sub Research Question 4 – Integrated Homeless Services Model Merits and Challenges. This was significant in pulling together primary and secondary data and guiding the direction of the overall research topic. According to the Harvard Centre for the Developing child (2019) when practitioners know how to connect with families, discover ways to listen, build trust and work and collaborate in finding solutions then outcomes
for children and families can be achieved. In agreement with this research (Bellis et al, 2014) argue that fostering responsive relationships with adults and children is also of significance in improving outcomes during one’s journey through homelessness. Integral to the model also is the Signs and Safety National Assessment framework approach adopted by Tusla (2017) which emphasis a commitment to building honest compassionate working relationships with children, families and related service users which all are very much in sync with sub question 4.

4.7 Non-Participative Observation

Non-participant Observation involves observing participants and activities without actively participating. This method was used to understand a phenomenon by entering youth club and staying separate from the activities being observed. Youth club was chosen as the central part of the model to ascertain the key input of the ‘voice’ of the child into the primary research. Liu and Maitlis, (2010) asserts that non-participant observation is often used in tangent with other data collection methods and can offer a more "nuanced and dynamic" appreciation of situations that cannot be as easily captured through other methods. The collection of detailed field notes provided much detailed information.

This approach is often scrutinised on the grounds that the very fact of their being observed may lead people to behave differently as for example in the famous case of the so-called Hawthorne effect. To overcome this, the researchers observed the same situations separately.

4.8 Participants

Participants were carefully selected through cross sectional purposive sampling very much based on their knowledge and expertise in the research area. “Purposive sampling is a strategic method of choosing participants on the basis of wanting to interview people who are relevant to the research question” (Bryman 2021, p334). Three people of varying degrees of professional experience working in the POD were chosen for the focus group 1 and three professionals with management experience were chosen for focus group 2. These samples were from a group of strong professionals with various backgrounds such as Social Work, Early Childhood Studies, Social Care, Addiction, Community Education and Training and Counselling, all working as experts in the field. (see demographics table below). Focus group 3 utilised a volunteer sample.
of service users experiencing family homelessness living in emergency B&B/Hotel accommodation/Family Hubs and Edel House. The fourth method nonparticipative observation of the model in action, youth club was chosen as a central part of the model to ascertain the key input of the ‘voice’ of the child into the primary research. All participants were then contacted by phone or email initially to ascertain their level of interest and willingness to be involved. Those who were open to being involved were furnished with a letter of consent indicating the aim of the study and the proposed methods of data collection including audio recordings.

Table 4.1. Focus Group 1 (Expertise in the Field)

<table>
<thead>
<tr>
<th>Participant</th>
<th>Job Title</th>
<th>Name of Workplace</th>
<th>Years of Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Social Care Worker</td>
<td>Tusla/Springboard</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>Early Childhood Studies</td>
<td>Good Shepherd Services</td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td>Community Education/Training/Addiction</td>
<td>Tusla/Springboard</td>
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</tbody>
</table>

Table 4.2. Focus Group 2 (Expertise in Management)

<table>
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<th>Years of Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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<td>Tusla/Springboard</td>
<td>30</td>
</tr>
<tr>
<td>2</td>
<td>Good Shepherd Services Manager</td>
<td>Good Shepherd Services</td>
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</tr>
<tr>
<td>3</td>
<td>Social Worker</td>
<td>Tusla/Springboard</td>
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Table 4.3. Focus Group 3 (Family Service Users i.e. Parents)

<table>
<thead>
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<th>Participant</th>
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<th>Male/Female</th>
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</thead>
<tbody>
<tr>
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<td>2</td>
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<td>3</td>
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<tr>
<td>4</td>
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<td>F</td>
</tr>
<tr>
<td>5</td>
<td>Homeless</td>
<td>F</td>
</tr>
</tbody>
</table>

### 4.9 Data Analysis

The focus group interview data in this research is analysed using a Thematic Analysis method. There is no universal agreement on what constitutes a thematic analysis and the closest to a universal definition used for this study is provided as:

“A method for identifying, analysing and reporting patterns within data.” (Braun & Clarke 2006 p79).

The patterns within the data which are identified and analysed here are grouped under ‘sub themes’ which are the recurrent presentational patterns which have been codified by multiple readings of the transcript data. The initial broad themes which exist ex ante were consistently identified at the outset, based on the thematic areas under which questions were grouped within the various sections of the focus group interview schedules (Crawley 2020)

This section presents the results of the study and is discussed considering the existing literature. The current study uses both thematic analysis and Interpretative Phenomenological Analysis (IPA) in as the combined methodology for codifying, analysing, and interpreting the results of the focus group interviews. The method of investigation used is focus group interviews, presented and analyses using a form of thematic analysis primarily driven by the Bryman’s methodology, but also incorporates a central element of that advanced by Crawley (2020). The wider sociological underpinnings of the methodology are underpinned by Phenomenology (Harvey & McDonald 1993; Punch 2013)
Interpretative Phenomenological Analysis (IPA) is grounded in Weberian phenomenology. This is a long-standing research approach in sociology (Harvey & McDonald 1993). A clear overall conceptualization of IPA methodology concerns the researcher giving the opportunity to the research participant(s) to make sense of how (s)he as an individual or as part of a group, while being questioned on any specific social phenomenon, make sense of the phenomenon in question, allowing the participant(s) to bring their own meaning and ideas to the question at hand when giving their considered answers to questions they have been asked which are open to interpretation, arising from qualitative interviews.

The generative themes, which are recurrent representational patterns which within the focus group data gave rise to the codified sub-themes. These are the generative themes which emanate directly from the qualitative data. The sub-themes constitute the essential emerging data from each focus group. These are then presented using a grid matrix for each focus group and in this sense the study utilizes a ‘framework’ thematic analysis method, as outlined in Bryman (2021).

4.10 Study limitations

This was an exploratory qualitative study. As such, the findings of this study must be considered considering several limitations:

1. The study findings from the focus groups are drawn from the narratives of a small sample (30) potentially limiting the generalisability of the results
2. The service users were all female.
3. The voice of the Child is not included. It would be important to look at the model from the child’s eyes but due to the global pandemic this was not possible.
4. A disadvantage of the non-participant observation is the Hawthorne Effect - people are likely to change their behaviour if they are aware that they are being observed. This was overcome by having different researchers observing the same event, (Gottfredson, 2005).
5. Time constraints and word count in this research added greatly to the limitations. This limitation meant it was not possible to use all primary and secondary data collected.
6. For the first two focus groups, an important requirement was that all participants would have an experienced background and expertise of working in family and child homelessness.
7. Due to the sensitive nature of the study, it was a challenge to recruit service users for the study

Nonetheless, the insight gained from this research proved important in establishing that an integrated approach to family and child homelessness can improve outcomes for service users.

4.11. Ethical Considerations

All research studies present ethical issues and predicaments which must be addressed before commencement of any research. The Principals of Ethical Research as put in place by the Economic and Social Research Council (ERSC 2005:1 cited in Gomm, 2008:366) were followed by the researcher and observed. The purpose of this is to ensure all participants are protected from harm (Bell, 2010). Before carrying out this research, participants were made fully aware of its purpose and their role in it. Informed consent from all participants was obtained (see Appendix 3). Confidentiality was at all times ensured and maintained. In addition, it was verbally reiterated to all participants that their participation was voluntary, and they could choose not to answer any question or engage at any stage. They were also informed that they stop and/or withdraw from the study at any stage. Participants were also verbally assured and reminded that their confidentiality was strictly protected at all stages and that all data files were password protected and stored in accordance with the Data Protection.

4.12 Conclusion

This chapter has outlined and described the methodology this researcher deemed most applicable regarding this research. It reviewed how data will be collected and analysed, where also the theoretical perspective of the researcher was made clear. Ethical considerations and limitations were also identified and outlined.
CHAPTER 5: RESULTS AND DISCUSSION

5.1 Introduction

This chapter presents the results of the data collection and discusses these results in relation to the literature identified in chapter 2. The themes that emanate from this data is analysed, using literature to develop matters identified.

5.2 Focus group with service users

The broad theme of ‘scale of homelessness’ is used in this section as the guiding theme, under which the emanating sub-themes, which arose from the in-depth focus group interviews, have emerged. The questions asked to identify the scale of homelessness and the main reasons for homelessness from the viewpoint of service users while also detailing concerns that users have in relation to the scale of homelessness. The emergent sub-themes and some of the essential commentary are detailed below.

<table>
<thead>
<tr>
<th>Sub theme</th>
<th>Focus Group Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of children involved in child homeless services in Cork</strong></td>
<td>‘I would say erm, I would say at least 500-700, that many…if not more’ [P2]</td>
</tr>
<tr>
<td></td>
<td>‘More, I would say, more’. [P3]</td>
</tr>
<tr>
<td></td>
<td>‘Yeah more, I’d say 900 to a 1000, I would say’. [P2]</td>
</tr>
<tr>
<td></td>
<td>‘100% more’ [P3]</td>
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<td></td>
<td>‘Seriously, it’s very difficult, you know. It’s not only where I live, It’s [homelessness] everywhere. Like you know. And it’s not like Cork City only, it is the county as well…’ [P5]</td>
</tr>
</tbody>
</table>
It’s everywhere, you seem to forget about the county, But …. Cork is a big county like…its everywhere [P2]

<table>
<thead>
<tr>
<th>Scale of homeless children</th>
<th>‘It’s rising’ [P2]</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>‘Rising, Yeah… Yeah’ [P3]</td>
</tr>
<tr>
<td></td>
<td>‘You see more coming to the homeless service’ [P2]</td>
</tr>
<tr>
<td></td>
<td>‘And you’ll hear of more people and more children coming in all the time’ [P3]</td>
</tr>
<tr>
<td></td>
<td>‘It’s weekly. It’s not like every couple of weeks like you know, it’s every few days…’ [P3]</td>
</tr>
<tr>
<td></td>
<td>‘Christ yeah …Every few day’s [P2]</td>
</tr>
<tr>
<td></td>
<td>‘Every few days, yeah’ [ P3]</td>
</tr>
<tr>
<td></td>
<td>‘But what can happen is you might get three families in one week then maybe quiet for a week and then another couple of weeks you’d have a load of families’ [P3]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Waiting lists</th>
<th>‘There is a waiting list for the emergency accommodation’ [P2]</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>‘Yeah [I waited] 6 months [for emergency care], and with a small child. Yeah he is 3 and a half like’ [P3]</td>
</tr>
<tr>
<td></td>
<td>‘And me 1 year and then 2 months to get here’ [P4]</td>
</tr>
</tbody>
</table>
‘I was for a couple of months in a hotel room with five children’ [P3]

I am on it [housing waiting list] for 4 years [P2]

I am on it [housing waiting list] 12 months [P5]

**Distrust of the decision makers/**

cause Cork City council aren’t caring enough for people’ [P2]

Like I am doing this [being homeless] for 12 months and it’s costing the state 30 grand. [P3]

Even if they gave us a quarter of that money at the start of those years, If I got 10 grand 12 months ago, I could have… Give me a house, a shell of a house even [P3]

‘I think the money they spent [on hotel accommodation] could get me a loan, in my accommodation, being homeless, they would have a house built at this stage’. [P2]

I am nowhere, 4 years I am on this [housing list]’ [P2]

‘And they just want to keep you waiting and waiting and every time you get on to them , there’s always an excuse upon an excuse upon an excuse, the number of letters I have gone in and no replies back off them. It’s a holy disgrace what they are doing and not even us they are doing it to …they are doing this to our kids [P2]

**Staff/ Consumer engagement**

I have letters gone in for my 5-year old to assess him for housing because he needs to be housed
The dominant themes above detect the scale of homelessness on families and children. Parents speak of the weekly and daily surge of children and families into homelessness. Also, the length of time one must wait for some form of accommodation whether this would be in a B&B, hotel room or family hub. The literature very much concurs with the themes emanating where the recent housing crisis has meant that homelessness has since cast a wider net and has reached previously unaffected groups Grotti *et al.*, (2018). Accordingly, the McVerry Trust (2019) further enhances the scale of homelessness stating the number of homeless families has increased by 348% since August 2014. More than one in three people in emergency accommodation is a child. The cost of Family Hubs and of emergency accommodation to the state is also highlighted by this focus group of service users and is reinforced by the literature where the recent Focus Ireland-TCD Spend on Homelessness Report (2020) states nearly 40,000 adults experienced homelessness in Ireland since 2014 while most of €1bn expenditure went on ‘passive’ emergency shelter.

### 5.2. Social and Psychological Risks of Homelessness to Children

The broad theme of ‘the social and psychological risks of homelessness to children is used in this section as the guiding theme, under which the emanating sub-themes, which arose from the in-depth focus group interviews, have emerged.
<table>
<thead>
<tr>
<th>Sub Theme</th>
<th>Focus Group Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Child needs</strong></td>
<td>‘Before Redclyffe, my kids, we were in Blarney Golf Resort’ My kids were, my 12-year-old and my five-year-old, one at the bottom and one at the top. My 8-year-old, she wasn’t sleeping with anyone in the bed with her because of the case, she was on her own and then a four-year-old in the cot. Then I had a two-year-old, she was one and a half then in another cot all inside stuck in one room with u’ [P2]</td>
</tr>
<tr>
<td></td>
<td>‘We were sleeping on a plastic bed. The plastic, you know, there no hygiene problem like, if we go, other people come in and use them, so they are plastic overall. I think it’s a good thing but it’s very nosey’ [P2]</td>
</tr>
<tr>
<td></td>
<td>There are no bed bugs. Spotless’ [P3]</td>
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<tr>
<td></td>
<td>It’s a good thing but it is [the bed] very uncomfortable [P4]</td>
</tr>
<tr>
<td></td>
<td>The baby sleeps with me because I have bunks in my room now. I can’t put my ADHD on the top, I can’t’ [P2]</td>
</tr>
<tr>
<td></td>
<td>There is no proper routine, you can’t have a routine [P3]</td>
</tr>
<tr>
<td></td>
<td>There’s no wheelchair access [in homeless hub] [P3]</td>
</tr>
</tbody>
</table>
| Child Social and emotional development | I can see alone that my kids are starting to act up, from the situation they are being in’ [P2]  

My child is ADHD, he is hyperactive and my baby…. they do not know if he has spina bifida. My 4-week-old was born with a thing on his back. At the moment I am not worried about it, as he grows older this could get worse and he could have spina bifida and then get nowhere with no one. [P2]  

…I my 12-year-old made a confirmation out of a homeless accommodation. She made her communion out of a homeless accommodation and now I have my 8-year-old make a communion in May out of a homeless accommodation. And my child is asking what we are doing for her… all her friends are asking if I am having a party for her. No, I am not. We must go back to [homeless shelter] [P2].  

It is horrible that all her class have parties [and she can’t]. [P2]  

Kids at that age shouldn’t be experiencing anxiety. No way [P3]  

The attitude of my 12-year-old. My 12-yearold never had an attitude. She was the sweetest child. Now she can’t cope. It’s all because of the situation she’s in [P2] |
| Child Physical and Mental health | ‘And my kids have disability and all that. It’s not helping. She had to wear a cast. She had cerebral palsy and only had an operation 8 months. %0 stitches she got in her leg. She was in a wheelchair for about six weeks. And I am over in XXXXXX. If my child must get another operation my child cannot go back in their cause, there is nowhere for her to go in a wheelchair’ [P2] |
My child had her cast taken down last week and I had to bring it back to enable Ireland. And my child’s leg was all covered in bruises from going up and down the stairs in XXXXX because the case is digging into my child’s legs. She has to wear cast all day long and she has to wear a cast going to bed at night’ [P2]

It’s an awful worry [child mental health] [P4]

Physically they [the children] tend to lash out and like that. Also, because there are 30 odd kids in there, and the language…language is an issue. Some kids are cursing in there and everyone else’s kids is picking that up [P3]

You have no routine with your own children. [P2]

…my child goes to the community school and he asked me if we could get one…. One of his friends asked him the other day where does he live and my small one says I live in a homeless place call Redclyffe. Then the other children turned to my kid and said ‘sorry we didn’t mean to upset you’ cause my child started breaking down crying’ [P2]

[My child] doesn’t know how to handle [homelessness] and she doesn’t know. She’s just…lashing out her attitude at everyone [P2]

**Child Cognitive and Academic impact**

Like even how she [the child] did her Christmas exam, now she did pretty well but at summer [exams] when we went to meet the teachers, they said she was very, very distracted, and so on. That’s she could do more work that what she is doing and that’s affecting her ability to go forward in life and how she’ll be doing in school, and that’s not her fault. It’s because of the situation she is in. [P3]

Some days I have gotten letters out from the school saying that she hasn’t done certain work [P2]
School is a problem. [P2]

My small one has started saying she doesn’t want to do her homework….my 5-year-old he is starting to say, ‘I’m not doing my homework’. [P3]

My kids are even being taken out of the class [because they can’t function properly] My 8-year-old and 5-year-old. My 8-year-old is starting it since he was in [living in hotel]. She can’t function properly [P2]

Well my 5-year-old is only in junior infants and now the school are after pulling me that’s she’s not concentrating properly [P3]

It has an effect of course being homeless. My daughter when she first got to preschool back in 2018, she was a happy girl and now the teachers are telling me, you know, that she is very upset in school and stuff like that. [P4]

Play and fun

…my girl is going in to class and she be crying because the other girls would all be about having parties in their houses and that or having birthdays or having sleepovers with their friends, my children are there saying ‘Mam can we do this or that? She can’t of course, I think …. it’s ruining their childhood; they have no childhood. [P2]
| Parent mental health & Physical health | ‘Mams never sleep’ [P4]  
No, we never sleep [P2]  
We never sleep basically [P3]  
You have to be strong for your children…even what breaks my heart is when my kids turn around to me and say ‘when are we getting a place to live and I have to say I don’t know love…we have to wait our turn to get a house. And our turn will come. What else can you say to a child [P2] |
| Opportunity for Employment/Education | Your life is on hold…you have no control [P2]  
I got 6 children… picking up children. I’ve a 12-o clock pickup, a half one pickup and half two pick up and a half three pick up. I’ve appointments 7 days a week with my kids. There is no time for anything else. [P3] |
| Opportunity to relax | Relax what’s that? My worry every day when I was in [hotel] … I didn’t know when I was going to get a phone call to say I had to move for my children. That was the worry every day. The unpacking and packing …and basically, we were living in the car every day. [P2]  
You can’t relax [P3] |
| Other: Concerns for the future | What’s my child going to be like in 10 years…this is going to have a massive impact on them unfortunately [p2]  
Something needs to be done, not even for us but for our children [P4] |

The central points identify the social and psychological risks of homelessness to children. The level of accommodation for these families is below standard. Parents and children are sharing small rooms while the making and eating of meals, the completion of homework is also conducted in these bed and breakfasts and hotel rooms. Each domain of children’s development
has been reported by parents to be affected because of homelessness. Moreover, opportunities to play and socialise/interact with peers and siblings is also impacted and restricted due to the nature of the accommodation provided. Burns (2019) asserts that the impact of being homeless is essentially shrouded in stigma and shame. The landmark report, No Place like Home by the Ombudsman for children (2019) concurs and highlights that children living in family hubs experience overwhelming feelings of ‘shame, guilt and anger’. Moreover, the concerns of homeless children have been documented, clearly showing that a lack of privacy, inadequate space, noise, not being able to have visitors/bring home friends, and a lack of quiet space to complete homework were all real challenges. Homelessness has put these children at risk of immediate physical, cognitive, social, and emotional challenges. Parents are concerned about their children’s immediate and future holistic development particularly their children’s behaviour and academic achievement. Fundamentally, these feelings of failure, shame and embarrassment have implications for sense of worth and dignity (Cairns, 2001). Essentially, educational outcomes are poorer as are physical and mental health outcomes (Cairns, 2001; Herman, 1997).

5.3 Integrated Homeless Model and Child Mental Health

The broad theme of ‘integrated homeless Service Model and Child Mental health’ to children is used in this section as the guiding theme, under which the emanating sub-themes, which arose from the in-depth focus group interviews, have emerged. There are approximately 9099 people officially homeless in Ireland (Dept of Housing 2022). Health and Social care workers who work with homeless parents and their children are trying to help families through this difficult situation, to reduce the serious social and health impact homeless has on children. To do this, services are provided that link up with homeless families. These include accommodation, food provision, one to one daily supports between various health and social care workers and children as well as well as specialised youth club services and after care. The parents the results on how these work for homeless parents.
<table>
<thead>
<tr>
<th>Sub Theme</th>
<th>Focus Group Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>One to One support: impact on holistic development</strong></td>
<td>My small one needs the one to one here. [P3]</td>
</tr>
<tr>
<td></td>
<td>We don’t have one to one in the B&amp;Bs [P2]</td>
</tr>
<tr>
<td></td>
<td>We have one to one support and it is 100% good. [P3]</td>
</tr>
<tr>
<td></td>
<td>I think they [children] can open more to them more than they would to us [P2]</td>
</tr>
<tr>
<td></td>
<td>The loneliness is horrible [P3] [ so one to one support helps]</td>
</tr>
<tr>
<td><strong>Specialised youth club: reduce stress /distress</strong></td>
<td>I come back every at 4pm every Tuesday ensuring we have everything done [before</td>
</tr>
</tbody>
</table>
youth club] and from 4 o clock on I never see my kids as happy, like they know straight away they’re getting out…they have freedom [P3]

My young one is 3 and a half and I go to youth club with him once a week and they do fantastic work [P2]

It gets them out of being stuck in that building and takes their minds off that [P2]

You know the child is kind of sad when they must leave [youth club] [P2]

Say then they are going to youth club, when it’s over, and they have to go back on the bus, imagine what’s going through those kids heads that they have to go back to that situation’ [P3]

I am 34 years of age and if I am feeling that (sad leaving youth club), just imagine how the kids are feeling [P2]

…they are jumping [going to youth club], they are feeling great [P2]

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**Central Points: Integrated Homeless Model.**

The central points that emerge strongly highlight that integrated homeless services are good for all experiencing homelessness and not only children. Participants report that children need, want, and enjoy support from integrated services. Participants feel that key workers are most approachable and responsive to children where available. Key (POD) workers were not
available to residents of B&Bs. To support this, the literature states that the key person approach developed by Goldschmied, & Jackson (1994) is a method of care associated with Early Childhood Care and Education (ECEC). The idea is that each child is assigned a particular educator who will act as their ‘go to’ person. Staff working in the youth club also provide emotional support to parents as well as children. Relationships with peers who are also users of the services are an important source of additional support for children. The literature very much coincides with these themes where Jennings (2019) also suggests that children experiencing trauma crave attention and affirmation and this Youth Club experience enables these children to receive appropriate and developmentally appropriate attention and care.

5.4 Integrated Homeless Service Merits and Challenges

The broad theme of ‘integrated homeless Service Model and Child Mental health’ to children is used in this section as the guiding theme, under which the emanating sub-themes, which arose from the in-depth focus group interviews, have emerged.

<table>
<thead>
<tr>
<th>Sub Theme</th>
<th>Focus Group Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pod - Responding to Needs of Children</td>
<td>Say then they are going to youth club, when it’s over, and they have to go back on the bus, imagine what’s going through those kids heads that they have to go back to that situation’ [P3]</td>
</tr>
<tr>
<td></td>
<td>‘…and it’s time to go back you [after youth club] can feel yourself already coming down with a bang because you’re back to where you don’t want to be’ [P2]</td>
</tr>
<tr>
<td></td>
<td>‘All things for the younger kids. Nothing for the older. I have a 12-year-old and there is nothing for her to do. By the time I come back up, she is up in that room and there is no one her age. Redclyffe there is nothing for that child to do. There’s no kids her age there. I am worried she’</td>
</tr>
<tr>
<td>Working collaboratively/ spirit of shared responsibility and communal effort</td>
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<td></td>
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<tr>
<td>“It’s extra help you get with a pod, they help you with scheduling your appointments” [P3]</td>
<td></td>
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<tr>
<td>I would have 3 appointments in a day, and they try to work around that and like if I’d no way to appointments they’d help you with things like that” [P4]</td>
<td></td>
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<tr>
<td>“I think if anything there should be more workers coming from the homeless into work. Like. The key workers...just to see we are homeless for a while and we’re here now. Because Nobody will ever know how we are feeling. Walk a day in our shows. There’s people out there, if they had a day in our shoes, they wouldn’t last a day…” [P4]</td>
<td></td>
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<tr>
<td>“There is only one key worker. Yeah, Yeah, they’re good. Oh, they’re cool. My key worker has changed I don’t have her anymore. I am after been signed over to another…. She is lovely. She helped me with my letters sent to City Hall and now City hall is after realizing they’re actually doing nothing’. [P3]</td>
<td></td>
</tr>
<tr>
<td>“The key workers here, they are fantastic” [P2] ‘You get treated like shit’ [P3] [in relation to working with other services outside the Pod]</td>
<td></td>
</tr>
<tr>
<td>“They don’t care about you” [P3]</td>
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</tbody>
</table>

is going to fall into depression from being stuck inside that room. She is too old for those activities’ [P2]

I think there should be allocated more things for the kids [like youth club]. Yeah, my 12-year-old. Nothing. My 12-year-old comes home from school straight to the room and she don’t come out, there is nothing for a 12-year-old. Most days I don’t have a battery on my phone [from child using it] [P3]

‘I have a daughter 12, she is the same’ [nothing for her to do besides youth club] [P4]
<table>
<thead>
<tr>
<th>Child’s Voice</th>
<th>No, they don’t you’re only a number [P2]</th>
</tr>
</thead>
<tbody>
<tr>
<td>I think they [the children] can open more than they would with us because they might feel the same way that we do, and they may be scared to open to their parents [P2]</td>
<td></td>
</tr>
<tr>
<td>‘Yeah, one of the kids was 8/9 years of age and she broke down in tears, it was horrific. She shouldn’t have to thinking of such things... It was horrible’ [P3]</td>
<td></td>
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<tr>
<td>[Youth club] gets them out from being stuck in that building and takes their minds off that [P3]</td>
<td></td>
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</tbody>
</table>
Key Worker Referrals

‘They have your file over, and you fill it in, … so they [the staff] do share it [information] [P2]

‘it’s getting referred, then there is more waiting ‘[P3]

‘Yeah, I must say my key worker is fantastic… it must be frustrating for them when they have to speak to someone to get things done. It’s the system. They try hard. [P2]

…but the key workers here, they’re fantastic. Yeah, they are. They will fight your corner now’ [P2]

[The key workers] …there is so much pressure they’re under now. …so, there are four people in Cork covering the B&Bs [P4]

‘It’s the HSE, I think the guys on the top aren’t responding for example to a referral ‘[P3]

‘…they [key worker] refer it over to the council and the council may not even look at it for months. [P2]

Note: P2, P3, P4, are each of the three focus group participants, no.1 is reserved for the interviewer.

5.5 Central points

The central points that emerge suggest that the integrated homeless services model has both merits and challenges. Participants appreciate and understand the importance of children participating in meaningful activities such as those provided at youth club. However, there was a request by focus group members for these services to be extended for children aged over 12 and particularly for girls. The integrated model is enmeshed in bidirectional relationships while support for families by key (POD) workers is one of the key strengths available to service users.
Pod key workers were valued and respected, while access to more key workers, particularly in the B&B provision was considered as a key necessity. Collaboration between workers and service users was also merited. The sharing of information and collaborative approach assists service users as teams share responsibility, provide support and exchange expertise. The Pod welcomes parents as part of the team and develop ongoing relationships with the key workers. However, this does not stop the waiting lists for additional supports including OT, SLT and other assessments. The Pod gives voice and visibility to the child and enables them to open again highlighting the importance of relationships between children and professionals. For some users, other formal supports (with HSE and City Council) was regarded with a level of distrust. The literature highlights the importance of relationship building and integrative care as stated by service users where the key person approach as stated previously, developed by Goldschmied, & Jackson (1994) is a method of care associated with Early Childhood Care and Education (ECEC). Equally, fostering responsive relationships with adults and children is also of significance in improving outcomes during one’s journey through homelessness (Bellis et al, 2014). Concurring with this research, the Harvard Centre (2019), further argues that responsive relationships assist in shielding toxic stress during difficult experiences.

Similarly, grim experiences such as homelessness, can spiral families into difficult areas such as risk assessment as these experiences can challenge a parent’s capacity to provide a safe and nurturing environment (Tusla 2019). The Scottish Government (2012) reiterates that approaches from services needs to be integrated and preventative to be effective. Achieving integrated care beckons those involved to ‘impose the patient’s perspective as the organising principle of service delivery’ (Lloyd et al, 2005: p7) A note of caution here is that “one form of integrated care does not fit all. There is no one model that is suited to all contexts, settings, and circumstances” (Pike and Mongan, 2014, p.123).

5.6 Policy implications

The broad theme of ‘policy implications’ is used in this section as the guiding theme, under which the emanating sub-themes, which arose from the in-depth focus group interviews, have emerged. These responses suggest that children who are experiencing homelessness would still need and benefit from one to one service for a period, even after being housed. Essentially, the trauma of homelessness does not stop once the child has been housed.
<table>
<thead>
<tr>
<th>Sub Theme</th>
<th>Focus Group Responses</th>
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<tbody>
<tr>
<td><em>Wraparound &amp; Continuity of Services</em></td>
<td>They are still useful and needed [when children are no longer homeless*” [P3]</td>
</tr>
<tr>
<td></td>
<td>Yes, yes [its needed] [P2,]</td>
</tr>
<tr>
<td></td>
<td>Yeah, they continue to need care, the kids through services’ [P2]</td>
</tr>
<tr>
<td>*Extension of services to other types of</td>
<td>families experiencing difficulties.*</td>
</tr>
<tr>
<td></td>
<td>‘families experiencing other difficulties could use the pod’ [P3]</td>
</tr>
<tr>
<td></td>
<td>Yes, they need it too [P2]</td>
</tr>
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</table>

Note: P2, P3, P4, are each of the three focus group participants, no.1 is reserved for the interviewer.

Wraparound delivery and continuity of services is considered necessary. This has been identified by the users to be flexible, and child and family centred. Provision is compassionate, comprehensive and provides a holistic programme of supports. Essentially, it is this collaborate, team-based approach that is deemed most suited to the needs of homeless children and their families. The literature authenticates these themes where this child-centred, child-led, and playful approach is rooted in relationships that welcome and honour every child’s lived experience and story. An integrated model that helps to establish a team around the child (SirajBlatchford *et al.*, 2007) reflects the spirit of shared responsibility and communal effort. Blackman (2002) has shown how family support and coordinated community involvement are the key to success with intervention. Adopting a bio-ecological systems model of integrated working and operates from Bronfenbrenner’s (1979) principle of multi-person systems of interaction.

Fundamentally, the trauma of being homeless does not stop when a house is provided with families reporting that children require the supports well after a house is secured. The shame and impact on self-esteem continues with parents reporting changes in children relationships with their peers even post homelessness. The Meitheal policy document (2013) links in here
where it strives to put the ‘child’ at the centre coordinating and integrating the correct services around the child in the home. Slaintecare (2019) and the Healy report (2014) agrees where it advocates for home led integrative care and support in the community. The services provided by the Pod are identified essential for children during this transition and period of adjustment. Moreover, the current users of this model identify that this support could and should be extended to other vulnerable groups like children in direct provision and traveller children. It was suggested that these children would benefit from this inter-agency collaborative holistic programme of supports. Ensure Families with children experiencing homelessness should be granted access to adequate supports to ensure that there is a seamless transition to this new way of living.

5.7 Focus Group with Staff Members

5.7.1 Focus Group Two- Managers, Co-ordinators, and Workers

This section thematically analyses a focus group of experts involved in delivering, managing, and co-ordinating family homeless services in Cork city. These results focus on: the scale of child homeless challenges; the social and psychological risks of homelessness to children; the effects of the integrated homeless service model on child mental health; the merits and challenges associated with this model and finishing with a section on specific policy implications.

Scale of Child Homelessness

<table>
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<tr>
<th>Sub Theme</th>
<th>Focus Group Responses</th>
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72
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<tr>
<th>Dramatic Increase</th>
<th>“Raising rapidly. It was raising, again goes on. We have had three families coming to homeless every day” (FG4)</th>
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<tbody>
<tr>
<td></td>
<td>“Yes. I suppose that’s how we develop to be there for the outreach team. In 2014, Edel house was able to meet the need of homeless families in Cork along with these four units in Shannon way that we use from time to time, but in 2015, where we had 13 families on a waiting list, and that was the first time that that had happened and that B&amp;B worker was put in place, now that’s 80 families”(FG3)</td>
</tr>
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</table>

| Homeless Emergency | “I think in 2014 time, I think we came across an emergency in homelessness. Yeah. And I think we are dealing with an emergency” (FG1) |

| Whole Family Homelessness | “See, you know, I think we have a context to it. Because it was the first time in my experience that I had experienced whole families becoming homeless families. I worked at the time as a volunteer in the eighties” (FG1) |

**Note:** FG1,3,4,5 is each of the three focus group participants, no.2 is reserved for the interviewer.

Focus Ireland informs that there were 8,876 people homeless in the week of the 25th – 31st of May 2020 across Ireland. Alarmingly, this number of homeless families has increased by 115% since May 2015. The existence of the ‘new homelessness’ of whole family homelessness, as distinct from individual homelessness, has been clearly emphasised. This has reached the status of an emergency. Edel House in 2014 were able to deal with demand with support from Shannon way House. However, they were unable to meet demand in 2015 with 13 families on a waiting list reaching 80 families in 2020
5.7.2 Social & Psychological Risks of Homelessness to Children

<table>
<thead>
<tr>
<th>Sub Theme</th>
<th>Focus Group Responses</th>
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<tbody>
<tr>
<td>Overcrowded Emergency Accommodation</td>
<td>“So, I remember going up the room when there was six kids and a mother” (FG4)</td>
</tr>
<tr>
<td>Social &amp; Educational Risk</td>
<td>“There was two four- or five-year olds and there was a kid trying to do study for his Junior Cert, sitting on the end of the bunk” (FG4)</td>
</tr>
<tr>
<td>Parents Coping Without Sleep</td>
<td>“We run a support group here and what comes up is the effect of lack of sleep and the inability to get through the next day” (FG4)</td>
</tr>
<tr>
<td>Homeless Onset Child Health Deterioration</td>
<td>“I could not believe the change in the child that I saw was very interesting. I couldn’t believe even physically how the child had gone back and emotionally and psychologically the child's school had been disrupted completely, couldn't get to school, no sleeping” (FG5)</td>
</tr>
<tr>
<td></td>
<td>“So psychologically, emotionally, in every way, there have been damage on a daily basis” (FG3)</td>
</tr>
<tr>
<td>Stigma</td>
<td>“the kids are aware that they are homeless and there’s a stigma attached to that so you can see that it has a completely different impact on them than when they were younger …it happens when they reach 8 years of age they start to become aware that there is something different about them and they can’t put their finger on it and that’s when you see a dip in their self-esteem and they start to become withdrawn”(FG4)</td>
</tr>
<tr>
<td>B &amp; Bs’ Poor Nutrition</td>
<td>“And then one of the worst things with B&amp;Bs is that they</td>
</tr>
</tbody>
</table>
can’t cook for themselves. You have no microwaves because now I don't have a microwave in the room. Yeah. So, the only thing they have is a kettle. So, they are only having biscuits and sandwiches. Nutritionally is not good (FG3)

“So misleading B&B, it should be just one B” (FG3)

<table>
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<tr>
<th>Children in Parenting Roles</th>
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<tbody>
<tr>
<td>“children take on the stress of their parents in a homeless situation. Absolutely, you’d see the older children sometimes minding the younger children. They're the ones who struggle the worst, who take on an extra responsibility for the family” (FG5)</td>
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“That's what they do. And I've had two boys saying: “When is my mom's turn to get a house. She's waiting longer than them, and they are after getting the house” (FG5)
et al., 2017). Restrictions on cooking and limited storage tend to lead to poor diet, resulting in inadequate nutrition for both children and parents. Take-away meals and cheap convenience foods are prevalent (Share & Hennessy, 2017) while the nature of communal living in family hubs is identified as a huge cause for concern in the ‘No Place Like Home’ Report (2019).

5.7.3 Integrated Homeless Service Model and Child Mental Health

<table>
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<tr>
<th>Sub Theme</th>
<th>Focus Group Responses</th>
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<tbody>
<tr>
<td>A Good Memory for Children</td>
<td>“can we give the children even one good memory, even one good memory that how we can do any at that basic level? That’s what started youth club. And it what kept it child centred” (FG5)</td>
</tr>
<tr>
<td>Fun, Recreation, Play and Child Development</td>
<td>“The idea is for children to have fun, and that’s what it validates. But that’s what children tell us they have is fun. And then think of the importance of fun and play in the development of a child. Yeah, that’s the bit that’s missing” (FG5)</td>
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<td></td>
<td>“I know a girl, Aoife, a childcare worker, she was supporting a child who was a private emergency accommodation. And one day after being out together, the child said so that’s my first time to have fun in two years” (FG5)</td>
</tr>
<tr>
<td>Child-Led Model</td>
<td>“We are taking a lead from the children here, you know so the children are like dictating to us how the program goes” (FG5)</td>
</tr>
<tr>
<td>Empowering Children</td>
<td>“We get professional reports coming out though the ears of the children and their parents what’s wrong and what’s dysfunctional what’s this and what’s that. But the children themselves are rarely listened to, but in this endeavour that’s behind the scenes” (FG5)</td>
</tr>
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</table>
Defusing Pressure on Families

“With Springboard, we then could put interventions in place. So, we’ve spent a lot of time here watching families fall to pieces and putting in reports, what you know, into social workers and CAMHS and all the other various services. You see the behaviour, but we didn’t have the resources to support them. But then once we start to go to sports and place, we were able to, if you imagine a pressure cooker, you already released pressure, but you release some of pressure and the family can function much easier” (FG3)

Family Support

“We have a program here and in Redcliffe, called making change…And so the main change is that they put in lots of different supports, including counselling, and cooking and budgeting. So that’s there in Redcliffe, and we tried to tie in parent support in the B&Bs as well (FG3)

There is strong evidence of the positive impact that the integrated homeless services model has on the lives of families and children. Children are placed at the centre in decisions around their needs and activities. The emphasis is on having a positive psychological impact on children, through fun, recreational and other activities. The work involves defusing the pressure on children, which arises from homelessness. The model also includes practical interventions to support parents such as providing counselling, cooking skills, budgeting skills and other supports. Jennings (2019) suggests that children experiencing trauma crave attention and affirmation and this Youth Club experience enables these children to receive appropriate and developmentally appropriate attention and care. In addition, much research highlights the importance of engagement and interaction with traumatised children and asserts that this time of interaction is essential to the holistic development of traumatised children. (Romero 2018; Pierson 2013; Jenson, 2009). Notably, many qualified practitioners from the POD, who understand children’s needs, development and challenges are available to the children with the aim of building positive, responsive, and respectful relationships with the children.
5.7.4. Integrated Homeless Services Model Merits & Challenges: Origins

<table>
<thead>
<tr>
<th>Sub Theme</th>
<th>Focus Group Responses</th>
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<tbody>
<tr>
<td>Inspiration for Interventions</td>
<td>“When we were framing what we do… we looked at a paediatrician in London, who worked with children who became homeless after the War… he talked about the whole being a facilitating environment where it facilitates your growth, you know, you have you, it’s your base, it’s your physical base for one thing, it’s your emotional base, it’s if you want to learn and do your homework, it’s in your home. It’s very hard to do that when you’re in a hotel room… So, you can get that foundation in… the elements that we try to build into the youth of this continuous you know, stability…” (FG4)</td>
</tr>
<tr>
<td>Inspiration for Pod Model- Whales</td>
<td>“We chose the pod deliberately in the early years, you know, we looked at a pod of whales that travelled around the world and like the pod itself is a collaborative collective thing. So, for instance, like at certain paths of negotiating the ocean, the leadership will change. The older ones might come back that stage and, in our pod, we had a coalition to do …volunteers, on paid work, temporary hours etc…” (FG1)</td>
</tr>
<tr>
<td>Inspiration for Special ‘Youth Club’</td>
<td>“In regard to the youth club, regardless of whether people are homeless or not, if kids learn their traumatic situation. They deserve at least some kind of happy memory. Yeah, yeah, that may sustain them, where they can turn around and say you know, it’s just crap, the life is crap, but I remember that.” (FG1)</td>
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The services have been inspired by interventions after the Second World War in the UK, to deal with trauma in families. There services provided attempt to work from a holistic ‘needs based’ response in helping homeless families. The dynamics of the organisation, based on the
idea of a pod of whales, was to provide a fluid, integrated and responsive series of interventions which can change and move rapidly. The focus of the youth club is to replace the painful memories of homelessness with happy memories, to unlearn some of the negative memory.

Bronfenbrenner and Morris (2006) asserts that to study child’s development we must not only look at the child and her immediate environment but also the interaction of the larger environment as well. Essentially, the child grows up in a set of systems. The establishment of formal collaborative structures involving relevant public agencies, the voluntary sector, the local community, and the identification or establishment of a local centre within each community will act as a focal point in delivery of resources for young people (Department of Health and Children 1998) was very much being viewed at this time. Note, this point the researcher found to be very interesting because even as far back as 1998 the thinking was like that of the POD and its response to homelessness.
### 5.8 Integrated Homeless Services Model Merits & Challenges: Pod-Led Model

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<tr>
<th>Sub Theme</th>
<th>Focus Group Responses</th>
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<tbody>
<tr>
<td><strong>Collaboration</strong></td>
<td>“We are working collaboratively with the families helping them see what their needs are and what best suits them” (FG3)</td>
</tr>
<tr>
<td><strong>Peer Support</strong></td>
<td>“And collaboration works seamlessly for peer support as well. Yeah. That's a lot of creative thinking. Peer support, yeah. Creative was first, Good Shepherd services, Springboard.” (FG1)</td>
</tr>
<tr>
<td><strong>Horizontal Integration Targeting</strong></td>
<td>“And we tried to get a collective different bunch of people who were in leadership and things like that…” (FG1)</td>
</tr>
<tr>
<td></td>
<td>“We have our pod meetings and we can see who’s struggling at the pod meetings, and we'd be trying to target support on those people” (FG3)</td>
</tr>
<tr>
<td><strong>Innovation, Creativity and Action</strong></td>
<td>“This was an action-oriented endeavour… all those kinds of things kind of came together around the pod, because it was a more creative way of looking at a group of people…You're talking about an actual event that you had to organize. You're talking about how you'd organize it (FG1)</td>
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</table>
There are clear and identifiable elements to the integrated services model under investigation, which make it new and innovative: families are empowered by professionals working in a collaborative way with them; Professionals collaborate among themselves through peer support and peer learning; There is a horizontal integration evident among peers from different professional backgrounds working together inter-professionally, in examining cases and generating solutions; this has become a creative endeavour; this creativity is epitomised with innovative solutions of providing specialised services which are normalised but are essentially targeted towards families and children with the greatest level of challenges. Research (Slaintecare 2017, HSE 2021) suggest that when interventions are centred on integration and partnership with service users and where the focus is on practical solutions and relationship building, common goals can be achieved. Similarly, in relation to family and child homelessness the approach from services needs to be integrated and preventative to be effective, thus focusing on the most vulnerable families where using a community model of partnership where ‘the engagement between these informal networks and the more formal state provided services that real partnership is developed and sustained and through which people come together in a way that supports and enables communities to meet local needs’ (Community Healthcare Organizations Report 2014 p32).

5.8.1 Integrated Homeless Services Model Merits & Challenges: Youth Club + Volunteers/Students + Community

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<tr>
<th>Sub Theme</th>
<th>Focus Group Responses</th>
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<tr>
<td>Broad and ‘Secret’ Services</td>
<td>“We have the broad services where we target lots of children and lots of adults. And then I think we good at different secret ones do we need to target in and support them that so that they don't get lost” (FG3)</td>
</tr>
<tr>
<td>Child-Focused, Child-Centred, Child-Led</td>
<td>“Yeah. Here's the wonderful thing from our perspective is the relationship built over time. Because it's a voluntary engagement. Yeah, by both the people in the youth club, the mothers, and the kids. They can come and go at any time. Its child friendly, child centred (the youth club) and child led. Yeah, we've asked the kids what should we do? What would you like to do…they need to run these; they need to afford them?” (FG4)</td>
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<tr>
<td>Volunteers Identifying Children’s Needs</td>
<td>“Identifying more needs that require taking action. dynamics, a dynamic system that can respond quickly… Like a volunteer, we had one child and the bus I remember, like, and it was the bus was the trigger, she kind of acted out on the bus, but like that there was a meeting and there was a father with a volunteer who was able to meet the child a couple of times in the week, following up and you could see the behaviour coming down. Again, that could be a child that will be referred to CAMHS, could be on a waiting list for several years before ever being seen and then being seen in a clinical setting. This was followed up almost immediately seamlessly, the child behaviour didn’t deteriorate because of the immediate follow up. And it was only witnessed in the bus” (FG1)</td>
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The child-focused and child-led nature of the model is re-emphasised further. The use of volunteers is particularly innovative: volunteers who offer a helping and supportive role, but who can detect situations where a child is regressing, before it escalates further, would seem to be a very positive development in a community care context. Furthermore, the establishment of the Community Health Care Organisations report in 2013 was very much steeped and enriched in the importance of developing a model of integrated care that is responsive to the needs of local communities (HSE 2013). The report places a robust emphasis on the importance of collaboration and integrative care within communities in striving to improve health and social wellbeing. Goodwin further influences our above model with his argument that
integrated care should promote health by bringing together health and social care with other players such as schools, community groups, families, industry and so on (Goodwin 2016).

5.8.2 Integrated Homeless Services Model Merits & Challenges: Relationships + Transferability

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<tr>
<th>Sub Theme</th>
<th>Focus Group Responses</th>
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<tr>
<td>Relationship-Focused for Success</td>
<td>“…you do intensive individual follow up, but because some of these kids are here, this is an ideal place to locate it because the workers have the relationship, the workers have the relationship with the kids…it’s all about having the relationship, you know, you just can't really lecture to them … you can’t just say I’m an expert now, do as I say… Unless you have a relationship nothing will work” (FG1)</td>
</tr>
<tr>
<td>Need for Rural Community Alternatives</td>
<td>“Parts of rural Cork then like west, north, east, South Cork there's very few services on the ground, you know, and you would come across families down there and they're in extreme difficulty. In the past we have done a bit triage service to try to initialise something in the community, but we are finding there are very few on the ground as opposed to the city- like when we get past the stage of triage work. Again, then we begin linking the child into the clubs and other services …but in County Cork that’s not the case” (FG3)</td>
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</table>
There are very clear efforts to work from a relationship-focused model. This is consistent with the empowerment of children and families already identified and putting the child at the centre in needs assessment and service delivery. Integral to the model is the Signs & Safety National Assessment Framework approach adopted by Tusla (2017) which emphasises a commitment to building honest compassionate working relationships with children, families, and related service users.

There are strong suggestions that this model, which predominantly operates in the city, would have significant transferability into rural areas of unmet need.

5.9 Policy Implications

- There was strong agreement with the statement that health and social care workers on the large care team known as the pod, all work together on the same level.

- It was also strongly agreed that the nature of this Pod of professionals working interprofessional, allowed for decisions based on shared information to be arrived-at.

- In turn, participants agreed that this interprofessional team, working together, often reduces the need for a child to be referred upwards to a person in a more senior position and the net effect is to make the service more user friendly. However, notwithstanding this, where a child needs to be referred to a higher-level intervention, this is done effectively, through the dialogue within the pod team.

- There was also strong agreement that this interprofessional pod team, working closely together, often speeds up the delivery of services, notwithstanding the continuation of waiting lists.

- Participants agreed that wrap around services will be needed for a period for many families, even after housing.
• Past trauma, which continues after housing, will necessitate specific support services for family members in a ‘transition’ phase after being housed.

• The need for services such as the youth club should only be needed by some families, for a short period after being housed.

• This integrated homeless services model has strong potential to be replicated successfully in other services.

• The current model has a strong ‘preventative’ focus and can even be less costly in the long run, by preventing family challenges from escalating.

5.10 Focus Group with Management in Springboard-TUSLA/Good Shepherd Services Cork

Focus Group Three- Specialised Managers

5.11 Integrated Homeless Services Model: merits & challenges

The broad theme of ‘Integrated Homeless Services: merits and challenges’ are used in this section as the guiding theme, under which the emanating sub-themes, which arose from the in-depth focus group interviews have emerged. A series of grid matrices follow which detail these sub themes, with corresponding illustration of them from focus group participants within the relevant matrix. Each grid matrix is followed with a summary of the data.

Fig 5.1
Focus group participants were asked to consider the diagrammatic representation of the model as detailed in Figure One above. The initial focus on the model starts with exploring how the various services which constitute the integrated services model actually function and the dynamics of the work, involving the interaction between professionals within the various constituent services with homeless service users and also their own inter-professional working arrangements in response. Within the various services, Edel House caters for whole families now. Redclyffe is constituted as a family hub and caters for both partners within the family and children. The emergent sub-themes and commentary are detailed below.

Funders: Pobal – Healthy Ireland, Tusla, HSE(Mental Health), Cork City Council
### Sub Theme: Family Key Worker Referrals (at Redclyffe & Edel House)

#### Focus Group Responses

- ‘…there will be allocation to key worker and the key worker then if there are kids in the family might refer them on to us here that we will be able to offer them youth club or boxing or anything’. (FGP 2)

- ‘So, any referrals would come back into the pod and then we’d look at it. (FGP 4)

### The Child’s Voice

- ‘I suppose when, once they’re involved in the service… there is the option for more focus on the children voices in there. So, we do have the youth club, we do have homework club, we do have the boxing facility, as well as individual workshops, should some of the children present as struggling as a result of the home situation, as well. So, we do have the option for an individual therapeutic intervention voice in there’. (FGP3)

### Pod at Centre Representing Child’s Voice

- ‘So, from center to pod where the child is at. So, any needs that the child require both from Edel house, Redcliffe, the B&B workers all come from center and it works out. So whatever services or whatever needs required would come focused back out into whatever the report’. (FGP 4)

### Pod at Centre of Professional Collaboration

- ‘We’ve developed like boxing and the homework club and stuff like that they would have come from a need we would have identified from the kids like the boxing for instance was something, we had a group of boys and they said, we're really interested in boxing. So, is there something we can do around that?’ . (FGP 2)

- ‘I suppose the pod is in the centre of it. And yeah, basically from that, there's a lot of collaboration work being done’. (FGP4)
The pod is kind of at the center of this diagram, and then it provides these interventions going upwards and then it radiates and has a, you know, two-way communication or two-way linkages or interaction with all the other services. (FGP3)

**Wrap-Around Services**

‘I suppose from both Edel house if you look at the wraparound, there are people coming from Redcliffe, springboard themselves, B&B workers comp. And I suppose anything that's in blue really is the workings that we're doing… The blue are the kind of interventions and the work that we do around it… So, let's see, for example, there are Penny dinners with link in with Penny dinners for food around, you know, whatever needs that the family requires.

’ (FGP 4)

**Note:** FG2,3,4 is each of the three focus group participants, no.1 is reserved for the interviewer.

The central points which emerge from the above is that there is a clear organisational structure for the delivery of services which involves significant collaboration between a variety of professionals, agencies, and service users, working together. Within the structure, as per Figure One, service-users can be identified in the services shaded in red, while the services which respond are shaded in blue. The POD, which is made up of approx. 20 social care/social work/other caring professionals is the nerve centre for inter-professional collaboration. The members of the POD work for all the various agencies described in the Figure One. But, as is evident from the focus group data above, the needs of the child are the central driver in terms of how professionals who work on the POD respond.

Implicitly, the needs of the child are also mediated by the child’s family, in addition to the child herself. The focus here is clearly ‘needs’ driven, the expressed needs of the child, living in exceptionally difficult homeless circumstances and giving the child the opportunity to express their feelings on what activities and interventions they feel they need. The agencies have responded by providing a multiplicity of outlets to cater for the child’s needs, which we can see, include: boxing, homework clubs, the youth club (including a multiplicity of various other activities in it, as we will be presented in the observation study), a specific-tailored therapeutic (understood in the broad sense as any helping) intervention for the child, or any other activity
which the child or a group of children feel they need, as mediated by themselves or a family member.

All families residing in the Redclyffe family hub or at Edel House are assigned a key worker. The key worker can channel information if necessary, into the interprofessional POD at the centre of the organisational structure. The needs of children are brought back for discussion to the POD at regular meetings and daily communication between members, daily or weekly. Also, of central significance is the ‘wraparound’ services for the child and family of the child, whether this is food (Penney Dinners or other), a youth club series of activities, educational resources (ETB/Forage), a Meitheal intervention or a homework club. There is a clear interagency collaboration in evidence.

*The wraparound team should be composed of people who have a strong commitment to the family’s well-being* (Bruns & Walker, 2008:4). Building on this, an integrated model that helps to establish a team around the child (Siraj-Blatchford et al., 2007) reflects the spirit of shared responsibility and communal effort. This is very clear as Blackman (2002) has shown how family support and coordinated community involvement are the key to success with intervention. These findings are not new as adopting a bio-ecological systems model of integrated working and operates on Bronfenbrenner’s (1979) principle of multi-person systems of interaction. ‘Wraparound’ is a process which aims to meet multiple needs and promote engagement through dialogue, collaboration, multidisciplinary practice, and service delivery in communities (Miles, & Brown, 2011; Walker, 2008). Essentially, with support from a team of professionals, the family’s needs and preferences all drive the work of the ‘wraparound’ approach.
### Sub Theme | Focus Group Responses
---|---
**Interprofessional Work & Learning Pod** | “…there's like a mixture of Social Work, social care, early years and then yet people have a lot of experience in different areas”. (FGP 4)

| | “I think that's why the pod is important, it’s probably because we all do have different qualifications and different experiences and if there was something that I had come across that I hadn't experienced, or I'd come to the pod…We might work together and said, Okay, I haven't done this before. But now I've done it now. And the next time it happens, they know what they going to do, and that’s why it works so good”. (FGP 4) |
| | “And here's your opportunity for peer learning, peer support within the pod like there is no hierarchy there is no dimensions in relation to a pyramid. It’s more like the level of skill of the professionals like across the table and everyone has brought something to the table that you can link in with other professions other skill set to broaden yourself as a professional. And to benefit the child”. (FGP3) |
| | ‘huge benefits for the child, which are huge benefits for the staff as well’ (FGP 3) |

The ‘Pod’ as described above, refers to an expert inter-professional group of workers who aim to provide integrated care delivery to homeless children from homeless families. The focus on sharing and pooling information and using peer support to enhance assessments and care delivery is impressive. This also adds value to each individual professional’s skills-set and increases skills value for the team, with the homeless child being the ultimate beneficiary. An
interesting challenge that Goodwin (2016) alludes to is that while having the necessary tools for a successful integrated care approach one of the key unmet challenges is how to move beyond these descriptive components in offering integrative care. Here, Goodwin refers to the ‘softer tissues’ of relationship building where nurturing a culture where new ways of working become the norm (Goodwin 2016).

5.11.3 Integrated Homeless Services: merits and challenges-The POD

<table>
<thead>
<tr>
<th>Sub Theme</th>
<th>Focus Group Responses</th>
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<tbody>
<tr>
<td>Continuous Pod Staff Communication</td>
<td>“I suppose it comes back to the pod on a monthly basis, but like we could be communicating on a daily” (FGP 4)</td>
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<td></td>
<td>“We can still phone each other and contact each other on a weekly or daily basis. Yeah, yeah. In relation to the children or the youth club, or any aspect of the service that we're all completing” (FGP 3)</td>
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<tr>
<td>Pod within a Pod</td>
<td>“…We're an instant rapid phone call or conversation or something can be put around a pod, within a pod can be formed…whilst then coming back to the pod as a whole or you give a synopsis or summary and keep everyone in the loop” (FGP 3)</td>
</tr>
<tr>
<td>Need for Model Replication</td>
<td>“…Which would suggest to me that there's an argument for another model of like this replication and then inter linkages between them”. (FGP 3)</td>
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<td>“Absolutely, even like, even like just of the top of my head, yeah, when we think of Cobh, we have so many clients in Cobh. And now we have a couple of them who do come up to youth club, but because they can drive”. (FGP 2)</td>
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</table>
Within the pod of inter-professional care workers there is feeling that this model is innovative. It’s clear that the informal communication between the network of professionals offers a ‘rapid response’ which is flexible and more responsive to the care needs of children in homeless families. There is a strong acceptance that this integrated care services model for homeless children has strong potential for replication elsewhere in County Cork. Collaboration and integration can be extremely important to those who are marginalised, vulnerable and have difficulty in accessing essential services because of their existing and presenting circumstances (WHO-UNICEF 2018, Tusla 2013).

5.11.4 Integrated Homeless Services: merits and challenges-Challenges

<table>
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<tr>
<th>Sub Theme</th>
<th>Focus Group Responses</th>
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<tr>
<td><em>Waiting Lists</em></td>
<td>“Always the waiting lists, always all right, yeah. Now what tends to happen is that you have people who are in B&amp;B, who would be we waiting…who's really struggling in the B&amp;B, maybe have two small kids, have a single mother and baby and might be prioritized on our waiting list for Edel house or Redcliffe”. (FGP 3)</td>
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The view from the response by professionals that homeless children and families who are in Redclyffe or Edel House and who differ from the more transitory service users entering and leaving Bed and Breakfast accommodation have higher levels of support. Those in B&Bs are not as anchored within the model and have less support planning in place, compared to the Redclyffe family hub or the Edel House, a dedicated facility for homeless women. Resource constraints were clearly highlighted by way of the waiting lists that exist for homeless accommodation, in particular access to Redclyffe family hub or Edel House. Mongan emphasises the point that it’s important to note and acknowledge that integration takes time to become successful and sustainable and may cost before it pays (Pike and Mongan, 2014, p.123). This wasn’t new where Darker noted that resource allocation is a key factor in ensuring a good balance of services and a well-functioning integrated model (Darker 2014). The researcher believes this to be of crucial importance in attaining an integrated model of care that improves outcomes for service users (families and young people).

5.11.5 Integrated Homeless Services: merits and challenges-Care Planning
| **Care planning formal & informal communication** | ‘There is a key worker assigned to each family’ (FGP4)  
‘So, there is a kind of a support plan for every child in Edel house and Redcliffe’ (FGP2)  
‘So, there's a kind of an informal thing going on. But it’s both formal and informal. There's professional work going on all the time Outside the pod and this seamless thing to be going on’ (FGP4) |
| ‘Co-ordination’ | ‘Yeah so I have a child care team meeting with my team and then we’d identify anyone you know we say like give them some support as we went through developmental checklist or like observations and all the rest of it we say all of this is actually something that we're worried about. And then from that, then we might identify that we want to bring it to the pod. Yeah, because I suppose there is certain work, we don't need to bring everybody to the pod. Yeah, yeah, yeah. There is certain work that we can do ourselves’ (FGP2)  
‘Trying to it's trying to just put a wraparound. Yeah. On to the wider services that are put in place’ (FGP3) |
| ‘POD holding it’ | ‘Yeah. But what we do is within the pod is we provide that initial or inter piece to hopefully cool the waters, calm the storm until or whilst the waiting’ (FGP4)  
‘It’s the scaffolding around a family or around the child’ (FGP 4) |
| ‘Early Intervention’ | ‘It’s just basically solidifying or kind of adding to this whole the whole concept of early intervention whatever your depiction is meant to do is provide that intervention before things escalate before things get to a level where serve more services are required. To provide early and immediate support Yeah, you're preventing things from going there. Yeah, sometimes that's a key…Little but now is enough’, (FGP5) |
There is side by side care planning and co-ordination daily in the teams such as individual therapeutic work, Youth club, Homework club, breakfast club, Equine therapy, and boxing, all working across Edel House and Redclyffe, in collaboration with the various service agencies across the city, such as Springboard, Foroige and Cork City Council. This co-ordination happens both at formal meetings but also informally between inter-professional teams, crystallized in the working of the ‘pod’ which represents the central focus of interprofessional care co-ordination and integrated care. There was as strong belief that, in the context of the continuous crises experienced by many families, that incisive, early interventions to prevent the deterioration of the social, economic, and psychological plight of families is critically important. Responding to crises, even when the whole series of problems cannot be resolved all at once, in a way that ‘holds’ the family together, a form of ‘triage’ until other more developed interventions are available is of the utmost importance and rapid response is the key to this. Both formal and informal communication mechanisms among integrated care professionals working as part of or connected to the pod, is critically important.

Contemporary thinking by recent policy makers in Ireland has a focus on a universal healthcare system where access to social and health care services is based on need ensuring timely access to quality, effective, integrated services (Slaintecare 2017, CHO 2013, DCYA 2014.). The all-party consensus on this was further reinforced by the position of the committee’s vision that ‘requires a system that is integrated in terms of all stages of an individual’s life, from cradle to the grave’ (ibid). These findings are nothing new where in essence an integrative homeless model which sets out to achieve working in collaboration with other agencies in devising plans for families in an attempt to support and ‘hold it’ brings Winnicott’s (1990) ‘Holding Environment’ to the fore. Essential to this is that consistent meaningful positive relationships are achieved with vulnerable children and families who are experiencing homelessness where trust and reciprocity of same between family and workers intervening is equally important and can support the reduction of trauma (Tobin and Murphy 2013).
### 5.11.6 Integrated Homeless Services: merits and challenges-Integrated Care

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<tr>
<th>Sub Theme</th>
<th>Focus Group Response</th>
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<tr>
<td>‘Horizontal integration’</td>
<td>‘We would see a horizontal integration between the various services, you'd see it on the pod in terms of the open dialogue…’ (FGP4)</td>
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<td>‘…in the pod, I think everyone is very equal when it comes to the meetings’(FGP2)</td>
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<tr>
<td>‘Horizontal &amp; Vertical Integration’</td>
<td>‘So even initially, within the pod, there would be a horizontal integration between professionals and the wider teams, our organization involved. But then in relation to the wider primary care network’(FGP4)</td>
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<td>‘Service-user-focused integration’</td>
<td>‘And sometimes the communication can be like, you know if someone starts linking in with a child from another service you would be like Oh, do you want to meet me first and I can fill you in on the backstory just so the child doesn’t have to go through everything again’ (FGP3)</td>
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<td>‘And with the moms. Like, are ye’ all right for me to bring the speech language therapists and see if there is anything I can do to help in the meantime until you can make appointments? And she was like Yeah, absolutely. So, I suppose’. (FGP3)</td>
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<td></td>
<td>‘Working as a collective’ (FGP3)</td>
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<td>‘I was out and a teacher from a school in Glenmore came up to speak to me because she knew that obviously they had identified some of the staff that were working there… And know that’s and that teacher that came to me to that because of what she said about the youth club or about all these people that work there. She said I'd love to link in with ye and offer you some support. Like, what can I’</td>
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There is clearly strong evidence of full-service integration within the homeless service model under investigation, both vertical and horizontal. It’s clear that professionals identify that all services are part of the Primary Care Network. The POD is essentially defined by horizontal integration. Being part of the PCN, it is vertically linked to specialist services also across all health and social care services. The ability of the pod to facilitate ‘seamless’ communication between professionals (‘the backstory’ above) is seen to be particularly advantageous. In addition, there is a wider and deep level of integration starting to unfold, not just between homeless care providers, but also with teachers in schools, as an example of wider interprofessional participation. There is a strong sense of positivity about this development. This links in with having the right culture of relationships at all levels be it horizontal or vertical in the integrative process is essential. This means demonstrating the importance of good relationships at all levels, from leaders to frontline practitioners. It means making the quality of relationships a priority for everyone, highlighted within the organization’s vision (Gillison 2017).
‘Relationship-based interprofessional working’

‘Yeah. It stems from like the initial focus on the relationship model. Yes, a focus on a trusting relationship with the child and family. So, we provide that by not interrogating them, day one, we let them get to know us as professionals. And then they know if we're coming with any suggestions or queries or additional supports, we might feel that would best meet the child. They can see why we’re coming with it, because we've had an open dialogue with them and that

open relationship with them anyway. So, they know it's coming from a wholehearted, caring place rather than a negative place. Yeah, like, your child needs this kind of almost authoritarian approach. They know we're not coming at it from that way. We're coming here from a considerate context, in a supportive manner because they've developed that relationship with us and that open dialogue and bluntness and honesty with between them and with ourselves today, you know’ (FGP5)

The relationship-based inter-professional model in evidence above looks particularly impressive. The work between various professionals, children and families is based on shared understanding and a non-interrogative approach. So, while the professionals working within and outside the pod vary from social care workers, social workers, speech and language therapists, support workers, psychologists and many others are ‘professionals’ in the sense of being expert at their role, there is a strong sense that professional power and any form of authoritarianism has been jettisoned, in favour of a more democratic, caring approach, which aims to nurture a more equal and understanding relationship between services users and professionals. Essentially, consistent meaningful positive relationships are fundamental for children and families who are experiencing homelessness.
Trust and reciprocity of same between family and workers intervening is equally important and can support the reduction of trauma (Tobin and Murphy 2013). The triangle of trust that develops between children, parents, and key people (workers) is essential for the success of any intervention. It needs to be very clear transparent and understood by all for it to be successful (Giddens 2013) The key person approach as discussed in the literature, is succinctly, a triangle of trust that a staff member and parent foster and share to support the child and their experiences. It is also essential to note that each part of that triangle has even sides and that no one participant is important than the other (Elfer, 2007).

Goodwin (2016), concurs where he refers to the ‘softer tissues’ of relationship building where nurturing a culture where new ways of working become the norm.

5.11.8 Integrated Homeless Services: Merits and Challenges- Final Conclusions

Focus group participants were asked for their level of agreement on several final questions related to the merits and challenges of the integrated homeless service model. Firstly, they were invited to agree or disagree with the contention that: Where children need to be referred to other health and social care services (e.g. CAAMHS, Dietician, Hospital) that they need, the referral is made quickly from somebody within this service?

The consensus on this question, was strong agreement from all members of the focus group:

‘We’d have some bit of a better understanding. Yeah, to spot it more quickly or sooner in relation to the key worker’.

Following on, participants were posed with the contention that, the health and social care workers on this large team, known as the ‘pod’, all work together on the same level? Notably, there was an overwhelming strong level of agreement by all members to this question. In addition, there was a unanimous agreement by all members of the focus group to the contention that working like this (as part of a pod) means they can decision based on shared information. Furthermore, all participants agreed also that this shared information reduces the need to refer a decision on the needs of a child upwards to a person in a more senior position and unanimously agreed that the net effect is to make the service more user-friendly.
When asked whether this shared information, which makes the service more user-friendly resulted in the speeding up of the delivery of services, there was no consensus and the response were far more equivocal:

‘It depends which service you are talking about’ (FGP2)

‘This all goes back to the resources. I suppose even with the lack of referrals that they don’t need resources to meet everybody’ (FGP2)

Finally, there was unanimous agreement, that the existence of this integrated homeless services model does mean that any issues that which need to be referred upwards can still be done effectively.

5.13 Policy Implications

On being asked a final round of questions on policy implications of all the above, the overriding consensus among members of the focus group was:

- Most families whose children have experienced a significant period of homelessness will still need the supports of one-to one service which their children currently receive for a period, even after becoming housed?

- Most families whose children have experienced a significant period of homelessness will still need the supports of the specialised youth club which their children currently receive for a period, even after becoming housed?

- The current integrated homeless service model can certainly be used to help other families and children in society experiencing similar difficulties.

- There is likely to be a strong transferability of the current integrated service homeless model to other care programmes attempting enhanced integrated care within the Primary Care Network.

5.12 Observation Study of Youth Club

The layout of Youth Club centred around four key rooms which were led by key people who facilitated the learning opportunities and activities (See Fig 4.1).
A review of the literature identifies extensive research showing toxic stress disrupts healthy child development by interfering with a child’s capacity to develop positive relationships with peers and adults (Jedd, Hunt, Cicchetti, Hunt, Cowell, Rogosch, ... & Thomas, 2015; Varese, SMEETS, DRUKKER, LIEVERSE, LATASTER, Viechtbauer, READ, VAN, OS, BENTALL, 2013; Anda, Dong, Brown, Felitti, Giles & Dube & Bremner, 2006; Felitti, Anda, Nordenberg, Williamson, Spitz, Edwards, Koss & Marks, 1998). Burns (2019:14) succinctly acknowledges that the impact of homelessness is all-encompassing in a child’s life causing many Adverse Childhood Experiences (ACE’s) and trauma.

Alarmingly, among parents experiencing homelessness, the rate of major depressive disorders is higher than in the general population while traumatic stress is nearly universal (Poleshuck, Cerrito, Leshoure, Finocan-Kaag, & Kearney, 2013). Evidently, homeless accommodation are facilities that are not conducive to the development of young children for many reasons including that these controlled environments impact on the capacity to parent (Swick 2009, Aviles and Helfrich, 2004). The report ‘No Place Like Home (2019:43) concurs, highlighting that ‘Rules, policies and procedures vary greatly between Hubs but commonly cause children frustration and confusion. Similarly, Swick (2009) further explains that many homeless environments are controlled, and many regulations can affect family life even going as far as institutionalising families within this controlled facility (Social Justice 2019; Swick, 2009). In addition, a child’s routine also changes with evidence suggesting that the stress of these environments elicit behavioural changes in children (Baptista et al., 2017).

Essentially, the results from this present study concurs with existing research. Indeed, the focus groups suggest that ‘home’ life is chaotic for children who are homeless, with parents reporting that children ‘act out’ and present with difficult behaviour which was not present before moving to homeless accommodation. It was also reported by parents that homeless children do not have the space in emergency accommodation to engage in exploratory and active play. Moreover, due to the nature of emergency accommodation and the lack of space and the need for ‘quiet time’, technology is utilised more by children which results in the reduction of adult child interactions.

Behaviour is complex and particularly for those impacted by adverse childhood experiences and toxic stress (Nicholson et al., 2019; Romero et al., 2018). At times when children (attending the Pod) presented with behaviour which was not ‘favourable’ or ‘appropriate’, this was understood by the key workers to be more like a reflex in response to the child’s repeated exposure to homelessness – which is undoubtedly an extremely stressful life event (Nicholson...
et al., 2019). The key workers never referred to the behaviour as ‘challenging’ or ‘bold’ while child centred techniques which embraced ‘connection’ were utilised to assist children. Children displaying any distressed behaviour were assisted by their key person to find a way to regulate their behaviour. On one occasion when a boy (aged 5) presented with an exaggerated and impulsive fight response during ‘drama’ which led to impulsivity and aggression, he was met with compassion and love. The Key person (worker) used appropriate sensory words to relate to the child’s stress response which not only assisted the child in regulating himself but assisted him to practice learning the terms associated with his internal sensations. The key worker spoke to the child using a warm caring tone while bending down to maintain eye contact. On this occasion, the key person responded to the child’s ‘fight’ response with ‘is your brain like a volcano? Let’s get you a glass of water’. While the Key workers may have done this unintentionally, this sensory literacy used can be seen to help children communicate how they are feeling and helps those who work with children to respond. (Nicholson et al., 2019)

This self-regulating strategy used by the key worker assisted the child calm his stress response system without adding shame, guilt, or rejection to his already hectic life experience. Children were clearly supported to recognise their emotions in all the rooms where the activities were offered. The predictability of the environment and freedom with limits offered the children a sense of control over the environment which is essential for children living impacted by trauma (Butler, 2020b; Jenson 2009, 1998). For younger children, the presence of their primary caregiver assisted them in exploring the environment while the child-centred activities (e.g. hand over hand painting) assisted in promoting the child-adult bond.

Existing research suggests that infants, toddlers, and children living in conditions of stress are more likely to have difficulty with both vertical and horizontal transitions (Butler, 2020; Nicholson et al., 2019), notably transitions were certainly supported by the key workers. For example, it was observed that a mother and key person (worker) sat with a child in a quiet area and shared a book. This regulating activity was seen to reduce the stress of both child and parent while also built trust between the key worker, parent, and child. Moreover, children’s transition from moving from the POD to the bus was also supported while this also afforded the key workers with an opportunity to remind the children that they will be missed until they return the following.
Fundamentally, taking this child-centred and trauma sensitive approach according to Butler (2020 and Butler et al., 2022 essentially means

1. It means understanding the prevalence and impact of trauma and ACEs.
2. It means understanding the role trauma plays in people lives.
3. And most importantly, it means understanding that any healing from trauma can only come from responsive relationships. (Butler, 2020a; Butler et al; 2022)

Essentially this research identifies that these key workers have a deep understanding of the physiological and neurological functioning of children impacted by trauma which leads to compassionate key workers with perceptive observation skills. However, they have identified novel ways to assist children downregulate their stress responses with common theme- they all involve connection and relationships. These key people in the POD are acting as buffers. They accept, welcome, and value children’s individuality, strengths, and creativity instead of labelling children and behaviour as challenging. Finally, and indeed,

..*most importantly, they [key workers] have an unwavering commitment to build consistent, caring and attended relationships with every child, every day so that they can communicate to each one that they are deeply loved, full of promise and possibility, and will be safe and protected in their care.* (Nicholson et al., 2019:226)

The layout of Youth Clun centred around four key room which were led by key people who facilitated the learning opportunities and activities (Fig 5.1)

![Figure 5.2 Key activities in room](image-url)
5.13 Emerging themes from the observation study

Key themes about youth club emerge and include:

1. **Relationships with children are essential**
   - Responsive
   - Respectful
   - Face to face interactions
   - Gestures
   - Physical contact
   - Intonation
   - Prosody
   - Child is seen, heard, and valued.
   - Dialogue is important

2. **Key traits of key people (workers)**
   - Compassionate
   - Loving
   - Kind
   - Caring
   - Empathy
   - Understanding
   - Non judgemental
   - Sense of humour
   - Flexible

3. **Responsive environment**
   - Playful
   - Predictable environment
   - Offers choice
   - Process led
• Homely
• Calm
• Solution focused
• Developmentally appropriate activities
• Freedom with limits
• Strong emotions are understood as defence mechanisms
• Child’s voice is heard, and child is seen and valued.
• New experiences offered

5.14 Overall concluding remark on observation study

This is an environment that is trauma sensitive and the key workers are trauma informed ensuring that the needs of the children attending are identified. This child-centred, child led, and playful approach is rooted in relationships that welcome and honour every child’s lived experience and story. This study seeks to address the gap by critiquing an Irish model of intervention specially designed for children impacted by homelessness in Ireland.
CHAPTER 6: CONCLUSION AND RECOMMENDATIONS

6.1 Introduction.
This study seeks to address the gap by critiquing an Irish model of intervention specially designed for children impacted by homelessness in Ireland. This section presents an overall conclusion to the study and identifies key recommendations. In addition, study limitations are addressed in this section. The conclusion and recommendations will be structured around the research questions set out at the beginning of the study.

6.2. Scale of child homelessness
The primary research has clearly illustrated the existence of the ‘new homelessness’ of whole family homelessness, as distinct from individual homelessness, has been clearly emphasised. This has reached the status of an emergency. Edel House in 2014 were able to deal with demand with support from Shannon way House. However, they were unable to meet demand in 2015 with 13 families on a waiting list reaching 80 families in 2020. Focus Ireland informs that there were 8,876 people homeless in the week of the 25th – 31st of May 2020 across Ireland. Alarmingly, this number of homeless families has increased by 115% since May 2015.

The dominant themes from service users detect the scale of homelessness on families and children. Parents speak of the weekly and daily surge of children and families into homelessness. Also, the length of time one must wait for some form of accommodation whether this would be in a B&B, hotel room, family hub, bedsit apartment or house. Equally the cost of all forms and types of emergency accommodation to the state is mentioned.

Evidence has emerged to suggest that family homelessness is due to housing market failure and low and precarious income as opposed to problems within the family (O’Sullivan, 2017). Despite the cause “Child homelessness has now become normalised in Ireland, but it should be a source of immense shame.” (McVerry, 2019). thousands of children and families are now presently staying and living in what are known as Family Hubs (shared accommodation), hotel rooms, Bed and Breakfests and hostels (Ombudsman 2017). As a result of this ‘lived experiences’ very often these children have become anxious, withdrawn, isolated, angry and confused with relationships both immediate and socially becoming severed and damaged leading to extremely traumatic and complex outcomes (Romero et al 2018, Sacks et al 2014).

A recent Government fiscal report (May 2019) indicated that by 2023 there will be 48,000 new house completions, yet the Childrens Rights Alliance (2019) reported that up to the third quarter of 2018, 45 million euro had already been put into family Hubs. In 2017 the Government began
to roll out family hubs only to be used in limited short-term circumstances (ibid) yet by the start of 2019 there were 26 hubs nationwide to accommodate 600 families a very clear change in Government policy. With delays in completion of permanent homes for people experiencing homelessness, with only 175 homes due for full completion in 2017 (Rebuilding Ireland progress report, 2017), the policy shifted towards family hubs and emergency accommodation mainly hotels and B&Bs.

The literature very much concurs with the themes emanating where the recent housing crisis has meant that homelessness has since cast a wider net and has reached previously unaffected groups Grotti et al., (2018). In the UK model, the time a vulnerable family can stay in emergency temporary accommodation most notably Hotels/B& Bs is six weeks, in Scotland it is 14 days (MLC 2019). The cost of Family Hubs and of emergency accommodation to the state is also highlighted by this focus group of service users and is reinforced by the literature where the recent Focus Ireland-TCD Spend on Homelessness Report (2020) states nearly 40,000 adults experienced homelessness in Ireland since 2014 while most of €1bn expenditure went on ‘passive’ emergency shelter. With the scale of family and child homelessness anchored very clearly in the literature and primary research the following recommendations are made.

Child homelessness has now become normalised in Ireland where thousands of children and families are now presently staying and living in what are known as Family Hubs (shared accommodation), hotel rooms, Bed and Breakfasts and hostels. This narrative or policy and an honest sincere debate on building houses deserves National attention as a matter of priority. With the scale of family and child homelessness anchored very clearly in the literature and primary research the following recommendations are made.

6.2.1 Recommendations on Scale of homelessness

1. The ‘passive’ spend on emergency accommodation by Government needs to be immediately addressed with more focus on long term sustainable secure accommodation and the employment/appointment of advocates/support workers to be provided to all families experiencing homelessness.

2. While there is no constitutional right to housing in Ireland an immediate endorsement of the UN Convention on the Rights of a Child, which Ireland has endorsed, is of utmost
importance giving children the right to an adequate standard of living, including the
delivery of quality housing for those children.

3. A need for the Government to put legislation in place that would recognise the best
interests of the child where decision makers when deciding where homeless families
should be placed, consider the best interest of the child. Equally a call for the right to
housing in the constitution with a move to a legal rights-based approach in the Housing
Act 1988. This will eliminate any discretion in the Act to that of a duty on the housing
authority to provide housing and emergency accommodation to homeless families and
children.

6.3 What social and psychological risks does homelessness present for children?
The central points of parents identify the social and psychological risks of homelessness to
children. The level of accommodation for these families is below standard. Parents and children
are sharing small rooms while the making and eating of meals, the completion of homework is
also conducted in these bed and breakfasts and hotel rooms. Each domain of children’s
development has been reported by parents to be affected because of homelessness. Moreover,
opportunities to play and socialise/interact with peers and siblings is also impacted and
restricted due to the nature of the accommodation provided. Burns (2019) asserts that the
impact of being homeless is essentially shrouded in stigma and shame. The landmark report,
No Place like Home by the Ombudsman for children (2019) agrees, and highlights that children
living in family hubs experience overwhelming feelings of ‘shame, guilt and anger’. Moreover,
the concerns of homeless children have been documented, clearly showing that a lack of
privacy, inadequate space, noise, not being able to have visitors/bring home friends, and a lack
of quiet space to complete homework were all real challenges. Homelessness has put these
children at risk of immediate physical, cognitive, social, and emotional challenges. Parents are
concerned about their children’s immediate and future holistic development particularly their
children’s behaviour and academic achievement. Fundamentally, these feelings of failure,
shame and embarrassment have implications for sense of worth and dignity (Cairns, 2001).
Essentially, educational outcomes are poorer as are physical and mental health outcomes
(Cairns, 2001; Herman, 1997).

These sentiments are also well fastened in the primary research of Staff. Homelessness is
impacting on families and children in almost every aspect of their lives. The deterioration in
the lives of families and children is caused by poor nutrition, overcrowding, cramped spaces, lack of sleep, loss of autonomy in such basic tasks as cooking and lack of sleep. This is clearly non-virtuous cycle. Children are being cast in parenting roles. The negative consequences impact on all aspects of the person: physically, psychologically, and emotionally. Many challenges exist for homeless children which can all be detrimental to their development, health, and well-being (Ombudsman 2019). These findings aren’t new as Swick (2009) explains that most homeless environments are controlled, and many regulations can affect family life even going as far as institutionalising families within this controlled facility (Social Justice 2019; Swick, 2009). In addition, a child’s routine also changes with evidence suggesting that the stress of these environments elicit behavioural changes in children (Baptista et al., 2017). Restrictions on cooking and limited storage tend to lead to poor diet, resulting inadequate nutrition for both children and parents. Take-away meals and cheap convenience foods are prevalent (Share & Hennessy, 2017) while the nature of communal living in family hubs is identified as a huge cause for concern in the ‘No Place Like Home’ Report (2019).

Based on the findings in the primary research and literature of the social and psychological impact of homelessness on children further recommendations are apparent.

People living in overcrowded or poor-quality accommodation are more likely to be in consistent poverty (Social Justice Ireland, 2019). Exposure to trauma is unfortunately common in children without a home (Ghosh Ippen, Harris, Van Horn, & Lieverman; 2011) and is certainly worthy of research, discussion and debate due to its significant prevalence, devastating impact and life-long consequences for our youngest citizens.

Burns (2019:14) succinctly acknowledges that the impact of homelessness is all-encompassing in a child’s life causing many Adverse Childhood Experiences (ACE’s) and trauma.

Restrictions on cooking and limited storage tend to lead to poor diet, resulting inadequate nutrition for both children and parents. Take-away meals and cheap convenience foods are prevalent (Share & Hennessy, 2017) while the nature of communal living in family hubs is identified as a huge cause for concern in the ‘No Place Like Home’ Report (2019). Poverty has significant implications for a child’s overall development, health, and wellbeing (Owen 2017). Moreover, the longer a child endures poverty, the greater the impact and legacy.
6.3.1 Recommendations in relation to the social and psychological risks homelessness present for children?
Interventions should include many qualified practitioners who understand children’s needs, development and challenges and are trauma informed are available to the children and families in homelessness with the aim of building positive, responsive, and respectful relationships with the children. The interventions should also be culturally sensitive.

1. Create trauma informed environments and space that support children’s emotional expressions and opportunities for outdoor play and exploration. These currently do not exist for most children experiencing homelessness.

2. Children experiencing the trauma of homelessness crave attention and affirmation and an outlet as outlined is essential during this period of trauma enabling these children to receive appropriate and developmentally appropriate attention and care.

3. Specific trauma informed training for all staff working in Family Homelessness NGOs Tusla Good Shepherd Services and Cork City Council employees who are the first point of contact for all Homeless Services users. This should include:

- Training of the widespread impact of homelessness and understand potential paths for recovery.
- recognise the signs and symptoms of trauma associated with being homeless
- fully integrate knowledge about trauma into policies, procedures, and practices.
- Strive to actively resist re-traumatisation.
- Training on self-care which is an ethical imperative
6.4. Are there psychological benefits of the new integrated service model in child homeless services?
This report poses several questions in relation to psychological benefits for children experiencing homelessness arising from the introduction of an integrated community care project across the city of Cork.

The primary research demonstrates that any intervention for children experiencing homelessness must be relationship based and involve the ‘key person approach’. Essentially, the model is demonstrating this approach and identifies that responsive and caring relationships and interactions with children are centre stage. This is a trauma sensitive approach. This child centred engagement offers an asset driven approach aimed at the holistic development the children attending the service.

Overall, the success of the model according to service users is determined by the quality of the interactions with children. The children are empowered by knowing that they can attend a service where they have a chance to succeed in a safe space where freedom with limits exist. It is the interactions with the children that make the model the success it is. The children are benefiting psychosocially according to their parents and the only suggestion is that many wishes for the model to be expanded to other age groups and to other fragile families and marginalized groups. There was a request by focus group members for these services to be extended for children aged over 12 and particularly for girls. Parents strongly highlight that integrated homeless services are good for all experiencing homeless and not only children. Participants report that children need, want, and enjoy support from integrated services. Parents feel that key workers are most approachable and responsive to children where available. Key (POD) workers weren’t as available to residents of B&Bs. Participants appreciate and understand the importance of children participating in meaningful activities such as those provided at youth club. The integrated model is enmeshed in bidirectional relationships while support for families by key (POD) workers is one of the key strengths available to service users. Pod key workers were valued and respected, while access to more key workers, particularly in the B&B provision was considered as a key necessity. Collaboration between workers and service users was also merited. The sharing of information and collaborative approach assists service users as teams share responsibility, provide support and exchange expertise. The Pod welcomes parents as part of the team and develop ongoing relationships with the key workers. However, this does not stop the waiting lists for additional supports including OT, SLT and other assessments. The Pod gives voice and visibility to the child and enables them to open again highlighting the importance of relationships between children and professionals. For
some users, other formal supports (with HSE and City Council) was regarded with a level of
do distrust.

Staff and experts in the primary research indicated the convincing evidence of the positive
impact that the integrated homeless services model has on the lives of families and children.
Children are placed at the centre in decisions around their needs and activities. The emphasis
is on having a positive psychological impact on children, through fun, recreational and other
activities. The focus of the youth club is to replace the painful memories of homelessness with
happy memories, to unlearn some of the negative memory. The work involves defusing the
pressure on children, which arises from homelessness. The model also includes practical
interventions to support parents such as providing counselling, cooking skills, budgeting skills
and other supports. Senior management specified in the primary research the side by side care
planning and co-ordination daily in the teams such as individual therapeutic work, Youth club,
Homework club, breakfast club, Equine therapy summer programmes and boxing, all working
across Edel House and Redclyffe(Family Hub), in collaboration with the various service
agencies across the city, such as Springboard, Foroige and Cork City Council. This
coordination happens both at formal meetings but also informally between inter-professional
teams, crystallized in the working of the ‘pod’ which represents the central focus of
interprofessional care co-ordination and integrated care. There was as strong belief that, in the
context of the continuous crises experienced by many families, that incisive, early interventions
to prevent the deterioration of the social, economic, and psychological plight of families is
critically important. Responding to crises, even when the whole series of problems cannot be
resolved all at once, in a way that ‘holds’ the family together, a form of ‘triage’ until other more
developed interventions are available is of the utmost importance and rapid response is the key
to this. Both formal and informal communication mechanisms among integrated care
professionals working as part of or connected to the pod, is critically important.

The services have been inspired by interventions after the Second World War in the UK, to
deal with trauma in families. There services provided, attempted to work from a holistic ‘needs
based’ response in helping homeless families. The dynamics of the organisation, based on the
idea of a pod of whales, was to provide a fluid, integrated and responsive series of interventions
which can change and move rapidly.

Bronfenbrenner and Morris (2006) asserts that to study child’s development we must not only
look at the child and her immediate environment but also the interaction of the larger
environment as well. Essentially, the child grows up in a set of systems.
Jennings (2019) suggests that children experiencing trauma crave attention and affirmation and this Youth Club experience enables these children to receive appropriate and developmentally appropriate attention and care. In addition, much research highlights the importance of engagement and interaction with traumatised children and asserts that this time of interaction is essential to the holistic development of traumatised children. (Romero 2018; Pierson 2013; Jenson, 2009). Notably, many qualified practitioners from the POD, who understand children’s needs, development and challenges are available to the children with the aim of building positive, responsive, and respectful relationships with the children.

The literature highlights the importance of relationship building and integrative care as stated by service users where the key person approach as stated previously, developed by Goldschmied, & Jackson (1994) is a method of care associated with Early Childhood Care and Education (ECEC). Equally, fostering responsive relationships with adults and children is also of significance in improving outcomes during one’s journey through homelessness (Bellis et al, 2014). Concurring with this research, the Harvard Centre (2019), further argues that responsive relationships assist in shielding toxic stress during difficult experiences.

The team around the child/key person approach is another significant aspect to this report in tackling family and child homelessness. Evidently, what is clear is that homelessness impacts the whole child and as a result any intervention to minimise and buffer the impact must take cognisance of the whole child and his or her holistic development and wellbeing. Key people have significant roles to support this healing. An integrated model that helps to establish a team around the child (Siraj-Blatchford et al., 2007) reflects the spirit of shared responsibility and communal effort. The wraparound team should be composed of people who have a strong commitment to the family’s well-being (Bruns & Walker, 2008:4).

This child-centred, child-led, and playful approach is rooted in relationships that welcome and honour every child’s lived experience and story. (Blackman, 2002; Tusla2013) has shown how family support and coordinated community involvement are the key to success with intervention. Adopting a bio-ecological systems model of integrated working and operates pm Bronfenbrenner’s (1979) principle of multi-person systems of interaction. Essential to this is that consistent meaningful positive relationships are achieved with vulnerable children and families who are experiencing homelessness where trust and reciprocity of same between family and workers intervening is equally important and can support the reduction of trauma
(Tobin and Murphy 2013). With the psychological benefits clearly attached to the primary research and literature further recommendations are made.

6.4.1 Recommendations in relation the psychological benefits of the new integrated service model in child homeless services?

1. The team around the child/key person approach is another significant aspect to this report in tackling family and child homelessness. Evidently, what is clear is that homelessness impacts the whole child and as a result any intervention to minimise and buffer the impact must take cognisance of the whole child and his or her holistic development and wellbeing.

2. The importance that each child is assigned a particular advocate/worker who will act as their ‘go to person’. This person supports the child and their family and continue to be the key person for key moments of emotional intimacy, building up a secure attachment with the child. While this may happen to some degree in some family hubs there is a significant need for this type worker in emergency accommodation (B&Bs/Hotels) where most family homelessness exists.

3. Essential is that consistent meaningful positive relationships are achieved with vulnerable children and families who are experiencing homelessness where trust and reciprocity of same between family and workers intervening is equally important and can support the reduction of trauma. This should include workers from all agencies and NGOs such as teachers and City Council workers who encounter homeless families where an understanding of trauma and its impact is a prerequisite.

6.5. The key elements of the integrated homeless service model and merits/ challenges associated with this model?

The primary research emanating from staff and management suggest that the integrated homeless services model has both merits and challenges. There are clear and identifiable elements to the integrated services model under investigation, which make it new and innovative: families are empowered by professionals working in a collaborative way with them; Professionals collaborate among themselves through peer support and peer learning; There is a horizontal integration evident among peers from different professional backgrounds working together inter-professionally, in examining cases and generating solutions; this has become a creative endeavour; this creativity is epitomised with innovative solutions of providing specialised services which are normalised but are essentially targeted towards families and children with the greatest level of challenges. What is also demonstrated in the primary research
of management is that there is a clear organisational structure for the delivery of services which involves significant collaboration between a variety of professionals, agencies, and service users, working together. The ‘Pod’ as described in the research, refers to an expert interprofessional group of workers who aim to provide integrated care delivery to homeless children from homeless families. The focus on sharing and pooling information and using peer support to enhance assessments and care delivery is impressive. This also adds value to each individual professional’s skills-set and increases skills value for the team, with the homeless child being the ultimate beneficiary. As is evident from the focus group, the needs of the child are the central driver in terms of how professionals who work on the POD respond.

Implicitly, the needs of the child are also mediated by the child’s family, in addition to the child herself. The focus here is clearly ‘needs’ driven, the expressed needs of the child, living in exceptionally difficult homeless circumstances and giving the child the opportunity to express their feelings on what activities and interventions they feel they need. The agencies have responded by providing a multiplicity of outlets to cater for the child’s needs, which we can see, include: boxing, homework clubs, the youth club (including a multiplicity of various other activities in it, as we will be presented in the observation study), a specific-tailored therapeutic (understood in the broad sense as any helping) intervention for the child, or any other activity which the child or a group of children feel they need, as mediated by themselves or a family member.

All families residing in the Redclyffe family hub or at Edel House are assigned a key worker. The key worker can channel information if necessary, into the interprofessional POD at the centre of the organisational structure. The needs of children are brought back for discussion to the POD at regular meetings and daily communication between members, daily or weekly. Also, of central significance is the ‘wraparound’ services for the child and family of the child, whether this is food (Penney Dinners or other), a youth club series of activities, educational resources (ETB/Forage), a Meitheal intervention or a homework club. There is a clear interagency collaboration in evidence. The primary research is clearly demonstrated in the literature. An interesting challenge that Goodwin (2016) alludes to is that while having the necessary tools for a successful integrated care approach one of the key unmet challenges is how to move beyond these descriptive components in offering integrative care. Here, Goodwin refers to the ‘softer tissues’ of relationship building where nurturing a culture where new ways of working become the norm (Goodwin 2016).
The wraparound team should be composed of people who have a strong commitment to the family’s well-being (Bruns & Walker, 2008:4). Building on this, an integrated model that helps to establish a team around the child (Siraj-Blatchford et al., 2007) reflects the spirit of shared responsibility and communal effort. This is very clear as Blackman (2002) has shown how family support and coordinated community involvement are the key to success with intervention. These findings are not new as adopting a bio-ecological systems model of integrated working and operates on Bronfenbrenner’s (1979) principle of multi-person systems of interaction. ‘Wraparound’ is a process which aims to meet multiple needs and promote engagement through dialogue, collaboration, multidisciplinary practice, and service delivery in communities (Miles, & Brown, 2011; Walker, 2008). Essentially, with support from a team of professionals, the family’s needs and preferences all drive the work of the ‘wraparound’ Research (Slaintecare 2017, HSE 2021) suggest that when interventions are centred on integration and partnership with service users and where the focus is on practical solutions and relationship building, common goals can be achieved. Similarly, in relation to family and child homelessness the approach from services needs to be integrated and preventative to be effective, thus focusing on the most vulnerable families where using a community model of partnership where ‘the engagement between these informal networks and the more formal state provided services that real partnership is developed and sustained and through which people come together in a way that supports and enables communities to meet local needs’ (Community Healthcare Organizations Report 2014 p32).

The child-focused and child-led nature of the model is re-emphasised further. The use of volunteers is particularly innovative: volunteers who offer a helping and supportive role, but who can detect situations where a child is regressing, before it escalates further, would seem to be a very positive development in a community care context. Furthermore, the establishment of the Community Health Care Organisations report in 2013 was very much steeped and enriched in the importance of developing a model of integrated care that is responsive to the needs of local communities (HSE 2013). The report places a robust emphasis on the importance of collaboration and integrative care within communities in striving to improve health and social wellbeing. Goodwin further influences our above model with his argument that integrated care should promote health by bringing together health and social care with other players such as schools, community groups, families, industry and so on (Goodwin 2016).
Pike and Mongan (2014) acknowledges that integration takes time to become successful and sustainable and may cost before it pays. This to be a key point in implementing or mirroring models such as CHO’s and Slaintecare for it to be a success in areas like Family Homelessness.

Tusla (2017) further emphasises a commitment to building honest compassionate working relationships with children, families, and related service users. Contemporary thinking by recent policy makers in Ireland very much has a focus on a universal healthcare system where access to social and health care services is based on need ensuring timely access to quality, effective, integrated services (Slaintecare 2017). The all-party consensus on this was further reinforced by the position of the committee’s vision that ‘requires a system that is integrated in terms of all stages of an individual’s life, from cradle to the grave’ (ibid p).

Integrated care is essentially the integration of all elements of health, social care and health promotion in to relatively seamless and interlinked holistic care services for all the various population health and social care groups at the closest possible level to the service user (Goodwin & Smith 2011, Darker 2014). With the service-user at the centre, there are clear and co-ordinated pathways to all the various integrated care services: based on the clearly established health and social care needs of a service user, throughout her journey, the full array of integrated health and social care services are organised in a timely fashion, with a strong focus on community care, and where the various professional health and social care teams possess awareness of the total and inter-linked array health and social care interventions, aimed at delivering the full package of care needs for the service user in a holistic way (HRB 2014; Slaintecare 2017).

In this context, there is a clear emphasis on the strong desirability for all necessary health and social care professionals/teams around the child in homelessness, to work in a collaborative and inter-professional way, based on shared care planning and co-ordination of activities, which make visible, clearly identified pathways between services at various levels of care (vertical integration) and between services, most often at the level of community care, across services at the same level (horizontal integration). With key elements of the integrated homeless services model grounded in the primary research and literature the ensuing recommendations are made.

An essential recommendation underlying this report is the importance of developing an integrated model of care which is responsive to the challenges and needs of local communities i.e. the ease through which a person can go through the different healthcare services to meet
their needs. This very much resonates with the journey and plight of families within homelessness.

6.5.1 Recommendation in relation to be key elements of the integrated homeless service model and merits/ challenges associated with this model?

1. There is a need for a clear emphasis on the strong desirability for all necessary health and social care professionals to work in a collaborative and inter-professional way, based on shared care planning and co-ordination of activities, which make visible, clearly identified pathways between services at various levels of care (vertical integration) and between services, most often at the level of community care, across services at the same level (horizontal integration).

2. As in the model described that integrated care should promote health by bringing together health and social care with other players such as schools, community groups, families, industry and so on

3. That the full array of integrated health and social care services are organised in a timely fashion, with a strong focus on community care, and where the various professional health and social care teams possess awareness of the total and inter-linked array health and social care.

4. In family and child homelessness the approach from services needs to be integrated and preventative to be effective, thus focusing on the most vulnerable families where using a community model of real partnership, the relationship between informal groups and state provided services is created and sustained enabling people to come together empowering communities to support local needs.

6.6. What are the public policy implications of the above?
There are strong suggestions that this model, which predominantly operates in the city, would have significant transferability into rural areas of unmet need. Moreover, management suggest in the primary research most families whose children have experienced a significant period of homelessness will still need the supports of one-to one service which their children currently receive for a period, even after becoming housed. Families whose children have experienced a significant period of homelessness will still need the supports of the specialised youth club which their children currently receive for a period, even after becoming housed. The current
integrated homeless service model can certainly be used to help other families and children in society experiencing similar difficulties.

The services provided by the Pod are identified essential for children during this transition and period of adjustment. Moreover, the current users of this model identify that this support could and should be extended to other vulnerable groups like children in direct provision and traveller children. It was suggested that these children would benefit from this inter-agency collaborative holistic programme of supports. Ensure Families with children experiencing homelessness should be granted access to adequate supports to ensure that there is a seamless transition to this new way of living.

To summarise, the over-riding consensus among members of the focus group was:

- Most families whose children have experienced a significant period of homelessness will still need the supports of **one-to one service** which their children currently receive for a period, even after becoming housed?

- Most families whose children have experienced a significant period of homelessness will still need the supports of the **specialised youth club** which their children currently receive for a period, even after becoming housed?

- The current integrated homeless service model can certainly be used to help other families and children in society experiencing similar difficulties.

- There is likely to be a strong transferability of the current integrated service homeless model to other care programmes attempting enhanced integrated care within the Primary Care Network.
Fundamentally, the trauma of being homeless does not stop when a house is provided with families reporting that children require the supports well after a house is secured. The shame and impact on self-esteem continues with parents reporting changes in children relationships with their peers even post homelessness.

Staff suggest in the primary research that very clear efforts to work from a relationship-focused model exist. This is consistent with the empowerment of children and families already identified and putting the child at the centre in needs assessment and service delivery. All of this is steeped in the literature. Integral to the model is the Signs & Safety National Assessment Framework approach adopted by Tusla (2017) which emphasises a commitment to building honest compassionate working relationships with children, families, and related service users. The Meitheal policy document (2013) links in here where it strives to put the ‘child’ at the centre coordinating and integrating the correct services around the child in the home. Slaintecare (2019) and the Healy report (2014) agrees where it advocates for home led integrative care and support in the community.

Recent commentary by the Irish Human Rights and Equality Commission on its examination of accommodation and homelessness in Ireland said that its belief that rise in Family and Child Homelessness has been “significantly exacerbated by Government policy choices” (IHREC 2019, P16).

In 2016, the UN Committee on the Rights of the Child examined Ireland. It expressed concern "at reports of families affected by homelessness facing significant delays in accessing social housing and frequently living in inappropriate, temporary or emergency accommodation on a long-term basis". While there is no constitutional right to housing in Ireland the UN Convention on the Rights of a Child, which Ireland has endorsed, gives children the right to an adequate standard of living, including the delivery of quality housing for those children (Brady 2019). While the convention may not apply directly in Irish law courts can use discretion in how much weight they apply to international law (ibid). The United Nations Committee on Economic, Social and Cultural Rights has stated that the right to a house is ‘integrally linked to other human rights’ (United Nations 1991). The No Child 2020 campaign (Irish Times 2019; Childrens Rights Alliance 2019) called on the Government to put legislation in place that would recognise the best interests of the child where decision makers when deciding where homeless families should be placed, consider the best interest of the child. Section 10 of the Housing Act 1988 gives an extensive level of discretion to housing authorities nationally on the type of
support and accommodation they can offer people but with no duty and no reference to families or children. (Muldoon 2019) argues that existing legislation needs to be changed to make it more inclusive of children and families and for housing authorities to consider families with children when allocating houses. Muldoon further claims that the right to housing in the constitution needs to be advanced with the Oireachtas examining the recommendations in a 2014 report on the eight Constitutional Convention on economic, social, and cultural rights. To reinforce Muldoon’s argument, the Mercy Law Centre (2019) calls for the right to housing in the constitution with a shift to a legal rights-based approach in the Housing Act 1988. This will eliminate any discretion in the Act to that of a duty on the housing authority to provide housing and emergency accommodation to homeless families and children.

Family hubs are a specific outcome of government policy (Focus Ireland 2019). They go on to say that majority of homeless families in homelessness crisis are in emergency accommodation where they receive a much lower level of accommodation and support residing mainly in hotel/B&Bs. Rather than the focus being on emergency accommodation there needs to be a collaborative concentration on long term solutions, that of an adequate supply of homes (ibid).

To conclude, several key concerns and issues have emanated (Dail Committee 2019) that should influence and guide public policy going forward in family and Child Homelessness mainly the following recommendations:

- Legislation to take account of the child’s best interests
- A Constitutional Right to Housing
- Legislation to place limits a time a family can stay in emergency accommodation
- The absence of an independent body to conduct regular inspections of homeless services
- Variations in standards of Family Hubs and Emergency Accommodation
- The ongoing practice of utilising one-night only emergency accommodation
- The need for support workers across all sectors of emergency accommodation.

‘The gap between policy intent and implementation can be closed by harnessing closer links between policymakers, researchers and practitioners involved in integrated care development’. (Lloyd and Wait 2005, p18). The subsequent recommendations have emerged from the primary research and literature on public policy implications for family and child homelessness.
6.6.1 Recommendations in relation to public policy implications for family and child homelessness

1. The all-party consensus on the vision of Slaintecare needs to be further reinforced by our Government which necessitates an integrated system for all stages of a person’s life.

2. That Government policy in addressing Family Homelessness has shifted towards family hubs and emergency accommodation mainly hotels and B&Bs requires an urgent review. The nature of communal living in family hubs is identified as a huge cause for concern in the ‘No Place Like Home’ report referenced earlier.

3. Child homelessness has now become somewhat normalised in Ireland where thousands of children and families are now presently staying and living in what are known as Family Hubs (shared accommodation), hotel rooms, Bed and Breakfasts and hostels. This narrative or policy deserves National attention as a matter of priority.

4. An independent, formal evaluation of the suitability of family hubs is needed where timelines of stay also need to be considered. Furthermore, inspection of these hubs through a national implementation quality standards framework for homeless services needs to be addressed. Equally the variation type and design of Hub.

5. Recent commentary by the Irish Human Rights and Equality Commission on its examination of accommodation and homelessness in Ireland said that its belief that rise in Family and Child Homelessness has been “significantly exacerbated by Government policy choices” (IHREC 2019, P16). This needs to be urgently explored and addressed by key stakeholders and with the Office of An-Taoiseach.
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Appendices
Appendix 1

Focus Group questions

Focus Group questions for service users/management/staff

Focus Group Semi-Structured Interview Schedule

(Springboard Research)

Participants

1. (a) Number _____
   (b) Breakdown M/F _________            ___________

Scale of Child Homelessness

2. Approximately, how many children do you think are in contact with the homeless services in Cork city?
   In hundreds?

3. Do you think the number of homeless children is rising or falling in the past three years, in your experience?

4. Would you like to comment on what you think are the main reasons for the increase in child homelessness?

Social & Psychological Risks of Homelessness to Children

5. I’d like to ask you to think about and comment on the effect of homelessness on your child’s/children’s lives in the following daily living areas:
   a. Sleeping Arrangements for Children and Parents
b. Quality of Accommodation for Children and Parents

c. Choice and Quality of Available Food for Children and Parents

d. Opportunities for Recreation and Play for Children

e. Getting Your Child to School

f. Your Child’s Performance at School

g. Heating for Children and Parents

h. Your Child’s Physical and Mental Health

i. Your Physical and Mental Health

j. Your Opportunity for Employment and/or Education & Training

k. Your Opportunity to Relax

l. Other

6. The National Institute of Mental Health (USA) defines childhood trauma as: “The experience of an event by a child that is emotionally painful or distressful, which often results in lasting mental and physical effects.”

Is homelessness putting your child at increased risk of trauma?

How?

7. For those living in homeless accommodation, help is offered by a variety of health and social care workers who attempt to help the situation.

Yes  No

If Yes, how does this work in practice?

What elements of this help are you happy with?

How does the interaction of a parent with health and social care professionals effect the role of the parent?

Integrated Homeless Service Model and Child Mental Health

8. There are approx. 10,500 people officially homeless in Ireland, living in emergency accommodation, including 4,000 children. This is totally unacceptable.

The provision of a decent home for homeless families should come first and be the ultimate solution.

The failure of the state in making this happen has meant that that the health and social care workers who work with homeless parents and their children are trying are trying
to help families in this very difficult situation, in trying to reduce the serious social and health impact that homelessness has on the children.

To do this, they have provided a range of services that they have tried to organise and link-up for homeless families and children. These include **accommodation, food provision, one-to-one daily supports between various health and social care workers and your child, specialised youth club services and aftercare.**

Could you comment on how this works in your experience?

(a) Do you fell that Children benefit from the one-to-one supports? Socially? Emotionally?
(b) Do you feel that the one-to-one supports improve a child’s mental health?
(c) Do you feel children benefit from the specialised youth club? Socially? Emotionally? In their Physical Health
(d) Do you feel that the specialised youth club improves a child’s mental health?

9. Referring to the fact that the National Institute of Mental Health (USA) defines childhood trauma as: “The experience of an event by a child that is emotionally painful or distressful, which often results in lasting mental and physical effects.” If you accept that homelessness is traumatic for your child/children, do you think that the various services being provided by health and social care workers in the homeless services, as described in the previous question (A to E) above, help to reduce the distress that homelessness can have on your child?

**Integrated Homeless Services Model Merits & Challenges**

10. (a) The various health and social care workers have developed an approach to working, sharing information and decision making together in inter-professional teams in what is termed a ‘Meitheal’ approach to respond to the needs of homeless families and children, in a more rapid and effective way.

Does this approach work in this way as planned?

What are the its strengths?

What are its weaknesses?

(b) This approach also tries to ensure that all the workers on what is known as ‘the pod’ are connected and aware of the needs of the homeless families and children
Does this approach work in this way as planned?

What are its strengths?

What are its weaknesses?

(C) In improving this connectivity and awareness, the hope is that family members are confident that all the various health and social care workers are aware of all the family’s needs and made feel the services is co-ordinated, organised, and responsive to their needs.

Is this hope borne out in reality?

What are its strengths?

What are its weaknesses?

(e) Where children need to be referred to other health and social care services (e.g. CAAMHS, Dietician, Hospital) that they need, the referral is made quickly from somebody within this service?

Yes       No

Comment

(f) The health and social care workers on this large team, known as the ‘pod’, all work together on the same level?

Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree

(g) Working like this means they can decision based on shared information? Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree

(h) This reduces the need to refer a decision on the needs of a child upwards to a person in a more senior position.

Strongly Agree    Agree    Undecided    Disagree    Strongly Disagree
(i) The net effect is to make the service more user-friendly.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

(j) This speeds up the delivery of services?

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

(k) Anything that needs to be referred upwards can still be done effectively.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

Policy Implications

11. Most families whose children have experienced a significant period of homelessness will still need the supports **one-to one services** which their children currently receive for a period, even after becoming housed?

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

Why?

12. Most families whose children have experienced a significant period of homelessness will still need the supports of the **specialised youth club** which their children currently receive for a period, even after becoming housed?

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

Why?

13. Can this homeless service model be used to help other families and children in society experiencing similar difficulties?

Yes  No
Could you name an example?

Comment

14. Overall, do you think this Pod homeless service model be expanded across Ireland?

Yes  No

Why?

What changes do you think could improve it?

Focus Group questions for managers
As in appendix 1

Focus Group questions for staff.

As in appendix 1
Appendix 2

Information Letter/Invitation to Participants

Dear

RE: ‘

My name is Traolach O’ Callaghan. I am currently undertaking a Research Masters at MTU Cork. The purpose of this study is to evaluate the Benefits for Children Experiencing Homelessness-Arising from the Introduction of an Integrated Community Care Project across the City of Cork

I am inviting you to participate in this study as I believe you have the appropriate knowledge and experience to be of benefit to the study. There are no known risks from being in this study and you will not benefit personally, however as a result of this study, recommendations will be made in the hope of improving the lives of children attending our services. Taking part in this study is completely voluntary and you can choose to opt out at any time. The information you provide will be kept completely confidential and your participation is totally anonymous.

I am writing to invite you to participate in this research. The focus group will take 45 mins and can be arranged at a time and place that suits you.

I have attached an information sheet on the study and if you would like to find out more, please contact me on mobile XXXXXXXX and by email at XXXXXXXXXX

Many thanks,

Yours faithfully,

______________

T O’Callaghan

Masters Student
Appendix 3
Informed Consent:

Date:

Title of study:
AN EVALUATION OF THE PSYCHOSOCIAL BENEFITS FOR CHILDREN EXPERIENCING HOMELESSNESS-ARISING FROM THE INTRODUCTION OF AN INTEGRATED COMMUNITY CARE PROJECT ACROSS THE CITY OF CORK

This study evaluates the benefits of the introduction of an integrated community care project for children experiencing homelessness. We are inviting you to partake in this study. There are no known risks from bring in this study and you will not benefit personally, however, we hope that others may benefit from what we learn because of this study. Taking part in this study is completely voluntary and you can choose to opt out at any time. The information you provide will be kept completely confidential and your participation is totally anonymous.

If you have any questions about the research study, please contact:

T’ O Callaghan

Dept of Applied Social Studies Email:

Mob: