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Parental Perceptions Regarding the Impact of Housing on Child Health

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Abstract

Introduction

Childhood poverty has life-long adverse impacts. We aimed to assess perceptions of parents of a cohort of children attending a paediatric emergency department regarding the impact of their housing on their child and family

Methods

From 01/11/2020 – 08/01/2021 a cross-sectional study was performed in a paediatric emergency department in Dublin

Results

Of 312 parents who completed a questionnaire, 4.5% (*n* = 14) reported themselves to be homeless. Homeless children were less likely to be registered with general practitioners (78.6% vs. 97.5%, *p* = .009) or be fully vaccinated (71.4% vs. 92.4%, *p* = .024). Homeless parents were more likely to feel unsafe at home (35.7% vs. 3.4%, *p* <.001), and to report that their housing negatively impacted their child's education (58.3% vs 10.7%, *p* <.001), physical health (45.5% vs 11.7, *p* = .007), and mental health (61.5% vs 12.6%, *p* <.001). Ten percent of non-homeless parents were concerned about losing their home. A lack of landlord permission to install child safety measures in the home was reported by 28% of all parents.

Conclusion

Homeless parents were more likely to report that their living situation negatively impacted their child's play, development, education, safety, and health.

Introduction

Increased non-urgent emergency department (ED) attendances are an inefficient use of healthcare leading to increased expenses, overcrowding and treatment delays, while compromising quality of care [1-3]. This has prompted increased interest in determining the precipitants of emergency healthcare utilisation.

Approximately 25% of United Kingdom (UK) children attend ED annually [4], with attendances increasing 4% per annum [3]. From 2006 – 2016, UK paediatric emergency admissions increased by 6%-9%, driven by increased infant admissions [3, 5].

UK data reports that 11% of paediatric ED attendances arrive by ambulance [6]. Despite 79% being triaged as non-urgent, 90% of parents feel the complaint warrants a same day assessment [4]. Self-referrals account for 52%-78% of paediatric ED attendances [3, 4, 6]. Self-reported reasons for paediatric ED self-referral include: perceived more appropriate ED issue (73%), perceived emergency (58%), perception general practitioner (GP) would refer (43%), expectation seen quicker than with GP (7%-31%), GP scheduling difficulties (19%), perceived better treatment (18%), perceived better staff (18%), convenience (3%), and dissatisfaction with GP (3%) [1, 4, 7].

UK studies report socio-demographic factors are the strongest predictors of adult ED attendances, including unemployment rate ratio *(RR)* = 1.4, 95% confidence interval (CI) [1.1, 1.8], and poor housing *RR* = 1.3, 95% CI [1, 1.8], with 32% of deprived populations attending ED in the past year [2].

These findings are replicated in Ireland. Studies comparing the most to least deprived adults report reduced outpatient healthcare use, and increased emergency admissions incidence rate ratio *(IRR)* = 4.3, 95% CI [4.2, 4.4], emergency readmissions *IRR* = 1.53, 95% CI [1.47, 1.6], and 30-day hospital mortality odds ratio *(OR)* = 1.6, 95% CI [1.4, 1.8] amongst the most deprived [8, 9].

These trends also occur in paediatric populations. European studies report increased ED attendances *IRR* = 1.6-2.2, self-referrals *OR* = 2, 95% CI [1.2, 3.4], and emergency admissions (↑55%) when comparing the most to least deprived children [1, 5, 7, 10]. Increased emergency admissions are observed in groups associated with deprivation and poor health literacy, including non-European parents hazard ratio *(HR)* = 1.23, 95% CI [1.18, 1.29], reduced maternal age *HR* = 1.3, 95% CI [1.2, 1.4], reduced maternal education *HR* = 1.18, 95% CI [1.12, 1.23], and maternal psychiatric disorder *HR* = 1.34, 95% CI [1.3, 1.39] [11].

In 2020, 20% of 0-17 year olds in Ireland were experiencing at least two types of deprivation. A further 17% were at risk of poverty [12]. Families are the fastest rising homeless group in Ireland, with low housing stock and private rental issues considered the main stimuli for the current housing crisis [13, 14]. The authors have previously demonstrated that homeless children in Ireland are more likely to belong to ethnic minorities and have increased emergency healthcare utilisation, while being less likely to have registered GPs and be fully vaccinated, compared to non-homeless children [13].

Although deprivation is associated with increased paediatric ED attendances, self-referrals, and emergency admissions, significant variations exist between facilities. Confounding factors related to deprivation and increased emergency healthcare utilisation include prematurity, low birth weight, being underweight, household smoke exposure, overcrowding and homelessness. Healthcare provider factors also vary widely [1, 3, 5, 10, 11].

Adverse childhood experiences, including poverty and inadequate housing, predict progressive lifestyle disadvantage following an intergenerational cycle, including physical and mental ill-health, academic and employment issues, substance misuse, criminality, teenage pregnancies, increased healthcare utilisation and adult homelessness [5, 15, 16].

We aimed to assess parental perceptions of a cohort of children regarding the impact of their housing on their child and family, and secondarily to explore emergency healthcare utilisation.

We hypothesised that homeless parents would be more likely to report negative impacts of housing on health, education, and well-being.

Methods

We conducted a cross-sectional survey in a tertiary paediatric (<16 years) ED. This hospital serves a deprived inner city area with a high proportion of local homeless accommodation. Of 54,000 annual attendances, 1.6% are homeless. The authors are aware of 139 homeless emergency accommodation facilities being used for families in our catchment area, including 28 addresses on one local street. We did not have access to demographic data regarding the local population of homeless families.

Respondents were identified as homeless if they self-identified as such, resided in government homeless accommodation, or Direct Provision. Direct Provision provides centrally allocated accommodation and living expenses to international protection applicants in Ireland [17].

All patients attending ED from 01/11/2020 – 08/01/2021 were eligible. Parents were invited to complete a questionnaire which was distributed during triage. The questionnaire was developed from a previous departmental survey [18]. Questions were asked regarding demographics, living situation, medical history, and healthcare utilisation. Parents were also invited to provide additional "free text" comments regarding their living situation. No interpreters were specifically available for this study. No literacy assistance was offered to parents.

Data were analysed using SPSS version 27. Numerical data were summarised using medians, interquartile range and Mann-Whitney tests as parametric assumptions were not met. Categorical variables were analysed using Chi-squared or Fisher's exact tests. Significant differences for non-binary categorical variables were assessed by comparing adjusted residuals.

Proportions were presented as valid percentages, accounting for missing data. Confidence intervals were calculated using the 'exact method'.

This study was approved by the Research and Ethics Committee of Children's Health Ireland at Temple Street.

Results

We report findings from the questionnaire with illustrative comments made by non-homeless respondents interspersed within the free text.

From 01/11/2020 – 08/01/2021, 312 questionnaires were completed (homeless = 14, 4.5%; non-homeless = 298, 95.5%). During this period there were 6,117 ED attendances.

Compared to the non-homeless, homeless children were less likely to be White Irish (30.8% vs. 78.9%), with over-representation of Irish Traveller (15.4% vs. 2%), black (23.1% vs. 4.1%) and other (23.1% vs. 2.7%) ethnicities $p < .001$ (Table 1).

Table 1: *Socio-demographic Characteristics*

	Non-homeless *n* = 298 (95.5%)			**Homeless** *n* = 14 (4.5%)			
Variable	*n*	%	95% CI	*n*	%	95% CI	*p* value
Age months *Mdn (IQR)*	72	(24-123)		16	(8-84)		.062
Ethnicity							
White Irish	232	78.9	[73.9, 83.2]	4	30.8	[12.7, 57.6]	χ^2 (6) = 37
Irish Traveller	6	2	[0.9, 4.4]	2	15.4	[4.3, 42.2]	*N* = 307
Other white	22	7.5	[5, 11.1]	0	0	[0, 22.8]	*p* <.001 [a]
Black	12	4.1	[2.4, 7]	3	23.1	[8.2, 50.3]	
Asian	14	4.8	[2.9, 7.8]	1	7.7	[1.4, 33.3]	
Other non-Irish	8	2.7	[1.4, 5.3]	3	23.1	[8.2, 50.3]	

Notes. Mdn = median. *IQR* = interquartile range.

[a] Analysis of adjusted residuals revealed significant differences were due to differences in White Irish, Irish Traveller, Black and other non-Irish ethnicities

Compared to the non-homeless, homeless children were less likely to have registered GPs (78.6% vs. 97.5%, $p = .009$) or be fully vaccinated (71.4% vs. 92.4%, $p = .024$). They were more likely to feel housing impacted their ability to maintain registration with a GP (23.1% vs. 1.5%, $p = .002$) (Table 2).

Table 2: *Healthcare Utilisation Trends*

	Non-homeless *n* = 298 (95.5%)			Homeless *n* = 14 (4.5%)			
Variable	*n*	%	95% CI	*n*	%	95% CI	*p* value
Previous medical history	58	19.8	[15.6, 24.7]	1	7.7	[1.4, 33.3]	.475
Registered GP	273	97.5	[94.9, 98.8]	11	78.6	[52.4, 92.4]	.009
Presenting complaint							
Medical	149	58.2	[52.1, 64.1]	9	75	[46.8, 91.1]	χ^2 (3) = 2.3 *N*
Injury	95	37.1	[31.4, 43.2]	2	16.7	[4.7, 44.8]	= 268
Surgical	11	4.3	[2.4, 7.5]	1	8.3	[1.5, 35.4]	*p* = .506
Psychiatric	1	0.4	[0.1, 2.2]	0	0	[0, 24.3]	
Self-referral	176	63.1	[57.3, 68.5]	11	78.6	[52.4, 92.4]	.239
Reason:							
None	63	35.2	[28.6, 42.4]	7	63.6	[35.4, 84.8]	χ^2 (5) = 4
Out of hours	49	27.4	[21.4, 34.3]	2	18.2	[5.1, 47.7]	*N* = 190
Injury	30	16.8	[12, 22.9]	1	9.1	[1.6, 37.7]	*p* = .552
GP scheduling difficulty	14	7.8	[4.7, 12.7]	0	0	[0, 25.9]	
No GP	1	0.6	[0.1, 3.1]	0	0	[0, 25.9]	
Emergency perceived	22	12.3	[8.3, 17.9]	1	9.1	[1.6, 37.7]	
6 month attendances							
GP Mdn (IQR)	1	(0-2)		2	(1-4)		.03
ED Mdn (IQR)	0	(0-1)		0	(0-3)		.33
Vaccination							
Complete / NA [a]	255	92.4	[88.7, 95]	10	71.4	[45.4, 88.3]	.024
Reason vaccination incomplete:							
Illness delay	2	12.5	[3.5, 36]	0	0	[0, 56.2]	χ^2 (3) = 1.6
GP scheduling	5	31.3	[14.2, 55.6]	2	66.7	[20.8, 93.9]	*N* = 19
Parental choice	8	50	[28, 72]	1	33	[6.2, 79.2]	*p* = .67
Other	1	6.3	[1.1, 28.3]	0	0	[0, 56.2]	
Housing impacts							
GP access	4	1.5	[0.6, 3.7]	3	23.1	[8.2, 50.3]	.002
Vaccines	2	0.7	[0.2, 2.6]	1	8.3	[1.5, 35.4]	.121

Notes. Mdn = median. *IQR* = interquartile range.

[a] Vaccination NA = child too young (<8 weeks) for vaccination

Median duration of homelessness was 13 months (interquartile range *[IQR]* = 3.8-27). Homeless accommodation comprised emergency accommodation (85.7%), Direct Provision (7.1%), and family (7.1%). Non-homeless accommodation comprised homeowner (50%), renting (29.9%), family (10.7%), social housing (8.7%), and mobile home (0.7%) (Table 3).

Table 3: *Housing Situation*

	Non-homeless			**Homeless**			
	n = 298 (95.5%)			*n* = 14 (4.5%)			
Variable	*n*	%	95% CI	*n*	%	95% CI	*p* value
Accommodation							
Home owner	149	50	[44.4, 55.6]	0	0	[0, 21.5]	χ^2 (6) = 289
Renting	89	29.9	[25, 35.3]	0	0	[0, 21.5]	*N* = 312
Social housing	26	8.7	[6, 12.5]	0	0	[0, 21.5]	*p* <.001
Mobile home	2	0.7	[0.2, 2.4]	0	0	[0, 21.5]	
Care of relative	32	10.7	[7.7, 14.8]	1	7.1	[1.3, 31.5]	
Direct provision	0	0	[0, 1.3]	1	7.1	[1.3, 31.5]	
Emergency homeless	0	0	[0, 1.3]	12	85.7	[60.1, 96]	
Feels unsafe at home	10	3.4	[1.8, 6.1]	5	35.7	[16.3, 61.2]	<.001
People: bedroom *(IQR)*	1.3	(1-1.7)		3	(1.6-3)		<.001
Concern losing home	23	8.3	[5.6, 12.1]	6	46.2	[23.2, 70.9]	.001
Facilities							
Cooking	284	98.6	[96.5, 99.5]	12	85.7	[60.1, 96]	.027
Indoor play	270	94.4	[91.1, 96.5]	5	35.7	[16.3, 61.2]	<.001
Outdoor play	244	90	[85.9, 93.1]	6	42.9	[21.4, 67.4]	<.001
No safety equipment	74	26.6	[21.8, 32.1]	6	46.2	[23.2, 70.9]	.2
Reason:							
No permission	16	24.6	[15.8, 36.3]	4	80	[37.6, 96.4]	χ^2 (4) = 7.3
Not needed for age	23	35.4	[24.9, 47.5]	1	20	[3.6, 62.5]	*N* = 70
Parental choice	15	23.1	[14.5, 34.6]	0	0	[0, 43.5]	*p* = .121
Cost	8	12.3	[6.4, 22.5]	0	0	[0, 43.5]	
Other	3	4.6	[1.6, 12.7]	0	0	[0, 43.5]	
Housing negatively impacts							
Healthcare access	25	9.3	[6.4, 13.4]	3	25	[8.9, 53.2]	.106
Play	47	17.5	[13.4, 22.5]	9	64.3	[38.8, 83.7]	<.001
Social development	38	14.1	[10.4, 18.7]	10	71.4	[45.4, 88.3]	<.001
Education	29	10.7	[7.6, 15]	7	58.3	[32, 80.7]	<.001
Physical health	31	11.7	[8.3, 16.1]	5	45.5	[21.3, 72]	.007
Mental health	34	12.6	[9.2, 17.1]	8	61.5	[35.5, 82.3]	<.001

Notes. IQR = interquartile range

Compared to the non-homeless, homeless parents were more likely to feel unsafe at home (35.7% vs. 3.4%, $p < .001$), and have concerns regarding losing their home (46.2% vs. 8.3%, $p = .001$). They were also less likely to have safe indoor (35.7% vs. 94.4%, $p < .001$) and outdoor (42.9% vs. 90%, $p < .001$) play facilities. There were no differences regarding home safety equipment, with 28.6% of all parents reporting no landlord permission to fit this (Tables 3-4).

"No cooker to prepare meals in rented house. No permission for safety equipment. Feels unsafe as being evicted due to house being sold." ***Non-homeless, renting***

"Bought house 13 years ago, made redundant, couldn't make payments, banks are seeking repossession. Not ideal." ***Non-homeless, home owner***

"It is a private rental, I once shared with friends and baby's father however we are no longer together and friendship with the friends have soured. I can no longer afford the rent." ***Non-homeless, renting***

There was no significant difference regarding the subjective impact of housing on healthcare access between homeless and non-homeless parents (25% vs. 9.3%, $p = .106$). However, compared to non-homeless, homeless parents felt their housing situation impacted their child's ability to play (64.3% vs. 17.5%, $p < .001$), social development 71.4% vs. 14.1%, $p < .001$), education (58.3% vs. 10.7%, $p < .001$), physical health (45.5% vs. 11.7%, $p = .007$) and mental health (61.5% vs. 12.6%, $p < .001$) (Table 3). Additional comments provide insight into suboptimal living conditions by both homeless parents (Table 4) and non-homeless parents (interspersed within free text). Many issues were raised, with common themes including safety, play, space, and stability.

"No permission for safety equipment as renting. Live in second floor balcony, no gates, no bars etc." ***Non-homeless, renting***

"Living situation horrible. Nowhere for them to play and some neighbours have drug and alcohol problems." ***Non-homeless, social housing***

From 2009 - 2019, attendances in this ED increased by 12.2%. There were no differences between homeless and non-homeless children regarding age, previous medical history, ED attendances, self-referrals and presenting complaint. Self-referrals accounted for 63.8% of presentations. Self-referral reasons included out of hours (26.8%), injury needing urgent treatment (16.3%), perceived emergency (12.1%), GP scheduling difficulty (7.4%), and no GP (0.5%). 36.8% had no particular reason for self-referring (Tables 1-3).

Table 4: *Comments by Homeless Parents*

Accommodation	Comments
Emergency homeless accommodation	Room is tiny, very dusty, not being told important information. Living in a small hotel room with a 9 year old boy and a 1 year old baby. Very hard to cook, wash clothes, play and get to school on time. Presented as put cockroach trap he found under bed into mouth. Mother unaware traps had been placed in hotel room.
	No outdoor or playing space. Hotel room, 3 people, king size bed & single bed. Only cooking facilities are 3 microwaves for 56 families.
	Feels unsafe in home as drug addicts in accommodation. Difficulty accessing GP as accommodation in city centre and GP on northside. Feels homelessness has effect on mental health.
	I would appreciate it if I had a bigger place for me and my kids because my son is almost 18 years old, and we have to share a one room apartment. He also has 2 sisters and it's so difficult!
	Feels unsafe as people smoke weed often. No permission to fit safety equipment. No place for baby even to move.
	It's very hard to stay in homeless accommodation with 5 children. I am waiting 2 years for house or anything and there are no supports. (1 parent, 5 children, 2 bedrooms)
	Difficulty keeping regular GP as I was homeless and moved around a lot. Housing situation affected vaccinations as I was 2 weeks late as my child had to stay with family.
	Difficulty keeping GP as living in city centre and GP on northside.
	Feels unsafe as very unstable
Direct provision	We live in direct provision centre in one room so no more facilities available there so its hard to raise child there. Difficulty accessing GP because we live in direct provision.
Care of relative	We are on a housing list for 11 years and have never been offered a place to live.

Discussion

We found significant differences between homeless and non-homeless parents regarding their perceptions of the impact housing has on child health. Homeless parents were more likely to feel unsafe at home than non-homeless, and to be concerned regarding losing their home. They were also more likely to report over-crowding, and less likely to have cooking or safe play facilities. Although homeless parents felt their housing situation impacted their child's ability to play, social development, education, and health, they did not feel their housing situation impacted their child's healthcare access. This is encouraging as Irish primary healthcare is not universally free. Multiple barriers prevent deprived groups accessing the healthcare to which they are entitled, many related to healthcare literacy [19].

Many of our findings have been replicated in previous UK [15, 20] and Irish [13] studies. Consistent with national and European data, we report over-representation of Irish Traveller, black and non-Irish ethnicities in homelessness (Table 1) [13, 21, 22].

Self-referral rate was high (63.8%), and comparable with UK data (52%-78%) [3, 4, 6]. We did not discern differences regarding self-referrals between homeless and non-homeless children, contrasting with Irish lone adult homelessness [23]. From 2009 – 2019 our ED attendances increased by 12.2%, lower than the reported UK increase of 4% per annum [3, 6]. This emphasises the need to optimise primary healthcare access to reduce inappropriate ED attendances.

Many non-homeless parents reported difficult living circumstances, including issues regarding space, antisocial activities, safety equipment, and play facilities. Using the European Typology of Homelessness and Housing Exclusion it is likely that some non-homeless families would have been considered homeless, especially those in the care of a relative (11%) and in mobile homes (0.7%) [24]. Alarmingly, almost 10% of non-homeless families had concerns regarding losing their home, with some having already been served eviction notices. This reflects the current housing crisis and its impact on young families [14, 25].

The study findings are limited by low numbers of homeless parent responses. This may have affected our ability to differentiate between homeless and non-homeless children. However, the proportion of homeless parents completing the questionnaire (4.5%) exceeds the proportion of annual homeless attendances (1.6%). Furthermore, the data appear to align with current literature [13-15].

This was a self-completed questionnaire, which is prone to bias. Missing data were common; there was no pattern regarding unanswered questions. The study was conducted in a busy ED. No staff were available to assist or remind the parents to complete it, which may have resulted in under-representation of those with lower literacy levels. The method of questionnaire distribution in triage does not allow a response rate calculation as the total number of questionnaires distributed is unclear.

This study shows that homeless children tend to have reduced primary healthcare access, with their housing situation affecting most aspects of their lives. Non-homeless families also reported many adverse effects of their housing situation. As our ED serves a deprived area of inner city Dublin, the standard of housing may differ little between homeless and non-homeless groups. The Faculties of Public Health Medicine and Paediatrics at the Royal College of Physicians of Ireland have expressed concern at the impacts of inadequate housing on children's health, including Direct Provision [17, 25].

Legislation should be introduced to assist families to make safety modifications to rented properties. Efforts should be made to increase uptake of primary care, rather than emergency services. Healthcare systems need to address increased ED attendances, self-referrals, and emergency admissions by optimising primary healthcare access.

Homeless parents report their housing situation impacts almost all aspects of their child's life. Many non-homeless parents are also living in difficult social circumstances with housing instability. The long-lasting impact of adverse childhood experiences have been well documented [5, 15, 16]. Further efforts need to be made to tackle childhood poverty to mitigate these effects.

Declaration of Conflicts of Interest:
The authors have no conflicts of interest to declare.

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References:

1. Ellbrant JA, Åkeson SJ, Karlsland Åkeson PM. Influence of awareness and availability of medical alternatives on parents seeking paediatric emergency care. Scand J Public Health. 2018;46(4):456-62.
2. Giebel C, McIntyre JC, Daras K, Gabbay M, Downing J, Pirmohamed M, et al. What are the social predictors of accident and emergency attendance in disadvantaged neighbourhoods? Results from a cross-sectional household health survey in the north west of England. BMJ Open. 2019;9(1):e022820.
3. Keeble E, Kassarova L. Focus on: Emergency hospital care for children and young people. What has changed in the past 10 years? ; 2017.
4. Hendry SJ, Beattie TF, Heaney D. Minor illness and injury: factors influencing attendance at a paediatric accident and emergency department. Arch Dis Child. 2005;90(6):629-33.
5. Kassarova L, Cheung R, Hargreaves D, Keeble E. Admissions of inequality: emergency hospital use for children and young people. 2017.
6. Sands R, Shanmugavadivel D, Stephenson T, Wood D. Medical problems presenting to paediatric emergency departments: 10 years on. Emerg Med J. 2012;29(5):379-82.
7. Rudge GM, Mohammed MA, Fillingham SC, Girling A, Sidhu K, Stevens AJ. The combined influence of distance and neighbourhood deprivation on Emergency Department attendance in a large English population: a retrospective database study. PLoS One. 2013;8(7):e67943.
8. Cournane S, Byrne D, Conway R, O'Riordan D, Coveney S, Silke B. Social deprivation and hospital admission rates, length of stay and readmissions in emergency medical admissions. Eur J Intern Med. 2015;26(10):766-71.
9. Conway R, Byrne D, O'Riordan D, Cournane S, Coveney S, Silke B. Influence of social deprivation, overcrowding and family structure on emergency medical admission rates. Qjm. 2016;109(10):675-80.
10. Cheung CR, Smith H, Thurland K, Duncan H, Semple MG. Population variation in admission rates and duration of inpatient stay for bronchiolitis in England. Arch Dis Child. 2013;98(1):57-9.
11. Lind J, Schollin Ask L, Juarez S, Hjern A. Hospital care for viral gastroenteritis in socio-economic and geographical context in Sweden 2006-2013. Acta Paediatr. 2018;107(11):2011-8.
12. Central Statistics Office. Survey on Income and Living Conditions (SILC) 2020 [28/03/2022]. Available from: https://www.cso.ie/en/releasesandpublications/ep/p-silc/surveyonincomeandlivingconditionssilc2020/povertyanddeprivation/.

13. O' Brien N, Quinn N, Joyce B, Bedford H, Crushell E. Emergency department utilisation by homeless children in Dublin, Ireland: a retrospective review. BMJ Paediatrics Open. 2022;6(1):e001368.
14. Lambert S, O'Callaghan D, Jump O. Young Families in the Homeless Crisis: Challenges and Solutions. Focus Ireland; 2018.
15. Harker L. Chance of a lifetime: The impact of bad housing on children's lives. 2006.
16. Public Health Wales. Responding to Adverse Childhood Experiences. 2019.
17. O' Brien N, Crushell E, Faculty of Paediatrics of RCPI. Children in direct provision: Royal College of Physicians of Ireland; 2019 [28/01/2022]. Available from: https://www.rcpi.ie/news/publication/children-in-direct-provision-a-position-paper-by-the-faculty-of-paediatrics/.
18. Hayes A-M, Joyce B, McNamara R, Okafor I. P264 Impact of homelessness on children presenting to a tertiary emergency department 2019 [08/02/2022]. A262-A3]. Available from: https://adc.bmj.com/content/archdischild/104/Suppl_3/A262.3.full.pdf.
19. O'Reilly F, Barror S, Hannigan A, Scriver S, Ruane L, MacFarlane A, et al. Homelessness: An Unhealthy State. Health status, risk behaviours and service utilisation among homeless people in two Irish cities. Dublin: Partnership for Health Equity; 2015.
20. Children's Commissioner. Bleak Houses: Tackling the crisis of family homelessness in England 2019 [06/03/2022]. Available from: https://www.childrenscommissioner.gov.uk/wp-content/uploads/2019/08/cco-bleak-houses-report-august-2019.pdf.
21. Pavee Point: Traveller and Roma Centre. Racial Discrimination against Irish travellers and Roma. Alternative Report: A Response to Ireland's Combined Fifth to Ninth Periodic Reports to the UN Committee on the Elimination of All Forms of Racial Discrimination. 2019.
22. European Observatory on Homelessness. Family Homelessness in Europe: EOH Comparative Studies on Homelessness. 2017.
23. Ní Cheallaigh C, Cullivan S, Sears J, Lawlee AM, Browne J, Kieran J, et al. Usage of unscheduled hospital care by homeless individuals in Dublin, Ireland: a cross-sectional study. BMJ Open. 2017;7(11):e016420.
24. Fédération Européenne d'Associations Nationales Travaillant avec les Sans-Abri (FEANTSA). ETHOS Typology on Homelessness and Housing Exclusion 2005 [24/11/2021]. Available from: https://www.feantsa.org/en/toolkit/2005/04/01/ethos-typology-on-homelessness-and-housing-exclusion.
25. Heslin J, Faculty of Public Health of RCPI, Faculty of Paediatrics of RCPI. The Impact of Homelessness and Inadequate Housing on Children's Health: Royal College of Physicians of Ireland; 2019 [28/01/2022]. Available from: https://www.rcpi.ie/news/publication/the-impact-of-homelessness-and-inadequate-housing-on-childrens-health/.