Review of Services
2006 - 2010

Good Shepherd Centre
Kilkenny

June 2010

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1. Introduction

The Board and Management of Good Shepherd Centre, Kilkenny (GSC), have commissioned an independent review of its homeless service provision. This review is taking place some five years after an initial independent review of GSC was commissioned in 2005 following the adoption of South-East Homeless Integrated Re-settlement Strategy and the appointment of the current Centre Manager. The review has been supported financially by Kilkenny Local Authorities and HSE South (South-East).

The Good Shepherd Centre was established in the 1980's and has a residential capacity for forty-seven single men. It is incorporated as a Company Limited by Guarantee and is a registered charity. GSC is one of two residential service providers for people who are homeless in Kilkenny, the other being Amber Women's Refuge. There are four Men's Hostels in the South-East Region comprising six Local Authorities, Carlow, Kilkenny, South Tipperary, Waterford City, Waterford County and Wexford.

Homeless services in the South-East have undergone major transformation since 2006 and the Good Shepherd Centre, Kilkenny, has been to the forefront of programme development and change. In the five years to the end of 2009 following the implementation of most aspects of the strategic plan, it is believed that homeless services have become more effective, open and streamlined in Kilkenny. It is believed that the development of formal structures, strategic alliances at frontline service delivery points and effective inter-agency co-operation have combined to provide service users with clear pathways to sustained independent living and a support structure in permanent, move-on accommodation to generate long-term, sustainable tenancies.

The 2006 re-configuration of GSC's priorities and ways of working have gradually and purposefully brought about the predominance of returning people accessing homeless services to sustained independent living as the prime objective of its services and the underlying theme to all of its services and approach to service delivery.

The Good Shepherd Centre has now commissioned a review and evaluation of the developments over that period of time (2006 – 2009) to try to capture the learning, while considering the possibility of the approach and development process within an examplar framework. In particular, it would like to identify the key elements which have had the most impact on driving the strategy forward, assess where there are any gaps in provision or emphasis and identify opportunities for future service proficiency.

GSC would like to assess the role its partners in service delivery including Kilkenny Homeless Action Team (KHAT) and the mechanics of inter-agency working which has under-pinned the approach, as well as looking at professional issues such as staff development, close working with County Council Social Work and Housing staff, the local Department of Psychiatry, and post-discharge sustained independent living support services. This is in the context of the shift in GSC's priorities, competences and expertise

away from 'hostel' accommodation services only, to re-settlement and sustained independent living programmes.

Board of Management June 2010

The current Board of Management comprises three members who preceded the introduction of the new approach and four members who have since been appointed. While the Board awaits a replacement for Reverend Lynas, Dean, St. Canice's Cathedral, Kilkenny, there is a strong combination of professional and other skills leading the organisation's operational and strategic development.

Board Member	Occupation	Date of Appointment
William Cuddihy (Chair)	General Practitioner	1990
Mgr. Kieron Kennedy	President, St Kieron's College and Diocesan Director of Soc Services	1990
Anne Marie Walsh	Housing Official, Kilkenny Local Authorities	2004
Paddy Kelly	HSE Representative	2007
Ian Coulter	Training Executive, Citizen Information Board.	2007
Michael Lanigan	Solicitor	2009
Fergus Keane	Secretary to Board	2006

Table 1 Board of Directors Good Shepherd Centre 2010

2. Approach

The Review has been carried out using primary and secondary research techniques.

Primary Research

The key strategic partners to the delivery of homeless services in Kilkenny who were interviewed as part of the Review were:

- **Management Committee GSC;**
- **Staff, GSC;**
- **Homeless Action Team members and participants (including other key informants detailed below)**
  - Voluntary Care and Service providers;
  - Tenancy Sustainment and Support Service providers;
  - Other Homeless Services Providers (hostels, refuges etc);
- **Social Work and Housing Officers of Kilkenny Local Authorities;**
- **HSE Health and Social Service professionals including:**
  - Executive Clinical Director, Department of Psychiatry, Kilkenny;
  - Discharge Manager St Luke's Hospital;
  - Clinic-based medical and care staff.
- **Service Users**

Interviews were conducted on a semi-structured basis and the key issues examined were the outworking of the key strategic elements of Assessment, Key Working, Personal Action Planning, Access to Health and Social support services, Move-on accommodation and sustainability of independent living. Other elements covered in the primary research was the work of the Homeless Action Team and how its contribution to the implementation of the core objectives of the homeless strategy resulting in the return of people who are homeless to independent living.

Staffing issues were also considered in the staff and management interviews and to some extent with the Service Users.

Interviews were used to record the key informants' experience of working with service users within the context of the new approach adopted in 2006 coinciding with the introduction of the new Regional Integrated Homeless Strategy, the Kilkenny Homeless Action Team and the re-configuration of the approach adopted by Good Shepherd Centre at that time.

In terms of the Service Users' Consultation, M & P had the opportunity to meet with most of the Service Users as part of the Review in 2006 and it was thought that this would provide a focus for a similar exercise in 2010.

GSC was interested in current and former Service Users' views of their experience of services at GSC and this has formed a component of the Review, in terms of identifying service delivery outcomes, pressure points and perspectives. Many residents of GSC have resettled in the locality and have retained their tenancies.

Secondary Research

The independent Review has made use of a range of secondary data relating to Service Users over the four-year period, 2006 – 2009. Data evaluation has facilitated an objective analysis of a range of indicators which have assisted in making an objective perspective of outcomes and, in particular, the strategic direction of the organisation in the period. It has also been possible to compare 2006 – 2009 data with earlier indices and outcomes.

Liaison

M & P has retained good consultative relationships with the Management during the conduct of the Review and all requests for information and assistance has been complied with in a timely and professional manner.

The Review proceeds by setting out;

- **the recommendations of the 2006 Review;**
- **the data analysis of service outcomes;**
- **a summary of the views of interviews;** ***and***
- **identification of outcomes and recommendations.**

3. Review

3.1 Recommendations of Review 2006

The 2006 Review took place at a watershed in the development of homeless services in the South-East. In a broad sense, Service Providers and Commissioners in the South-East acknowledged the imperative for residential services to move away from a relatively one-dimensional service of containment to the more dynamic model of Throughcare. Throughcare is a client-centred, continuum of care approach which sees its prime aim as returning people to sustained independent living using a multi-agency model of collaboration and service delivery.

Some of the recommended changes in the working methods arising from the 2006 Review of GSC are as follows:

- **Introduce way of working or working culture which concentrates on the encouragement of residents to take control of every dimension of their own lives including accommodation, learning and training, self- and personal development, social and recreational life, employment, medication control, relationships and personal responsibility;**
- **Assessment of all people who present as homeless within three weeks by professionally-trained worker;**
- **Care plan to be prepared by professionally-trained worker and endorsed by Homeless Action Team;**
- **Each person to have Key Worker who will work proactively with resident and allocate a minimum of 1.5 hours per week direct contact time;**
- **Continue to re-settle residents to housing in the community as soon as possible after admission and no longer than six months;**
- **Key Worker (or appointed person) to continue to support re-settled resident on outreach programme for up to six months maximum or delegated to third party;**
- **Residents should be referred to specialist residential services if the scope of the Good Shepherd Centre programme is not resourced to provide solutions for the resident – the outcome of assessment approved by Homeless Action Team;**
- **Relevant data to be held on all residents in electronic format, protected and available only to inhouse and network personnel who are professionally-trained and members of professional organisations which subscribe to data protection ethics;**
- **System to be put in place which tracks re-settled and leaving residents who have presented as homeless;**
- **Re-settled residents to be offered the option of the Centre's services at any time in the future;**
- **Establish Users' Council which comprises re-settled ex-residents and current residents;**
- **Establish formal weekly team meetings for Care Team which reviews all Residents' Care Plans;**
- **Work closely with HSE-SE Area personnel and the Homeless Action Team members in the implementation of the work;**
- **Continue to develop networks and working relationships with agencies in the homeless sector with a view to enhancing the quality and effectiveness of the work through integrated and multi-agency working.**

The development of policies such as those above relies on the integrated approach by all stakeholders in the strategy including Local Authorities, HSE and voluntary agencies such as the Good Shepherd Centre. The new approach has inter-agency co-operation and working methods at its core, and has sought to concentrate local professional resources to identify pathways for service users to return to sustained independent living and retain their tenancies into the long-term.

This was a pioneering approach to homeless service delivery in Ireland at the time and GSC Management and Staff embraced it enthusiastically. Kilkenny Local Authorities, HSE South (South-East) and other Service Providers supported the new strategy and the Homeless Action Team was formed and considered all people accessing homeless services in Kilkenny.

3.2 Data Analysis

GSC has recorded the relevant details of Residents' use of the facility and their onward journey. The Review will present a comprehensive analysis of the data over the past number of years.

Year	Admissions	New	Repeat Admissions	New Admissions %	Repeat Admissions %
2003	138	65	73	47%	53%
2004	102	57	45	56%	44%
2005	105	52	53	50%	50%
2006	138	97	41	70%	30%
2007	141	116	25	82%	18%
2008	122	100	22	82%	18%
2009	119	93	26	78%	22%

Table 2 Admissions to GSC 2003 – 2009

Table 2 outlines that the admission of people to GSC has increased since 2006, and while the figure was 119 in 2009, this was still higher than in 2004 and 2005.

Data in Table 1 clearly indicates that the annual number of new admissions has been consistently higher in the 2006 – 2009 period than 2003 – 2005. This has been made possible through the more permanent outcomes for residents as represented by the reducing number of people admitted more than once in the 2006 – 2009 period. Residents are returning at a much-reduced rate now from a high of 53% of all admissions in 2003 to a low of 18% in 2008. The data for 2009 will reveal that the repeat admissions in 2009 were a relatively small number of individuals (15).

On an activity basis, Table 1 also points out that GSC is providing homeless services to approximately twice as many individuals annually from 2006. For example in the year prior to the changes, 2005, there were 52 new people accessing residential services out of 105 total admissions while in 2009, there were 93 new individuals from 119 total admissions. This is not

only an indication of improved 'reach' to more people experiencing homelessness in Kilkenny, but a more effective service characterised by significantly fewer people returning on fewer occasions.

3.2.1 Length of Stay

A key indicator of effectiveness, particularly when taken in the context of other associated data, is the length of time residents remain in homeless accommodation. The preferred strategic model indicates that residents should be returned to sustained independent living as soon as possible with supports where required. This prevents institutionalisation and provides a genuine outcome focus for Key Worker and client alike, and determines the nature and scope of the support to be offered to the client while in residential accommodation to achieve the preferred outcome.

At the same time, too brief a length of stay will mitigate against good quality preparation for sustained independent living while long periods deliver diminishing marginal returns to the client with consecutive weeks of their residence. The optimum period in residential or emergency accommodation will vary with the needs of the client but are determined by the skills and experience of the Key Worker and the management of the accommodation centre.

All residents at GSC have Personal Action Plans and Key Workers.

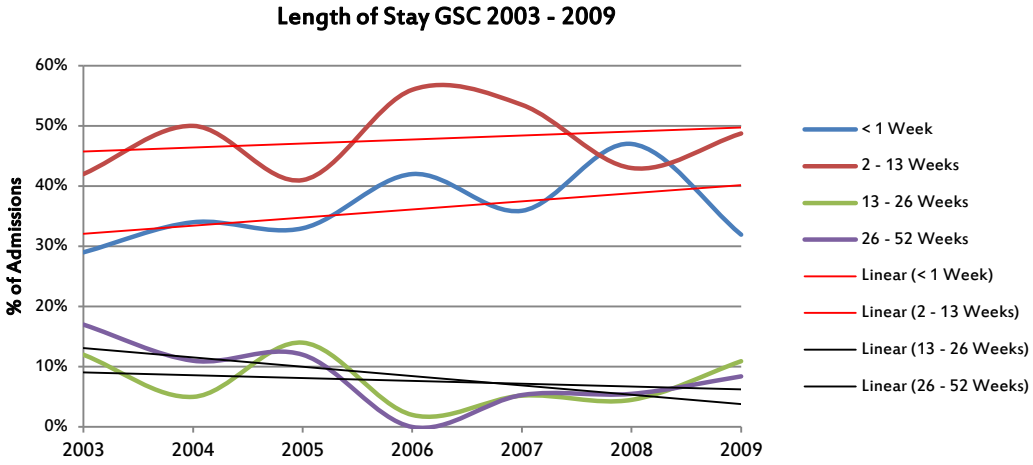


Chart 1 Length of Stay and Trendlines GSC 2003 – 2009

Chart 1 sets out the analysis of the lengths of stay (LOS) of admissions over the 2003 – 2009 period and compares four LOSs:

- **less than 1 week;**
- **between 2 and 13 weeks;**
- **between 13 and 26 week; and**
- **between 26 and 52 weeks.**

M & P has analysed the LOS with GSC and it is clear that different trends have emerged over the pre-2006 and post-2006 periods. The LOS is based on 'admission' rather than individuals and the data is suggesting that much

of the LOS pre-2006 referred to the same people leaving and being re-admitted.

LOS GSC	< 1 Week	2 - 13 Weeks	13 - 26 Weeks	26 - 52 Weeks
2003	29%	42%	12%	17%
2004	34%	50%	5%	11%
2005	33%	41%	14%	12%
2006	42%	56%	2%	0%
2007	36%	54%	5%	5%
2008	47%	43%	5%	6%
2009	32%	49%	11%	8%

Table 3 Length of Stay GSC 2003 - 2009

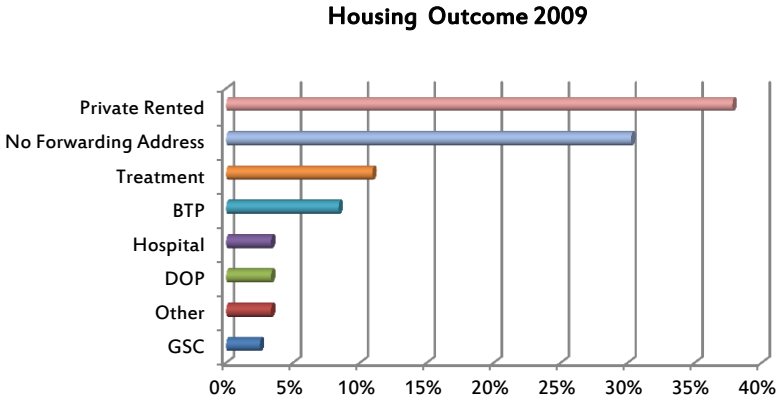
Therefore, while there appear to be only slight but significant reductions in the 26 – 52 week stays of residents from 2003 to 2009, they are actually more pronounced since there were significantly fewer repeat clients. The same is true in the opposite direction for the < 1 week and 2 – 13 weeks LOSs.

It is fair to imply that the data suggests that residents are being encouraged to stay for shorter periods as a result of their eventual outcome being more successful in their permanent housing outcome.

The trendlines in Chart 1 show an increasing number of residents in the shorter periods of stay and fewer in the longer periods of stay.

3.2.2 Outcomes

Housing outcomes for 2009 are detailed in Chart 2 below. The majority of residents returned to sustained independent living in the Private Rented Sector (38%), although 30% exited GSC providing no forwarding address



(NFA).

Chart 2 Housing Outcome GSC 2009

A small number (8%) moved to Brother Thomas Place (BTP), a development of eight apartments officially opened in February 2007 to provide a transitional programme for clients who required a longer period preparatory support. The apartments are located on the grounds of the Good Shepherd Centre and were constructed with funding from the

Capital Assistance Scheme used to support long term homeless into independent living.

A part-time Support Worker key works residents whose Personal Action Plans (PAPs) are prepared with a view to them returning to independent living. Most are referred from GSC although strong links have been developed with the Department of Psychiatry in Kilkenny and they refer a number of clients with a view to preparing them for independent living. Residents may stay no longer than one year at BTP, and almost make a planned move to sustained independent living in the locality.

3.2.2 PLANNED MOVES

A disquieting feature of all emergency accommodation outcomes is the propensity for residents to complete their stay without leaving any forwarding details and in an unplanned manner. For most this means that they move to emergency accommodation either locally or some other town or city in Ireland, thus prolonging their homelessness and exacerbating associated needs.

GSC compiles data on residents' outcomes on leaving GSC, and is particularly interested in planned moves. A planned move is one where the client completes his residency and leaves GSC on a planned basis, which can be to permanent housing, family, sheltered housing etc.

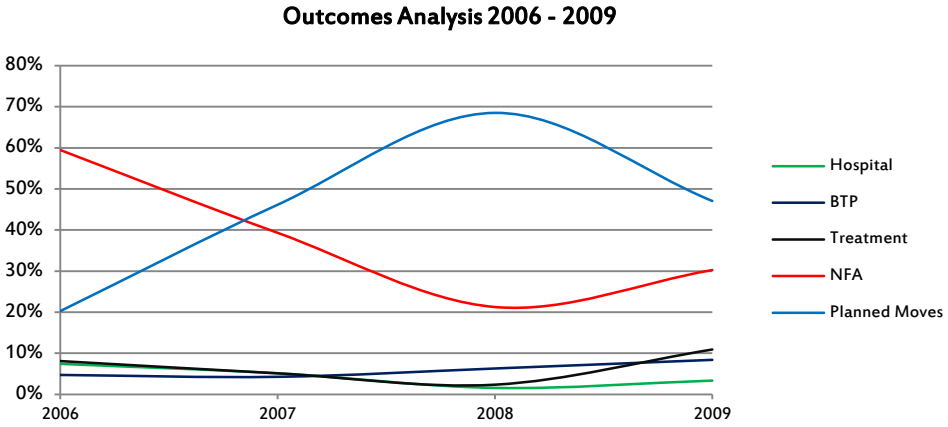


Chart 3 Outcome GSC 2003 – 2009

In Chart 3 above unplanned moves are captured as NFA – No Forwarding Address – and GSC has reduced this occurrence from 60% of all residents in 2006 to 30% in 2009. This compares well with other emergency accommodation provision where the occurrence (NFA) can be as high as 85% of all residents. In the 2006 – 2009 period, the number of planned moves has risen from 20% to almost 50% reaching almost 70% in 2008. Referrals to Hospital, BTP and Treatment are detailed separately since the eventual housing outcome for these residents is uncertain until they complete their stay at those locations.

The next paragraph looks at the relationship between outcome and length of stay as experienced by residents at GSC in 2009.

3.2.3 Outcome and Length of Stay GSC 2009

The average Length of Stay by residents in 2009 was 45.5 days. When the LOS is measured against outcome for GSC in 2009, one can see a marked correlation between the two variables.

Outcome	% Moves in 2009	Average LOS (Days)
No Forwarding Address	39%	10.6
Private Rented	50%	48.8
BTP	11%	151.0
Total	100%	45.5

Table 4 Outcome and Length of Stay GSC 2009

Table 4 demonstrates that the longer the stay in GSC, the more positive the outcome. Half of the residents who left GSC in 2009 found housing in the Private Rented accommodation and had stayed on average seven weeks (48.8 days). A smaller number, 11%, moved to a transitional programme in BTP, and stayed on average 21 weeks before that move was made. By contrast, the 39% of residents who moved on without any forwarding address (NFA), stayed one and a half weeks (10.6 days) on average. GSC has developed a robust portfolio of Throughcare support services and focused, one-to-one key working expertise which will be detailed in paragraph 3.3, and it is thought that this has been the cornerstone of achieving higher than average positive housing outcomes for residents.

3.2.4 Frequency of Admission

Table 5 shows that 84% of residents in 2009 were admitted once, 9% twice and 4% three times. A smaller number were admitted for and five times. Comparative data for emergency accommodation for men suggests that only 35% are admitted once and 65% on multiple occasions in any one year. In another emergency facility for homeless men, 54% were admitted once, 46% more than once and the average LOS was 15 days.

Seven of the multiple admissions (47%) were residents who had moved to the Private Rented sector but who required additional support to sustain their tenancy. Three (20%) were in the NFA category and five (33%) were clients who eventually were referred to BTP.

Frequency of Admission 2009	Number	%
Once	78	84%
2 Times	8	9%
3 Times	4	4%
4 Times	2	2%
5 Times	1	1%
	93	100%

Table 5 Frequency of ADMISSION GSC 2009

The key implications from this analysis is that persistent support has a positive role to play to achieve good outcomes and that the Personal Action Plan is not just for the duration of the resident's stay at GSC but must continue into their tenancy. Clearly, GSC has a policy of retaining key working connections with the client into their tenancy through the working of the Homeless Action Team whose membership includes the Tenancy Support Service which is available to some of the residents moving to independent accommodation.

3.2.5 Age Distribution

Chart 4 demonstrates the age variations of people accessing homeless services at GSC during the 2003 – 2009 period. Of significance is the reduction of the 66+ years of age men to zero from 2006. While this may be a reflection of demand, it is also the result of people being referred to appropriate services, such as Welfare, Nursing or Older People's Homes rather than remaining in Men's Hostels where they are less likely to be in receipt of the range of services that older men need.

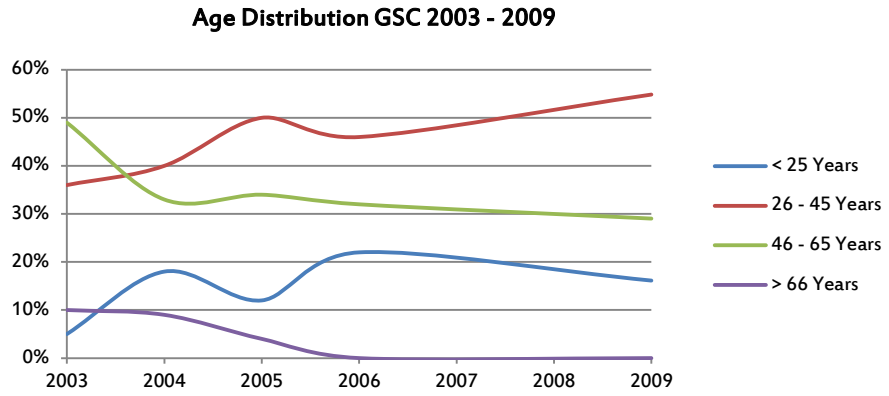


Chart 4 Age Distribution GSC Residents 2003 – 2009

The table also outlines the rising trend of younger people accessing homeless services from 37% in 2003 to 54% in 2009 for the 25 – 45-Year old category and 5% in 2003 to 18% for the under 25-Year old category. The 46 – 65-Year old category has decreased from 59% in 2003 to 29% in 2009. The main implication of the younger age profile is the influence it has on the range and type support services provided for residents. Vocational pursuits and training which assist people to return to work as part of their Personal Action Plan, are crucial for those of working age.

3.2.6 Referral Source

Referral Source history can be an indicator of the working relationships between the GSC and the range of agencies and organisations which come into contact with people experiencing homelessness. In other parts of Ireland, the experience is that between 75% and 85% of people self-refer to homeless services, which, in itself, is an indicator of their disconnection with mainstream services.

For GSC in 2009, self-referral was just 47% of admissions, the remainder being from Kilkenny Local Authorities, Cuan Mhuire, Hospital, Gardaí, and the Department of Psychiatry in Kilkenny (Chart 5 refers).

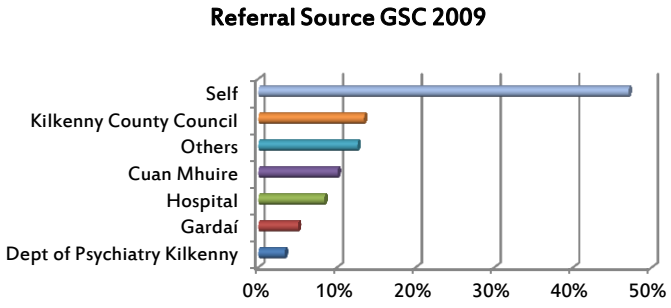


Chart 5 Referral Source GSC Residents 2009

In 2006, GSC sought referral protocols from as many possible sources of its residents as possible, and it is true to say that most, if not all, referrals are planned. The key implication here is that if a person is referred to GSC, their profile and needs are forwarded in advance, facilitating a smooth transition from one service to another, and the preparation of a more accurate and informed Personal Action Plan which can be actioned more quickly. This makes for more efficient use of resources and provides more effective and efficient outcomes for the resident.

Membership and the outworking of Kilkenny HAT (KHAT) has been crucial in facilitating good working relationships with Kilkenny Local Authorities, the Discharge Management in Kilkenny hospitals, the Gardaí, and more recently, the frontline, clinical and nursing management side of the Department of Psychiatry, Kilkenny, who recently joined KHAT.

3.2.7 Funding of Services

Analysis of the financial data for GSC denotes a monetary increase of 40% over the eight-year, 2002 – 2009 period. The real increase, in economic terms, is significantly less than that when cost of living increases are considered.

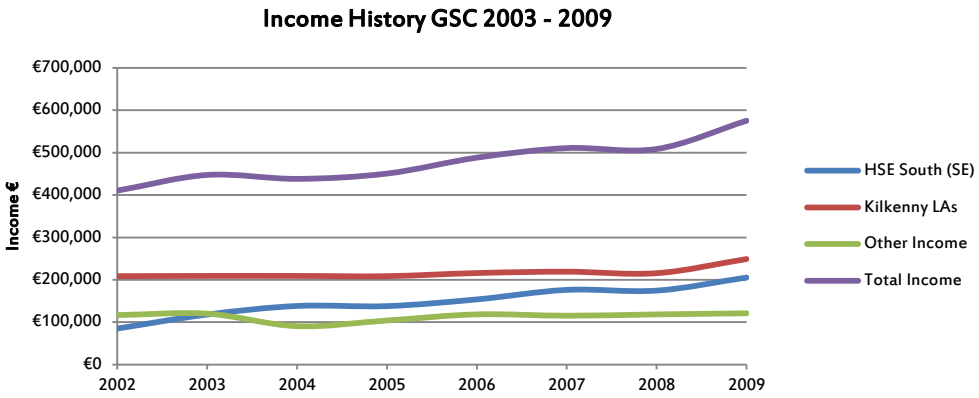


Chart 6 Income Summary GSC 2002 – 2009

The income increase over the four-year, 2006 – 2009 period is shown in Table 6 as 18%.

Income Source	Income Growth	
	2002 - 2009	2006 - 2009
HSE South (South-East)	142%	34%
Kilkenny LAs	19%	15%
Other Income	4%	2%
Total	**40%**	**18%**

Table 6 Income Growth GSC Short and Long-Term 2002 – 2009

HSE funding has increased gradually over the period – by 142% from 2002 – 2009 and 34% from 200 – 2009. Kilkenny Local Authorities' composite funding has risen by 19% from 2002 – 2009 and 15% from 2006 – 2009, while Other Income, including donations and once-off funding support, by 4% and 2% for the two periods.

Prior to the previous Review in 2006, the staff complement was eight - Manager, three Care Workers and four Domestic Staff. At the end of 2009, the staff complement was thirteen – Manager, eight Care Workers (7 FTE) and four Domestic Staff. This increase reflects the considerable change in the nature of the work which now provides high quality Key Working and a commitment to the Throughcare Model. These elements are labour intensive but derive improved outcomes as outlined in Paragraph 3.2 where twice as many people are now accessing GSC's residential services and not returning to homelessness.

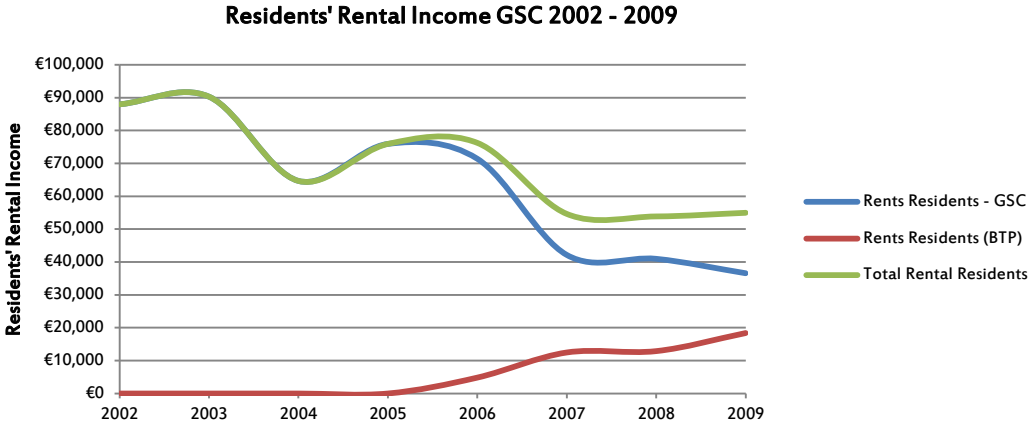


Chart 7 Residents' Rental Income Summary GSC 2002 – 2009

At the same time, one can see from Chart 7 that a stable income source, Residents' Rent, has declined over the period from €90k in 2002 to €55k in 2009. In turn, this reflects the efficiencies derived from the shorter length of stay by residents and realising the commitment to return people to sustained independent living as quickly as possible and not to detain them unnecessarily in institutional care from which it is more difficult to rehabilitate people the longer they remain there. GSC has become a 'victim of its own success' generating enhanced outcomes to more people from the target group but deriving lower rental income as a result. While the strategic outcomes were part of the plan and have been realised, it has been difficult in the current climate to replace the income lost from the traditional long-term residencies before 2006 and the Centre has been operating at an annual €35k - €40k deficit (6% of total income). It was

anticipated that this could have been absorbed within current income streams or that operating costs could be reduced accordingly but these solutions have remained elusive and other measures will have to be considered.

M & P has also reviewed the cost per unit – the units selected being new residents on the one hand and admissions on the other in a calendar year. The most useful statistic is the 'New Resident' one although cost per admission can be useful from a year-on-year comparison point of view.

Table 7 below sets out the cost per unit annually from 2003 – 2009. It is a relatively loose use of data comparison, but it serves to make some sort of comparison and sheds some light on the annual performance, relating income to output.

	2009	2008	2007	2006	2005	2004	2003
Total Income	€575,300	€508,587	€510,682	€488,169	€450,587	€438,116	€447,311
New Residents	93	100	116	97	52	57	65
Admissions	119	120	141	138	105	102	138
Cost per New Residents	€6,186	€5,086	€4,402	€5,033	€8,665	€7,686	€6,882
Cost per Admission	€4,834	€4,238	€3,622	€3,537	€4,291	€4,295	€3,241

Table 7 Unit Cost Analysis GSC 2003 - 2009

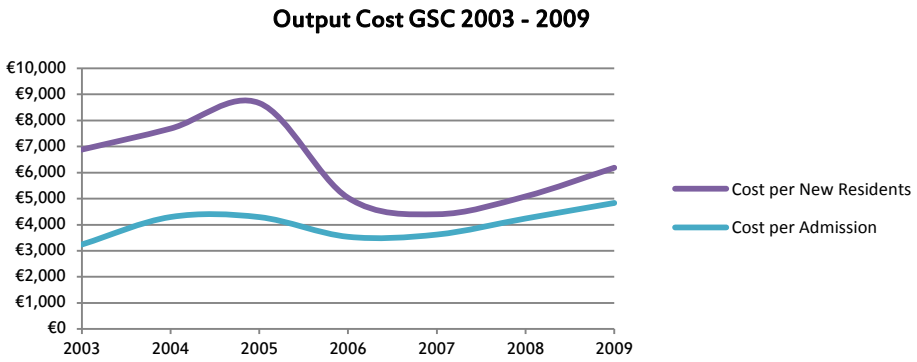


Chart 8 Output Cost GSC 2003 – 2009

Table 7 and Chart 8 compare the unit costs over the 2003 – 2009 period (the period for which funding details were provided). The cost per admission has stayed relatively stable in monetary terms but the cost per New Resident has reduced somewhat. When translated into real cost (allowing for annual inflation), both have reduced considerably, while the important 'New Resident' cost has come down even more. In monetary terms the reduction in 'New Resident' cost is almost 42% between the high in 2005 of €8,665 just prior to the changes, and the low of €4,238 in 2008. The reduction between 2005 and 2009 is 29% in monetary terms. Both are clearly even greater reductions in real terms.

In summary, despite the funding levels increasing from HSE South (South-East) and Kilkenny Local Authorities, the service is more efficient and more effective based on the cost per unit data.

Section 3.3 outlines the support services available at Good Shepherd Centre.

3.3 Staffing & Support Services

3.3.1 Staff Profile

There are thirteen members of staff at GSC providing care and support on a 24-hour, 7-day a week basis.

Frontline service is provided by the Manager and eight staff to residents and potential residents. There are six Care Workers (5.5 FTE), one Support Worker (part time at 19½ hours per week, BTP)) and one Life Skills Worker. Four Domestic Workers provide cooking and ancillary services at GSC.

Staff Member	Post	Qualifications/Experience	In Post Since
Fergus Keane	Manager	BA Applied Social Studies	2006
Pat Carroll	Care Worker	BA Social Care	1989
Finbarr Hourigan	Care Worker/Admin	Dip. Social Care	1990
Aidan Quigley	Care Worker	BA Social Care	2006
Louis Fitzmaurice	Care Worker	Dip. Drama Therapy	2006
Ann McMullan	Care Worker (25 hrs pw)	Dip. Addiction Studies	2006
Ann Jones	Life Skills Co-ordinator	BA Social Care	2007
Angela Finnegan	Care Worker	B Sc (Hons) Environmental Biology	2009
Angela Broderick	Support Worker (19½ hrs pw)	BA Applied Social Studies	2008
Bernie Ryan	Domestic Worker	Experience	2007
Brigid Fitzpatrick	Domestic Worker	Experience	1998
Joan Ward	Domestic Worker	Experience	2000
A N Other	Domestic Worker	Experience	2009

Table 8 Staff and Management GSC June 2010

Staff work on a rotational basis 24/7 and key working is provided on a shared basis to ensure that all residents have access to informed support at all times. In general, two Care Workers are present during day time and one at night. Life Skills and Support Work are provided during the day.

Care workers are responsible for assessment, preparing residents' personal action plans, key working, client support, reviewing plans, liaising with residents in their new tenancies and ensuring the smooth operation of the Centre. All staff liaise with health professionals and other key organisations in the community in relation to the residents and have a multi-disciplinary role. Partnership and multi-agency co-operation are the key elements of residents' successful journeys back to sustained independent living and the staff at GSC have considerable expertise at co-ordinating these roles.

3.3.2 Life Skills Programme

The Life Skills Programme was established in 2007 and is offered to residents, most of whom avail of at least one of the modules. It aims to equip adults with the skills they need to maintain their accommodation, while also focusing on building self-esteem and enriching their lives as a whole. The programme is open to homeless adults or those at risk of becoming homeless. External agencies including MABS, Schizophrenia

Ireland and the Adult Guidance Service have also facilitated sessions with the trainees, covering various areas. Validation applications have been made for many of the modules.

Service users mentioned in the one-to-one interviews in the course of this review that they appreciated the flexibility of the programme, that it is client centred and addresses skills that they need in independent living.

Modules

The modules being offered to trainees are as follows:

1. Budgeting;
2. Cooking (includes menus, household cleaning, using domestic appliances etc.);
3. Communications;
4. Coping skills;
5. Personal and Interpersonal Skills;
6. Self-Advocacy;
7. Preparation for Work;
8. Art & Design;
9. Mathematics;
10. Computer Literacy;
11. 6-week photography course.

Non-modular work is also offered to trainees which includes:

- **Painting classes;**
- **The Veg Shed project;**

Trainees and ex-residents grow their own vegetables which then can be enjoyed either in their own accommodation or in the Centre. Trainees meet once a month to discuss concerns, ideas, and opinions. The meeting is carried out in a formal manner, with each of the trainees taking it in turn to record the minutes. The objective of the project is to ensure that the trainees feel a sense of ownership over the project while trainees guide the process and are involved in decision making at every step.

- **Recreation and leisure activities;**

Trainees meet once weekly to engage in a group activity i.e. bowling, driving range, cinema etc. Ex-Trainees who have moved on to their own accommodation also avail of this module and can provide as role models as well as gaining from the activity. This activity helps trainees to bond as a group, while also serving to build their self-esteem in a social setting.

- **Photography and creative writing course;**
- **Motivational training course;**
- **On-going support in dealing with personal issues, in a non-threatening environment.**

The programme also acts as a referral agent to other local services i.e. FÁS Training, the adult guidance service, MABS, counselling etc. These services have also been invited and have on occasions delivered presentations

about the service that they offer to the trainees, in order to build relationships and raise awareness.

3.3.3 Staff Consultation

All frontline service staff as detailed in Table 6 above were interviewed as part of this assignment. Domestic staff were not interviewed on this occasion on account of time and logistics.

In general, the staff interviewed are highly-motivated, enthusiastic individuals whose experience and expertise has been crucial in driving the progressive agenda of the Good Shepherd Centre.

Five of the eight members of staff (excluding the Manager) were in the employ of GSC prior to the changes in 2006, while three have been recruited subsequently. All of the pre-2006 staff have found the changes in service delivery positive and have had little problem adapting to the more proactive and purposeful approach. All agree that the service is more client-focused and that communications and co-operation with associated agencies and organisations has added to the quality of outcome for the clients.

All have specific and well-developed skills and expertise across the range of residents' needs and some have a background in substance misuse which is an area of increasing demand within service users. The Team meets fortnightly to discuss residents' personal action plans and developments in service provision at GSC. All believe that re-settlement should be an integrated component of the Personal Action Plan and that they should be responsible for the crucial resettlement element including tenancy sustainment. Some believe that GSC has the capacity to become a one-stop shop for homelessness in the area and that an interactive website could be established to support it.

Administration

Some have concerns at the amount of paperwork required to support the system including a referral form, administration form, personal action plan and other administrative detail. While there may be some initiative to improve this state of affairs, agencies such as GSC should be aware of the exigencies attached to untoward incidents to their residents and the importance of written records in the event of any subsequent enquiries. Good governance is essential element in today's litigious environment and particularly when agencies such as GSC are providing services on behalf of agencies with the statutory authority and responsibility for the service users.

Staffing Rota and Arrangements

Staff members felt that the handover process, between one shift and the next, could be improved, and that staffing arrangements could better facilitate team synergy. At the moment, the rota system ensures that there are two care staff on duty during the day (approx. 9 to 5) and one at night

(19.45 – 09.15). Staff feel that there is little quality time for team contact and that such contact may provide enhanced outcomes for residents and provide for improved working relationships to that end. There is little doubt that the economies of scale have a bearing on the number of staff as well as funding considerations.

Substantial time and effort over the past four years has gone into expanding the care staff from 3 to 5.5 FTE and the logistics of providing twenty-four hour, seven-day-a week cover by professional staff. At the same time, the GSC team has further expanded by two additional members of staff. The newly-recruited Care Worker delivering the Life Skills Programme has added an additional dimension to the overall service and the Support Worker for residents at BTP has added further expertise and skillsets to the team. Many positive benefits have derived from this, as outlined by the GSC residents' outcome data above over the recent years. The new client-centred service delivery approach has provided intensive and attentive support to residents, better relationships have ensued and high quality work has delivered improved outcomes.

Given the tight economic climate and the limited prospect of additional income in the short to medium term, It might be opportune to re-visit the staffing configuration and consider the timeframes when the critical support which is delivering results, is most effective. For example, it might be the case that during the sleeping hours of 10.00pm to 8.00am and weekends, or one of the days at the weekend, that care staff need not be on duty. This gap could be filled by responsible, non-care staff, with urgent business or admissions (which seem to be sufficiently rare now at this time of night) deferred until the next day-time shift comprising care staff. On the face of it, this could mean that at least three care staff could be co-working at the same time and that all five could be convened more easily more often, increasing staff connectivity and liaison and deriving even better outcomes for clients.

Substance Misuse

All staff raised the issue of the increasing incidence of residents experiencing homelessness also misusing various substances including heroin. This is a mounting challenge and while several care staff have good expertise in the area, it is important that clarification of responsibilities is acknowledged. GSC's clear specialism is in preparing people who are homeless for independent living. Residents' backgrounds are wide and varied and all personal action plans will require the input of relevant expertise from specialists in the area(s) of need of each resident. The HSE Carlow/Kilkenny Substance Misuse Office has recently augmented its team (June 2010) by two Addictions Counsellor within the Community and Statutory Addictions Programme (CASA) and it is suggested here that links are strengthened between CASA and the Team. There are some connections already but as yet, the KHAT does not include anyone from the HSE Addictions Team. Other substance misuse treatment services are being augmented in Carlow/Kilkenny and it would a major

step forward for these suggested links to be formalised given the increasing incidence of heroin and other serious substance misuse among GSC's service users and the importance of having these issues addressed expediently as part of their return to independent living. In 2009, 11% of GSC's residents were referred to Addictions Treatment Services as part of their Personal Action Plan. Such links would also provide a credible advisory support to all GSC staff in addressing the needs of serious drugs users who are also homeless.

3.3.4 Department of Psychiatry St. Luke's Hospital Kilkenny

GSC and the KHAT have developed strong links with the Department of Psychiatry in St. Luke's Hospital, Kilkenny (DOP). Initially, the relationship was one where GSC relied on DOP for emergency and formal support for its residents. In 2008, DOP nominated one of its Clinical Nurse Managers as a representative to the KHAT which has strengthened the relationship and provided a more streamlined process for clients.

Recently, GSC has made a submission with the support of DOP Kilkenny for the provision of housing units to accommodate clients who can be supported in independent living. Clients have been identified within the KHAT process and within DOP's appraisal systems. GSC would provide the expertise to prepare residents of GSC and patients at DOP for sustained independent living and an appropriate level of support to sustain their new tenancies. These residents would also have ongoing access to all the support resources at GSC including the Life Skills Programme and links with vocational agencies and employers. The application is currently under consideration by Kilkenny Local Authorities (July 2010) under the Capital Assistance Scheme.

M & P would assert that this is one of the key outcomes from the Homeless Action Team process where appropriate housing and supports are identified for residents and patients with specific needs but who have the capability to live independently with good preparation and ongoing support. This would not be possible without the operation of the KHAT process where all people accessing homeless services are reviewed within their Personal Action Plan and short, medium and long-term needs.

3.3.5 HSE Community Welfare Officer

The HSE Community Welfare Officer (CWO) for Carlow/Kilkenny provides high quality support to clients and service providers alike. He works closely with KHAT, of which he is also a member, and is a key member of the partnership. All service users are supported through the office of the CWO and is also a crucial link between providers and clients when residents move to independent living.

3.3.6 Tenancy Support Services

Focus Ireland were appointed by Kilkenny Local Authorities for an eighteen-month period to provide Tenancy Support Services (TSS) in the

Kilkenny area. Some of the residents of GSC who are moving to sustained independent living receive TSS services from this service.

The Model being applied within the SE Homeless Integrated Strategy requires all residents who move to sustained independent living to avail of appropriate supports as part of their personal action plan. This is based on the observation that this move is the most crucial in the plan itself and that it is the actual objective of the work provided in emergency and transitional accommodation. Most tenancies fail without support for ex-residents in their new accommodation and most access homeless services on a continuous basis, compromising the impact of the Key Working.

M & P believes that Key Working and the personal action plan should extend into the tenancy of all resettled people, be monitored and act as a key indicator of the efficacy of the preparatory work. This is known as the Throughcare Model rather than separate tranches of support traditionally described as standalone services such as 'incare', 'aftercare' and 'sustained care'. It is variously described as a seamless and integrated assessment and planning process providing for integrated multi-agency assessment and service planning that identifies the needs of an individual and develops appropriate internal and external pathways providing enduring service interventions. Successful resettlement is based on a number of factors and for service users of emergency accommodation, the experience is that one of the key determinants is the personal relationships that are established in the pathway and implementation of the personal action plan by the Key Worker and the Service Provider, GSC in this case.

M & P also believes that the resettlement outcome, as the most important outcome of provision of homeless services, should be monitored on a formal basis year-on-year. All people who have moved on should be 'tracked' and recorded for a period of at least five years after they leave emergency accommodation. This presents some challenges but it ought to be possible to check the tenancies of all people who resettle from emergency and transitional services locally and record their status. This could be carried through the KHAT collectively and involve the Key Worker from GSC, the CWO and Kilkenny Local Authorities.

3.3.7 Kilkenny Local Authorities

Kilkenny Local Authorities have been fully supportive of the homeless initiatives emanating from GSC and the Homeless Action Team. KLA staff are fully integrated into the working plan of GSC and address the particular issues of housing availability and various housing schemes which will impact on accommodation for people accessing emergency homeless services. The Senior Social Worker, Margaret Newport, is involved in all discussions and guides the co-operation and co-ordination of multi-disciplinary work in Kilkenny.

3.3.8 Kilkenny Homeless Action Team

Kilkenny Homeless Action Team (KHAT) was established in 2006 and has been a very influential multi-agency group in the re-configuration and delivery of homeless services in Kilkenny in recent times. Six separate key agencies are represented on KHAT which is chaired by Margaret Newport, Senior Social Worker, Kilkenny Local Authorities, and meets weekly (Table 9 refers).

All people accessing homeless services in Kilkenny are referred to KHAT for review and progress of their personal action plans and agencies. The weekly meeting ensures that service providers are aware of impending timelines for clients' needs and can ensure the seamless provision of services on the pathway to sustained independent living.

Member	Agency
Margaret Newport	Kilkenny Local Authorities
Paddy Kelly	HSE South (South-East)
Tina Sullivan	Amber Women's Refuge
Audrey Casey	Focus Ireland
Kasia Nolan	Department of Psychiatry Kilkenny
Mary Cashin	Kilkenny Local Authorities (Admin)
Fergus Keane	Good Shepherd Centre

Table 9 Kilkenny Homeless Action Team July 2010

There are two residential facilities in Kilkenny, Amber Women's Refuge and Good Shepherd Centre. The two agencies co-operate at every level and other agencies on KHAT value their service in order to meet their statutory and other obligations and responsibilities.

3.3.9 Service Users

A cross section of Service Users participated in interviews for the Review. The interviews were face-to-face, open-ended and relaxed. Most were current residents and some ex-residents but living locally. All expressed unqualified support for the Centre Team and its work. M & P was keen to identify Service Users' perception of their priorities and it was clear that their physical and mental health and return to permanent accommodation were top of the list. All mentioned the good relationships with their Key Workers and other staff and their understanding of their needs. They were all aware of their needs and what they had to do within their control to achieve their aims. All of the interviewees felt that the staff and management had the their health and long-term interest at heart and were fully appreciative of the range of supports made available to them to achieve the desired outcomes.

The next section is abroad discussion on some of the key points upon which recommendations are made for the future.

4. Commentary & Recommendations

GSC has always been open and transparent about its services and development since 2006 and the review in 2010 is the second in five years. The Management and Staff adopted the South-East Integrated Resettlement Strategy 2006 and have embraced change and implemented the recommendations of its initial review in 2006. Three of the original staff undertook Social Care academic training to first degree and diploma level, and all subsequently-recruited care staff have relevant academic backgrounds to first degree level. GSC regards itself as a centre for homeless services now rather than an accommodation-only hostel. In fact, it has discarded the designation 'the hostel' for the more suitable 'the Centre'.

The scope and nature of its services have responded to the developing need within homelessness and within contemporary models of service delivery. All residents are encouraged in the first instance, to contemplate their return to sustained independent living and the actions and milestones that they have to reach to achieve it. Staff are highly-motivated in general and have this as the underlying objective of the service at GSC. Support programmes such as the Life Skills Programme and Key Working which extends into ex-residents' tenancies in most cases, reinforce the personal relationships between worker and resident and have proved effective in attaining a higher number of residents, shorter lengths of stay and more planned moves into permanent accommodation.

The Transitional Programmes provided at BTP which have a maximum twelve months' duration on average, have facilitated a more intensive level of work for residents with greater needs for their return to sustained independent living, provided by its own Support Worker and integrated into the Centre's core facilities.

In short, GSC has developed its expertise to a level where it could be better-described as a Re-Settlement Service in line with the 2006 strategy for the South-East. Such a service profile relies on highly-motivated staff, innovative support programmes for clients, the availability of appropriate housing and good working relationships with other agencies. The ability of staff to 'move' people accessing homeless services from a state of multiple crisis to sustained independent living, is complex, multifaceted and possible. Multi-agency working both within the confines of KHAT and through working relationships generated through KHAT, have focused the energies of all relevant agencies on the pathway for each client.

GSC's aspiration to reinforce its prime role as a Re-Settlement specialist is evidenced through its funding application to the Capital Assistance Scheme to work in partnership with the Department of Psychiatry in supporting mutual clients in specific housing. This co-operation would see the Throughcare Model applied to specific clients with Mental Health needs who experience homelessness, in seamless way through the work and staff at the DoP and GSC. For both agencies, this planned moving of clients reflects their working philosophies in 2010 and co-operation at this

level may become more prevalent as patients suffering from mental ill-health but confined or repeatedly returning to institutional care, are relocated to independent living with supports. There is evidence that a proportion of clients who relocate from Mental Health institutions or care, in an unplanned way, eventually end up in homeless services.

Some recommendations arising from the Review, which the Board, Management and Staff of GSC might wish to consider are summarised below. The rationale for most has been articulated in the narrative of the document while some may require more information and discussion to consider in greater detail. The main recommendations relate to the following areas:

1. **Re-Settlement – an integral component of the Personal Action Plan;**
2. **Staffing Re-Configuration suggestions;**
3. **Increase in the incidence of Substance Misuse among Service Users and local developments;**
4. **Developing accommodation options and specific target groups;**
5. **Data and Tracking.**

4.1 Re-Settlement

Given the importance of placing and sustaining residents in tenancies, it is M & P's recommendation that that this function should be delivered and managed by the Key Worker for the resident. All residents should have the housing outcome as the 'end product' of their pathway through homeless services and it is thought that improved and sustained outcomes are more likely if that element or component of the Personal Action Plan is provided by the person who has generated the motivation in the resident to complete his pathway and make the move.

It is recommended that this approach and change in strategy is piloted for two years and could involve the recruitment of two additional members of staff.

4.2 Staffing Re-Configuration

As detailed above, the current staffing system was developed before the more recent addition of staff (see Table 8, Page 17). Two Care staff are on duty for twelve-hour shifts during the day and one at night. Team dynamic and synergy on client issues may be improved through a re-configuration which maximises care staff presence during the waking hours and the working day of agencies and organisations ion whom Key Workers rely on for client support. Non-care staff could be employed during the hours of 10.00pm and 9.00am. This re-configuration could generate increased liaison between staff on clients' pathways and immediate and long-term needs. It could also occasion an increased availability of intensive supports for residents by Key Workers. If there is to be an increased resource towards the Re-Settlement component and other support services, these

can be delivered more efficiently between the hours of 9.00am and 10.00pm thus optimising the efficiency of all Care staff.

It is recommended that the Management and Staff consider these issues in 2010 for implementation in 2011 at the latest.

4.3 Emerging Challenges and Opportunities – Substance Misuse

All staff mentioned the increasing incidence of substance misuse within their target group and particularly, heroin and other serious addictive substances. Resources have recently increased in HSE South (South-East)'s Carlow/Kilkenny Substance Misuse Team (SMT) where there are additional addictions counsellors with a Methadone Clinic (due to open August 2010) and Detox beds in the pipeline.

It is recommended that GSC develop formal working relationships with the SMT and recruit its expertise in working with residents on-site or by arrangement.

4.4 Target Groups and Specified Accommodation

One of the key outcomes of the operation of KHAT and the HAT concept, has been the identification of the specific needs of people accessing homeless services and their housing needs. Collaboration with the DoP is an example of this. There may be an opportunity extend this service to other key target groups including young people leaving care, prisoners and substance misusers. These are difficult areas where a seamless Throughcare approach could prevent homelessness.

4.5 Data and Tracking

Generally speaking the data capture at GSC is satisfactory and management and staff can extract relevant data for monitoring purposes. On a Regional basis, it would be better if some uniform data capture system was created so that comparison could be made and analyses carried out. KHAT captures client/referral information on a weekly basis and could build this resource into a coherent annualised format which could then be used for planning and performance. The purpose of the data research is to construct a profile of homelessness activity and trends. Each record of admission should include accurate information on the following variables:

- Gender;
- DOB;
- Marital/Relationship Status;
- Place of Origin (Town, County, Country);
- Last Address (Town/County/Country);
- PPS No;
- Date of Admission;
- Date of Departure;
- Length of Time Homeless before Presenting;
- Reason for Homelessness (on this occasion);
- How Long Homeless to Date;
- Identified Addictions Need;
- Key Worker;

- Care/Support Plan;
- Outcome - Destination on Leaving Service (LA Housing, Private Rented, Other Homeless Service – specify - in local area);
- Current location of former Service User.

These can then be analysed for the period under review to provide planning and performance analyses.

In terms of Re-Settlement, it would be useful to formally 'track' ex-residents for a period of five years following their move to independent living or whatever type of housing they have acquired. There may be some difficulties with this, but it is the only way of determining the sustainability of outcomes. Where, ongoing supports are provided, it is a simple task to record the housing status of the re-settled person, and once the formal support has terminated, a telephone call or house call may be required. Local conditions and practice could determine the methods used to carry out this essential monitoring.

M & P would like to thank all Management, Staff, Service Users, partner Agencies and Organisations who contributed to the completion of this review.