FOCUS Ireland

Challenging homelessness. Changing lives.

Executive Summary

Multidisciplinary Team for Homeless Families Feasibility Study

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

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

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

1. Introduction and Background

1.1 Introduction and Context

Focus Ireland works with homeless families in a variety of ways including a combination of case management approaches and supported housing models. Through this work, Focus Ireland identified a cohort of families (approximately 10–20% of families experiencing homelessness) whose capacity to exit homelessness and sustain stable accommodation was negatively impacted not only by broader housing circumstances, but also additional and complex needs.[1] These included: mental health difficulties, addiction, child welfare concerns etc.

One possible approach to adequately support this cohort of families to exit homelessness is through the establishment of a multi-disciplinary team (MDT) to deliver integrated health and mental health support. Thus, in June 2021, S3 Solutions was commissioned by Focus Ireland to undertake research exploring the feasibility of applying a multidisciplinary team approach for families experiencing homelessness or who remain at risk of a return to homelessness due to complex needs. The objectives of the research were to:

- Examine best practice and alternative approaches in supporting homeless families with complex needs
- Assess current service provision for currently homeless and recently housed families with additional and complex needs
- Appraise the value and impact of a MDT approach to families experiencing or at risk of homelessness with additional and complex needs including a detailed operational plan for a MDT service

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

Exploring how best to meet the needs of families with complex needs aligns with Focus Ireland's strategic direction of increasing the organisation's ability to respond to the complex needs of identified priority groups accessing its services. It also aligns with key priorities in the homelessness and health policy in Ireland. This includes:

- Laying the Foundations Housing Actions,
- Rebuilding Ireland Action Plan for Housing and Homelessness,
- The Policy and Procedural Guidance for Housing Authorities in Relation to Assisting Victims of Domestic Violence with Emergency and Long-term Accommodation Needs,
- The 2020 Programme for Government,
- The 2021 Housing for All strategy,
- The Homeless Action Plan Framework for Dublin 2022–2024,
- The 2021–2023 Sláintecare Implementation Strategy,
- The Healthy Ireland Strategic Action Plan 2021–2025,
- The HSE Corporate Plan 2021–2024,
- A Vision for Change, National Drugs Strategy: Reducing Harm, Supporting Recovery.

1.2 Family Homelessness in Ireland

There is no universally accepted or legislated definition of homelessness across the EU. The most systematic conceptual framework for defining homelessness and housing exclusion is ETHOS (the European Typology of Homelessness and Housing Exclusion). This includes four distinct categories of homelessness and housing exclusion: 'rooflessness', 'houselessness', living in 'insecure' accommodation and living in 'inadequate' accommodation. In terms of family homelessness, this implies a family unit consisting of at least one adult and one minor child or one pregnant woman.[2] Homeless families in emergency shelters, temporary accommodation, hostels and other specific accommodation provision for homeless people are included in this definition.[3]

As of December 2022, there were 1,594 families reported as homeless in Ireland; this includes 3,422 children and 2,619 adults.[4] 72% lived in Dublin, 54% were single parents and a third of new families presenting to homeless services are non-Irish.[5] Data from Focus Ireland reveals that approximately 12% of children in families that it supports were born into homelessness.[6]

2 University of Oxford Department of Social Policy and Intervention (2017)
3 Family Homeless in Europe (2017)
4 Department of Housing, Local Government and Heritage (2023)
5 European Commission (2018)
6 Focus Ireland (2022c)

Please note that a complete Bibliography is provided in the longer version report

However, these figures are lower than the reality. Women at risk of domestic violence, who have dependent children with them, and who use domestic violence services such as refuges are not recorded as homeless in Ireland. The same situation is found in those who are hidden homelessness, i.e., a family, without their own housing, staying with friends, relatives or acquaintances because they have no alternative.[7] This leads to potential undercounting of family homelessness.

While strategies are in place to prevent families from requiring emergency accommodation, and to support families to exit emergency accommodation, the number of families presenting as homeless in Ireland has increased by 363% since July 2014. In Dublin the number of families presenting as homeless each month has risen from an average of 15 in 2013 to 77 in 2022.[8] A distinctive feature of family homelessness in Ireland, especially in Dublin, is the length of time that families remain homeless. According to Focus Ireland, the reason Dublin holds such a high percentage of Ireland's homeless is that there is a slower progression from emergency accommodation to secure accommodation compared to other areas of the country.[9]

Although the most common triggers of homelessness among families relates to insufficient housing supply and private rented sector issues, family circumstances have been found to be a cause of homelessness in 30–40% of cases.[10, 11] These circumstances include relationship breakdown, family violence, and family conflict, and family reunification. Other causes of family homelessness are attributed to issues such as property damage due to fire, no income source, anti-social behaviour, and leaving direct provision with permission to remain, loss of work/cut hours, and instability due to frequent transitions between living situations.[12]

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

It is in this context that the need for this research emerged.

7 Ibid
8 Focus Ireland (2022a)
9 Focus Ireland (2021)
10 European Observatory on Homelessness (2017)
11 Culhane, D.P & Metraux, S. (2008)
12 European Observatory on Homelessness (2017)

2. Research Methodology

2.1 Approaches to Data Collection and Limitations

A qualitative research design was adopted and the scope of the research was limited to Dublin given that more than three quarters of homeless families resided here. The research findings are informed by the following activity carried out between June 2021 and July 2022.

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

Research limitations included:

- Use of secondary research conducted in America and which lacked long term follow up,
- Unavailability of secondary research comparing effectiveness of multidisciplinary teams with other models,
- COVID-19 restrictions necessitated remote based interviews and limited the extent all research participants could contribute fully,
- Research incentives for families potentially caused bias,
- Insufficient representation from a health perspective e.g., Public Health Nurses.

3. Literature Review

3.1 Complex Needs

Despite many strategies in place to prevent family homelessness and to support families to exit emergency accommodation, the causes and consequences of homelessness can result in high support or complex needs among families. People with complex needs experience a constellation of social and personal problems that co-exist, overlap and interlock to create a complex profile.[13] Multiple and complex needs implies both:[14]

- **Breadth of need** – multiple needs that are interrelated or interconnected and
- **Depth of need** – profound, severe, serious or intense needs.[15]

Among homeless families, complex needs may include but are not limited to:

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

13 Shelter Scotland (2016)
14 Bromfield, L et al., (2012)
15 Rankin, J and Regan, S (2004)

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

Homeless people with complex needs experience various challenges regarding their awareness, access and experience of the services they need. This includes:[16]

- Lack of or inaccessible information, poorly advertised services and low awareness of what services can offer; a particular problem for BAME communities, refugees, and asylum seekers.
- Service exclusion due to criteria governing service use or needs assessed as 'too complex' and inflexible service criteria prevent continuity of care
- Some targets undermine the will to work with clients with multiple needs
- Lack of referrals between agencies/inappropriate referrals limit access to services they need
- Long waiting lists worsen problems for those with multiple needs
- Some feel staff attitudes are insensitive/unhelpful which prevents trust
- Many receive repeated assessments which is stressful
- A 'silo mentality' works against co-ordination of support and risks people receiving inappropriate services with poor outcomes
- Medical 'dual diagnosis' labels limit the range of options
- Assessment, support planning and resources can be inadequate for people affected by transitions, delaying access/limiting people's rights
- Minority ethnic communities, refugees and asylum seekers do not always receive sensitive assessment or access interpreters/translators
- Non-engagement with services occurs because of lack of trust and confidence, cultural insensitivities, services' systems or cultures being incompatible with lifestyles, poverty impacts, and people not being ready to address problems. In turn, non-engagement may exacerbate low level problems and exclusion. For some, persistent exclusion may result, interspersed with crises related to health or homelessness for example.

16 Rosengard, A. et al (2007)

- Gaps in health and social care services and a lack of housing and employment services that are integrated into health and social care services are cited as a key challenge for providers when working with individuals who have complex needs.[17] Cutbacks in health and HSE budgets limiting the availability of resources to care for homeless individuals with complex needs, stigma, restrictive catchment areas for drug treatment and detox services, inflexible services, discharge protocols are lacking, scarce specialised services, and a high absence of services in rural areas are also noted as key challenges.

In addition to the above, homeless people often must prioritise provision for basic human needs (e.g., finding shelter and food) over accessing health and social care[18] and are often care avoidant, despite requiring specific care. Their complex and multiple needs can be stressful and make it difficult to find solutions and/or cause them to enter 'survival mode' requiring them to focus on basic needs and day-to-day living.[19] This relates to Maslow's hierarchy of need, a five-tier model of human needs which suggests that basic needs such as physiological needs (food, warmth, shelter) and safety needs must be addressed as a priority before a person can focus on their psychological needs and self-fulfilment. This is augmented by research which shows the strongest needs identified among the homeless are basic needs with very few expressing needs in the higher-order categories of love and belonging, self-esteem, and self-actualisation.[20]

3.2 Multidisciplinary Team Approaches (MDT)

One possible approach to adequately support homeless families with complex needs is a multi-disciplinary team (MDT) to deliver integrated health and mental health support. In 2017, Crisis, a national homeless charity in the UK, commissioned the Social Care Institute for Excellence (SCIE) to conduct a rapid evidence assessment (REA) of current and past services targeted at addressing and reducing homelessness.[21] The review suggests that sustained services, targeted to meet specific needs across time (because needs can change) are effective. It notes that the most effective services for families included multiple components which offered both rapid and sustained support and were delivered within a multiagency framework.

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

For service users, MDTs have been found to be more flexible and adaptable than other systems of care whilst also offering better continuity of care. MDTs can also improve access to services for services users, with reduced waiting times for referral as all

17 Rankin, J. & Regan, S. (2004).
18 Omerov, P. et al. (2020)
19 Klop, H.T. et al. (2018)
20 Fleury M.J. (2021).
21 Sheik, S. and Teeman, D. (2021)

required parties are already involved.[22] For staff and care systems, MDTs promote better communication between professionals from different backgrounds; provide a shared identity and purpose which promotes team cohesion; and result in resources being used more efficiently through reduced duplication, greater productivity and preventative care approaches.[23] Further benefits for workforces include reduced isolation, improved morale and job satisfaction and reduced stress.[24] Examples in practice show the following impact of MDT's for homeless populations:

- **In Cork, the Adult Homeless Multidisciplinary Team (MDT)** which provided a full spectrum of addiction, mental health, and medical services on an in-reach and assertive outreach basis was shown to deliver the following: reduced average hep C rate among the homeless population by 17%, increased access to methadone substitution treatment and reduced number of overdoses by 50%[25]
- **In Newcastle, England**, an MDT for those who were homeless supported households to reduce housing arrears, rent shortfalls and debt. It also supported residents to gain additional income via benefits, to gain free furniture enabling 83% of families to escape the benefit cap, to move closer to work, school, or social networks, or away from potential harm and harassment. Some residents were also supported to gain employment and to improve their wellbeing. The findings of the Newcastle pilot MDT homelessness project suggest that the MDT had produced a measurable reduction in the risk of homelessness for those households who have engaged with them.[26]
- **In Wales, an MDT for homeless people** was found to have improved service coordination and service relationships, improved referrals, and joint targets. The MDT received 367 referrals after it began and 293 of these cases were opened to specialist workers. Further, of the 168 cases which have since been closed, 72% of service users have secured or maintained their accommodation.[27]
- **The Family Assertive Community Treatment (FACT) programme in Chicago, Illinois** provided integrated, family-focused treatment and support services for young, homeless, at-risk mothers, who had at least one child five years of age or younger and a co-occurring mental health and/or substance abuse disorder.[28] FACT's multi-disciplinary, coordinated team provided intensive care targeted toward each family's individual goals and delivered the following outcomes: improved housing stability, improved housing satisfaction, improved education, reduced parental stress, improved housing situation, increased income and improved developmental scores among children.
- **The Inner Southern Homelessness Service (ISHS) in South Australia** found success in using multi-disciplinary teams to improve health outcomes of homeless children and families. ISHS delivers nurse-led interventions with homeless families and has found that when case managers and nurse practitioners work together, the situations of homeless families improve as they are better connected with employment services, health interventions, and prevention programmes, which in turn improves health status.[29]

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22 Ainscough Associates (2021)
23 Social Care Institute for Excellence (2018a)
24 NHS England (2021)
25 O'Reilly (2003)
26 Parker, C. and Harrison, C. (2019)
27 Kinghorn, F. and Basset, L. (2019)
28 Strengthening At Risk and Homeless Young Mothers and Children (2012)
29 Parry, Y.K., Harryba, S., Horsfall, S. (2015)

- **In Santa Monica, California, the Homeless Multi-disciplinary Street Team (HMST)** adopted the Assertive Community Treatment model of Case Management which included facilitating interim and permanent supportive housing, connecting clients to existing services, and being responsive to staff at other community organisations such as hospitals, the police department, the city attorney's office, and the fire department.[30] Its evaluation involved the development of a logic model for the intervention. Key outcomes of the approach included improved health and wellbeing for clients, increased housed clients, reduced public costs, decreased recidivism rates, increased regular engagement with health services and, in the longer term, decreased number of chronically homeless people.

There is also economic evidence that homelessness multidisciplinary teams represent value for money and are potentially cost saving.[31] Having specialist multidisciplinary teams or designated leads should mean better integration and efficiency of services, more streamlined and personalised care and improved engagement with care and support, which in turn should lead to reduced morbidity, mortality and associated costs. Such a service model can mean better management of resources, for example, a reduction in inappropriate referrals, inappropriate use of hospital beds, and duplication of effort as well as a reduction in wider public sector costs, including local authority homelessness services, because people will be more likely to maintain their accommodation.

The key challenges to multi-disciplinary teams include:[32, 33]

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

30 Ashwood, J.S., Patel, K., Kravitz, D., Adamson, D.M, and Audrey Burnam, M. (2019)
31 National Centre for Health and Social Care Excellence (2022)
32 Cordis Bright (2018)
33 Madge S. and Khair K. (2000)

4.
Research Findings

4.1 Family Perspective

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

Characteristics		No. of Participants
Gender	Female	13
	Male	8
Relationship status	Single	6
	Married	15
Number of children	One	2
	Two	7
	Three	4
	Four	5
	Five	2
Ethnicity	White Irish	4
	Irish Traveller	5
	Ethnic Minority	12
Housing status	Emergency Accommodation	17
	Temporary Accommodation (e.g., George's Hill)[34]	2
	Permanent Social Housing	2
Duration of homelessness	Less than 6 months	5
	6 months – 1 year	8
	1 year – 2 years	4
	2 years – 5 years	0
	5 years +	4
Main service	Family Homeless Action Team[35]	20
	Family Centre[36]	1

Included in the research sample were individuals who had arrived in Ireland prior to and during the COVID-19 pandemic. During this time, several measures were put in place to support the homeless population and newly resident migrant families were subsequently able to avoid traditional service access barriers and instead experience rapid access to accommodation.[37] This offers useful context to their experiences of homelessness and homeless services in Ireland.

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

35 The Family Homeless Action Team (FHAT) work with families becoming homeless in the four Dublin local authority areas.Family HAT uses a case management model, based on a needs' assessment, with the primary goal of supporting families to exit homelessness ideally within 6 months.

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

37 Mercy Law Resource Centre (2020) *Minority Groups and Housing Services: Barriers to Access*.

Complex Needs

Many interviewees shared insight to the challenges they were experiencing alongside homelessness, which, together, can contribute to complex support needs.

- Twenty individuals were unemployed and of the fifteen individuals who were married, only three had a spouse who was in employment. The majority of families were subsequently dependent on social welfare as an income source.
- The five individuals from a Traveller background described that they had low levels of education and difficulty with understanding or filling in forms or communicating via email.
- Of the twelve individuals from a migrant background, nine were from a Roma background and did not speak English.
- Four individuals described that they suffered from poor mental health, two of whom also had a child who suffered from poor mental health, with one diagnosed as suicidal and in special care.
- Three mothers described experiences of domestic abuse, two of which were prior experiences while one was on-going and linked to their husband's addiction issues. Six individuals also explained that they or their spouse had some form of physical health issue. These included liver disease, epilepsy, psoriasis and back problems. One parent was also pregnant at the time of the interview and two parents described that their children were sick.
- Two mothers expressed challenges with their children attending school with one child being expelled.
- One mother expressed that they were raised in foster care, had experienced family breakdown with their foster parent, and found it difficult to support their child's attendance due to their own depression and subsequently had their own four children placed in care across three separate counties.
- Two mothers also explained that their children had special or additional needs including autism or attention deficit hyperactive disorder (ADHD).

The above information demonstrates the multiple support needs among the study's sample.

Journeys to Homelessness

Although the research did not explicitly ask individuals to describe their journeys to homelessness, eighteen parents offered insight on their causes of homelessness. For nine individuals who had a Roma background, their homelessness was caused by their family's recent immigration to Ireland. For five parents, family circumstances including overcrowding and relationship breakdown caused their homelessness. Private sector issues such as rental increases or eligibility issues were the cause of homelessness for three families and for one, this was linked to anti-social behaviour with their neighbours.

Factors Creating a Positive Experience of Services

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

- **Attitude and Approach of Key Worker:** For nine families, the positive approach and attitude of staff, particularly their key worker was noted as facilitating a positive experience of services for them. Their empathetic and respectful nature coupled with their friendly, honest and non-judgemental approach helped families to feel welcome and comfortable when accessing services and support. The willingness of the key workers to listen and understand all of their needs was also highlighted as beneficial. For those who experienced challenges or barriers when first seeking support e.g., being ignored by service providers or feeling a sense of loneliness and isolation, the approach and attitude of staff was vital for rebuilding trust in service providers.
- **Instant Access to Support:** Six families described that instant access to support and the immediate availability of their key workers helped to facilitate a positive experience of services for them. Parents described that their key workers were 'there the whole time if you really need them' and that 'they would struggle without this access to support'. One parent described how beneficial and important it was that their key workers office was based in the same building as they lived, therefore they 'only had to make a quick call to get instant support'. For those who were not based in the same office, having access to their key worker's telephone number to call as needed was important. This ease of access and responsive approach was also considered paramount for one family who had exited homelessness.
- **Provision of Practical, Needs Based, Essential Supports:** Nearly all families (n=16) identified that the provision of practical, hands-on, needs based support was important for facilitating a positive experience for them. This related to income supports in the form of vouchers or donations to assist with the cost of essential items and support to complete important paperwork related to social welfare entitlements such as registering for a public personal service number (PPS), child benefit and income support. It also related to housing related support in terms of receiving access to temporary accommodation and support to contact the council, gain references for housing, arrange viewings, and complete paperwork for access to the housing assistance payment or securing residency permits. As well as this, practical assistance with travel, education and English lessons were noted as important.

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

Factors Creating a Negative Experience of Services

The following factors were cited as creating a negative experience for families:

- **Low Awareness of Services:** Consistent with the findings from the literature review, nine families made explicit reference to a low level of awareness of services and supports when they first became homeless. This created a negative experience for individuals, exacerbating feelings of isolation and loneliness during a time of crisis. Although several families reported that their friends made them aware of supports, for those with no or limited support networks, the situation was worse. It is important to note, six individuals from a Roma background had arrived in Ireland during the COVID-19 pandemic and subsequently they were placed immediately into a hotel to quarantine followed by emergency accommodation. Their initial experiences of homelessness and subsequent experiences of seeking support and navigating the homeless system in Ireland differed to their counterparts who had arrived prior to the pandemic. Low level awareness of services was not identified as an issue for them.
- **Slow Service Responsiveness:** For eight parents, a negative experience of services was attributed to the slow responsiveness and poor communication from services. For five parents this was linked to experiences with their key worker while for three this was related to experiences of seeking support. Families conveyed a level of frustration with the unavailability of services and those in place to support them. They described experiences of reaching out for support, not receiving a response, or being told that they will hear back only to receive no response. In one family's example, after they made contact for support, there was nothing immediately available for them. In other examples, parents felt ignored and unsupported. This diminished hope and exacerbated worry. One parent acknowledged that their key worker was not as responsive as they would like due to being busy.
- **Navigating the Housing and Social Welfare System:** The most prominent issue creating a negative service experience for families was the duration of their homelessness. This was compounded by the uncertainty, challenges, and barriers they faced when navigating the housing and social welfare system. Despite receiving support from key workers in the areas of housing and social welfare, housing ambiguity and system related barriers heightened feelings of frustration, hopelessness, stress and sadness. For example, the length of time to receive an application decision, difficulty with meeting eligibility requirements, applications being turned down and the requirement to complete a new application for support in each county were described. This was a particular challenge for families from an ethnic minority background who were newly resident in Ireland. A lack of available landlords willing to accept the Housing Assistance Payment, the demand for housing and lack of appropriate housing to accommodate family needs were also noted.

- **Experiences of Emergency and Temporary Accommodation:** While overall, families expressed a level of gratitude with being placed in emergency or temporary accommodation, nine parents conveyed frustration and challenges with their current situation. They described accommodation as 'too small', 'busy' or overcrowded, 'uncomfortable' and 'inconvenient'. In some circumstances, families described that their accommodation lacked cooking facilities or food storage facilities which created further strain on their income and in others, the lack of onsite parking facilities had imposed risks of fines or created difficulty for them to rest. For two families with experience of congregate housing, they described how they and their children were exposed to even greater trauma citing that people around them often had poor mental health, psychiatric disorders, suffered addiction or were suicidal. Being moved from place to place was also cited as creating a negative experience for families as were the curfews imposed in some temporary accommodations.
- **Staff Changeover:** Although many individuals reported a positive experience with their key worker, for three research participants, the changeover or turnover of key workers created a negative experience for them. Varying spirit levels, interest, concern and ability or readiness to help were reported. Resultantly individuals compared key workers as 'good' and 'bad'. In one case, the changeover of staff before the closure of their case created a feeling of 'abandonment'.
- **Lack of Holistic Support and Unmet Needs:** Despite recognition that services had provided essential support across important areas of housing, health and income, fifteen individuals identified areas where their needs remained unmet. This related to the following: physical health needs (N=7), mental health needs (N=6) and educational needs (N=4).

Despite facing a language barrier, four families from a Roma background did not feel they needed educational support or had no interest in learning English, two of whom indicated intent to rely on their child for translation. There was also a consistent perception among families from a Roma background that everything would be fine once housed and that their language barrier would not present any challenges in terms of theirs and their child's health or their child's education. Their inability to identify additional needs beyond housing mirrors the findings in the literature review where basic human needs such as finding shelter and food are prioritised.

4.2 Staff Perspective

Complex Needs

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

Staff noted that families with complex needs often had poor coping skills, existing in crisis and living in circumstances which they struggle to cope with. The trauma associated with prolonged homelessness coupled with affordability of counselling, long waiting lists for treatment and intervention were noted as exacerbating mental health conditions.

Reference was made to services exposing families to other families with complex needs and placing a singular family unit in a dwelling which is too small to comfortably accommodate. This was described by staff as causing "continued exposure to trauma" and exacerbating challenges with exiting or sustaining an exit from homelessness. It was also highlighted that homeless families with complex needs often did not have a medical card and were unable to access basic health support. This was cited as contributing to the onset of preventable illnesses and injuries.

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

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

In terms of practical barriers for homeless families with complex needs, staff explained that often families are referred to many different services, making it difficult to keep track of who they are referred to and why. Practical barriers also exist around location. Hubs for

services to address complex needs are largely located in city centres. Families become dependent on these services, making it difficult for them to relocate and engage with other services elsewhere, particularly when moving services requires joining a waiting list. Other practical issues surround the contacting of services, with families who have experienced trauma linked to domestic violence requiring help to contact support services.

Challenges and Impact on Service Providers

As with the impact of complex needs on families, the impact on staff is wide-ranging.

- **Expertise and Experience:** Staff reported that they were expected to "wear many hats," listening to and responding to those with a range of needs, from mental health conditions, trauma, and addiction, to support with housing forms and education and employment. Staff frequently lacked the expertise necessary to adequately handle these issues. This makes it difficult for families to be fully assessed and supported, leading to undiagnosed needs such as mental health conditions and learning difficulties which will have a knock-on effect on the life of the homeless individual and their family.
- **Expectations of Customers:** It was highlighted that homeless families with complex needs often want the staff to "do all the supports for them,"; an expectation which staff are unable to meet.
- **Capacity:** Staff reported that they were also unable to investigate and fully understand the complex needs of homeless families due the demands on their time created by the volume of families requiring multiple supports coupled with low levels of resources. Staff noted the difficulty they faced in managing the multiple services families' require and monitoring the policy and operational changes of these services and local authorities. Difficultly arises in this area when families are moved around as catchment areas for services are different, and policies *"never stay the same."* The consensus from staff on this topic was that it is a slow process, and more support is needed as their services currently *"never have enough staff".*
- **Availability of Services:** Services are in high demand, there are not enough spaces for support, and there is a lack of provision in areas outside of Dublin. Resultingly, staff attempt to keep families within their services, compounding pressure on waiting lists
- **Accessibility of Services:** Staff reflected that it is often difficult to understand the criteria for accessing support. The thresholds for social workers and housing were highlighted as unclear and staff reported that their relationships with social workers and local authorities require development to add consistency to the service and awareness across the team.
- **Suitability of Current Offering:** Staff reported that the current provision *"sets families up to fail"*, as it does not address the breadth of customer's complex needs. It was perceived that services are not set up to deal with multiple languages or illiteracy and that current service offerings rely on Housing Assistance Payments which are not tenable as families with complex needs have additional problems which are not addressed. Resultingly, families are placed in a home with no independent living, money management, or home management skills and struggle to maintain their tenancy. Furthermore, it was reported that many current services

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

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

Multidisciplinary Team

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

An MDT would make staff jobs less difficult, remove pressures on their time, and mean that homeless families are more likely to get the support they need. Multi-dimensional work would facilitate connections with other staff members, giving staff a better sense of what is going on and focusing services. This was highlighted as important as the long-term strategy for a service can be lost when the focus is on responding to high demand in the moment. Facilitated by the interlinking of staff, homeless families may need to access fewer appointments as knowledge can be shared amongst staff. Fewer appointments may reduce the likelihood of homeless families being re-traumatised by having to repeat their experiences. An MDT approach would be a mechanism for facilitating early intervention, particularly for children, reducing the likelihood of adverse childhood experiences, enabling early diagnosis, and reducing the number of children taken into care. This would have knock on effects for schools which could then apply for supports to address the needs of these children, which in turn would improve their experience of education and increase their likelihood of employment, breaking the cycle of homelessness for families.

The elements noted as necessary for a MDT approach were: Housing supports; Primary care supports (i.e., GPs/Public Health Nurses); Mental health supports/ Psychotherapy; Occupational therapy; Speech and language therapy; Addiction counselling; Family support; Language and translation support; Childcare; A focus on skills such as independent living and money management; Relationships with local authorities. The inclusion of primary care and mental health supports would rectify the lack of communication staff have with these services. Staff placed a premium on an MDT service model that would address needs *"right away," "put follow-on in place"* and *"adopt a trauma-informed approach."*

4.3 Stakeholder Perspective

Family Homelessness and Complex Needs

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

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

The role of language barriers and illiteracy among homeless families with complex needs in creating challenges with navigating the school system for their child and creating uncertainty with regards to social welfare entitlements was also highlighted. This was underscored as a more pronounced issue for migrant families. Stakeholders noted that a lack of access to appropriate kitchen or cooking facilities coupled with the affordability of healthy food comprised another issue for homeless families with complex needs. This was linked to malnutrition, dietary problems, and the creation of development and growth delays among children.

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

Challenges and Gaps in Provision for Families with Complex Needs

Stakeholders identified the following challenges and gaps in provision for homeless families with complex needs:

- **Coordination, Communication and Continuity of Support:** Understanding the extent to which the issues faced by homeless families are intrinsic or the result of their environment requires input and expertise from a range of professionals. Stakeholders felt interagency communication in this area was lacking, highlighting that the current

system is fragmented, that services and departments typically operate in silos, and don't know what the other is doing. This presents a challenge to coordinated responses, particularly when services for families with complex needs are required simultaneously. The continuity of support provided for homeless families who are moved from place to place was also noted as inhibitive. Examples of current practice such as 'case conferences' were recognised as positive steps in this area, but there was a consistent view that communication between and across services was lacking and that such examples were not common practice.

- **Capacity and Resources:** Stakeholders noted that all services working to support homeless families are under resourced and lack capacity to support individuals and families with complex needs, citing that they often have 'to take account of additional needs or logistics beyond their reach.' The rate at which people in distress were entering Ireland was said to be overwhelming the systems and responsible departments and the range of support needs between and among homeless families with complex needs was considered particularly challenging. There are 'traditional homeless and marginalised' people and there are homeless families from a migrant background. Adequately supporting these families requires different skill sets.
- **Availability and Accessibility of Services:** Families with complex needs typically require immediate access to a variety of supports across multiple disciplines. Stakeholders identified that these supports are either not readily available or are inaccessible. Mental health, dentistry, and disability services were noted as key gaps in provision, with lengthy waiting lists, service criteria, and regulations noted as barriers. Furthermore, it was noted that some mainstream services will only work with an individual once other needs are being met, thereby creating access challenges.
- **Responsibility:** The lack of single or collective responsibility for families with complex needs at a national level was also highlighted as a core challenge for services in effectively meeting needs.

A Multidisciplinary Team Approach

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

- **Service Usage:** It was noted that an MDT approach which addresses the multiple needs of homeless families could improve service usage, with access to support in turn reducing the impact of complex needs and increasing sustainable exists from homelessness.
- **Reduction in Cost:** Stakeholders reported that for some services, the employment of an MDT approach would lead to reductions in cost. The example was provided of supports which address both housing and health. If the impact of health as a complex need is reduced and health status improved, stakeholders highlighted that there would be a reduction in unnecessary suffering which further compound needs. This would in turn lead to a reduction in costs for the health service as demand decreased.
- **Availability of Services:** An MDT approach would improve timeframes for accessing support, reduce waiting times, and pressures on services. If support was provided in-house, the burden of ensuring an appointment was attended by a customer was removed as when a family needs support, the support team are "already there."

- **Relationships with Service Providers:** A MDT service model that includes dedicated in-house supports for families with complex needs would enable families to engage the same professionals at each of their appointments, to build trusting relationships, increase service usage and reduce the need to repeat experiences which are linked to trauma.
- **Expertise:** The qualifications and abilities of case managers were recognised, but stakeholders highlighted that they are not supposed to provide more than generalist support. A need for specialist expertise was noted as important for addressing the complex needs of homeless families. An MDT team which case managers could tap into and then coordinate supports through was highlighted as a remedy to current issues in this area.

Anticipated Challenges

Stakeholders reported that the implementation and delivery of MDT provision would not be without challenge. Key challenges identified included:

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

Key Considerations for Successful Delivery of MDT

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

- **Buy-In and Coordination:** Once families are accessing care, the focus should be on progressing their support to a point where the family is no longer unduly impacted by complex needs and therefore no longer needs to avail of the MDT service. Stakeholders highlighted that this would require high-level, even national coordination, so that existing systems of support could assume responsibility for families once their complex needs are addressed.
- **Communication:** An MDT approach should include a system which promotes ease in the sharing of salient information. This is true of both information pertaining to the family, but also the sharing of key knowledge, expertise, and learning which will promote a high standard of care and improve the capacity of staff.

- **Networks of Expertise:** Stakeholders felt that an MDT approach should heavily rely on the expertise of specialists in respective areas, allowing for the construction of a network of local support and the promotion of knowledge about what is available. This would allow case managers to direct families with complex needs to the most appropriate supports.
- **Steering Group:** The creation of a steering group would be essential to ensuring an MDT approach could be designed, implemented, and delivered. This would address gaps in the knowledge of services about how to implement an effective MDT approach and provide oversight on the management and allocation of resources.
- **Case Management:** Existing assessment structures and case managers should be able to adapt to a new operating system. Stakeholders reported that it would be important to ensure that each case was managed by a singular case manager, who draws on the support of the MDT and focuses the direction of support. This would ensure a level of coordination in the unique care of each individual family, with a focus on both immediate and longer-term needs.
- **Equitable Access:** Whilst access to services for families with complex needs would be a success in itself, there would need to be a consideration of equal access for migrant and native populations. This is true of where the complex needs of these populations overlap, but also where they differ and require specific support.

Key Components of an MDT Appraoch

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

- Primary care supports such as GPs
- Public health nurses
- Mental health nurses
- Child and adult clinical psychologists
- Psychiatrist
- Addiction specialists
- Counsellors
- Child and family support workers
- Case manager
- Peer worker

It was reported that some of the roles identified did not require a full-time position and could be provided by other services through a blend of in-house and partnership delivery. For example, a GP could form part of the MDT but participate on a part-time basis alongside their responsibilities in their GP practice, or the MDT could work with the GPs which homeless families are already registered with. Additionally, whilst stakeholders did not feel certain organisations should form part of the core MDT team, it was noted that they could be involved in an advisory capacity, in partnership, or as part of the steering committee. Key suggestions in this instance included:

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

5. Conclusion and Recommendations

5.1 Conclusions

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

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

However, consultation with families, staff and stakeholders highlights that the current approach is not effective at supporting families who have complex needs:

- **Needs Assessment:** With the volume of needs and cases the staff have coupled with a lack of expertise and experience in the areas of mental health, disability, developmental needs, addiction, some family's needs are not being assessed/addressed.
- **Availability of and Access to Services:** There is a lack of available services to refer on to and lengthy waiting lists are creating barriers to access especially in areas related to mental health and disability. As a result, the complexity of their needs worsens.
- **Continuity of Support:** The current system is fragmented and services operate with limited communication/shared learning or knowledge about one another, this presents a challenge to coordinated responses, particularly when services for families with complex needs are required simultaneously and when families are required to move location/addresses during homelessness.
- **Capacity and Resources:** Services working to support homeless families are under resourced and lack capacity to support individuals and families with complex needs and often have 'to take account of additional needs or logistics beyond their reach.'

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

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

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

5.2 MDT for Homeless Families in Ireland

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

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

The research advisory group sifted each option against a set of key criteria and identified a preferred model for an operational plan to be developed. **The preferred option was Option 4 whereby Focus Ireland employ a multidisciplinary team to deliver services in house as required and work in partnership through a memorandum of understanding with other stakeholders and services to make referrals to services as appropriate.**

MDT Staff Team

The model requires investment in a multidisciplinary team to act as experts, providing and coordinating care in line with family's needs. The research identified a long list of staff who could form part of a multi-disciplinary team approach for homeless families with complex needs. Informed by the consultation process and the key challenges identified for families with complex needs, the following staff roles were prioritised: General Practitioner, Psychiatrist, Public Health Nurse, Clinical Psychologist, Child Psychologist, Addiction Support Worker, Family and Child Support Worker and Translator.

As recommended in the literature, to effectively deliver care through an MDT approach, a single identified individual, should oversee and facilitate the work of the whole team. The following table presents a core staff team for the initial formation of an MDT in Focus Ireland. This includes a combination of employed staff and access to key experts through a memorandum of understanding. The research highlighted that a key consideration for Focus Ireland when forming an in-house MDT is ensuring appropriate clinical governance for relevant staff. It is therefore proposed that clinicians form part of the multi-disciplinary team through a memorandum of understanding. This will allow for full clinical governance.

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

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

Steering Commmittee

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

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

The purpose of the steering group is to oversee the work of the MDT model, share information, reinforce clinical governance and to utilise their networks and experience to expediate referrals to relevant support and services where relevant. The steering committee should also raise awareness across health and housing so that services and departments supporting vulnerable individuals are aware of its presence. As complex needs for families may change over time, the steering committee will have a key role in assessing the extent to which the MDT meets the needs of those requiring support. Where demand for a specific area of expertise or speciality is high, the steering committee should consider how best to integrate this service in the MDT e.g., via service brokerage, MOU or employment.

Guiding Principles and Measuring Success

The purpose of the MDT is to enhance access to services and support for families with complex needs. The team should adhere to the guiding principles developed by NICE (2022).[38] Its measures of success relate to the following key indicators: Length of time families spend in homelessness, Speed at which families access key services and Families' perception of their experience/support. To effectively evaluate the success of the MDT, appropriate evaluation practice should be implemented from the outset.

38 National Institute for Health and Care Excellence (2022)

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