Evaluation of Focus Ireland's Therapeutic Service

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Table of Contents

List of Tables

List of Figures

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About the author

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Executive Summary

Context to the Therapeutic Service

The motivation for the introduction of a Therapeutic Service in Focus Ireland was driven by two factors. Firstly, the changed policy context outlined in the *Pathway to Home* model (2010) meant that Focus Ireland had a reduced period of six months to engage with individuals and families experiencing homelessness. Secondly, Focus Ireland recognised that there was an increased complexity of needs among individuals presenting to their services. People with these high needs were becoming more prevalent to services, and were at risk of becoming entrenched or experiencing episodic periods of homelessness.

Prior to the changed policy context, Focus Ireland had already introduced a number of measures to address the increasingly complex needs of people experiencing homelessness. In order to support these initiatives and further improve customer outcomes, Focus Ireland introduced a Therapeutic Service consisting of a Counselling Psychologist, Behavioural Specialist and Play Therapist for an initial pilot period of 12 months.

The aim of the service is to provide psychotherapeutic intervention, clinical assessment, behaviour modification, and psycho-education to Focus Ireland customers. The introduction of the service also aimed to establish a Psychologically Informed Environment (PIE) with a view to providing sensitivity and clarity of the therapeutic and emotional issues to address the complex needs of customers, and to adapt the services and staff methods of engagement through policy development, training, staff support and development.

Purpose of the evaluation

Focus Ireland is committed to regular reviews and evaluations of its work and services in order to objectively assess the quality, effectiveness and outcomes of its services, and to provide transparency for funders and other key stakeholders. To adhere to this commitment, Focus Ireland commissioned an evaluation of the Therapeutic Service to be completed by a fully independent researcher. It was anticipated that the findings of the evaluation would be used to agree and negotiate therapeutic services in the long-term with statutory and/or other stakeholders.

Methodology

The evaluation took a mixed-methods approach whereby both quantitative and qualitative methodologies were used. Preliminary briefing and planning meetings were held between

the evaluator and Focus Ireland stakeholders. From these discussions a comprehensive outcomes-measurement framework was developed. This provided a structured means by which to define the indicators necessary to measure the outcomes of the intervention.

Two sources of administrative data were analysed in this evaluation. Focus Ireland's Management Information Processing system (MIPs) and PASS (Pathway Accommodation and Support System), which is a national centralised case management system used in the homeless sector and by Focus Ireland.

Qualitative information was collected from focus groups and semi-structured interviews, which included the Therapeutic Service team; the Services Manager; Director of Services, and referral project staff. Semi-structured interviews were also conducted with Focus Ireland customers who engaged with the Therapeutic Service, and stakeholders external to Focus Ireland who had some level of involvement with the service.

In agreement with Focus Ireland and the Therapeutic Team, information on all customer referrals received by the team from the start of the project until the 31st December 2012 were included in the evaluation. The evaluation was limited to three services: Aylward Green, the National Family Case Management service and Cheid Cheim. Focus Ireland ethical guidelines for conducting research (Focus Ireland, 2011) were adhered to throughout the evaluation process.

Results

Administrative information recorded in MIPs showed that, on average, the Counselling Psychologist engaged with 16 customers per month, while both the Play Therapist and Behavioural Specialist had an average of 17 cases per month.

The Therapeutic Service Team engaged with 74 Focus Ireland customers during the evaluation period. These consisted of 49 adults and 25 children.

The needs of individual customers referred to the Counselling Psychologist varied greatly. The main reasons for referrals given were low mood, bereavement, suicidal ideation and difficulty coping.

Among the children referred to the Play Therapist, behavioural and emotional problems were the two main reasons identified.

Customers were referred to the Behavioural Specialist where there was a specific need identified for behaviour modification. Improved self-motivation and a lack of follow through with tasks were common referral reasons.

Therapeutic Interventions

The Counselling Psychologist was tasked with providing both one-to-one and family group psycho-therapeutic interventions, assessments and education to families and young people. The Counselling Psychologist was also responsible for enabling the development of a Psychologically Informed Environment (PIE), which involves staff development that ensures contact between staff and customers is therapeutic with interactions intended to foster growth and change. The Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM) measurement tool was used to assess the therapeutic intervention outcomes.

Results from the analysis of the clinical CORE outcomes-measurement tool show a clear improvement in customers' well-being and functioning, with a number of customers moving outside the clinical range of distress as measured by CORE.

The task of the Play Therapist was to provide individual play therapy to children aged 3 to 13 years and consultancy to staff working in Aylward Green, the National Family Case Management service, and the Prevention and Specific Speech and Language Impairment services.

To clinically assess children's psychological adjustment across a number of behavioural and psychosocial domains, the Play Therapist used the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997). This is a valid and reliable brief (25-item) screening tool designed to assess emotional health and problem behaviours among children and adolescents. SDQ questionnaires were completed by the children's parents; referring staff member; and where appropriate children themselves; before, during, and upon completion of play therapy.

The majority of children were found to have reduced emotional and behavioural difficulties and an improved emotional state. The high attendance rate of the children also demonstrated their positive experience of play therapy.

The Behavioural Specialist was employed to cater to customers of Focus Ireland's Youth and Aftercare Services. The specific task of the therapist was to help enable positive changes in the behaviour of adolescents and young adults aged 16-25 years by providing a behaviour support plan to young people displaying at risk and/or challenging behaviour.

The behaviours for which the Behavioural Specialist intervened predominantly involved alcohol and substance abuse, aggressive behaviour towards persons or property, and a lack of motivation.

The nature of the work conducted by the Behavioural Specialist was consultative in nature. Therefore, the interventions were not as observably structured or quantifiable as those of the other members of the Therapeutic Team. Measurement of the impact of the Behavioural Specialist was also hampered by the absence of a standardised clinical assessment tool.

The Psychologically Informed Environment

Having identified the need for a new, innovative approach to providing services to people experiencing homelessness, Focus Ireland sought a framework that would complement the existing social care skills within the organisation. The Psychologically Informed Environment (PIE) was identified as a suitable framework for this purpose. The PIE framework facilitates staff development that ensures that contact between staff and customers is therapeutic. Interactions between staff and customers are intended to foster growth and change thereby maximising positive customer impacts and also supporting an effective and safe work environment.

To evaluate the impact of PIE, the Counselling Psychologist designed and administered a survey questionnaire among staff before the introduction of the framework, and again 12 months later. The questionnaire consisted of a total of 35 questions which captured information on ten separate domains. As well as responding to single item Likert scale questions, staff were also provided the opportunity to provide qualitative comment on each item.

During the 12 month period, there was an increase in the scores on each of the ten domains demonstrating the positive impact that PIE had among staff. From the qualitative responses provided, reflective practice was identified as central to this change. Also, there was a clear shift in the language used by respondents to one where discussions of the service and interactions with customers were couched in psychological and therapeutic terms.

Consultations

Consultations with project staff showed that they were aware of the need to complement the work already being carried out with new innovative approaches. Therefore, they were excited by the prospect of having an in-house Therapeutic Service available to them. However, despite Focus Ireland management communicating details of the proposed service

to staff, they were initially somewhat unclear as to the role of the Therapeutic Team within the organisation.

Both Focus Ireland project staff and customers complemented the Therapeutic Team for the ease in which referrals could be made to the service. Customers also applauded the assistance they received from project workers in arranging referrals.

Trust and consistency of the relationship between customers and the Therapeutic Team were highlighted as very important by a number of customers and other stakeholders external to Focus Ireland.

The benefit of the holistic whole-family approach of the Therapeutic Team, which in many instances saw both children and parent's engage in therapy, was also emphasised as leading to better outcomes for customers than had been the case previously.

Among adults that engaged with the Therapeutic Service Team, many commented that they felt they were being empowered with the mechanisms necessary to cope with everyday life and the multitude of problems they encountered in experiencing homelessness.

In terms of children's engagement with play therapy, the parents of children, Focus Ireland staff, and external stakeholders all reported that they observed significant improvement in the children, particularly their self-esteem and confidence.

The importance of case managers and project workers in enabling customers to engage with the Therapeutic Service Team was highlighted.

There were difficulties apparent with the role of the Behavioural Specialist. Much of this was due to a perceived poor match between the behavioural approach and the service setting, particularly in Cheid Cheim.

Conclusions

While the evaluation period does not allow for a full assessment of whether the Therapeutic Service was successful in reducing the duration of and episodic return to homelessness aspired to in the *Pathway to Home* model, there is little doubt that it has met Focus Ireland's objective to *'support its customers and their children to reach stability'* in their lives. This belief is well supported by both objective information from clinical assessment tools, and also the subjective opinions of stakeholders, including importantly, Focus Ireland customers themselves.

There was also clear evidence of the successful implementation of the Psychologically Informed Environment within Aylward Green.

Recommendations

The main recommendation arising from this evaluation is that a Review Group should be established to fully consider the experiences of the Therapeutic Service pilot project. After a period of reflection it should be decided how best to deliver a Therapeutic Service within Focus Ireland.

1. Context to the Therapeutic Service

The over-arching aim of the introduction of the Therapeutic Service by Focus Ireland was to '*support its customers and their children to reach stability and move on to permanent accommodation successfully*'. The necessity for a new innovative approach to assisting individuals and families experiencing homelessness was driven by two factors. Firstly, the introduction of the Therapeutic Service was precipitated by a changed policy context with the *Pathway to Home* model recommending that households experiencing homelessness should not remain in homeless services for longer than six months (Homeless Agency, 2009). This recommendation was made in order to reduce both the duration and number of episodes of homelessness. The second factor was the increasingly complex needs of customers presenting to services. People with high needs were becoming more prevalent to services, and were at risk of becoming entrenched or experiencing episodic periods of homelessness.

To address this, Focus Ireland management sought a psychologically informed approach to complement the existing skills sets within Focus Ireland which were situated predominantly within a social care framework.

The Dublin Region Homeless Executive's (DRHE) *Pathway to Home* model (2010) sets out to reduce the duration and episodic returns to homelessness for people in the four Dublin local authority areas. The *Pathway to Home* model sets out three interconnecting components to achieve this:

1. Interventions and services that prevent homelessness;
2. Temporary accommodation and homeless services;
3. Housing with supports.

It is acknowledged within the *Pathway to Home* model that implementation of the necessary actions to promote and sustain this vision will take some time. These developments aim to ensure that the risks associated with someone becoming and remaining homeless will be minimised as a result of effective and co-ordinated preventative policies and services.

Prior to the implementation of the *Pathway to Home* model, many individuals spent extended periods of time in homelessness, with some experiencing frequent returns due to the instability of their housing and/or personal circumstances. In line with *The Way Home: A Strategy to Address Adult Homelessness in Ireland 2008-2013* (Department of the Environment, Heritage and Local Government, 2008) a key recommendation of the *Pathway to Home* model proposes that individuals and families experiencing homelessness should

not remain in homeless services for a period of longer than 6 months. The *Pathway to Home* model aims to provide services that are person-centred and are delivered at the earliest possible point of intervention. Central to this is diverting the person at-risk from experiencing homelessness or from having to enter temporary accommodation. A person-centred approach implies that assessments are integral to the planning and development of actions across the various life domains, such as housing, health and income (Hermans, 2012). This means that every homeless person will receive a personal plan known as the Holistic Needs Assessment (HNA), in which needs and services are identified, including: healthcare; mental health and/or addiction requirements; legal and family issues; income adequacy; training; education and employment; life skills; counselling; and housing to assist individuals along the pathway towards an exit from homelessness.

Homeless individuals have typically been portrayed as leading chaotic, risky lives trapped in a downward spiral of drug use, along with mental health and other health problems, and expected to remain in long-term homelessness (Mallett, Rosenthal, Keys, Averill, 2010:1). Numerous studies have identified many social factors as increasing the risk of becoming homeless. These include family breakdown, drug addiction, imprisonment, challenging behaviour, domestic abuse and a previous history of state care (Mayock and O'Sullivan, 2007). In addition, people who become homeless may have economic and social characteristics and support needs that predate homelessness, which are then exacerbated by the experience of homelessness. An analysis of homeless entries in Finland indicates that they are often a result of a complex interaction of structural, institutional, relationship and personal factors (Busch-Geertsema, O'Sullivan, Pleace, et al., 2010).

Within the context of Focus Ireland's work with homeless youth, families and single adults, the majority of people accessing services present with a range of difficulties including: drug use, low educational attainment, lacking basic social skills, exposure to poverty and child neglect, recidivism, parenting issues, and psychological issues. Some customers are second generation homeless. The experience of homelessness is multi-faceted and can have different effects on the individuals and families who experience it. However, there is little doubt that experiencing homelessness has a significant impact on an individual's functioning and wellbeing. For example, a Focus Ireland study on the mental health status of homeless children and their families (Waldron, Tobin, and McQuaid, 2000) found that the homeless children in the study had higher rates of behavioural problems than those found in the general population.

Barnes (1999) found that homeless parents were often socially isolated with few sources of personal support. Furthermore, while many homeless individuals report a history of criminal behaviour, they themselves are vulnerable to victimisation, including physical and verbal abuse, larceny, sexual harassment and violence (Baron, 2003; Gaetz, 2004). Homelessness and homeless people take many diverse forms; therefore there is no one single solution to providing sustainable exits from homelessness. While the aim of homeless services is ultimately to support homeless individuals and households in securing adequate, sustainable and affordable housing, the means by which this can be achieved are as varied as the stories of homeless people themselves. Individual biographies also dictate that people experiencing homelessness often require a variety of additional supports if they are to successfully exit homelessness and maintain a home. While all people experiencing homelessness have a need for adequate, sustainable and affordable housing, the extent to which they will require additional support varies considerably (Busch-Geertsemal, O'Sullivan, Pleace, et al., 2010).

International and Irish research evidence suggests that people who are homeless frequently experience a range of mental health issues and disorders (Feeney, McGee, Holohan, et al., 2000; McKeown, 1999; Stephens, 2002). The conditions vary in type and severity, from those recovering from the effects of previous trauma, episodes of depression, to those with enduring and chronic psychiatric illnesses such as schizophrenia. The *Pathway to Home* model estimates between 50% and 70% of households in homeless services has some mental health and/or addiction support need. These needs are understood to range across a continuum of low to high, with many of those individuals capable of living independently once their needs have been formally assessed and treatment programmes are made available to them. Supporting homeless individuals through psychiatric illness is particularly challenging when the person is exposed to any form of substance misuse.

Substance misuse is one of the most incriminating factors affecting an individual's ability to exit homelessness and return to a quality and independent lifestyle. Alcohol misuse has been frequently identified as a feature for many who experience homelessness in Ireland (O'Cinneide and Mooney 1972; Costello and Howley, 1999). More recently drug abuse has featured as a considerable problem for people experiencing homelessness (Cleary, Talbot, Galvin, and Wall, 2004; Crawley and Daly, 2004; Mayock and O'Sullivan, 2007). Many homeless drug users link their homelessness to their drug use (Cox and Lawless, 1999). Others identify the experience of homelessness as exacerbating their drug consumption levels and the type of drug used (Crawley and Daly, 2004). As a consequence of homelessness and earlier experiences of trauma, drug use may be activated as a coping

strategy to relieve existing difficulties in the absence of more positive and constructive styles of coping (Bender et al., 2003). Substance misuse appears to centre on the need to counteract negative feelings, experiences and emotions and as such acts as a form of self-medication (Mayock and Carr, 2008). The term 'concurrent disorders' is used to describe the combination of mental health and substance misuse. When homelessness is present this relationship can be further complicated and reinforced (Mayock and Carr, 2008). Subsequently, homeless individuals with alcohol problems, drug addictions or mental illness are viewed as one of the most vulnerable and underprivileged groups in society (Coumans and Spreen, 2003).

Within the current context of Focus Ireland's work with those experiencing or at risk of homelessness, it delivers a range of housing advice and support services. These include: supported housing for individuals, families, and young people at risk; educational projects; and tenancy sustainment through individualised community-based supports. Similar to the findings outlined above, a significant proportion of those accessing these services present with a range of interconnected and complex difficulties. These include: drug misuse, criminal justice issues, experiences of child neglect and trauma, low education attainment, poverty, parenting issues and mental health concerns.

The six months duration stipulated in the *Pathways to Home* model in which to engage and stabilise a homeless individual or household is a challenge, particularly in light of an observed increased in the complexity of needs being presented over time. It is against this backdrop that Focus Ireland has decided to introduce a team to deliver a range of therapeutic services to support its customers and their children to reach stability and a successful move on to independent living and permanent accommodation.

Prior to the changed policy context brought about by the *Pathway to Home* model, Focus Ireland had already introduced a number of measures to address the increasingly complex needs of people experiencing homelessness. These included: the Care and Case Management model, Holistic Needs Assessment, PASS (a centralised case management system), and individual models of service delivery.

In order to support these initiatives and further improve customer outcomes, Focus Ireland introduced a Therapeutic Service consisting of a Counselling Psychologist, Behavioural Specialist and Play Therapist for an initial pilot period of 12 months. Initially, Focus Ireland sought to employ the services of a Clinical Psychologist but were unsuccessful in this recruitment. After advice from external agents, it was decided to employ a Counselling Psychologist instead. This decision had no impact on the type of Therapeutic Service to be

provided, as both counselling and clinical psychologists are trained to provide counselling and psychotherapy. Indeed, the American Psychological Association (APA) ceased distinguishing many years ago between clinical and counselling psychology.

1.1 Aims and objectives of the Therapeutic Service

The aims and objectives of the Therapeutic Services were outlined in the Draft Therapy Framework prepared by Focus Ireland.

Aims:

The primary aim of the service is to provide psychotherapeutic intervention, clinical assessment, behaviour modification, and psycho-education to Focus Ireland customers. In providing these interventions customers will be supported in stabilising and improving both psychological and social outcomes in support of social inclusion.

The secondary aim of the service is to establish a Psychologically Informed Environment (PIE) which aims to provide sensitivity and clarity of the therapeutic and emotional issues to address the complex needs of customers, and to adapt the services and staff methods of engagement through policy development, training, staff support and development.

The service aims therefore to support homeless households to exit homelessness and sustain accommodation long-term by promoting psychological and emotional well-being for children, young people, families and single adults.

The objectives of the service are:

1. To establish a Therapeutic Service for homeless youth, families and single people accessing Focus Ireland services. To work in adherence to Focus Ireland Models of Service.

2. To ensure appropriate referrals, assessment and disengagement processes are conducted or sourced and appropriate interventions are provided where appropriate.

3. The service will work from 9.30am to 5.30pm, and extend to evening as necessary. One-to-one intervention, group work and psycho-education in conjunction with customers and staff are conducted to the highest ethical and professional standards. In addition, to provide appropriate staff and organisational consultancy as required on systems, referrals to clinical services and individual matters.

4. To develop partnerships with professional clinical bodies and services, medical services and general HSE clinical and childcare services.

5. The service will agree protocols of engagement with other community and clinical services to agree methods of interagency work.

6. To agree outcome indicators and participate in full with the evaluation of the pilot service and provide other appropriate statistics and information that may be required throughout the pilot period.

7. The service will capture information and data in relation to the trends and numbers of households it engages with and liaise with the H.S.E., D.R.H.E. and other stake-holders to advocate for appropriate levels of service resources and accommodation to sustain this service.

There are three models of intervention within the service that reflect the specific roles of the three clinical practitioners employed.

1. The Counselling Psychologist: Provide both one-to-one and family group psycho-therapeutic interventions, assessments and education to families and young people. The Psychologist is based in Aylward Green and engages customers across the life span. The Counselling Psychologist also had primary responsibility for enabling the development of a Psychologically Informed Environment, which involves staff development that ensures contact between staff and customers is therapeutic with interactions intended to foster growth and change.

2. The Play Therapist: Provide individual and group play therapy to children aged 3 to 13 years and consultancy to staff working in Aylward Green, the National Family Case Management service, and the Prevention and Support to Home services.

3. The Behavioural Specialist: Provide assessment and intervention to young people displaying at risk and/or challenging behaviour in Focus Ireland's Youth Homeless and Aftercare services. The service will also be consultative in nature.

In addition to the above, it was envisioned that the provision of the Therapeutic Service would benefit the wider organisation in developing a Psychologically Informed Environment. PIE refers to service environments where there is a need to recognise the psychological and emotional aspects of their work (Haigh, 2012; Johnson & Haigh, 2010). In other words they are intended to help services and their staff to reflect on and understand the nature of the

emotional and behavioural problems associated with homelessness, and to work both creatively and constructively to address these issues.

1.2 Support and Monitoring Structure

Focus Ireland has well-structured management and reporting guidelines. Its internal audit and control processes ensure that inputs, outcomes and process activities are monitored and evaluated on an ongoing and regular basis and that best practise standards are upheld at all times. The Draft Therapy Framework document states that the Therapeutic Service will issue performance monitoring reports as required and participate in regular reviews to ensure that agreed targets and outcomes are being achieved.

Three groups were proposed to support Focus Ireland's Therapeutic Service:

1. RAADG - Referrals, Admissions and Assessments and Disengagement Group. This group consists of the three therapists.

2. Implementation Advisory Group. The group monitors best practise and ensures ethical and regulatory standards are met by the service. The group has core attendees, including, the three therapists, Project Leader, and Service Manager. The Group may invite other Focus Ireland disciplines as necessary, such as the Services Standards Officer, Human Resources and Advocacy. The group reports to the senior Service Manager, who in turn reports to the Steering Group and Director of Services on operational matters.

3. Steering Group. A Therapeutic Steering Group was established by Focus Ireland to oversee the establishment of the Therapeutic Service and recruitment of the Therapeutic Team. While it was initially envisioned that this group would also monitor and support the completion of the evaluation of the Therapeutic Service, this role was instead led by the Research Officer in Focus Ireland and an implementation group headed by a Focus Ireland Service Manager.

2. Purpose of the evaluation

Focus Ireland is committed to regular reviews and evaluations of its work and services in order to objectively assess the quality, effectiveness and outcomes of its services, and to provide transparency for funders and other key stakeholders. To adhere to this commitment Focus Ireland commissioned an evaluation of the Therapeutic Service to be completed by a fully independent researcher from the School of Social Policy, Trinity College Dublin. It is envisioned that the findings of this evaluation will be utilised to agree and negotiate therapeutic services in the long-term with statutory and/or other stakeholders. The specific objectives of the evaluation were to:

1. Document the model of service delivery and interventions of the Therapeutic Service.
2. Identify, gather, measure and analyse the outputs and outcomes of the services against agreed targets, interventions, performance indicators and planned outcomes.
3. Identify potential barriers/blockages/challenges (e.g. structural, financial, policy, service delivery etc.) that might impede the work of the Therapeutic Service.
4. Highlight the good practice (standards) and lessons learned from the new Therapeutic Service.
5. Generate evidenced-based findings on the specific outcomes from the Therapeutic interventions for children, young people and families in moving on from homelessness, improving their quality of life and sustaining their accommodation in the long-term.

2.1 Format of the evaluation report

Having provided background information on the development of the Therapeutic Service within Focus Ireland, Section 3 of the evaluation report provides a description of the methodological approach. Section 4 details the overall activity levels of the service during the evaluation period, and Section 5 contains the results of the specific interventions of each of the three therapists. The Psychologically Informed Environment is discussed in Section 6. The results of the consultative process undertaken are discussed in Section 7. The report finishes with concluding remarks and recommendations arising from the findings.

3. Methodology

Preliminary briefing and planning meetings were held with the evaluator, Focus Ireland and the three members of the Therapeutic Service Team with a view to developing a comprehensive outcomes-measurement framework. An outcomes-measurement framework involves defining the indicators necessary to measure the outcomes of the intervention under consideration. At its most basic level, an outcomes-measurement framework should capture what the project is 'doing' and what it is 'changing'. In this particular instance the framework details the specific data collection tools used by Focus Ireland and the Therapeutic Team; defines the indicators necessary to compile information on the success or otherwise of the processes in place; and establishes parameters with regard to the timeframe of the evaluation and criteria of customer engagements to be considered.

A table summarising the contents of the outcomes-measurement framework is presented below, which provides details of the inputs, activities, outputs, and short-term outcomes of the Therapeutic Service. Although there is a great deal of congruence between the three Therapeutic services, particularly where intermediate and long-term outcomes are concerned, it is important that the distinct processes and tools used by the three individual therapists are captured. For this reason the table is divided in such a way as to make this distinction clear. The inputs included are common to all three therapists.

Table 1 Outcomes-measurement framework

Inputs	Project funding; Premises, facilities and equipment; Existing Focus Ireland infrastructure; Policies and procedures. Staffing resources- Behavioural Therapist, Counselling Psychologist, Play Therapist, Supporting staff, Project Leader (part of), Services Manager (part of), Director of Services (part of), Research Officer (part of), Steering and Implementation Groups.					
Behavioural Specialist						
Activities	Referred to the therapist by FI staff	Referral reasons recorded	Initial assessment	Intervention	On-going assessment	Disengagement
Outputs	Focus Ireland referral form completed	Behavioural support provided for: • Establishing routine; • Motivation; • Managing aggressive behaviour.	Functional Assessment Interview Form that is used to record: • Customer details; • Strengths and weaknesses; • Target behaviours; • Environmental factors (including daily routine); • Antecedent factors; • Identifying functions; • Efficiency of behaviour.	(1) Behaviour support plans; (2) Practical tools; (3) Incentives / external rewards.	BS meets with case managers/project workers for a period of six months: weekly for the first month; fortnightly for second monthly; and monthly thereafter. • Verbal aggression; • Physical aggression; • Property destruction; • Absenteeism; • General compliance; • Financial management / rent arrears etc.	Clients will be discharged when the referral reason is addressed. At this stage the support plan is phased out and responsibility for managing their behaviour is handed to the client.
Short-term Outcomes	(1) Referral problem behaviour successfully changed. (2) Measurable improvement in specific behaviours for which the client was referred.					

Play Therapist						
Activities	Referred to the therapist by FI staff	Referral reasons recorded	Initial assessment	Intervention	On-going assessment	Disengagement
Outputs	There are three possible routes to engagement with the play therapist: (1) Invited for therapy by the play therapist; (2) Referred to the therapist by staff of Aylward Green or National Family Case Management; (3) All children resident in Aylward Green will be invited to participate. When referred Focus Ireland referral form will be used.	• Behavioural problems; • Emotional problems; • Developmental issues; • Relationship difficulties; • Traumatic life events; • ADHD; • Withdrawn / anxious; • Nightmares / bed wetting; • Autistic spectrum; • Communication difficulties; • Poor play skills; • Bullying – victim or perpetrator; • Experienced abuse; • Selective mutism. •	Play therapy assessment forms completed by (a) parent; (b) referrer / child support staff; Strengths and Difficulties Questionnaire (SDQ) completed by referrer / child support; SDQ will also be administered to children aged 7+ years if suitable; Parent SDQ; Parent interview form.	The number of sessions will ultimately depend on individual needs. Typically there are an initial six sessions offered per customer. Play therapy will be client led and non-directive. Group sessions to deal with a specific issue.	• Attendance record; • Review records every six weeks; • SDQ for parent, child, and referrer / child support; • Feedback meetings with professionals e.g. child support workers/teachers.	End form; Strengths and Difficulties Questionnaires.
Short-term Outcomes	(1) Quantified improvement in specific behaviours for which the client was referred. (2) Improvement in SDQ scores from first engagement to disengagement.					

Counselling Psychologist						
Activities	Focus Ireland customers referred to the therapist by staff of Aylward Green or self-referral. Engagement with external clinical/psychiatric services. Support the development of a Psychologically Informed Environment in Aylward Green.	Referral reasons recorded	Initial assessment	Intervention	On-going assessment	Disengagement
Outputs	When referred FI referral form will be used. Questionnaire administered to Focus Ireland staff at beginning and end of pilot period to measure changes in the Psychologically Informed Environment.	• Depression; • Anxiety; • Trauma / complex trauma; • Relationship difficulties; • Stress management • Parenting difficulties; • Anxiety; • Risk / self-harm.	Intake / assessment interview forms which include: • CORE therapy assessment form; • CORE outcome measures.	• Weekly counselling sessions informed by an integrated relational approach; • Coping skills; • Cognitive Behavioural Therapy (CBT); • Emotional regulation.	• Attendance record; • CORE outcome measures; • CORE 10.	• CORE outcome measures; • Collated attendance record; • Success in initial and/or subsequent referral reasons; • Success in reaching overall goals; • CORE Goal Attainment Form.
Short-term outcomes	(1) Overall presentation and engagement; (2) Impact on client expectations; (3) Improved insight; (4) Improved emotional regulation; (5) Therapeutic alliance; (6) Reduction of anxiety; (7) Reduction of risk/self-harm.					

3.1 Data sources

Two sources of administrative data were used and analysed in this evaluation. Focus Ireland's Management Information Processing system (MIPs) was used by the Therapeutic Team to record information on the overall activity levels of the service up to January 2013. Specifically, information was recorded on a monthly basis from August to January 2013 on staffing; therapies; consultancies; process activities (which included the monthly number of referrals and assessments); and customer movement, outcomes, and disengagements. Information from MIPs was used to inform the evaluation of the overall activity levels within the service. It should be noted that information was only recorded in this database to the end of December 2012. Subsequently, aggregate information on the activity levels of each therapist was recorded on PASS (Pathway Accommodation and Support System).

The second administrative data source was PASS which is the national centralised case management system used in the homeless sector and by Focus Ireland. Information obtained from this database was used to provide a profile of customers who engaged with the Therapeutic Service throughout the first six months of the pilot period. In order to protect the rights and confidentiality of individuals, all customer information from this system was anonymised prior to being made available for inclusion in the evaluation.

While the clinical data collection tools used by particular therapists differ by necessity, the routine collection of data pertaining to customers who the Therapeutic Team engaged with has a number of distinct phases which reflects the usual cycle of therapeutic engagement:

1. Background information on Focus Ireland customers referred to the service which are considered pertinent to therapeutic engagement was provided by the referrer, or in the case of self-referrals, by the customer;
2. Specific reasons for the customers referral to the service were recorded;
3. Details of the initial therapeutic assessment were documented;
4. Details of all interventions were reported;
5. Details of any on-going therapeutic assessment were documented;
6. Information on customer disengagement with the service was logged. This record included details of the reasons for disengagement and the results of final assessments.

Initial referral information was recorded on a Therapeutic Service referral form. Details were recorded about the specific reason(s) why individual children (with parental consent) and adults were referred to the Therapeutic Team. Each of the three therapists also recorded detailed information on specific goals that were hoped to be achieved through therapeutic intervention. Meeting these goals constitutes the clearest measuring stick by which to evaluate the service.

Based on the documents and supplementary information provided by each therapist, a data collection tool was created to aid the collation of all relevant information. The tool consisted of a therapy-specific excel workbook which reflected the data fields that are currently recorded by the therapists. Given the sensitive nature of data collected, the active workbooks were protected with passwords known only to the therapists and the evaluator. In order to ensure customer anonymity, no names were recorded in the workbooks and customers were identifiable only by their PASS ID.

3.2 Inclusion criteria

In consultation with Focus Ireland and the Therapeutic Team, information on all customer referrals received by the team from the start of the project until the 31st December 2012 were included with a view to evaluating customer engagement with the service. The evaluation was limited to three services: Aylward Green, the National Family Case Management service and Cheid Cheim. The selection of these three services was based on their being best matched to the development of the pilot project. The priority area for the Counselling Psychologist was Aylward Green wherein a holistic, whole-family approach to therapeutic intervention was of value. As the Play Therapist's work was centred on children, the priority services were Aylward Green and National Family Case Management. Cheid Cheim was included as the Behavioural Specialist predominantly focused on working with young people.

3.3 Consultations

Qualitative information was collected from a range of key stakeholders. With the formal written consent of participants, all interviews were digitally recorded and subsequently transcribed verbatim. During transcription all identifying information was anonymised with a view to maintaining confidentiality of the information collected. Once transcribed, the original recordings were destroyed.

3.3.1 Focus Ireland staff

Focus groups were conducted with the Therapeutic staff, Services Manager, Director of Services, and referral project staff. In total, four focus groups were conducted with 13 participants.

3.3.2 External stakeholders

Four semi-structured interviews were conducted with stakeholders external to Focus Ireland who had some level of involvement with the service. Details of the consultations conducted with both Focus Ireland staff and external stakeholders are provided in Table 2.

Table 2 Details of participants consulted as part of the evaluation

Focus group 1	
Therapy team	Counselling Psychologist
	Play Therapist
	Behavioural Specialist
Focus group 2	
Focus Ireland management	Service Manager
	Project Leader managing the Therapeutic Service
	Project Leader
	Director of Services
	Team Leader
Focus group 3	
Focus Ireland project staff	Child Support Worker (x2)
	Case Manager
Focus group 4	
Focus Ireland project staff	Case manager (x2)
Semi-structured interviews	
	After-schools development worker
	HSE social worker
	School principal
	Clinical supervisor

3.3.3 Customer interviews

Individual interviews were conducted with five Focus Ireland customers who engaged directly with at least one of the Therapeutic Service Team. It was agreed that children under the age of 16 years would not be included due to ethical considerations, however, it should be noted that four of the five customers interviewed had children who also engaged with the Play Therapist.

3.4 Procedures

This section provided details of the procedures involved in completing the evaluation.

3.4.1 Sample selection

As already noted, administrative and clinical data on all customers referred to the service up to December 31st 2012 were included for analysis in this evaluation. At no point was any information which would render participants identifiable to the evaluator, such as names or contact details, provided or sought.

Participants for the focus groups were selected on the basis of their status as key informants, that is, individuals who offer 'perspective information about the setting, important events, and individuals' (Bryman, 2004).

Information on the external stakeholders to be considered for inclusion in the consultation phase of the evaluation was provided by the Therapeutic Team. Those invited to participate were considered largely representative of the agencies outside of Focus Ireland with whom the Therapeutic Team interacted regularly.

It was initially envisioned that customers who had engaged with any one of the Therapeutic Team would be randomly selected for interview. However, in consultation with the Therapeutic Team it was decided to select customers for interviews using a convenience sample. This decision was made for two reasons. Firstly and most importantly, the evaluator and the Therapeutic Team were conscious of not inviting customers to attend interview where participation might impact negatively on the therapeutic process. Secondly, many of the customers who had engaged with the Therapeutic Service during the initial six months of the pilot period had moved from Focus Ireland accommodation in the interim, which made establishing contact with them difficult.

In order to maintain the anonymity of customers, initial contact was made through the Therapeutic Team whereby customers were provided with an information sheet that

contained details on what would be involved in doing an interview with the evaluator. If a customer agreed to participate in an interview, their contact details were then passed onto the evaluator. Each customer who participated was given a €15 Dunnes Stores Voucher in recognition of the time they gave to the evaluation.

3.4.2 Consent

Each participant was provided with an information sheet which contained background information on the evaluation and details on the purpose of the interview. A brief description of the areas to be addressed during interview was also included. Distinct information sheets were provided for Focus Ireland staff, external stakeholders, and customers. Please see Appendix 1 for an example of the information sheet distributed to Focus Ireland staff and Appendix 2 for the information sheet provided to customers. Before interviews commenced, participants were verbally informed of the purpose of the interview and assured of the confidentiality of the information provided. Finally, each participant signed a form consenting to the interview.

3.4.3 Ethical considerations

Focus Ireland's ethical guidelines for conducting research (Focus Ireland, 2011) were adhered to throughout the evaluation process. All potential interviewees were assured that participation in the evaluation was voluntary and formal written consent was obtained prior to interview. Interviewees were informed that they could withdraw their consent at any time during the interview. Details were also provided with regard to the handling of interview data, including the steps taken to anonymise all transcriptions. At each stage of the evaluation process, care was taken to protect participants' confidentiality and anonymity.

In order to further protect both customer anonymity and confidentiality, and to respect the customer-therapist relationship, the results of the quantitative analysis that examines the details of the therapeutic interventions are reported at an aggregate level. This ensures that individual customers cannot be identified by particular details of their involvement.

3.5 Analytic approach

This evaluation takes a mixed-methods approach whereby both quantitative and qualitative methodologies are utilised. The quantitative analysis is limited to descriptive statistics only. Conducting tests of statistical significance in order to further evidence change was deemed inappropriate due to the small number of data points included in the analysis. Qualitative data collection consisted of semi-structured interviews and focus groups with key informants.

4. Results

4.1 Overall activity levels of the Therapeutic Team

In this section, details of the overall activity levels of the Therapeutic Team are presented. Information is included for the first six months of the pilot period (August 2012 to December 2012). During this time, information was recorded in MIPs on a monthly basis. Subsequently information on monthly activities was recorded in PASS.

4.1.1 Capacity

The maximum number of customers that each member of the Therapeutic Team was considered capable of engaging with in any given month was 20. The actual number of cases engaged with by the members of the Therapeutic Team in each month of the pilot period is presented in Table 3 below.

Table 3 Number of customers engaged

	August	September	October	November	December
Counselling Psychologist	14	14	16	19	19
Play Therapist	17	17	18	17	17
Behavioural Specialist	16	16	17	17	17

On average the Counselling Psychologist engaged with 16 customers per month, while both the Play Therapist and Behavioural Specialist had an average of 17 cases per month. It is important when considering these figures to bear in mind that these numbers do not refer to new or opening cases as many customers engaged with the service for longer than one month. The number of customers engaged by the Counselling Psychologist constitutes 82% of capacity. The corresponding figures for the Play Therapist and Behavioural Specialist were 86% and 83% respectively.

4.1.2 Activity

In terms of the activities of the Therapeutic Team recorded in MIPs, the Counselling Psychologist developed an average of 16 customer support plans each month during the evaluation period. The average number of support plans developed by the Play Therapist and Behavioural Specialist was 15 and 3 respectively. The number of support plans provided each month is presented in Table 4 below. The number of treatment plans produced by the Therapeutic Team is also shown in this table. On average, the Counselling Psychologist

devised 16 individual treatment plans, while the Play Therapist produced 15 per month on average. There was no comparable figure available for the Behavioural Specialist due to the nature of their customer engagement which is discussed later in this report.

Table 4 Number of customers engaged

	August	September	October	November	December
Ongoing Support Plans					
Counselling Psychologist	10	14	16	19	19
Play Therapist	15	15	15	15	15
Behavioural Specialist	3	3	3	3	3
Treatment Plans					
Counselling Psychologist	10	14	16	19	19
Play Therapist	15	15	15	15	15
Behavioural Specialist	n/a*	n/a	n/a	n/a	n/a

* n/a Not Applicable

4.1.3 Customer profile

Information on the characteristics of customers referred to the service up to 31st December 2012 and referral information recorded by the Therapeutic Team were provided from PASS. The results are shown in Table 5 below.

Table 5 Total number of referrals received by the service and profile of the customers referred

	Counselling Psychologist	Play Therapist	Behavioural Specialist
No. of referrals	26	25	23
Gender			
Male	8	15	16
Female	18	10	7
Age			
Range	17 – 44 years	3 – 12 years	9 – 25 years
Average	29.8 years	6.9 years	20.2 years
Dependent children			
Yes	20	n/a*	2
No	5	n/a	21
Customer living with dependent children			
Yes	17	n/a	0
No	---	n/a	---
Housing list status			
Accepted with homeless priority	13	n/a	14
Processing	4	n/a	3
Rejected	1	n/a	0
Focus Ireland Project			
Aylward Green	23	14	---
National Family Case Management	---	9	---
George's Hill	---	1	18
Cheid Cheim	1	---	4
Privately rented accommodation	2	1	1

*n/a not applicable

Among customers aged 18 years and older, family circumstances was the most commonly recorded reason for customers' homeless status, followed by having to leave previous accommodation due to being unable to pay rent. Substance abuse was the next most often cited reason for homelessness, and five customers were reported to be in the process of leaving care.

4.2 Therapeutic activities

This section provides a description of specific therapeutic interventions undertaken by each of the therapists and includes details of the reasons for referral, initial and on-going assessments, and customer outcomes from therapeutic interventions.

Due to the unique nature of each of the three therapeutic services provided within the overall framework and the different profiles of customers referred to each, the results that follow are presented separately for each therapist with regard to customer profile, referrals, assessments, and outcomes.

4.2.1 Referrals

The variety of reasons given for making an initial referral to the Therapeutic Team reflects the complex nature of the needs presented by many of Focus Ireland's customers to whom the service was available. Among the children referred to the Play Therapist, behavioural and emotional problems were the two main reasons provided for the referral. A number of the children also demonstrated difficulties with relationships (family and/or peer) and communication. There were also a small number of children for whom bullying, either as victim or perpetrator, was of central concern. The reasons for referral recorded also noted the exposure of many of the children to traumatic life events among which homelessness is considered an important life event.

The reasons recorded for referrals to the Therapeutic Team were varied which reflects the complex nature of the needs of this customer group. In many cases this resulted in complex combinations of referral reasons being provided for each customer. In light of this and with due regard to protecting the anonymity of customers which may have been compromised if a comprehensive listing of unique referral reasons was presented, word clouds are presented in Figures 1, 2, and 6 to illustrate the key referral reasons captured. A word cloud is a method by which text can be presented graphically with greater prominence given to words that appear more frequently. It has been used here to illustrate both the broad range of presenting issues among customers referred to the Counselling Psychologist (Figure 1) while also highlighting those reasons which appear with the greatest regularity. While a number of referral reasons were common among some of the customers referred to the service (such as low mood, bereavement, suicidal ideation and difficulty coping), the needs of individual customers varied greatly.

Figure 1 Referral reasons recorded for customers of the Counselling Psychologist (created using www.wordle.net)

Customers referred to the Behaviourist Specialist were mostly from Focus Ireland's Youth and Aftercare services and this is reflected in the age profile of the therapists' customers who tended to be in their late teens or early twenties. Customers were referred to the Behavioural Specialist in cases where there was specific need identified for behaviour modification. Again a word cloud has been created to show the variety of referral reasons recorded. It is clear from Figure 2 that drug use and a need for improved self-motivation which was also manifest in a lack of follow through with tasks were common reasons where behavioural intervention was deemed appropriate.

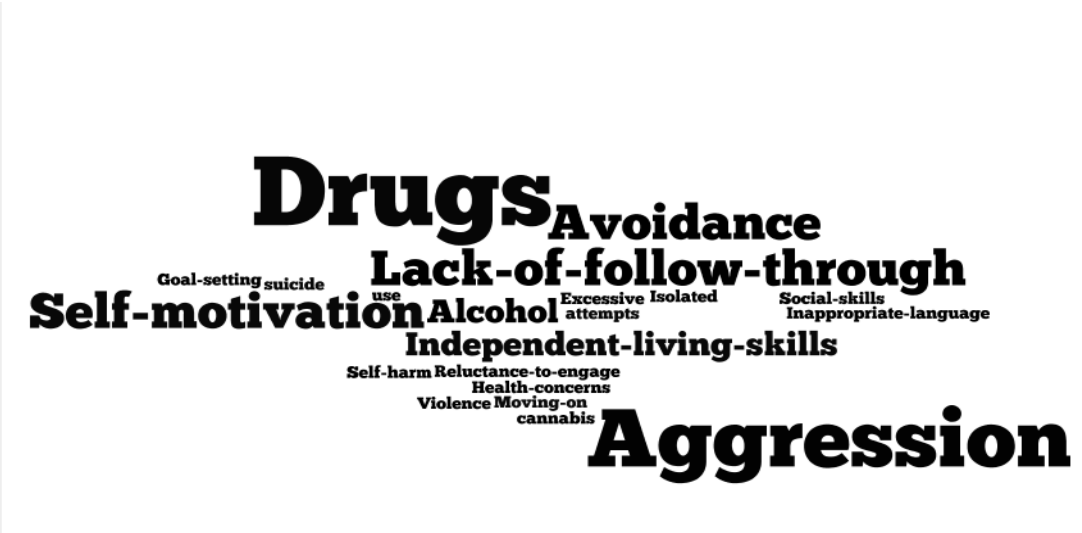

Figure 2 Referral reasons recorded for customers of the Behavioural Specialist (created using www.wordle.net)

5. Therapeutic interventions

The therapeutic interventions undertaken by the Therapeutic Team differ greatly and for this reason the details of the specific work of each therapist is presented separately. For each therapist, aggregate data is presented from all relevant stages of intervention. The results below consider the reasons why therapy was deemed appropriate; assesses the impact of therapeutic intervention drawing on clinical assessments; and provides evidence of subjective changes in customers. The implications of these findings are addressed in conjunction with the findings from the staff, stakeholder, and customer consultations in subsequent sections.

5.1 Counselling Psychologist

The Counselling Psychologist was tasked with providing both one-to-one and family group psycho-therapeutic interventions, assessments and education to families and young people. The Psychologist is based in Aylward Green and engages customers across the life span. The Counselling Psychologist also had primary responsibility for enabling the development of a Psychologically Informed Environment in Aylward Green, which involves staff development that ensures contact between staff and customers is therapeutic with interactions intended to foster growth and change.

5.1.1 Assessments

In this section the results of the initial clinical assessments conducted by the Counselling Psychologist are addressed.

The Counselling Psychologist used the Clinical Outcomes in Routine Evaluation-Outcome Measure[1] (CORE-OM) measurement tool which is a framework designed to assess change within psychotherapy and other disciplines (Barkham, Evans, Margison, et al., 1998; Evans, Mellor-Clark, Margison, et al., 2000). The tool is designed to capture information on an index of distress and is considered suitable for use as both an initial screening tool and outcome measure. However, it is not a diagnostic tool, that is, it cannot be used to diagnose specific disorders (CORE system user manual).

[1] Further details on the CORE measurement tools can be accessed at www.coreims.co.uk

This customer completed tool consists of 34 items covering four domains:

- Subjective well-being (4 items; maximum score=16);
- Problems / symptoms (12 items; maximum score=48);
- Life functioning (12 items; maximum score=48);
- Risk/harm (6 items; maximum score=24).

Each of the 34 items within the CORE measurement framework is scored on a five-point Likert scale that ranges from zero to four, with higher scores indicating a greater number of problems and/or higher level of distress. The CORE user manual also provides normative data scores for clinical and non-clinical populations. This means that scores can be compared to normative data in order to ascertain whether an individual's score falls within the non-clinical or clinical range. The framework also enables scores to be calculated for overall distress and each of the four domains. The risk domain should not be considered a scale measure or index instead it serves as a clinical indicator of a customer being a risk to themselves or others (CORE system user manual).

A previously published examination of the psychometric properties of the tool demonstrated good test-retest reliability, convergent validity, and large differences between clinical and non-clinical groups. The tool was also found to be adequately sensitive to change (Evans, Connell, Barkham, et al., 2002). Results were available for 21 initial CORE assessments conducted by the Counselling Psychologist. Total scores on each of the four domains are presented in Table 6 below.

Table 6 Results of initial CORE assessment – total clinical score, and total and mean score on each of the four domains

	Total score	Std Dev.	Mean score	Std Dev.
Well-being	8.6	3.1	2.1	0.9
Symptoms	26.4	12.5	2.2	1.0
Functioning	22.1	6.9	1.9	0.6
Risk	2.2	1.8	0.4	0.3
Total clinical score	18.9	7.6	n/a	n/a

For each domain, these scores were higher than that expected in non-clinical populations (CORE system user manual) indicating a greater level of difficulty among this clinical

sample. Upon completion of the assessment, the customers' presenting difficulties were then reviewed and rated. Two of the 21 customers were observed to be outside of the clinical range which means that their scores were similar to that of a non-clinical population; three were mild level; six moderate level; seven moderate to severe; and three customers scored in the severe clinical range.

5.1.2 Therapeutic interventions

Customers had an average of 19 therapeutic sessions with the Counselling Psychologist, from a minimum of four to a maximum of 40. The total number of sessions recorded during the inclusion period was 372. There were also a large number of therapy sessions arranged which were not attended (n=232) with an average of 12 sessions per customer not attended.

In terms of the specific therapeutic interventions, 20 customers completed psychodynamic therapy; 18 attended cognitive-behavioural therapy; 20 had person-centred therapy; and three completed systemic therapy. Other therapies provided to customers included bereavement counselling, motivational interviewing, addiction counselling, and harm reduction. Twenty of the 22 customers for whom information was available attended individual therapy sessions, while two took part in family therapeutic sessions.

During engagement with customers the Counselling Psychologist identified a range of issues to be addressed in therapeutic intervention. Table 7 below shows the number of customers identified as presenting with each issue for which information was recorded during the initial assessment. The corresponding numbers recorded when customer outcomes were assessed are also shown. In all instances customers were assessed to have more than one presenting issue which is indicative of the multitude of needs which the Counselling Psychologist addressed with customers.

Table 7 The number of customers presenting to assessment for therapeutic intervention with specific difficulties and the corresponding numbers at outcomes assessment

	Initial assessment	Outcome assessment	Percentage change
Depression	17	15	-12%
Anxiety / stress	24	19	-21%
Psychosis	3	3	0%
Personality problems	3	6	+100%
Cognitive / learning	1	2	+100%

	Initial assessment	Outcome assessment	Percentage change
Physical problems	3	3	0%
Addictions	18	15	-17%
Trauma / abuse	20	17	-15%
Bereavement	18	15	-17%
Self-esteem	10	9	-10%
Interpersonal	20	18	-10%
Living / welfare	19	16	-16%
Work / academic	2	4	+100%
Specific risks identified			
Suicide	19	4	-79%
Self-harm	6	4	-33%
Harm to others	8	3	-63%
Legal / forensic	5	2	-60%

5.1.3 Subjective benefits of therapy

As well as the clinical measures captured by CORE, the Counselling Psychologist also recorded information on the success or otherwise of a number of problems which the therapeutic intervention aimed to addressed. As shown in Figure 3 below, among customers for whom specific problems were addressed, a positive improvement was recorded for a sizeable majority.

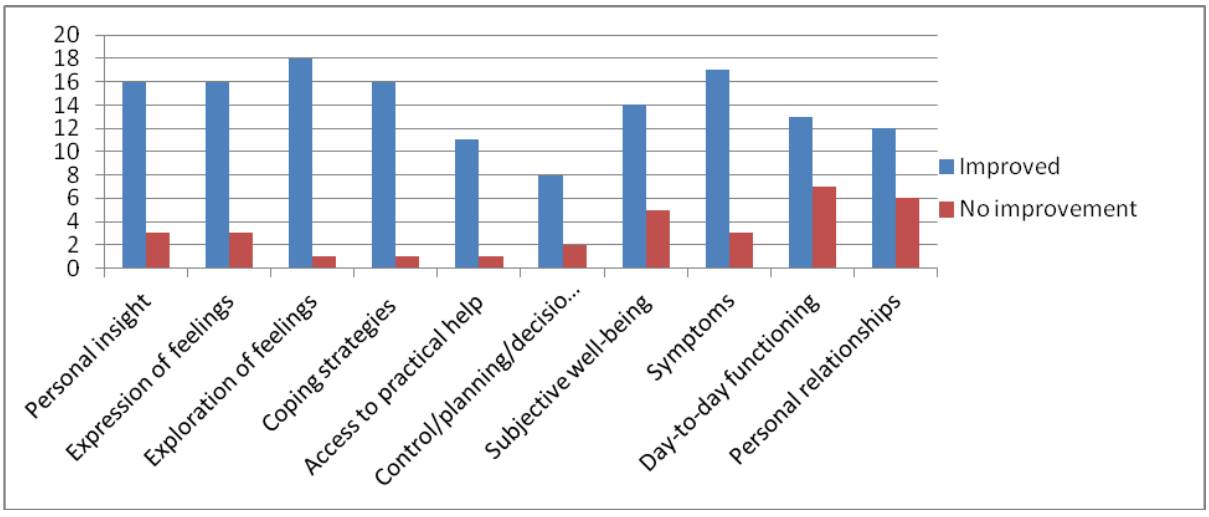

Figure 3 Number of customers who saw an improvement or no improvement in problems addressed during therapeutic intervention by the Counselling Psychologist

The areas in which the greatest numbers of customers were recorded to have improved were exploration of feelings and presenting symptoms. Of those who engaged only a small number were observed to have experienced no improvement.

5.1.4 Clinical assessments

End CORE outcome assessments were completed with 13 customers within the inclusion period. As shown in Figure 4 below, there was a clear reduction in the total scores reported on each of the four sub-scales and the total core distress index. A reduction in scores reflects an improvement.

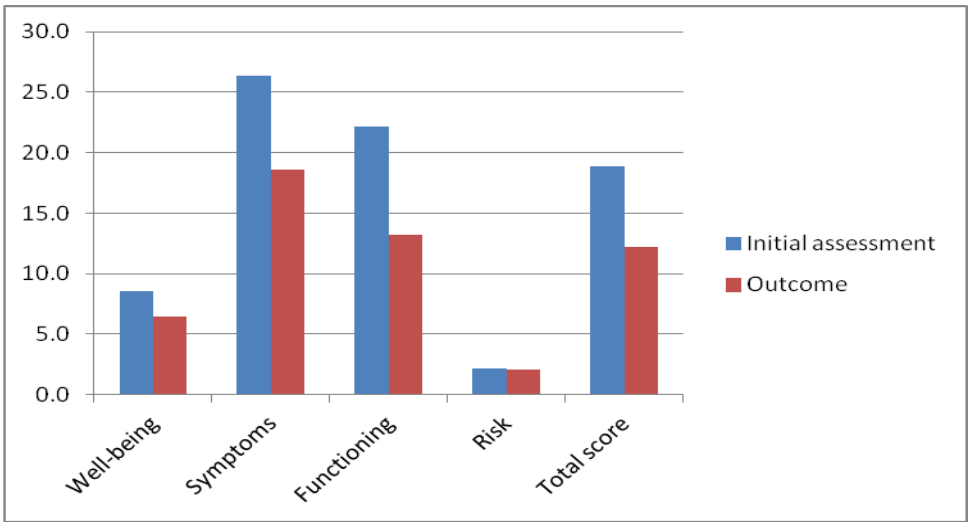

Figure 4 Comparison of CORE domain and total scores from initial assessment to outcome assessment

Among the 13 customers for whom information was available from both the initial and outcome CORE assessments, the average reduction in well-being scores was 1.5 on a scale of 1-16; symptom scores decreased by 7.0 on a scale of 1-48; functioning scores were reduced by 9.2 points on average on a scale of 1-48; there was a slight reduction in risk from 2.2 at initial assessment to 2.1 at outcome assessment; and finally total core distress scores reduced by 7.3 on average.

Figure 5 below shows the number of respondents classified as being on the clinical range of distress at initial assessment and again at outcome assessment. There was a clear shift from left to right in terms of severity meaning that fewer customers were considered at the higher severity clinical range with four now falling outside of the clinical range compared to only one at initial assessment.

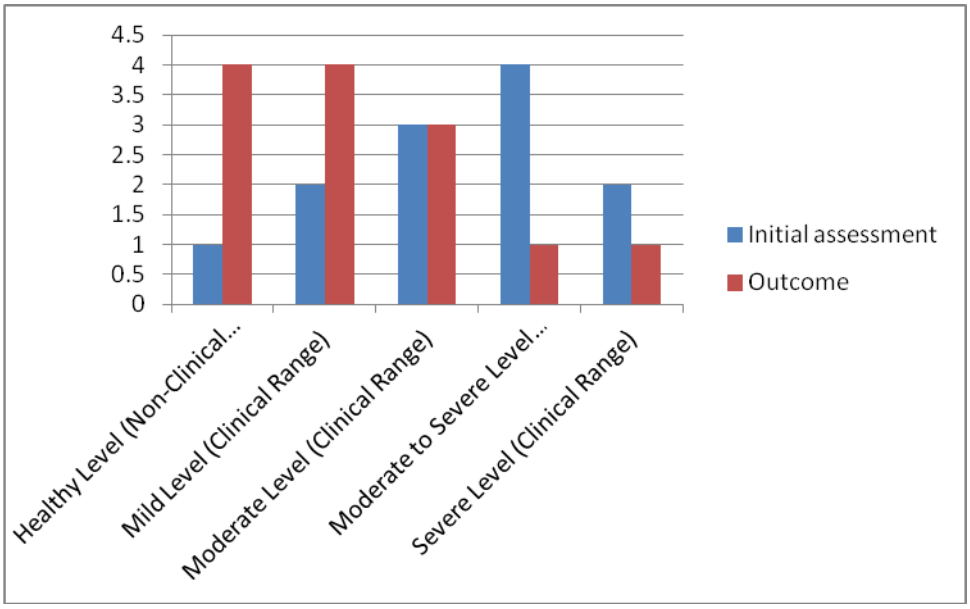

Figure 5 Number of customers classified by level of severity of problems at initial and outcome assessment

5.1.5 Conclusion

Using a number of measurement tools it is clear that the Therapeutic intervention of the Counselling Psychologist had a positive impact on customers. Results from the analysis of the clinical CORE outcomes measurement tool show a clear improvement in customers' well-being and functioning. There was also a reduction in the severity of presenting problems, and their total scores. There was little change in terms of risk. As well as these clinical outcomes, a number of customers were observed to have improved emotionally and behavioural with for example positive change observed in levels of personal insight, and improved coping strategies demonstrated.

A comparison of the number of difficulties present and risks identified between initial and outcome assessment also demonstrates how therapy reduced the problems customers faced. In particular, the Counselling Psychologist successfully addressed suicidal ideation among a number of customers.

Finally, the therapeutic interventions of the Counselling Psychologist resulted in a number of customers moving outside the clinical range of distress as measured by CORE.

5.2 Play Therapist

The Play Therapist was tasked with providing individual play therapy to children aged 3 to 13 years and consultancy to staff working in Aylward Green, the National Family Case Management service, and the Prevention and Specific Speech and Language Impairment (SSLI) services.

5.2.1 Assessments

After referral both the child's parents and referrer, which in the main was their child support worker, completed initial assessment forms. Among other things, parents were asked to provide details of the children's strengths, problem behaviours and specific behaviours which they hoped might change as a result of their child's engagement with play therapy. Due to the myriad of unique strengths reported by parents it is neither feasible to report them in detail nor appropriate if customer confidentiality is to be maintained. It is clear however, that parents did identify a number of positive strengths in their children. Among the most common positive characteristics reported were children being sporty, caring, and helpful and in the home and with siblings. The children were reported by parents to have a complex range of problem behaviours which can be broadly classified as behavioural and emotional. In order to present a picture of the types of problematic behaviours identified by parents a word cloud is presented in Figure 6 which gives prominence to words that appear more often in the information recorded during initial parental assessment.

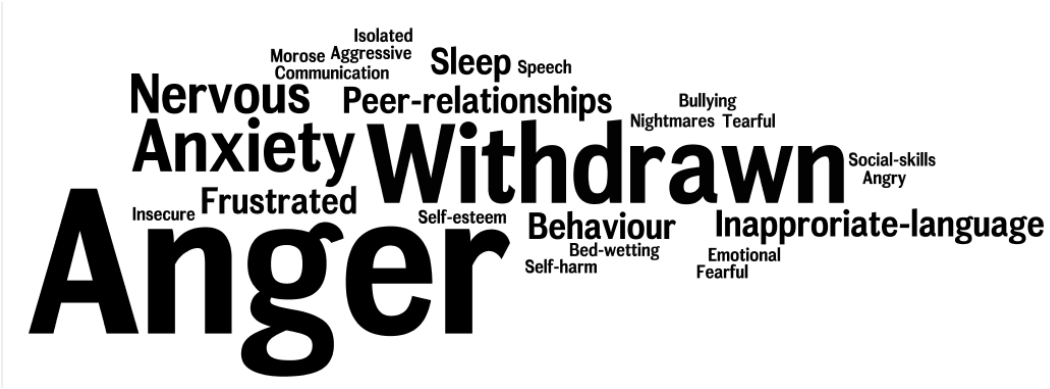

Figure 6 Children's problem behaviours identified by parents during initial assessment by the Play Therapist (created using www.wordle.net)

As shown in Figure 6, many of the children were prone to displaying high levels of anger which frequently manifested in temper tantrums. Many of the children were also withdrawn and introverted, while numerous others were observed to be anxious or nervous.

While similarly varied, a great number of the changes in the children's behaviour and outlook which parents hoped play therapy would engender in their children involved improvements in their confidence and self-esteem, while others were more focused on their children's emotional and anger issues.

Initial assessments were also conducted by the Play Therapist with the individual who referred the child to the Therapeutic Service, which tended to be the child's support worker. There was a great deal of congruence between parental and referrer reports of the difficulties which the children presented and also in their hopes of change from engagement with the Play Therapist. In addition, the referrer also provided information on significant life events experienced by the children. The most significant event in terms of recurrence was the experience of homelessness itself and associated issues, such as chaotic lifestyles, and a lack of stability in their lives including frequently moving schools. Many of the children's households were also characterised by parental relationship difficulties with a small number of children having witnessed domestic violence. A number of the children had also experienced bereavement in their life.

To clinically assess children's psychological adjustment across behavioural and psychosocial domains, the Play Therapist used the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997). The SDQ is a brief (25-item) screening tool designed to assess emotional health and problem behaviours among children and adolescents. The SDQ has been demonstrated to have good concurrent validity, correlating highly with both the Rutter scales (Goodman, 1997) and the Child Behaviour Checklist (Goodman & Scott, 1999; Klasen, Woerner, Wolke, et al., 2000; Koskelainen, Sourander, Kaljonen, 2001; Becker, Woerner, Hasselhorn et al., 2004; all cited in Murray, McCrory, Thornton, et al., 2011). The five-factor structure of the SDQ has also been confirmed in numerous studies. The SDQ has been shown to discriminate well between clinical and community-based samples (Goodman, 1997; Goodman and Scott, 1999; Klasen et al, 2000), and importantly for evaluation purposes, it is sensitive to changes in behaviour following intervention (Mathai, Anderson and Bourne, 2003). Finally, the scale has also been found to have good internal (Goodman, 2001) and test-retest reliability (Hawes and Dadds, 2004).

Scores can be calculated across five domains:

- Emotional Symptoms (e.g. 'Child has many fears, is easily scared');
- Hyperactivity/Inattention (e.g. 'Child is constantly fidgeting or squirming');
- Conduct Problems (e.g. 'Child often fights with other children or bullies them');

- Peer Relationship Problems (e.g. 'Child is rather solitary, tends to play alone');
- Pro-social (positive) Behaviour (e.g. 'Child is considerate of other people's feelings').

Each subscale comprises five items and a Total Difficulties Score is obtained by summing the scores of the four deficit-focused scales. The pro-social behaviour scale is not included in the Total Difficulties Score as it reflects a positive trait while higher scores on the other four subscales reflect difficulties. Item scores have a possible range of zero to 10, while the Total Difficulties Score ranges from zero to 40. From the Total Difficulties Score, children can be classified as normal, borderline or abnormal with regard to their behaviour, emotional and relationship functioning, based on community sample scores provided by the scale developers (Goodman, 1997). The cut-offs used for each of the SDQ[2] sub-scales and Total Difficulty Scores are shown in Table 8 below.

Table 8 Cut-off scores for classification as normal, borderline, or abnormal for each sub-scale of the SDQ questionnaire and total difficulties

	Normal	Borderline	Abnormal
Emotional symptoms	0 – 3	4	5 – 10
Conduct problems	0 – 2	3	4 – 10
Hyperactivity/Inattention	0 – 5	6	7 – 10
Peer relationship problems	0 – 2	3	4 – 10
Pro-social behaviour	6 – 10	5	0 – 4
Total Difficulties	0 – 13	14 – 16	17 – 40

The Play Therapist administered the questionnaire, for each child referred to the service, to the referring project worker; the child's parent(s); and where appropriate, the children themselves. As many of the children with whom the Play Therapist engaged with were too young to complete the questionnaire, only the results from the referrer and parent completed questionnaires are assessed here. SDQ questionnaires were completed by both at three time points: initial assessment, on-going assessment, and end assessment.

The mean scores from both the parental and referrer completed questionnaires, presented in Table 9 below, are higher than those reported in the most recent nationally representative study of nine-year old children in Ireland. The pro-social scores of the children assessed are lower than that observed in the general population. This shows that the children assessed by

[2] Further details on the SDQ measurement instrument can be found at www.sdqinfo.com.

the Play Therapist had poorer psychological adjustment compared to children from the general population (Williams, Greene, Doyle et al., 2009: 75).

While the mean scores from parental and referrer reports were similar, the finding that parents of the children reported higher difficulty scores is similar to that observed in other studies that have shown that parents tend to report more problematic behaviours (Mathai, Anderson and Bourne, 2002; Papageorgiou, Kalyva, Dafoulis and Vostanis, 2008; Williams, Greene, Doyle et al., 2009).

Table 9 Mean scores for each SDQ sub-scale and total difficulties based on parental and referrer reports at initial assessment

	Parental report (N=21)	Referrer report (N=17)
Emotional symptoms	4.9	4.7
Conduct problems	4.3	3.1
Hyperactivity/Inattention	5.8	4.7
Peer relationship problems	3.4	2.9
Pro-social behaviour	8.3	7.2
Total difficulties	18.8	15.4

Using the cut-off scores for each of the scales, Figure 7 shows the percentage of children scored by parents and referrers as normal, borderline, abnormal, on each sub-scale and their Total Difficulty Score.

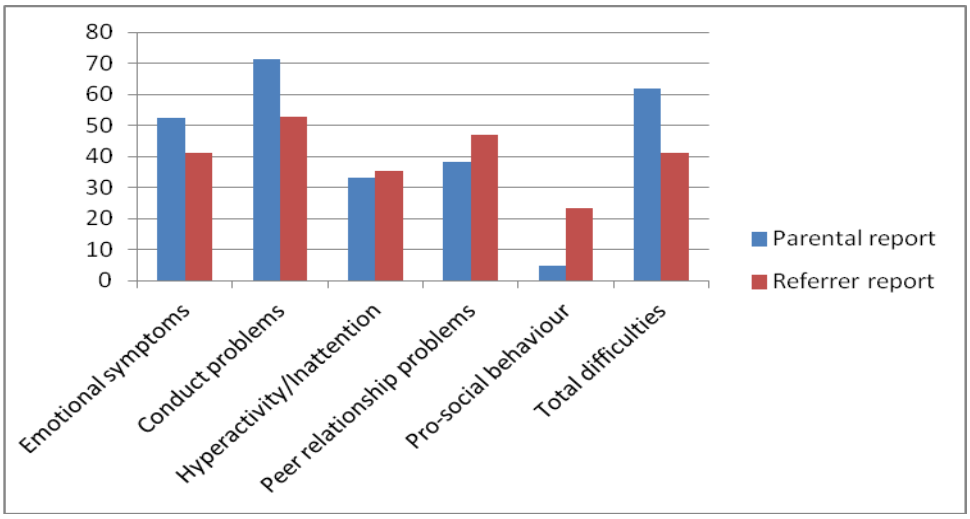

Figure 7 Percentage of children classified as abnormal on each SDQ sub-scale and total difficulties based on parental and referrer reports at initial assessment

Analysis of data from *Growing Up in Ireland – The National Longitudinal Study of Children* that contains a sample of over 8,000 nine-year olds found that 85.2% fell within the normal range, with 7.7% found to be borderline, and the remaining 7.1% in the abnormal range for total difficulties. A comparison of these results with those observed among children included in the evaluation showed that the children engaging with the Play Therapist were far more likely than those from the wider population to be classified within the abnormal range in terms of total difficulties reported. A large majority (70%) of the children were also classified in the abnormal range for conduct problems, and there was also a high percentage in the abnormal range for each of the other sub-scales.

SDQ questionnaires were again administered by the Play Therapist to both parents and the individual who referred the child for ongoing assessment. Mean scores from both reports are presented in Table 10 below.

Table 10 Mean scores for each SDQ sub-scale and total difficulties based on parental and referrer reports at follow-up (ongoing) assessment

	Parental report (N=14)	**Referrer report (N=12)**
Emotional symptoms	3.1	3.8
Conduct problems	2.5	2.6
Hyperactivity/Inattention	3.7	3.4
Peer relationship problems	1.5	2.3
Pro-social behaviour	9.5	7.8
Total difficulties	10.2	12.3

A comparison of the results presented in Tables 9 and 10 shows that there was a reduction in the mean score of each of the difficulty scales reported by both parents and referrers. There was also an increase in the mean scores reported on the positive pro-social scale. This demonstrates a reduction in the level of difficulties presented by the children since they began engaging with the Play Therapist.

Parents (n=8) and referrers (n=11) completed a final assessment using the SDQ questionnaire upon completion of the play therapy intervention. The mean scores shown in Table 11 below indicate that there was a continued reduction in the children's difficulty scores throughout the therapeutic process.

Table 11 Mean scores for each SDQ sub-scale and total difficulties based on parental and referrer reports at final assessment

	Parental report (N=8)	Referrer report (N=11)
Emotional symptoms	2.0	3.2
Conduct problems	3.4	0.6
Hyperactivity/Inattention	2.0	1.8
Peer relationship problems	1.8	1.2
Pro-social behaviour	9.6	8.7
Total Difficulties	9.0	6.7

The SDQ scores reported at final assessment were comparable to those found in the general population of nine-year old children in Ireland (Williams, Greene, Doyle et al., 2009: 75). Based on parental reports, the children who had engaged with the Play Therapist had an average emotional symptoms score of 2.0 compared to 2.1 in the general population; a score of 3.4 on conduct problems compared to 1.4; a score of 2.0 on the hyperactivity/inattention sub-scale compared to 3.3; a score of 1.8 in peer relationship problems compared to 1.3; and a pro-social score of 9.0 compared to 8.9 in the general population.

Figure 8 below shows the mean scores on each sub-scale and total difficulties based on parental reports at initial, on-going, and end assessment. For each of the difficulty sub-scales, mean scores decreased clearly from initial to end assessment while the children's pro-social skills increased. The Total Difficulty Scores reported for the children also clearly decreased over time, with the biggest reduction recorded for the period from initial to on-going assessment. It should be noted that there were few final assessment SDQ questionnaires completed by the children's parents. In most instances this was because the child was still attending play therapy at the end of the inclusion period for the evaluation.

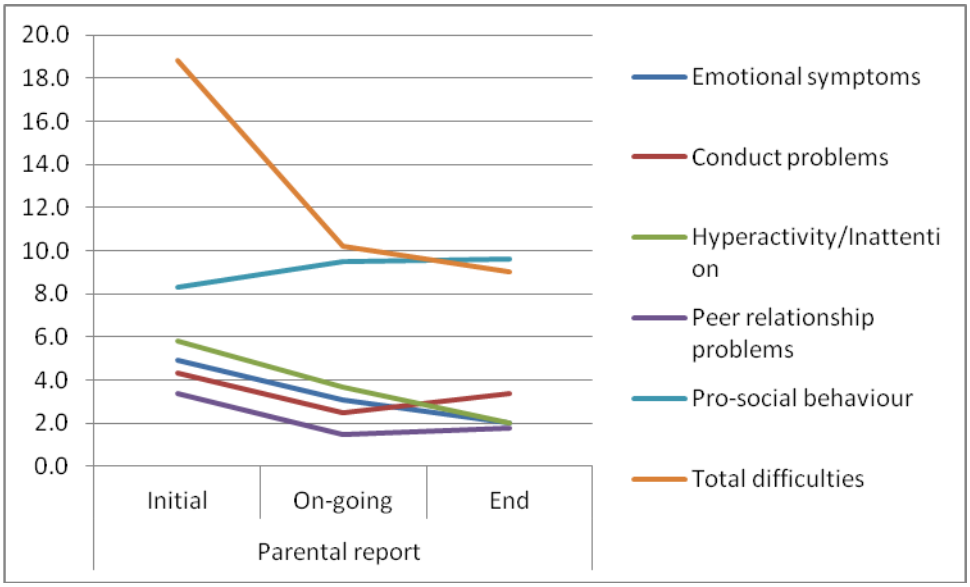

Figure 8 Mean SDQ scores based on parental reports at initial, on-going, and final assessment

A similar trend was observed from the SDQ results based on referrer reports with the children's mean scores on each of the difficulty sub-scales, and the Total Difficulty Score, reducing over the period of engagement with the Play Therapist. A slight increase was also observed among scores on th epositive pro-social sub-scale.

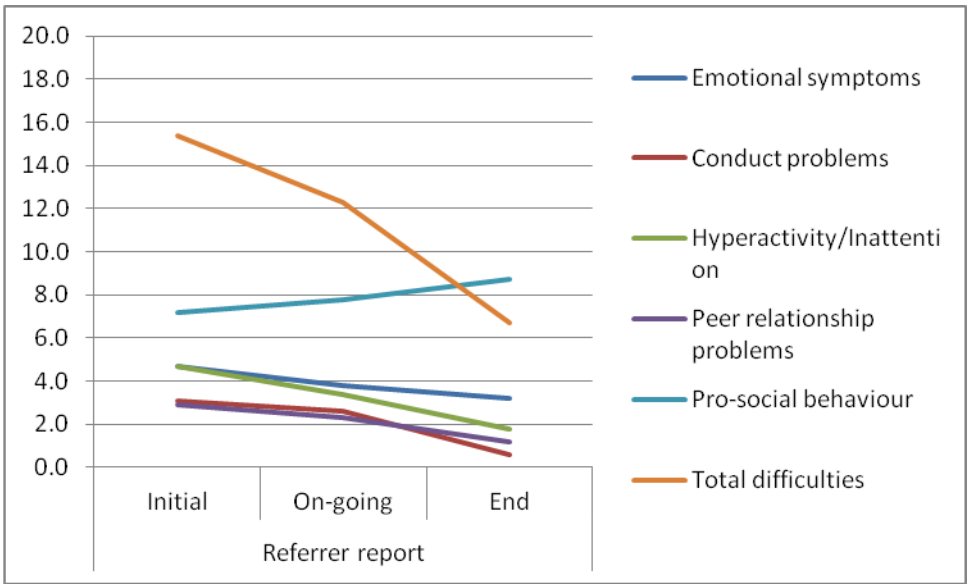

Figure 9 Mean SDQ scores based on referrer reports at initial, on-going, and final assessment

The results presented in Table 12 below shows clearly the positive impact that play therapy had on children's strengths and difficulties. Examining the results from the initial SDQ questionnaires completed by parents a large number of the children were in the abnormal

range for all of the difficulty sub-scales, and 13 of the 21 children for whom an initial score on the SDQ was calculated were deemed to have an abnormal level of difficulties overall. Among the eight children for whom information was completed when they finished their engagement with the Play Therapist, only one was considered to fall within the abnormal overall difficulty range according to parental reports. A similar trend was observed based on the results of SDQs completed by the children's referrers. Referrers were less likely than the parents to score the children in the abnormal range on the negative sub-scales or in terms of total difficulties during initial assessment. Among the eleven children for whom end of therapy SDQs were completed only three were considered by their referrer to have abnormally high scores with regard to emotional symptoms while none were observed to score problematically in any of the other scales or in terms of overall difficulty.

Table 12 The number of children classified as being in the abnormal range on each of the SDQ sub-scales and total difficulties based on parental and referrer reports at initial, on-going, and final assessment

	Parental report			Referrer report		
	Initial	**Ongoing**	**End**	**Initial**	**Ongoing**	**End**
Emotional symptoms	11	4	0	7	5	3
Conduct problems	15	4	4	9	3	0
Hyperactivity/Inattention	7	2	0	6	3	0
Peer relationship problems	8	1	2	8	3	0
Pro-social behaviour	1	0	0	4	3	0
Total difficulties	13	2	1	7	3	0

5.2.2 Review records

As part of the therapeutic intervention, the Play Therapist also regularly reviewed the key issues to be addressed with each child. Another important aspect of the review process was the summation of information regarding each child's level of engagement with play therapy. In almost all cases the children's attendance was consistently excellent with a number of children reported to have attended all sessions offered. It was also possible to confirm the high level of reported attendance from information collected at the end of therapeutic engagement which showed a 75% rate of attendance.

5.2.3 End forms

During the evaluation inclusion period the Play Therapist recorded four planned and eight unplanned disengagements from therapy, with a further 11 on-going interventions. The most common reason for unplanned disengagements was the family moving on from Focus

Ireland accommodation. As part of the Play Therapist's routine data collection, success or otherwise in achieving the aims of therapeutic intervention agreed as part of the initial parental assessment was recorded. Given the unique and complex nature of the needs of the children who engaged with the service it is not possible to describe in detail the information recorded. However, the information showed that there was a marked improvement observed by parents, particularly with regard to the children's confidence, self-esteem, assertiveness, and emotionality. Examples of specific behavioural change accredited by parents to the intervention of the Play Therapist included reduced tantrums and better sleep patterns.

5.2.4 Conclusions

Results from the clinical assessment tool (the SDQ questionnaire) used to assess the levels of difficulties presented by the children referred to the Play Therapist clearly demonstrates the positive impact that the therapeutic process had. Children's improved emotional state is also evidenced by positive changes with regard to pro-social behaviour. The high attendance rate of the children is also indicative of their positive experience of play therapy.

5.3 Behavioural Specialist

The Behavioural Specialist was employed to cater to customers of Focus Ireland's Youth and Aftercare Services. The specific task of the therapist was to help enable positive changes in the behaviour of adolescents and young adults aged 16-25 years availing of this service by providing assessment and intervention by way of a behaviour support plan to young people displaying at risk and/or challenging behaviour. A secondary role was to provide consultative services to Focus Ireland staff and management.

5.3.1 Assessments

Of the 23 referrals to the Behavioural Specialist, 18 were made by key and project workers within Focus Ireland's Youth and Aftercare Services. The Play Therapist made one referral, and there was one self-referral.

5.3.2 Interventions

The work of the Behavioural Specialist differed greatly from that of the other two members of the Therapeutic Team. Whereas the Play Therapist and Counselling Psychologist utilised formal clinical assessments from which it was possible to gauge the effect of therapeutic intervention for customers, the Behavioural Specialist practiced Applied Behaviour Analysis

(ABA; see Sheridan and Deering, 2009 for an example of its application) which is most synonymous with autism spectrum disorder although the method has been used in a wide range of fields. Previously known as Behaviour Modification, this approach involves the analysis of behaviour with a view to functionally assessing the relationship between a given behaviour and an individual's environment. Methods within the ABA framework such as behaviour contracts and rewards are used with a view to positively modifying the risk behaviour.

The behaviours for which the Behavioural Specialist intervened predominantly involved alcohol and substance abuse, aggressive behaviour towards persons or property, and a lack of motivation. While it was originally planned that a behaviour support plan would be recorded for each person engaged by the Behavioural Specialist, the nature of the engagements proved to be less structured than envisioned. In practice, this meant that interactions between the Behavioural Specialist and individual Focus Ireland customers were largely ad-hoc and no support plan was developed or recorded. Therefore, details of the interventions undertaken with only eight Focus Ireland customers were made available for inclusion in this evaluation. The specific behaviours addressed were: alcohol and drug abuse; motivation and support around attendance at work placements and education; improvements in peer relationships; support in securing accommodation and moving on from supported accommodation; and reducing incidence of damage to property. Support was also provided to key workers within Focus Ireland's Youth and Aftercare Services to assist them in supporting customers.

Due to the confidentiality of the customer-therapist relationship it is not possible to provide details of specific interventions afforded to these eight customers. However, by way of example, a behaviour support plan which was recorded by the Behavioural Specialist is provided in Figure 10. This chart demonstrates how the Behavioural Specialist observes and records the number of incidents of the behaviour of concern and then intervenes by one of the methods available within the ABA framework. The incidence of the behaviour is then recorded. If the behaviour is modified there should be a marked decrease in occurrences. Through the implementation of this support plan the Behavioural Specialist demonstrated the successes discussed above.

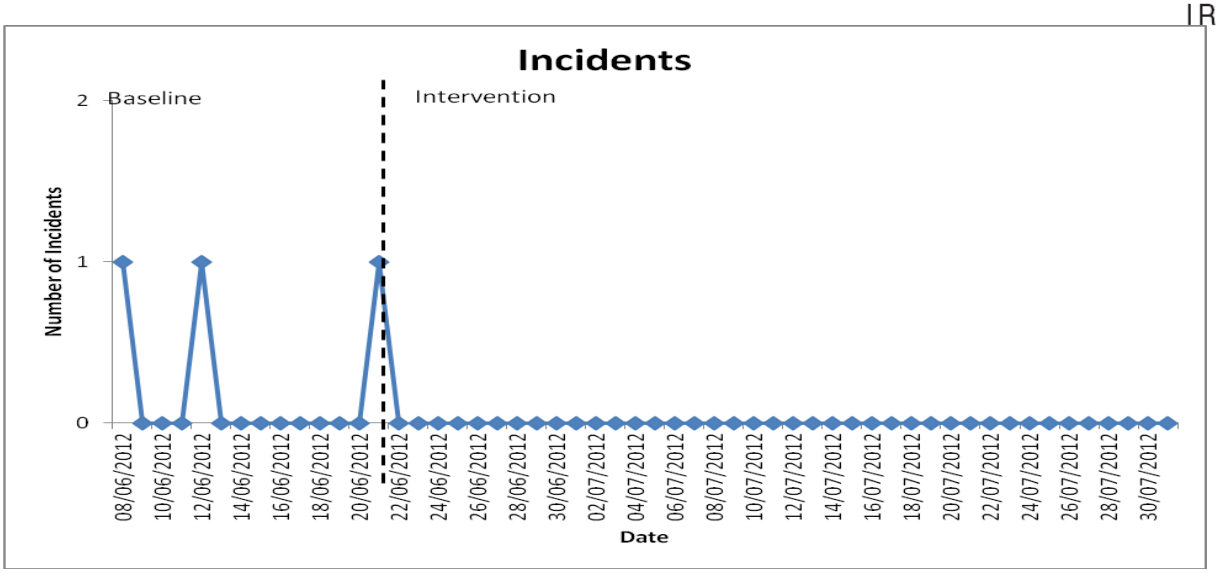

Figure 10 Example of a behaviour support plan implemented by the Behavioural Specialist

Further to the interventions already discussed, as of August 2013 the Behavioural Specialist has had on-going engagement with 14 customers, all but one are from Focus Ireland's Supported Temporary Accommodation.

The Behavioural Specialist also provided brief information on eight customers with whom they had a consultative relationship with but did not action a formal behaviour support plan. Of these, four customers had only brief engagement as they moved out of Focus Ireland supported accommodation; two failed to engage with the service having had one-to-one consultations; one was referred to an external counselling service; and one was referred to the Focus Ireland Counselling Psychologist. Furthermore the Behavioural Specialist provided consultative support to staff with regard to customers' mental health and substance misuse.

5.3.3 Conclusions

It is more difficult to measure the success and outcomes of the work of the Behavioural Specialist due to the absence of a specific clinical assessment tool. As discussed further in Section 7 below, the nature of the work conducted by the Behavioural Specialist was not as observably structured as that of the other members of the Therapeutic Team. Rather than the intervention consisting of a series of one-to-one therapeutic intervention sessions, much of the work of the Behavioural Specialist was more consultative in nature and as such there are limitations as to the amount of information that could be made available for objective analysis in this evaluation.

6. The Psychologically Informed Environment

Focus Ireland recognised that the Therapeutic Service required an approach that *"lacks rigidity and grows with our customers emotional and psychological needs".* This approach was taken with a view to adapting the supports offered to individuals and families experiencing homelessness to one that enabled greater consideration of their emotional and psychological needs. In light of the changed policy context which meant that Focus Ireland now had a shortened time-frame in which to engage with customers, and the increasing complexity of the problems presented by customers, Focus Ireland management recognised the need for a new, innovative approach to their engagement with people experiencing homelessness.

Key to deciding on a new approach for the organisation was a desire to complement the available existing skills sets within Focus Ireland which were situated predominantly within a social care framework. The Psychologically Informed Environment was identified as a suitable framework within which value could be added to the existing core social care skills. As well as placing greater value on reflective practice as a tool by which staff have a greater sense of the work they are carrying out, the PIE framework also introduced other methodologies such as the recovery approach, Cognitive Behaviour Theory (CBT), and attachment theory. It was felt that CBT would provide a means by which behaviour could now be understood rather than simply managed, which had been the case previously, while attachment theory provided a suitable approach by which to improve family dynamics. Also key was the fact that PIE is a relational approach which is also the case with social care practice. This meant that the language and concepts used within the PIE framework were readily accessible to social care practitioners. Therefore, this new approach taken by Focus Ireland not only introduced a more psychological informed approach to their services, but also upheld many of the key principles of social care.

A key aspect of the PIE approach is a move away from staff simply managing behaviour, to one where staff are supported in managing relationships. This way it is hoped that customers will be empowered to make positive changes in their lives (Keats, Maguire, Johnson, et al., 2012). The PIE approach recognises that many homeless people have experienced complex trauma during their life and that many customers have long-standing difficulties (Communities and Local Government, 2010).

> *"The concept of a 'psychologically informed environment' then describes the outcome of an attempt to identify, adapt and consciously use those features of the managed environment in such a way as to allow the resources and the day-to-day functioning of the service to be focussed on addressing the psychological needs and emotional issues thrown up by the residents*" (Johnson and Haigh, 2010).

Rather than staff training or acquiring new skills the key to the successful implementation of PIE is reflective practice, that is, shared and thoughtful learning from experience (Johnson and Haigh, 2010). Johnson and Haigh (2010) identify three key advantages to reflective practice. Firstly, it encourages staff recognition of customer's difficulties which in turn promotes a sense among customers of being listened to. Secondly, it helps staff to deal with the emotional challenges of their work thereby reducing anxiety. Thirdly, staff can learn from each other's knowledge and experience by promoting staff discussion and constructive feedback.

This process then facilitates staff development that ensures that contact between staff and customers is therapeutic; this does not suggest that every staff member acts as therapist, but that interactions are intended to foster growth and change thereby maximising positive customer impacts and also supporting an effective and safe work environment. The move to a Psychologically Informed Environment is marked by a paradigm shift in the way that staff think of, and discuss their service and interactions with customers to one where discourse is couched in terms of the emotional and psychological needs of the customers.

Reflective practice in this instance typically involves staff meeting in small groups that are generally facilitated by an individual with training in a psychotherapeutic model. In the case of Focus Ireland's Therapeutic Service, the Counselling Psychologist and Play Therapist have been the facilitators.

The results of a questionnaire survey conducted by the Counselling Psychologist among staff at Aylward Green are presented in this section. The questionnaire, which is provided in Appendix 3, was developed by the Counselling Psychologist based on the Enabling Environments Service Self-Assessment Tool, with a view to capturing change in the opinions of staff which are attributable to the introduction of PIE. The questionnaire was completed anonymously by staff from Aylward Green at the beginning of the Therapeutic Services pilot period (July 2012) and again twelve months later (July / August 2013). The completed questionnaires were provided to the evaluator for collation.

The questionnaire captured information on ten domains:

- Belonging – the nature and quality of relationships are of primary importance (four items);
- Boundaries – there are expectations of behaviour and processes (three items);
- Communication – it is recognised that people communicate in different ways (four items);
- Development – there are opportunities to be spontaneous and try new things (three items);
- Involvement – residents and staff share responsibility for the environment (four items);
- Containment – support is available for both residents and staff (four items);
- Structure – engagement and purposeful activity is actively encouraged (three items);
- Empowerment – power and authority are open to discussion (three items);
- Leadership – leadership takes responsibility for the environment being enabling (four items);
- Openness – external relationships are sought (three items).

Responses to all items were recorded on a ten-point scale, with higher scores indicating agreement with positive statements. For interpretation of the results reported below, higher scores reflected positive attitudes. The questionnaire was completed fully by 30 respondents, 15 at the beginning of the pilot period and 15 at the end. Fourteen of the 15 respondents at both time points worked directly with customers while the other respondent was a service support worker. Due to the information being anonymous, it was not possible to match specific respondent responses from the first and second wave of data collection.

As shown in Figure 11, at the first wave of data collection, both 'boundaries' which consisted of three questions about the clarity and ability to review expectations of both staff and residents behaviour; and 'structure' which referred to engagement and purposeful activity within Aylward Green were scored the lowest (mean=3.6). Respondents rated 'containment' the highest with a mean score of 6.4 out of a maximum of ten. Containment was operationalised here to refer to emotional and professional support for both staff and

residents. At the second wave of data collection in July / August 2013, 'containment' was again the highest rated domain with a mean score of 7.4. 'Structure' remained the lowest rated feature, although it should be noted that it had improved during the pilot period from a mean score of 3.6 to 5.7.

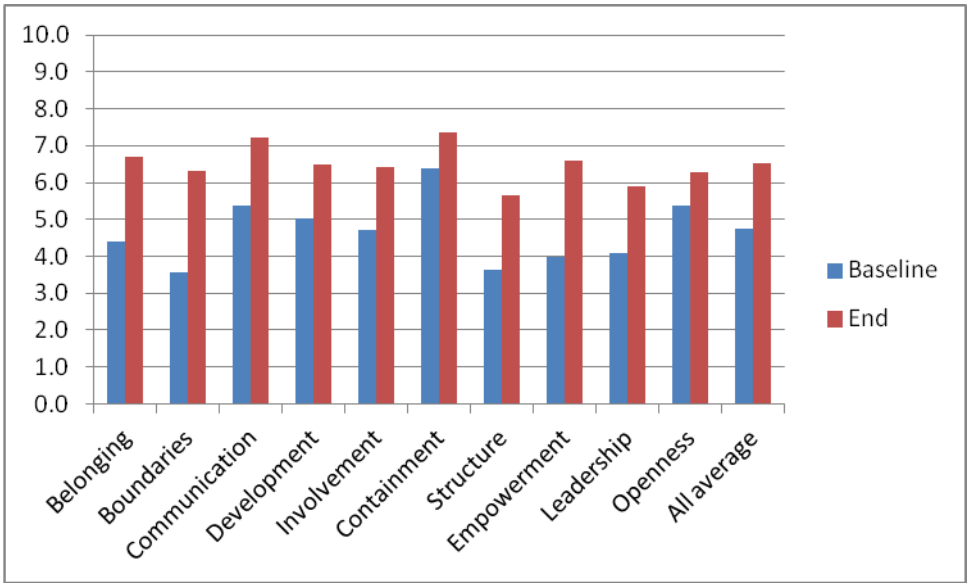

Figure 11 Mean scores on each PIE domain, and mean overall score of PIE questionnaire

At the beginning of the pilot period the overall mean score was 4.7, and this increased by 68% to 6.5. As shown in Figure 11, an increase was observed in the mean scores of each of the domains during the pilot period. The greatest increase was observed in attitudes towards 'boundaries' within the service, with an increase in mean scores of 2.8. The smallest change was observed in attitudes to 'openness' which referred to external relationships. For this domain there was a 0.9 increase in mean scores from an initial score of 5.4 to an end score of 6.3.

6.1 Qualitative responses to PIE questionnaire

As well as the quantitative questionnaire items, participants were provided with the opportunity to comment further on specific questions, both before and after the initial implementation of PIE. This qualitative information was collated and the main themes arising under each of the ten domains are discussed below.

In terms of **belonging,** many staff members commented that there was little encouragement for new customers to Aylward Green to get involved with other customers. In many cases, new customers were actively advised to *"keep away from each other"*. However, there was

general agreement that newcomers to the service were encouraged to seek support from staff. Outside of occasional residents meetings and formal contact between staff and residents, many participants commented that there were few opportunities for staff and residents to develop relationships. The lack of a sense of community referred to by a number of staff members was reflected in the absence of any formal or informal means of marking families moving on from Aylward Green.

Twelve months after the initial questionnaire, respondents stated that there were more opportunities available to promote a sense of belonging among both staff and residents. Specifically, the introduction of new short courses and regular coffee mornings as part of the implementation of the PIE framework were cited as particularly valuable.

> *"By having regular coffee mornings and training on site, residents and staff have time to get to know one another in a more relaxed environment".*

> *"Though some of these opportunities have not always been availed of, I believe that they are more beneficial and wholesome ways to meet and interact, rather than sitting in neighbours houses for hours on end".*

These increased opportunities for staff and residents to interact outside of formal key working was viewed by many as greatly improving the environment and the relationships within it:

> *"As our relationships have improved with our residents, I feel that an environment of solidarity and encouragement is developing between our residents. Through observation it can be seen that our residents reach out to newcomers and help them settle into the community".*

When children move on from the service, their leaving is marked by presenting them with a card. Although families often leave the service with little notice and in a rushed manner, which limits opportunities to mark their leaving, there has been a marked improvement in this area. Compared to the initial comments provided before the implementation of the PIE framework, there was a noticeable change in the significance placed on this aspect of the service with many commenting on the importance of marking the occasion of residents leaving the service:

> *"On the morning of people leaving, staff and residents are invited to the café area for tea to mark the leaving. Marking someone leaving is as important as assisting them to settle in when they first arrive".*

More generally, there was a greater sense reported that staff and residents were learning about building relationships:

> *"I believe that staff and residents are learning about building relationships as it is the core of our everyday interaction with one another. Staff using their skills and shared reflective practice for building good rapport with residents works really well".*

The second domain on which information was collected as part of the PIE questionnaire concerned **boundaries**. This refers to the maintenance and review of expectations of behaviour and processes. Although it was reported that expectations were communicated to residents, in general it was felt that there was a lack of clarity regarding how these expectations were to be maintained. Difficulties arising from this were exacerbated by an inconsistent implementation of expectations.

> *"Inconsistent processes have led to poor behaviour in clients and continued lack of respect to staff. Policies and procedures need to be updated".*

> *"There is inconsistent application of behaviour management and sanctions."*

Outside of review meetings it was also felt that there was no open process whereby both staff and residents could review expectations.

There was evidence provided that this aspect of the service had also improved over the course of the 12 months pilot period. There was now a more formal method to review residents' expectations on an on-going basis. Comments from staff also demonstrated a greater awareness of perspective of residents with regard to maintaining and implementing expectations. Again, the change in the language used by staff in discussing expectations was noteworthy. The following comments were typical of the manner in which staff and resident's expectations were now discussed:

> *"From doing the staff training I see that the relationships between staff and residents have an impact on their behaviour. Residents know that if something negative happens we will not just automatically ask them to leave. We will meet and discuss the issue. This is an essential part of the recovery process".*

> *"Attachment theory has also deepened our understanding of the way in which, for better or worse, customers do not always easily change the ways in which they view others and their expectations of relationships".*

Regarding **communication**, there was evidence provided that both residents and staff were supported in communicating effectively:

> *"Staff members seem genuinely open to communicating ideas and concerns. Residents also have always given me the opportunity to communicate with them and I feel that I do the same in turn".*

When asked if staff and residents recognised that how people act is a form of communication, the consensus was that staff did but residents did not. It was also noticeable that when asked about the 'variety of ways to communicate', respondents spoke predominantly of physical methods of communication such as verbal, face-to-face, and role play. By the end of the pilot period, the language used by respondents when commenting on communication had changed dramatically. Rather than limiting their comments to physical methods of communication, the discourse was broadened to include other methods of communication. This demonstrated a clear improvement in staff's awareness that the way people act is itself a form of communication:

> *"Non-verbal techniques, such as nods of the head, eye contact, and proximity are used between staff and residents".*

Greater opportunities for reflective practice introduced as part of the implementation of the PIE framework was consistently referred to across all domains on which information was collected. It was seen as 'crucial' to providing opportunities for both staff and residents to discuss the feelings behind the way people act. A number of respondents specifically referred to PIE as lead to a marked improvement in their understanding of the importance of communication:

> *"Since commencing the PIE training I have become more aware of my communication with clients. I am aware that every interaction with a client is a form of intervention. I feel that from talking to residents, they too are aware that their actions are a form of communication".*

Information was captured on two aspects of both staff and resident **development** and their understanding of risk and risky behaviour. Firstly, participants were asked their opinion of management support for spontaneity and whether or not there was scope for staff and residents to try new things. In general it was reported that staff were supported by management in trying new things, but that attempts to do so were constrained by existing policies, procedures, and financial and time constraints. There was no consensus regarding opportunities for residents to try new things, with some staff members reporting that

residents were encouraged and supported in doing so, while others reported that this was not the case.

It was felt that staff had a good understanding of risk and risky behaviour and that this was communicated to residents through key working. However, a number of staff commented that while residents had some understanding of risky behaviour they often did not have the tools required to alter their behaviours:

> *"Residents are supported in this. They may be aware that a behaviour is risky but may be unable to stop or discontinue the behaviour".*

Evidence was provided for a greater degree of spontaneity and opportunities to try new things during the pilot period. Examples of this included an ice cream party, the marking of International Women's Day, and the establishment of a football team. These types of activity have improved staff and resident engagement within the service:

> *"Alongside the room for spontaneity is an element of fun and laughter that did not exist before. Staff and residents are observed to be much more at ease with each other and enjoy each other's company".*

With regard to risk and risky behaviour, many of the respondents commented how this aspect of the service had also improved through the implementation of the PIE framework:

> *"Understanding of risky behaviour has improved a lot in the last few months. Reduce the use and other such courses are an opportunity for residents to explore risky behaviour with each other. Education is the key, even if it is in the form of a two hour talk given by someone from outside".*

The next section contained a number of questions on staff and resident **involvement** within the environment of Aylward Green. The roles and responsibilities of staff within the service were clearly defined, which meant that there was not much variation in the roles or responsibilities. The majority of respondents reported that residents had little or no role or responsibilities within the environment. Among the reasons given for this was residents not wishing to be more involved; a lack of encouragement or empowerment by staff; and health and safety constraints sometimes being a barrier to residents taking a more proactive role in the environment.

There was evidence provided of residents playing an active role in their own development through key working, although it was noted by some that this process was not collaborative enough. Although staff were reported to contribute to the positive development of others,

residents were believed to make no contribution and as noted earlier were oftentimes encouraged to *"keep themselves to themselves"*.

Also, while there was some evidence of staff involvement in decisions about the environment, this was not the case for residents:

> *"Staff are constantly asked for input and advice, however, residents need to become more active in this process. Staff need to encourage this with regular updates and feedback required".*

Since the implementation of the PIE framework there has been a marked change in the perspectives of staff on their roles. Whereas before the pilot period, staff consistently reported their responsibilities as limited within clearly defined roles, there now appears to be far greater variety in their responsibilities:

> *"For staff I feel that our roles have changed in a positive way over the past year. We now work with our residents with the view of each person being a member of a family unit. Our roles are specific but we work with the family as a whole. Many staff members have become involved in different aspects of the service that they may not have before".*

Although, a number of participants commented that the responsibilities of residents remained largely limited to their home, there was some evidence provided to support the view that residents' contributions had also improved:

> *"Through customer participation, residents have begun to play a part in our service provision – family trips, group work, sharing knowledge and experience".*

> *"Through our PIE training it was agreed that both staff and residents are involved in making decisions about the new plans and the on-going development of the service".*

The next domain was **containment** wherein respondents were asked for their opinion on the supports available to both staff and residents. There was an acceptance that both staff and residents could feel vulnerable. Residents received strong emotional support from staff and while there was strong peer support for members of staff, supervision was reported to be inconsistent. This was echoed in the opinions voiced on reflective supervision with many reporting that this was not as consistent as required.

Commenting on reflective supervision, one respondent noted that it happens:

> *"In individual cases but is not necessarily the norm. Staff voice frustration with regard to their needs and concerns being met".*

Many of the respondents attributed an improvement in the availability and consistency of support which they experienced in the service.

> *"Since starting the PIE training, I feel I have become more open with expressing my vulnerability in relation to my work. I also feel that management are more understanding to our need for support".*

Reflective practice and greater peer support were identified by many as key drivers of this improvement:

> *"We support each other through this [reflective practice] and listen to each other's issues that may be affecting our work".*

> *"Peer support is recognised, valued, and encouraged because it improves development for all and can create new ways to practice for a fast changing environment which at times can be quite demanding. By peer support being recognised, valued and supported, I believe it boosts my morale".*

The next aspect of the Psychologically Informed Environment was on **structure**, which refers to the degree to which engagement and purposeful activity is actively encouraged. Childcare was the only aspect of the service where a consistent daily routine was reported to exist. With regard to the daily routine within the environment more generally, it was felt that this was inconsistent:

> *"Although there are certain tasks that I must complete every day, the nature of my work means that each day is different and I don't know until the day what my workload will be".*

However, the absence of a daily structure was not considered problematic and there was an acceptance that this was due to the nature of the work being carried out:

> *"Daily routines are as structured as they can be but due to the nature of the work, things can change quite quickly and routines are impacted".*

It was also noted that there were few opportunities for both staff and residents to formally meet as a group and this was coupled with a lack of spontaneous activities that involved both staff and residents.

The consistent nature of the children's daily routine was again commented on at the end of the 12 month pilot period. However, with the exception of coffee mornings there was little change recognised with regard to the absence of daily routines for adults. Similarly, while there were some examples provided of spontaneous activities that involved both residents and staff, these opportunities remained infrequent.

In terms of **empowerment**, it was reported that staff in particular could challenge decisions and promote their own ideas. In the main, staff meetings were identified as the suitable forum for this. While residents were also encouraged to challenge decisions, it was felt that there was a degree of apathy among residents and that they did not have the necessary skills to do this in a constructive manner. In cases where ideas were voiced by staff and residents, it was felt that these ideas were seldom implemented with limited resources cited as a barrier.

Again, this was an area where PIE was commended as having led to a noticeable improvement. Many staff reported that communication between management and staff had improved and this had led to staff feeling that they were more involved in the decision-making process.

> *"I feel that in recent months this is an element of practice that has greatly improved for the staff team. Through more effective communication between management and staff, a more secure working environment has been created".*

Customers were also observed to be more empowered within the service and resident's ideas were actively being sought, as part of PIE, about new developments in the project. Overall, the empowerment expressed by staff and observed in residents was noted to have improved significantly as a result of the implementation of the PIE framework.

> *"I also think that as our relationships with our residents have improved they also feel more empowered and encouraged to challenge decisions and ask questions. I think there is a greater respect for all residents and their opinions".*

There was some criticism voiced of **leadership** within the service. Many respondents commented how the management structures were unclear and there was a need for better communication from those in authority to both staff and residents. This was also reflected in

the widely held opinion that those in positions of leadership were not active participants in the life of the community:

> *"Upper management seem to be removed from residents but available to staff".*

> *"Reviews and meetings are attended [by management] but they should be more available to residents".*

It was also noted by a number of respondents that the environment was not always the right place for the people within it, with substance abuse a particular problem:

> *"Aylward Green is meant to be a drug and alcohol free zone. Many residents appear intoxicated on a daily basis. Therefore, this project is not right for them. Clearer requirements for residents need to be put in place".*

Opinions provided on leadership at the end of the 12 month pilot period were mixed, with only some respondents noting an improvement. Unlike the responses provided under the other domain headings, there was a noticeable absence of references to the PIE framework and reflective practice. In general, participants reported that management structures were clear and that there were opportunities for staff to take on leadership roles. However, these opportunities did not extend to customers with many commenting that there remained little interaction between residents and management.

Difficulties also persisted with regard to the suitability of the service for some residents, particularly those engaging in drug and alcohol abuse. The following was typical of the contribution of a number of participants on this issue:

> *"At times this has not been the right environment for people. However, people are never refused from being admitted to the project even when they are vulnerable to the environment. Residents have expressed to staff that the environment can be extremely difficult for those who are using substances."*

The final domain on which respondents were asked to comment was **openness**, which referred to the degree to which external relationships were sought. Many respondents reported that the environment was welcoming to visits from external professionals. However, a large majority of respondents commented that the physical environment was unwelcoming and that residents were not allowed any visitors.

> *"Reception staff are extremely friendly and most staff people would meet are pleasant. The physical environment is extremely unfriendly".*

"The iron gates outside are off-putting to visitors. There is no provision at all for visitors [to residents]".

It was also stated that both staff and residents were encouraged to participate in activities outside of the environment but that opportunities to do so were limited due to a lack of resources. Importantly for the implementation of the PIE framework, it was generally agreed that both staff and residents were very open and responsive to evaluation and learning.

The policy of not permitting residents to receive visitors in the complex remained in place. This was commented upon by almost all of the respondents and was viewed by many as being difficult for some residents. However, there was also general acceptance of this among staff given the nature of the project:

"The environment is not open to visitors, but I feel this is acceptable as this project deals with families that are in crisis, which can be difficult. I feel many residents would not want to have the added stress of having unwanted visitors and strangers witnessing this."

Both residents and staff continued to be encouraged to participate in activities outside the environment, with evidence of staff being more involved in local services related to the project. Activities for residents also continued to be encouraged and supported with a view to their *"using their time in a positive manner".* Examples of the type of activities taken up by residents included: gym membership, 'football for Focus', summer trips, and family days in the local community for parents and children.

Finally under the openness domain, there was strong support for the view that everyone in the project was open and responsive to evaluation and learning. Reflective practice was viewed by many as an important aspect of this with the use of the Outcomes Star Framework[3] among residents also noted as a positive development:

"All staff members are taking part in reflective practice which is a time for us to get constructive criticism and support from our colleagues. This is also received in supervision. Residents take part in their own evaluation and learning in the Outcome Star process and review meetings."

[3] Information on Outcomes Star Framework can be found at: www.outcomesstar.org.uk

6.2 Conclusion

The results of this survey questionnaire suggest that staff felt that there had been an improvement in the degree to which Aylward Green constituted a Psychological Informed Environment. There was an improvement observed both overall and for each of the ten domains on which quantitative survey questionnaire data was collected. As noted earlier, the PIE framework does not lend itself to easy measurement, and to gauge its successful implementation or otherwise requires a softer qualitative approach be taken. With this in mind the comments provided by participants when completing the questionnaire were also assessed.

The most noteworthy change from the pre- to post-evaluation period from the perspective of participants was the transformation in the type of language used. At the end of the pilot period, respondents were far more likely to refer to their work and customers in a therapeutic manner, using terms such as ‘boundaries, ‘people-centred’, ‘coping skills’, ‘crisis’, and ‘trauma’. This shift in the frame of reference used by staff provides clear evidence of PIE having led to a paradigm shift in the way that staff discussed the service and interactions with customers to one where discourse is couched in terms of the emotional and psychological needs of the customers.

It was also clear from the information provided that staff did not view the implementation of PIE as prescriptive or being enforced on them. Instead they viewed the knowledge they acquired under this framework as coming about due to a greater sense of being listened to and an increased sharing of knowledge between staff. The main driver of this was reflective practice. It is this particular aspect which respondents highlighted consistently as fostering the development of a Psychologically Informed Environment.

7. Consultations

This section considers the results of the consultative process which was undertaken as part of the evaluation. Focus groups were held with five members of the Focus Ireland Management Team; the three therapists from the Therapeutic Team; two Focus Ireland Child Support Workers; and three Focus Ireland Case Managers. Five Focus Ireland customers; and four stakeholders external to Focus Ireland who had some knowledge and interaction with the Therapeutic Service were also interviewed individually. The aim of the consultation process was to get the subjective opinions of a broad range of individuals who could offer a variety of perspectives. Secondly, the information from this process complemented the more objective measurements used to gauge the clinical and organisational impact of the service during the pilot period.

Establishing the Therapeutic Service

Focus Ireland is committed to supporting families and preventing children from experiencing homelessness, and recognises that the support model the organisation operated was not best suited to adequately addressing the myriad of complex behaviours associated with familial homelessness. Due to the increasing complexity of needs among customers presenting to Focus Ireland, coupled with difficulties in accessing auxiliary or complementary services that would support Focus Ireland in achieving its goals for customers, Focus Ireland management decided to establish their own pilot service. At a policy level this decision was also hastened by the publication of the *Pathway to Home* model that stipulated that households experiencing homelessness should not remain in homeless services for more than six months (Homeless Agency, 2009):

Having identified the need for a Therapeutic Service, Focus Ireland management then had to decide what form the services would take. This involved a period of reflection within Focus Ireland whereby the main challenges the service was required to address were identified. As stated by the management team:

> *"The plan was an upward level of intervention. There was the services that they [the Therapist Team] could provide directly themselves, and an add-on was also a level of consultancy they could offer staff in terms of having a much deeper impact themselves, even in terms of understanding behaviour in terms of developing strategies".*

It was acknowledged that the Therapeutic Service also provided an opportunity for Focus Ireland to continue their efforts to support families experiencing homelessness.

> *"There was a real commitment to our experience, our knowledge, our need to support families and to try and prevent children experiencing homelessness for long periods of time".*

It was also apparent that staff working in Focus Ireland services recognised the need to complement the work already being carried out with new approaches to deal with, for example, difficult behaviours they were encountering among children. This had prompted one member of staff to train in Play Therapy. Focus Ireland project staff also recognised the need for such a service. As one project worker stated:

> *"I think it is something the organisation has been looking for years really, in terms of direct access to specialised services especially for children and adults going through homelessness and I think one of the main barriers for people going through homelessness is that lack of services. Free and readily available and ready to hand services, you know, not getting waiting lists or time or location constraints which are big issues of the homeless community".*

Similarly, external stakeholders who had interacted with the service had also recognised that there was a need for Therapeutic support for families in homelessness which had been lacking and with the few existing services difficult to access.

> *"So what you have are clients who need really good high quality psychological services and in truth without the provision of those services it is hard for me to imagine how any other intervention can be effective around housing or stabilising people's lives. It is astonishing to me that it has taken us this long to establish posts like these in services like this because it is such an essential part of the jigsaw".*

Focus Ireland management, supported by the Health Service Executive's Director of Psychology, developed a competency framework on the basis of therapeutic best practise with the view to integrating the Therapeutic Service into existing social care systems and practises. As part of the implementation process, Service Managers and Project Workers were consulted at team meetings in order to input into how the Therapeutic Service might be utilised to achieve the greatest impact, and also how the Therapeutic Team would be incorporated into existing teams and structures to begin therapeutic work straight away. Changes in practice necessitated by the introduction of the Therapeutic Service were also discussed. For example, whereas information about Focus Ireland customers is shared

between staff and management, the need for customer confidentiality and other ethical considerations specific to the Therapeutic Service were communicated. Focus Ireland management also provided details of the objectives and limitations of the evaluation of the pilot project, and a working group was established to assist in achieving shared objectives.

All Focus Ireland staff consulted as part of this evaluation stated that they were excited by the prospect of having an in-house Therapeutic Service available to them. In particular, staff from Aylward Green were:

> "*Excited at the prospect that they would have specific insight into the specific issues with homeless kids and homeless adults*".

Despite the consultation process carried out, some staff from the Youth and Aftercare services reported that they were not informed adequately of the objectives of the Therapeutic Service and were somewhat unclear of the role of the Therapeutic Team and which services were to be made available to them.

When the Therapeutic Team was put in place, staff from the Youth and Aftercare services had most direct dealings with the Behavioural Specialist however they also expected to have access to the Counselling Psychology service. This was something they had identified an increased need for due to an upsurge in the number of customers presenting with mental health issues which necessitates assessment and treatment if they are to successfully exit homelessness.

The inclusion criteria established for the pilot project identified Aylward Green as the priority service for the Counselling Psychologist. Staff from the Youth and Aftercare services stated that they understood there were necessary limits on the capacity of the Counselling Psychologist to be available to a number of services within Focus Ireland. However, they did find the experience *"frustrating",* as despite the clear inclusion criteria they were still under the impression that they could refer their customers to the Counselling Psychologist. This experience led them to continue the practice of referring customers to external services which:

> *"Is sad and confusing that we can't use our own internal resources. You would kind of hope that you could even use the Therapeutic Team to be stronger advocates for someone".*

The Therapeutic Team were also aware that there was a sense among some Focus Ireland services that the Therapeutic Service would be available to them, an aspiration the team

agreed was *"unrealistic"* logistically. The Therapeutic Team attended staff meetings in Aylward Green and the National Family Case Management service, and they were aware of a lot of enthusiasm for the service. However, there was a need for better management of expectations as it was not possible to balance so many demands, both clinical and consultative, among only three therapists.

In order to ensure a holistic assessment, support plan, and interventions, the Therapeutic Team needed to merge with existing services, practises and standards within Focus Ireland. In achieving this, both the Play Therapist and Counselling Psychologist found that *"fitting in"* to the service was relatively easy. In part, this was because they were already known to the staff and because there was a great deal of immediate staff buy-in, particularly around reflective practice. Also, Aylward Green in particular had greater experience of a multi-disciplinary approach to addressing the needs of families experiencing homelessness.

Getting established within the Youth and Aftercare services was more problematic for the Behavioural Specialist, with staff reporting poor levels of awareness of the specific role of the Behavioural Specialist and the benefits that this type of intervention might bring to their service. The type of service provided by the Youth and Aftercare services, coupled with a less structured type of engagement with customers, also made it difficult for the Behavioural Specialist service to establish itself in that setting.

<u>The referral process</u>

Initially it was decided that staff would complete a team referral form and submit this to a central email address to be reviewed by the Therapeutic Team every second Friday with a view to assigning a particular therapist to the customer. However, this process did not work and now referrals are made directly to the therapist. The initial process was implemented as the team thought that there would be more overlap in their customers and while a child assessment by the Play Therapist has sometimes morphed into a family assessment, in most cases it is clear to whom the customer should be referred particularly given the distinct age profile of customers with whom the therapists engage with. The need for this method of initial referral has now been largely negated by the fact that all families entering Aylward Green are now assessed soon after arrival and a decision is made as to what is the most suitable form of engagement for them. In cases were referrals are made by staff the Therapeutic Team recognise the need for greater education and awareness of what information is required about customers in order for them to make an informed decision.

Staff were keen to complement the Therapeutic Team on their responsiveness to referrals and were appreciative of the speed in which acknowledgements were received. However, there was some confusion as to the remit of the Behavioural Specialist and which customers they might refer to them. Also for staff working with children there was some confusion as to whether or not children could be referred to them:

> *"Their sense was around behavioural and emotional issues and that's why we would most refer to the Play Therapist. There is some confusion as to who we would refer to the Behaviour Therapist. Because we are aware that the play therapy stops at 12, so it's just that gap between 12 and 16. There is definitely some confusion about the Behavioural Therapist".*

Customers reported finding it easy and straight forward to make a referral to the service and applauded the assistance of project workers in arranging referrals. Of the external stakeholders who were involved with families and in particular with regard to children, all also reported that securing a referral was straight forward while also emphasising the central role that Focus Ireland key workers played in this process.

The only negative feature of the referral process commented on was in terms of the documentation required and the time needed to complete an initial assessment form. This is not so much an issue now for customers living in Aylward Green, as family assessments are conducted routinely.

Customer engagement

As most of the Focus Ireland customers interviewed for this evaluation were still engaging with the Therapeutic Service, consultations were intentionally limited in their scope. This was agreed in order to eliminate the risk of consultations impacting in any way on the therapeutic process. It was also necessary to ensure customer anonymity and the confidentiality of information provided by them.

Of the five customers consulted as part of this evaluation, two were referred to the Counselling Psychologist by their key worker; a key worker also referred another customer to the Counselling Psychologist while two of her young children were referred to the Play Therapist; and two customers who were partners had children who were engaged with the Play Therapist, and it was through this relationship that the family was also introduced to the Counselling Psychologist and Behavioural Specialist. This last case is a good example of the ability of the Therapeutic Team to engage with an entire family to better address the complex interplay of difficulties. A number of themes emerged from the consultations with customers.

Trust brought about by consistency and continuity

More than one customer stated that they found it beneficial to have a therapeutic relationship with the same therapist throughout their engagement. A number of the customers had poor experiences of previous therapy, which they felt was at least in part due to regularly changing therapists which involved constantly trying to develop new trusting relationships. As one customer stated:

> *"The counsellors up in [local Health Centre] there, they come and go. You don't know who you're talking to one week to another.... just couldn't click".*

An external stakeholder who had referred children to the Play Therapist also commented on the consistency of the service with regard to both the therapist and the children:

> *"And once it started it was very consistent, [Play Therapist] was there when she was supposed to be and the kids knew that and it was something that became a special time for them and I think both boys pretty much consistently attended".*

They also saw the benefits for children in having access to a child specific service, something just for them:

> *"Having a Therapeutic Service is going to be invaluable and I think having something like play therapy which is non-directive and you know is at the child's pace is the way to go because by their very nature I think a lot of the parents are going to be mistrustful and you know we do see a lot of kids reluctant to engage in something directive or answer questions. You know, they are suspicious of services because their parents are, that would be my experience anyway".*

A holistic approach

A major strength of the service that was consistently referred to by customers was its holistic approach whereby the whole person was central to the issue as opposed to therapy limiting itself to any one particular difficulty:

> *"That's the thing. I was going to a drugs counsellor before but he was just talking about me drugs addiction, wasn't everything. With [Counselling Psychologist] it's just everything. Just not one thing you're talking about".*

> *"You can talk to [Counselling Psychologist] about anything and everything".*

This holistic approach was also apparent in the whole-family approach taken by the Therapeutic Team, which saw them intervene with both parents and children in many cases. This view was echoed by the families interviewed who had engaged with all three therapists. These families felt that they were being dealt with as a whole family for the first time. For them this meant that improvements in one family member were not being undone by other family members' difficulties or behavioural problems.

Coping skills

Among adult customers, a recurring theme was that they felt their engagement with the service was providing them with the skills necessary to cope with everyday life and problems they encountered.

> *"I'm learning to deal with me grief, something I could never even talk about".*

Customers also noted how others had seen the positive influence that therapy was having on them:

> *"Even one of me sister-in-law says to me, 'Are you still seeing the counsellor?' and she says 'you'd know by the way you're carrying yourself'. Cause other times I'd just fall to pieces".*

As noted earlier, the adults in some families engaged with the Counselling Psychologist while their children also attended play therapy. The positive impact this had on the children was discussed, with one parent reporting that:

> *"They [two children] love going to the Play Therapist and playing. The teachers have noticed their behaviour has improved an awful lot. Before the other one wouldn't talk to the teachers. She'd shy away, but now she's talking a lot more. And she would never answer questions in school, now she's putting her hand up and chatting to the teacher and problem solving".*

This improvement in the children was complemented by improved coping skills among the parents.

> *"Before when the kids would start messing you'd get frustrated 'cause they're not doing what they're told and that but when you go to [Counselling Psychologist] he eases your mind like, he puts it into perspective what you should do with the kids and all that. How you should talk to them. Not to be shouting and all that, to go down to*

their level and talk to them. 'Cause before I used come out with awful headaches from stress and that but now I'm not as stressed. So it is good".

One family interviewed were particularly complementary of the impact that the Behavioural Specialist had on both of their children's behaviour and their own parenting skills, particularly in enabling them to set boundaries for their children and for the children in turn to accept and abide by those boundaries.

Children's engagement

A number of the children of the customers interviewed also attended the Play Therapist. The reasons understood by their parents as to why they were referred to the Play Therapist included: behavioural difficulties, communication problems, emotional difficulties, low self-esteem, and anger. All the parents had noted considerable improvements in their children, with two noting how teachers from the children's school had also commented on the positive change in their behaviour and outlook. The whole-family approach taken by the Therapeutic Service also resulted in better communication within the family, with noticeably less shouting and a stronger parent-child bond reported. Other important improvements identified in a number of the children were greater *"self-esteem"* and *"confidence"*.

The Play Therapist was also commended for maintaining engagement even when families moved from Aylward Green. While this helped to maintain the consistency of the therapeutic relationship, it also caused some logistical problems which is discussed further on the section on capacity. A children support workers commented on the lasting impact play therapy had on the children:

"...space to be a child and have the opportunity to you know play and stuff like that. It is their space with the Play Therapist to act out and kind work with their behavioural and emotional problems so that definitely does carry when they do move in to their apartment or house or whatever".

While another commented:

"I would see a huge difference in the kids in our own after schools here and in our home visits. I don't know, their self-esteem, their confidence, they are just like different children really".

Role of case managers and key workers

The role of case managers in enabling the therapist-customer relationship to strive is hugely important. On a practical level case managers and key workers have the vital role of being the access point for families to the Therapeutic Service. While this responsibility is immediately apparent within Aylward Green, it is also an essential link to the service for homeless families engaging with services such as the National Family Case Management service and others. As one external stakeholder highlighted:

> *"So the family would have gotten a key worker and a child support worker from Focus Ireland and then I would have met with the child support worker and we would have been discussing what the children's needs were in the family. One of the recommendations we would have said was that play therapy would have been fantastic. We would have had experience of other Play Therapists coming and kind of doing voluntary work with us so we knew the benefits of it and knew these children needed it. And as it happened that is when the play therapy became available in Focus Ireland".*

The potentially detrimental impact of not having a key worker was raised by one of the external stakeholders who had referred a number of children to the Therapeutic Service:

> *"One of the problems we would find is that a lot of our families don't have key workers so they are on a list for it. Depending on where they are at with that they can't access it. So we have had a couple of kids that would benefit from it but they can't access it through a key worker, so that can kind of slow it up".*

Case managers also play an important clinical role in maintaining the differentiation between therapy and case management. As described by a member of the Therapeutic Team:

> *"I think it is better that the case management process is there....a middle man really helps. Also, it really helps with their attendance. It makes a nice differentiation between a clinical role and a case management role. Early on I was almost case manager which was a mistake. It's incredibly important to have those boundaries in terms of roles. I'm doing therapy where they live so there has to be a line, a time where they aren't in therapy. The case manager is their port of call and you do the therapy".*

The role of the Behavioural Specialist

There were a number of difficulties concerning the role of the behavioural aspect of the Therapeutic Service. There was some initial confusion as to the role of the Behavioural Specialist and how it would fit within existing structures, with the shift system operating within services problematic as there was often little overlap in the times the therapist and key workers were present. For the staff there was also a feeling that there was too much overlap in the work they were doing and that expected of the Behavioural Specialist, a situation which differed greatly from the clearly distinguished roles of case managers and the Therapeutic Service elsewhere. For example, staff spoke of customers commenting on a perceived duplication of roles. Customers were reported to have queried staff on the need to engage with the Behavioural Specialist as well as their existing support workers, with one customer reported to have asked a Project Worker:

> *"Why do I have to link in with [Behaviour Therapist] about it when I have already talked to you about it? I have already done the work with you about it so why am I going back now to repeat myself when I am already saying everything I need to say here".*

While another staff member commented on how this situation had created some confusion for customers of the service.

> *"Even though the guys knew who the manager was and knew who the two case managers were, they couldn't understand why the therapist was having this say in how the service was going to be run and what they were allowed to have, and they got confused by that and you know I think they stopped engaging".*

Many of the difficulties encountered were attributed to a poor match between the behavioural approach and the setting, and this was communicated by a number of staff. The Focus Ireland management team also acknowledged that there had been difficulties regarding the role of the Behavioural Specialist in Cheid Cheim, where it was recognised that there may be a "clash of culture" between the analytic behavioural approach and the focus of the service on supporting independent living among young adults who are often times transitioning from care. This raises the question of whether the ABA approach to behaviour modification represents a suitable framework to employ among this particular cohort.

There were also structural factors that exacerbated this. While referrals to the Play Therapist and Counselling Psychologist were amenable to structured appointments, this was not the case within the Aftercare service in Cheid Cheim, particularly as the nature of the key

support work carried out meant that it was more reactive in nature. This did not lend itself well to a more structured and analytic behavioural approach.

> *"If something was going on for someone they would come in and we would spend an hour with them either singularly or together and we would work through a thing and then, as [co-worker] said, if someone had a crisis it was dealt with there and then because we were both trained in that area and we would talk them through it".*

This was less of an issue when the work of the Behavioural Specialist moved to George's Hill and the focus of the work carried out adapted to addressing basic living skills such cooking skills, personal hygiene, and opening bank accounts.

The Behavioural Specialist and staff suggested that there could be an expanded role for the Behavioural Specialist in terms of organisational behavioural management, which the therapist is trained in. For example, one member of staff commented how a behavioural perspective might benefit the way their team operated:

> *"I think there is probably room for almost a behaviour analyst piece of research to go in to teams. The team does this, this is what happens, here is the pattern, and I think that it would be useful to talk about it and I would love that from that service [provided by the Behavioural Specialist]".*

Capacity

While the Play Therapist was commended by parents, support workers, and external stakeholders for engaging with children off-site, this created some difficulty with regard to capacity and was an issue referred to by the Therapeutic Team, other Focus Ireland staff, and external stakeholders. For example one external stakeholder stated that:

> *"I don't see [the Play Therapist] being able to reach all of the kids that need it. Like, it is brilliant that she is out there and she is doing it but I don't think she is going to be able to make it stretch".*

There is also a need to be cognisant of the impact that travelling off-site has on the ability of the Therapeutic Team to manage the high volume of assessments, therapeutic intervention, and staff consultations. This is a particular issue for the Play Therapist who, as already noted, quite often travels to sites outside of Aylward Green to provide therapy to children. Another issue specific to the Play Therapist is the need for better resources to allow for adequate equipment and maintain the physical space needed to perform the interventions.

Focus Ireland provided clinical supervision for the Therapeutic Team and has an established education policy whereby staff can avail of education and training opportunities. This policy recognises the need for continuing professional development and commits to the provision of education opportunities which are relevant to the organisational needs of Focus Ireland and to the benefit of its employees. Despite this, the members of the Therapeutic Team stated that more resources were necessary for them to avail of adequate clinical supervision. This was also the case with regard to the necessity for them to maintain their required level of Continuing Professional Development. This highlights the need for greater awareness among Focus Ireland management of the professional development requirements of specific therapeutic disciplines. Addressing this and allowing for how it might impact on their capacity to engage with customers will benefit the Therapeutic Team, and ultimately the customers they engage with and the wider Focus Ireland community.

Finally it must be noted that the Therapeutic Team have proven very adaptable throughout the pilot period and have made numerous changes since beginning the service. The Therapeutic Team was in agreement that:

> "*It is a very different service now than it was conceived of 12 months ago".*

Referring staff were also cognisant of the willingness of the team to adapt processes and structures in order to improve the service:

> *"Wanted to offer a service where it could be as flexible as possible and I think he [the Counselling Psychologist] realised after a while that it wasn't going to work with people dropping appointments, not showing up, so [he] had to make it a little more structured. So I think the way he runs it now is [Therapist] has initial meeting and people are given three opportunities to attend. If they miss three they are given a letter or a phone call after each one and then I think it's maybe after the third or fourth one they are sent a letter saying 'look you know maybe you are not ready for it at the moment, please come see me again and re-engage', which a lot of them do you know. So [Therapist] has worked hard on the structure".*

<u>The Psychologically Informed Environment (PIE)</u>

An important aspect of the work of the Therapeutic Service and the Counselling Psychologist in particular involves enabling the introduction of a Psychologically Informed Environment in Aylward Green. While objective evidence was provided earlier to demonstrate the impact this had on staff in Aylward Green, the importance of this aspect of the service was a recurrent theme in discussions with both Focus Ireland management and staff. It is clear

from these consultations that the introduction of PIE has been transformative with a *"huge energy"* emanating from both staff and customers in Aylward Green. The reflective practice aspect of PIE was also commended by a number of staff:

> *"We hadn't been doing it before but it is really good, like it is a really good use of time rather than having our usual team meeting. We bring case studies and we reflect on what was done and what could have been done, stuff that we could bring to team meetings. So it is really beneficial. We have [reflective practice] on a weekly or fortnightly basis, depending on the family, which is really good as well because you can delegate and make sure things are being done, or get advice. So it is just more inclusive or grounded or something".*

Support workers outside of Aylward Green were aware of PIE but felt they did not have a clear understanding of what it involved. They were however very aware of the positive impact it was having on those taking part in it and felt it was something that might benefit other services within the organisation. The potential for PIE to make a real impact on the wider organisation was also commented on by an external stakeholder:

> *"It is the consultation part of this post to Focus Ireland rather than just the psychotherapy service where you really have the scope to really change how things are done".*

While some objective evidence for the support of PIE has been provided, it is accepted as being a difficult construct to measure. Although a Clinical Supervisor with in-depth knowledge of the framework did suggest a feasible method of measuring the success of PIE to be:

> *"If I was looking for a variable to see if this has worked I would really be looking to see across the board in places where there has been a targeting of a PIE, are staff more able to converse and think in psychological ideas alongside many other ideas as well".*

This certainly seems to be what has been achieved and was a key difference that both Focus Ireland management and staff eluded to without prompting.

> *"We grappled at it for years, and suddenly you now had a lens to look through. Allows all of these dominos to fall into place, where it brought into sharp focus for me 'what is my role in engagement with a customer?' and we talk about behaviours. I think behaviours is one that is out there and we think 'they behave like this'. We change their behaviours without going 'why?' And when you start to view it through the lens of someone who is born into poverty, and you have all these little add-ons, trauma after trauma after trauma, it's to get people into that language".*

Even informally the implementation of PIE appears to have radically altered the culture of the organisations:

> *"It has even changed the conversations at lunch-time and even informally. Formally people meet and do work around case management and care plans. But informally we are having very, sometimes, quite deep conversations, or philosophical conversations that we wouldn't have had, about human behaviour and life, and about how we all interact with each other. Certainly there's a level of sophistication".*

As well as impacting on Focus Ireland staff, the encouragement of PIE has also reaped benefits for the families allowing for greater customer participation within their environment.

A lack of clarity as to whether the Therapeutic Service would be maintained after the pilot period was an obvious stressor for the Therapeutic Team. This potentially had a negative impact on the ability of the team to provide the service to the best possible standards. Aside from personal concerns over whether or not there would be a position for the therapists within Focus Ireland, it also impacted clinically.

Firstly, referrals were still being received by the therapists when they had only a matter of weeks remaining in their employment contracts. This meant that clinical decisions around whether or not to engage a customer were coloured by the knowledge that the therapist may not be there in a matter of weeks. Furthermore, the importance of consistency in the therapist-customer relationship was highlighted earlier as it was a recurrent theme in a number of interviews. Maintaining this consistency requires that the therapist knows that they will be in situ for the duration of the therapeutic engagement. When working with customers who have experienced possibly numerous traumas and in many instances have had negative experiences of a previous therapeutic intervention, it is essential that the

therapist is in a position whereby they know that they will be able to engage the customer for the required length of time. This is a prerequisite to establishing trust in the relationship.

Beyond customer engagement, the lack of clarity regarding the duration of the service also impacted on the Therapeutic Team's ability to respond to requests from staff from other services within Focus Ireland for training, as again they were not able to commit to responsibilities beyond their contract date.

7.1 Conclusions

Aside from difficulties in embedding the Behaviourist Specialist role within the organisation and the uncertainty caused by the absence of a decision as to whether to continue the Therapeutic Service beyond the pilot period, there was an overwhelmingly positive response to the service. The evidence provided in this section complements the positive clinical results reported earlier and clearly demonstrates how staff, customers, and others working within the homeless sector have benefited greatly from its establishment.

8. Financial considerations

Given recent reductions in the availability of State and other sources of funding, the desire for organisations such as Focus Ireland to conduct ‘cost-benefit’ or ‘cost-effectiveness’ analyses of projects like the Therapeutic Service has never been more prevalent. However, to undertake a ‘cost-benefit’ analysis in this evaluation would require that the cost incurred in providing the Therapeutic Service be examined against the hypothetical cost entailed from not providing such a service. Furthermore, the over-arching aim of the Therapeutic Service is to empower individuals and families to exit homelessness and to equip them with the skills necessary to remain out of homelessness.

Given the short timeframe of this evaluation, the long-term benefits of the Therapeutic Service cannot be quantified at this time. Equally, it is not feasible to assign a monetary value on many of the softer outcomes identified in this evaluation, such as improved relationships within families. For these reasons and others, it considered unsound to attempt to assign a cost to intangible outcomes and therefore only the actual financial costs incurred by Focus Ireland in delivering the service are presented in this section.

Focus Ireland provided all the funding for the one-year pilot period of the Therapeutic Service. In total, the service cost Focus Ireland €171,707 for the 12 month period. This consisted of €2,016 for administration costs; €1,903 for programme activities; €31,404 for shared service costs; and the remainder was direct staff costs incurred in employing the three members of the Therapeutic Team.

9. Final conclusions

Although the evaluation period does not allow for a full assessment of whether the Therapeutic Service was successful in reducing the duration of and episodic return to homelessness aspired to in the *Pathway to Home* model, there is little doubt that it has met Focus Ireland's objective to *'support its customers and their children to reach stability'* in their lives. It has achieved this by taking a holistic person-centred, and where appropriate, family-centred approach to address the complex needs of homeless individuals and families who have been exposed to many traumas. In doing so, Focus Ireland has made a significant impact on their customers' functioning and wellbeing. The service has also demonstrated itself to be capable of meeting the considerably varied support needs of homeless families.

The primary aim of the Therapeutic Service was to provide psychotherapeutic intervention, clinical assessment, behaviour modification, and psycho-education to Focus Ireland customers. In providing these interventions it was hoped that customers would be supported in stabilising and improving both psychological and social outcomes in support of social inclusion.

There is a great deal of evidence provided in this evaluation report to support the conclusion that this goal has been met. The Therapeutic Team has achieved the stated aim of ensuring that appropriate referrals, assessment and disengagement processes are conducted and that appropriate interventions are provided. There is an appropriate referral system in place that was adapted from its initial inception so as to better meet the needs of both Focus Ireland staff and customers. The service has also developed within Aylward Green to a point whereby homeless families entering the service are assessed soon after entry. This is now conducted on a routine basis which negates the need for further staff referrals. This approach also means that Therapeutic intervention is more likely to be on a whole-family basis, which has been highlighted as being of great benefit to customers. The referral process from the Youth and Aftercare services to the Behavioural Specialist is not as well defined, and this appears at least in part to be due to a lack of clarity as to the precise role of the Behavioural Specialist among both staff and customers.

The results of clinical assessments and the opinions of the customers also demonstrate that individuals and their families have been empowered both psychological and socially, which no doubt aids social inclusion. Beyond the clinical results reported here, there was also an abundance of enthusiasm for the service expressed by Case Managers and other Focus Ireland staff, external stakeholders, and importantly the customers, many of whom had recommended the service to others.

The secondary aim of the service was to establish a Psychologically Informed Environment which aims to provide sensitivity and clarity of the therapeutic and emotional issues to address the complex needs of customers, and to adapt the services and staff methods of engagement through policy development, training, staff support and development. Again there is ample evidence of this goal having been successfully achieved and the Counselling Psychologist deserves particular praise for his role in this.

Given the duration of the pilot period and the subsequent unavailability of information pertaining to the longer term situation of the families, it is not possible to provide objective evidence of the service successfully supporting customers to exit and remain out of homelessness. However, it is apparent that the clearest way in which the Therapeutic Service improves the chances of families exiting homelessness and maintaining a home is in empowering them to cope with problems that arise. The necessary level of resilience needed to achieve this is not simply an aspiration - a number of customers commented that the Therapeutic intervention has equipped them with the skills necessary to better manage stressful life events.

The Therapeutic Service has clearly filled a gap in meeting the needs of this most vulnerable group and Focus Ireland deserves plaudits for taking the step of introducing the service. The Therapeutic Team themselves also deserve recognition for leading the development of the service from within, and having a dramatic impact on both Focus Ireland staff and customers during the brief period the service has been in place.

Given the enthusiasm for the service and the excitement it has engendered among stakeholders, Focus Ireland now have an opportunity to make a significant impact on how individuals experiencing homelessness and the people who work with them address this multi-faceted problem. In the longer term the hope must be that this may also help prevent intergenerational homelessness.

10. Recommendations

1) Focus Ireland should establish a Review Group which is tasked with reflecting on the experiences of the Therapeutic Service pilot project. This group should contribute to the decision of how best to implement a Therapeutic Service within the organisation.

2) Despite consultations with Focus Ireland project management and staff, further efforts should be made to ensure that they are fully aware of the roles and objectives of the Therapeutic Service Team, as well as limitations in terms of their scope and capacity.

3) The Review Group should consider the suitability of the Behavioural Specialist discipline within the organisation. In particular, the utility of this discipline within the Youth and Aftercare services should be considered.

4) The possibility of a greater consultative and staff training role for the Therapeutic Team should be considered. In doing so the potential impact that this might have on the capacity of the team to engage with customers must be taken into account.

5) There is the potential for the Behavioural Specialist to make a greater contribution in terms of organisational behavioural management among project teams. However, the efficacy of Applied Behaviour Analysis, as practiced by the Behavioural Specialist among the particular customer group, is questionable and it is recommended that the role should not be continued in its current form.

6) There should be improved partnership with external clinical services experts. These experts could constitute a valuable clinical resource for the Therapeutic Team, and could act as an independent arbitrator with regard to discussions concerning ethical issues and the capacity of the team to deliver both clinical and consultative targets set by Focus Ireland. Furthermore, they may also act as a valuable conduit to external services.

7) The introduction of an element of reflective practice should be considered. This would assist the organisation in better understanding the impact for both staff and families in dealing with the trauma of homelessness.

8) The suitability and feasibility of implementing the PIE framework in other Focus Ireland services should be considered. With regard to resources, one approach might involve its implementation being managed by one person within each service who would champion the framework. This role should be facilitated by the Counselling

Psychologist with support from the organisation. In practice this requires the Counselling Psychologist conducting a needs assessment within individual services with a view to deriving a clear implementation plan. Necessary training would then be facilitated by the Counselling Psychologist. Once provided with the necessary skills, each champion could then facilitate the implementation of the PIE framework within their service.

9) The Review Group should reflect on the result of the recommended implementation of the PIE framework with a view to considering the implications this might have for the theoretical framework within which Focus Ireland addresses the needs of people experiencing homelessness.

10) Procedures regarding the Therapeutic Team's engagement with clinical supervisors and their opportunities to engage in Continuing Professional Development should be formalised. Initially, this will require a better shared understanding between Focus Ireland and the Therapeutic Team as to their professional development requirements. There is also an opportunity for greater input from external clinical services experts to contribute to this.

11) In order to continue to provide the Therapeutic Service to Focus Ireland customers it is imperative that existing and potential sources of funding are engaged. These sources should include statutory, corporate and other philanthropic sources.

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Appendix 1

INFORMATION SHEET FOR RESEARCH PARTICIPANTS

A Review of Focus Ireland's Therapeutic Services

WHAT IS THIS RESEARCH ABOUT?

In July 2012 Focus Ireland introduced a new Therapeutic Service in Dublin comprised of a Clinical Psychologist, Behavioural Specialist and Play Therapist. The aim of this service is to provide one-to-one interventions, group work for vulnerable individuals and families, and consultancy to staff to interpret behaviour and plan strategies to engage customers to stabilise and improve their social and psychological outcomes. An independent researcher has been engaged by Focus Ireland to conduct a review of the quality, effectiveness and outcomes of this new service. As part of this process we are hoping to conduct focus groups with a number of Focus Ireland staff and other stakeholders who have had dealings with the service.

WHAT DOES TAKING PART INVOLVE?

If you choose to participate you will be invited to take part in a focus group that will take about one hour. The focus group will take place at a time and in a location suitable to all participants in September 2013. With your permission, we will audiotape the focus group to help us to record participants' input accurately. Some of the areas we would like to discuss are:

- Your understanding of the role of the Therapeutic Service in Focus Ireland.
- Your personal experience of the Therapeutic Service.
- Your needs with regard to the Therapeutic Service and whether these are being met.
- Whether the Therapeutic Service is meeting the needs of relevant customers.
- How you would like to see the service develop.

WHAT HAPPENS TO THE INFORMATION?

It is intended that the results of these discussions will contribute to a report evaluating the quality, effectiveness and outcomes of the Therapeutic Service in Focus Ireland. The audio tapes of our discussion will be typed and the original recording destroyed. We will remove all names of people and places that you mention during the discussion when we type up our conversation. Typed transcripts will be stored securely in an office that only the researchers

has access to. Only the researchers will have access to the transcripts of our discussion and once the report is completed the written transcripts will also be destroyed. What you tell the researcher is completely **confidential**. The researcher cannot tell any other person what you have said.

WHAT IF I CHANGE MY MIND?

If you decide at any time before or during the discussion that you do not want to continue you can do that. You can also decide what questions you do, or do not, want to answer.

HOW DO I FIND OUT MORE?

If you have any queries you can phone or email me and I will be happy to answer any questions you may have. My contact details are: XX, Mobile Tel: XX; email: XX.

Thank you for taking the time to read this information sheet.

Appendix 2

INFORMATION SHEET FOR RESEARCH PARTICIPANTS

A Review of Focus Ireland's Therapeutic Services

WHAT IS THIS RESEARCH ABOUT?

As you know Focus Ireland started providing a Therapeutic service in Dublin recently. The service is made up of a Clinical Psychologist, Behavioural Specialist and Play Therapist. The service wants to give one-to-one meetings, and group work individuals and families, and to help them on their way out of homelessness. We are hoping to interview a few of the customers that have used the service to find out what they think about it.

WHAT DOES TAKING PART INVOLVE?

If you agree to take part I will arrange with you to have a chat that will last about 30 minutes at a time and place that suits you sometime in October 2013. If you agree, we will tape the interview so that we can be sure that we recorded what you said correctly. Some of the things we would like to ask you about are:

- How you came to use the service.
- What was it like using the service?
- What you think about the service in general.
- Whether you think the service helped you or not.
- If you think the service might be good for other people too.
- Any future plans to use the service.

WHAT HAPPENS TO THE INFORMATION?

The information you give will be used to help us write a report so that Focus Ireland can see what the service does for customers. The audio tapes of our discussion will be typed up and then the tape will be destroyed. We will take out all names of people and places that you mention we type up our conversation. The typed conversation will be kept in a safe place so no one else will be able to see it. Once the report is finished the typed conversation will also be destroyed. What you tell the researcher is completely **confidential**. The researcher cannot tell any other person what you have said.

WHAT IF I CHANGE MY MIND?

If you decide at any time before or during the interview that you do not want to continue you can do that. You can also decide what questions you do, or do not, want to answer.

HOW DO I FIND OUT MORE?

If you have any questions you can phone or email me and I will happily answer them. My contact details are: XX, Mobile Tel: XX; email: XX.

Thank you for taking the time to read this information sheet and please note that a €15 Dunnes Stores Vouchers will be given as a thank you for taking the time to be interviewed.

Appendix 3

Enabling Environments Questionnaire

Please fill in the questionnaire honestly based on your opinion of the service as it stands now.

Do not agree Strongly agree

1 2 3 4 5 6 7 8 9 10

Please tick the box that reflects the group your job belongs to.

☐ Project Worker
Team Leader
Contact Worker
Project Leader
Family Support Worker
Therapeutic Services

☐ Cleaning
Catering
Security
Maintenance
Reception

Belonging

The Nature and Quality of Relationships are of Primary Importance

1. Staff and residents support newcomers to get involved with others
   1 2 3 4 5 6 7 8 9 10

2. There are opportunities for staff and residents to get to know each other
   1 2 3 4 5 6 7 8 9 10

3. There are ways to mark people leaving
   1 2 3 4 5 6 7 8 9 10

4. Staff and residents are learning about building relationships
   1 2 3 4 5 6 7 8 9 10

Boundaries

There are expectations of behaviour and processes to maintain and review them

5. Staff and residents can describe the expectations and how they are maintained
   1 2 3 4 5 6 7 8 9 10

6. There is a consistent approach to implementing these expectations
   1 2 3 4 5 6 7 8 9 10

7. There is an open process to review expectations which includes staff and residents
   1 2 3 4 5 6 7 8 9 10

Communication

It is recognised that people communicate in different ways

8. Staff and residents are supported to communicate effectively
   1 2 3 4 5 6 7 8 9 10

9. There are opportunities for staff and residents to discuss the feelings behind the way people act
   1 2 3 4 5 6 7 8 9 10

10. Staff and residents are encouraged to use a variety of ways to communicate
    1 2 3 4 5 6 7 8 9 10

11. Staff and residents recognise how the way people act is a form of communication
    1 2 3 4 5 6 7 8 9 10

Development

There are opportunities to be spontaneous and try new things

12. There is management support for spontaneity

1 2 3 4 5 6 7 8 9 10

13. Staff and residents are able to try new things
1 2 3 4 5 6 7 8 9 10

14. Staff and residents are supported to understand risk and risky behaviour
1 2 3 4 5 6 7 8 9 10

Involvement

Residents and Staff share responsibility for the environment

15. Staff and residents take a variety of roles and responsibilities within the environment
1 2 3 4 5 6 7 8 9 10

16. Staff and residents are involved in planning their own development
1 2 3 4 5 6 7 8 9 10

17. Staff and residents are involved in contributing to the development of others
1 2 3 4 5 6 7 8 9 10

18. Staff and residents are involved in making decisions about the environment
1 2 3 4 5 6 7 8 9 10

Containment

Support is Available for Both Residents and Staff

19. It is acceptable for anyone to feel vulnerable and receive the emotional support they need
1 2 3 4 5 6 7 8 9 10

20. Staff and residents feel listened to and understood by others around them
1 2 3 4 5 6 7 8 9 10

21. Staff have regular reflective supervision with a consistent supervisor

1 2 3 4 5 6 7 8 9 10

22. Peer-support is recognised, valued and encouraged

1 2 3 4 5 6 7 8 9 10

Structure

Engagement and Purposeful Activity is Actively Encouraged

23. There is a consistent structure or daily routine

1 2 3 4 5 6 7 8 9 10

24. There are regular meetings or groups that include significant numbers of both staff and residents

1 2 3 4 5 6 7 8 9 10

25. There are spontaneous activities that involve staff and residents

1 2 3 4 5 6 7 8 9 10

Empowerment

Power and Authority are Open to Discussion

26. Staff and residents are able to challenge decisions and ask questions

1 2 3 4 5 6 7 8 9 10

27. Staff and residents feel supported by those in authority

1 2 3 4 5 6 7 8 9 10

28. Staff and residents are able to have their ideas implemented

1 2 3 4 5 6 7 8 9 10

Leadership

Leadership Takes Responsibility for the Environment Being Enabling

29. There are clear management structures which include opportunities for involvement from staff and residents

1 2 3 4 5 6 7 8 9 10

30. The leadership ensures that the environment is the right place for the people within it

1 2 3 4 5 6 7 8 9 10

31. People with a leadership role are active participants in the life of the community

1 2 3 4 5 6 7 8 9 10

32. There is continuity of staff

1 2 3 4 5 6 7 8 9 10

Openness

External Relationships are sought

33. The environment is welcoming to visitors

1 2 3 4 5 6 7 8 9 10

34. Staff and residents are supported to participate in activities outside the environment

1 2 3 4 5 6 7 8 9 10

35. Everyone is open and responsive to evaluation and learning

1 2 3 4 5 6 7 8 9 10